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114TH CONGRESS
2d Session

HOUSE OF REPRESENTATIVES

REPT. 114–604
Part 1

HELPING HOSPITALS IMPROVE PATIENT CARE ACT OF 2016

R E P O R T

OF THE

COMMITTEE ON WAYS AND MEANS

JUNE 7, 2016.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

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114TH CONGRESS 2d Session } HOUSE OF REPRESENTATIVES { REPT. 114–604 Part 1

HELPING HOSPITALS IMPROVE PATIENT CARE ACT OF 2016

JUNE 7, 2016.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. BRADY of Texas, from the Committee on Ways and Means, submitted the following

R E P O R T

[To accompany H.R. 5273]

[Including cost estimate of the Congressional Budget Office]

The Committee on Ways and Means, to whom was referred the bill (H.R. 5273) to amend title XVIII of the Social Security Act to provide for regulatory relief under the Medicare program for certain providers of services and suppliers and increased transparency in hospital coding and enrollment data, and for other purposes, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

The amendment is as follows:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Helping Hospitals Improve Patient Care Act of 2016".

(b) TABLE OF CONTENTS.—The table of contents for this Act is as follows:

Sec. 1. Short title; table of contents.

TITLE I—PROVISIONS RELATING TO MEDICARE PART A

Sec. 101. Development of Medicare study for HCPCS version of MS–DRG codes for similar hospital services.
Sec. 102. Establishing beneficiary equity in the Medicare hospital readmission program.
Sec. 103. Five-year extension of the rural community hospital demonstration program.
Sec. 104. Regulatory relief for LTCHs.
Sec. 105. Savings from IPPS MACRA pay-for through not applying documentation and coding adjustments.

TITLE II—PROVISIONS RELATING TO MEDICARE PART B

Sec. 201. Continuing Medicare payment under HOPD prospective payment system for services furnished by mid-build off-campus outpatient departments of providers.
Sec. 202. Treatment of cancer hospitals in off-campus outpatient department of a provider policy.
Sec. 203. Treatment of eligible professionals in ambulatory surgical centers for meaningful use and MIPS.

TITLE III—OTHER MEDICARE PROVISIONS

Sec. 301. Delay in authority to terminate contracts for Medicare Advantage plans failing to achieve minimum quality ratings.

Sec. 302. Requirement for enrollment data reporting for Medicare.
Sec. 303. Updating the Welcome to Medicare package.

TITLE I—PROVISIONS RELATING TO MEDICARE PART A

SEC. 101. DEVELOPMENT OF MEDICARE STUDY FOR HCPCS VERSION OF MS–DRG CODES FOR SIMILAR HOSPITAL SERVICES.

Section 1886 of the Social Security Act (42 U.S.C. 1395ww) is amended by adding at the end the following new subsection:

"(t) RELATING SIMILAR INPATIENT AND OUTPATIENT HOSPITAL SERVICES.—

"(1) DEVELOPMENT OF HCPCS VERSION OF MS–DRG CODES.—

"(A) IN GENERAL.—Not later than January 1, 2018, the Secretary shall develop HCPCS versions for MS–DRGs that is similar to the ICD–10–PCS for such MS–DRGs such that, to the extent possible, the MS–DRG assignment shall be similar for a claim coded with the HCPCS version as an identical claim coded with a ICD–10–PCS code.

"(B) COVERAGE OF SURGICAL MS–DRGS.—In carrying out subparagraph (A), the Secretary shall develop HCPCS versions of MS–DRG codes for not fewer than 10 surgical MS–DRGs.

"(C) PUBLICATION AND DISSEMINATION OF THE HCPCS VERSIONS OF MS–DRGS.—

"(i) IN GENERAL.—The Secretary shall develop a HCPCS MS–DRG definitions manual and software that is similar to the definitions manual and software for ICD–10–PCS codes for such MS–DRGs. The Secretary shall post the HCPCS MS–DRG definitions manual and software on the Internet website of the Centers for Medicare & Medicaid Services. The HCPCS MS–DRG definitions manual and software shall be in the public domain and available for use and redistribution without charge.

"(ii) USE OF PREVIOUS ANALYSIS DONE BY MEDPAC.—In developing the HCPCS MS–DRG definitions manual and software under clause (i), the Secretary shall consult with the Medicare Payment Advisory Commission and shall consider the analysis done by such Commission in translating outpatient surgical claims into inpatient surgical MS–DRGs in preparing chapter 7 (relating to hospital short-stay policy issues) of its 'Medicare and the Health Care Delivery System' report submitted to Congress in June 2015.

"(D) DEFINITION AND REFERENCE.—In this paragraph:

"(i) HCPCS.—The term 'HCPCS' means, with respect to hospital items and services, the code under the Healthcare Common Procedure Coding System (HCPCS) (or a successor code) for such items and services.

"(ii) ICD–10–PCS.—The term 'ICD–10–PCS' means the International Classification of Diseases, 10th Revision, Procedure Coding System, and includes a subsequent revision of such International Classification of Diseases, Procedure Coding System.".

SEC. 102. ESTABLISHING BENEFICIARY EQUITY IN THE MEDICARE HOSPITAL READMISSION PROGRAM.

(a) TRANSITIONAL ADJUSTMENT FOR DUAL ELIGIBLE POPULATION.—Section 1886(q)(3) of the Social Security Act (42 U.S.C. 1395ww(q)(3)) is amended—

(1) in subparagraph (A), by inserting "subject to subparagraph (D)," after "purposes of paragraph (1),"; and

(2) by adding at the end the following new subparagraph:

"(D) TRANSITIONAL ADJUSTMENT FOR DUAL ELIGIBLES.—

"(i) IN GENERAL.—In determining a hospital's adjustment factor under this paragraph for purposes of making payments for discharges occurring during and after fiscal year 2019, and before the application of clause (i) of subparagraph (E), the Secretary shall assign hospitals to groups (as defined by the Secretary under clause (ii)) and apply the applicable provisions of this subsection using a methodology in a manner that allows for separate comparison of hospitals within each such group, as determined by the Secretary.

"(ii) DEFINING GROUPS.—For purposes of this subparagraph, the Secretary shall define groups of hospitals based on their overall proportion, of the inpatients who are entitled to, or enrolled for, benefits under part A, who are full-benefit dual eligible individuals (as defined in sec-

tion 1935(c)(6)). In defining groups, the Secretary shall consult the Medicare Payment Advisory Commission and may consider the analysis done by such Commission in preparing the portion of its report submitted to Congress in June 2013 relating to readmissions.

"(iii) MINIMIZING REPORTING BURDEN ON HOSPITALS.—In carrying out this subparagraph, the Secretary shall not impose any additional reporting requirements on hospitals.

"(iv) BUDGET NEUTRAL DESIGN METHODOLOGY.—The Secretary shall design the methodology to implement this subparagraph so that the estimated total amount of reductions in payments under this subsection equals the estimated total amount of reductions in payments that would otherwise occur under this subsection if this subparagraph did not apply.".

(b) SUBSEQUENT ADJUSTMENTS BASED ON IMPACT REPORTS.—Section 1886(q)(3) of the Social Security Act (42 U.S.C. 1395ww(q)(3)), as amended by subsection (a), is further amended by adding at the end the following new subparagraph:

"(E) CHANGES IN RISK ADJUSTMENT.—

"(i) CONSIDERATION OF RECOMMENDATIONS IN IMPACT REPORTS.—The Secretary may take into account the studies conducted and the recommendations made by the Secretary under section 2(d)(1) of the IMPACT Act of 2014 (Public Law 113–185; 42 U.S.C. 1395lll note) with respect to the application under this subsection of risk adjustment methodologies. Nothing in this clause shall be construed as precluding consideration of the use of groupings of hospitals.".

(c) MEDPAC STUDY ON READMISSIONS PROGRAM.—The Medicare Payment Advisory Commission shall conduct a study to review overall hospital readmissions described in section 1886(q)(5)(E) of the Social Security Act (42 U.S.C. 1395ww(q)(5)(E)) and whether such readmissions are related to any changes in outpatient and emergency services furnished. The Commission shall submit to Congress a report on such study in its report to Congress in June 2017.

(d) ADDRESSING ISSUE OF CERTAIN PATIENTS.—Subparagraph (E) of section 1886(q)(3) of the Social Security Act (42 U.S.C. 1395ww(q)(3)), as added by subsection (b), is further amended by adding at the end the following new clause:

"(ii) CONSIDERATION OF EXCLUSION OF PATIENT CASES BASED ON V OR OTHER APPROPRIATE CODES.—In promulgating regulations to carry out this subsection with respect to discharges occurring after fiscal year 2018, the Secretary may consider the use of V or other ICD-related codes for removal of a readmission. The Secretary may consider modifying measures under this subsection to incorporate V or other ICD-related codes at the same time as other changes are being made under this subparagraph.".

(e) REMOVAL OF CERTAIN READMISSIONS.—Subparagraph (E) of section 1886(q)(3) of the Social Security Act (42 U.S.C. 1395ww(q)(3)), as added by subsection (b) and amended by subsection (d), is further amended by adding at the end the following new clause:

"(iii) REMOVAL OF CERTAIN READMISSIONS.—In promulgating regulations to carry out this subsection, with respect to discharges occurring after fiscal year 2018, the Secretary may consider removal as a readmission of an admission that is classified within one or more of the following: transplants, end-stage renal disease, burns, trauma, psychosis, or substance abuse. The Secretary may consider modifying measures under this subsection to remove readmissions at the same time as other changes are being made under this subparagraph.".

SEC. 103. FIVE-YEAR EXTENSION OF THE RURAL COMMUNITY HOSPITAL DEMONSTRATION PROGRAM.

(a) EXTENSION.—Section 410A of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 42 U.S.C. 1395ww note), as amended by sections 3123 and 10313 of the Patient Protection and Affordable Care Act (Public Law 111–148), is amended—

(1) in subsection (a)(5), by striking "5-year extension period" and inserting "10-year extension period"; and

(2) in subsection (g)—

(A) in the subsection heading, by striking "FIVE-YEAR" and inserting "TEN-YEAR";

(B) in paragraph (1), by striking "additional 5-year" and inserting "additional 10-year";

(C) by striking "5-year extension period" and inserting "10-year extension period" each place it appears;

(D) in paragraph (4)(B)—

(i) in the matter preceding clause (i), by inserting "each 5-year period in" after "hospital during"; and

(ii) in clause (i), by inserting "each applicable 5-year period in" after "the first day of"; and

(E) by adding at the end the following new paragraphs:

"(5) OTHER HOSPITALS IN DEMONSTRATION PROGRAM.—During the second 5 years of the 10-year extension period, the Secretary shall apply the provisions of paragraph (4) to rural community hospitals that are not described in paragraph (4) but are participating in the demonstration program under this section as of December 30, 2014, in a similar manner as such provisions apply to rural community hospitals described in paragraph (4).

"(6) EXPANSION OF DEMONSTRATION PROGRAM TO RURAL AREAS IN ANY STATE.—

"(A) IN GENERAL.—The Secretary shall, notwithstanding subsection (a)(2) or paragraph (2) of this subsection, not later than 120 days after the date of the enactment of this paragraph, issue a solicitation for applications to select up to the maximum number of additional rural community hospitals located in any State to participate in the demonstration program under this section for the second 5 years of the 10-year extension period without exceeding the limitation under paragraph (3) of this subsection.

"(B) PRIORITY.—In determining which rural community hospitals that submitted an application pursuant to the solicitation under subparagraph (A) to select for participation in the demonstration program, the Secretary—

"(i) shall give priority to rural community hospitals located in one of the 20 States with the lowest population densities (as determined by the Secretary using the 2015 Statistical Abstract of the United States); and

"(ii) may consider—

"(I) closures of hospitals located in rural areas in the State in which the rural community hospital is located during the 5-year period immediately preceding the date of the enactment of this paragraph; and

"(II) the population density of the State in which the rural community hospital is located.".

(b) CHANGE IN TIMING FOR REPORT.—Subsection (e) of such section 410A is amended—

(1) by striking "Not later than 6 months after the completion of the demonstration program under this section" and inserting "Not later than August 1, 2018"; and

(2) by striking "such program" and inserting "the demonstration program under this section".

SEC. 104. REGULATORY RELIEF FOR LTCHS.

(a) TECHNICAL CHANGE TO THE MEDICARE LONG-TERM CARE HOSPITAL MORATORIUM EXCEPTION.—

(1) IN GENERAL.—Section 114(d)(7) of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (42 U.S.C. 1395ww note), as amended by sections 3106(b) and 10312(b) of Public Law 111–148, section 1206(b)(2) of the Pathway for SGR Reform Act of 2013 (division B of Public Law 113–67), and section 112 of the Protecting Access to Medicare Act of 2014, is amended by striking "The moratorium under paragraph (1)(A)" and inserting "Any moratorium under paragraph (1)".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect as if included in the enactment of section 112 of the Protecting Access to Medicare Act of 2014.

(b) MODIFICATION TO MEDICARE LONG-TERM CARE HOSPITAL HIGH COST OUTLIER PAYMENTS.—Section 1886(m) of the Social Security Act (42 U.S.C. 1395ww(m)) is amended by adding at the end the following new paragraph:

"(7) TREATMENT OF HIGH COST OUTLIER PAYMENTS.—

"(A) ADJUSTMENT TO THE STANDARD FEDERAL PAYMENT RATE FOR ESTIMATED HIGH COST OUTLIER PAYMENTS.—Under the system described in paragraph (1), for fiscal years beginning on or after October 1, 2017, the Secretary shall reduce the standard Federal payment rate as if the estimated aggregate amount of high cost outlier payments for standard Federal payment rate discharges for each such fiscal year would be equal to 8 percent of estimated aggregate payments for standard Federal payment rate discharges for each such fiscal year.

"(B) LIMITATION ON HIGH COST OUTLIER PAYMENT AMOUNTS.—Notwithstanding subparagraph (A), the Secretary shall set the fixed loss amount

for high cost outlier payments such that the estimated aggregate amount of high cost outlier payments made for standard Federal payment rate discharges for fiscal years beginning on or after October 1, 2017, shall be equal to 99.6875 percent of 8 percent of estimated aggregate payments for standard Federal payment rate discharges for each such fiscal year.

"(C) WAIVER OF BUDGET NEUTRALITY.—Any reduction in payments resulting from the application of subparagraph (B) shall not be taken into account in applying any budget neutrality provision under such system.

"(D) NO EFFECT ON SITE NEUTRAL HIGH COST OUTLIER PAYMENT RATE.—This paragraph shall not apply with respect to the computation of the applicable site neutral payment rate under paragraph (6).".

SEC. 105. SAVINGS FROM IPPS MACRA PAY-FOR THROUGH NOT APPLYING DOCUMENTATION AND CODING ADJUSTMENTS.

Section 7(b)(1)(B)(iii) of the TMA, Abstinence Education, and QI Programs Extension Act of 2007 (Public Law 110–90), as amended by section 631(b) of the American Taxpayer Relief Act of 2012 (Public Law 122–240) and section 414(1)(B)(iii) of the Medicare Access and CHIP Reauthorization Act of 2015 (Public Law 114–10), is amended by striking "an increase of 0.5 percentage points for discharges occurring during each of fiscal years 2018 through 2023" and inserting "an increase of 0.4590 percentage points for discharges occurring during fiscal year 2018 and 0.5 percentage points for discharges occurring during each of fiscal years 2019 through 2023".

TITLE II—PROVISIONS RELATING TO MEDICARE PART B

SEC. 201. CONTINUING MEDICARE PAYMENT UNDER HOPD PROSPECTIVE PAYMENT SYSTEM FOR SERVICES FURNISHED BY MID-BUILD OFF-CAMPUS OUTPATIENT DEPARTMENTS OF PROVIDERS.

(a) IN GENERAL.—Section 1833(t)(21) of the Social Security Act (42 U.S.C. 1395l(t)(21)) is amended—

(1) in subparagraph (B)—

(A) in clause (i), by striking "clause (ii)" and inserting "the subsequent provisions of this subparagraph"; and

(B) by adding at the end the following new clauses:

"(iii) DEEMED TREATMENT FOR 2017.—For purposes of applying clause (ii) with respect to applicable items and services furnished during 2017, a department of a provider (as so defined) not described in such clause is deemed to be billing under this subsection with respect to covered OPD services furnished prior to November 2, 2015, if the Secretary received from the provider prior to December 2, 2015, an attestation (pursuant to section 413.65(b)(3) of title 42 of the Code of Federal Regulations) that such department was a department of a provider (as so defined).

"(iv) ALTERNATIVE EXCEPTION BEGINNING WITH 2018.—For purposes of paragraph (1)(B)(v) and this paragraph with respect to applicable items and services furnished during 2018 or a subsequent year, the term 'off-campus outpatient department of a provider' also shall not include a department of a provider (as so defined) that is not described in clause (ii) if—

"(I) the Secretary receives from the provider an attestation (pursuant to such section 413.65(b)(3)) not later than December 31, 2016 (or, if later, 60 days after the date of the enactment of this clause), that such department met the requirements of a department of a provider specified in section 413.65 of title 42 of the Code of Federal Regulations;

"(II) the provider includes such department as part of the provider on its enrollment form in accordance with the enrollment process under section 1866(j); and

"(III) the department met the mid-build requirement of clause (v) and the Secretary receives, not later than 60 days after the date of the enactment of this clause, from the chief executive officer or chief operating officer of the provider a written certification that the department met such requirement.

"(v) MID-BUILD REQUIREMENT DESCRIBED.—The mid-build requirement of this clause is, with respect to a department of a provider, that before November 2, 2015, the provider had a binding written agree-

ment with an outside unrelated party for the actual construction of such department.

"(vii) AUDIT.—Not later than December 31, 2018, the Secretary shall audit the compliance with requirements of clause (iv) with respect to each department of a provider to which such clause applies. If the Secretary finds as a result of an audit under this clause that the applicable requirements were not met with respect to such department, the department shall not be excluded from the term 'off-campus outpatient department of a provider' under such clause.

"(viii) IMPLEMENTATION.—For purposes of implementing clauses (iii) through (vii):

"(I) Notwithstanding any other provision of law, the Secretary may implement such clauses by program instruction or otherwise.

"(II) Subchapter I of chapter 35 of title 44, United States Code, shall not apply.

"(III) For purposes of carrying out this subparagraph with respect to clauses (iii) and (iv) (and clause (vii) insofar as it relates to clause (iv)), the Secretary shall provide for the transfer from the Supplementary Medical Insurance Trust Fund under section 1841, of $10,000,000 to the Centers for Medicare & Medicaid Services Program Management Account to remain available until December 31, 2018."; and

(2) in subparagraph (E), by adding at the end the following new clause:

"(iv) The determination of an audit under subparagraph (B)(vii).".

(b) EFFECTIVE DATE.—The amendments made by this section shall be effective as if included in the enactment of section 603 of the Bipartisan Budget Act of 2015 (Public Law 114–74).

SEC. 202. TREATMENT OF CANCER HOSPITALS IN OFF-CAMPUS OUTPATIENT DEPARTMENT OF A PROVIDER POLICY.

(a) IN GENERAL.—Section 1833(t)(21)(B) of the Social Security Act (42 U.S.C. 1395l(t)(21)(B)), as amended by section 201(a), is amended—

(1) by inserting after clause (v) the following new clause:

"(vi) EXCLUSION FOR CERTAIN CANCER HOSPITALS.—For purposes of paragraph (1)(B)(v) and this paragraph with respect to applicable items and services furnished during 2017 or a subsequent year, the term 'off-campus outpatient department of a provider' also shall not include a department of a provider (as so defined) that is not described in clause (ii) if the provider is a hospital described in section 1886(d)(1)(B)(v) and—

"(I) in the case of a department that met the requirements of section 413.65 of title 42 of the Code of Federal Regulations after November 1, 2015, and before the date of the enactment of this clause, the Secretary receives from the provider an attestation that such department met such requirements not later than 60 days after such date of enactment; or

"(II) in the case of a department that meets such requirements after such date of enactment, the Secretary receives from the provider an attestation that such department meets such requirements not later than 60 days after the date such requirements are first met with respect to such department.";

(2) in clause (vii), by inserting after the first sentence the following: "Not later than 2 years after the date the Secretary receives an attestation under clause (vi) relating to compliance of a department of a provider with requirements referred to in such clause, the Secretary shall audit the compliance with such requirements with respect to the department."; and

(3) in clause (viii)(III), by adding at the end the following: "For purposes of carrying out this subparagraph with respect to clause (vi) (and clause (vii) insofar as it relates to such clause), the Secretary shall provide for the transfer from the Supplementary Medical Insurance Trust Fund under section 1841, of $2,000,000 to the Centers for Medicare & Medicaid Services Program Management Account to remain available until expended."".

(b) OFFSETTING SAVINGS.—Section 1833(t)(18) of the Social Security Act (42 U.S.C. 1395l(t)(18)) is amended—

(1) in subparagraph (B), by inserting ", subject to subparagraph (C)," after "shall"; and

(2) by adding at the end the following new subparagraph:

"(C) TARGET PCR ADJUSTMENT.—In applying section 419.43(i) of title 42 of the Code of Federal Regulations to implement the appropriate adjustment under this paragraph for services furnished on or after January 1,

2018, the Secretary shall use a target PCR that is 1.0 percentage points less than the target PCR that would otherwise apply. In addition to the percentage point reduction under the previous sentence, the Secretary may consider making an additional percentage point reduction to such target PCR that takes into account payment rates for applicable items and services described in paragraph (21)(C) other than for services furnished by hospitals described in section 1886(d)(1)(B)(v). In making any budget neutrality adjustments under this subsection for 2018 or a subsequent year, the Secretary shall not take into account the reduced expenditures that result from the application of this subparagraph.".

(c) EFFECTIVE DATE.—The amendments made by this section shall be effective as if included in the enactment of section 603 of the Bipartisan Budget Act of 2015 (Public Law 114–74).

SEC. 203. TREATMENT OF ELIGIBLE PROFESSIONALS IN AMBULATORY SURGICAL CENTERS FOR MEANINGFUL USE AND MIPS.

(a) IN GENERAL.—Section 1848(a)(7)(D) of the Social Security Act (42 U.S.C. 1395w–4(a)(7)(D)) is amended—

(1) by striking "HOSPITAL-BASED ELIGIBLE PROFESSIONALS" and all that follows through "No payment" and inserting the following: "HOSPITAL-BASED AND AMBULATORY SURGICAL CENTER-BASED ELIGIBLE PROFESSIONALS.—

"(i) HOSPITAL-BASED.—No payment"; and

(2) by adding at the end the following new clauses:

"(ii) AMBULATORY SURGICAL CENTER-BASED.—Subject to clause (iv), no payment adjustment may be made under subparagraph (A) for 2017 and 2018 in the case of an eligible professional with respect to whom substantially all of the covered professional services furnished by such professional are furnished in an ambulatory surgical center.

"(iii) DETERMINATION.—The determination of whether an eligible professional is an eligible professional described in clause (ii) may be made on the basis of—

"(I) the site of service (as defined by the Secretary); or

"(II) an attestation submitted by the eligible professional.

Determinations made under subclauses (I) and (II) shall be made without regard to any employment or billing arrangement between the eligible professional and any other supplier or provider of services.

"(iv) SUNSET.—Clause (ii) shall no longer apply as of the first year that begins more than 3 years after the date on which the Secretary determines, through notice and comment rulemaking, that certified EHR technology applicable to the ambulatory surgical center setting is available.".

(b) CONTINUED APPLICATION OF CERTAIN PROVISIONS UNDER MIPS.—Section 1848(o)(2)(D) of the Social Security Act (42 U.S.C. 1395w–4(o)(2)(D)) is amended by adding at the end the following new sentence: "The provisions of subparagraphs (B) and (D) of subsection (a)(7), including the application of clause (iv) of such subparagraph (D), shall apply to assessments of MIPS eligible professionals under subsection (q) with respect to the performance category described in subsection (q)(2)(A)(iv) in a manner similar to the manner in which such provisions apply with respect to payment adjustments made under subsection (a)(7)(A).".

TITLE III—OTHER MEDICARE PROVISIONS

SEC. 301. DELAY IN AUTHORITY TO TERMINATE CONTRACTS FOR MEDICARE ADVANTAGE PLANS FAILING TO ACHIEVE MINIMUM QUALITY RATINGS.

(a) FINDINGS.—Consistent with the studies provided under the IMPACT Act of 2014 (Public Law 113–185), it is the intent of Congress—

(1) to continue to study and request input on the effects of socioeconomic status and dual-eligible populations on the Medicare Advantage STARS rating system before reforming such system with the input of stakeholders; and

(2) pending the results of such studies and input, to provide for a temporary delay in authority of the Centers for Medicare & Medicaid Services (CMS) to terminate Medicare Advantage plan contracts solely on the basis of performance of plans under the STARS rating system.

(b) DELAY IN MA CONTRACT TERMINATION AUTHORITY FOR PLANS FAILING TO ACHIEVE MINIMUM QUALITY RATINGS.—Section 1857(h) of the Social Security Act (42 U.S.C. 1395w–27(h)) is amended by adding at the end the following new paragraph:

"(3) DELAY IN CONTRACT TERMINATION AUTHORITY FOR PLANS FAILING TO ACHIEVE MINIMUM QUALITY RATING.—During the period beginning on the date of the enactment of this paragraph and through the end of plan year 2018, the Secretary may not terminate a contract under this section with respect to the offering of an MA plan by a Medicare Advantage organization solely because the MA plan has failed to achieve a minimum quality rating under the 5-star rating system under section 1853(o)(4).".

SEC. 302. REQUIREMENT FOR ENROLLMENT DATA REPORTING FOR MEDICARE.

Section 1874 of the Social Security Act (42 U.S.C. 1395kk) is amended by adding at the end the following new subsection:

"(g) REQUIREMENT FOR ENROLLMENT DATA REPORTING.—

"(1) IN GENERAL.—Each year (beginning with 2016), the Secretary shall submit to the Committees on Ways and Means and Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate a report on Medicare enrollment data (and, in the case of part A, on data on individuals receiving benefits under such part) as of a date in such year specified by the Secretary. Such data shall be presented—

"(A) by Congressional district and State; and

"(B) in a manner that provides for such data based on—

"(i) fee-for-service enrollment (as defined in paragraph (2));

"(ii) enrollment under part C (including separate for aggregate enrollment in MA–PD plans and aggregate enrollment in MA plans that are not MA–PD plans); and

"(iii) enrollment under part D.

"(2) FEE-FOR-SERVICE ENROLLMENT DEFINED.—For purpose of paragraph (1)(B)(i), the term 'fee-for-service enrollment' means aggregate enrollment (including receipt of benefits other than through enrollment) under—

"(A) part A only;

"(B) part B only; and

"(C) both part A and part B.".

SEC. 303. UPDATING THE WELCOME TO MEDICARE PACKAGE.

(a) IN GENERAL.—Not later than 12 months after the last day of the period for the request of information described in subsection (b), the Secretary of Health and Human Services shall, taking into consideration information collected pursuant to subsection (b), update the information included in the Welcome to Medicare package to include information, presented in a clear and simple manner, about options for receiving benefits under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), including through the original medicare fee-for-service program under parts A and B of such title (42 U.S.C. 1395c et seq., 42 U.S.C. 1395j et seq.), Medicare Advantage plans under part C of such title (42 U.S.C. 1395w–21 et seq.), and prescription drug plans under part D of such title (42 U.S.C. 1395w–101 et seq.)). The Secretary shall make subsequent updates to the information included in the Welcome to Medicare package as appropriate.

(b) REQUEST FOR INFORMATION.—Not later than six months after the date of the enactment of this Act, the Secretary of Health and Human Services shall request information, including recommendations, from stakeholders (including patient advocates, issuers, and employers) on information included in the Welcome to Medicare package, including pertinent data and information regarding enrollment and coverage for Medicare eligible individuals.

I. SUMMARY AND BACKGROUND

A. PURPOSE AND SUMMARY

The bill, H.R. 5273, the "Helping Hospitals Improve Patient Care Act of 2016" ("HIP–C"), as ordered reported by the Committee on Ways and Means on May 24, 2016, would address payment issues for Medicare providers and better inform Medicare beneficiaries on how to enroll in the program. The main focus of HIP–C is to provide relief for those hospitals that were "mid-build" when the Bipartisan Budget Act of 2015 ("BBA '15") was signed into law. The bill also includes numerous policies promoted by Ways and Means Committee members.

HIP–C provides an exception for those Hospital Outpatient Departments ("HOPDs") that were mid-build at the time of enactment

of the BBA '15. "Mid-build" is defined as a provider that had a binding written agreement with an outside, unrelated, party for the actual construction of the HOPD before November 2, 2016. Each HOPD will be required to submit a certification from the provider's Chief Executive Officer/Chief Operating Officer that the HOPD meets the definition of mid-build within 60 days of the date of enactment. Further, each mid-build HOPD will be required to submit an attestation, subject to an audit by the Centers for Medicare and Medicaid Services (CMS), that it meets the requirements of being provider-based (PBD) (42 Code of Federal Regulations 413.65) by December 31, 2016 (or 60 days after the date of enactment, if later).

HIP–C also affords all off-campus HOPDs that are part of a cancer hospital (defined as having an exemption from Medicare's prospective payment systems) an additional exemption from section 603 of the BBA '15. The bill also requires all future cancer HOPDs to attest to meeting the requirements of being PBD, subject to an audit by CMS. HIP–C includes a payment reduction to the target payment-to-cost ratio that is used to calculate the additional payments cancer hospitals receive.

Further, HIP–C addresses several concerns about section 3025 of the Affordable Care Act of 2010 (P.L. 111–148; "ACA"), the Hospital Readmissions Reduction Program ("HRRP"), which stakeholders have raised. The chief concern has been that the HRRP does not take into account socioeconomic status of the hospitals' patients when calculating the payment penalties for the 30-day readmission measures. HIP–C requires the Secretary to implement a transitional risk adjustment methodology to payment penalties to serve as a proxy of socio-economic status for the HRRP. CMS will continue to publicly report hospitals' performance on HRRP measures. In addition to the new payment calculation, the bill clarifies that the Secretary is able to permanently use a more refined methodology for the HRRP following the analysis required by the Improving Medicare Post-Acute Care Transformation Act of 2014 ("IMPACT"). The bill also requires a study by the Medicare Payment Advisory Commission ("MedPAC"), and allows for an analysis of "V-codes" and an exploration of potential exclusions.

There are several other sections in the bill, including: a crosswalk to translate inpatient hospital codes to outpatient hospital codes; an extension to the Rural Community Demonstration Program; a "mid-build" exception to the current law moratorium on bed expansion for Long-Term Care Hospitals ("LTCHs"); a reduction to the inpatient hospital payment update that was included in the Medicare and CHIP Reauthorization Act of 2015 ("MACRA"); an exclusion for physicians who furnish substantially all of their Medicare services at ambulatory surgical centers ("ASC") from the penalties under the Electronic Health Records ("EHR") Incentives Program and subsequent program under the Merit-Based Incentive Payment System ("MIPS"); a delay for three years in the authority to terminate Medicare Advantage ("MA") contracts based solely on plans' failing to achieve minimum quality ratings under the STARS rating system; a requirement for the Secretary to publish Medicare enrollment data on an annual basis for MA, Part D, and fee-for-service; and a requirement for the Secretary to revise the pre-Medi-

care eligibility enrollment notification to include the available options for receiving benefits under the Medicare program.

B. Background and Need for Legislation

On May 18, 2016, Health Subcommittee Chairman Tiberi (R–OH) and Ranking Member McDermott (D–WA), introduced H.R. 5273, legislation to advance reforms for hospitals and other Medicare providers. The Committee on Ways and Means received the primary referral for the bill because the bill includes Medicare provisions that fall within the jurisdiction of the Committee, including relevant provisions of the Social Security Act.

Over the past several years, there has been an increase in the rate of physician practices converted into HOPDs in order to take advantage of the higher reimbursement rates. Section 603 of BBA '15 acted to change this misalignment in the Medicare program. Specifically, section 603 codified the CMS definition of PBD off-campus HOPDs as those locations that are not on the main campus of a hospital and are located between 250 yards and 35 miles from the main campus. Further, the section defined a "new" PBD HOPD as an entity that was not currently billing for outpatient services as of date of enactment, which effectively grandfathered any off-campus PBD HOPD that was billing outpatient services before date of enactment (November 2, 2015). The practical effect of this policy is that new off-campus PBD HOPDs would be eligible for only physician fee schedule or ambulatory surgical center payment rates rather than the higher hospital outpatient payment rate.

The Committee has a concern with Section 603 of the BBA '15 because it did not exclude from the new payment rates those off-campus HOPDs that were mid-build before the date of enactment and inadvertently included "cancer hospitals" or those hospitals that are exempt from Medicare's inpatient and outpatient prospective payment systems.

C. Legislative History

Background

H.R. 5273 was introduced on May 18, 2016, and was referred to the Committee on Ways and Means and additionally to the Committee on Energy and Commerce.

Committee hearings

On September 9, 2011, the Committee on Ways and Means Subcommittee on Health held a hearing to examine the impact mergers and acquisitions in the health care sector are having on Medicare spending, beneficiary costs and private health insurance premiums.

On July 24, 2014, the Committee on Ways and Means Subcommittee on Health held a hearing on the status of the MA program.

On May 19, 2015, the Committee on Ways and Means Subcommittee on Health held a hearing to examine competition in the Medicare program, including the use of moratoria.

On July 22, 2015, the Committee on Ways and Means Subcommittee on Health held a hearing on hospital payment issues, including the differences between inpatient and outpatient reim-

bursement, medical education and disproportionate share hospital (DSH) payments.

On July 28, 2015, the Committee on Ways and Means Subcommittee on Health held a hearing on the status of rural health for Medicare beneficiaries and to highlight Member priorities.

Committee action

The Committee on Ways and Means marked up H.R. 5273, the "Helping Hospitals Improve Patient Care Act of 2015," on May 24, 2016, and ordered the bill, as amended, favorably reported (with a quorum being present). In addition, the Committee on Ways and Means previously marked up the following bills that were also included in H.R. 5273:

H.R. 887: The Committee on Ways and Means marked up H.R. 887, the "Electronic Health Fairness Act of 2015," on February 26, 2015, and ordered the bill favorably reported to the House of Representatives as amended by a voice vote (with a quorum present).

H.R. 2505: The Committee on Ways and Means marked up H.R. 2505, the "Medicare Advantage Coverage Transparency Act of 2015," on June 2, 2015, and ordered the bill favorably reported to the House of Representatives as amended by a voice vote (with a quorum being present).

H.R. 2506: The Committee on Ways and Means marked up H.R. 2506, "Senior's Health Care Plan Protection Act of 2015," on June 2, 2015, and ordered the bill, as amended, favorably reported (with a quorum being present).

H.R. 2580: The Committee on Ways and Means marked up H.R. 2580, "LTCH Technical Correction Act of 2015," on June 2, 2015, and ordered the bill, as amended, favorably reported (with a quorum being present).

II. EXPLANATION OF THE BILL

PRESENT LAW

Under current law, the Secretary is not required to link the codes that are used to compare delivery of similar services between the inpatient and outpatient hospital settings. Today, the CMS requires inpatient hospitals to submit International Classification of Disease (ICD–10) codes and requires outpatient hospitals to submit Healthcare Common Procedure Classification System (HCPCS) codes for reimbursement purposes.

The current law hospital readmissions program, the Hospital Readmissions Reduction Program (HRRP), as mandated by section 3025 of the ACA. Beginning October 1, 2014, and thereafter, a hospital can be penalized as much as 3 percent of its annual market basket update if the hospital has a higher than expected rate of readmissions.

The current law rural community hospital demonstration was mandated by section 410A of the "Medicare Modernization Act of 2003" (P.L. 108–173). The demonstration was further extended by section 10313 of the ACA. In order to participate in the demonstration, a hospital must be located in Alaska, Arizona, Arkansas, Colorado, Idaho, Iowa, Kansas, Maine, Minnesota, Mississippi, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Utah, and Wyoming.

The current law LTCH moratorium was created by section 1206 of the Bipartisan Budget Act of 2013 (P.L. 113–67; "BBA '13"). Beginning January 1, 2015, through September 30, 2017, section 1206 established the LTCH moratorium. Specifically, section 1206 modified section 114(d) of the "Medicare, Medicaid and SCHIP Extension Act of 2007" (P.L. 110–173), as amended by sections 3106(b) and 10312(b) of the ACA.

Three months after BBA '13 of 2013 (P.L. 113–67) was signed into law, Congress further modified the LTCH moratorium with section 112 of the Protecting Access to Medicare Act of 2014 (P.L. 113–93; "PAMA"). PAMA provided for an exception for LTCH buildings that were mid-build.

Under current law, hospitals are receiving a 0.8 percent reduction in payments, as mandated by section 605 of the American Taxpayer Relief Act of 2012 (P.L. 112–240; "ATRA"). The annual update for hospitals was subsequently altered by 411 of the MACRA (P.L. 114–10). Prior to the implementation of MACRA, hospitals were expected to receive an additional estimated 3.2 percent update for fiscal year 2018. However, under MACRA, hospitals are scheduled to receive an additional 0.5 percent update for fiscal years 2018 through 2023.

Under current law, there are four basic settings where Medicare patients can receive outpatient services (care that does not require an overnight stay): independent physician offices, ASCs, clinical labs, and HOPDs. Similarly, there are four different payment systems that apply to the services provided in these settings: (1) Outpatient Prospective Payment System ("OPPS"); (2) ASC payment system; (3) clinical lab fee schedule ("CLFS"); and (4) the physician fee schedule ("PFS"). In general, the OPPS pays significantly higher reimbursement rates than the PFS, CLFS or ASC payment systems. Section 603 of the Bipartisan Budget Act of 2015 ("BBA '15") changed the payments to the lower PFS, CLFS or ASC reimbursement level for those off-campus HOPDs who were not billing the OPPS prior to November 2, 2015. However, BBA '15 did not provide for an exception for the off-campus HOPDs that were mid-build when the law took effect.

The current law PPS-exemption for cancer hospitals was authorized in the Tax, Equity and Fiscal Responsibility Act of 1982 (P.L. 97–248; "TEFRA"). Further, section 3138 of the ACA authorized CMS to amend the outpatient payment methodology to reimburse cancer hospitals based on a target payment-to-cost ratio ("PCR") or the weighted average PCR for all PPS hospitals. When a cancer hospital's individual PCR is lower than the target PCR, CMS provides an add-on payment for outpatient services during cost report settlement that equalizes the two PCRs. Under current law, section 603 of BBA '15 also applies to cancer hospitals. Therefore, under current law, new off-campus centers for which cancer hospitals begin billing for outpatient services after November 2, 2015 would not qualify for the cancer hospital payments.

The American Recovery and Reinvestment Act) of 2009 (P.L. 111–5; "ARRA") established incentives for physicians and other professionals, collectively referred to as "eligible professionals," and for hospitals to adopt EHR technology that meet certain certification standards. The ARRA excluded the services of physicians who furnish "substantially all" of their services in an inpatient hos-

pital or hospital emergency department using the facilities' EHR system.

Under current law, the Secretary has the authority to terminate Medicare Advantage contracts based on STARS rating system established by the Secretary through the regulatory process. Further, current law does not require the CMS to publish Medicare enrollment data by Congressional District, state, or zip code.

Currently, seniors receive a welcome notification from Medicare three months prior to enrollment eligibility. This notification does not clearly explain key information about the choices that the beneficiaries will face when looking to enroll.

EXPLANATION OF PROVISIONS

Section 101 of H.R. 5273 requires the Secretary to translate inpatient hospital codes (International Classification of Disease) to outpatient hospital (Healthcare Common Procedure Classification System) codes for 10 surgical procedures. This "crosswalk" is required to be completed no later than January 1, 2018.

Section 102 of H.R. 5273 requires the Secretary to implement a transitional risk adjustment methodology to serve as a proxy of socio-economic status for the HRRP, including the clarification that the calculation should apply only to a hospital's Medicare population. In addition to the transitional adjustment, the section clarifies that the Secretary is able to permanently use a more refined methodology following the analysis required by the IMPACT Act. The section also requires a study by the MedPAC, and allows for an analysis of "V-codes" and an exploration of potential exclusions.

Section 103 of H.R. 5273 requires the Secretary to extend the current-law Rural Community Hospital Demonstration for an additional 5 years. The extension also permits the Secretary to include hospitals that have recently closed in eligible states.

Section 104 of H.R. 5273 provides regulatory relief by allowing LTCHs to qualify for a "mid-build" exception to the current law moratorium on bed expansion. The section is offset by a reduction to LTCH outlier payments, requiring a higher threshold for LTCH discharges to qualify for outlier payments.

Section 105 of H.R. 5273 reduces the payment update that was included in the bipartisan MACRA. Specifically, the update of 0.5 percent for fiscal year 2018 is changed to an update of 0.4590.

Section 201 of H.R. 5273 provides for an exception to section 603 of BBA '15 for HOPDs that were defined as "mid-build" prior to November 2, 2015. "Mid-build" is defined as a provider that had a binding written agreement with an outside, unrelated, party for the actual construction of the HOPD. To qualify as "mid-build," each HOPD will be required to submit a certification from the provider's Chief Executive Officer/Chief Operating Officer that the HOPD meets the definition of mid-build prior to 60 days after the date of enactment. Further, each mid-build HOPD will be required to submit an attestation that it meets the requirements of being provider-based (42 CFR 413.65) by December 31, 2016 or if later, 60 days after the date of enactment. In addition, the section also requires the Secretary to audit the accuracy of these attestations. HOPDs that meet all of above requirements will receive the full HOPD payment rate beginning January 1, 2018 instead of the lower physician fee schedule or ambulatory surgical center payments re-

quired under the BBA '15. Finally, those off-campus HOPDs that submitted a voluntary attestation prior to December 2, 2015 will receive the full HOPD payment rate beginning January 1, 2017.

Section 202 of H.R. 5273 provides that PPS-exempt cancer hospitals are not included in the payment changes made under section 603 of the BBA '15. This ensures that these facilities' payments continue under their existing separate system, as opposed to the inpatient and outpatient PPS systems. The section also requires cancer HOPDs to attest and requires the Secretary to audit the accuracy of the attestation. Section 202 also includes a payment reduction to the target payment-to-cost ratio that is used to calculate the additional payments that PPS-exempt cancer hospitals receive.

Section 203 of H.R. 5273 excludes physicians who furnish substantially all of their Medicare services at an ASC from the penalties under the EHR Incentives Program and subsequent program under MIPS. This exclusion ends three years after the Secretary of Health and Human Services, in consultation with stakeholders, determines that EHRs are available at the ASC setting.

Section 301 of H.R. 5273 delays for three years the authority to terminate MA contracts based solely on plans' failing to achieve minimum quality ratings under the Medicare Advantage STARS rating system. The delay would not prevent CMS from terminating plans for the other ten performance categories considered in the Past Cycle Performance Review at any time.

Section 302 of H.R. 5273 requires the Secretary to publish Medicare enrollment data by Congressional District, zip code, and state on an annual basis. This data includes MA, Part D, and fee-for-service enrollment data.

Section 303 of H.R. 5273 requires the Secretary to revise the pre-Medicare eligibility enrollment notification to include, in a simplified manner, the available options for receiving benefits under the Medicare program, including through the original Medicare fee-for-service program, MA, and Part D. The section also requires the Secretary to reach out to stakeholders on their recommendations on what such notice would include.

REASONS FOR CHANGE

As noted in its March 2015 Report to Congress, MedPAC "used several proprietary crosswalks of Current Procedural Terminology (and equivalent HCPCS) to ICD procedure codes because an official Medicare crosswalk does not exist." In order to more accurately compare, for both clinical and reimbursement purposes, inpatient and outpatient surgical procedures, H.R. 5273 requires the Secretary to develop a crosswalk linking codes. While the bill requires the publication and dissemination of the crosswalk, including software, the bill does not provide the Secretary the authority to use the crosswalk for implementing changes in reimbursement.

As documented in its June 2013 Report to Congress, MedPAC recommended that the Congress consider providing the Secretary the authority to "evaluate hospital readmission rates against a group of peers with a similar share of poor Medicare beneficiaries as a way to adjust readmission penalties for socioeconomic status." Further, hospitals have raised several concerns about the HRRP. Chief among those concerns has been not taking socio-economic status into account when calculating HRRP payment adjustments.

Therefore, H.R. 5273 requires the Secretary to use a transitional adjustment under which hospitals would be placed into groups with similar percentages of dually eligible patients, as compared to their overall Medicare population to determine any payment adjustments.

H.R. 5273 extends the rural community hospital demonstration because it is authorized only through the end of 2015. The extension will provide additional time to develop permanent policy.

The Committee intended for the change made with section 112 of the PAMA to provide for an exception process that applied to both new building and expansion of beds. Due to a legislative drafting error, the exception process was not included for expansion of beds. Therefore, H.R. 5273 calls for a technical fix to the current law LTCH moratorium exception process.

The Committee intends to fully offset the cost of H.R. 5273. Therefore, the annual update for hospitals, as modified by MACRA, is reduced for fiscal year 2018.

Since BBA '15 did not account for hospital outpatient departments that were mid-build, it was essential to allow projects that were mid-build before the date of enactment (November 2, 2015) the ability to receive the higher outpatient payments that were in effect when the projects began construction. In the past, Congress has afforded Medicare providers an exception for mid-build projects, such as the LTCH moratorium included in section 114 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (P.L. 110–173; "MMSEA") and section 112 of the PAMA. Therefore, H.R. 5273 allows for this exception.

As stated above, section 603 of BBA '15 inadvertently included cancer hospitals. It was not the intent of Congress to include cancer hospitals under section 603 of BBA '15. Therefore, H.R. 5273 carves cancer hospitals out of section 603.

Including ASC patient encounters in the total number of patient encounters to be furnished in a setting with certified EHR technology puts physicians who practice in the ASC setting at a disadvantage. It holds them accountable for using certified EHR technology despite the fact that Congress did not offer incentives for ASCs to adopt EHR technology as it did for other care settings. Therefore, H.R. 5273 provides an exception for physicians practicing in ASCs.

CMS should provide a more transparent accounting of Medicare enrollment data to Congress and other relevant government offices. Therefore, H.R. 5273 provides for better understanding of how Medicare is serving the health care needs of the nation as well as individual congressional districts.

Seniors should have access to the plans that they choose and want. A decision to terminate a Medicare Advantage contract can be very disruptive, particularly to low-income or dually eligible beneficiaries, as well as those with limited medical access. Research and studies have shown that STARS measures may unduly affect plans that serve these beneficiaries. Therefore, H.R. 5273 delays for three years the Secretary's authority to terminate plans solely due to a lack of meeting minimum STARS measures while studies continue, such as those required under the IMPACT Act.

The decision process when seniors are eligible to enroll in Medicare can be complex, and making incorrect or late decisions can af-

fect seniors financially. H.R. 5273 would send the initial notification that seniors receive earlier and expand it to include information on all of the choices for enrollment once they are Medicare eligible in a clear and concise manner.

EFFECTIVE DATES

The effective date of section 101 is January 1, 2018.

The effective dates in section 102 are October 1, 2018 for the dually eligible adjustment and June 2017 for the MedPAC Report to Congress.

The effective date of section 103 is the date of enactment.

The effective dates in section 104 are April 1, 2014 for the LTCH bed moratorium and October 1, 2017 for the LTCH outlier change.

The effective date of section 105 is October 1, 2017.

The effective dates in section 201 are January 1, 2017 for deemed HOPDs and January 1, 2018 for mid-build HOPDs, 60 days after the date of enactment for the mid-build certification, December 31, 2016 (or 60 days after the date if later) for submission of the attestation and December 31, 2018 for auditing.

The effective dates in section 202 are November 2, 2015 for the exemption from Section 603 of BBA '15 and January 1, 2018 for the payment-to-cost ratio adjustment.

The effective date of section 203 is January 1, 2017.

The effective date of section 301 is the date of enactment.

The effective date of section 302 is 2016.

The effective dates for section 303 are 6 months after the date of enactment for the request for information and 12 months after the date of the request for information to update the Welcome to Medicare package.

III. VOTES OF THE COMMITTEE

In compliance with clause 3(b) of rule XIII of the Rules of the House of Representatives, the following statement is made concerning the vote of the Committee on Ways and Means in its consideration of H.R. 5273, the "Helping Hospitals Improve Patient Care Act of 2015," on May 24, 2016.

The bill, H.R. 5273, was ordered favorably reported as amended by voice vote (with a quorum being present).

IV. BUDGET EFFECTS OF THE BILL

A. Committee Estimate of Budgetary Effects

In compliance with clause 3(d) of rule XIII of the Rules of the House of Representatives, the following statement is made concerning the effects on the budget of the bill, H.R. 5273, as reported. The Committee agrees with the estimate prepared by the Congressional Budget Office (CBO), which is included below.

B. Statement Regarding New Budget Authority and Tax Expenditures Budget Authority

In compliance with clause 3(c)(2) of rule XIII of the Rules of the House of Representatives, the Committee states that the bill involves no new or increased budget authority. The Committee states further that the bill involves no new or increased tax expenditures.

C. Cost Estimate Prepared by the Congressional Budget Office

In compliance with clause 3(c)(3) of rule XIII of the Rules of the House of Representatives, requiring a cost estimate prepared by the CBO, the following statement by CBO is provided.

U.S. Congress,
Congressional Budget Office,
Washington, DC, June 3, 2016.

Hon. Kevin Brady,
Chairman, Committee on Ways and Means,
House of Representatives, Washington, DC.

Dear Mr. Chairman: The Congressional Budget Office has prepared the enclosed cost estimate for H.R. 5273, the Helping Hospitals Improve Patient Care Act of 2016.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Lori Housman.

Sincerely,

Keith Hall.

Enclosure.

H.R. 5273—Helping Hospitals Improve Patient Care Act of 2016

Summary: H.R. 5273 would modify Medicare payment rules for certain hospital outpatient departments and some hospital inpatient services, increase the number of beds for long-term care hospitals (LTCHs), extend a demonstration involving rural community hospitals, modify meaningful use standards for some physicians practicing in ambulatory surgical centers, and delay the Center for Medicare and Medicaid Services' (CMS) authority to terminate certain Medicare Advantage (MA) contracts.

CBO estimates that enacting H.R. 5273 would increase direct spending by $50 million over the 2017–2021 period but decrease direct spending by $14 million over the 2017–2026 period. Pay-as-you-go procedures apply because enacting the legislation would affect direct spending. Enacting the bill would not affect revenues.

CBO estimates that enacting the legislation would not increase net direct spending or on-budget deficits by more than $5 billion in any of the four consecutive 10-year periods beginning in 2027.

H.R. 5273 contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA) and would impose no costs on state, local, or tribal governments.

Estimated cost to the Federal Government: The estimated budgetary effect of H.R. 5273 is shown in the following table. The costs of this legislation fall within budget function 570 (Medicare).

	By fiscal year, in millions of dollars—											
	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2017–2021	2017–2026
INCREASES OR DECREASES (−) IN DIRECT SPENDING [a] [b]												
TITLE I—PROVISIONS RELATING TO MEDICARE PART A:												
Rural hospital demonstration	26	102	−29	−77	0	0	−6	−19	−17	0	22	−21
Long-term care hospitals	−1	5	10	0	−2	−2	−2	−2	−3	−3	12	0
IPPS update	0	−55	−70	−75	−80	−85	−90	−90	−100	−105	−280	−750
TITLE II—PROVISIONS RELATING TO MEDICARE PART B:												
Payment rules for off-campus outpatient departments	20	50	60	70	80	90	90	90	100	110	280	760
Payment rules for off-campus outpatient departments of cancer hospitals	5	5	5	5	0	0	−5	−5	−5	−5	20	0
Electronic health records in ambulatory surgical centers	4	9	4	0	0	0	0	0	0	0	17	17
TITLE III—OTHER MEDICARE PROVISIONS:												
Delay termination for Medicare Advantage plans	0	−5	−10	−5	0	0	0	0	0	0	−20	−20
Total, Net Increases or Decreases (−) in Direct Spending Outlays	54	111	−30	−82	−2	3	−13	−27	−25	−3	50	−14
NET INCREASE OR DECREASE (−) IN THE DEFICIT FROM INCREASES OR DECREASES (−) IN DIRECT SPENDING												
Impact on Deficit	54	111	−30	−82	−2	3	−13	−27	−25	−3	50	−14

Notes: Components may not add to totals because of rounding. IPPS = inpatient prospective payment system; TRICARE = the health plan operated by the Department of Defense.

[a] Budget authority equals outlays for direct spending provisions. All changes in direct spending are on-budget.

[b] All Medicare provisions include interactions with Medicare Advantage payments, Medicare Part A and Part B premiums, and TRICARE.

Basis of estimate:

TITLE I. PROVISIONS AFFECTING MEDICARE PART A

Rural hospital demonstration. Section 103 of the bill would extend the Rural Community Hospital Demonstration Program for an additional five years and allow more hospitals to enter the demonstration. Under the demonstration program, Medicare pays certain hospitals in rural areas on the basis of the reasonable costs they incur instead of using the payment rates determined by Medicare's Inpatient Prospective Payment System (IPPS). CBO estimates that enacting this provision would increase direct spending in fiscal years 2017 and 2018. However, when the cost reports for those years are settled (generally five years after the fiscal year ends), the Medicare program would recoup those increases in payments by reducing the payment rates for all hospitals paid under the IPPS. Those changes in payments to hospitals also would affect payment rates for Medicare Advantage plans, which are based on spending in the fee-for-service part of Medicare. CBO estimates that the initial increases in payments to MA plans would be smaller than the subsequent reductions (when the hospitals' cost reports are settled) because the share of Medicare beneficiaries enrolled in MA is projected to increase over the next ten years. In total, CBO estimates that section 103 would reduce direct spending for Medicare by $21 million over the 2017–2026 period.

Long-term care hospitals. Title I would lift a moratorium in current law that prohibits existing long-term care hospitals (LTCHs) from increasing the number of beds in their facilities. CBO estimates that provision would increase payments to LTCHs by about $20 million over the 2017–2026 period. To offset that increase, payment rates for LTCH services would be reduced by 0.08 percent beginning in 2017. In combination, CBO estimates those provisions would have no net budgetary effect over the 2017–2026 period.

IPPS update. The bill would reduce the update to IPPS payment rates for services furnished in fiscal year 2018 by 0.04 percentage points. CBO estimates that provision would reduce direct spending for Medicare by $750 million over the 2017–2026 period.

Other provisions. Title I also would require the Secretary of Health and Human Services to develop a mechanism that would enable services provided in an outpatient department to be assigned to the diagnosis-related groups that are used to set payment rates for hospital inpatient services. In addition, Title I would require the Secretary to modify the criteria for determining which hospitals are subject to payment reductions related to high readmission rates. CBO estimates those provisions would have no budgetary effect.

TITLE II. PROVISIONS AFFECTING MEDICARE PART B

Payment rules for off-campus outpatient departments. Section 201 would exempt certain hospital outpatient departments (HOPDs) from payment rules established in the Bipartisan Budget Act of 2015 (BBA15). Those payment rules require Medicare to pay for services furnished in new off-campus facilities using the payment rates that would have been in effect if the services were per-

formed in an office setting or an ambulatory surgical center beginning in 2018.[1]

Off-campus facilities that were already billing as HOPDs when BBA15 was enacted continue to receive the higher payment rates that apply to an outpatient department on the campus of a hospital. H.R. 5273 would allow off-campus facilities that were under construction on November 2, 2015, to be paid at the same rates as an HOPD beginning in 2018. H.R. 5273 would require such facilities to document and attest that status, and the Secretary of Health and Human Services would be required to conduct audits during 2017 and 2018.

Nearly 100 hospitals have identified themselves as having off-campus facilities under construction on November 2, 2015. Based on that information, CBO estimates that increasing payment rates for services provided in those facilities would increase net Medicare spending by $750 million over the 2017–2026 period. H.R. 5273 would also provide an additional $10 million in funding for implementing section 201.

Payment rules for off-campus outpatient departments of cancer hospitals. Section 202 would exclude new off-campus facilities in cancer hospitals that are exempt from Medicare's prospective payment system from the lower payment rates established in BBA15. Payment rates for services in these new off-campus facilities would continue under the rules in place prior to enactment of BBA15 and would generally be higher. Those facilities would have to attest that they qualify for those higher payment rates and the Secretary would be required to audit that attestation. The bill would provide $2 million for those audits. In addition, section 202 would apply an across-the-board 1 percent reduction to payment rates for services furnished by outpatient departments of cancer hospitals in 2018. Taken together, CBO estimates the provisions of section 202 would increase direct spending by $20 million over the 2017–2021 period, but would have no net budgetary effect over the 2017–2026 period.

Electronic health records in ambulatory surgical centers. Section 203 of H.R 5273 would exempt eligible professionals based in an ambulatory surgical center (ASC) from being subject to payment reductions for failing to meet the requirements for meaningful use of electronic health records (EHRs) that were established by the Health Information Technology Act of 2009. That exemption would apply to payments made in calendar years 2017 and 2018 and would continue under the Merit-Based Incentive Payment System (MIPS) starting in 2019. The exemption would expire three years after the Secretary determines that certified EHR technology applicable to ASCs is available.

Very few ASCs currently have EHR technology. Thus, section 203 would enable about 2,000 ASC-based professionals to avoid penalties related to their use of EHR. Under current law, CBO expects those penalties to average about $3,000 for each professional in calendar years 2017 and 2018. Beginning in 2019 under the

[1] In Medicare, payment rates for the same service vary based on the setting. Services provided in an office setting by physicians and health professionals are paid a single fee from the physician fee schedule (PFS). For services provided in facilities, such as HOPD or ambulatory surgical centers, Medicare pays the practitioner a fee from the PFS, which is lower than the comparable fee in the professional's office, and a facility fee to either the HOPD or ASC. Generally, the total payment rate for services provided in facilities is higher than the rate for the same service provided in an office.

MIPS program, any change in Medicare payments to professionals based in ASCs would be offset by changes in payment rates to other professionals. CBO estimates that section 203 would result in fewer penalties, which would increase direct spending by $17 million over the 2017–2026 period.

TITLE III. OTHER MEDICARE PROVISIONS

Delay termination for Medicare Advantage plans. Under current law, the Centers for Medicare and Medicaid Services (CMS) has announced that, beginning with plan year 2017, it will not renew contracts with Medicare Advantage plans that fail, for three consecutive years, to achieve at least three stars under the five-star quality-rating system. The bill would delay CMS' authority to terminate those contracts until plan year 2020. Thus, enacting the legislation would permit certain plans that otherwise would not be renewed under current law to continue operating through 2019. Those plans tend to receive slightly lower payments than other Medicare Advantage plans in the same areas, in part because they do not receive bonus payments under the five-star rating system.

CBO projects that very few beneficiaries—less than 0.1 percent of MA enrollees—will be enrolled in plans that fail to achieve minimum quality ratings, and thus would be subject to the changes under the legislation. Permitting those plans to continue operating would reduce direct spending by $20 million over the 2017–2026 period, CBO estimates.

CMS has announced that one contract will not be eligible for renewal in 2017. Although H.R. 5273 would make that contract eligible for renewal, CBO assumes that the legislation would be enacted towards the end of fiscal year 2016, after the point when insurance carriers must submit materials in order to participate in the program in 2017. Thus, in CBO's judgment, the legislation would have no effect on spending or on the number of plans that will participate in the MA program during that year.

Other provisions. H.R. 5273 would require CMS to publish data on enrollment in the fee-for-service and Medicare Advantage components of the Medicare program at the state and Congressional-district level and provide clear descriptions of the fee-for-service, Medicare Advantage, and Part D prescription drug programs in the "Welcome to Medicare" package that is given to new enrollees. CBO estimates those provisions would not affect direct spending because neither would affect Medicare's coverage rules or payment rates.

Pay-As-You-Go considerations: The Statutory Pay-As-You-Go Act of 2010 establishes budget-reporting and enforcement procedures for legislation affecting direct spending or revenues. The net changes in outlays that are subject to those pay-as-you-go procedures are shown in the following table.

CBO ESTIMATE OF PAY-AS-YOU-GO EFFECTS FOR H.R. 5273, AS ORDERED REPORTED BY THE HOUSE COMMITTEE ON WAYS AND MEANS ON MAY 24, 2016

	By fiscal year, in millions of dollars—												
	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2016–2021	2016–2026
	NET INCREASE OR DECREASE (−) IN THE DEFICIT												
Statutory Pay-As-You-Go Impact	0	54	111	−30	−82	−2	3	−13	−27	−25	−3	50	−14

Increase in long-term direct spending and deficits: CBO estimates that enacting the legislation would not increase net direct spending or on-budget deficits by more than $5 billion in any of the four consecutive 10-year periods beginning in 2027.

Intergovernmental and private-sector impact: H.R. 5273 contains no intergovernmental or private-sector mandates as defined in UMRA, and would not affect the budgets of state, local, or tribal governments.

Previous CBO estimate: On July 17, 2015 CBO transmitted a cost estimate for S. 607, the Rural Community Hospital Demonstration Extension Act of 2015 as reported by the Senate Committee on Finance on June 24, 2015. Section 103 of H.R. 5273 is similar to S. 607. Differences in the estimated budgetary effects of the two bills reflect the fact that section 103 of H.R. 5273 would allow additional hospitals to join the Rural Community Hospital demonstration.

On June 15, 2015 CBO transmitted a cost estimate for H.R. 2580, the LTCH Technical Correction Act of 2015 as reported by the House Committee on Ways and Means on June 2, 2015. Section 104 of H.R. 5273 is similar to H.R. 2580. Changes in the budgetary effects of the two bills reflect changes in CBO's baseline projections under current law.

CBO has published two previous estimates of bills similar to provisions in section 203, which would modify the treatment of eligible professionals in ambulatory surgical centers for meaningful use and MIPS. CBO transmitted a cost estimate for H.R. 887 on March 12, 2015, and an estimate for S. 1347 on July 16, 2015; those two bills had identical language and were both entitled the Electronic Health Fairness Act of 2015. Differences in the estimated budgetary effects in section 203 from those previous estimates reflect differences in the legislative language.

On June 12, 2015, CBO transmitted a cost estimate for H.R. 2506, the Seniors' Health Care Plan Protection Act of 2015, as reported by the House Committee on Ways and Means on June 2, 2015. Section 301 of H.R. 5273 is similar to H.R. 2506. Differences in the estimated budgetary effects of the two bills reflect updated information on plan performance in the star-ratings system.

Estimate prepared by: Federal Costs: Lori Housman, Jamease Kowalczyk, Paul Masi, Kevin McNellis, and Zoë Williams; Impact on State, Local, and Tribal Governments: Zachary Byrum; Impact on the Private Sector: Amy Petz.

Estimate approved by: Holly Harvey, Deputy Assistant Director for Budget Analysis.

V. OTHER MATTERS TO BE DISCUSSED UNDER THE RULES OF THE HOUSE

A. Committee Oversight Findings and Recommendation

With respect to clause 3(c)(1) of rule XIII of the Rules of the House of Representatives, the Committee advises that the findings and recommendations of the Committee, based on oversight activities under clause 2(b)(1) of rule X of the Rules of the House of Representatives, are incorporated in the descriptive portions of this report.

B. Statement of General Performance Goals and Objectives

With respect to clause 3(c)(4) of rule XIII of the Rules of the House of Representatives, the Committee advises that the bill contains no measure that authorizes funding, so no statement of general performance goals and objectives for which any measure authorizes funding is required.

C. Information Relating to Unfunded Mandates

This information is provided in accordance with section 423 of the Unfunded Mandates Reform Act of 1995 (Pub. L. No. 104–4).

The Committee has determined that the bill does not contain Federal mandates on the private sector. The Committee has determined that the bill does not impose a Federal intergovernmental mandate on State, local, or tribal governments.

D. Congressional Earmarks, Limited Tax Benefits, and Limited Tariff Benefits

With respect to clause 9 of rule XXI of the Rules of the House of Representatives, the Committee has carefully reviewed the provisions of the bill, and states that the provisions of the bill do not contain any congressional earmarks, limited tax benefits, or limited tariff benefits within the meaning of the rule.

E. Duplication of Federal Programs

In compliance with Sec. 3(g)(2) of H. Res. 5 (114th Congress), the Committee states that no provision of the bill establishes or reauthorizes: (1) a program of the Federal Government known to be duplicative of another Federal program; (2) a program included in any report from the Government Accountability Office to Congress pursuant to section 21 of Public Law 111–139; or (3) a program related to a program identified in the most recent Catalog of Federal Domestic Assistance, published pursuant to the Federal Program Information Act (Pub. L. No. 95–220, as amended by Pub. L. No. 98–169).

F. Disclosure of Directed Rule Makings

In compliance with Sec. 3(i) of H. Res. 5 (114th Congress), the following statement is made concerning directed rule makings: The Committee estimates that the bill requires no directed rule makings within the meaning of such section.

VI. CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

A. Text of Existing Law Amended or Repealed by the Bill, as Reported

In compliance with clause 3(e)(1)(A) of rule XIII of the Rules of the House of Representatives, the text of each section proposed to be amended or repealed by the bill, as reported, is shown below:

SOCIAL SECURITY ACT

* * * * * * *

TITLE XVIII—HEALTH INSURANCE FOR THE AGED AND DISABLED

* * * * * * *

Part B—Supplementary Medical Insurance Benefits for the Aged and Disabled

* * * * * * *

PAYMENT OF BENEFITS

Sec. 1833. (a) Except as provided in section 1876, and subject to the succeeding provisions of this section, there shall be paid from the Federal Supplementary Medical Insurance Trust Fund, in the case of each individual who is covered under the insurance program established by this part and incurs expenses for services with respect to which benefits are payable under this part, amounts equal to—(1) in the case of services described in section 1832(a)(1)—80 percent of the reasonable charges for the services; except that (A) an organization which provides medical and other health services (or arranges for their availability) on a prepayment basis (and either is sponsored by a union or employer, or does not provide, or arrange for the provision of, any inpatient hospital services) may elect to be paid 80 percent of the reasonable cost of services for which payment may be made under this part on behalf of individuals enrolled in such organization in lieu of 80 percent of the reasonable charges for such services if the organization undertakes to charge such individuals no more than 20 percent of such reasonable cost plus any amounts payable by them as a result of subsection (b), (B) with respect to items and services described in section 1861(s)(10)(A), the amounts paid shall be 100 percent of the reasonable charges for such items and services, (C) with respect to expenses incurred for those physicians' services for which payment may be made under this part that are described in section 1862(a)(4), the amounts paid shall be subject to such limitations as may be prescribed by regulations, (D) with respect to clinical diagnostic laboratory tests for which payment is made under this part (i)(I) on the basis of a fee schedule under subsection (h)(1) (for tests furnished before January 1, 2017) or section 1834(d)(1), the amount paid shall be equal to 80 percent (or 100 percent, in the case of such tests for which payment is made on an assignment-related basis) of the lesser of the amount determined under such fee schedule, the limitation amount for that test determined under sub-

section (h)(4)(B), or the amount of the charges billed for the tests, or (II) under section 1834A (for tests furnished on or after January1, 2017), the amount paid shall be equal to 80 percent(or 100 percent, in the case of such tests for which payment is made on an assignment-related basis) of the lesser of the amount determined under such section or the amount of the charges billed for the tests, or (ii) for tests furnished before January 1, 2017,on the basis of a negotiated rate established under subsection (h)(6), the amount paid shall be equal to 100 percent of such negotiated rate,,(E) with respect to services furnished to individuals who have been determined to have end stage renal disease, the amounts paid shall be determined subject to the provisions of section 1881,(F) with respect to clinical social worker services under section 1861(s)(2)(N), the amounts paid shall be 80 percent of the lesser of (i) the actual charge for the services or (ii) 75 percent of the amount determined for payment of a psychologist under clause (L),

(G) with respect to facility services furnished in connection with a surgical procedure specified pursuant to subsection (i)(1)(A) and furnished to an individual in an ambulatory surgical center described in such subsection, for services furnished beginning with the implementation date of a revised payment system for such services in such facilities specified in subsection (i)(2)(D), the amounts paid shall be 80 percent of the lesser of the actual charge for the services or the amount determined by the Secretary under such revised payment system,

(H) with respect to services of a certified registered nurse anesthetist under section 1861(s)(11), the amounts paid shall be 80 percent of the least of the actual charge, the prevailing charge that would be recognized (or, for services furnished on or after January 1, 1992, the fee schedule amount provided under section 1848) if the services had been performed by an anesthesiologist, or the fee schedule for such services established by the Secretary in accordance with subsection (l), (I) with respect to covered items (described in section 1834(a)(13)), the amounts paid shall be the amounts described in section 1834(a)(1), and(J) with respect to expenses incurred for radiologist services (as defined in section 1834(b)(6)), subject to section 1848, the amounts paid shall be 80 percent of the lesser of the actual charge for the services or the amount provided under the fee schedule established under section 1834(b), (K) with respect to certified nurse-midwife services under section 1861(s)(2)(L), the amounts paid shall be 80 percent of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary for the purposes of this subparagraph (but in no event shall such fee schedule exceed 65 percent of the prevailing charge that would be allowed for the same service performed by a physician, or, for services furnished on or after January 1, 1992, 65 percent (or 100 percent for services furnished on or after January 1, 2011) of the fee schedule amount provided under section 1848 for the same service performed by a physician), (L) with respect to qualified psychologist services under section 1861(s)(2)(M), the amounts paid shall be 80 percent of the lesser of the actual charge for the services or the amount deter-

mined by a fee schedule established by the Secretary for the purposes of this subparagraph, (M) with respect to prosthetic devices and orthotics and prosthetics (as defined in section 1834(h)(4)), the amounts paid shall be the amounts described in section 1834(h)(1), (N) with respect to expenses incurred for physicians' services (as defined in section 1848(j)(3)) other than personalized prevention plan services (as defined in section 1861(hhh)(1)), the amounts paid shall be 80 percent of the payment basis determined under section 1848(a)(1), (O) with respect to services described in section 1861(s)(2)(K) (relating to services furnished by physician assistants, nurse practitioners, or clinic nurse specialists), the amounts paid shall be equal to 80 percent of (i) the lesser of the actual charge or 85 percent of the fee schedule amount provided under section 1848, or (ii) in the case of services as an assistant at surgery, the lesser of the actual charge or 85 percent of the amount that would otherwise be recognized if performed by a physician who is serving as an assistant at surgery, (P) with respect to surgical dressings, the amounts paid shall be the amounts determined under section 1834(i), (Q) with respect to items or services for which fee schedules are established pursuant to section 1842(s), the amounts paid shall be 80 percent of the lesser of the actual charge or the fee schedule established in such section, (R) with respect to ambulance services, (i) the amounts paid shall be 80 percent of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary under section 1834(l) and (ii) with respect to ambulance services described in section 1834(l)(8), the amounts paid shall be the amounts determined under section 1834(g) for outpatient critical access hospital services, (S) with respect to drugs and biologicals (including intravenous immune globulin (as defined in section 1861(zz))) not paid on a cost or prospective payment basis as otherwise provided in this part (other than items and services described in subparagraph (B)), the amounts paid shall be 80 percent of the lesser of the actual charge or the payment amount established in section 1842(o) (or, if applicable, under section 1847, 1847A, or 1847B), (T) with respect to medical nutrition therapy services (as defined in section 1861(vv)), the amount paid shall be 80 percent (or 100 percent if such services are recommended with a grade of A or B by the United States Preventive Services Task Force for any indication or population and are appropriate for the individual) of the lesser of the actual charge for the services or 85 percent of the amount determined under the fee schedule established under section 1848(b) for the same services if furnished by a physician, (U) with respect to facility fees described in section 1834(m)(2)(B), the amounts paid shall be 80 percent of the lesser of the actual charge or the amounts specified in such section, (V) notwithstanding subparagraphs (I) (relating to durable medical equipment), (M) (relating to prosthetic devices and orthotics and prosthetics), and (Q) (relating to 1842(s) items), with respect to competitively priced items and services (described in section 1847(a)(2)) that are furnished in a competitive area, the amounts paid shall be the amounts described in section 1847(b)(5), (W) with respect to

additional preventive services (as defined in section 1861(ddd)(1)), the amount paid shall be (i) in the case of such services which are clinical diagnostic laboratory tests, the amount determined under subparagraph (D) (if such subparagraph were applied, by substituting "100 percent" for "80 percent"), and (ii) in the case of all other such services, 100 percent of the lesser of the actual charge for the service or the amount determined under a fee schedule established by the Secretary for purposes of this subparagraph, (X) with respect to personalized prevention plan services (as defined in section 1861(hhh)(1)), the amount paid shall be 100 percent of the lesser of the actual charge for the services or the amount determined under the payment basis determined under section 1848, (Y) with respect to preventive services described in subparagraphs (A) and (B) of section 1861(ddd)(3) that are appropriate for the individual and, in the case of such services described in subparagraph (A), are recommended with a grade of A or B by the United States Preventive Services Task Force for any indication or population, the amount paid shall be 100 percent of (i) except as provided in clause (ii), the lesser of the actual charge for the services or the amount determined under the fee schedule that applies to such services under this part, and (ii) in the case of such services that are covered OPD services (as defined in subsection (t)(1)(B)), the amount determined under subsection (t), (Z) with respect to Federally qualified health center services for which payment is made under section 1834(o), the amounts paid shall be 80 percent of the lesser of the actual charge or the amount determined under such section, and (AA) with respect to an applicable disposable device (as defined in paragraph (2) of section 1834(s)) furnished to an individual pursuant to paragraph (1) of such section, the amount paid shall be equal to 80 percent of the lesser of the actual charge or the amount determined under paragraph (3) of such section;

(2) in the case of services described in section 1832(a)(2) (except those services described in subparagraphs (C), (D), (E), (F), (G), (H), and (I) of such section and unless otherwise specified in section 1881)—

(A) with respect to home health services (other than a covered osteoporosis drug) (as defined in section 1861(kk)), the amount determined under the prospective payment system under section 1895;

(B) with respect to other items and services (except those described in subparagraph (C), (D), or (E) of this paragraph and except as may be provided in section 1886 or section 1888(e)(9))—

(i) furnished before January 1, 1999, the lesser of—

(I) the reasonable cost of such services, as determined under section 1861(v), or

(II) the customary charges with respect to such services,—less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A), but in no case may the payment for such other services exceed 80 percent of such reasonable cost, or

(ii) if such services are furnished before January 1, 1999, by a public provider of services, or by another provider which demonstrates to the satisfaction of the Secretary that a significant portion of its patients are low-income (and requests that payment be made under this clause), free of charge or at nominal charges to the public, 80 percent of the amount determined in accordance with section 1814(b)(2), or

(iii) if such services are furnished on or after January 1, 1999, the amount determined under subsection (t), or

(iv) if (and for so long as) the conditions described in section 1814(b)(3) are met, the amounts determined under the reimbursement system described in such section;

(C) with respect to services described in the second sentence of section 1861(p), 80 percent of the reasonable charges for such services;

(D) with respect to clinical diagnostic laboratory tests for which payment is made under this part (i)(I)on the basis of a fee schedule determined under subsection(h)(1) (for tests furnished before January 1, 2017) or section 1834(d)(1), the amount paid shall be equal to 80 percent (or 100 percent, in the case of such tests for which payment is made on an assignment-related basis or to a provider having an agreement under section 1866) of the lesser of the amount determined under such fee schedule, the limitation amount for that test determined under subsection (h)(4)(B), or the amount of the charges billed for the tests, or (II) under section 1834A (for tests furnished on or after January 1, 2017), the amount paid shall be equal to 80 percent (or 100 percent, in the case of such tests for which payment is made on an assignment-related basis or to a provider having an agreement under section 1866) of the lesser of the amount determined under such section or the amount of the charges billed for the tests, or (ii) for tests furnished before January 1, 2017, on the basis of a negotiated rate established under subsection (h)(6), the amount paid shall be equal to 100 percent of such negotiated rate for such tests;

(E) with respect to—

(i) outpatient hospital radiology services (including diagnostic and therapeutic radiology, nuclear medicine and CAT scan procedures, magnetic resonance imaging, and ultrasound and other imaging services, but excluding screening mammography and, for services furnished on or after January 1, 2005, diagnostic mammography), and

(ii) effective for procedures performed on or after October 1, 1989, diagnostic procedures (as defined by the Secretary) described in section 1861(s)(3) (other than diagnostic x-ray tests and diagnostic laboratory tests),

the amount determined under subsection (n) or, for services or procedures performed on or after January 1, 1999, subsection (t);

(F) with respect to a covered osteoporosis drug (as defined in section 1861(kk)) furnished by a home health agency, 80 percent of the reasonable cost of such service, as determined under section 1861(v);

(G) with respect to items and services described in section 1861(s)(10)(A), the lesser of—

(i) the reasonable cost of such services, as determined under section 1861(v), or

(ii) the customary charges with respect to such services; and

(H) with respect to personalized prevention plan services (as defined in section 1861(hhh)(1)) furnished by an outpatient department of a hospital, the amount determined under paragraph (1)(X),

or, if such services are furnished by a public provider of services, or by another provider which demonstrates to the satisfaction of the Secretary that a significant portion of its patients are low-income (and requests that payment be made under this provision), free of charge or at nominal charges to the public, the amount determined in accordance with section 1814(b)(2);

(3) in the case of services described in section 1832(a)(2)(D)—

(A) except as provided in subparagraph (B), the costs which are reasonable and related to the cost of furnishing such services or which are based on such other tests of reasonableness as the Secretary may prescribe in regulations, including those authorized under section 1861(v)(1)(A), less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A), but in no case may the payment for such services (other than for items and services described in section 1861(s)(10)(A)) exceed 80 percent of such costs; or

(B) with respect to the services described in clause (ii) of section 1832(a)(2)(D) that are furnished to an individual enrolled with a MA plan under part C pursuant to a written agreement described in section 1853(a)(4), the amount (if any) by which—

(i) the amount of payment that would have otherwise been provided (I) under subparagraph (A) (calculated as if "100 percent" were substituted for "80 percent" in such subparagraph) for such services if the individual had not been so enrolled, or (II) in the case of such services furnished on or after the implementation date of the prospective payment system under section 1834(o), under such section (calculated as if "100 percent" were substituted for "80 percent" in such section) for such services if the individual had not been so enrolled; exceeds

(ii) the amount of the payments received under such written agreement for such services (not including any financial incentives provided for in such agreement such as risk pool payments, bonuses, or withholds),

less the amount the federally qualified health center may charge as described in section 1857(e)(3)(B);

(4) in the case of facility services described in section 1832(a)(2)(F), and outpatient hospital facility services furnished in connection with surgical procedures specified by the Secretary pursuant to section 1833(i)(1)(A), the applicable amount as determined under paragraph (2) or (3) of subsection (i) or subsection (t);

(5) in the case of covered items (described in section 1834(a)(13)) the amounts described in section 1834(a)(1);

(6) in the case of outpatient critical access hospital services, the amounts described in section 1834(g);

(7) in the case of prosthetic devices and orthotics and prosthetics (as described in section 1834(h)(4)), the amounts described in section 1834(h);

(8) in the case of—

(A) outpatient physical therapy services, outpatient speech-language pathology services, and outpatient occupational therapy services furnished—

(i) by a rehabilitation agency, public health agency, clinic, comprehensive outpatient rehabilitation facility, or skilled nursing facility,

(ii) by a home health agency to an individual who is not homebound, or

(iii) by another entity under an arrangement with an entity described in clause (i) or (ii); and

(B) outpatient physical therapy services, outpatient speech-language pathology services, and outpatient occupational therapy services furnished—

(i) by a hospital to an outpatient or to a hospital inpatient who is entitled to benefits under part A but has exhausted benefits for inpatient hospital services during a spell of illness or is not so entitled to benefits under part A, or

(ii) by another entity under an arrangement with a hospital described in clause (i),

the amounts described in section 1834(k); and

(9) in the case of services described in section 1832(a)(2)(E) that are not described in paragraph (8), the amounts described in section 1834(k).

Paragraph (3)(A) shall not apply to Federally qualified health center services furnished on or after the implementation date of the prospective payment system under section 1834(0).

(b) Before applying subsection (a) with respect to expenses incurred by an individual during any calendar year, the total amount of the expenses incurred by such individual during such year (which would, except for this subsection, constitute incurred expenses from which benefits payable under subsection (a) are determinable) shall be reduced by a deductible of $75 for calendar years before 1991, $100 for 1991 through 2004, $110 for 2005, and for a subsequent year the amount of such deductible for the previous year increased by the annual percentage increase in the monthly actuarial rate under section 1839(a)(1) ending with such subsequent year (rounded to the nearest $1); except that (1) such total amount shall not include expenses incurred for preventive services described in subparagraph (A) of section 1861(ddd)(3) that are recommended with a grade of A or B by the United States Preventive

Services Task Force for any indication or population and are appropriate for the individual., (2) such deductible shall not apply with respect to home health services (other than a covered osteoporosis drug (as defined in section 1861(kk))), (3) such deductible shall not apply with respect to clinical diagnostic laboratory tests for which payment is made under this part (A) under subsection (a)(1)(D)(i) or (a)(2)(D)(i) on an assignment-related basis, or to a provider having an agreement under section 1866, or (B) for tests furnished before January 1, 2017,on the basis of a negotiated rate determined under subsection (h)(6), (4) such deductible shall not apply to Federally qualified health center services, (5) such deductible shall not apply with respect to screening mammography (as described in section 1861(jj)), (6) such deductible shall not apply with respect to screening pap smear and screening pelvic exam (as described in section 1861(nn)), (7) such deductible shall not apply with respect to ultrasound screening for abdominal aortic aneurysm (as defined in section 1861(bbb)), (8) such deductible shall not apply with respect to colorectal cancer screening tests (as described in section 1861(pp)(1)), (9) such deductible shall not apply with respect to an initial preventive physical examination (as defined in section 1861(ww)), and (10) such deductible shall not apply with respect to personalized prevention plan services (as defined in section 1861(hhh)(1)). The total amount of the expenses incurred by an individual as determined under the preceding sentence shall, after the reduction specified in such sentence, be further reduced by an amount equal to the expenses incurred for the first three pints of whole blood (or equivalent quantities of packed red blood cells, as defined under regulations) furnished to the individual during the calendar year, except that such deductible for such blood shall in accordance with regulations be appropriately reduced to the extent that there has been a replacement of such blood (or equivalent quantities of packed red blood cells, as so defined); and for such purposes blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual shall be deemed replaced when the institution or other person furnishing such blood (or such equivalent quantities of packed red blood cells, as so defined) is given one pint of blood for each pint of blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual with respect to which a deduction is made under this sentence. The deductible under the previous sentence for blood or blood cells furnished an individual in a year shall be reduced to the extent that a deductible has been imposed under section 1813(a)(2) to blood or blood cells furnished the individual in the year. Paragraph (1) of the first sentence of this subsection shall apply with respect to a colorectal cancer screening test regardless of the code that is billed for the establishment of a diagnosis as a result of the test, or for the removal of tissue or other matter or other procedure that is furnished in connection with, as a result of, and in the same clinical encounter as the screening test.

(c)(1) Notwithstanding any other provision of this part, with respect to expenses incurred in a calendar year in connection with the treatment of mental, psychoneurotic, and personality disorders of an individual who is not an inpatient of a hospital at the time such expenses are incurred, there shall be considered as incurred expenses for purposes of subsections (a) and (b)—

(A) for expenses incurred in years prior to 2010, only 62½ percent of such expenses;

(B) for expenses incurred in 2010 or 2011, only 68¾ percent of such expenses;

(C) for expenses incurred in 2012, only 75 percent of such expenses;

(D) for expenses incurred in 2013, only 81¼ percent of such expenses; and

(E) for expenses incurred in 2014 or any subsequent calendar year, 100 percent of such expenses.

(2) For purposes of subparagraphs (A) through (D) of paragraph (1), the term "treatment" does not include brief office visits (as defined by the Secretary) for the sole purpose of monitoring or changing drug prescriptions used in the treatment of such disorders or partial hospitalization services that are not directly provided by a physician

(d) No payment may be made under this part with respect to any services furnished an individual to the extent that such individual is entitled (or would be entitled except for section 1813) to have payment made with respect to such services under part A.

(e) No payment shall be made to any provider of services or other person under this part unless there has been furnished such information as may be necessary in order to determine the amounts due such provider or other person under this part for the period with respect to which the amounts are being paid or for any prior period.

(f) In establishing limits under subsection (a) on payment for rural health clinic services provided by rural health clinics (other than such clinics in hospitals with less than 50 beds), the Secretary shall establish such limit, for services provided—

(1) in 1988, after March 31, at $46 per visit, and

(2) in a subsequent year, at the limit established under this subsection for the previous year increased by the percentage increase in the MEI (as defined in section 1842(i)(3)) applicable to primary care services (as defined in section 1842(i)(4)) furnished as of the first day of that year.

(g)(1) Subject to paragraphs (4) and (5), in the case of physical therapy services of the type described in section 1861(p) and speech-language pathology services of the type described in such section through the application of section 1861(ll)(2), but (except as provided in paragraph (6)) not described in subsection (a)(8)(B), and physical therapy services and speech-language pathology services of such type which are furnished by a physician or as incident to physicians' services, with respect to expenses incurred in any calendar year, no more than the amount specified in paragraph (2) for the year shall be considered as incurred expenses for purposes of subsections (a) and (b).

(2) The amount specified in this paragraph—

(A) for 1999, 2000, and 2001, is $1,500, and

(B) for a subsequent year is the amount specified in this paragraph for the preceding year increased by the percentage increase in the MEI (as defined in section 1842(i)(3)) for such subsequent year;

except that if an increase under subparagraph (B) for a year is not a multiple of $10, it shall be rounded to the nearest multiple of $10.

(3) Subject to paragraphs (4) and (5), in the case of occupational therapy services (of the type that are described in section 1861(p) (but (except as provided in paragraph (6)) not described in subsection (a)(8)(B)) through the operation of section 1861(g) and of such type which are furnished by a physician or as incident to physicians' services), with respect to expenses incurred in any calendar year, no more than the amount specified in paragraph (2) for the year shall be considered as incurred expenses for purposes of subsections (a) and (b).

(4) This subsection shall not apply to expenses incurred with respect to services furnished during 2000, 2001, 2002, 2004, and 2005.

(5)(A) With respect to expenses incurred during the period beginning on January 1, 2006, and ending on December 31, 2017, for services, the Secretary shall implement a process under which an individual enrolled under this part may, upon request of the individual or a person on behalf of the individual, obtain an exception from the uniform dollar limitation specified in paragraph (2), for services described in paragraphs (1) and (3) if the provision of such services is determined to be medically necessary and if the requirement of subparagraph (B) is met. Under such process, if the Secretary does not make a decision on such a request for an exception within 10 business days of the date of the Secretary's receipt of the request made in accordance with such requirement, the Secretary shall be deemed to have found the services to be medically necessary.

(B) In the case of outpatient therapy services for which an exception is requested under the first sentence of subparagraph (A), the claim for such services shall contain an appropriate modifier (such as the KX modifier used as of the date of the enactment of this subparagraph) indicating that such services are medically necessary as justified by appropriate documentation in the medical record involved.

(C)(i) In applying this paragraph with respect to a request for an exception with respect to expenses that would be incurred for outpatient therapy services (including services described in subsection (a)(8)(B)) that would exceed the threshold described in clause (ii) for a year, the request for such an exception, for services furnished on or after October 1, 2012, shall be subject to a manual medical review process that, subject to subparagraph (E), is similar to the manual medical review process used for certain exceptions under this paragraph in 2006.

(ii) The threshold under this clause for a year is $3,700. Such threshold shall be applied separately—

(I) for physical therapy services and speech-language pathology services; and

(II) for occupational therapy services.

(D) With respect to services furnished on or after January 1, 2013, where payment may not be made as a result of application of paragraphs (1) and (3), section 1879 shall apply in the same manner as such section applies to a denial that is made by reason of section 1862(a)(1).

(E)(i) In place of the manual medical review process under subparagraph (C)(i), the Secretary shall implement a process for medical review under this subparagraph under which the Secretary shall identify and conduct medical review for services described in subparagraph (C)(i) furnished by a provider of services or supplier (in this subparagraph referred to as a "therapy provider") using such factors as the Secretary determines to be appropriate.

(ii) Such factors may include the following:

(I) The therapy provider has had a high claims denial percentage for therapy services under this part or is less compliant with applicable requirements under this title.

(II) The therapy provider has a pattern of billing for therapy services under this part that is aberrant compared to peers or otherwise has questionable billing practices for such services, such as billing medically unlikely units of services in a day.

(III) The therapy provider is newly enrolled under this title or has not previously furnished therapy services under this part.

(IV) The services are furnished to treat a type of medical condition.

(V) The therapy provider is part of group that includes another therapy provider identified using the factors determined under this subparagraph.

(iii) For purposes of carrying out this subparagraph, the Secretary shall provide for the transfer, from the Federal Supplementary Medical Insurance Trust Fund under section 1841, of $5,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for fiscal years 2015 and 2016, to remain available until expended. Such funds may not be used by a contractor under section 1893(h) for medical reviews under this subparagraph.

(iv) The targeted review process under this subparagraph shall not apply to services for which expenses are incurred beyond the period for which the exceptions process under subparagraph (A) is implemented.

(6)(A) In applying paragraphs (1) and (3) to services furnished during the period beginning not later than October 1, 2012, and ending on December 31, 2017, the exclusion of services described in subsection (a)(8)(B) from the uniform dollar limitation specified in paragraph (2) shall not apply to such services furnished during 2012 through 2017.

(B)(i) With respect to outpatient therapy services furnished beginning on or after January 1, 2013, and before January 1, 2014, for which payment is made under section 1834(g), the Secretary shall count toward the uniform dollar limitations described in paragraphs (1) and (3) and the threshold described in paragraph (5)(C) the amount that would be payable under this part if such services were paid under section 1834(k)(1)(B) instead of being paid under section 1834(g).

(ii) Nothing in clause (i) shall be construed as changing the method of payment for outpatient therapy services under section 1834(g).

(h)(1)(A) Subject to section 1834(d)(1), the Secretary shall establish fee schedules for clinical diagnostic laboratory tests (including prostate cancer screening tests under section 1861(oo) consisting of

prostate-specific antigen blood tests) for which payment is made under this part, other than such tests performed by a provider of services for an inpatient of such provider.

(B) In the case of clinical diagnostic laboratory tests performed by a physician or by a laboratory (other than tests performed by a qualified hospital laboratory (as defined in subparagraph (D)) for outpatients of such hospital), the fee schedules established under subparagraph (A) shall be established on a regional, statewide, or carrier service area basis (as the Secretary may determine to be appropriate) for tests furnished on or after July 1, 1984.

(C) In the case of clinical diagnostic laboratory tests performed by a qualified hospital laboratory (as defined in subparagraph (D)) for outpatients of such hospital, the fee schedules established under subparagraph (A) shall be established on a regional, statewide, or carrier service area basis (as the Secretary may determine to be appropriate) for tests furnished on or after July 1, 1984.

(D) In this subsection, the term "qualified hospital laboratory" means a hospital laboratory, in a sole community hospital (as defined in section 1886(d)(5)(D)(iii)), which provides some clinical diagnostic laboratory tests 24 hours a day in order to serve a hospital emergency room which is available to provide services 24 hours a day and 7 days a week.

(2)(A)(i) Except as provided in clause (v), subparagraph (B), and paragraph (4), the Secretary shall set the fee schedules at 60 percent (or, in the case of a test performed by a qualified hospital laboratory (as defined in paragraph (1)(D)) for outpatients of such hospital, 62 percent) of the prevailing charge level determined pursuant to the third and fourth sentences of section 1842(b)(3) for similar clinical diagnostic laboratory tests for the applicable region, State, or area for the 12-month period beginning July 1, 1984, adjusted annually (to become effective on January 1 of each year) by, subject to clause (iv), a percentage increase or decrease equal to the percentage increase or decrease in the Consumer Price Index for All Urban Consumers (United States city average) minus, for each of the years 2009 and 2010, 0.5 percentage points, and, for tests furnished before the dateof enactment of section 1834A, subject to such other adjustments as the Secretary determines are justified by technological changes.

(ii) Notwithstanding clause (i)—

(I) any change in the fee schedules which would have become effective under this subsection for tests furnished on or after January 1, 1988, shall not be effective for tests furnished during the 3-month period beginning on January 1, 1988,

(II) the Secretary shall not adjust the fee schedules under clause (i) to take into account any increase in the consumer price index for 1988,

(III) the annual adjustment in the fee schedules determined under clause (i) for each of the years 1991, 1992, and 1993 shall be 2 percent, and

(IV) the annual adjustment in the fee schedules determined under clause (i) for each of the years 1994 and 1995, 1998 through 2002, and 2004 through 2008 shall be 0 percent.

(iii) In establishing fee schedules under clause (i) with respect to automated tests and tests (other than cytopathology tests) which before July 1, 1984, the Secretary made subject to a limit based on

lowest charge levels under the sixth sentence of section 1842(b)(3) performed after March 31, 1988, the Secretary shall reduce by 8.3 percent the fee schedules otherwise established for 1988, and such reduced fee schedules shall serve as the base for 1989 and subsequent years.

(iv) After determining the adjustment to the fee schedules under clause (i), the Secretary shall reduce such adjustment—

(I) for 2011 and each subsequent year, by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II); and

(II) for each of 2011 through 2015, by 1.75 percentage points.

Subclause (I) shall not apply in a year where the adjustment to the fee schedules determined under clause (i) is 0.0 or a percentage decrease for a year. The application of the productivity adjustment under subclause (I) shall not result in an adjustment to the fee schedules under clause (i) being less than 0.0 for a year. The application of subclause (II) may result in an adjustment to the fee schedules under clause (i) being less than 0.0 for a year, and may result in payment rates for a year being less than such payment rates for the preceding year.

(v) The Secretary shall reduce by 2 percent the fee schedules otherwise determined under clause (i) for 2013, and such reduced fee schedules shall serve as the base for 2014 and subsequent years.

(B) The Secretary may make further adjustments or exceptions to the fee schedules to assure adequate reimbursement of (i) emergency laboratory tests needed for the provision of bona fide emergency services, and (ii) certain low volume high-cost tests where highly sophisticated equipment or extremely skilled personnel are necessary to assure quality.

(3) In addition to the amounts provided under the fee schedules (for tests furnished before January 1, 2017)or under section 1834A (for tests furnished on or afterJanuary 1, 2017), subject to subsection (b)(5) of such section, the Secretary shall provide for and establish (A) a nominal fee to cover the appropriate costs in collecting the sample on which a clinical diagnostic laboratory test was performed and for which payment is made under this part, except that not more than one such fee may be provided under this paragraph with respect to samples collected in the same encounter, and (B) a fee to cover the transportation and personnel expenses for trained personnel to travel to the location of an individual to collect the sample, except that such a fee may be provided only with respect to an individual who is homebound or an inpatient in an inpatient facility (other than a hospital). In establishing a fee to cover the transportation and personnel expenses for trained personnel to travel to the location of an individual to collect a sample, the Secretary shall provide a method for computing the fee based on the number of miles traveled and the personnel costs associated with the collection of each individual sample, but the Secretary shall only be required to apply such method in the case of tests furnished during the period beginning on April 1, 1989, and ending on December 31, 1990, by a laboratory that establishes to the satisfaction of the Secretary (based on data for the 12-month period ending June 30, 1988) that (i) the laboratory is dependent upon payments under this title for at least 80 percent of its collected revenues for clinical diagnostic laboratory tests, (ii) at least 85 percent of its gross revenues for such tests are attributable to tests per-

formed with respect to individuals who are homebound or who are residents in a nursing facility, and (iii) the laboratory provided such tests for residents in nursing facilities representing at least 20 percent of the number of such facilities in the State in which the laboratory is located.

(4)(A) In establishing any fee schedule under this subsection, the Secretary may provide for an adjustment to take into account, with respect to the portion of the expenses of clinical diagnostic laboratory tests attributable to wages, the relative difference between a region's or local area's wage rates and the wage rate presumed in the data on which the schedule is based.

(B) For purposes of subsections (a)(1)(D)(i) and (a)(2)(D)(i), the limitation amount for a clinical diagnostic laboratory test performed—

(i) on or after July 1, 1986, and before April 1, 1988, is equal to 115 percent of the median of all the fee schedules established for that test for that laboratory setting under paragraph (1),

(ii) after March 31, 1988, and before January 1, 1990, is equal to the median of all the fee schedules established for that test for that laboratory setting under paragraph (1),

(iii) after December 31, 1989, and before January 1, 1991, is equal to 93 percent of the median of all the fee schedules established for that test for that laboratory setting under paragraph (1),

(iv) after December 31, 1990, and before January 1, 1994, is equal to 88 percent of such median,

(v) after December 31, 1993, and before January 1, 1995, is equal to 84 percent of such median,

(vi) after December 31, 1994, and before January 1, 1996, is equal to 80 percent of such median,

(vii) after December 31, 1995, and before January 1, 1998, is equal to 76 percent of such median, and

(viii) after December 31, 1997, is equal to 74 percent of such median (or 100 percent of such median in the case of a clinical diagnostic laboratory test performed on or after January 1, 2001, that the Secretary determines is a new test for which no limitation amount has previously been established under this subparagraph).

(5)(A) In the case of a bill or request for payment for a clinical diagnostic laboratory test for which payment may otherwise be made under this part on an assignment-related basis or under a provider agreement under section 1866, payment may be made only to the person or entity which performed or supervised the performance of such test; except that—

(i) if a physician performed or supervised the performance of such test, payment may be made to another physician with whom he shares his practice,

(ii) in the case of a test performed at the request of a laboratory by another laboratory, payment may be made to the referring laboratory but only if—

(I) the referring laboratory is located in, or is part of, a rural hospital,

(II) the referring laboratory is wholly owned by the entity performing such test, the referring laboratory wholly

owns the entity performing such test, or both the referring laboratory and the entity performing such test are wholly-owned by a third entity, or

(III) not more than 30 percent of the clinical diagnostic laboratory tests for which such referring laboratory (but not including a laboratory described in subclause (II)), receives requests for testing during the year in which the test is performed are performed by another laboratory, and

(iii) in the case of a clinical diagnostic laboratory test provided under an arrangement (as defined in section 1861(w)(1)) made by a hospital, critical access hospital, or skilled nursing facility, payment shall be made to the hospital or skilled nursing facility.

(B) In the case of such a bill or request for payment for a clinical diagnostic laboratory test for which payment may otherwise be made under this part, and which is not described in subparagraph (A), payment may be made to the beneficiary only on the basis of the itemized bill of the person or entity which performed or supervised the performance of the test.

(C) Payment for a clinical diagnostic laboratory test, including a test performed in a physician's office but excluding a test performed by a rural health clinic may only be made on an assignment-related basis or to a provider of services with an agreement in effect under section 1866.

(D) A person may not bill for a clinical diagnostic laboratory test, including a test performed in a physician's office but excluding a test performed by a rural health clinic, other than on an assignment-related basis. If a person knowingly and willfully and on a repeated basis bills for a clinical diagnostic laboratory test in violation of the previous sentence, the Secretary may apply sanctions against the person in the same manner as the Secretary may apply sanctions against a physician in accordance with paragraph (2) of section 1842(j) in the same manner such paragraphs apply with respect to a physician. Paragraph (4) of such section shall apply in this subparagraph in the same manner as such paragraph applies to such section.

(6) For tests furnished before January 1, 2017, inthe case of any diagnostic laboratory test payment for which is not made on the basis of a fee schedule under paragraph (1), the Secretary may establish a payment rate which is acceptable to the person or entity performing the test and which would be considered the full charge for such tests. Such negotiated rate shall be limited to an amount not in excess of the total payment that would have been made for the services in the absence of such rate.

(7) Notwithstanding paragraphs (1) and (4)and section 1834A, the Secretary shall establish a national minimum payment amount under this part for a diagnostic or screening pap smear laboratory test (including all cervical cancer screening technologies that have been approved by the Food and Drug Administration as a primary screening method for detection of cervical cancer) equal to $14.60 for tests furnished in 2000. For such tests furnished in subsequent years, such national minimum payment amount shall be adjusted annually as provided in paragraph (2).

(8)(A) The Secretary shall establish by regulation procedures for determining the basis for, and amount of, payment under this sub-

section for any clinical diagnostic laboratory test with respect to which a new or substantially revised HCPCS code is assigned on or after January 1, 2005 (in this paragraph referred to as "new tests").

(B) Determinations under subparagraph (A) shall be made only after the Secretary—

(i) makes available to the public (through an Internet website and other appropriate mechanisms) a list that includes any such test for which establishment of a payment amount under this subsection is being considered for a year;

(ii) on the same day such list is made available, causes to have published in the Federal Register notice of a meeting to receive comments and recommendations (and data on which recommendations are based) from the public on the appropriate basis under this subsection for establishing payment amounts for the tests on such list;

(iii) not less than 30 days after publication of such notice convenes a meeting, that includes representatives of officials of the Centers for Medicare & Medicaid Services involved in determining payment amounts, to receive such comments and recommendations (and data on which the recommendations are based);

(iv) taking into account the comments and recommendations (and accompanying data) received at such meeting, develops and makes available to the public (through an Internet website and other appropriate mechanisms) a list of proposed determinations with respect to the appropriate basis for establishing a payment amount under this subsection for each such code, together with an explanation of the reasons for each such determination, the data on which the determinations are based, and a request for public written comments on the proposed determination; and

(v) taking into account the comments received during the public comment period, develops and makes available to the public (through an Internet website and other appropriate mechanisms) a list of final determinations of the payment amounts for such tests under this subsection, together with the rationale for each such determination, the data on which the determinations are based, and responses to comments and suggestions received from the public.

(C) Under the procedures established pursuant to subparagraph (A), the Secretary shall—

(i) set forth the criteria for making determinations under subparagraph (A); and

(ii) make available to the public the data (other than proprietary data) considered in making such determinations.

(D) The Secretary may convene such further public meetings to receive public comments on payment amounts for new tests under this subsection as the Secretary deems appropriate.

(E) For purposes of this paragraph:

(i) The term "HCPCS" refers to the Health Care Procedure Coding System.

(ii) A code shall be considered to be "substantially revised" if there is a substantive change to the definition of the test or procedure to which the code applies (such as a new analyte or

a new methodology for measuring an existing analyte-specific test).

(9) Notwithstanding any other provision in this part, in the case of any diagnostic laboratory test for HbA1c that is labeled by the Food and Drug Administration for home use and is furnished on or after April 1, 2008, the payment rate for such test shall be the payment rate established under this part for a glycated hemoglobin test (identified as of October 1, 2007, by HCPCS code 83036 (and any succeeding codes)).

(i)(1) The Secretary shall, in consultation with appropriate medical organizations—

(A) specify those surgical procedures which are appropriately (when considered in terms of the proper utilization of hospital inpatient facilities) performed on an inpatient basis in a hospital but which also can be performed safely on an ambulatory basis in an ambulatory surgical center (meeting the standards specified under section 1832(a)(2)(F)(i)), critical access hospital, or hospital outpatient department, and

(B) specify those surgical procedures which are appropriately (when considered in terms of the proper utilization of hospital inpatient facilities) performed on an inpatient basis in a hospital but which also can be performed safely on an ambulatory basis in a physician's office.

The lists of procedures established under subparagraphs (A) and (B) shall be reviewed and updated not less often than every 2 years, in consultation with appropriate trade and professional organizations.

(2)(A) For services furnished prior to the implementation of the system described in subparagraph (D), subject to subparagraph (E), the amount of payment to be made for facility services furnished in connection with a surgical procedure specified pursuant to paragraph (1)(A) and furnished to an individual in an ambulatory surgical center described in such paragraph shall be equal to 80 percent of a standard overhead amount established by the Secretary (with respect to each such procedure) on the basis of the Secretary's estimate of a fair fee which—

(i) takes into account the costs incurred by such centers, or classes of centers, generally in providing services furnished in connection with the performance of such procedure, as determined in accordance with a survey (based upon a representative sample of procedures and facilities) of the actual audited costs incurred by such centers in providing such services,

(ii) takes such costs into account in such a manner as will assure that the performance of the procedure in such a center will result in substantially less amounts paid under this title than would have been paid if the procedure had been performed on an inpatient basis in a hospital, and

(iii) in the case of insertion of an intraocular lens during or subsequent to cataract surgery includes payment which is reasonable and related to the cost of acquiring the class of lens involved.

Each amount so established shall be reviewed and updated not later than July 1, 1987, and annually thereafter to take account of varying conditions in different areas.

(B) The amount of payment to be made under this part for facility services furnished, in connection with a surgical procedure specified pursuant to paragraph (1)(B), in a physician's office shall be equal to 80 percent of a standard overhead amount established by the Secretary (with respect to each such procedure) on the basis of the Secretary's estimate of a fair fee which—

(i) takes into account additional costs, not usually included in the professional fee, incurred by physicians in securing, maintaining, and staffing the facilities and ancillary services appropriate for the performance of such procedure in the physician's office, and

(ii) takes such items into account in such a manner which will assure that the performance of such procedure in the physician's office will result in substantially less amounts paid under this title than would have been paid if the services had been furnished on an inpatient basis in a hospital.

Each amount so established shall be reviewed and updated not later than July 1, 1987, and annually thereafter to take account of varying conditions in different areas.

(C)(i) Notwithstanding the second sentence of each of subparagraphs (A) and (B), except as otherwise specified in clauses (ii), (iii), and (iv), if the Secretary has not updated amounts established under such subparagraphs or under subparagraph (D), with respect to facility services furnished during a fiscal year (beginning with fiscal year 1986 or a calendar year (beginning with 2006)), such amounts shall be increased by the percentage increase in the Consumer Price Index for all urban consumers (U.S. city average) as estimated by the Secretary for the 12-month period ending with the midpoint of the year involved.

(ii) In each of the fiscal years 1998 through 2002, the increase under this subparagraph shall be reduced (but not below zero) by 2.0 percentage points.

(iii) In fiscal year 2004, beginning with April 1, 2004, the increase under this subparagraph shall be the Consumer Price Index for all urban consumers (U.S. city average) as estimated by the Secretary for the 12-month period ending with March 31, 2003, minus 3.0 percentage points.

(iv) In fiscal year 2005, the last quarter of calendar year 2005, and each of calendar years 2006 through 2009, the increase under this subparagraph shall be 0 percent.

(D)(i) Taking into account the recommendations in the report under section 626(d) of Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the Secretary shall implement a revised payment system for payment of surgical services furnished in ambulatory surgical centers.

(ii) In the year the system described in clause (i) is implemented, such system shall be designed to result in the same aggregate amount of expenditures for such services as would be made if this subparagraph did not apply, as estimated by the Secretary and taking into account reduced expenditures that would apply if subparagraph (E) were to continue to apply, as estimated by the Secretary.

(iii) The Secretary shall implement the system described in clause (i) for periods in a manner so that it is first effective begin-

ning on or after January 1, 2006, and not later than January 1, 2008.

(iv) The Secretary may implement such system in a manner so as to provide for a reduction in any annual update for failure to report on quality measures in accordance with paragraph (7).

(v) In implementing the system described in clause (i) for 2011 and each subsequent year, any annual update under such system for the year, after application of clause (iv), shall be reduced by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II). The application of the preceding sentence may result in such update being less than 0.0 for a year, and may result in payment rates under the system described in clause (i) for a year being less than such payment rates for the preceding year.

(vi) There shall be no administrative or judicial review under section 1869, 1878, or otherwise, of the classification system, the relative weights, payment amounts, and the geographic adjustment factor, if any, under this subparagraph.

(E) With respect to surgical procedures furnished on or after January 1, 2007, and before the effective date of the implementation of a revised payment system under subparagraph (D), if—

(i) the standard overhead amount under subparagraph (A) for a facility service for such procedure, without the application of any geographic adjustment, exceeds

(ii) the Medicare OPD fee schedule amount established under the prospective payment system for hospital outpatient department services under paragraph (3)(D) of section 1833(t) for such service for such year, determined without regard to geographic adjustment under paragraph (2)(D) of such section,

the Secretary shall substitute under subparagraph (A) the amount described in clause (ii) for the standard overhead amount for such service referred to in clause (i).

(3)(A) The aggregate amount of the payments to be made under this part for outpatient hospital facility services or critical access hospital services furnished before January 1, 1999, in connection with surgical procedures specified under paragraph (1)(A) shall be equal to the lesser of—

(i) the amount determined with respect to such services under subsection (a)(2)(B); or

(ii) the blend amount (described in subparagraph (B)).

(B)(i) The blend amount for a cost reporting period is the sum of—

(I) the cost proportion (as defined in clause (ii)(I)) of the amount described in subparagraph (A)(i), and

(II) the ASC proportion (as defined in clause (ii)(II)) of the standard overhead amount payable with respect to the same surgical procedure as if it were provided in an ambulatory surgical center in the same area, as determined under paragraph (2)(A), less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A).

(ii) Subject to paragraph (4), in this paragraph:

(I) The term "cost proportion" means 75 percent for cost reporting periods beginning in fiscal year 1988, 50 percent for portions of cost reporting periods beginning on or after October 1, 1988, and ending on or before December 31, 1990, and 42

percent for portions of cost reporting periods beginning on or after January 1, 1991.

(II) The term "ASC proportion" means 25 percent for cost reporting periods beginning in fiscal year 1988, 50 percent for portions of cost reporting periods beginning on or after October 1, 1988, and ending on or before December 31, 1990, and 58 percent for portions of cost reporting periods beginning on or after January 1, 1991.

(4)(A) In the case of a hospital that—

(i) makes application to the Secretary and demonstrates that it specializes in eye services or eye and ear services (as determined by the Secretary),

(ii) receives more than 30 percent of its total revenues from outpatient services, and

(iii) on October 1, 1987—

(I) was an eye specialty hospital or an eye and ear specialty hospital, or

(II) was operated as an eye or eye and ear unit (as defined in subparagraph (B)) of a general acute care hospital which, on the date of the application described in clause (i), operates less than 20 percent of the beds that the hospital operated on October 1, 1987, and has sold or otherwise disposed of a substantial portion of the hospital's other acute care operations,

the cost proportion and ASC proportion in effect under subclauses (I) and (II) of paragraph (3)(B)(ii) for cost reporting periods beginning in fiscal year 1988 shall remain in effect for cost reporting periods beginning on or after October 1, 1988, and before January 1, 1995.

(B) For purposes of this subparagraph (A)(iii)(II), the term "eye or eye and ear unit" means a physically separate or distinct unit containing separate surgical suites devoted solely to eye or eye and ear services.

(5)(A) The Secretary is authorized to provide by regulations that in the case of a surgical procedure, specified by the Secretary pursuant to paragraph (1)(A), performed in an ambulatory surgical center described in such paragraph, there shall be paid (in lieu of any amounts otherwise payable under this part) with respect to the facility services furnished by such center and with respect to all related services (including physicians' services, laboratory, X-ray, and diagnostic services) a single all-inclusive fee established pursuant to subparagraph (B), if all parties furnishing all such services agree to accept such fee (to be divided among the parties involved in such manner as they shall have previously agreed upon) as full payment for the services furnished.

(B) In implementing this paragraph, the Secretary shall establish with respect to each surgical procedure specified pursuant to paragraph (1)(A) the amount of the all-inclusive fee for such procedure, taking into account such factors as may be appropriate. The amount so established with respect to any surgical procedure shall be reviewed periodically and may be adjusted by the Secretary, when appropriate, to take account of varying conditions in different areas.

(6) Any person, including a facility having an agreement under section 1832(a)(2)(F)(i), who knowingly and willfully presents, or

causes to be presented, a bill or request for payment, for an intraocular lens inserted during or subsequent to cataract surgery for which payment may be made under paragraph (2)(A)(iii), is subject to a civil money penalty of not to exceed $2,000. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

(7)(A) For purposes of paragraph (2)(D)(iv), the Secretary may provide, in the case of an ambulatory surgical center that does not submit, to the Secretary in accordance with this paragraph, data required to be submitted on measures selected under this paragraph with respect to a year, any annual increase provided under the system established under paragraph (2)(D) for such year shall be reduced by 2.0 percentage points. A reduction under this subparagraph shall apply only with respect to the year involved and the Secretary shall not take into account such reduction in computing any annual increase factor for a subsequent year.

(B) Except as the Secretary may otherwise provide, the provisions of subparagraphs (B), (C), (D), and (E) of paragraph (17) of section 1833(t) shall apply with respect to services of ambulatory surgical centers under this paragraph in a similar manner to the manner in which they apply under such paragraph and, for purposes of this subparagraph, any reference to a hospital, outpatient setting, or outpatient hospital services is deemed a reference to an ambulatory surgical center, the setting of such a center, or services of such a center, respectively.

(j) Whenever a final determination is made that the amount of payment made under this part either to a provider of services or to another person pursuant to an assignment under section 1842(b)(3)(B)(ii) was in excess of or less than the amount of payment that is due, and payment of such excess or deficit is not made (or effected by offset) within 30 days of the date of the determination, interest shall accrue on the balance of such excess or deficit not paid or offset (to the extent that the balance is owed by or owing to the provider) at a rate determined in accordance with the regulations of the Secretary of the Treasury applicable to charges for late payments.

(k) With respect to services described in section 1861(s)(10)(B), the Secretary may provide, instead of the amount of payment otherwise provided under this part, for payment of such an amount or amounts as reasonably reflects the general cost of efficiently providing such services.

(l)(1)(A) The Secretary shall establish a fee schedule for services of certified registered nurse anesthetists under section 1861(s)(11).

(B) In establishing the fee schedule under this paragraph the Secretary may utilize a system of time units, a system of base and time units, or any appropriate methodology.

(C) The provisions of this subsection shall not apply to certain services furnished in certain hospitals in rural areas under the provisions of section 9320(k) of the Omnibus Budget Reconciliation Act of 1986, as amended by section 6132 of the Omnibus Budget Reconciliation Act of 1989.

(2) Except as provided in paragraph (3), the fee schedule established under paragraph (1) shall be initially based on audited data

from cost reporting periods ending in fiscal year 1985 and such other data as the Secretary determines necessary.

(3)(A) In establishing the initial fee schedule for those services, the Secretary shall adjust the fee schedule to the extent necessary to ensure that the estimated total amount which will be paid under this title for those services plus applicable coinsurance in 1989 will equal the estimated total amount which would be paid under this title for those services in 1989 if the services were included as inpatient hospital services and payment for such services was made under part A in the same manner as payment was made in fiscal year 1987, adjusted to take into account changes in prices and technology relating to the administration of anesthesia.

(B) The Secretary shall also reduce the prevailing charge of physicians for medical direction of a certified registered nurse anesthetist, or the fee schedule for services of certified registered nurse anesthetists, or both, to the extent necessary to ensure that the estimated total amount which will be paid under this title plus applicable coinsurance for such medical direction and such services in 1989 and 1990 will not exceed the estimated total amount which would have been paid plus applicable coinsurance but for the enactment of the amendments made by section 9320 of the Omnibus Budget Reconciliation Act of 1986. A reduced prevailing charge under this subparagraph shall become the prevailing charge but for subsequent years for purposes of applying the economic index under the fourth sentence of section 1842(b)(3).

(4)(A) Except as provided in subparagraphs (C) and (D), in determining the amount paid under the fee schedule under this subsection for services furnished on or after January 1, 1991, by a certified registered nurse anesthetist who is not medically directed—

(i) the conversion factor shall be—

(I) for services furnished in 1991, $15.50,

(II) for services furnished in 1992, $15.75,

(III) for services furnished in 1993, $16.00,

(IV) for services furnished in 1994, $16.25,

(V) for services furnished in 1995, $16.50,

(VI) for services furnished in 1996, $16.75, and

(VII) for services furnished in calendar years after 1996, the previous year's conversion factor increased by the update determined under section 1848(d) for physician anesthesia services for that year;

(ii) the payment areas to be used shall be the fee schedule areas used under section 1848 (or, in the case of services furnished during 1991, the localities used under section 1842(b)) for purposes of computing payments for physicians' services that are anesthesia services;

(iii) the geographic adjustment factors to be applied to the conversion factor under clause (i) for services in a fee schedule area or locality is—

(I) in the case of services furnished in 1991, the geographic work index value and the geographic practice cost index value specified in section 1842(q)(1)(B) for physicians' services that are anesthesia services furnished in the area or locality, and

(II) in the case of services furnished after 1991, the geographic work index value, the geographic practice cost

index value, and the geographic malpractice index value used for determining payments for physicians' services that are anesthesia services under section 1848,

with 70 percent of the conversion factor treated as attributable to work and 30 percent as attributable to overhead for services furnished in 1991 (and the portions attributable to work, practice expenses, and malpractice expenses in 1992 and thereafter being the same as is applied under section 1848).

(B)(i) Except as provided in clause (ii) and subparagraph (D), in determining the amount paid under the fee schedule under this subsection for services furnished on or after January 1, 1991, and before January 1, 1994, by a certified registered nurse anesthetist who is medically directed, the Secretary shall apply the same methodology specified in subparagraph (A).

(ii) The conversion factor used under clause (i) shall be—

(I) for services furnished in 1991, $10.50,

(II) for services furnished in 1992, $10.75, and

(III) for services furnished in 1993, $11.00.

(iii) In the case of services of a certified registered nurse anesthetist who is medically directed or medically supervised by a physician which are furnished on or after January 1, 1994, the fee schedule amount shall be one-half of the amount described in section 1848(a)(5)(B) with respect to the physician.

(C) Notwithstanding subclauses (I) through (V) of subparagraph (A)(i)—

(i) in the case of a 1990 conversion factor that is greater than $16.50, the conversion factor for a calendar year after 1990 and before 1996 shall be the 1990 conversion factor reduced by the product of the last digit of the calendar year and one-fifth of the amount by which the 1990 conversion factor exceeds $16.50; and

(ii) in the case of a 1990 conversion factor that is greater than $15.49 but less than $16.51, the conversion factor for a calendar year after 1990 and before 1996 shall be the greater of—

(I) the 1990 conversion factor, or

(II) the conversion factor specified in subparagraph (A)(i) for the year involved.

(D) Notwithstanding subparagraph (C), in no case may the conversion factor used to determine payment for services in a fee schedule area or locality under this subsection, as adjusted by the adjustment factors specified in subparagraphs (A)(iii), exceed the conversion factor used to determine the amount paid for physicians' services that are anesthesia services in the area or locality.

(5)(A) Payment for the services of a certified registered nurse anesthetist (for which payment may otherwise be made under this part) may be made on the basis of a claim or request for payment presented by the certified registered nurse anesthetist furnishing such services, or by a hospital, critical access hospital, physician, group practice, or ambulatory surgical center with which the certified registered nurse anesthetist furnishing such services has an employment or contractual relationship that provides for payment to be made under this part for such services to such hospital, critical access hospital, physician, group practice, or ambulatory surgical center.

(B) No hospital or critical access hospital that presents a claim or request for payment for services of a certified nurse anesthetist under this part may treat any uncollected coinsurance amount imposed under this part with respect to such services as a bad debt of such hospital or critical access hospital for purposes of this title.

(6) If an adjustment under paragraph (3)(B) results in a reduction in the reasonable charge for a physicians' service and a nonparticipating physician furnishes the service to an individual entitled to benefits under this part after the effective date of the reduction, the physician's actual charge is subject to a limit under section 1842(j)(1)(D).

(m)(1) In the case of physicians' services furnished in a year to an individual, who is covered under the insurance program established by this part and who incurs expenses for such services, in an area that is designated (under section 332(a)(1)(A) of the Public Health Service Act) as a health professional shortage area as identified by the Secretary prior to the beginning of such year, in addition to the amount otherwise paid under this part, there also shall be paid to the physician (or to an employer or facility in the cases described in clause (A) of section 1842(b)(6)) (on a monthly or quarterly basis) from the Federal Supplementary Medical Insurance Trust Fund an amount equal to 10 percent of the payment amount for the service under this part.

(2) For each health professional shortage area identified in paragraph (1) that consists of an entire county, the Secretary shall provide for the additional payment under paragraph (1) without any requirement on the physician to identify the health professional shortage area involved. The Secretary may implement the previous sentence using the method specified in subsection (u)(4)(C).

(3) The Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services a list of the health professional shortage areas identified in paragraph (1) that consist of a partial county to facilitate the additional payment under paragraph (1) in such areas.

(4) There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, respecting—

(A) the identification of a county or area;

(B) the assignment of a specialty of any physician under this paragraph;

(C) the assignment of a physician to a county under this subsection; or

(D) the assignment of a postal ZIP Code to a county or other area under this subsection.

(n)(1)(A) The aggregate amount of the payments to be made for all or part of a cost reporting period for services described in subsection (a)(2)(E)(i) furnished under this part on or after October 1, 1988, and before January 1, 1999, and for services described in subsection (a)(2)(E)(ii) furnished under this part on or after October 1, 1989, and before January 1, 1999, shall be equal to the lesser of—

(i) the amount determined with respect to such services under subsection (a)(2)(B), or

(ii) the blend amount for radiology services and diagnostic procedures determined in accordance with subparagraph (B).

(B)(i) The blend amount for radiology services and diagnostic procedures for a cost reporting period is the sum of—

(I) the cost proportion (as defined in clause (ii)) of the amount described in subparagraph (A)(i); and

(II) the charge proportion (as defined in clause (ii)(II)) of 62 percent (for services described in subsection (a)(2)(E)(i)), or (for procedures described in subsection (a)(2)(E)(ii)), 42 percent or such other percent established by the Secretary (or carriers acting pursuant to guidelines issued by the Secretary) based on prevailing charges established with actual charge data, of the prevailing charge or (for services described in subsection (a)(2)(E)(i) furnished on or after January 1, 1989) the fee schedule amount established for participating physicians for the same services as if they were furnished in a physician's office in the same locality as determined under section 1842(b), less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A).

(ii) In this subparagraph:

(I) The term "cost proportion" means 50 percent, except that such term means 65 percent in the case of outpatient radiology services for portions of cost reporting periods which occur in fiscal year 1989 and in the case of diagnostic procedures described in subsection (a)(2)(E)(ii) for portions of cost reporting periods which occur in fiscal year 1990, and such term means 42 percent in the case of outpatient radiology services for portions of cost reporting periods beginning on or after January 1, 1991.

(II) The term "charge proportion" means 100 percent minus the cost proportion.

(o)(1) In the case of shoes described in section 1861(s)(12)—

(A) no payment may be made under this part, with respect to any individual for any year, for the furnishing of—

(i) more than one pair of custom molded shoes (including inserts provided with such shoes) and 2 additional pairs of inserts for such shoes, or

(ii) more than one pair of extra-depth shoes (not including inserts provided with such shoes) and 3 pairs of inserts for such shoes, and

(B) with respect to expenses incurred in any calendar year, no more than the amount of payment applicable under paragraph (2) shall be considered as incurred expenses for purposes of subsections (a) and (b).

Payment for shoes (or inserts) under this part shall be considered to include payment for any expenses for the fitting of such shoes (or inserts).

(2)(A) Except as provided by the Secretary under subparagraphs (B) and (C), the amount of payment under this paragraph for custom molded shoes, extra-depth shoes, and inserts shall be the amount determined for such items by the Secretary under section 1834(h).

(B) The Secretary may establish payment amounts for shoes and inserts that are lower than the amount established under section 1834(h) if the Secretary finds that shoes and inserts of an appropriate quality are readily available at or below the amount established under such section.

(C) In accordance with procedures established by the Secretary, an individual entitled to benefits with respect to shoes described in section 1861(s)(12) may substitute modification of such shoes instead of obtaining one (or more, as specified by the Secretary) pair of inserts (other than the original pair of inserts with respect to such shoes). In such case, the Secretary shall substitute, for the payment amount established under section 1834(h), a payment amount that the Secretary estimates will assure that there is no net increase in expenditures under this subsection as a result of this subparagraph.

(3) In this title, the term "shoes" includes, except for purposes of subparagraphs (A)(ii) and (B) of paragraph (2), inserts for extra-depth shoes.

(q)(1) Each request for payment, or bill submitted, for an item or service furnished by an entity for which payment may be made under this part and for which the entity knows or has reason to believe there has been a referral by a referring physician (within the meaning of section 1877) shall include the name and unique physician identification number for the referring physician.

(2)(A) In the case of a request for payment for an item or service furnished by an entity under this part on an assignment-related basis and for which information is required to be provided under paragraph (1) but not included, payment may be denied under this part.

(B) In the case of a request for payment for an item or service furnished by an entity under this part not submitted on an assignment-related basis and for which information is required to be provided under paragraph (1) but not included—

(i) if the entity knowingly and willfully fails to provide such information promptly upon request of the Secretary or a carrier, the entity may be subject to a civil money penalty in an amount not to exceed $2,000, and

(ii) if the entity knowingly, willfully, and in repeated cases fails, after being notified by the Secretary of the obligations and requirements of this subsection to provide the information required under paragraph (1), the entity may be subject to exclusion from participation in the programs under this Act for a period not to exceed 5 years, in accordance with the procedures of subsections (c), (f), and (g) of section 1128.

The provisions of section 1128A (other than subsections (a) and (b)) shall apply to civil money penalties under clause (i) in the same manner as they apply to a penalty or proceeding under section 1128A(a).

(r)(1) With respect to services described in section 1861(s)(2)(K)(ii) (relating to nurse practitioner or clinical nurse specialist services), payment may be made on the basis of a claim or request for payment presented by the nurse practitioner or clinical nurse specialist furnishing such services, or by a hospital, critical access hospital, skilled nursing facility or nursing facility (as defined in section 1919(a)), physician, group practice, or ambulatory surgical center with which the nurse practitioner or clinical nurse specialist has an employment or contractual relationship that provides for payment to be made under this part for such services to such hospital, physician, group practice, or ambulatory surgical center.

(2) No hospital or critical access hospital that presents a claim or request for payment under this part for services described in section 1861(s)(2)(K)(ii) may treat any uncollected coinsurance amount imposed under this part with respect to such services as a bad debt of such hospital for purposes of this title.

(s) The Secretary may not provide for payment under subsection (a)(1)(A) with respect to an organization unless the organization provides assurances satisfactory to the Secretary that the organization meets the requirement of section 1866(f) (relating to maintaining written policies and procedures respecting advance directives).

(t) PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES.—

(1) AMOUNT OF PAYMENT.—

(A) IN GENERAL.—With respect to covered OPD services (as defined in subparagraph (B)) furnished during a year beginning with 1999, the amount of payment under this part shall be determined under a prospective payment system established by the Secretary in accordance with this subsection.

(B) DEFINITION OF COVERED OPD SERVICES.—For purposes of this subsection, the term "covered OPD services"—

(i) means hospital outpatient services designated by the Secretary;

(ii) subject to clause (iv), includes inpatient hospital services designated by the Secretary that are covered under this part and furnished to a hospital inpatient who (I) is entitled to benefits under part A but has exhausted benefits for inpatient hospital services during a spell of illness, or (II) is not so entitled;

(iii) includes implantable items described in paragraph (3), (6), or (8) of section 1861(s);

(iv) does not include any therapy services described in subsection (a)(8) or ambulance services, for which payment is made under a fee schedule described in section 1834(k) or section 1834(l) and does not include screening mammography (as defined in section 1861(jj)), diagnostic mammography, or personalized prevention plan services (as defined in section 1861(hhh)(1)); and

(v) does not include applicable items and services (as defined in subparagraph (A) of paragraph (21)) that are furnished on or after January 1, 2017, by an off-campus outpatient department of a provider (as defined in subparagraph (B) of such paragraph).

(2) SYSTEM REQUIREMENTS.—Under the payment system—

(A) the Secretary shall develop a classification system for covered OPD services;

(B) the Secretary may establish groups of covered OPD services, within the classification system described in subparagraph (A), so that services classified within each group are comparable clinically and with respect to the use of resources and so that an implantable item is classified to the group that includes the service to which the item relates;

(C) the Secretary shall, using data on claims from 1996 and using data from the most recent available cost reports, establish relative payment weights for covered OPD services (and any groups of such services described in subparagraph (B)) based on median (or, at the election of the Secretary, mean) hospital costs and shall determine projections of the frequency of utilization of each such service (or group of services) in 1999;

(D) subject to paragraph (19), the Secretary shall determine a wage adjustment factor to adjust the portion of payment and coinsurance attributable to labor-related costs for relative differences in labor and labor-related costs across geographic regions in a budget neutral manner;

(E) the Secretary shall establish, in a budget neutral manner, outlier adjustments under paragraph (5) and transitional pass-through payments under paragraph (6) and other adjustments as determined to be necessary to ensure equitable payments, such as adjustments for certain classes of hospitals;

(F) the Secretary shall develop a method for controlling unnecessary increases in the volume of covered OPD services;

(G) the Secretary shall create additional groups of covered OPD services that classify separately those procedures that utilize contrast agents from those that do not; and

(H) with respect to devices of brachytherapy consisting of a seed or seeds (or radioactive source), the Secretary shall create additional groups of covered OPD services that classify such devices separately from the other services (or group of services) paid for under this subsection in a manner reflecting the number, isotope, and radioactive intensity of such devices furnished, including separate groups for palladium-103 and iodine-125 devices and for stranded and non-stranded devices furnished on or after July 1, 2007.

For purposes of subparagraph (B), items and services within a group shall not be treated as "comparable with respect to the use of resources" if the highest median cost (or mean cost, if elected by the Secretary under subparagraph (C)) for an item or service within the group is more than 2 times greater than the lowest median cost (or mean cost, if so elected) for an item or service within the group; except that the Secretary may make exceptions in unusual cases, such as low volume items and services, but may not make such an exception in the case of a drug or biological that has been designated as an orphan drug under section 526 of the Federal Food, Drug and Cosmetic Act.

(3) CALCULATION OF BASE AMOUNTS.—

(A) AGGREGATE AMOUNTS THAT WOULD BE PAYABLE IF DEDUCTIBLES WERE DISREGARDED.—The Secretary shall estimate the sum of—

(i) the total amounts that would be payable from the Trust Fund under this part for covered OPD services

in 1999, determined without regard to this subsection, as though the deductible under section 1833(b) did not apply, and

(ii) the total amounts of copayments estimated to be paid under this subsection by beneficiaries to hospitals for covered OPD services in 1999, as though the deductible under section 1833(b) did not apply.

(B) UNADJUSTED COPAYMENT AMOUNT.—

(i) IN GENERAL.—For purposes of this subsection, subject to clause (ii), the "unadjusted copayment amount" applicable to a covered OPD service (or group of such services) is 20 percent of the national median of the charges for the service (or services within the group) furnished during 1996, updated to 1999 using the Secretary's estimate of charge growth during the period.

(ii) ADJUSTED TO BE 20 PERCENT WHEN FULLY PHASED IN.—If the pre-deductible payment percentage for a covered OPD service (or group of such services) furnished in a year would be equal to or exceed 80 percent, then the unadjusted copayment amount shall be 20 percent of amount determined under subparagraph (D).

(iii) RULES FOR NEW SERVICES.—The Secretary shall establish rules for establishment of an unadjusted copayment amount for a covered OPD service not furnished during 1996, based upon its classification within a group of such services.

(C) CALCULATION OF CONVERSION FACTORS.—

(i) FOR 1999.—

(I) IN GENERAL.—The Secretary shall establish a 1999 conversion factor for determining the medicare OPD fee schedule amounts for each covered OPD service (or group of such services) furnished in 1999. Such conversion factor shall be established on the basis of the weights and frequencies described in paragraph (2)(C) and in such a manner that the sum for all services and groups of the products (described in subclause (II) for each such service or group) equals the total projected amount described in subparagraph (A).

(II) PRODUCT DESCRIBED.—The Secretary shall determine for each service or group the product of the medicare OPD fee schedule amounts (taking into account appropriate adjustments described in paragraphs (2)(D) and (2)(E)) and the estimated frequencies for such service or group.

(ii) SUBSEQUENT YEARS.—Subject to paragraph (8)(B), the Secretary shall establish a conversion factor for covered OPD services furnished in subsequent years in an amount equal to the conversion factor established under this subparagraph and applicable to such services furnished in the previous year increased by the OPD fee schedule increase factor specified under clause (iv) for the year involved.

(iii) ADJUSTMENT FOR SERVICE MIX CHANGES.—Insofar as the Secretary determines that the adjustments for service mix under paragraph (2) for a previous year (or estimates that such adjustments for a future year) did (or are likely to) result in a change in aggregate payments under this subsection during the year that are a result of changes in the coding or classification of covered OPD services that do not reflect real changes in service mix, the Secretary may adjust the conversion factor computed under this subparagraph for subsequent years so as to eliminate the effect of such coding or classification changes.

(iv) OPD FEE SCHEDULE INCREASE FACTOR.—For purposes of this subparagraph, subject to paragraph (17) and subparagraph (F) of this paragraph, the "OPD fee schedule increase factor" for services furnished in a year is equal to the market basket percentage increase applicable under section 1886(b)(3)(B)(iii) to hospital discharges occurring during the fiscal year ending in such year, reduced by 1 percentage point for such factor for services furnished in each of 2000 and 2002. In applying the previous sentence for years beginning with 2000, the Secretary may substitute for the market basket percentage increase an annual percentage increase that is computed and applied with respect to covered OPD services furnished in a year in the same manner as the market basket percentage increase is determined and applied to inpatient hospital services for discharges occurring in a fiscal year.

(D) CALCULATION OF MEDICARE OPD FEE SCHEDULE AMOUNTS.—The Secretary shall compute a medicare OPD fee schedule amount for each covered OPD service (or group of such services) furnished in a year, in an amount equal to the product of—

(i) the conversion factor computed under subparagraph (C) for the year, and

(ii) the relative payment weight (determined under paragraph (2)(C)) for the service or group.

(E) PRE-DEDUCTIBLE PAYMENT PERCENTAGE.—The pre-deductible payment percentage for a covered OPD service (or group of such services) furnished in a year is equal to the ratio of—

(i) the medicare OPD fee schedule amount established under subparagraph (D) for the year, minus the unadjusted copayment amount determined under subparagraph (B) for the service or group, to

(ii) the medicare OPD fee schedule amount determined under subparagraph (D) for the year for such service or group.

(F) PRODUCTIVITY AND OTHER ADJUSTMENT.—After determining the OPD fee schedule increase factor under subparagraph (C)(iv), the Secretary shall reduce such increase factor—

(i) for 2012 and subsequent years, by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II); and

(ii) for each of 2010 through 2019, by the adjustment described in subparagraph (G).

The application of this subparagraph may result in the increase factor under subparagraph (C)(iv) being less than 0.0 for a year, and may result in payment rates under the payment system under this subsection for a year being less than such payment rates for the preceding year.

(G) OTHER ADJUSTMENT.—For purposes of subparagraph (F)(ii), the adjustment described in this subparagraph is—

(i) for each of 2010 and 2011, 0.25 percentage point;

(ii) for each of 2012 and 2013, 0.1 percentage point;

(iii) for 2014, 0.3 percentage point;

(iv) for each of 2015 and 2016, 0.2 percentage point; and

(v) for each of 2017, 2018, and 2019, 0.75 percentage point.

(4) MEDICARE PAYMENT AMOUNT.—The amount of payment made from the Trust Fund under this part for a covered OPD service (and such services classified within a group) furnished in a year is determined, subject to paragraph (7), as follows:

(A) FEE SCHEDULE ADJUSTMENTS.—The medicare OPD fee schedule amount (computed under paragraph (3)(D)) for the service or group and year is adjusted for relative differences in the cost of labor and other factors determined by the Secretary, as computed under paragraphs (2)(D) and (2)(E).

(B) SUBTRACT APPLICABLE DEDUCTIBLE.—Reduce the adjusted amount determined under subparagraph (A) by the amount of the deductible under section 1833(b), to the extent applicable.

(C) APPLY PAYMENT PROPORTION TO REMAINDER.—The amount of payment is the amount so determined under subparagraph (B) multiplied by the pre-deductible payment percentage (as determined under paragraph (3)(E)) for the service or group and year involved, plus the amount of any reduction in the copayment amount attributable to paragraph (8)(C).

(5) OUTLIER ADJUSTMENT.—

(A) IN GENERAL.—Subject to subparagraph (D), the Secretary shall provide for an additional payment for each covered OPD service (or group of services) for which a hospital's charges, adjusted to cost, exceed—

(i) a fixed multiple of the sum of—

(I) the applicable medicare OPD fee schedule amount determined under paragraph (3)(D), as adjusted under paragraph (4)(A) (other than for adjustments under this paragraph or paragraph (6)); and

(II) any transitional pass-through payment under paragraph (6); and

(ii) at the option of the Secretary, such fixed dollar amount as the Secretary may establish.

(B) AMOUNT OF ADJUSTMENT.—The amount of the additional payment under subparagraph (A) shall be determined by the Secretary and shall approximate the marginal cost of care beyond the applicable cutoff point under such subparagraph.

(C) LIMIT ON AGGREGATE OUTLIER ADJUSTMENTS.—

(i) IN GENERAL.—The total of the additional payments made under this paragraph for covered OPD services furnished in a year (as estimated by the Secretary before the beginning of the year) may not exceed the applicable percentage (specified in clause (ii)) of the total program payments estimated to be made under this subsection for all covered OPD services furnished in that year. If this paragraph is first applied to less than a full year, the previous sentence shall apply only to the portion of such year.

(ii) APPLICABLE PERCENTAGE.—For purposes of clause (i), the term "applicable percentage" means a percentage specified by the Secretary up to (but not to exceed)—

(I) for a year (or portion of a year) before 2004, 2.5 percent; and

(II) for 2004 and thereafter, 3.0 percent.

(D) TRANSITIONAL AUTHORITY.—In applying subparagraph (A) for covered OPD services furnished before January 1, 2002, the Secretary may—

(i) apply such subparagraph to a bill for such services related to an outpatient encounter (rather than for a specific service or group of services) using OPD fee schedule amounts and transitional pass-through payments covered under the bill; and

(ii) use an appropriate cost-to-charge ratio for the hospital involved (as determined by the Secretary), rather than for specific departments within the hospital.

(E) EXCLUSION OF SEPARATE DRUG AND BIOLOGICAL APCS FROM OUTLIER PAYMENTS.—No additional payment shall be made under subparagraph (A) in the case of ambulatory payment classification groups established separately for drugs or biologicals.

(6) TRANSITIONAL PASS-THROUGH FOR ADDITIONAL COSTS OF INNOVATIVE MEDICAL DEVICES, DRUGS, AND BIOLOGICALS.—

(A) IN GENERAL.—The Secretary shall provide for an additional payment under this paragraph for any of the following that are provided as part of a covered OPD service (or group of services):

(i) CURRENT ORPHAN DRUGS.—A drug or biological that is used for a rare disease or condition with respect to which the drug or biological has been designated as an orphan drug under section 526 of the Federal Food, Drug and Cosmetic Act if payment for the drug or biological as an outpatient hospital service under this part was being made on the first date that the system under this subsection is implemented.

(ii) CURRENT CANCER THERAPY DRUGS AND BIOLOGICALS AND BRACHYTHERAPY.—A drug or biological that is used in cancer therapy, including (but not limited to) a chemotherapeutic agent, an antiemetic, a hematopoietic growth factor, a colony stimulating factor, a biological response modifier, a bisphosphonate, and a device of brachytherapy or temperature monitored cryoablation, if payment for such drug, biological, or device as an outpatient hospital service under this part was being made on such first date.

(iii) CURRENT RADIOPHARMACEUTICAL DRUGS AND BIOLOGICAL PRODUCTS.—A radiopharmaceutical drug or biological product used in diagnostic, monitoring, and therapeutic nuclear medicine procedures if payment for the drug or biological as an outpatient hospital service under this part was being made on such first date.

(iv) NEW MEDICAL DEVICES, DRUGS, AND BIOLOGICALS.—A medical device, drug, or biological not described in clause (i), (ii), or (iii) if—

(I) payment for the device, drug, or biological as an outpatient hospital service under this part was not being made as of December 31, 1996; and

(II) the cost of the drug or biological or the average cost of the category of devices is not insignificant in relation to the OPD fee schedule amount (as calculated under paragraph (3)(D)) payable for the service (or group of services) involved.

(B) USE OF CATEGORIES IN DETERMINING ELIGIBILITY OF A DEVICE FOR PASS-THROUGH PAYMENTS.—The following provisions apply for purposes of determining whether a medical device qualifies for additional payments under clause (ii) or (iv) of subparagraph (A):

(i) ESTABLISHMENT OF INITIAL CATEGORIES.—

(I) IN GENERAL.—The Secretary shall initially establish under this clause categories of medical devices based on type of device by April 1, 2001. Such categories shall be established in a manner such that each medical device that meets the requirements of clause (ii) or (iv) of subparagraph (A) as of January 1, 2001, is included in such a category and no such device is included in more than one category. For purposes of the preceding sentence, whether a medical device meets such requirements as of such date shall be determined on the basis of the program memoranda issued before such date.

(II) AUTHORIZATION OF IMPLEMENTATION OTHER THAN THROUGH REGULATIONS.—The categories may be established under this clause by program memorandum or otherwise, after consultation with groups representing hospitals, manufacturers of medical devices, and other affected parties.

(ii) ESTABLISHING CRITERIA FOR ADDITIONAL CATEGORIES.—

(I) IN GENERAL.—The Secretary shall establish criteria that will be used for creation of additional categories (other than those established under clause (i)) through rulemaking (which may include use of an interim final rule with comment period).

(II) STANDARD.—Such categories shall be established under this clause in a manner such that no medical device is described by more than one category. Such criteria shall include a test of whether the average cost of devices that would be included in a category and are in use at the time the category is established is not insignificant, as described in subparagraph (A)(iv)(II).

(III) DEADLINE.—Criteria shall first be established under this clause by July 1, 2001. The Secretary may establish in compelling circumstances categories under this clause before the date such criteria are established.

(IV) ADDING CATEGORIES.—The Secretary shall promptly establish a new category of medical devices under this clause for any medical device that meets the requirements of subparagraph (A)(iv) and for which none of the categories in effect (or that were previously in effect) is appropriate.

(iii) PERIOD FOR WHICH CATEGORY IS IN EFFECT.—A category of medical devices established under clause (i) or (ii) shall be in effect for a period of at least 2 years, but not more than 3 years, that begins—

(I) in the case of a category established under clause (i), on the first date on which payment was made under this paragraph for any device described by such category (including payments made during the period before April 1, 2001); and

(II) in the case of any other category, on the first date on which payment is made under this paragraph for any medical device that is described by such category.

(iv) REQUIREMENTS TREATED AS MET.—A medical device shall be treated as meeting the requirements of subparagraph (A)(iv), regardless of whether the device meets the requirement of subclause (I) of such subparagraph, if—

(I) the device is described by a category established and in effect under clause (i); or

(II) the device is described by a category established and in effect under clause (ii) and an application under section 515 of the Federal Food, Drug, and Cosmetic Act has been approved with respect to the device, or the device has been cleared for market under section 510(k) of such Act, or the device is exempt from the requirements of section 510(k) of such Act pursuant to subsection (l) or (m) of section 510 of such Act or section 520(g) of such Act.

Nothing in this clause shall be construed as requiring an application or prior approval (other than that described in subclause (II)) in order for a covered device described by a category to qualify for payment under this paragraph.

(C) LIMITED PERIOD OF PAYMENT.—

(i) DRUGS AND BIOLOGICALS.—The payment under this paragraph with respect to a drug or biological shall only apply during a period of at least 2 years, but not more than 3 years, that begins—

(I) on the first date this subsection is implemented in the case of a drug or biological described in clause (i), (ii), or (iii) of subparagraph (A) and in the case of a drug or biological described in subparagraph (A)(iv) and for which payment under this part is made as an outpatient hospital service before such first date; or

(II) in the case of a drug or biological described in subparagraph (A)(iv) not described in subclause (I), on the first date on which payment is made under this part for the drug or biological as an outpatient hospital service.

(ii) MEDICAL DEVICES.—Payment shall be made under this paragraph with respect to a medical device only if such device—

(I) is described by a category of medical devices established and in effect under subparagraph (B); and

(II) is provided as part of a service (or group of services) paid for under this subsection and provided during the period for which such category is in effect under such subparagraph.

(D) AMOUNT OF ADDITIONAL PAYMENT.—Subject to subparagraph (E)(iii), the amount of the payment under this paragraph with respect to a device, drug, or biological provided as part of a covered OPD service is—

(i) in the case of a drug or biological, the amount by which the amount determined under section 1842(o) (or if the drug or biological is covered under a competitive acquisition contract under section 1847B, an amount determined by the Secretary equal to the average price for the drug or biological for all competitive acquisition areas and year established under such section as calculated and adjusted by the Secretary for purposes of this paragraph) for the drug or biological exceeds the portion of the otherwise applicable medicare OPD fee schedule that the Secretary determines is associated with the drug or biological; or

(ii) in the case of a medical device, the amount by which the hospital's charges for the device, adjusted to cost, exceeds the portion of the otherwise applicable medicare OPD fee schedule that the Secretary determines is associated with the device.

(E) LIMIT ON AGGREGATE ANNUAL ADJUSTMENT.—

(i) IN GENERAL.—The total of the additional payments made under this paragraph for covered OPD services furnished in a year (as estimated by the Secretary before the beginning of the year) may not exceed the applicable percentage (specified in clause (ii)) of the total program payments estimated to be made under this subsection for all covered OPD services furnished in that year. If this paragraph is first applied to less than a full year, the previous sentence shall apply only to the portion of such year.

(ii) APPLICABLE PERCENTAGE.—For purposes of clause (i), the term "applicable percentage" means—

(I) for a year (or portion of a year) before 2004, 2.5 percent; and

(II) for 2004 and thereafter, a percentage specified by the Secretary up to (but not to exceed) 2.0 percent.

(iii) UNIFORM PROSPECTIVE REDUCTION IF AGGREGATE LIMIT PROJECTED TO BE EXCEEDED.—If the Secretary estimates before the beginning of a year that the amount of the additional payments under this paragraph for the year (or portion thereof) as determined under clause (i) without regard to this clause will exceed the limit established under such clause, the Secretary shall reduce pro rata the amount of each of the additional payments under this paragraph for that year (or portion thereof) in order to ensure that the aggregate additional payments under this paragraph (as so estimated) do not exceed such limit.

(F) LIMITATION OF APPLICATION OF FUNCTIONAL EQUIVALENCE STANDARD.—

(i) IN GENERAL.—The Secretary may not publish regulations that apply a functional equivalence standard to a drug or biological under this paragraph.

(ii) APPLICATION.—Clause (i) shall apply to the application of a functional equivalence standard to a drug or biological on or after the date of enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 unless—

(I) such application was being made to such drug or biological prior to such date of enactment; and

(II) the Secretary applies such standard to such drug or biological only for the purpose of determining eligibility of such drug or biological for additional payments under this paragraph and not for the purpose of any other payments under this title.

(iii) RULE OF CONSTRUCTION.—Nothing in this subparagraph shall be construed to effect the Secretary's authority to deem a particular drug to be identical to another drug if the 2 products are pharmaceutically equivalent and bioequivalent, as determined by the Commissioner of Food and Drugs.

(7) TRANSITIONAL ADJUSTMENT TO LIMIT DECLINE IN PAYMENT.—

(A) BEFORE 2002.—Subject to subparagraph (D), for covered OPD services furnished before January 1, 2002, for which the PPS amount (as defined in subparagraph (E)) is—

(i) at least 90 percent, but less than 100 percent, of the pre-BBA amount (as defined in subparagraph (F)), the amount of payment under this subsection shall be increased by 80 percent of the amount of such difference;

(ii) at least 80 percent, but less than 90 percent, of the pre-BBA amount, the amount of payment under this subsection shall be increased by the amount by which (I) the product of 0.71 and the pre-BBA amount, exceeds (II) the product of 0.70 and the PPS amount;

(iii) at least 70 percent, but less than 80 percent, of the pre-BBA amount, the amount of payment under this subsection shall be increased by the amount by which (I) the product of 0.63 and the pre-BBA amount, exceeds (II) the product of 0.60 and the PPS amount; or

(iv) less than 70 percent of the pre-BBA amount, the amount of payment under this subsection shall be increased by 21 percent of the pre-BBA amount.

(B) 2002.—Subject to subparagraph (D), for covered OPD services furnished during 2002, for which the PPS amount is—

(i) at least 90 percent, but less than 100 percent, of the pre-BBA amount, the amount of payment under this subsection shall be increased by 70 percent of the amount of such difference;

(ii) at least 80 percent, but less than 90 percent, of the pre-BBA amount, the amount of payment under this subsection shall be increased by the amount by which (I) the product of 0.61 and the pre-BBA amount, exceeds (II) the product of 0.60 and the PPS amount; or

(iii) less than 80 percent of the pre-BBA amount, the amount of payment under this subsection shall be increased by 13 percent of the pre-BBA amount.

(C) 2003.—Subject to subparagraph (D), for covered OPD services furnished during 2003, for which the PPS amount is—

(i) at least 90 percent, but less than 100 percent, of the pre-BBA amount, the amount of payment under this subsection shall be increased by 60 percent of the amount of such difference; or

(ii) less than 90 percent of the pre-BBA amount, the amount of payment under this subsection shall be increased by 6 percent of the pre-BBA amount.

(D) HOLD HARMLESS PROVISIONS.—

(i) TEMPORARY TREATMENT FOR CERTAIN RURAL HOSPITALS.—(I) In the case of a hospital located in a rural area and that has not more than 100 beds or a sole

community hospital (as defined in section 1886(d)(5)(D)(iii)) located in a rural area, for covered OPD services furnished before January 1, 2006, for which the PPS amount is less than the pre-BBA amount, the amount of payment under this subsection shall be increased by the amount of such difference.

(II) In the case of a hospital located in a rural area and that has not more than 100 beds and that is not a sole community hospital (as defined in section 1886(d)(5)(D)(iii)), for covered OPD services furnished on or after January 1, 2006, and before January 1, 2013, for which the PPS amount is less than the pre-BBA amount, the amount of payment under this subsection shall be increased by the applicable percentage of the amount of such difference. For purposes of the preceding sentence, the applicable percentage shall be 95 percent with respect to covered OPD services furnished in 2006, 90 percent with respect to such services furnished in 2007, and 85 percent with respect to such services furnished in 2008, 2009, 2010, 2011, or 2012.

(III) In the case of a sole community hospital (as defined in section 1886(d)(5)(D)(iii)) that has not more than 100 beds, for covered OPD services furnished on or after January 1, 2009, and before January 1, 2013, for which the PPS amount is less than the pre-BBA amount, the amount of payment under this subsection shall be increased by 85 percent of the amount of such difference. In the case of covered OPD services furnished on or after January 1, 2010, and before March 1, 2012, the preceding sentence shall be applied without regard to the 100-bed limitation.

(ii) PERMANENT TREATMENT FOR CANCER HOSPITALS AND CHILDREN'S HOSPITALS.—In the case of a hospital described in clause (iii) or (v) of section 1886(d)(1)(B), for covered OPD services for which the PPS amount is less than the pre-BBA amount, the amount of payment under this subsection shall be increased by the amount of such difference.

(E) PPS AMOUNT DEFINED.—In this paragraph, the term "PPS amount" means, with respect to covered OPD services, the amount payable under this title for such services (determined without regard to this paragraph), including amounts payable as copayment under paragraph (8), coinsurance under section 1866(a)(2)(A)(ii), and the deductible under section 1833(b).

(F) PRE-BBA AMOUNT DEFINED.—

(i) IN GENERAL.—In this paragraph, the "pre-BBA amount" means, with respect to covered OPD services furnished by a hospital in a year, an amount equal to the product of the reasonable cost of the hospital for such services for the portions of the hospital's cost reporting period (or periods) occurring in the year and the base OPD payment-to-cost ratio for the hospital (as defined in clause (ii)).

(ii) BASE PAYMENT-TO-COST-RATIO DEFINED.—For purposes of this subparagraph, the "base payment-to-cost ratio" for a hospital means the ratio of—

(I) the hospital's reimbursement under this part for covered OPD services furnished during the cost reporting period ending in 1996 (or in the case of a hospital that did not submit a cost report for such period, during the first subsequent cost reporting period ending before 2001 for which the hospital submitted a cost report), including any reimbursement for such services through cost-sharing described in subparagraph (E), to

(II) the reasonable cost of such services for such period.

The Secretary shall determine such ratios as if the amendments made by section 4521 of the Balanced Budget Act of 1997 were in effect in 1996.

(G) INTERIM PAYMENTS.—The Secretary shall make payments under this paragraph to hospitals on an interim basis, subject to retrospective adjustments based on settled cost reports.

(H) NO EFFECT ON COPAYMENTS.—Nothing in this paragraph shall be construed to affect the unadjusted copayment amount described in paragraph (3)(B) or the copayment amount under paragraph (8).

(I) APPLICATION WITHOUT REGARD TO BUDGET NEUTRALITY.—The additional payments made under this paragraph—

(i) shall not be considered an adjustment under paragraph (2)(E); and

(ii) shall not be implemented in a budget neutral manner.

(8) COPAYMENT AMOUNT.—

(A) IN GENERAL.—Except as provided in subparagraphs (B) and (C), the copayment amount under this subsection is the amount by which the amount described in paragraph (4)(B) exceeds the amount of payment determined under paragraph (4)(C).

(B) ELECTION TO OFFER REDUCED COPAYMENT AMOUNT.—The Secretary shall establish a procedure under which a hospital, before the beginning of a year (beginning with 1999), may elect to reduce the copayment amount otherwise established under subparagraph (A) for some or all covered OPD services to an amount that is not less than 20 percent of the medicare OPD fee schedule amount (computed under paragraph (3)(D)) for the service involved. Under such procedures, such reduced copayment amount may not be further reduced or increased during the year involved and the hospital may disseminate information on the reduction of copayment amount effected under this subparagraph.

(C) LIMITATION ON COPAYMENT AMOUNT.—

(i) TO INPATIENT HOSPITAL DEDUCTIBLE AMOUNT.—In no case shall the copayment amount for a procedure performed in a year exceed the amount of the inpa-

tient hospital deductible established under section 1813(b) for that year.

(ii) TO SPECIFIED PERCENTAGE.—The Secretary shall reduce the national unadjusted copayment amount for a covered OPD service (or group of such services) furnished in a year in a manner so that the effective copayment rate (determined on a national unadjusted basis) for that service in the year does not exceed the following percentage:

(I) For procedures performed in 2001, on or after April 1, 2001, 57 percent.

(II) For procedures performed in 2002 or 2003, 55 percent.

(III) For procedures performed in 2004, 50 percent.

(IV) For procedures performed in 2005, 45 percent.

(V) For procedures performed in 2006 and thereafter, 40 percent.

(D) NO IMPACT ON DEDUCTIBLES.—Nothing in this paragraph shall be construed as affecting a hospital's authority to waive the charging of a deductible under section 1833(b).

(E) COMPUTATION IGNORING OUTLIER AND PASS-THROUGH ADJUSTMENTS.—The copayment amount shall be computed under subparagraph (A) as if the adjustments under paragraphs (5) and (6) (and any adjustment made under paragraph (2)(E) in relation to such adjustments) had not occurred.

(9) PERIODIC REVIEW AND ADJUSTMENTS COMPONENTS OF PROSPECTIVE PAYMENT SYSTEM.—

(A) PERIODIC REVIEW.—The Secretary shall review not less often than annually and revise the groups, the relative payment weights, and the wage and other adjustments described in paragraph (2) to take into account changes in medical practice, changes in technology, the addition of new services, new cost data, and other relevant information and factors. The Secretary shall consult with an expert outside advisory panel composed of an appropriate selection of representatives of providers to review (and advise the Secretary concerning) the clinical integrity of the groups and weights. Such panel may use data collected or developed by entities and organizations (other than the Department of Health and Human Services) in conducting such review.

(B) BUDGET NEUTRALITY ADJUSTMENT.—If the Secretary makes adjustments under subparagraph (A), then the adjustments for a year may not cause the estimated amount of expenditures under this part for the year to increase or decrease from the estimated amount of expenditures under this part that would have been made if the adjustments had not been made. In determining adjustments under the preceding sentence for 2004 and 2005, the Secretary shall not take into account under this subparagraph or para-

graph (2)(E) any expenditures that would not have been made but for the application of paragraph (14).

(C) UPDATE FACTOR.—If the Secretary determines under methodologies described in paragraph (2)(F) that the volume of services paid for under this subsection increased beyond amounts established through those methodologies, the Secretary may appropriately adjust the update to the conversion factor otherwise applicable in a subsequent year.

(10) SPECIAL RULE FOR AMBULANCE SERVICES.—The Secretary shall pay for hospital outpatient services that are ambulance services on the basis described in section 1861(v)(1)(U), or, if applicable, the fee schedule established under section 1834(l).

(11) SPECIAL RULES FOR CERTAIN HOSPITALS.—In the case of hospitals described in clause (iii) or (v) of section 1886(d)(1)(B)—

(A) the system under this subsection shall not apply to covered OPD services furnished before January 1, 2000; and

(B) the Secretary may establish a separate conversion factor for such services in a manner that specifically takes into account the unique costs incurred by such hospitals by virtue of their patient population and service intensity.

(12) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise of—

(A) the development of the classification system under paragraph (2), including the establishment of groups and relative payment weights for covered OPD services, of wage adjustment factors, other adjustments, and methods described in paragraph (2)(F);

(B) the calculation of base amounts under paragraph (3);

(C) periodic adjustments made under paragraph (6);

(D) the establishment of a separate conversion factor under paragraph (8)(B); and

(E) the determination of the fixed multiple, or a fixed dollar cutoff amount, the marginal cost of care, or applicable percentage under paragraph (5) or the determination of insignificance of cost, the duration of the additional payments, the determination and deletion of initial and new categories (consistent with subparagraphs (B) and (C) of paragraph (6)), the portion of the medicare OPD fee schedule amount associated with particular devices, drugs, or biologicals, and the application of any pro rata reduction under paragraph (6).

(13) AUTHORIZATION OF ADJUSTMENT FOR RURAL HOSPITALS.—

(A) STUDY.—The Secretary shall conduct a study to determine if, under the system under this subsection, costs incurred by hospitals located in rural areas by ambulatory payment classification groups (APCs) exceed those costs incurred by hospitals located in urban areas.

(B) AUTHORIZATION OF ADJUSTMENT.—Insofar as the Secretary determines under subparagraph (A) that costs incurred by hospitals located in rural areas exceed those

costs incurred by hospitals located in urban areas, the Secretary shall provide for an appropriate adjustment under paragraph (2)(E) to reflect those higher costs by January 1, 2006.

(14) DRUG APC PAYMENT RATES.—

(A) IN GENERAL.—The amount of payment under this subsection for a specified covered outpatient drug (defined in subparagraph (B)) that is furnished as part of a covered OPD service (or group of services)—

(i) in 2004, in the case of—

(I) a sole source drug shall in no case be less than 88 percent, or exceed 95 percent, of the reference average wholesale price for the drug;

(II) an innovator multiple source drug shall in no case exceed 68 percent of the reference average wholesale price for the drug; or

(III) a noninnovator multiple source drug shall in no case exceed 46 percent of the reference average wholesale price for the drug;

(ii) in 2005, in the case of—

(I) a sole source drug shall in no case be less than 83 percent, or exceed 95 percent, of the reference average wholesale price for the drug;

(II) an innovator multiple source drug shall in no case exceed 68 percent of the reference average wholesale price for the drug; or

(III) a noninnovator multiple source drug shall in no case exceed 46 percent of the reference average wholesale price for the drug; or

(iii) in a subsequent year, shall be equal, subject to subparagraph (E)—

(I) to the average acquisition cost for the drug for that year (which, at the option of the Secretary, may vary by hospital group (as defined by the Secretary based on volume of covered OPD services or other relevant characteristics)), as determined by the Secretary taking into account the hospital acquisition cost survey data under subparagraph (D); or

(II) if hospital acquisition cost data are not available, the average price for the drug in the year established under section 1842(o), section 1847A, or section 1847B, as the case may be, as calculated and adjusted by the Secretary as necessary for purposes of this paragraph.

(B) SPECIFIED COVERED OUTPATIENT DRUG DEFINED.—

(i) IN GENERAL.—In this paragraph, the term "specified covered outpatient drug" means, subject to clause (ii), a covered outpatient drug (as defined in section 1927(k)(2)) for which a separate ambulatory payment classification group (APC) has been established and that is—

(I) a radiopharmaceutical; or

(II) a drug or biological for which payment was made under paragraph (6) (relating to pass-

through payments) on or before December 31, 2002.

(ii) EXCEPTION.—Such term does not include—

(I) a drug or biological for which payment is first made on or after January 1, 2003, under paragraph (6);

(II) a drug or biological for which a temporary HCPCS code has not been assigned; or

(III) during 2004 and 2005, an orphan drug (as designated by the Secretary).

(C) PAYMENT FOR DESIGNATED ORPHAN DRUGS DURING 2004 AND 2005.—The amount of payment under this subsection for an orphan drug designated by the Secretary under subparagraph (B)(ii)(III) that is furnished as part of a covered OPD service (or group of services) during 2004 and 2005 shall equal such amount as the Secretary may specify.

(D) ACQUISITION COST SURVEY FOR HOSPITAL OUTPATIENT DRUGS.—

(i) ANNUAL GAO SURVEYS IN 2004 AND 2005.—

(I) IN GENERAL.—The Comptroller General of the United States shall conduct a survey in each of 2004 and 2005 to determine the hospital acquisition cost for each specified covered outpatient drug. Not later than April 1, 2005, the Comptroller General shall furnish data from such surveys to the Secretary for use in setting the payment rates under subparagraph (A) for 2006.

(II) RECOMMENDATIONS.—Upon the completion of such surveys, the Comptroller General shall recommend to the Secretary the frequency and methodology of subsequent surveys to be conducted by the Secretary under clause (ii).

(ii) SUBSEQUENT SECRETARIAL SURVEYS.—The Secretary, taking into account such recommendations, shall conduct periodic subsequent surveys to determine the hospital acquisition cost for each specified covered outpatient drug for use in setting the payment rates under subparagraph (A).

(iii) SURVEY REQUIREMENTS.—The surveys conducted under clauses (i) and (ii) shall have a large sample of hospitals that is sufficient to generate a statistically significant estimate of the average hospital acquisition cost for each specified covered outpatient drug. With respect to the surveys conducted under clause (i), the Comptroller General shall report to Congress on the justification for the size of the sample used in order to assure the validity of such estimates.

(iv) DIFFERENTIATION IN COST.—In conducting surveys under clause (i), the Comptroller General shall determine and report to Congress if there is (and the extent of any) variation in hospital acquisition costs for drugs among hospitals based on the volume of covered OPD services performed by such hospitals or

other relevant characteristics of such hospitals (as defined by the Comptroller General).

(v) COMMENT ON PROPOSED RATES.—Not later than 30 days after the date the Secretary promulgated proposed rules setting forth the payment rates under subparagraph (A) for 2006, the Comptroller General shall evaluate such proposed rates and submit to Congress a report regarding the appropriateness of such rates based on the surveys the Comptroller General has conducted under clause (i).

(E) ADJUSTMENT IN PAYMENT RATES FOR OVERHEAD COSTS.—

(i) MEDPAC REPORT ON DRUG APC DESIGN.—The Medicare Payment Advisory Commission shall submit to the Secretary, not later than July 1, 2005, a report on adjustment of payment for ambulatory payment classifications for specified covered outpatient drugs to take into account overhead and related expenses, such as pharmacy services and handling costs. Such report shall include—

(I) a description and analysis of the data available with regard to such expenses;

(II) a recommendation as to whether such a payment adjustment should be made; and

(III) if such adjustment should be made, a recommendation regarding the methodology for making such an adjustment.

(ii) ADJUSTMENT AUTHORIZED.—The Secretary may adjust the weights for ambulatory payment classifications for specified covered outpatient drugs to take into account the recommendations contained in the report submitted under clause (i).

(F) CLASSES OF DRUGS.—For purposes of this paragraph:

(i) SOLE SOURCE DRUGS.—The term "sole source drug" means—

(I) a biological product (as defined under section 1861(t)(1)); or

(II) a single source drug (as defined in section 1927(k)(7)(A)(iv)).

(ii) INNOVATOR MULTIPLE SOURCE DRUGS.—The term "innovator multiple source drug" has the meaning given such term in section 1927(k)(7)(A)(ii).

(iii) NONINNOVATOR MULTIPLE SOURCE DRUGS.—The term "noninnovator multiple source drug" has the meaning given such term in section 1927(k)(7)(A)(iii).

(G) REFERENCE AVERAGE WHOLESALE PRICE.—The term "reference average wholesale price" means, with respect to a specified covered outpatient drug, the average wholesale price for the drug as determined under section 1842(o) as of May 1, 2003.

(H) INAPPLICABILITY OF EXPENDITURES IN DETERMINING CONVERSION, WEIGHTING, AND OTHER ADJUSTMENT FACTORS.—Additional expenditures resulting from this paragraph shall not be taken into account in establishing the conversion, weighting, and other adjustment factors for

2004 and 2005 under paragraph (9), but shall be taken into account for subsequent years.

(15) PAYMENT FOR NEW DRUGS AND BIOLOGICALS UNTIL HCPCS CODE ASSIGNED.—With respect to payment under this part for an outpatient drug or biological that is covered under this part and is furnished as part of covered OPD services for which a HCPCS code has not been assigned, the amount provided for payment for such drug or biological under this part shall be equal to 95 percent of the average wholesale price for the drug or biological.

(16) MISCELLANEOUS PROVISIONS.—

(A) APPLICATION OF RECLASSIFICATION OF CERTAIN HOSPITALS.—If a hospital is being treated as being located in a rural area under section 1886(d)(8)(E), that hospital shall be treated under this subsection as being located in that rural area.

(B) THRESHOLD FOR ESTABLISHMENT OF SEPARATE APCS FOR DRUGS.—The Secretary shall reduce the threshold for the establishment of separate ambulatory payment classification groups (APCs) with respect to drugs or biologicals to $50 per administration for drugs and biologicals furnished in 2005 and 2006.

(C) PAYMENT FOR DEVICES OF BRACHYTHERAPY AND THERAPEUTIC RADIOPHARMACEUTICALS AT CHARGES ADJUSTED TO COST.—Notwithstanding the preceding provisions of this subsection, for a device of brachytherapy consisting of a seed or seeds (or radioactive source) furnished on or after January 1, 2004, and before January 1, 2010, and for therapeutic radiopharmaceuticals furnished on or after January 1, 2008, and before January 1, 2010, the payment basis for the device or therapeutic radiopharmaceutical under this subsection shall be equal to the hospital's charges for each device or therapeutic radiopharmaceutical furnished, adjusted to cost. Charges for such devices or therapeutic radiopharmaceuticals shall not be included in determining any outlier payment under this subsection.

(D) SPECIAL PAYMENT RULE.—

(i) IN GENERAL.—In the case of covered OPD services furnished on or after April 1, 2013, in a hospital described in clause (ii), if—

(I) the payment rate that would otherwise apply under this subsection for stereotactic radiosurgery, complete course of treatment of cranial lesion(s) consisting of 1 session that is multisource Cobalt 60 based (identified as of January 1, 2013, by HCPCS code 77371 (and any succeeding code) and reimbursed as of such date under APC 0127 (and any succeeding classification group)); exceeds

(II) the payment rate that would otherwise apply under this subsection for linear accelerator based stereotactic radiosurgery, complete course of therapy in one session (identified as of January 1, 2013, by HCPCS code G0173 (and any succeeding

code) and reimbursed as of such date under APC 0067 (and any succeeding classification group)),

the payment rate for the service described in subclause (I) shall be reduced to an amount equal to the payment rate for the service described in subclause (II).

(ii) HOSPITAL DESCRIBED.—A hospital described in this clause is a hospital that is not—

(I) located in a rural area (as defined in section 1886(d)(2)(D));

(II) classified as a rural referral center under section 1886(d)(5)(C); or

(III) a sole community hospital (as defined in section 1886(d)(5)(D)(iii)).

(iii) NOT BUDGET NEUTRAL.—In making any budget neutrality adjustments under this subsection for 2013 (with respect to covered OPD services furnished on or after April 1, 2013, and before January 1, 2014) or a subsequent year, the Secretary shall not take into account the reduced expenditures that result from the application of this subparagraph.

(E) APPLICATION OF APPROPRIATE USE CRITERIA FOR CERTAIN IMAGING SERVICES.—For provisions relating to the application of appropriate use criteria for certain imaging services, see section 1834(q).

(F) PAYMENT INCENTIVE FOR THE TRANSITION FROM TRADITIONAL X-RAY IMAGING TO DIGITAL RADIOGRAPHY.—Notwithstanding the previous provisions of this subsection:

(i) LIMITATION ON PAYMENT FOR FILM X-RAY IMAGING SERVICES.—In the case of an imaging service that is an X-ray taken using film and that is furnished during 2017 or a subsequent year, the payment amount for such service (including the X-ray component of a packaged service) that would otherwise be determined under this section (without application of this paragraph and before application of any other adjustment under this subsection) for such year shall be reduced by 20 percent.

(ii) PHASED-IN LIMITATION ON PAYMENT FOR COMPUTED RADIOGRAPHY IMAGING SERVICES.—In the case of an imaging service that is an X-ray taken using computed radiography technology (as defined in section 1848(b)(9)(C))—

(I) in the case of such a service furnished during 2018, 2019, 2020, 2021, or 2022, the payment amount for such service (including the X-ray component of a packaged service) that would otherwise be determined under this section (without application of this paragraph and before application of any other adjustment under this subsection) for such year shall be reduced by 7 percent; and

(II) in the case of such a service furnished during 2023 or a subsequent year, the payment amount for such service (including the X-ray com-

ponent of a packaged service) that would otherwise be determined under this section (without application of this paragraph and before application of any other adjustment under this subsection) for such year shall be reduced by 10 percent.

(iii) APPLICATION WITHOUT REGARD TO BUDGET NEUTRALITY.—The reductions made under this subparagraph—

(I) shall not be considered an adjustment under paragraph (2)(E); and

(II) shall not be implemented in a budget neutral manner.

(iv) IMPLEMENTATION.—In order to implement this subparagraph, the Secretary shall adopt appropriate mechanisms which may include use of modifiers.

(17) QUALITY REPORTING.—

(A) REDUCTION IN UPDATE FOR FAILURE TO REPORT.—

(i) IN GENERAL.—For purposes of paragraph (3)(C)(iv) for 2009 and each subsequent year, in the case of a subsection (d) hospital (as defined in section 1886(d)(1)(B)) that does not submit, to the Secretary in accordance with this paragraph, data required to be submitted on measures selected under this paragraph with respect to such a year, the OPD fee schedule increase factor under paragraph (3)(C)(iv) for such year shall be reduced by 2.0 percentage points.

(ii) NON-CUMULATIVE APPLICATION.—A reduction under this subparagraph shall apply only with respect to the year involved and the Secretary shall not take into account such reduction in computing the OPD fee schedule increase factor for a subsequent year.

(B) FORM AND MANNER OF SUBMISSION.—Each subsection (d) hospital shall submit data on measures selected under this paragraph to the Secretary in a form and manner, and at a time, specified by the Secretary for purposes of this paragraph.

(C) DEVELOPMENT OF OUTPATIENT MEASURES.—

(i) IN GENERAL.—The Secretary shall develop measures that the Secretary determines to be appropriate for the measurement of the quality of care (including medication errors) furnished by hospitals in outpatient settings and that reflect consensus among affected parties and, to the extent feasible and practicable, shall include measures set forth by one or more national consensus building entities.

(ii) CONSTRUCTION.—Nothing in this paragraph shall be construed as preventing the Secretary from selecting measures that are the same as (or a subset of) the measures for which data are required to be submitted under section 1886(b)(3)(B)(viii).

(D) REPLACEMENT OF MEASURES.—For purposes of this paragraph, the Secretary may replace any measures or indicators in appropriate cases, such as where all hospitals are effectively in compliance or the measures or indicators

have been subsequently shown not to represent the best clinical practice.

(E) AVAILABILITY OF DATA.—The Secretary shall establish procedures for making data submitted under this paragraph available to the public. Such procedures shall ensure that a hospital has the opportunity to review the data that are to be made public with respect to the hospital prior to such data being made public. The Secretary shall report quality measures of process, structure, outcome, patients' perspectives on care, efficiency, and costs of care that relate to services furnished in outpatient settings in hospitals on the Internet website of the Centers for Medicare & Medicaid Services.

(18) AUTHORIZATION OF ADJUSTMENT FOR CANCER HOSPITALS.—

(A) STUDY.—The Secretary shall conduct a study to determine if, under the system under this subsection, costs incurred by hospitals described in section 1886(d)(1)(B)(v) with respect to ambulatory payment classification groups exceed those costs incurred by other hospitals furnishing services under this subsection (as determined appropriate by the Secretary). In conducting the study under this subparagraph, the Secretary shall take into consideration the cost of drugs and biologicals incurred by such hospitals.

(B) AUTHORIZATION OF ADJUSTMENT.—Insofar as the Secretary determines under subparagraph (A) that costs incurred by hospitals described in section 1886(d)(1)(B)(v) exceed those costs incurred by other hospitals furnishing services under this subsection, the Secretary shall provide for an appropriate adjustment under paragraph (2)(E) to reflect those higher costs effective for services furnished on or after January 1, 2011.

(19) FLOOR ON AREA WAGE ADJUSTMENT FACTOR FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES IN FRONTIER STATES.—

(A) IN GENERAL.—Subject to subparagraph (B), with respect to covered OPD services furnished on or after January 1, 2011, the area wage adjustment factor applicable under the payment system established under this subsection to any hospital outpatient department which is located in a frontier State (as defined in section 1886(d)(3)(E)(iii)(II)) may not be less than 1.00. The preceding sentence shall not be applied in a budget neutral manner.

(B) LIMITATION.—This paragraph shall not apply to any hospital outpatient department located in a State that receives a non-labor related share adjustment under section 1886(d)(5)(H).

(20) NOT BUDGET NEUTRAL APPLICATION OF REDUCED EXPENDITURES RESULTING FROM QUALITY INCENTIVES FOR COMPUTED TOMOGRAPHY.—The Secretary shall not take into account the reduced expenditures that result from the application of section 1834(p) in making any budget neutrality adjustments this subsection.

(21) SERVICES FURNISHED BY AN OFF-CAMPUS OUTPATIENT DEPARTMENT OF A PROVIDER.—

(A) APPLICABLE ITEMS AND SERVICES.—For purposes of paragraph (1)(B)(v) and this paragraph, the term "applicable items and services" means items and services other than items and services furnished by a dedicated emergency department (as defined in section 489.24(b) of title 42 of the Code of Federal Regulations).

(B) OFF-CAMPUS OUTPATIENT DEPARTMENT OF A PROVIDER.—

(i) IN GENERAL.—For purposes of paragraph (1)(B)(v) and this paragraph, subject to clause (ii), the term "off-campus outpatient department of a provider" means a department of a provider (as defined in section 413.65(a)(2) of title 42 of the Code of Federal Regulations, as in effect as of the date of the enactment of this paragraph) that is not located—

(I) on the campus (as defined in such section 413.65(a)(2)) of such provider; or

(II) within the distance (described in such definition of campus) from a remote location of a hospital facility (as defined in such section 413.65(a)(2)).

(ii) EXCEPTION.—For purposes of paragraph (1)(B)(v) and this paragraph, the term "off-campus outpatient department of a provider" shall not include a department of a provider (as so defined) that was billing under this subsection with respect to covered OPD services furnished prior to the date of the enactment of this paragraph.

(C) AVAILABILITY OF PAYMENT UNDER OTHER PAYMENT SYSTEMS.—Payments for applicable items and services furnished by an off-campus outpatient department of a provider that are described in paragraph (1)(B)(v) shall be made under the applicable payment system under this part (other than under this subsection) if the requirements for such payment are otherwise met.

(D) INFORMATION NEEDED FOR IMPLEMENTATION.—Each hospital shall provide to the Secretary such information as the Secretary determines appropriate to implement this paragraph and paragraph (1)(B)(v) (which may include reporting of information on a hospital claim using a code or modifier and reporting information about off-campus outpatient departments of a provider on the enrollment form described in section 1866(j)).

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

(i) The determination of the applicable items and services under subparagraph (A) and applicable payment systems under subparagraph (C).

(ii) The determination of whether a department of a provider meets the term described in subparagraph (B).

(iii) Any information that hospitals are required to report pursuant to subparagraph (D).

(u) INCENTIVE PAYMENTS FOR PHYSICIAN SCARCITY AREAS.—

(1) IN GENERAL.—In the case of physicians' services furnished on or after January 1, 2005, and before July 1, 2008—

(A) by a primary care physician in a primary care scarcity county (identified under paragraph (4)); or

(B) by a physician who is not a primary care physician in a specialist care scarcity county (as so identified),

in addition to the amount of payment that would otherwise be made for such services under this part, there also shall be paid an amount equal to 5 percent of the payment amount for the service under this part.

(2) DETERMINATION OF RATIOS OF PHYSICIANS TO MEDICARE BENEFICIARIES IN AREA.—Based upon available data, the Secretary shall establish for each county or equivalent area in the United States, the following:

(A) NUMBER OF PHYSICIANS PRACTICING IN THE AREA.—The number of physicians who furnish physicians' services in the active practice of medicine or osteopathy in that county or area, other than physicians whose practice is exclusively for the Federal Government, physicians who are retired, or physicians who only provide administrative services. Of such number, the number of such physicians who are—

(i) primary care physicians; or

(ii) physicians who are not primary care physicians.

(B) NUMBER OF MEDICARE BENEFICIARIES RESIDING IN THE AREA.—The number of individuals who are residing in the county and are entitled to benefits under part A or enrolled under this part, or both (in this subsection referred to as "individuals").

(C) DETERMINATION OF RATIOS.—

(i) PRIMARY CARE RATIO.—The ratio (in this paragraph referred to as the "primary care ratio") of the number of primary care physicians (determined under subparagraph (A)(i)), to the number of individuals determined under subparagraph (B).

(ii) SPECIALIST CARE RATIO.—The ratio (in this paragraph referred to as the "specialist care ratio") of the number of other physicians (determined under subparagraph (A)(ii)), to the number of individuals determined under subparagraph (B).

(3) RANKING OF COUNTIES.—The Secretary shall rank each such county or area based separately on its primary care ratio and its specialist care ratio.

(4) IDENTIFICATION OF COUNTIES.—

(A) IN GENERAL.—The Secretary shall identify—

(i) those counties and areas (in this paragraph referred to as "primary care scarcity counties") with the lowest primary care ratios that represent, if each such county or area were weighted by the number of individuals determined under paragraph (2)(B), an aggregate total of 20 percent of the total of the individuals determined under such paragraph; and

(ii) those counties and areas (in this subsection referred to as "specialist care scarcity counties") with the lowest specialist care ratios that represent, if each such county or area were weighted by the number of individuals determined under paragraph (2)(B), an aggregate total of 20 percent of the total of the individuals determined under such paragraph.

(B) PERIODIC REVISIONS.—The Secretary shall periodically revise the counties or areas identified in subparagraph (A) (but not less often than once every three years) unless the Secretary determines that there is no new data available on the number of physicians practicing in the county or area or the number of individuals residing in the county or area, as identified in paragraph (2).

(C) IDENTIFICATION OF COUNTIES WHERE SERVICE IS FURNISHED.—For purposes of paying the additional amount specified in paragraph (1), if the Secretary uses the 5-digit postal ZIP Code where the service is furnished, the dominant county of the postal ZIP Code (as determined by the United States Postal Service, or otherwise) shall be used to determine whether the postal ZIP Code is in a scarcity county identified in subparagraph (A) or revised in subparagraph (B).

(D) SPECIAL RULE.—With respect to physicians' services furnished on or after January 1, 2008, and before July 1, 2008, for purposes of this subsection, the Secretary shall use the primary care scarcity counties and the specialty care scarcity counties (as identified under the preceding provisions of this paragraph) that the Secretary was using under this subsection with respect to physicians' services furnished on December 31, 2007.

(E) JUDICIAL REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise, respecting—

116.(i) the identification of a county or area;

(ii) the assignment of a specialty of any physician under this paragraph;

(iii) the assignment of a physician to a county under paragraph (2); or

(iv) the assignment of a postal ZIP Code to a county or other area under this subsection.

(5) RURAL CENSUS TRACTS.—To the extent feasible, the Secretary shall treat a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725)), as an equivalent area for purposes of qualifying as a primary care scarcity county or specialist care scarcity county under this subsection.

(6) PHYSICIAN DEFINED.—For purposes of this paragraph, the term "physician" means a physician described in section 1861(r)(1) and the term "primary care physician" means a physician who is identified in the available data as a general practitioner, family practice practitioner, general internist, or obstetrician or gynecologist.

(7) PUBLICATION OF LIST OF COUNTIES; POSTING ON WEBSITE.—With respect to a year for which a county or area is identified or revised under paragraph (4), the Secretary shall identify such counties or areas as part of the proposed and final rule to implement the physician fee schedule under section 1848 for the applicable year. The Secretary shall post the list of counties identified or revised under paragraph (4) on the Internet website of the Centers for Medicare & Medicaid Services.

(v) INCREASE OF FQHC PAYMENT LIMITS.—In the case of services furnished by Federally qualified health centers (as defined in section 1861(aa)(4)), the Secretary shall establish payment limits with respect to such services under this part for services furnished—

(1) in 2010, at the limits otherwise established under this part for such year increased by $5; and

(2) in a subsequent year, at the limits established under this subsection for the previous year increased by the percentage increase in the MEI (as defined in section 1842(i)(3)) for such subsequent year.

(w) METHODS OF PAYMENT.—The Secretary may develop alternative methods of payment for items and services provided under clinical trials and comparative effectiveness studies sponsored or supported by an agency of the Department of Health and Human Services, as determined by the Secretary, to those that would otherwise apply under this section, to the extent such alternative methods are necessary to preserve the scientific validity of such trials or studies, such as in the case where masking the identity of interventions from patients and investigators is necessary to comply with the particular trial or study design.

(x) INCENTIVE PAYMENTS FOR PRIMARY CARE SERVICES.—

(1) IN GENERAL.—In the case of primary care services furnished on or after January 1, 2011, and before January 1, 2016, by a primary care practitioner, in addition to the amount of payment that would otherwise be made for such services under this part, there also shall be paid (on a monthly or quarterly basis) an amount equal to 10 percent of the payment amount for the service under this part.

(2) DEFINITIONS.—In this subsection:

(A) PRIMARY CARE PRACTITIONER.—The term "primary care practitioner" means an individual—

(i) who—

(I) is a physician (as described in section 1861(r)(1)) who has a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine; or

(II) is a nurse practitioner, clinical nurse specialist, or physician assistant (as those terms are defined in section 1861(aa)(5)); and

(ii) for whom primary care services accounted for at least 60 percent of the allowed charges under this part for such physician or practitioner in a prior period as determined appropriate by the Secretary.

(B) PRIMARY CARE SERVICES.—The term "primary care services" means services identified, as of January 1, 2009,

by the following HCPCS codes (and as subsequently modified by the Secretary):

(i) 99201 through 99215.

(ii) 99304 through 99340.

(iii) 99341 through 99350.

(3) COORDINATION WITH OTHER PAYMENTS.—The amount of the additional payment for a service under this subsection and subsection (m) shall be determined without regard to any additional payment for the service under subsection (m) and this subsection, respectively. The amount of the additional payment for a service under this subsection and subsection (z) shall be determined without regard to any additional payment for the service under subsection (z) and this subsection, respectively.

(4) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise, respecting the identification of primary care practitioners under this subsection.

(y) INCENTIVE PAYMENTS FOR MAJOR SURGICAL PROCEDURES FURNISHED IN HEALTH PROFESSIONAL SHORTAGE AREAS.—

(1) IN GENERAL.—In the case of major surgical procedures furnished on or after January 1, 2011, and before January 1, 2016, by a general surgeon in an area that is designated (under section 332(a)(1)(A) of the Public Health Service Act) as a health professional shortage area as identified by the Secretary prior to the beginning of the year involved, in addition to the amount of payment that would otherwise be made for such services under this part, there also shall be paid (on a monthly or quarterly basis) an amount equal to 10 percent of the payment amount for the service under this part.

(2) DEFINITIONS.—In this subsection:

(A) GENERAL SURGEON.—In this subsection, the term "general surgeon" means a physician (as described in section 1861(r)(1)) who has designated CMS specialty code 02–General Surgery as their primary specialty code in the physician's enrollment under section 1866(j).

(B) MAJOR SURGICAL PROCEDURES.—The term "major surgical procedures" means physicians' services which are surgical procedures for which a 10-day or 90-day global period is used for payment under the fee schedule under section 1848(b).

(3) COORDINATION WITH OTHER PAYMENTS.—The amount of the additional payment for a service under this subsection and subsection (m) shall be determined without regard to any additional payment for the service under subsection (m) and this subsection, respectively. The amount of the additional payment for a service under this subsection and subsection (z) shall be determined without regard to any additional payment for the service under subsection (z) and this subsection, respectively.

(4) APPLICATION.—The provisions of paragraph (2) and (4) of subsection (m) shall apply to the determination of additional payments under this subsection in the same manner as such provisions apply to the determination of additional payments under subsection (m).

(z) INCENTIVE PAYMENTS FOR PARTICIPATION IN ELIGIBLE ALTERNATIVE PAYMENT MODELS.—

(1) PAYMENT INCENTIVE.—

(A) IN GENERAL.—In the case of covered professional services furnished by an eligible professional during a year that is in the period beginning with 2019 and ending with 2024 and for which the professional is a qualifying APM participant with respect to such year, in addition to the amount of payment that would otherwise be made for such covered professional services under this part for such year, there also shall be paid to such professional an amount equal to 5 percent of the estimated aggregate payment amounts for such covered professional services under this part for the preceding year. For purposes of the previous sentence, the payment amount for the preceding year may be an estimation for the full preceding year based on a period of such preceding year that is less than the full year. The Secretary shall establish policies to implement this subparagraph in cases in which payment for covered professional services furnished by a qualifying APM participant in an alternative payment model—

(i) is made to an eligible alternative payment entity rather than directly to the qualifying APM participant; or

(ii) is made on a basis other than a fee-for-service basis (such as payment on a capitated basis).

(B) FORM OF PAYMENT.—Payments under this subsection shall be made in a lump sum, on an annual basis, as soon as practicable.

(C) TREATMENT OF PAYMENT INCENTIVE.—Payments under this subsection shall not be taken into account for purposes of determining actual expenditures under an alternative payment model and for purposes of determining or rebasing any benchmarks used under the alternative payment model.

(D) COORDINATION.—The amount of the additional payment under this subsection or subsection (m) shall be determined without regard to any additional payment under subsection (m) and this subsection, respectively. The amount of the additional payment under this subsection or subsection (x) shall be determined without regard to any additional payment under subsection (x) and this subsection, respectively. The amount of the additional payment under this subsection or subsection (y) shall be determined without regard to any additional payment under subsection (y) and this subsection, respectively.

(2) QUALIFYING APM PARTICIPANT.—For purposes of this subsection, the term "qualifying APM participant" means the following:

(A) 2019 AND 2020.—With respect to 2019 and 2020, an eligible professional for whom the Secretary determines that at least 25 percent of payments under this part for covered professional services furnished by such professional during the most recent period for which data are available (which may be less than a year) were attributable to such services furnished under this part through an eligible alternative payment entity.

(B) 2021 AND 2022.—With respect to 2021 and 2022, an eligible professional described in either of the following clauses:

(i) MEDICARE PAYMENT THRESHOLD OPTION.—An eligible professional for whom the Secretary determines that at least 50 percent of payments under this part for covered professional services furnished by such professional during the most recent period for which data are available (which may be less than a year) were attributable to such services furnished under this part through an eligible alternative payment entity.

(ii) COMBINATION ALL-PAYER AND MEDICARE PAYMENT THRESHOLD OPTION.—An eligible professional—

(I) for whom the Secretary determines, with respect to items and services furnished by such professional during the most recent period for which data are available (which may be less than a year), that at least 50 percent of the sum of—

(aa) payments described in clause (i); and

(bb) all other payments, regardless of payer (other than payments made by the Secretary of Defense or the Secretary of Veterans Affairs and other than payments made under title XIX in a State in which no medical home or alternative payment model is available under the State program under that title),

meet the requirement described in clause (iii)(I) with respect to payments described in item (aa) and meet the requirement described in clause (iii)(II) with respect to payments described in item (bb);

(II) for whom the Secretary determines at least 25 percent of payments under this part for covered professional services furnished by such professional during the most recent period for which data are available (which may be less than a year) were attributable to such services furnished under this part through an eligible alternative payment entity; and

(III) who provides to the Secretary such information as is necessary for the Secretary to make a determination under subclause (I), with respect to such professional.

(iii) REQUIREMENT.—For purposes of clause (ii)(I)—

(I) the requirement described in this subclause, with respect to payments described in item (aa) of such clause, is that such payments are made to an eligible alternative payment entity; and

(II) the requirement described in this subclause, with respect to payments described in item (bb) of such clause, is that such payments are made under arrangements in which—

(aa) quality measures comparable to measures under the performance category described in section 1848(q)(2)(B)(i) apply;

(bb) certified EHR technology is used; and

(cc) the eligible professional participates in an entity that—

(AA) bears more than nominal financial risk if actual aggregate expenditures exceeds expected aggregate expenditures; or

(BB) with respect to beneficiaries under title XIX, is a medical home that meets criteria comparable to medical homes expanded under section 1115A(c).

(C) BEGINNING IN 2023.—With respect to 2023 and each subsequent year, an eligible professional described in either of the following clauses:

(i) MEDICARE PAYMENT THRESHOLD OPTION.—An eligible professional for whom the Secretary determines that at least 75 percent of payments under this part for covered professional services furnished by such professional during the most recent period for which data are available (which may be less than a year) were attributable to such services furnished under this part through an eligible alternative payment entity.

(ii) COMBINATION ALL-PAYER AND MEDICARE PAYMENT THRESHOLD OPTION.—An eligible professional—

(I) for whom the Secretary determines, with respect to items and services furnished by such professional during the most recent period for which data are available (which may be less than a year), that at least 75 percent of the sum of—

(aa) payments described in clause (i); and

(bb) all other payments, regardless of payer (other than payments made by the Secretary of Defense or the Secretary of Veterans Affairs and other than payments made under title XIX in a State in which no medical home or alternative payment model is available under the State program under that title),

meet the requirement described in clause (iii)(I) with respect to payments described in item (aa) and meet the requirement described in clause (iii)(II) with respect to payments described in item (bb);

(II) for whom the Secretary determines at least 25 percent of payments under this part for covered professional services furnished by such professional during the most recent period for which data are available (which may be less than a year) were attributable to such services furnished under this part through an eligible alternative payment entity; and

(III) who provides to the Secretary such information as is necessary for the Secretary to make a determination under subclause (I), with respect to such professional.

(iii) REQUIREMENT.—For purposes of clause (ii)(I)—

(I) the requirement described in this subclause, with respect to payments described in item (aa) of such clause, is that such payments are made to an eligible alternative payment entity; and

(II) the requirement described in this subclause, with respect to payments described in item (bb) of such clause, is that such payments are made under arrangements in which—

(aa) quality measures comparable to measures under the performance category described in section 1848(q)(2)(B)(i) apply;

(bb) certified EHR technology is used; and

(cc) the eligible professional participates in an entity that—

(AA) bears more than nominal financial risk if actual aggregate expenditures exceeds expected aggregate expenditures; or

(BB) with respect to beneficiaries under title XIX, is a medical home that meets criteria comparable to medical homes expanded under section 1115A(c).

(D) USE OF PATIENT APPROACH.—The Secretary may base the determination of whether an eligible professional is a qualifying APM participant under this subsection and the determination of whether an eligible professional is a partial qualifying APM participant under section 1848(q)(1)(C)(iii) by using counts of patients in lieu of using payments and using the same or similar percentage criteria (as specified in this subsection and such section, respectively), as the Secretary determines appropriate.

(3) ADDITIONAL DEFINITIONS.—In this subsection:

(A) COVERED PROFESSIONAL SERVICES.—The term "covered professional services" has the meaning given that term in section 1848(k)(3)(A).

(B) ELIGIBLE PROFESSIONAL.—The term "eligible professional" has the meaning given that term in section 1848(k)(3)(B) and includes a group that includes such professionals.

(C) ALTERNATIVE PAYMENT MODEL (APM).—The term "alternative payment model" means, other than for purposes of subparagraphs (B)(ii)(I)(bb) and (C)(ii)(I)(bb) of paragraph (2), any of the following:

(i) A model under section 1115A (other than a health care innovation award).

(ii) The shared savings program under section 1899.

(iii) A demonstration under section 1866C.

(iv) A demonstration required by Federal law.

(D) ELIGIBLE ALTERNATIVE PAYMENT ENTITY.—The term "eligible alternative payment entity" means, with respect to a year, an entity that—

(i) participates in an alternative payment model that—

(I) requires participants in such model to use certified EHR technology (as defined in subsection (o)(4)); and

(II) provides for payment for covered professional services based on quality measures comparable to measures under the performance category described in section 1848(q)(2)(B)(i); and

(ii)(I) bears financial risk for monetary losses under such alternative payment model that are in excess of a nominal amount; or

(II) is a medical home expanded under section 1115A(c).

(4) LIMITATION.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise, of the following:

(A) The determination that an eligible professional is a qualifying APM participant under paragraph (2) and the determination that an entity is an eligible alternative payment entity under paragraph (3)(D).

(B) The determination of the amount of the 5 percent payment incentive under paragraph (1)(A), including any estimation as part of such determination.

(z) MEDICAL REVIEW OF SPINAL SUBLUXATION SERVICES.—

(1) IN GENERAL.—The Secretary shall implement a process for the medical review (as described in paragraph (2)) of treatment by a chiropractor described in section 1861(r)(5) by means of manual manipulation of the spine to correct a subluxation (as described in such section) of an individual who is enrolled under this part and apply such process to such services furnished on or after January 1, 2017, focusing on services such as—

(A) services furnished by a such a chiropractor whose pattern of billing is aberrant compared to peers; and

(B) services furnished by such a chiropractor who, in a prior period, has a services denial percentage in the 85th percentile or greater, taking into consideration the extent that service denials are overturned on appeal.

(2) MEDICAL REVIEW.—

(A) PRIOR AUTHORIZATION MEDICAL REVIEW.—

(i) IN GENERAL.—Subject to clause (ii), the Secretary shall use prior authorization medical review for services described in paragraph (1) that are furnished to an individual by a chiropractor described in section 1861(r)(5) that are part of an episode of treatment that includes more than 12 services. For purposes of the preceding sentence, an episode of treatment shall be determined by the underlying cause that justifies the need for services, such as a diagnosis code.

(ii) ENDING APPLICATION OF PRIOR AUTHORIZATION MEDICAL REVIEW.—The Secretary shall end the application of prior authorization medical review under clause (i) to services described in paragraph (1) by such a chiropractor if the Secretary determines that the chiropractor has a low denial rate under such prior authorization medical review. The Secretary may subsequently reapply prior authorization medical review to such chiropractor if the Secretary determines it to be appropriate and the chiropractor has, in the time period subsequent to the determination by the

Secretary of a low denial rate with respect to the chiropractor, furnished such services described in paragraph (1).

(iii) EARLY REQUEST FOR PRIOR AUTHORIZATION REVIEW PERMITTED.—Nothing in this subsection shall be construed to prevent such a chiropractor from requesting prior authorization for services described in paragraph (1) that are to be furnished to an individual before the chiropractor furnishes the twelfth such service to such individual for an episode of treatment.

(B) TYPE OF REVIEW.—The Secretary may use pre-payment review or post-payment review of services described in section 1861(r)(5) that are not subject to prior authorization medical review under subparagraph (A).

(C) RELATIONSHIP TO LAW ENFORCEMENT ACTIVITIES.—The Secretary may determine that medical review under this subsection does not apply in the case where potential fraud may be involved.

(3) NO PAYMENT WITHOUT PRIOR AUTHORIZATION.—With respect to a service described in paragraph (1) for which prior authorization medical review under this subsection applies, the following shall apply:

(A) PRIOR AUTHORIZATION DETERMINATION.—The Secretary shall make a determination, prior to the service being furnished, of whether the service would or would not meet the applicable requirements of section 1862(a)(1)(A).

(B) DENIAL OF PAYMENT.—Subject to paragraph (5), no payment may be made under this part for the service unless the Secretary determines pursuant to subparagraph (A) that the service would meet the applicable requirements of such section 1862(a)(1)(A).

(4) SUBMISSION OF INFORMATION.—A chiropractor described in section 1861(r)(5) may submit the information necessary for medical review by fax, by mail, or by electronic means. The Secretary shall make available the electronic means described in the preceding sentence as soon as practicable.

(5) TIMELINESS.—If the Secretary does not make a prior authorization determination under paragraph (3)(A) within 14 business days of the date of the receipt of medical documentation needed to make such determination, paragraph (3)(B) shall not apply.

(6) APPLICATION OF LIMITATION ON BENEFICIARY LIABILITY.—Where payment may not be made as a result of the application of paragraph (2)(B), section 1879 shall apply in the same manner as such section applies to a denial that is made by reason of section 1862(a)(1).

(7) REVIEW BY CONTRACTORS.—The medical review described in paragraph (2) may be conducted by medicare administrative contractors pursuant to section 1874A(a)(4)(G) or by any other contractor determined appropriate by the Secretary that is not a recovery audit contractor.

(8) MULTIPLE SERVICES.—The Secretary shall, where practicable, apply the medical review under this subsection in a manner so as to allow an individual described in paragraph (1) to obtain, at a single time rather than on a service-by-service

basis, an authorization in accordance with paragraph (3)(A) for multiple services.

(9) CONSTRUCTION.—With respect to a service described in paragraph (1) that has been affirmed by medical review under this subsection, nothing in this subsection shall be construed to preclude the subsequent denial of a claim for such service that does not meet other applicable requirements under this Act.

(10) IMPLEMENTATION.—

(A) AUTHORITY.—The Secretary may implement the provisions of this subsection by interim final rule with comment period.

(B) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to medical review under this subsection.

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PAYMENT FOR PHYSICIANS' SERVICES

SEC. 1848. (a) PAYMENT BASED ON FEE SCHEDULE.—

(1) IN GENERAL.—Effective for all physicians' services (as defined in subsection (j)(3)) furnished under this part during a year (beginning with 1992) for which payment is otherwise made on the basis of a reasonable charge or on the basis of a fee schedule under section 1834(b), payment under this part shall instead be based on the lesser of—

(A) the actual charge for the service, or

(B) subject to the succeeding provisions of this subsection, the amount determined under the fee schedule established under subsection (b) for services furnished during that year (in this subsection referred to as the "fee schedule amount").

(2) TRANSITION TO FULL FEE SCHEDULE.—

(A) LIMITING REDUCTIONS AND INCREASES TO 15 PERCENT IN 1992.—

(i) LIMIT ON INCREASE.—In the case of a service in a fee schedule area (as defined in subsection (j)(2)) for which the adjusted historical payment basis (as defined in subparagraph (D)) is less than 85 percent of the fee schedule amount for services furnished in 1992, there shall be substituted for the fee schedule amount an amount equal to the adjusted historical payment basis plus 15 percent of the fee schedule amount otherwise established (without regard to this paragraph).

(ii) LIMIT IN REDUCTION.—In the case of a service in a fee schedule area for which the adjusted historical payment basis exceeds 115 percent of the fee schedule amount for services furnished in 1992, there shall be substituted for the fee schedule amount an amount equal to the adjusted historical payment basis minus 15 percent of the fee schedule amount otherwise established (without regard to this paragraph).

(B) SPECIAL RULE FOR 1993, 1994, AND 1995.—If a physicians' service in a fee schedule area is subject to the provi-

sions of subparagraph (A) in 1992, for physicians' services furnished in the area—

(i) during 1993, there shall be substituted for the fee schedule amount an amount equal to the sum of—

(I) 75 percent of the fee schedule amount determined under subparagraph (A), adjusted by the update established under subsection (d)(3) for 1993, and

(II) 25 percent of the fee schedule amount determined under paragraph (1) for 1993 without regard to this paragraph;

(ii) during 1994, there shall be substituted for the fee schedule amount an amount equal to the sum of—

(I) 67 percent of the fee schedule amount determined under clause (i), adjusted by the update established under subsection (d)(3) for 1994 and as adjusted under subsection (c)(2)(F)(ii) and under section 13515(b) of the Omnibus Budget Reconciliation Act of 1993, and

(II) 33 percent of the fee schedule amount determined under paragraph (1) for 1994 without regard to this paragraph; and

(iii) during 1995, there shall be substituted for the fee schedule amount an amount equal to the sum of—

(I) 50 percent of the fee schedule amount determined under clause (ii) adjusted by the update established under subsection (d)(3) for 1995, and

(II) 50 percent of the fee schedule amount determined under paragraph (1) for 1995 without regard to this paragraph.

(C) SPECIAL RULE FOR ANESTHESIA AND RADIOLOGY SERVICES.—With respect to physicians' services which are anesthesia services, the Secretary shall provide for a transition in the same manner as a transition is provided for other services under subparagraph (B). With respect to radiology services, "109 percent" and "9 percent" shall be substituted for "115 percent" and "15 percent", respectively, in subparagraph (A)(ii).

(D) ADJUSTED HISTORICAL PAYMENT BASIS DEFINED.—

(i) IN GENERAL.—In this paragraph, the term "adjusted historical payment basis" means, with respect to a physicians' service furnished in a fee schedule area, the weighted average prevailing charge applied in the area for the service in 1991 (as determined by the Secretary without regard to physician specialty and as adjusted to reflect payments for services with customary charges below the prevailing charge or other payment limitations imposed by law or regulation) adjusted by the update established under subsection (d)(3) for 1992.

(ii) APPLICATION TO RADIOLOGY SERVICES.—In applying clause (i) in the case of physicians' services which are radiology services (including radiologist services, as defined in section 1834(b)(6)), but excluding nuclear medicine services that are subject to section 6105(b) of

the Omnibus Budget Reconciliation Act of 1989, there shall be substituted for the weighted average prevailing charge the amount provided under the fee schedule established for the service for the fee schedule area under section 1834(b).

(iii) NUCLEAR MEDICINE SERVICES.—In applying clause (i) in the case of physicians' services which are nuclear medicine services, there shall be substituted for the weighted average prevailing charge the amount provided under section 6105(b) of the Omnibus Budget Reconciliation Act of 1989.

(3) INCENTIVES FOR PARTICIPATING PHYSICIANS AND SUPPLIERS.—In applying paragraph (1)(B) in the case of a nonparticipating physician or a nonparticipating supplier or other person, the fee schedule amount shall be 95 percent of such amount otherwise applied under this subsection (without regard to this paragraph). In the case of physicians' services (including services which the Secretary excludes pursuant to subsection (j)(3)) of a nonparticipating physician, supplier, or other person for which payment is made under this part on a basis other than the fee schedule amount, the payment shall be based on 95 percent of the payment basis for such services furnished by a participating physician, supplier, or other person.

(4) SPECIAL RULE FOR MEDICAL DIRECTION.—

(A) IN GENERAL.—With respect to physicians' services furnished on or after January 1, 1994, and consisting of medical direction of two, three, or four concurrent anesthesia cases, except as provided in paragraph (5), the fee schedule amount to be applied shall be equal to one-half of the amount described in subparagraph (B).

(B) AMOUNT.—The amount described in this subparagraph, for a physician's medical direction of the performance of anesthesia services, is the following percentage of the fee schedule amount otherwise applicable under this section if the anesthesia services were personally performed by the physician alone:

(i) For services furnished during 1994, 120 percent.

(ii) For services furnished during 1995, 115 percent.

(iii) For services furnished during 1996, 110 percent.

(iv) For services furnished during 1997, 105 percent.

(v) For services furnished after 1997, 100 percent.

(5) INCENTIVES FOR ELECTRONIC PRESCRIBING.—

(A) ADJUSTMENT.—

(i) IN GENERAL.—Subject to subparagraph (B) and subsection (m)(2)(B), with respect to covered professional services furnished by an eligible professional during 2012, 2013 or 2014, if the eligible professional is not a successful electronic prescriber for the reporting period for the year (as determined under subsection (m)(3)(B)), the fee schedule amount for such services furnished by such professional during the year (including the fee schedule amount for purposes of determining a payment based on such amount) shall be equal to the applicable percent of the fee schedule amount that would otherwise apply to such

services under this subsection (determined after application of paragraph (3) but without regard to this paragraph).

(ii) APPLICABLE PERCENT.—For purposes of clause (i), the term "applicable percent" means—

(I) for 2012, 99 percent;

(II) for 2013, 98.5 percent; and

(III) for 2014, 98 percent.

(B) SIGNIFICANT HARDSHIP EXCEPTION.—The Secretary may, on a case-by-case basis, exempt an eligible professional from the application of the payment adjustment under subparagraph (A) if the Secretary determines, subject to annual renewal, that compliance with the requirement for being a successful electronic prescriber would result in a significant hardship, such as in the case of an eligible professional who practices in a rural area without sufficient Internet access.

(C) APPLICATION.—

(i) PHYSICIAN REPORTING SYSTEM RULES.—Paragraphs (5), (6), and (8) of subsection (k) shall apply for purposes of this paragraph in the same manner as they apply for purposes of such subsection.

(ii) INCENTIVE PAYMENT VALIDATION RULES.—Clauses (ii) and (iii) of subsection (m)(5)(D) shall apply for purposes of this paragraph in a similar manner as they apply for purposes of such subsection.

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

(i) ELIGIBLE PROFESSIONAL; COVERED PROFESSIONAL SERVICES.—The terms "eligible professional" and "covered professional services" have the meanings given such terms in subsection (k)(3).

(ii) PHYSICIAN REPORTING SYSTEM.—The term "physician reporting system" means the system established under subsection (k).

(iii) REPORTING PERIOD.—The term "reporting period" means, with respect to a year, a period specified by the Secretary.

(6) SPECIAL RULE FOR TEACHING ANESTHESIOLOGISTS.—With respect to physicians' services furnished on or after January 1, 2010, in the case of teaching anesthesiologists involved in the training of physician residents in a single anesthesia case or two concurrent anesthesia cases, the fee schedule amount to be applied shall be 100 percent of the fee schedule amount otherwise applicable under this section if the anesthesia services were personally performed by the teaching anesthesiologist alone and paragraph (4) shall not apply if—

(A) the teaching anesthesiologist is present during all critical or key portions of the anesthesia service or procedure involved; and

(B) the teaching anesthesiologist (or another anesthesiologist with whom the teaching anesthesiologist has entered into an arrangement) is immediately available to furnish anesthesia services during the entire procedure.

(7) INCENTIVES FOR MEANINGFUL USE OF CERTIFIED EHR TECHNOLOGY.—

(A) ADJUSTMENT.—

(i) IN GENERAL.—Subject to subparagraphs (B) and (D), with respect to covered professional services furnished by an eligible professional during each of 2015 through 2018, if the eligible professional is not a meaningful EHR user (as determined under subsection (o)(2)) for an EHR reporting period for the year, the fee schedule amount for such services furnished by such professional during the year (including the fee schedule amount for purposes of determining a payment based on such amount) shall be equal to the applicable percent of the fee schedule amount that would otherwise apply to such services under this subsection (determined after application of paragraph (3) but without regard to this paragraph).

(ii) APPLICABLE PERCENT.—Subject to clause (iii), for purposes of clause (i), the term "applicable percent" means—

(I) for 2015, 99 percent (or, in the case of an eligible professional who was subject to the application of the payment adjustment under section 1848(a)(5) for 2014, 98 percent);

(II) for 2016, 98 percent; and

(III) for 2017 and 2018, 97 percent.

(iii) AUTHORITY TO DECREASE APPLICABLE PERCENTAGE FOR 2018.—For 2018, if the Secretary finds that the proportion of eligible professionals who are meaningful EHR users (as determined under subsection (o)(2)) is less than 75 percent, the applicable percent shall be decreased by 1 percentage point from the applicable percent in the preceding year.

(B) SIGNIFICANT HARDSHIP EXCEPTION.—The Secretary may, on a case-by-case basis (and, with respect to the payment adjustment under subparagraph (A) for 2017, for categories of eligible professionals, as established by the Secretary and posted on the Internet website of the Centers for Medicare & Medicaid Services prior to December 15, 2015, an application for which must be submitted to the Secretary by not later than March 15, 2016), exempt an eligible professional from the application of the payment adjustment under subparagraph (A) if the Secretary determines, subject to annual renewal, that compliance with the requirement for being a meaningful EHR user would result in a significant hardship, such as in the case of an eligible professional who practices in a rural area without sufficient Internet access. In no case may an eligible professional be granted an exemption under this subparagraph for more than 5 years.

(C) APPLICATION OF PHYSICIAN REPORTING SYSTEM RULES.—Paragraphs (5), (6), and (8) of subsection (k) shall apply for purposes of this paragraph in the same manner as they apply for purposes of such subsection.

(D) NON-APPLICATION TO HOSPITAL-BASED ELIGIBLE PROFESSIONALS.—No payment adjustment may be made under

subparagraph (A) in the case of hospital-based eligible professionals (as defined in subsection (o)(1)(C)(ii)).

(E) DEFINITIONS.—For purposes of this paragraph:

(i) COVERED PROFESSIONAL SERVICES.—The term "covered professional services" has the meaning given such term in subsection (k)(3).

(ii) EHR REPORTING PERIOD.—The term "EHR reporting period" means, with respect to a year, a period (or periods) specified by the Secretary.

(iii) ELIGIBLE PROFESSIONAL.—The term "eligible professional" means a physician, as defined in section 1861(r).

(8) INCENTIVES FOR QUALITY REPORTING.—

(A) ADJUSTMENT.—

(i) IN GENERAL.—With respect to covered professional services furnished by an eligible professional during each of 2015 through 2018, if the eligible professional does not satisfactorily submit data on quality measures for covered professional services for the quality reporting period for the year (as determined under subsection (m)(3)(A)), the fee schedule amount for such services furnished by such professional during the year (including the fee schedule amount for purposes of determining a payment based on such amount) shall be equal to the applicable percent of the fee schedule amount that would otherwise apply to such services under this subsection (determined after application of paragraphs (3), (5), and (7), but without regard to this paragraph).

(ii) APPLICABLE PERCENT.—For purposes of clause (i), the term "applicable percent" means—

(I) for 2015, 98.5 percent; and

(II) for 2016, 2017, and 2018, 98 percent.

(B) APPLICATION.—

(i) PHYSICIAN REPORTING SYSTEM RULES.—Paragraphs (5), (6), and (8) of subsection (k) shall apply for purposes of this paragraph in the same manner as they apply for purposes of such subsection.

(ii) INCENTIVE PAYMENT VALIDATION RULES.—Clauses (ii) and (iii) of subsection (m)(5)(D) shall apply for purposes of this paragraph in a similar manner as they apply for purposes of such subsection.

(C) DEFINITIONS.—For purposes of this paragraph:

(i) ELIGIBLE PROFESSIONAL; COVERED PROFESSIONAL SERVICES.—The terms "eligible professional" and "covered professional services" have the meanings given such terms in subsection (k)(3).

(ii) PHYSICIAN REPORTING SYSTEM.—The term "physician reporting system" means the system established under subsection (k).

(iii) QUALITY REPORTING PERIOD.—The term "quality reporting period" means, with respect to a year, a period specified by the Secretary.

(9) INFORMATION REPORTING ON SERVICES INCLUDED IN GLOBAL SURGICAL PACKAGES.—With respect to services for which a

physician is required to report information in accordance with subsection (c)(8)(B)(i), the Secretary may through rulemaking delay payment of 5 percent of the amount that would otherwise be payable under the physician fee schedule under this section for such services until the information so required is reported.

(b) ESTABLISHMENT OF FEE SCHEDULES.—

(1) IN GENERAL.—Before November 1 of the preceding year, for each year beginning with 1998, subject to subsection (p), the Secretary shall establish, by regulation, fee schedules that establish payment amounts for all physicians' services furnished in all fee schedule areas (as defined in subsection (j)(2)) for the year. Except as provided in paragraph (2), each such payment amount for a service shall be equal to the product of—

(A) the relative value for the service (as determined in subsection (c)(2)),

(B) the conversion factor (established under subsection (d)) for the year, and

(C) the geographic adjustment factor (established under subsection (e)(2)) for the service for the fee schedule area.

(2) TREATMENT OF RADIOLOGY SERVICES AND ANESTHESIA SERVICES.—

(A) RADIOLOGY SERVICES.—With respect to radiology services (including radiologist services, as defined in section 1834(b)(6)), the Secretary shall base the relative values on the relative value scale developed under section 1834(b)(1)(A), with appropriate modifications of the relative values to assure that the relative values established for radiology services which are similar or related to other physicians' services are consistent with the relative values established for those similar or related services.

(B) ANESTHESIA SERVICES.—In establishing the fee schedule for anesthesia services for which a relative value guide has been established under section 4048(b) of the Omnibus Budget Reconciliation Act of 1987, the Secretary shall use, to the extent practicable, such relative value guide, with appropriate adjustment of the conversion factor, in a manner to assure that the fee schedule amounts for anesthesia services are consistent with the fee schedule amounts for other services determined by the Secretary to be of comparable value. In applying the previous sentence, the Secretary shall adjust the conversion factor by geographic adjustment factors in the same manner as such adjustment is made under paragraph (1)(C).

(C) CONSULTATION.—The Secretary shall consult with the Physician Payment Review Commission and organizations representing physicians or suppliers who furnish radiology services and anesthesia services in applying subparagraphs (A) and (B).

(3) TREATMENT OF INTERPRETATION OF ELECTROCARDIOGRAMS.—The Secretary—

(A) shall make separate payment under this section for the interpretation of electrocardiograms performed or ordered to be performed as part of or in conjunction with a visit to or a consultation with a physician, and

(B) shall adjust the relative values established for visits and consultations under subsection (c) so as not to include relative value units for interpretations of electrocardiograms in the relative value for visits and consultations.

(4) SPECIAL RULE FOR IMAGING SERVICES.—

(A) IN GENERAL.—In the case of imaging services described in subparagraph (B) furnished on or after January 1, 2007, if—

(i) the technical component (including the technical component portion of a global fee) of the service established for a year under the fee schedule described in paragraph (1) without application of the geographic adjustment factor described in paragraph (1)(C), exceeds

(ii) the Medicare OPD fee schedule amount established under the prospective payment system for hospital outpatient department services under paragraph (3)(D) of section 1833(t) for such service for such year, determined without regard to geographic adjustment under paragraph (2)(D) of such section,

the Secretary shall substitute the amount described in clause (ii), adjusted by the geographic adjustment factor described in paragraph (1)(C), for the fee schedule amount for such technical component for such year.

(B) IMAGING SERVICES DESCRIBED.—For purposes of this paragraph, imaging services described in this subparagraph are imaging and computer-assisted imaging services, including X-ray, ultrasound (including echocardiography), nuclear medicine (including positron emission tomography), magnetic resonance imaging, computed tomography, and fluoroscopy, but excluding diagnostic and screening mammography, and for 2010, 2011, and the first 2 months of 2012, dual-energy x-ray absorptiometry services (as described in paragraph (6)).

(C) ADJUSTMENT IN IMAGING UTILIZATION RATE.—With respect to fee schedules established for 2011, 2012, and 2013, in the methodology for determining practice expense relative value units for expensive diagnostic imaging equipment under the final rule published by the Secretary in the Federal Register on November 25, 2009 (42 CFR 410 et al.), the Secretary shall use a 75 percent assumption instead of the utilization rates otherwise established in such final rule. With respect to fee schedules established for 2014 and subsequent years, in such methodology, the Secretary shall use a 90 percent utilization rate.

(D) ADJUSTMENT IN TECHNICAL COMPONENT DISCOUNT ON SINGLE-SESSION IMAGING INVOLVING CONSECUTIVE BODY PARTS.—For services furnished on or after July 1, 2010, the Secretary shall increase the reduction in payments attributable to the multiple procedure payment reduction applicable to the technical component for imaging under the final rule published by the Secretary in the Federal Register on November 21, 2005 (part 405 of title 42, Code of Federal Regulations) from 25 percent to 50 percent.

(5) TREATMENT OF INTENSIVE CARDIAC REHABILITATION PROGRAM.—

(A) IN GENERAL.—In the case of an intensive cardiac rehabilitation program described in section 1861(eee)(4), the Secretary shall substitute the Medicare OPD fee schedule amount established under the prospective payment system for hospital outpatient department service under paragraph (3)(D) of section 1833(t) for cardiac rehabilitation (under HCPCS codes 93797 and 93798 for calendar year 2007, or any succeeding HCPCS codes for cardiac rehabilitation).

(B) DEFINITION OF SESSION.—Each of the services described in subparagraphs (A) through (E) of section 1861(eee)(3), when furnished for one hour, is a separate session of intensive cardiac rehabilitation.

(C) MULTIPLE SESSIONS PER DAY.—Payment may be made for up to 6 sessions per day of the series of 72 one-hour sessions of intensive cardiac rehabilitation services described in section 1861(eee)(4)(B).

(6) TREATMENT OF BONE MASS SCANS.—For dual-energy x-ray absorptiometry services (identified in 2006 by HCPCS codes 76075 and 76077 (and any succeeding codes)) furnished during 2010, 2011, and the first 2 months of 2012, instead of the payment amount that would otherwise be determined under this section for such years, the payment amount shall be equal to 70 percent of the product of—

(A) the relative value for the service (as determined in subsection (c)(2)) for 2006;

(B) the conversion factor (established under subsection (d)) for 2006; and

(C) the geographic adjustment factor (established under subsection (e)(2)) for the service for the fee schedule area for 2010, 2011, and the first 2 months of 2012, respectively.

(7) ADJUSTMENT IN DISCOUNT FOR CERTAIN MULTIPLE THERAPY SERVICES.—In the case of therapy services furnished on or after January 1, 2011, and before April 1, 2013, and for which payment is made under fee schedules established under this section, instead of the 25 percent multiple procedure payment reduction specified in the final rule published by the Secretary in the Federal Register on November 29, 2010, the reduction percentage shall be 20 percent. In the case of such services furnished on or after April 1, 2013, and for which payment is made under such fee schedules, instead of the 25 percent multiple procedure payment reduction specified in such final rule, the reduction percentage shall be 50 percent.

(8) ENCOURAGING CARE MANAGEMENT FOR INDIVIDUALS WITH CHRONIC CARE NEEDS.—

(A) IN GENERAL.—In order to encourage the management of care for individuals with chronic care needs the Secretary shall, subject to subparagraph (B), make payment (as the Secretary determines to be appropriate) under this section for chronic care management services furnished on or after January 1, 2015, by a physician (as defined in section 1861(r)(1)), physician assistant or nurse practitioner

(as defined in section 1861(aa)(5)(A)), clinical nurse specialist (as defined in section 1861(aa)(5)(B)), or certified nurse midwife (as defined in section 1861(gg)(2)).

(B) POLICIES RELATING TO PAYMENT.—In carrying out this paragraph, with respect to chronic care management services, the Secretary shall—

(i) make payment to only one applicable provider for such services furnished to an individual during a period;

(ii) not make payment under subparagraph (A) if such payment would be duplicative of payment that is otherwise made under this title for such services; and

(iii) not require that an annual wellness visit (as defined in section 1861(hhh)) or an initial preventive physical examination (as defined in section 1861(ww)) be furnished as a condition of payment for such management services.

(9) SPECIAL RULE TO INCENTIVIZE TRANSITION FROM TRADITIONAL X-RAY IMAGING TO DIGITAL RADIOGRAPHY.—

(A) LIMITATION ON PAYMENT FOR FILM X-RAY IMAGING SERVICES.—In the case of an imaging service (including the imaging portion of a service) that is an X-ray taken using film and that is furnished during 2017 or a subsequent year, the payment amount for the technical component (including the technical component portion of a global service) of such service that would otherwise be determined under this section (without application of this paragraph and before application of any other adjustment under this section) for such year shall be reduced by 20 percent.

(B) PHASED-IN LIMITATION ON PAYMENT FOR COMPUTED RADIOGRAPHY IMAGING SERVICES.—In the case of an imaging service (including the imaging portion of a service) that is an X-ray taken using computed radiography technology—

(i) in the case of such a service furnished during 2018, 2019, 2020, 2021, or 2022, the payment amount for the technical component (including the technical component portion of a global service) of such service that would otherwise be determined under this section (without application of this paragraph and before application of any other adjustment under this section) for such year shall be reduced by 7 percent; and

(ii) in the case of such a service furnished during 2023 or a subsequent year, the payment amount for the technical component (including the technical component portion of a global service) of such service that would otherwise be determined under this section (without application of this paragraph and before application of any other adjustment under this section) for such year shall be reduced by 10 percent.

(C) COMPUTED RADIOGRAPHY TECHNOLOGY DEFINED.—For purposes of this paragraph, the term "computed radiography technology" means cassette-based imaging which utilizes an imaging plate to create the image involved.

(D) IMPLEMENTATION.—In order to implement this paragraph, the Secretary shall adopt appropriate mechanisms which may include use of modifiers.

(10) REDUCTION OF DISCOUNT IN PAYMENT FOR PROFESSIONAL COMPONENT OF MULTIPLE IMAGING SERVICES.—In the case of the professional component of imaging services furnished on or after January 1, 2017, instead of the 25 percent reduction for multiple procedures specified in the final rule published by the Secretary in the Federal Register on November 28, 2011, as amended in the final rule published by the Secretary in the Federal Register on November 16, 2012, the reduction percentage shall be 5 percent.

(11) SPECIAL RULE FOR CERTAIN RADIATION THERAPY SERVICES.—The code definitions, the work relative value units under subsection (c)(2)(C)(i), and the direct inputs for the practice expense relative value units under subsection (c)(2)(C)(ii) for radiation treatment delivery and related imaging services (identified in 2016 by HCPCS G-codes G6001 through G6015) for the fee schedule established under this subsection for services furnished in 2017 and 2018 shall be the same as such definitions, units, and inputs for such services for the fee schedule established for services furnished in 2016.

(c) DETERMINATION OF RELATIVE VALUES FOR PHYSICIANS' SERVICES.—

(1) DIVISION OF PHYSICIANS' SERVICES INTO COMPONENTS.—In this section, with respect to a physicians' service:

(A) WORK COMPONENT DEFINED.—The term "work component" means the portion of the resources used in furnishing the service that reflects physician time and intensity in furnishing the service. Such portion shall—

(i) include activities before and after direct patient contact, and

(ii) be defined, with respect to surgical procedures, to reflect a global definition including pre-operative and post-operative physicians' services.

(B) PRACTICE EXPENSE COMPONENT DEFINED.—The term "practice expense component" means the portion of the resources used in furnishing the service that reflects the general categories of expenses (such as office rent and wages of personnel, but excluding malpractice expenses) comprising practice expenses.

(C) MALPRACTICE COMPONENT DEFINED.—The term "malpractice component" means the portion of the resources used in furnishing the service that reflects malpractice expenses in furnishing the service.

(2) DETERMINATION OF RELATIVE VALUES.—

(A) IN GENERAL.—

(i) COMBINATION OF UNITS FOR COMPONENTS.—The Secretary shall develop a methodology for combining the work, practice expense, and malpractice relative value units, determined under subparagraph (C), for each service in a manner to produce a single relative value for that service. Such relative values are subject to adjustment under subparagraph (F)(i) and section

13515(b) of the Omnibus Budget Reconciliation Act of 1993.

(ii) EXTRAPOLATION.—The Secretary may use extrapolation and other techniques to determine the number of relative value units for physicians' services for which specific data are not available and shall take into account recommendations of the Physician Payment Review Commission and the results of consultations with organizations representing physicians who provide such services.

(B) PERIODIC REVIEW AND ADJUSTMENTS IN RELATIVE VALUES.—

(i) PERIODIC REVIEW.—The Secretary, not less often than every 5 years, shall review the relative values established under this paragraph for all physicians' services.

(ii) ADJUSTMENTS.—

(I) IN GENERAL.—The Secretary shall, to the extent the Secretary determines to be necessary and subject to subclause (II) and paragraph (7), adjust the number of such units to take into account changes in medical practice, coding changes, new data on relative value components, or the addition of new procedures. The Secretary shall publish an explanation of the basis for such adjustments.

(II) LIMITATION ON ANNUAL ADJUSTMENTS.—Subject to clauses (iv) and (v), the adjustments under subclause (I) for a year may not cause the amount of expenditures under this part for the year to differ by more than $20,000,000 from the amount of expenditures under this part that would have been made if such adjustments had not been made.

(iii) CONSULTATION.—The Secretary, in making adjustments under clause (ii), shall consult with the Medicare Payment Advisory Commission and organizations representing physicians.

(iv) EXEMPTION OF CERTAIN ADDITIONAL EXPENDITURES FROM BUDGET NEUTRALITY.—The additional expenditures attributable to—

(I) subparagraph (H) shall not be taken into account in applying clause (ii)(II) for 2004;

(II) subparagraph (I) insofar as it relates to a physician fee schedule for 2005 or 2006 shall not be taken into account in applying clause (ii)(II) for drug administration services under the fee schedule for such year for a specialty described in subparagraph (I)(ii)(II);

(III) subparagraph (J) insofar as it relates to a physician fee schedule for 2005 or 2006 shall not be taken into account in applying clause (ii)(II) for drug administration services under the fee schedule for such year; and

(IV) subsection (b)(6) shall not be taken into account in applying clause (ii)(II) for 2010, 2011, or the first 2 months of 2012.

(v) EXEMPTION OF CERTAIN REDUCED EXPENDITURES FROM BUDGET-NEUTRALITY CALCULATION.—The following reduced expenditures, as estimated by the Secretary, shall not be taken into account in applying clause (ii)(II):

(I) REDUCED PAYMENT FOR MULTIPLE IMAGING PROCEDURES.—Effective for fee schedules established beginning with 2007, reduced expenditures attributable to the multiple procedure payment reduction for imaging under the final rule published by the Secretary in the Federal Register on November 21, 2005 (42 CFR 405, et al.) insofar as it relates to the physician fee schedules for 2006 and 2007.

(II) OPD PAYMENT CAP FOR IMAGING SERVICES.—Effective for fee schedules established beginning with 2007, reduced expenditures attributable to subsection (b)(4).

(III) CHANGE IN UTILIZATION RATE FOR CERTAIN IMAGING SERVICES.—Effective for fee schedules established beginning with 2011, reduced expenditures attributable to the changes in the utilization rate applicable to 2011 and 2014, as described in the first and second sentence, respectively, of subsection (b)(4)(C).

(VI) ADDITIONAL REDUCED PAYMENT FOR MULTIPLE IMAGING PROCEDURES.—Effective for fee schedules established beginning with 2010 (but not applied for services furnished prior to July 1, 2010), reduced expenditures attributable to the increase in the multiple procedure payment reduction from 25 to 50 percent (as described in subsection (b)(4)(D)).

(VII) REDUCED EXPENDITURES FOR MULTIPLE THERAPY SERVICES.—Effective for fee schedules established beginning with 2011, reduced expenditures attributable to the multiple procedure payment reduction for therapy services (as described in subsection (b)(7)).

(VIII) REDUCED EXPENDITURES ATTRIBUTABLE TO APPLICATION OF QUALITY INCENTIVES FOR COMPUTED TOMOGRAPHY.—Effective for fee schedules established beginning with 2016, reduced expenditures attributable to the application of the quality incentives for computed tomography under section 1834(p)

(IX) REDUCTIONS FOR MISVALUED SERVICES IF TARGET NOT MET.—Effective for fee schedules beginning with 2016, reduced expenditures attributable to the application of the target recapture amount described in subparagraph (O)(iii).

(X) REDUCED EXPENDITURES ATTRIBUTABLE TO INCENTIVES TO TRANSITION TO DIGITAL RADIOGRAPHY.—Effective for fee schedules established beginning with 2017, reduced expenditures attributable to subparagraph (A) of subsection (b)(9) and effective for fee schedules established beginning with 2018, reduced expenditures attributable to subparagraph (B) of such subsection.

(XI) DISCOUNT IN PAYMENT FOR PROFESSIONAL COMPONENT OF IMAGING SERVICES.—Effective for fee schedules established beginning with 2017, reduced expenditures attributable to subsection (b)(10).

(vi) ALTERNATIVE APPLICATION OF BUDGET-NEUTRALITY ADJUSTMENT.—Notwithstanding subsection (d)(9)(A), effective for fee schedules established beginning with 2009, with respect to the 5-year review of work relative value units used in fee schedules for 2007 and 2008, in lieu of continuing to apply budget-neutrality adjustments required under clause (ii) for 2007 and 2008 to work relative value units, the Secretary shall apply such budget-neutrality adjustments to the conversion factor otherwise determined for years beginning with 2009.

(C) COMPUTATION OF RELATIVE VALUE UNITS FOR COMPONENTS.—For purposes of this section for each physicians' service—

(i) WORK RELATIVE VALUE UNITS.—The Secretary shall determine a number of work relative value units for the service or group of services based on the relative resources incorporating physician time and intensity required in furnishing the service or group of services.

(ii) PRACTICE EXPENSE RELATIVE VALUE UNITS.—The Secretary shall determine a number of practice expense relative value units for the service for years before 1999 equal to the product of—

(I) the base allowed charges (as defined in subparagraph (D)) for the service, and

(II) the practice expense percentage for the service (as determined under paragraph (3)(C)(ii)),

and for years beginning with 1999 based on the relative practice expense resources involved in furnishing the service or group of services. For 1999, such number of units shall be determined based 75 percent on such product and based 25 percent on the relative practice expense resources involved in furnishing the service. For 2000, such number of units shall be determined based 50 percent on such product and based 50 percent on such relative practice expense resources. For 2001, such number of units shall be determined based 25 percent on such product and based 75 percent on such relative practice expense resources. For a subsequent year, such number of units shall be de-

termined based entirely on such relative practice expense resources.

(iii) MALPRACTICE RELATIVE VALUE UNITS.—The Secretary shall determine a number of malpractice relative value units for the service or group of services for years before 2000 equal to the product of—

(I) the base allowed charges (as defined in subparagraph (D)) for the service or group of services, and

(II) the malpractice percentage for the service or group of services (as determined under paragraph (3)(C)(iii)),

and for years beginning with 2000 based on the malpractice expense resources involved in furnishing the service or group of services.

(D) BASE ALLOWED CHARGES DEFINED.—In this paragraph, the term "base allowed charges" means, with respect to a physician's service, the national average allowed charges for the service under this part for services furnished during 1991, as estimated by the Secretary using the most recent data available.

(E) REDUCTION IN PRACTICE EXPENSE RELATIVE VALUE UNITS FOR CERTAIN SERVICES.—

(i) IN GENERAL.—Subject to clause (ii), the Secretary shall reduce the practice expense relative value units applied to services described in clause (iii) furnished in—

(I) 1994, by 25 percent of the number by which the number of practice expense relative value units (determined for 1994 without regard to this subparagraph) exceeds the number of work relative value units determined for 1994,

(II) 1995, by an additional 25 percent of such excess, and

(III) 1996, by an additional 25 percent of such excess.

(ii) FLOOR ON REDUCTIONS.—The practice expense relative value units for a physician's service shall not be reduced under this subparagraph to a number less than 128 percent of the number of work relative value units.

(iii) Services covered.—For purposes of clause (i), the services described in this clause are physicians' services that are not described in clause (iv) and for which—

(I) there are work relative value units, and

(II) the number of practice expense relative value units (determined for 1994) exceeds 128 percent of the number of work relative value units (determined for such year).

(iv) EXCLUDED SERVICES.—For purposes of clause (iii), the services described in this clause are services which the Secretary determines at least 75 percent of which are provided under this title in an office setting.

(F) BUDGET NEUTRALITY ADJUSTMENTS.—The Secretary—

(i) shall reduce the relative values for all services (other than anesthesia services) established under this paragraph (and in the case of anesthesia services, the conversion factor established by the Secretary for such services) by such percentage as the Secretary determines to be necessary so that, beginning in 1996, the amendment made by section 13514(a) of the Omnibus Budget Reconciliation Act of 1993 would not result in expenditures under this section that exceed the amount of such expenditures that would have been made if such amendment had not been made, and

(ii) shall reduce the amounts determined under subsection (a)(2)(B)(ii)(I) by such percentage as the Secretary determines to be required to assure that, taking into account the reductions made under clause (i), the amendment made by section 13514(a) of the Omnibus Budget Reconciliation Act of 1993 would not result in expenditures under this section in 1994 that exceed the amount of such expenditures that would have been made if such amendment had not been made.

(G) ADJUSTMENTS IN RELATIVE VALUE UNITS FOR 1998.—

(i) IN GENERAL.—The Secretary shall—

(I) subject to clauses (iv) and (v), reduce the practice expense relative value units applied to any services described in clause (ii) furnished in 1998 to a number equal to 110 percent of the number of work relative value units, and

(II) increase the practice expense relative value units for office visit procedure codes during 1998 by a uniform percentage which the Secretary estimates will result in an aggregate increase in payments for such services equal to the aggregate decrease in payments by reason of subclause (I).

(ii) SERVICES COVERED.—For purposes of clause (i), the services described in this clause are physicians' services that are not described in clause (iii) and for which—

(I) there are work relative value units, and

(II) the number of practice expense relative value units (determined for 1998) exceeds 110 percent of the number of work relative value units (determined for such year).

(iii) EXCLUDED SERVICES.—For purposes of clause (ii), the services described in this clause are services which the Secretary determines at least 75 percent of which are provided under this title in an office setting.

(iv) LIMITATION ON AGGREGATE REALLOCATION.—If the application of clause (i)(I) would result in an aggregate amount of reductions under such clause in excess of $390,000,000, such clause shall be applied by substituting for 110 percent such greater percentage as the Secretary estimates will result in the aggregate amount of such reductions equaling $390,000,000.

(v) NO REDUCTION FOR CERTAIN SERVICES.—Practice expense relative value units for a procedure performed in an office or in a setting out of an office shall not be reduced under clause (i) if the in-office or out-of-office practice expense relative value, respectively, for the procedure would increase under the proposed rule on resource-based practice expenses issued by the Secretary on June 18, 1997 (62 Federal Register 33158 et seq.).

(H) ADJUSTMENTS IN PRACTICE EXPENSE RELATIVE VALUE UNITS FOR CERTAIN DRUG ADMINISTRATION SERVICES BEGINNING IN 2004.—

(i) USE OF SURVEY DATA.—In establishing the physician fee schedule under subsection (b) with respect to payments for services furnished on or after January 1, 2004, the Secretary shall, in determining practice expense relative value units under this subsection, utilize a survey submitted to the Secretary as of January 1, 2003, by a physician specialty organization pursuant to section 212 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 if the survey—

(I) covers practice expenses for oncology drug administration services; and

(II) meets criteria established by the Secretary for acceptance of such surveys.

(ii) PRICING OF CLINICAL ONCOLOGY NURSES IN PRACTICE EXPENSE METHODOLOGY.—If the survey described in clause (i) includes data on wages, salaries, and compensation of clinical oncology nurses, the Secretary shall utilize such data in the methodology for determining practice expense relative value units under subsection (c).

(iii) WORK RELATIVE VALUE UNITS FOR CERTAIN DRUG ADMINISTRATION SERVICES.—In establishing the relative value units under this paragraph for drug administration services described in clause (iv) furnished on or after January 1, 2004, the Secretary shall establish work relative value units equal to the work relative value units for a level 1 office medical visit for an established patient.

(iv) DRUG ADMINISTRATION SERVICES DESCRIBED.—The drug administration services described in this clause are physicians' services—

(I) which are classified as of October 1, 2003, within any of the following groups of procedures: therapeutic or diagnostic infusions (excluding chemotherapy); chemotherapy administration services; and therapeutic, prophylactic, or diagnostic injections;

(II) for which there are no work relative value units assigned under this subsection as of such date; and

(III) for which national relative value units have been assigned under this subsection as of such date.

(I) ADJUSTMENTS IN PRACTICE EXPENSE RELATIVE VALUE UNITS FOR CERTAIN DRUG ADMINISTRATION SERVICES BEGINNING WITH 2005.—

(i) IN GENERAL.—In establishing the physician fee schedule under subsection (b) with respect to payments for services furnished on or after January 1, 2005 or 2006, the Secretary shall adjust the practice expense relative value units for such year consistent with clause (ii).

(ii) USE OF SUPPLEMENTAL SURVEY DATA.—

(I) IN GENERAL.—Subject to subclause (II), if a specialty submits to the Secretary by not later than March 1, 2004, for 2005, or March 1, 2005, for 2006, data that includes expenses for the administration of drugs and biologicals for which the payment amount is determined pursuant to section 1842(o), the Secretary shall use such supplemental survey data in carrying out this subparagraph for the years involved insofar as they are collected and provided by entities and organizations consistent with the criteria established by the Secretary pursuant to section 212(a) of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999.

(II) LIMITATION ON SPECIALTY.—Subclause (I) shall apply to a specialty only insofar as not less than 40 percent of payments for the specialty under this title in 2002 are attributable to the administration of drugs and biologicals, as determined by the Secretary.

(III) APPLICATION.—This clause shall not apply with respect to a survey to which subparagraph (H)(i) applies.

(J) PROVISIONS FOR APPROPRIATE REPORTING AND BILLING FOR PHYSICIANS' SERVICES ASSOCIATED WITH THE ADMINISTRATION OF COVERED OUTPATIENT DRUGS AND BIOLOGICALS.—

(i) EVALUATION OF CODES.—The Secretary shall promptly evaluate existing drug administration codes for physicians' services to ensure accurate reporting and billing for such services, taking into account levels of complexity of the administration and resource consumption.

(ii) USE OF EXISTING PROCESSES.—In carrying out clause (i), the Secretary shall use existing processes for the consideration of coding changes and, to the extent coding changes are made, shall use such processes in establishing relative values for such services.

(iii) IMPLEMENTATION.—In carrying out clause (i), the Secretary shall consult with representatives of physician specialties affected by the implementation of section 1847A or section 1847B, and shall take such

steps within the Secretary's authority to expedite such considerations under clause (ii).

(iv) SUBSEQUENT, BUDGET NEUTRAL ADJUSTMENTS PERMITTED.—Nothing in subparagraph (H) or (I) or this subparagraph shall be construed as preventing the Secretary from providing for adjustments in practice expense relative value units under (and consistent with) subparagraph (B) for years after 2004, 2005, or 2006, respectively.

(K) POTENTIALLY MISVALUED CODES.—

(i) IN GENERAL.—The Secretary shall—

(I) periodically identify services as being potentially misvalued using criteria specified in clause (ii); and

(II) review and make appropriate adjustments to the relative values established under this paragraph for services identified as being potentially misvalued under subclause (I).

(ii) IDENTIFICATION OF POTENTIALLY MISVALUED CODES.—For purposes of identifying potentially misvalued codes pursuant to clause (i)(I), the Secretary shall examine codes (and families of codes as appropriate) based on any or all of the following criteria:

(I) Codes that have experienced the fastest growth.

(II) Codes that have experienced substantial changes in practice expenses.

(III) Codes that describe new technologies or services within an appropriate time period (such as 3 years) after the relative values are initially established for such codes.

(IV) Codes which are multiple codes that are frequently billed in conjunction with furnishing a single service.

(V) Codes with low relative values, particularly those that are often billed multiple times for a single treatment.

(VI) Codes that have not been subject to review since implementation of the fee schedule.

(VII) Codes that account for the majority of spending under the physician fee schedule.

(VIII) Codes for services that have experienced a substantial change in the hospital length of stay or procedure time.

(IX) Codes for which there may be a change in the typical site of service since the code was last valued.

(X) Codes for which there is a significant difference in payment for the same service between different sites of service.

(XI) Codes for which there may be anomalies in relative values within a family of codes.

(XII) Codes for services where there may be efficiencies when a service is furnished at the same time as other services.

(XIII) Codes with high intra-service work per unit of time.

(XIV) Codes with high practice expense relative value units.

(XV) Codes with high cost supplies.

(XVI) Codes as determined appropriate by the Secretary.

(iii) REVIEW AND ADJUSTMENTS.—

(I) The Secretary may use existing processes to receive recommendations on the review and appropriate adjustment of potentially misvalued services described in clause (i)(II).

(II) The Secretary may conduct surveys, other data collection activities, studies, or other analyses as the Secretary determines to be appropriate to facilitate the review and appropriate adjustment described in clause (i)(II).

(III) The Secretary may use analytic contractors to identify and analyze services identified under clause (i)(I), conduct surveys or collect data, and make recommendations on the review and appropriate adjustment of services described in clause (i)(II).

(IV) The Secretary may coordinate the review and appropriate adjustment described in clause (i)(II) with the periodic review described in subparagraph (B).

(V) As part of the review and adjustment described in clause (i)(II), including with respect to codes with low relative values described in clause (ii), the Secretary may make appropriate coding revisions (including using existing processes for consideration of coding changes) which may include consolidation of individual services into bundled codes for payment under the fee schedule under subsection (b).

(VI) The provisions of subparagraph (B)(ii)(II) and paragraph (7) shall apply to adjustments to relative value units made pursuant to this subparagraph in the same manner as such provisions apply to adjustments under subparagraph (B)(ii)(I).

(iv) TREATMENT OF CERTAIN RADIATION THERAPY SERVICES.—Radiation treatment delivery and related imaging services identified under subsection (b)(11) shall not be considered as potentially misvalued services for purposes of this subparagraph and subparagraph (O) for 2017 and 2018.

(L) VALIDATING RELATIVE VALUE UNITS.—

(i) IN GENERAL.—The Secretary shall establish a process to validate relative value units under the fee schedule under subsection (b).

(ii) COMPONENTS AND ELEMENTS OF WORK.—The process described in clause (i) may include validation of work elements (such as time, mental effort and professional judgment, technical skill and physical effort, and stress due to risk) involved with furnishing a service and may include validation of the pre-, post-, and intra-service components of work.

(iii) SCOPE OF CODES.—The validation of work relative value units shall include a sampling of codes for services that is the same as the codes listed under subparagraph (K)(ii).

(iv) METHODS.—The Secretary may conduct the validation under this subparagraph using methods described in subclauses (I) through (V) of subparagraph (K)(iii) as the Secretary determines to be appropriate.

(v) ADJUSTMENTS.—The Secretary shall make appropriate adjustments to the work relative value units under the fee schedule under subsection (b). The provisions of subparagraph (B)(ii)(II) shall apply to adjustments to relative value units made pursuant to this subparagraph in the same manner as such provisions apply to adjustments under subparagraph (B)(ii)(II).

(M) AUTHORITY TO COLLECT AND USE INFORMATION ON PHYSICIANS' SERVICES IN THE DETERMINATION OF RELATIVE VALUES.—

(i) COLLECTION OF INFORMATION.—Notwithstanding any other provision of law, the Secretary may collect or obtain information on the resources directly or indirectly related to furnishing services for which payment is made under the fee schedule established under subsection (b). Such information may be collected or obtained from any eligible professional or any other source.

(ii) USE OF INFORMATION.—Notwithstanding any other provision of law, subject to clause (v), the Secretary may (as the Secretary determines appropriate) use information collected or obtained pursuant to clause (i) in the determination of relative values for services under this section.

(iii) TYPES OF INFORMATION.—The types of information described in clauses (i) and (ii) may, at the Secretary's discretion, include any or all of the following:

(I) Time involved in furnishing services.

(II) Amounts and types of practice expense inputs involved with furnishing services.

(III) Prices (net of any discounts) for practice expense inputs, which may include paid invoice prices or other documentation or records.

(IV) Overhead and accounting information for practices of physicians and other suppliers.

(V) Any other element that would improve the valuation of services under this section.

(iv) INFORMATION COLLECTION MECHANISMS.—Information may be collected or obtained pursuant to this subparagraph from any or all of the following:

(I) Surveys of physicians, other suppliers, providers of services, manufacturers, and vendors.

(II) Surgical logs, billing systems, or other practice or facility records.

(III) Electronic health records.

(IV) Any other mechanism determined appropriate by the Secretary.

(v) TRANSPARENCY OF USE OF INFORMATION.—

(I) IN GENERAL.—Subject to subclauses (II) and (III), if the Secretary uses information collected or obtained under this subparagraph in the determination of relative values under this subsection, the Secretary shall disclose the information source and discuss the use of such information in such determination of relative values through notice and comment rulemaking.

(II) THRESHOLDS FOR USE.—The Secretary may establish thresholds in order to use such information, including the exclusion of information collected or obtained from eligible professionals who use very high resources (as determined by the Secretary) in furnishing a service.

(III) DISCLOSURE OF INFORMATION.—The Secretary shall make aggregate information available under this subparagraph but shall not disclose information in a form or manner that identifies an eligible professional or a group practice, or information collected or obtained pursuant to a nondisclosure agreement.

(vi) INCENTIVE TO PARTICIPATE.—The Secretary may provide for such payments under this part to an eligible professional that submits such solicited information under this subparagraph as the Secretary determines appropriate in order to compensate such eligible professional for such submission. Such payments shall be provided in a form and manner specified by the Secretary.

(vii) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to information collected or obtained under this subparagraph.

(viii) DEFINITION OF ELIGIBLE PROFESSIONAL.—In this subparagraph, the term "eligible professional" has the meaning given such term in subsection (k)(3)(B).

(ix) FUNDING.—For purposes of carrying out this subparagraph, in addition to funds otherwise appropriated, the Secretary shall provide for the transfer, from the Federal Supplementary Medical Insurance Trust Fund under section 1841, of $2,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for each fiscal year beginning with fiscal year 2014. Amounts transferred under the

preceding sentence for a fiscal year shall be available until expended.

(N) AUTHORITY FOR ALTERNATIVE APPROACHES TO ESTABLISHING PRACTICE EXPENSE RELATIVE VALUES.—The Secretary may establish or adjust practice expense relative values under this subsection using cost, charge, or other data from suppliers or providers of services, including information collected or obtained under subparagraph (M).

(O) TARGET FOR RELATIVE VALUE ADJUSTMENTS FOR MISVALUED SERVICES.—With respect to fee schedules established for each of 2016 through 2018, the following shall apply:

(i) DETERMINATION OF NET REDUCTION IN EXPENDITURES.—For each year, the Secretary shall determine the estimated net reduction in expenditures under the fee schedule under this section with respect to the year as a result of adjustments to the relative values established under this paragraph for misvalued codes.

(ii) BUDGET NEUTRAL REDISTRIBUTION OF FUNDS IF TARGET MET AND COUNTING OVERAGES TOWARDS THE TARGET FOR THE SUCCEEDING YEAR.—If the estimated net reduction in expenditures determined under clause (i) for the year is equal to or greater than the target for the year—

(I) reduced expenditures attributable to such adjustments shall be redistributed for the year in a budget neutral manner in accordance with subparagraph (B)(ii)(II); and

(II) the amount by which such reduced expenditures exceeds the target for the year shall be treated as a reduction in expenditures described in clause (i) for the succeeding year, for purposes of determining whether the target has or has not been met under this subparagraph with respect to that year.

(iii) EXEMPTION FROM BUDGET NEUTRALITY IF TARGET NOT MET.—If the estimated net reduction in expenditures determined under clause (i) for the year is less than the target for the year, reduced expenditures in an amount equal to the target recapture amount shall not be taken into account in applying subparagraph (B)(ii)(II) with respect to fee schedules beginning with 2016.

(iv) TARGET RECAPTURE AMOUNT.—For purposes of clause (iii), the target recapture amount is, with respect to a year, an amount equal to the difference between—

(I) the target for the year; and

(II) the estimated net reduction in expenditures determined under clause (i) for the year.

(v) TARGET.—For purposes of this subparagraph, with respect to a year, the target is calculated as 0.5 percent (or, for 2016, 1.0 percent) of the estimated amount of expenditures under the fee schedule under this section for the year.

(3) COMPONENT PERCENTAGES.—For purposes of paragraph (2), the Secretary shall determine a work percentage, a practice expense percentage, and a malpractice percentage for each physician's service as follows:

(A) DIVISION OF SERVICES BY SPECIALTY.—For each physician's service or class of physicians' services, the Secretary shall determine the average percentage of each such service or class of services that is performed, nationwide, under this part by physicians in each of the different physician specialties (as identified by the Secretary).

(B) DIVISION OF SPECIALTY BY COMPONENT.—The Secretary shall determine the average percentage division of resources, among the work component, the practice expense component, and the malpractice component, used by physicians in each of such specialties in furnishing physicians' services. Such percentages shall be based on national data that describe the elements of physician practice costs and revenues, by physician specialty. The Secretary may use extrapolation and other techniques to determine practice costs and revenues for specialties for which adequate data are not available.

(C) DETERMINATION OF COMPONENT PERCENTAGES.—

(i) WORK PERCENTAGE.—The work percentage for a service (or class of services) is equal to the sum (for all physician specialties) of—

(I) the average percentage division for the work component for each physician specialty (determined under subparagraph (B)), multiplied by

(II) the proportion (determined under subparagraph (A)) of such service (or services) performed by physicians in that specialty.

(ii) PRACTICE EXPENSE PERCENTAGE.—For years before 2002, the practice expense percentage for a service (or class of services) is equal to the sum (for all physician specialties) of—

(I) the average percentage division for the practice expense component for each physician specialty (determined under subparagraph (B)), multiplied by

(II) the proportion (determined under subparagraph (A)) of such service (or services) performed by physicians in that specialty.

(iii) MALPRACTICE PERCENTAGE.—For years before 1999, the malpractice percentage for a service (or class of services) is equal to the sum (for all physician specialties) of—

(I) the average percentage division for the malpractice component for each physician specialty (determined under subparagraph (B)), multiplied by

(II) the proportion (determined under subparagraph (A)) of such service (or services) performed by physicians in that specialty.

(D) PERIODIC RECOMPUTATION.—The Secretary may, from time to time, provide for the recomputation of work

percentages, practice expense percentages, and malpractice percentages determined under this paragraph.

(4) ANCILLARY POLICIES.—The Secretary may establish ancillary policies (with respect to the use of modifiers, local codes, and other matters) as may be necessary to implement this section.

(5) CODING.—The Secretary shall establish a uniform procedure coding system for the coding of all physicians' services. The Secretary shall provide for an appropriate coding structure for visits and consultations. The Secretary may incorporate the use of time in the coding for visits and consultations. The Secretary, in establishing such coding system, shall consult with the Physician Payment Review Commission and other organizations representing physicians.

(6) NO VARIATION FOR SPECIALISTS.—The Secretary may not vary the conversion factor or the number of relative value units for a physicians' service based on whether the physician furnishing the service is a specialist or based on the type of specialty of the physician.

(7) PHASE-IN OF SIGNIFICANT RELATIVE VALUE UNIT (RVU) REDUCTIONS.—Effective for fee schedules established beginning with 2016, for services that are not new or revised codes, if the total relative value units for a service for a year would otherwise be decreased by an estimated amount equal to or greater than 20 percent as compared to the total relative value units for the previous year, the applicable adjustments in work, practice expense, and malpractice relative value units shall be phased-in over a 2-year period.

(8) GLOBAL SURGICAL PACKAGES.—

(A) PROHIBITION OF IMPLEMENTATION OF RULE REGARDING GLOBAL SURGICAL PACKAGES.—

(i) IN GENERAL.—The Secretary shall not implement the policy established in the final rule published on November 13, 2014 (79 Fed. Reg. 67548 et seq.), that requires the transition of all 10-day and 90-day global surgery packages to 0-day global periods.

(ii) CONSTRUCTION.—Nothing in clause (i) shall be construed to prevent the Secretary from revaluing misvalued codes for specific surgical services or assigning values to new or revised codes for surgical services.

(B) COLLECTION OF DATA ON SERVICES INCLUDED IN GLOBAL SURGICAL PACKAGES.—

(i) IN GENERAL.—Subject to clause (ii), the Secretary shall through rulemaking develop and implement a process to gather, from a representative sample of physicians, beginning not later than January 1, 2017, information needed to value surgical services. Such information shall include the number and level of medical visits furnished during the global period and other items and services related to the surgery and furnished during the global period, as appropriate. Such information shall be reported on claims at the end of the global period or in another manner specified by the Secretary. For purposes of carrying out this para-

graph (other than clause (iii)), the Secretary shall transfer from the Federal Supplemental Medical Insurance Trust Fund under section 1841 $2,000,000 to the Center for Medicare & Medicaid Services Program Management Account for fiscal year 2015. Amounts transferred under the previous sentence shall remain available until expended.

(ii) REASSESSMENT AND POTENTIAL SUNSET.—Every 4 years, the Secretary shall reassess the value of the information collected pursuant to clause (i). Based on such a reassessment and by regulation, the Secretary may discontinue the requirement for collection of information under such clause if the Secretary determines that the Secretary has adequate information from other sources, such as qualified clinical data registries, surgical logs, billing systems or other practice or facility records, and electronic health records, in order to accurately value global surgical services under this section.

(iii) INSPECTOR GENERAL AUDIT.—The Inspector General of the Department of Health and Human Services shall audit a sample of the information reported under clause (i) to verify the accuracy of the information so reported.

(C) IMPROVING ACCURACY OF PRICING FOR SURGICAL SERVICES.—For years beginning with 2019, the Secretary shall use the information reported under subparagraph (B)(i) as appropriate and other available data for the purpose of improving the accuracy of valuation of surgical services under the physician fee schedule under this section.

(d) CONVERSION FACTORS.—

(1) ESTABLISHMENT.—

(A) IN GENERAL.—The conversion factor for each year shall be the conversion factor established under this subsection for the previous year (or, in the case of 1992, specified in subparagraph (B)) adjusted by the update (established under paragraph (3)) for the year involved (for years before 2001) and, for years beginning with 2001 and ending with 2025, multiplied by the update (established under paragraph (4) or a subsequent paragraph) for the year involved. There shall be two separate conversion factors for each year beginning with 2026, one for items and services furnished by a qualifying APM participant (as defined in section 1833(z)(2)) (referred to in this subsection as the "qualifying APM conversion factor") and the other for other items and services (referred to in this subsection as the "nonqualifying APM conversion factor"), equal to the respective conversion factor for the previous year (or, in the case of 2026, equal to the single conversion factor for 2025) multiplied by the update established under paragraph (20) for such respective conversion factor for such year.

(B) SPECIAL PROVISION FOR 1992.—For purposes of subparagraph (A), the conversion factor specified in this subparagraph is a conversion factor (determined by the Sec-

retary) which, if this section were to apply during 1991 using such conversion factor, would result in the same aggregate amount of payments under this part for physicians' services as the estimated aggregate amount of the payments under this part for such services in 1991.

(C) SPECIAL RULES FOR 1998.—Except as provided in subparagraph (D), the single conversion factor for 1998 under this subsection shall be the conversion factor for primary care services for 1997, increased by the Secretary's estimate of the weighted average of the three separate updates that would otherwise occur were it not for the enactment of chapter 1 of subtitle F of title IV of the Balanced Budget Act of 1997.

(D) SPECIAL RULES FOR ANESTHESIA SERVICES.—The separate conversion factor for anesthesia services for a year shall be equal to 46 percent of the single conversion factor (or, beginning with 2026, applicable conversion factor) established for other physicians' services, except as adjusted for changes in work, practice expense, or malpractice relative value units.

(E) PUBLICATION AND DISSEMINATION OF INFORMATION.—The Secretary shall—

(i) cause to have published in the Federal Register not later than November 1 of each year (beginning with 2000) the conversion factor which will apply to physicians' services for the succeeding year, the update determined under paragraph (4) for such succeeding year, and the allowed expenditures under such paragraph for such succeeding year; and

(ii) make available to the Medicare Payment Advisory Commission and the public by March 1 of each year (beginning with 2000) an estimate of the sustainable growth rate and of the conversion factor which will apply to physicians' services for the succeeding year and data used in making such estimate.

(3) UPDATE FOR 1999 AND 2000.—

(A) IN GENERAL.—Unless otherwise provided by law, subject to subparagraph (D) and the budget-neutrality factor determined by the Secretary under subsection (c)(2)(B)(ii), the update to the single conversion factor established in paragraph (1)(C) for 1999 and 2000 is equal to the product of—

(i) 1 plus the Secretary's estimate of the percentage increase in the MEI (as defined in section 1842(i)(3)) for the year (divided by 100), and

(ii) 1 plus the Secretary's estimate of the update adjustment factor for the year (divided by 100),

minus 1 and multiplied by 100.

(B) UPDATE ADJUSTMENT FACTOR.—For purposes of subparagraph (A)(ii), the "update adjustment factor" for a year is equal (as estimated by the Secretary) to—

(i) the difference between (I) the sum of the allowed expenditures for physicians' services (as determined under subparagraph (C)) for the period beginning April 1, 1997, and ending on March 31 of the year in-

volved, and (II) the amount of actual expenditures for physicians' services furnished during the period beginning April 1, 1997, and ending on March 31 of the preceding year; divided by

(ii) the actual expenditures for physicians' services for the 12-month period ending on March 31 of the preceding year, increased by the sustainable growth rate under subsection (f) for the fiscal year which begins during such 12-month period.

(C) DETERMINATION OF ALLOWED EXPENDITURES.—For purposes of this paragraph and paragraph (4), the allowed expenditures for physicians' services for the 12-month period ending with March 31 of—

(i) 1997 is equal to the actual expenditures for physicians' services furnished during such 12-month period, as estimated by the Secretary; or

(ii) a subsequent year is equal to the allowed expenditures for physicians' services for the previous year, increased by the sustainable growth rate under subsection (f) for the fiscal year which begins during such 12-month period.

(D) RESTRICTION ON VARIATION FROM MEDICARE ECONOMIC INDEX.—Notwithstanding the amount of the update adjustment factor determined under subparagraph (B) for a year, the update in the conversion factor under this paragraph for the year may not be—

(i) greater than 100 times the following amount: (1.03 + (MEI percentage/100)) − 1; or

(ii) less than 100 times the following amount: (0.93 + (MEI percentage/100)) − 1,

where "MEI percentage" means the Secretary's estimate of the percentage increase in the MEI (as defined in section 1842(i)(3)) for the year involved.

(4) UPDATE FOR YEARS BEGINNING WITH 2001 AND ENDING WITH 2014.—

(A) IN GENERAL.—Unless otherwise provided by law, subject to the budget-neutrality factor determined by the Secretary under subsection (c)(2)(B)(ii) and subject to adjustment under subparagraph (F), the update to the single conversion factor established in paragraph (1)(C) for a year beginning with 2001 and ending with 2014 is equal to the product of—

(i) 1 plus the Secretary's estimate of the percentage increase in the MEI (as defined in section 1842(i)(3)) for the year (divided by 100); and

(ii) 1 plus the Secretary's estimate of the update adjustment factor under subparagraph (B) for the year.

(B) UPDATE ADJUSTMENT FACTOR.—For purposes of subparagraph (A)(ii), subject to subparagraph (D) and the succeeding paragraphs of this subsection, the "update adjustment factor" for a year is equal (as estimated by the Secretary) to the sum of the following:

(i) PRIOR YEAR ADJUSTMENT COMPONENT.—An amount determined by—

(I) computing the difference (which may be positive or negative) between the amount of the allowed expenditures for physicians' services for the prior year (as determined under subparagraph (C)) and the amount of the actual expenditures for such services for that year;

(II) dividing that difference by the amount of the actual expenditures for such services for that year; and

(III) multiplying that quotient by 0.75.

(ii) CUMULATIVE ADJUSTMENT COMPONENT.—An amount determined by—

(I) computing the difference (which may be positive or negative) between the amount of the allowed expenditures for physicians' services (as determined under subparagraph (C)) from April 1, 1996, through the end of the prior year and the amount of the actual expenditures for such services during that period;

(II) dividing that difference by actual expenditures for such services for the prior year as increased by the sustainable growth rate under subsection (f) for the year for which the update adjustment factor is to be determined; and

(III) multiplying that quotient by 0.33.

(C) DETERMINATION OF ALLOWED EXPENDITURES.—For purposes of this paragraph:

(i) PERIOD UP TO APRIL 1, 1999.—The allowed expenditures for physicians' services for a period before April 1, 1999, shall be the amount of the allowed expenditures for such period as determined under paragraph (3)(C).

(ii) TRANSITION TO CALENDAR YEAR ALLOWED EXPENDITURES.—Subject to subparagraph (E), the allowed expenditures for—

(I) the 9-month period beginning April 1, 1999, shall be the Secretary's estimate of the amount of the allowed expenditures that would be permitted under paragraph (3)(C) for such period; and

(II) the year of 1999, shall be the Secretary's estimate of the amount of the allowed expenditures that would be permitted under paragraph (3)(C) for such year.

(iii) YEARS BEGINNING WITH 2000.—The allowed expenditures for a year (beginning with 2000) is equal to the allowed expenditures for physicians' services for the previous year, increased by the sustainable growth rate under subsection (f) for the year involved.

(D) RESTRICTION ON UPDATE ADJUSTMENT FACTOR.—The update adjustment factor determined under subparagraph (B) for a year may not be less than −0.07 or greater than 0.03.

(E) RECALCULATION OF ALLOWED EXPENDITURES FOR UPDATES BEGINNING WITH 2001.—For purposes of determining the update adjustment factor for a year beginning with

2001, the Secretary shall recompute the allowed expenditures for previous periods beginning on or after April 1, 1999, consistent with subsection (f)(3).

(F) TRANSITIONAL ADJUSTMENT DESIGNED TO PROVIDE FOR BUDGET NEUTRALITY.—Under this subparagraph the Secretary shall provide for an adjustment to the update under subparagraph (A)—

(i) for each of 2001, 2002, 2003, and 2004, of −0.2 percent; and

(ii) for 2005 of +0.8 percent.

(5) UPDATE FOR 2004 AND 2005.—The update to the single conversion factor established in paragraph (1)(C) for each of 2004 and 2005 shall be not less than 1.5 percent.

(6) UPDATE FOR 2006.—The update to the single conversion factor established in paragraph (1)(C) for 2006 shall be 0 percent.

(7) CONVERSION FACTOR FOR 2007.—

(A) IN GENERAL.—The conversion factor that would otherwise be applicable under this subsection for 2007 shall be the amount of such conversion factor divided by the product of—

(i) 1 plus the Secretary's estimate of the percentage increase in the MEI (as defined in section 1842(i)(3)) for 2007 (divided by 100); and

(ii) 1 plus the Secretary's estimate of the update adjustment factor under paragraph (4)(B) for 2007.

(B) NO EFFECT ON COMPUTATION OF CONVERSION FACTOR FOR 2008.—The conversion factor under this subsection shall be computed under paragraph (1)(A) for 2008 as if subparagraph (A) had never applied.

(8) UPDATE FOR 2008.—

(A) IN GENERAL.—Subject to paragraph (7)(B), in lieu of the update to the single conversion factor established in paragraph (1)(C) that would otherwise apply for 2008, the update to the single conversion factor shall be 0.5 percent.

(B) NO EFFECT ON COMPUTATION OF CONVERSION FACTOR FOR 2009.—The conversion factor under this subsection shall be computed under paragraph (1)(A) for 2009 and subsequent years as if subparagraph (A) had never applied.

(9) UPDATE FOR 2009.—

(A) IN GENERAL.—Subject to paragraphs (7)(B) and (8)(B), in lieu of the update to the single conversion factor established in paragraph (1)(C) that would otherwise apply for 2009, the update to the single conversion factor shall be 1.1 percent.

(B) NO EFFECT ON COMPUTATION OF CONVERSION FACTOR FOR 2010 AND SUBSEQUENT YEARS.—The conversion factor under this subsection shall be computed under paragraph (1)(A) for 2010 and subsequent years as if subparagraph (A) had never applied.

(10) UPDATE FOR JANUARY THROUGH MAY OF 2010.—

(A) IN GENERAL.—Subject to paragraphs (7)(B), (8)(B), and (9)(B), in lieu of the update to the single conversion factor established in paragraph (1)(C) that would other-

wise apply for 2010 for the period beginning on January 1, 2010, and ending on May 31, 2010, the update to the single conversion factor shall be 0 percent for 2010.

(B) NO EFFECT ON COMPUTATION OF CONVERSION FACTOR FOR REMAINING PORTION OF 2010 AND SUBSEQUENT YEARS.—The conversion factor under this subsection shall be computed under paragraph (1)(A) for the period beginning on June 1, 2010, and ending on December 31, 2010, and for 2011 and subsequent years as if subparagraph (A) had never applied.

(11) UPDATE FOR JUNE THROUGH DECEMBER OF 2010.—

(A) IN GENERAL.—Subject to paragraphs (7)(B), (8)(B), (9)(B), and (10)(B), in lieu of the update to the single conversion factor established in paragraph (1)(C) that would otherwise apply for 2010 for the period beginning on June 1, 2010, and ending on December 31, 2010, the update to the single conversion factor shall be 2.2 percent.

(B) NO EFFECT ON COMPUTATION OF CONVERSION FACTOR FOR 2011 AND SUBSEQUENT YEARS.—The conversion factor under this subsection shall be computed under paragraph (1)(A) for 2011 and subsequent years as if subparagraph (A) had never applied.

(12) UPDATE FOR 2011.—

(A) IN GENERAL.—Subject to paragraphs (7)(B), (8)(B), (9)(B), (10)(B), and (11)(B), in lieu of the update to the single conversion factor established in paragraph (1)(C) that would otherwise apply for 2011, the update to the single conversion factor shall be 0 percent.

(B) NO EFFECT ON COMPUTATION OF CONVERSION FACTOR FOR 2012 AND SUBSEQUENT YEARS.—The conversion factor under this subsection shall be computed under paragraph (1)(A) for 2012 and subsequent years as if subparagraph (A) had never applied.

(13) UPDATE FOR 2012.—

(A) IN GENERAL.—Subject to paragraphs (7)(B), (8)(B), (9)(B), (10)(B), (11)(B), and (12)(B), in lieu of the update to the single conversion factor established in paragraph (1)(C) that would otherwise apply for 2012, the update to the single conversion factor shall be zero percent.

(B) NO EFFECT ON COMPUTATION OF CONVERSION FACTOR FOR 2013 AND SUBSEQUENT YEARS.—The conversion factor under this subsection shall be computed under paragraph (1)(A) for 2013 and subsequent years as if subparagraph (A) had never applied.

(14) UPDATE FOR 2013.—

(A) IN GENERAL.—Subject to paragraphs (7)(B), (8)(B), (9)(B), (10)(B), (11)(B), (12)(B), and (13)(B), in lieu of the update to the single conversion factor established in paragraph (1)(C) that would otherwise apply for 2013, the update to the single conversion factor for such year shall be zero percent.

(B) NO EFFECT ON COMPUTATION OF CONVERSION FACTOR FOR 2014 AND SUBSEQUENT YEARS.—The conversion factor under this subsection shall be computed under paragraph

(1)(A) for 2014 and subsequent years as if subparagraph (A) had never applied.

(15) UPDATE FOR 2014.—

(A) IN GENERAL.—Subject to paragraphs (7)(B), (8)(B), (9)(B), (10)(B), (11)(B), (12)(B), (13)(B), and (14)(B), in lieu of the update to the single conversion factor established in paragraph (1)(C) that would otherwise apply for 2014, the update to the single conversion factor shall be 0.5 percent.

(B) NO EFFECT ON COMPUTATION OF CONVERSION FACTOR FOR SUBSEQUENT YEARS.—The conversion factor under this subsection shall be computed under paragraph (1)(A) for 2015 and subsequent years as if subparagraph (A) had never applied.

(16) UPDATE FOR JANUARY THROUGH JUNE OF 2015.—Subject to paragraphs (7)(B), (8)(B), (9)(B), (10)(B), (11)(B), (12)(B), (13)(B), (14)(B), and (15)(B), in lieu of the update to the single conversion factor established in paragraph (1)(C) that would otherwise apply for 2015 for the period beginning on January 1, 2015, and ending on June 30, 2015, the update to the single conversion factor shall be 0.0 percent.

(17) UPDATE FOR JULY THROUGH DECEMBER OF 2015.—The update to the single conversion factor established in paragraph (1)(C) for the period beginning on July 1, 2015, and ending on December 31, 2015, shall be 0.5 percent.

(18) UPDATE FOR 2016 THROUGH 2019.—The update to the single conversion factor established in paragraph (1)(C) for 2016 and each subsequent year through 2019 shall be 0.5 percent.

(19) UPDATE FOR 2020 THROUGH 2025.—The update to the single conversion factor established in paragraph (1)(C) for 2020 and each subsequent year through 2025 shall be 0.0 percent.

(20) UPDATE FOR 2026 AND SUBSEQUENT YEARS.—For 2026 and each subsequent year, the update to the qualifying APM conversion factor established under paragraph (1)(A) is 0.75 percent, and the update to the nonqualifying APM conversion factor established under such paragraph is 0.25 percent.

(e) GEOGRAPHIC ADJUSTMENT FACTORS.—

(1) ESTABLISHMENT OF GEOGRAPHIC INDICES.—

(A) IN GENERAL.—Subject to subparagraphs (B), (C), (E), (G), (H), and (I), the Secretary shall establish—

(i) an index which reflects the relative costs of the mix of goods and services comprising practice expenses (other than malpractice expenses) in the different fee schedule areas compared to the national average of such costs,

(ii) an index which reflects the relative costs of malpractice expenses in the different fee schedule areas compared to the national average of such costs, and

(iii) an index which reflects ¼ of the difference between the relative value of physicians' work effort in each of the different fee schedule areas and the national average of such work effort.

(B) CLASS-SPECIFIC GEOGRAPHIC COST-OF-PRACTICE INDICES.—The Secretary may establish more than one index under subparagraph (A)(i) in the case of classes of physicians' services, if, because of differences in the mix of

goods and services comprising practice expenses for the different classes of services, the application of a single index under such clause to different classes of such services would be substantially inequitable.

(C) PERIODIC REVIEW AND ADJUSTMENTS IN GEOGRAPHIC ADJUSTMENT FACTORS.—The Secretary, not less often than every 3 years, shall, in consultation with appropriate representatives of physicians, review the indices established under subparagraph (A) and the geographic index values applied under this subsection for all fee schedule areas. Based on such review, the Secretary may revise such index and adjust such index values, except that, if more than 1 year has elapsed since the date of the last previous adjustment, the adjustment to be applied in the first year of the next adjustment shall be ½ of the adjustment that otherwise would be made.

(D) USE OF RECENT DATA.—In establishing indices and index values under this paragraph, the Secretary shall use the most recent data available relating to practice expenses, malpractice expenses, and physician work effort in different fee schedule areas.

(E) FLOOR AT 1.0 ON WORK GEOGRAPHIC INDEX.—After calculating the work geographic index in subparagraph (A)(iii), for purposes of payment for services furnished on or after January 1, 2004, and before January 1, 2018, the Secretary shall increase the work geographic index to 1.00 for any locality for which such work geographic index is less than 1.00.

(G) FLOOR FOR PRACTICE EXPENSE, MALPRACTICE, AND WORK GEOGRAPHIC INDICES FOR SERVICES FURNISHED IN ALASKA.—For purposes of payment for services furnished in Alaska on or after January 1, 2004, and before January 1, 2006, after calculating the practice expense, malpractice, and work geographic indices in clauses (i), (ii), and (iii) of subparagraph (A) and in subparagraph (B), the Secretary shall increase any such index to 1.67 if such index would otherwise be less than 1.67. For purposes of payment for services furnished in the State described in the preceding sentence on or after January 1, 2009, after calculating the work geographic index in subparagraph (A)(iii), the Secretary shall increase the work geographic index to 1.5 if such index would otherwise be less than 1.5

(H) PRACTICE EXPENSE GEOGRAPHIC ADJUSTMENT FOR 2010 AND SUBSEQUENT YEARS.—

(i) FOR 2010.—Subject to clause (iii), for services furnished during 2010, the employee wage and rent portions of the practice expense geographic index described in subparagraph (A)(i) shall reflect ½ of the difference between the relative costs of employee wages and rents in each of the different fee schedule areas and the national average of such employee wages and rents.

(ii) FOR 2011.—Subject to clause (iii), for services furnished during 2011, the employee wage and rent portions of the practice expense geographic index de-

scribed in subparagraph (A)(i) shall reflect ½ of the difference between the relative costs of employee wages and rents in each of the different fee schedule areas and the national average of such employee wages and rents.

(iii) HOLD HARMLESS.—The practice expense portion of the geographic adjustment factor applied in a fee schedule area for services furnished in 2010 or 2011 shall not, as a result of the application of clause (i) or (ii), be reduced below the practice expense portion of the geographic adjustment factor under subparagraph (A)(i) (as calculated prior to the application of such clause (i) or (ii), respectively) for such area for such year.

(iv) ANALYSIS.—The Secretary shall analyze current methods of establishing practice expense geographic adjustments under subparagraph (A)(i) and evaluate data that fairly and reliably establishes distinctions in the costs of operating a medical practice in the different fee schedule areas. Such analysis shall include an evaluation of the following:

(I) The feasibility of using actual data or reliable survey data developed by medical organizations on the costs of operating a medical practice, including office rents and non-physician staff wages, in different fee schedule areas.

(II) The office expense portion of the practice expense geographic adjustment described in subparagraph (A)(i), including the extent to which types of office expenses are determined in local markets instead of national markets.

(III) The weights assigned to each of the categories within the practice expense geographic adjustment described in subparagraph (A)(i).

(v) REVISION FOR 2012 AND SUBSEQUENT YEARS.—As a result of the analysis described in clause (iv), the Secretary shall, not later than January 1, 2012, make appropriate adjustments to the practice expense geographic adjustment described in subparagraph (A)(i) to ensure accurate geographic adjustments across fee schedule areas, including—

(I) basing the office rents component and its weight on office expenses that vary among fee schedule areas; and

(II) considering a representative range of professional and non-professional personnel employed in a medical office based on the use of the American Community Survey data or other reliable data for wage adjustments.

Such adjustments shall be made without regard to adjustments made pursuant to clauses (i) and (ii) and shall be made in a budget neutral manner.

(I) FLOOR FOR PRACTICE EXPENSE INDEX FOR SERVICES FURNISHED IN FRONTIER STATES.—

(i) IN GENERAL.—Subject to clause (ii), for purposes of payment for services furnished in a frontier State (as defined in section 1886(d)(3)(E)(iii)(II)) on or after January 1, 2011, after calculating the practice expense index in subparagraph (A)(i), the Secretary shall increase any such index to 1.00 if such index would otherwise be less that 1.00. The preceding sentence shall not be applied in a budget neutral manner.

(ii) LIMITATION.—This subparagraph shall not apply to services furnished in a State that receives a nonlabor related share adjustment under section 1886(d)(5)(H).

(2) COMPUTATION OF GEOGRAPHIC ADJUSTMENT FACTOR.—For purposes of subsection (b)(1)(C), for all physicians' services for each fee schedule area the Secretary shall establish a geographic adjustment factor equal to the sum of the geographic cost-of-practice adjustment factor (specified in paragraph (3)), the geographic malpractice adjustment factor (specified in paragraph (4)), and the geographic physician work adjustment factor (specified in paragraph (5)) for the service and the area.

(3) GEOGRAPHIC COST-OF-PRACTICE ADJUSTMENT FACTOR.—For purposes of paragraph (2), the "geographic cost-of-practice adjustment factor", for a service for a fee schedule area, is the product of—

(A) the proportion of the total relative value for the service that reflects the relative value units for the practice expense component, and

(B) the geographic cost-of-practice index value for the area for the service, based on the index established under paragraph (1)(A)(i) or (1)(B) (as the case may be).

(4) GEOGRAPHIC MALPRACTICE ADJUSTMENT FACTOR.—For purposes of paragraph (2), the "geographic malpractice adjustment factor", for a service for a fee schedule area, is the product of—

(A) the proportion of the total relative value for the service that reflects the relative value units for the malpractice component, and

(B) the geographic malpractice index value for the area, based on the index established under paragraph (1)(A)(ii).

(5) GEOGRAPHIC PHYSICIAN WORK ADJUSTMENT FACTOR.—For purposes of paragraph (2), the "geographic physician work adjustment factor", for a service for a fee schedule area, is the product of—

(A) the proportion of the total relative value for the service that reflects the relative value units for the work component, and

(B) the geographic physician work index value for the area, based on the index established under paragraph (1)(A)(iii).

(6) USE OF MSAS AS FEE SCHEDULE AREAS IN CALIFORNIA.—

(A) IN GENERAL.—Subject to the succeeding provisions of this paragraph and notwithstanding the previous provisions of this subsection, for services furnished on or after January 1, 2017, the fee schedule areas used for payment

under this section applicable to California shall be the following:

(i) Each Metropolitan Statistical Area (each in this paragraph referred to as an "MSA"), as defined by the Director of the Office of Management and Budget as of December 31 of the previous year, shall be a fee schedule area.

(ii) All areas not included in an MSA shall be treated as a single rest-of-State fee schedule area.

(B) TRANSITION FOR MSAS PREVIOUSLY IN REST-OF-STATE PAYMENT LOCALITY OR IN LOCALITY 3.—

(i) IN GENERAL.—For services furnished in California during a year beginning with 2017 and ending with 2021 in an MSA in a transition area (as defined in subparagraph (D)), subject to subparagraph (C), the geographic index values to be applied under this subsection for such year shall be equal to the sum of the following:

(I) CURRENT LAW COMPONENT.—The old weighting factor (described in clause (ii)) for such year multiplied by the geographic index values under this subsection for the fee schedule area that included such MSA that would have applied in such area (as estimated by the Secretary) if this paragraph did not apply.

(II) MSA-BASED COMPONENT.—The MSA-based weighting factor (described in clause (iii)) for such year multiplied by the geographic index values computed for the fee schedule area under subparagraph (A) for the year (determined without regard to this subparagraph).

(ii) OLD WEIGHTING FACTOR.—The old weighting factor described in this clause—

(I) for 2017, is 5/6; and

(II) for each succeeding year, is the old weighting factor described in this clause for the previous year minus 1/6.

(iii) MSA-BASED WEIGHTING FACTOR.—The MSA-based weighting factor described in this clause for a year is 1 minus the old weighting factor under clause (ii) for that year.

(C) HOLD HARMLESS.—For services furnished in a transition area in California during a year beginning with 2017, the geographic index values to be applied under this subsection for such year shall not be less than the corresponding geographic index values that would have applied in such transition area (as estimated by the Secretary) if this paragraph did not apply.

(D) TRANSITION AREA DEFINED.—In this paragraph, the term "transition area" means each of the following fee schedule areas for 2013:

(i) The rest-of-State payment locality.

(ii) Payment locality 3.

(E) REFERENCES TO FEE SCHEDULE AREAS.—Effective for services furnished on or after January 1, 2017, for Cali-

fornia, any reference in this section to a fee schedule area shall be deemed a reference to a fee schedule area established in accordance with this paragraph.

(f) SUSTAINABLE GROWTH RATE.—

(1) PUBLICATION.—The Secretary shall cause to have published in the Federal Register not later than—

(A) November 1, 2000, the sustainable growth rate for 2000 and 2001; and

(B) November 1 of each succeeding year through 2014 the sustainable growth rate for such succeeding year and each of the preceding 2 years.

(2) SPECIFICATION OF GROWTH RATE.—The sustainable growth rate for all physicians' services for a fiscal year (beginning with fiscal year 1998 and ending with fiscal year 2000) and a year beginning with 2000 and ending with 2014 shall be equal to the product of—

(A) 1 plus the Secretary's estimate of the weighted average percentage increase (divided by 100) in the fees for all physicians' services in the applicable period involved,

(B) 1 plus the Secretary's estimate of the percentage change (divided by 100) in the average number of individuals enrolled under this part (other than Medicare+Choice plan enrollees) from the previous applicable period to the applicable period involved,

(C) 1 plus the Secretary's estimate of the annual average percentage growth in real gross domestic product per capita (divided by 100) during the 10-year period ending with the applicable period involved, and

(D) 1 plus the Secretary's estimate of the percentage change (divided by 100) in expenditures for all physicians' services in the applicable period (compared with the previous applicable period) which will result from changes in law and regulations, determined without taking into account estimated changes in expenditures resulting from the update adjustment factor determined under subsection (d)(3)(B) or (d)(4)(B), as the case may be,

minus 1 and multiplied by 100.

(3) DATA TO BE USED.—For purposes of determining the update adjustment factor under subsection (d)(4)(B) for a year beginning with 2001, the sustainable growth rates taken into consideration in the determination under paragraph (2) shall be determined as follows:

(A) FOR 2001.—For purposes of such calculations for 2001, the sustainable growth rates for fiscal year 2000 and the years 2000 and 2001 shall be determined on the basis of the best data available to the Secretary as of September 1, 2000.

(B) FOR 2002.—For purposes of such calculations for 2002, the sustainable growth rates for fiscal year 2000 and for years 2000, 2001, and 2002 shall be determined on the basis of the best data available to the Secretary as of September 1, 2001.

(C) FOR 2003 AND SUCCEEDING YEARS.—For purposes of such calculations for a year after 2002—

(i) the sustainable growth rates for that year and the preceding 2 years shall be determined on the basis of the best data available to the Secretary as of September 1 of the year preceding the year for which the calculation is made; and

(ii) the sustainable growth rate for any year before a year described in clause (i) shall be the rate as most recently determined for that year under this subsection.

Nothing in this paragraph shall be construed as affecting the sustainable growth rates established for fiscal year 1998 or fiscal year 1999.

(4) DEFINITIONS.—In this subsection:

(A) SERVICES INCLUDED IN PHYSICIANS' SERVICES.—The term "physicians' services" includes other items and services (such as clinical diagnostic laboratory tests and radiology services), specified by the Secretary, that are commonly performed or furnished by a physician or in a physician's office, but does not include services furnished to a Medicare+Choice plan enrollee.

(B) MEDICARE+CHOICE PLAN ENROLLEE.—The term "Medicare+Choice plan enrollee" means, with respect to a fiscal year, an individual enrolled under this part who has elected to receive benefits under this title for the fiscal year through a Medicare+Choice plan offered under part C, and also includes an individual who is receiving benefits under this part through enrollment with an eligible organization with a risk-sharing contract under section 1876.

(C) APPLICABLE PERIOD.—The term "applicable period" means—

(i) a fiscal year, in the case of fiscal year 1998, fiscal year 1999, and fiscal year 2000; or

(ii) a calendar year with respect to a year beginning with 2000;

as the case may be.

(g) LIMITATION ON BENEFICIARY LIABILITY.—

(1) LIMITATION ON ACTUAL CHARGES.—

(A) IN GENERAL.—In the case of a nonparticipating physician or nonparticipating supplier or other person (as defined in section 1842(i)(2)) who does not accept payment on an assignment-related basis for a physician's service furnished with respect to an individual enrolled under this part, the following rules apply:

(i) APPLICATION OF LIMITING CHARGE.—No person may bill or collect an actual charge for the service in excess of the limiting charge described in paragraph (2) for such service.

(ii) NO LIABILITY FOR EXCESS CHARGES.—No person is liable for payment of any amounts billed for the service in excess of such limiting charge.

(iii) CORRECTION OF EXCESS CHARGES.—If such a physician, supplier, or other person bills, but does not collect, an actual charge for a service in violation of clause (i), the physician, supplier, or other person shall reduce on a timely basis the actual charge billed

for the service to an amount not to exceed the limiting charge for the service.

(iv) REFUND OF EXCESS COLLECTIONS.—If such a physician, supplier, or other person collects an actual charge for a service in violation of clause (i), the physician, supplier, or other person shall provide on a timely basis a refund to the individual charged in the amount by which the amount collected exceeded the limiting charge for the service. The amount of such a refund shall be reduced to the extent the individual has an outstanding balance owed by the individual to the physician.

(B) SANCTIONS.—If a physician, supplier, or other person—

(i) knowingly and willfully bills or collects for services in violation of subparagraph (A)(i) on a repeated basis, or

(ii) fails to comply with clause (iii) or (iv) of subparagraph (A) on a timely basis,

the Secretary may apply sanctions against the physician, supplier, or other person in accordance with paragraph (2) of section 1842(j). In applying this subparagraph, paragraph (4) of such section applies in the same manner as such paragraph applies to such section and any reference in such section to a physician is deemed also to include a reference to a supplier or other person under this subparagraph.

(C) TIMELY BASIS.—For purposes of this paragraph, a correction of a bill for an excess charge or refund of an amount with respect to a violation of subparagraph (A)(i) in the case of a service is considered to be provided "on a timely basis", if the reduction or refund is made not later than 30 days after the date the physician, supplier, or other person is notified by the carrier under this part of such violation and of the requirements of subparagraph (A).

(2) LIMITING CHARGE DEFINED.—

(A) FOR 1991.—For physicians' services of a physician furnished during 1991, other than radiologist services subject to section 1834(b), the "limiting charge" shall be the same percentage (or, if less, 25 percent) above the recognized payment amount under this part with respect to the physician (as a nonparticipating physician) as the percentage by which—

(i) the maximum allowable actual charge (as determined under section 1842(j)(1)(C) as of December 31, 1990, or, if less, the maximum actual charge otherwise permitted for the service under this part as of such date) for the service of the physician, exceeds

(ii) the recognized payment amount for the service of the physician (as a nonparticipating physician) as of such date.

In the case of evaluation and management services (as specified in section 1842(b)(16)(B)(ii)), the preceding sentence shall be applied by substituting "40 percent" for "25 percent".

(B) FOR 1992.—For physicians' services furnished during 1992, other than radiologist services subject to section 1834(b), the "limiting charge" shall be the same percentage (or, if less, 20 percent) above the recognized payment amount under this part for nonparticipating physicians as the percentage by which—

(i) the limiting charge (as determined under subparagraph (A) as of December 31, 1991) for the service, exceeds

(ii) the recognized payment amount for the service for nonparticipating physicians as of such date.

(C) AFTER 1992.—For physicians' services furnished in a year after 1992, the "limiting charge" shall be 115 percent of the recognized payment amount under this part for nonparticipating physicians or for nonparticipating suppliers or other persons.

(D) RECOGNIZED PAYMENT AMOUNT.—In this section, the term "recognized payment amount" means, for services furnished on or after January 1, 1992, the fee schedule amount determined under subsection (a) (or, if payment under this part is made on a basis other than the fee schedule under this section, 95 percent of the other payment basis), and, for services furnished during 1991, the applicable percentage (as defined in section 1842(b)(4)(A)(iv)) of the prevailing charge (or fee schedule amount) for nonparticipating physicians for that year.

(3) LIMITATION ON CHARGES FOR MEDICARE BENEFICIARIES ELIGIBLE FOR MEDICAID BENEFITS.—

(A) IN GENERAL.—Payment for physicians' services furnished on or after April 1, 1990, to an individual who is enrolled under this part and eligible for any medical assistance (including as a qualified medicare beneficiary, as defined in section 1905(p)(1)) with respect to such services under a State plan approved under title XIX may only be made on an assignment-related basis and the provisions of section 1902(n)(3)(A) apply to further limit permissible charges under this section.

(B) PENALTY.—A person may not bill for physicians' services subject to subparagraph (A) other than on an assignment-related basis. No person is liable for payment of any amounts billed for such a service in violation of the previous sentence. If a person knowingly and willfully bills for physicians' services in violation of the first sentence, the Secretary may apply sanctions against the person in accordance with section 1842(j)(2).

(4) PHYSICIAN SUBMISSION OF CLAIMS.—

(A) IN GENERAL.—For services furnished on or after September 1, 1990, within 1 year after the date of providing a service for which payment is made under this part on a reasonable charge or fee schedule basis, a physician, supplier, or other person (or an employer or facility in the cases described in section 1842(b)(6)(A))—

(i) shall complete and submit a claim for such service on a standard claim form specified by the Secretary to the carrier on behalf of a beneficiary, and

(ii) may not impose any charge relating to completing and submitting such a form.

(B) PENALTY.—(i) With respect to an assigned claim wherever a physician, provider, supplier or other person (or an employer or facility in the cases described in section 1842(b)(6)(A)) fails to submit such a claim as required in subparagraph (A), the Secretary shall reduce by 10 percent the amount that would otherwise be paid for such claim under this part.

(ii) If a physician, supplier, or other person (or an employer or facility in the cases described in section 1842(b)(6)(A)) fails to submit a claim required to be submitted under subparagraph (A) or imposes a charge in violation of such subparagraph, the Secretary shall apply the sanction with respect to such a violation in the same manner as a sanction may be imposed under section 1842(p)(3) for a violation of section 1842(p)(1).

(5) ELECTRONIC BILLING; DIRECT DEPOSIT.—The Secretary shall encourage and develop a system providing for expedited payment for claims submitted electronically. The Secretary shall also encourage and provide incentives allowing for direct deposit as payments for services furnished by participating physicians. The Secretary shall provide physicians with such technical information as necessary to enable such physicians to submit claims electronically. The Secretary shall submit a plan to Congress on this paragraph by May 1, 1990.

(6) MONITORING OF CHARGES.—

(A) IN GENERAL.—The Secretary shall monitor—

(i) the actual charges of nonparticipating physicians for physicians' services furnished on or after January 1, 1991, to individuals enrolled under this part, and

(ii) changes (by specialty, type of service, and geographic area) in (I) the proportion of expenditures for physicians' services provided under this part by participating physicians, (II) the proportion of expenditures for such services for which payment is made under this part on an assignment-related basis, and (III) the amounts charged above the recognized payment amounts under this part.

(B) REPORT.—The Secretary shall, by not later than April 15 of each year (beginning in 1992), report to the Congress information on the extent to which actual charges exceed limiting charges, the number and types of services involved, and the average amount of excess charges and information regarding the changes described in subparagraph (A)(ii).

(C) PLAN.—If the Secretary finds that there has been a significant decrease in the proportions described in subclauses (I) and (II) of subparagraph (A)(ii) or an increase in the amounts described in subclause (III) of that subparagraph, the Secretary shall develop a plan to address such a problem and transmit to Congress recommendations regarding the plan. The Medicare Payment Advisory Commission shall review the Secretary's plan and rec-

ommendations and transmit to Congress its comments regarding such plan and recommendations.

(7) MONITORING OF UTILIZATION AND ACCESS.—

(A) IN GENERAL.—The Secretary shall monitor—

(i) changes in the utilization of and access to services furnished under this part within geographic, population, and service related categories,

(ii) possible sources of inappropriate utilization of services furnished under this part which contribute to the overall level of expenditures under this part, and

(iii) factors underlying these changes and their interrelationships.

(B) REPORT.—The Secretary shall by not later than April 15, of each year (beginning with 1991) report to the Congress on the changes described in subparagraph (A)(i) and shall include in the report an examination of the factors (including factors relating to different services and specific categories and groups of services and geographic and demographic variations in utilization) which may contribute to such changes.

(C) RECOMMENDATIONS.—The Secretary shall include in each annual report under subparagraph (B) recommendations—

(i) addressing any identified patterns of inappropriate utilization,

(ii) on utilization review,

(iii) on physician education or patient education,

(iv) addressing any problems of beneficiary access to care made evident by the monitoring process, and

(v) on such other matters as the Secretary deems appropriate.

The Medicare Payment Advisory Commission shall comment on the Secretary's recommendations and in developing its comments, the Commission shall convene and consult a panel of physician experts to evaluate the implications of medical utilization patterns for the quality of and access to patient care.

(h) SENDING INFORMATION TO PHYSICIANS.—Before the beginning of each year (beginning with 1992), the Secretary shall send to each physician or nonparticipating supplier or other person furnishing physicians' services (as defined in section 1848(j)(3)) furnishing physicians' services under this part, for services commonly performed by the physician, supplier, or other person, information on fee schedule amounts that apply for the year in the fee schedule area for participating and non-participating physicians, and the maximum amount that may be charged consistent with subsection (g)(2). Such information shall be transmitted in conjunction with notices to physicians, suppliers, and other persons under section 1842(h) (relating to the participating physician program) for a year.

(i) MISCELLANEOUS PROVISIONS.—

(1) RESTRICTION ON ADMINISTRATIVE AND JUDICIAL REVIEW.—There shall be no administrative or judicial review under section 1869 or otherwise of—

(A) the determination of the adjusted historical payment basis (as defined in subsection (a)(2)(D)(i)),

(B) the determination of relative values and relative value units under subsection (c), including adjustments under subsections (c)(2)(F), (c)(2)(H), and (c)(2)(I) and section 13515(b) of the Omnibus Budget Reconciliation Act of 1993,

(C) the determination of conversion factors under subsection (d), including without limitation a prospective redetermination of the sustainable growth rates for any or all previous fiscal years,

(D) the establishment of geographic adjustment factors under subsection (e),

(E) the establishment of the system for the coding of physicians' services under this section, and

(F) the collection and use of information in the determination of relative values under subsection (c)(2)(M).

(2) ASSISTANTS-AT-SURGERY.—

(A) IN GENERAL.—Subject to subparagraph (B), in the case of a surgical service furnished by a physician, if payment is made separately under this part for the services of a physician serving as an assistant-at-surgery, the fee schedule amount shall not exceed 16 percent of the fee schedule amount otherwise determined under this section for the global surgical service involved.

(B) DENIAL OF PAYMENT IN CERTAIN CASES.—If the Secretary determines, based on the most recent data available, that for a surgical procedure (or class of surgical procedures) the national average percentage of such procedure performed under this part which involve the use of a physician as an assistant at surgery is less than 5 percent, no payment may be made under this part for services of an assistant at surgery involved in the procedure.

(3) NO COMPARABILITY ADJUSTMENT.—For physicians' services for which payment under this part is determined under this section—

(A) a carrier may not make any adjustment in the payment amount under section 1842(b)(3)(B) on the basis that the payment amount is higher than the charge applicable, for comparable services and under comparable circumstances, to the policyholders and subscribers of the carrier,

(B) no payment adjustment may be made under section 1842(b)(8), and

(C) section 1842(b)(9) shall not apply.

(j) DEFINITIONS.—In this section:

(1) CATEGORY.—For services furnished before January 1, 1998, the term "category" means, with respect to physicians' services, surgical services (as defined by the Secretary and including anesthesia services), primary care services (as defined in section 1842(i)(4)), and all other physicians' services. The Secretary shall define surgical services and publish such definitions in the Federal Register no later than May 1, 1990, after consultation with organizations representing physicians.

(2) FEE SCHEDULE AREA.—Except as provided in subsection (e)(6)(D), the term "fee schedule area" means a locality used

under section 1842(b) for purposes of computing payment amounts for physicians' services.

(3) PHYSICIANS' SERVICES.—The term "physicians' services" includes items and services described in paragraphs (1), (2)(A), (2)(D), (2)(G), (2)(P) (with respect to services described in subparagraphs (A) and (C) of section 1861(oo)(2)), (2)(R) (with respect to services described in suparagraphs (B), (C), and (D) of section 1861(pp)(1)), (2)(S), (2)(W), (2)(AA), (2)(DD), (2)(EE), (2)(FF) (including administration of the health risk assessment), (3), (4), (13), (14) (with respect to services described in section 1861(nn)(2)), and (15) of section 1861(s) (other than clinical diagnostic laboratory tests and, except for purposes of subsection (a)(3), (g), and (h) such other items and services as the Secretary may specify).

(4) PRACTICE EXPENSES.—The term "practice expenses" includes all expenses for furnishing physicians' services, excluding malpractice expenses, physician compensation, and other physician fringe benefits.

(k) QUALITY REPORTING SYSTEM.—

(1) IN GENERAL.—The Secretary shall implement a system for the reporting by eligible professionals of data on quality measures specified under paragraph (2). Such data shall be submitted in a form and manner specified by the Secretary (by program instruction or otherwise), which may include submission of such data on claims under this part.

(2) USE OF CONSENSUS-BASED QUALITY MEASURES.—

(A) FOR 2007.—

(i) IN GENERAL.—For purposes of applying this subsection for the reporting of data on quality measures for covered professional services furnished during the period beginning July 1, 2007, and ending December 31, 2007, the quality measures specified under this paragraph are the measures identified as 2007 physician quality measures under the Physician Voluntary Reporting Program as published on the public website of the Centers for Medicare & Medicaid Services as of the date of the enactment of this subsection, except as may be changed by the Secretary based on the results of a consensus-based process in January of 2007, if such change is published on such website by not later than April 1, 2007.

(ii) SUBSEQUENT REFINEMENTS IN APPLICATION PERMITTED.—The Secretary may, from time to time (but not later than July 1, 2007), publish on such website (without notice or opportunity for public comment) modifications or refinements (such as code additions, corrections, or revisions) for the application of quality measures previously published under clause (i), but may not, under this clause, change the quality measures under the reporting system.

(iii) IMPLEMENTATION.—Notwithstanding any other provision of law, the Secretary may implement by program instruction or otherwise this subsection for 2007.

(B) FOR 2008 AND 2009.—

(i) IN GENERAL.—For purposes of reporting data on quality measures for covered professional services furnished during 2008 and 2009, the quality measures specified under this paragraph for covered professional services shall be measures that have been adopted or endorsed by a consensus organization (such as the National Quality Forum or AQA), that include measures that have been submitted by a physician specialty, and that the Secretary identifies as having used a consensus-based process for developing such measures. Such measures shall include structural measures, such as the use of electronic health records and electronic prescribing technology.

(ii) PROPOSED SET OF MEASURES.—Not later than August 15 of each of 2007 and 2008, the Secretary shall publish in the Federal Register a proposed set of quality measures that the Secretary determines are described in clause (i) and would be appropriate for eligible professionals to use to submit data to the Secretary in 2008 or 2009, as applicable. The Secretary shall provide for a period of public comment on such set of measures.

(iii) FINAL SET OF MEASURES.—Not later than November 15 of each of 2007 and 2008, the Secretary shall publish in the Federal Register a final set of quality measures that the Secretary determines are described in clause (i) and would be appropriate for eligible professionals to use to submit data to the Secretary in 2008 or 2009, as applicable.

(C) FOR 2010 AND SUBSEQUENT YEARS.—

(i) IN GENERAL.—Subject to clause (ii), for purposes of reporting data on quality measures for covered professional services furnished during 2010 and each subsequent year, subject to subsection (m)(3)(C), the quality measures (including electronic prescribing quality measures) specified under this paragraph shall be such measures selected by the Secretary from measures that have been endorsed by the entity with a contract with the Secretary under section 1890(a).

(ii) EXCEPTION.—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), the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary, such as the AQA alliance.

(D) OPPORTUNITY TO PROVIDE INPUT ON MEASURES FOR 2009 AND SUBSEQUENT YEARS.—For each quality measure (including an electronic prescribing quality measure) adopted by the Secretary under subparagraph (B) (with respect to 2009) or subparagraph (C), the Secretary shall ensure that eligible professionals have the opportunity to

provide input during the development, endorsement, or selection of measures applicable to services they furnish.

(3) COVERED PROFESSIONAL SERVICES AND ELIGIBLE PROFESSIONALS DEFINED.—For purposes of this subsection:

(A) COVERED PROFESSIONAL SERVICES.—The term "covered professional services" means services for which payment is made under, or is based on, the fee schedule established under this section and which are furnished by an eligible professional.

(B) ELIGIBLE PROFESSIONAL.—The term "eligible professional" means any of the following:

(i) A physician.

(ii) A practitioner described in section 1842(b)(18)(C).

(iii) A physical or occupational therapist or a qualified speech-language pathologist.

(iv) Beginning with 2009, a qualified audiologist (as defined in section 1861(ll)(3)(B)).

(4) USE OF REGISTRY-BASED REPORTING.—As part of the publication of proposed and final quality measures for 2008 under clauses (ii) and (iii) of paragraph (2)(B), the Secretary shall address a mechanism whereby an eligible professional may provide data on quality measures through an appropriate medical registry (such as the Society of Thoracic Surgeons National Database) or through a Maintenance of Certification program operated by a specialty body of the American Board of Medical Specialties that meets the criteria for such a registry, as identified by the Secretary.

(5) IDENTIFICATION UNITS.—For purposes of applying this subsection, the Secretary may identify eligible professionals through billing units, which may include the use of the Provider Identification Number, the unique physician identification number (described in section 1833(q)(1)), the taxpayer identification number, or the National Provider Identifier. For purposes of applying this subsection for 2007, the Secretary shall use the taxpayer identification number as the billing unit.

(6) EDUCATION AND OUTREACH.—The Secretary shall provide for education and outreach to eligible professionals on the operation of this subsection.

(7) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, of the development and implementation of the reporting system under paragraph (1), including identification of quality measures under paragraph (2) and the application of paragraphs (4) and (5).

(8) IMPLEMENTATION.—The Secretary shall carry out this subsection acting through the Administrator of the Centers for Medicare & Medicaid Services.

(9) CONTINUED APPLICATION FOR PURPOSES OF MIPS AND FOR CERTAIN PROFESSIONALS VOLUNTEERING TO REPORT.—The Secretary shall, in accordance with subsection (q)(1)(F), carry out the provisions of this subsection—

(A) for purposes of subsection (q); and

(B) for eligible professionals who are not MIPS eligible professionals (as defined in subsection (q)(1)(C)) for the year involved.

(l) PHYSICIAN ASSISTANCE AND QUALITY INITIATIVE FUND.—

(1) ESTABLISHMENT.—The Secretary shall establish under this subsection a Physician Assistance and Quality Initiative Fund (in this subsection referred to as the "Fund") which shall be available to the Secretary for physician payment and quality improvement initiatives, which may include application of an adjustment to the update of the conversion factor under subsection (d).

(2) FUNDING.—

(A) AMOUNT AVAILABLE.—

(i) IN GENERAL.—Subject to clause (ii), there shall be available to the Fund the following amounts:

(I) For expenditures during 2008, an amount equal to $150,500,000.

(II) For expenditures during 2009, an amount equal to $24,500,000.

(ii) LIMITATIONS ON EXPENDITURES.—

(I) 2008.—The amount available for expenditures during 2008 shall be reduced as provided by subparagraph (A) of section 225(c)(1) and section 524 of the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2008 (division G of the Consolidated Appropriations Act, 2008).

(II) 2009.—The amount available for expenditures during 2009 shall be reduced as provided by subparagraph (B) of such section 225(c)(1).

(B) TIMELY OBLIGATION OF ALL AVAILABLE FUNDS FOR SERVICES.—The Secretary shall provide for expenditures from the Fund in a manner designed to provide (to the maximum extent feasible) for the obligation of the entire amount available for expenditures, after application of subparagraph (A)(ii), during—

(i) 2008 for payment with respect to physicians' services furnished during 2008; and

(ii) 2009 for payment with respect to physicians' services furnished during 2009.

(C) PAYMENT FROM TRUST FUND.—The amount specified in subparagraph (A) shall be available to the Fund, as expenditures are made from the Fund, from the Federal Supplementary Medical Insurance Trust Fund under section 1841.

(D) FUNDING LIMITATION.—Amounts in the Fund shall be available in advance of appropriations in accordance with subparagraph (B) but only if the total amount obligated from the Fund does not exceed the amount available to the Fund under subparagraph (A). The Secretary may obligate funds from the Fund only if the Secretary determines (and the Chief Actuary of the Centers for Medicare & Medicaid Services and the appropriate budget officer certify) that there are available in the Fund sufficient amounts to cover

all such obligations incurred consistent with the previous sentence.

(E) CONSTRUCTION.—In the case that expenditures from the Fund are applied to, or otherwise affect, a conversion factor under subsection (d) for a year, the conversion factor under such subsection shall be computed for a subsequent year as if such application or effect had never occurred.

(m) INCENTIVE PAYMENTS FOR QUALITY REPORTING.—

(1) INCENTIVE PAYMENTS.—

(A) IN GENERAL.—For 2007 through 2014, with respect to covered professional services furnished during a reporting period by an eligible professional, if—

(i) there are any quality measures that have been established under the physician reporting system that are applicable to any such services furnished by such professional for such reporting period;

(ii) the eligible professional satisfactorily submits (as determined under this subsection) to the Secretary data on such quality measures in accordance with such reporting system for such reporting period,

in addition to the amount otherwise paid under this part, there also shall be paid to the eligible professional (or to an employer or facility in the cases described in clause (A) of section 1842(b)(6)) or, in the case of a group practice under paragraph (3)(C), to the group practice, from the Federal Supplementary Medical Insurance Trust Fund established under section 1841 an amount equal to the applicable quality percent of the Secretary's estimate (based on claims submitted not later than 2 months after the end of the reporting period) of the allowed charges under this part for all such covered professional services furnished by the eligible professional (or, in the case of a group practice under paragraph (3)(C), by the group practice) during the reporting period.

(B) APPLICABLE QUALITY PERCENT.—For purposes of subparagraph (A), the term "applicable quality percent" means—

(i) for 2007 and 2008, 1.5 percent; and

(ii) for 2009 and 2010, 2.0 percent;

(iii) for 2011, 1.0 percent; and

(iv) for 2012, 2013, and 2014, 0.5 percent.

(2) INCENTIVE PAYMENTS FOR ELECTRONIC PRESCRIBING.—

(A) IN GENERAL.—Subject to subparagraph (D), for 2009 through 2013, with respect to covered professional services furnished during a reporting period by an eligible professional, if the eligible professional is a successful electronic prescriber for such reporting period, in addition to the amount otherwise paid under this part, there also shall be paid to the eligible professional (or to an employer or facility in the cases described in clause (A) of section 1842(b)(6)) or, in the case of a group practice under paragraph (3)(C), to the group practice, from the Federal Supplementary Medical Insurance Trust Fund established under section 1841 an amount equal to the applicable electronic prescribing percent of the Secretary's estimate

(based on claims submitted not later than 2 months after the end of the reporting period) of the allowed charges under this part for all such covered professional services furnished by the eligible professional (or, in the case of a group practice under paragraph (3)(C), by the group practice) during the reporting period.

(B) LIMITATION WITH RESPECT TO ELECTRONIC PRESCRIBING QUALITY MEASURES.—The provisions of this paragraph and subsection (a)(5) shall not apply to an eligible professional (or, in the case of a group practice under paragraph (3)(C), to the group practice) if, for the reporting period (or, for purposes of subsection (a)(5), for the reporting period for a year)—

(i) the allowed charges under this part for all covered professional services furnished by the eligible professional (or group, as applicable) for the codes to which the electronic prescribing quality measure applies (as identified by the Secretary and published on the Internet website of the Centers for Medicare & Medicaid Services as of January 1, 2008, and as subsequently modified by the Secretary) are less than 10 percent of the total of the allowed charges under this part for all such covered professional services furnished by the eligible professional (or the group, as applicable); or

(ii) if determined appropriate by the Secretary, the eligible professional does not submit (including both electronically and nonelectronically) a sufficient number (as determined by the Secretary) of prescriptions under part D.

If the Secretary makes the determination to apply clause (ii) for a period, then clause (i) shall not apply for such period.

(C) APPLICABLE ELECTRONIC PRESCRIBING PERCENT.—For purposes of subparagraph (A), the term "applicable electronic prescribing percent" means—

(i) for 2009 and 2010, 2.0 percent;

(ii) for 2011 and 2012, 1.0 percent; and

(iii) for 2013, 0.5 percent.

(D) LIMITATION WITH RESPECT TO EHR INCENTIVE PAYMENTS.—The provisions of this paragraph shall not apply to an eligible professional (or, in the case of a group practice under paragraph (3)(C), to the group practice) if, for the EHR reporting period the eligible professional (or group practice) receives an incentive payment under subsection (o)(1)(A) with respect to a certified EHR technology (as defined in subsection (o)(4)) that has the capability of electronic prescribing.

(3) SATISFACTORY REPORTING AND SUCCESSFUL ELECTRONIC PRESCRIBER AND DESCRIBED.—

(A) IN GENERAL.—For purposes of paragraph (1), an eligible professional shall be treated as satisfactorily submitting data on quality measures for covered professional services for a reporting period (or, for purposes of sub-

section (a)(8), for the quality reporting period for the year) if quality measures have been reported as follows:

(i) THREE OR FEWER QUALITY MEASURES APPLICABLE.—If there are no more than 3 quality measures that are provided under the physician reporting system and that are applicable to such services of such professional furnished during the period, each such quality measure has been reported under such system in at least 80 percent of the cases in which such measure is reportable under the system.

(ii) FOUR OR MORE QUALITY MEASURES APPLICABLE.—If there are 4 or more quality measures that are provided under the physician reporting system and that are applicable to such services of such professional furnishedduring the period, at least 3 such quality measures have been reported under such system in at least 80 percent of the cases in which the respective measure is reportable under the system.

For years after 2008, quality measures for purposes of this subparagraph shall not include electronic prescribing quality measures.

(B) SUCCESSFUL ELECTRONIC PRESCRIBER.—

(i) IN GENERAL.—For purposes of paragraph (2) and subsection (a)(5), an eligible professional shall be treated as a successful electronic prescriber for a reporting period (or, for purposes of subsection (a)(5), for the reporting period for a year) if the eligible professional meets the requirement described in clause (ii), or, if the Secretary determines appropriate, the requirement described in clause (iii). If the Secretary makes the determination under the preceding sentence to apply the requirement described in clause (iii) for a period, then the requirement described in clause (ii) shall not apply for such period.

(ii) REQUIREMENT FOR SUBMITTING DATA ON ELECTRONIC PRESCRIBING QUALITY MEASURES.—The requirement described in this clause is that, with respect to covered professional services furnished by an eligible professional during a reporting period (or, for purposes of subsection (a)(5), for the reporting period for a year), if there are any electronic prescribing quality measures that have been established under the physician reporting system and are applicable to any such services furnished by such professional for the period, such professional reported each such measure under such system in at least 50 percent of the cases in which such measure is reportable by such professional under such system.

(iii) REQUIREMENT FOR ELECTRONICALLY PRESCRIBING UNDER PART D.—The requirement described in this clause is that the eligible professional electronically submitted a sufficient number (as determined by the Secretary) of prescriptions under part D during the reporting period (or, for purposes of subsection (a)(5), for the reporting period for a year).

(iv) USE OF PART D DATA.—Notwithstanding sections 1860D-15(d)(2)(B) and 1860D-15(f)(2), the Secretary may use data regarding drug claims submitted for purposes of section 1860D-15 that are necessary for purposes of clause (iii), paragraph (2)(B)(ii), and paragraph (5)(G).

(v) STANDARDS FOR ELECTRONIC PRESCRIBING.—To the extent practicable, in determining whether eligible professionals meet the requirements under clauses (ii) and (iii) for purposes of clause (i), the Secretary shall ensure that eligible professionals utilize electronic prescribing systems in compliance with standards established for such systems pursuant to the Part D Electronic Prescribing Program under section 1860D–4(e).

(C) SATISFACTORY REPORTING MEASURES FOR GROUP PRACTICES.—

(i) IN GENERAL.—By January 1, 2010, the Secretary shall establish and have in place a process under which eligible professionals in a group practice (as defined by the Secretary) shall be treated as satisfactorily submitting data on quality measures under subparagraph (A) and as meeting the requirement described in subparagraph (B)(ii) for covered professional services for a reporting period (or, for purposes of subsection (a)(5), for a reporting period for a year, or, for purposes of subsection (a)(8), for a quality reporting period for the year) if, in lieu of reporting measures under subsection (k)(2)(C), the group practice reports measures determined appropriate by the Secretary, such as measures that target high-cost chronic conditions and preventive care, in a form and manner, and at a time, specified by the Secretary.

(ii) STATISTICAL SAMPLING MODEL.—The process under clause (i) shall provide and, for 2016 and subsequent years, may provide for the use of a statistical sampling model to submit data on measures, such as the model used under the Physician Group Practice demonstration project under section 1866A.

(iii) NO DOUBLE PAYMENTS.—Payments to a group practice under this subsection by reason of the process under clause (i) shall be in lieu of the payments that would otherwise be made under this subsection to eligible professionals in the group practice for satisfactorily submitting data on quality measures.

(D) SATISFACTORY REPORTING MEASURES THROUGH PARTICIPATION IN A QUALIFIED CLINICAL DATA REGISTRY.—For 2014 and subsequent years, the Secretary shall treat an eligible professional as satisfactorily submitting data on quality measures under subparagraph (A) and, for 2016 and subsequent years, subparagraph (A) or (C) if, in lieu of reporting measures under subsection (k)(2)(C), the eligible professional is satisfactorily participating, as determined by the Secretary, in a qualified clinical data registry (as described in subparagraph (E)) for the year.

(E) QUALIFIED CLINICAL DATA REGISTRY.—

(i) IN GENERAL.—The Secretary shall establish requirements for an entity to be considered a qualified clinical data registry. Such requirements shall include a requirement that the entity provide the Secretary with such information, at such times, and in such manner, as the Secretary determines necessary to carry out this subsection.

(ii) CONSIDERATIONS.—In establishing the requirements under clause (i), the Secretary shall consider whether an entity—

(I) has in place mechanisms for the transparency of data elements and specifications, risk models, and measures;

(II) requires the submission of data from participants with respect to multiple payers;

(III) provides timely performance reports to participants at the individual participant level; and

(IV) supports quality improvement initiatives for participants.

(iii) MEASURES.—With respect to measures used by a qualified clinical data registry—

(I) sections 1890(b)(7) and 1890A(a) shall not apply; and

(II) measures endorsed by the entity with a contract with the Secretary under section 1890(a) may be used.

(iv) CONSULTATION.—In carrying out this subparagraph, the Secretary shall consult with interested parties.

(v) DETERMINATION.—The Secretary shall establish a process to determine whether or not an entity meets the requirements established under clause (i). Such process may involve one or both of the following:

(I) A determination by the Secretary.

(II) A designation by the Secretary of one or more independent organizations to make such determination.

(F) AUTHORITY TO REVISE SATISFACTORILY REPORTING DATA.—For years after 2009, the Secretary, in consultation with stakeholders and experts, may revise the criteria under this subsection for satisfactorily submitting data on quality measures under subparagraph (A) and the criteria for submitting data on electronic prescribing quality measures under subparagraph (B)(ii).

(4) FORM OF PAYMENT.—The payment under this subsection shall be in the form of a single consolidated payment.

(5) APPLICATION.—

(A) PHYSICIAN REPORTING SYSTEM RULES.—Paragraphs (5), (6),and (8) of subsection (k) shall apply for purposes of this subsection in the same manner as they apply for purposes of such subsection.

(B) COORDINATION WITH OTHER BONUS PAYMENTS.—The provisions of this subsection shall not be taken into account in applying subsections (m) and (u) of section 1833 and any payment under such subsections shall not be

taken into account in computing allowable charges under this subsection.

(C) IMPLEMENTATION.—Notwithstanding any other provision of law, for 2007, 2008, and 2009, the Secretary may implement by program instruction or otherwise this subsection.

(D) VALIDATION.—

(i) IN GENERAL.—Subject to the succeeding provisions of this subparagraph, for purposes of determining whether a measure is applicable to the covered professional services of an eligible professional under this subsection for 2007 and 288, the Secretary shall presume that if an eligible professional submits data for a measure, such measure is applicable to such professional.

(ii) METHOD.—The Secretary may establish procedures to validate (by sampling or other means as the Secretary determines to be appropriate) whether measures applicable to covered professional services of an eligible professional have been reported.

(iii) DENIAL OF PAYMENT AUTHORITY.—If the Secretary determines that an eligible professional (or, in the case of a group practice under paragraph (3)(C), the group practice) has not reported measures applicable to covered professional services of such professional, the Secretary shall not pay the incentive payment under this subsection. If such payments for such period have already been made, the Secretary shall recoup such payments from the eligible professional (or the group practice).

(E) LIMITATIONS ON REVIEW.—

Except as provided in subparagraph (I), there shall be no administrative or judicial review under 1869, section 1878, or otherwise of

(i) the determination of measures applicable to services furnished by eligible professionals under this subsection;

(ii) the determination of satisfactory reporting under this subsection;

(iii) the determination of a successful electronic prescriber under paragraph (3), the limitation under paragraph (2)(B), and the exception under subsection (a)(5)(B); and

(iv) the determination of any incentive payment under this subsection and the payment adjustment under paragraphs (5)(A) and (8)(A) of subsection (a).

(F) EXTENSION.—For 2008 through reporting periods occurring in 2015, the Secretary shall establish and, for reporting periods occurring in 2016 and subsequent years, the Secretary may establish alternative criteria for satisfactorily reporting under this subsection and alternative reporting periods under paragraph (6)(C) for reporting groups of measures under subsection (k)(2)(B) and for reporting using the method specified in subsection (k)(4).

(G) POSTING ON WEBSITE.—The Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services, in an easily understandable format, a list of the names of the following:

(i) The eligible professionals (or, in the case of reporting under paragraph (3)(C), the group practices) who satisfactorily submitted data on quality measures under this subsection.

(ii) The eligible professionals (or, in the case of reporting under paragraph (3)(C), the group practices) who are successful electronic prescribers.

(H) FEEDBACK.—The Secretary shall provide timely feedback to eligible professionals on the performance of the eligible professional with respect to satisfactorily submitting data on quality measures under this subsection.

(I) INFORMAL APPEALS PROCESS.—The Secretary shall, by not later than January 1, 2011, establish and have in place an informal process for eligible professionals to seek a review of the determination that an eligible professional did not satisfactorily submit data on quality measures under this subsection.

(6) DEFINITIONS.—For purposes of this subsection:

(A) ELIGIBLE PROFESSIONAL; COVERED PROFESSIONAL SERVICES.—The terms "eligible professional" and "covered professional services" have the meanings given such termsin subsection (k)(3).

(B) PHYSICIAN REPORTING SYSTEM.—The term "physician reporting system" means the system established under subsection (k).

(C) REPORTING PERIOD.—

(i) IN GENERAL.—Subject to clauses (ii) and (iii), the term "reporting period" means—

(I) for 2007, the period beginning on July 1, 2007, and ending on December 31, 2007; and

(II) for 2008 and subsequent years, the entire year.

(ii) AUTHORITY TO REVISE REPORTING PERIOD.—For years after 2009, the Secretary may revise the reporting period under clause (i) if the Secretary determines such revision is appropriate, produces valid results on measures reported, and is consistent with the goals of maximizing scientific validity and reducing administrative burden. If the Secretary revises such period pursuant to the preceding sentence, the term "reporting period" shall mean such revised period.

(iii) REFERENCE.—Any reference in this subsection to a reporting period with respect to the application of subsection (a)(5) (a)(8) shall be deemed a reference to the reporting period under subsection (a)(5)(D)(iii) or the quality reporting period under subsection (a)(8)(D)(iii), respectively.

(7) INTEGRATION OF PHYSICIAN QUALITY REPORTING AND EHR REPORTING.—Not later than January 1, 2012, the Secretary shall develop a plan to integrate reporting on quality measures under this subsection with reporting requirements under sub-

section (o) relating to the meaningful use of electronic health records. Such integration shall consist of the following:

(A) The selection of measures, the reporting of which would both demonstrate—

(i) meaningful use of an electronic health record for purposes of subsection (o); and

(ii) quality of care furnished to an individual.

(B) Such other activities as specified by the Secretary.

(8) ADDITIONAL INCENTIVE PAYMENT.—

(A) IN GENERAL.—For 2011 through 2014, if an eligible professional meets the requirements described in subparagraph (B), the applicable quality percent for such year, as described in clauses (iii) and (iv) of paragraph (1)(B), shall be increased by 0.5 percentage points.

(B) REQUIREMENTS DESCRIBED.—In order to qualify for the additional incentive payment described in subparagraph (A), an eligible professional shall meet the following requirements:

(i) The eligible professional shall—

(I) satisfactorily submit data on quality measures for purposes of paragraph (1) for a year; and

(II) have such data submitted on their behalf through a Maintenance of Certification Program (as defined in subparagraph (C)(i)) that meets—

(aa) the criteria for a registry (as described in subsection (k)(4)); or

(bb) an alternative form and manner determined appropriate by the Secretary.

(ii) The eligible professional, more frequently than is required to qualify for or maintain board certification status—

(I) participates in such a Maintenance of Certification program for a year; and

(II) successfully completes a qualified Maintenance of Certification Program practice assessment (as defined in subparagraph (C)(ii)) for such year.

(iii) A Maintenance of Certification program submits to the Secretary, on behalf of the eligible professional, information—

(I) in a form and manner specified by the Secretary, that the eligible professional has successfully met the requirements of clause (ii) (which may be in the form of a structural measure);

(II) if requested by the Secretary, on the survey of patient experience with care (as described in subparagraph (C)(ii)(II)); and

(III) as the Secretary may require, on the methods, measures, and data used under the Maintenance of Certification Program and the qualified Maintenance of Certification Program practice assessment.

(C) DEFINITIONS.—For purposes of this paragraph:

(i) The term "Maintenance of Certification Program" means a continuous assessment program, such as

qualified American Board of Medical Specialties Maintenance of Certification program or an equivalent program (as determined by the Secretary), that advances quality and the lifelong learning and self-assessment of board certified specialty physicians by focusing on the competencies of patient care, medical knowledge, practice-based learning, interpersonal and communication skills and professionalism. Such a program shall include the following:

(I) The program requires the physician to maintain a valid, unrestricted medical license in the United States.

(II) The program requires a physician to participate in educational and self-assessment programs that require an assessment of what was learned.

(III) The program requires a physician to demonstrate, through a formalized, secure examination, that the physician has the fundamental diagnostic skills, medical knowledge, and clinical judgment to provide quality care in their respective specialty.

(IV) The program requires successful completion of a qualified Maintenance of Certification Program practice assessment as described in clause (ii).

(ii) The term "qualified Maintenance of Certification Program practice assessment" means an assessment of a physician's practice that—

(I) includes an initial assessment of an eligible professional's practice that is designed to demonstrate the physician's use of evidence-based medicine;

(II) includes a survey of patient experience with care; and

(III) requires a physician to implement a quality improvement intervention to address a practice weakness identified in the initial assessment under subclause (I) and then to remeasure to assess performance improvement after such intervention.

(9) CONTINUED APPLICATION FOR PURPOSES OF MIPS AND FOR CERTAIN PROFESSIONALS VOLUNTEERING TO REPORT.—The Secretary shall, in accordance with subsection (q)(1)(F), carry out the processes under this subsection—

(A) for purposes of subsection (q); and

(B) for eligible professionals who are not MIPS eligible professionals (as defined in subsection (q)(1)(C)) for the year involved.

(n) PHYSICIAN FEEDBACK PROGRAM.—

(1) ESTABLISHMENT.—

(A) IN GENERAL.—

(i) ESTABLISHMENT.—The Secretary shall establish a Physician Feedback Program (in this subsection referred to as the "Program").

(ii) REPORTS ON RESOURCES.—The Secretary shall use claims data under this title (and may use other data) to provide confidential reports to physicians (and, as determined appropriate by the Secretary, to groups of physicians) that measure the resources involved in furnishing care to individuals under this title.

(iii) INCLUSION OF CERTAIN INFORMATION.—If determined appropriate by the Secretary, the Secretary may include information on the quality of care furnished to individuals under this title by the physician (or group of physicians) in such reports.

(B) RESOURCE USE.—The resources described in subparagraph (A)(ii) may be measured—

(i) on an episode basis;

(ii) on a per capita basis; or

(iii) on both an episode and a per capita basis.

(2) IMPLEMENTATION.—The Secretary shall implement the Program by not later than January 1, 2009.

(3) DATA FOR REPORTS.—To the extent practicable, reports under the Program shall be based on the most recent data available.

(4) AUTHORITY TO FOCUS INITIAL APPLICATION.—The Secretary may focus the initial application of the Program as appropriate, such as focusing the Program on—

(A) physician specialties that account for a certain percentage of all spending for physicians' services under this title;

(B) physicians who treat conditions that have a high cost or a high volume, or both, under this title;

(C) physicians who use a high amount of resources compared to other physicians;

(D) physicians practicing in certain geographic areas; or

(E) physicians who treat a minimum number of individuals under this title.

(5) AUTHORITY TO EXCLUDE CERTAIN INFORMATION IF INSUFFICIENT INFORMATION.—The Secretary may exclude certain information regarding a service from a report under the Program with respect to a physician (or group of physicians) if the Secretary determines that there is insufficient information relating to that service to provide a valid report on that service.

(6) ADJUSTMENT OF DATA.—To the extent practicable, the Secretary shall make appropriate adjustments to the data used in preparing reports under the Program, such as adjustments to take into account variations in health status and other patient characteristics. For adjustments for reports on utilization under paragraph (9), see subparagraph (D) of such paragraph.

(7) EDUCATION AND OUTREACH.—The Secretary shall provide for education and outreach activities to physicians on the operation of, and methodologies employed under, the Program.

(8) DISCLOSURE EXEMPTION.—Reports under the Program shall be exempt from disclosure under section 552 of title 5, United States Code.

(9) REPORTS ON UTILIZATION.—

(A) DEVELOPMENT OF EPISODE GROUPER.—

(i) IN GENERAL.—The Secretary shall develop an episode grouper that combines separate but clinically related items and services into an episode of care for an individual, as appropriate.

(ii) TIMELINE FOR DEVELOPMENT.—The episode grouper described in subparagraph (A) shall be developed by not later than January 1, 2012.

(iii) PUBLIC AVAILABILITY.—The Secretary shall make the details of the episode grouper described in subparagraph (A) available to the public.

(iv) ENDORSEMENT.—The Secretary shall seek endorsement of the episode grouper described in subparagraph (A) by the entity with a contract under section 1890(a).

(B) REPORTS ON UTILIZATION.—Effective beginning with 2012, the Secretary shall provide reports to physicians that compare, as determined appropriate by the Secretary, patterns of resource use of the individual physician to such patterns of other physicians.

(C) ANALYSIS OF DATA.—The Secretary shall, for purposes of preparing reports under this paragraph, establish methodologies as appropriate, such as to—

(i) attribute episodes of care, in whole or in part, to physicians;

(ii) identify appropriate physicians for purposes of comparison under subparagraph (B); and

(iii) aggregate episodes of care attributed to a physician under clause (i) into a composite measure per individual.

(D) DATA ADJUSTMENT.—In preparing reports under this paragraph, the Secretary shall make appropriate adjustments, including adjustments—

(i) to account for differences in socioeconomic and demographic characteristics, ethnicity, and health status of individuals (such as to recognize that less healthy individuals may require more intensive interventions); and

(ii) to eliminate the effect of geographic adjustments in payment rates (as described in subsection (e)).

(E) PUBLIC AVAILABILITY OF METHODOLOGY.—The Secretary shall make available to the public—

(i) the methodologies established under subparagraph (C);

(ii) information regarding any adjustments made to data under subparagraph (D); and

(iii) aggregate reports with respect to physicians.

(F) DEFINITION OF PHYSICIAN.—In this paragraph:

(i) IN GENERAL.—The term "physician" has the meaning given that term in section 1861(r)(1).

(ii) TREATMENT OF GROUPS.—Such term includes, as the Secretary determines appropriate, a group of physicians.

(G) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the establishment of the methodology

under subparagraph (C), including the determination of an episode of care under such methodology.

(10) COORDINATION WITH OTHER VALUE-BASED PURCHASING REFORMS.—The Secretary shall coordinate the Program with the value-based payment modifier established under subsection (p) and, as the Secretary determines appropriate, other similar provisions of this title.

(11) REPORTS ENDING WITH 2017.—Reports under the Program shall not be provided after December 31, 2017. See subsection (q)(12) for reports under the eligible professionals Merit-based Incentive Payment System.

(o) INCENTIVES FOR ADOPTION AND MEANINGFUL USE OF CERTIFIED EHR TECHNOLOGY.—

(1) INCENTIVE PAYMENTS.—

(A) IN GENERAL.—

(i) IN GENERAL.—Subject to the succeeding subparagraphs of this paragraph, with respect to covered professional services furnished by an eligible professional during a payment year (as defined in subparagraph (E)), if the eligible professional is a meaningful EHR user (as determined under paragraph (2)) for the EHR reporting period with respect to such year, in addition to the amount otherwise paid under this part, there also shall be paid to the eligible professional (or to an employer or facility in the cases described in clause (A) of section 1842(b)(6)), from the Federal Supplementary Medical Insurance Trust Fund established under section 1841 an amount equal to 75 percent of the Secretary's estimate (based on claims submitted not later than 2 months after the end of the payment year) of the allowed charges under this part for all such covered professional services furnished by the eligible professional during such year.

(ii) NO INCENTIVE PAYMENTS WITH RESPECT TO YEARS AFTER 2016.—No incentive payments may be made under this subsection with respect to a year after 2016.

(B) LIMITATIONS ON AMOUNTS OF INCENTIVE PAYMENTS.—

(i) IN GENERAL.—In no case shall the amount of the incentive payment provided under this paragraph for an eligible professional for a payment year exceed the applicable amount specified under this subparagraph with respect to such eligible professional and such year.

(ii) AMOUNT.—Subject to clauses (iii) through (v), the applicable amount specified in this subparagraph for an eligible professional is as follows:

(I) For the first payment year for such professional, $15,000 (or, if the first payment year for such eligible professional is 2011 or 2012, $18,000).

(II) For the second payment year for such professional, $12,000.

(III) For the third payment year for such professional, $8,000.

(IV) For the fourth payment year for such professional, $4,000.

(V) For the fifth payment year for such professional, $2,000.

(VI) For any succeeding payment year for such professional, $0.

(iii) PHASE DOWN FOR ELIGIBLE PROFESSIONALS FIRST ADOPTING EHR AFTER 2013.—If the first payment year for an eligible professional is after 2013, then the amount specified in this subparagraph for a payment year for such professional is the same as the amount specified in clause (ii) for such payment year for an eligible professional whose first payment year is 2013.

(iv) INCREASE FOR CERTAIN ELIGIBLE PROFESSIONALS.—In the case of an eligible professional who predominantly furnishes services under this part in an area that is designated by the Secretary (under section 332(a)(1)(A) of the Public Health Service Act) as a health professional shortage area, the amount that would otherwise apply for a payment year for such professional under subclauses (I) through (V) of clause (ii) shall be increased by 10 percent. In implementing the preceding sentence, the Secretary may, as determined appropriate, apply provisions of subsections (m) and (u) of section 1833 in a similar manner as such provisions apply under such subsection.

(v) NO INCENTIVE PAYMENT IF FIRST ADOPTING AFTER 2014.—If the first payment year for an eligible professional is after 2014 then the applicable amount specified in this subparagraph for such professional for such year and any subsequent year shall be $0.

(C) NON-APPLICATION TO HOSPITAL-BASED ELIGIBLE PROFESSIONALS.—

(i) IN GENERAL.—No incentive payment may be made under this paragraph in the case of a hospital-based eligible professional.

(ii) HOSPITAL-BASED ELIGIBLE PROFESSIONAL.—For purposes of clause (i), the term "hospital-based eligible professional" means, with respect to covered professional services furnished by an eligible professional during the EHR reporting period for a payment year, an eligible professional, such as a pathologist, anesthesiologist, or emergency physician, who furnishes substantially all of such services in a hospital inpatient or emergency room setting and through the use of the facilities and equipment, including qualified electronic health records, of the hospital. The determination of whether an eligible professional is a hospital-based eligible professional shall be made on the basis of the site of service (as defined by the Secretary) and without regard to any employment or billing arrangement between the eligible professional and any other provider.

(D) PAYMENT.—

(i) FORM OF PAYMENT.—The payment under this paragraph may be in the form of a single consolidated payment or in the form of such periodic installments as the Secretary may specify.

(ii) COORDINATION OF APPLICATION OF LIMITATION FOR PROFESSIONALS IN DIFFERENT PRACTICES.—In the case of an eligible professional furnishing covered professional services in more than one practice (as specified by the Secretary), the Secretary shall establish rules to coordinate the incentive payments, including the application of the limitation on amounts of such incentive payments under this paragraph, among such practices.

(iii) COORDINATION WITH MEDICAID.—The Secretary shall seek, to the maximum extent practicable, to avoid duplicative requirements from Federal and State governments to demonstrate meaningful use of certified EHR technology under this title and title XIX. The Secretary may also adjust the reporting periods under such title and such subsections in order to carry out this clause.

(E) PAYMENT YEAR DEFINED.—

(i) IN GENERAL.—For purposes of this subsection, the term "payment year" means a year beginning with 2011.

(ii) FIRST, SECOND, ETC. PAYMENT YEAR.—The term "first payment year" means, with respect to covered professional services furnished by an eligible professional, the first year for which an incentive payment is made for such services under this subsection. The terms "second payment year", "third payment year", "fourth payment year", and "fifth payment year" mean, with respect to covered professional services furnished by such eligible professional, each successive year immediately following the first payment year for such professional.

(2) MEANINGFUL EHR USER.—

(A) IN GENERAL.—An eligible professional shall be treated as a meaningful EHR user for an EHR reporting period for a payment year (or, for purposes of subsection (a)(7), for an EHR reporting period under such subsection for a year, or pursuant to subparagraph (D) for purposes of subsection (q), for a performance period under such subsection for a year) if each of the following requirements is met:

(i) MEANINGFUL USE OF CERTIFIED EHR TECHNOLOGY.—The eligible professional demonstrates to the satisfaction of the Secretary, in accordance with subparagraph (C)(i), that during such period the professional is using certified EHR technology in a meaningful manner, which shall include the use of electronic prescribing as determined to be appropriate by the Secretary.

(ii) INFORMATION EXCHANGE.—The eligible professional demonstrates to the satisfaction of the Secretary, in accordance with subparagraph (C)(i), that

during such period such certified EHR technology is connected in a manner that provides, in accordance with law and standards applicable to the exchange of information, for the electronic exchange of health information to improve the quality of health care, such as promoting care coordination, and the professional demonstrates (through a process specified by the Secretary, such as the use of an attestation) that the professional has not knowingly and willfully taken action (such as to disable functionality) to limit or restrict the compatibility or interoperability of the certified EHR technology.

(iii) REPORTING ON MEASURES USING EHR.—Subject to subparagraph (B)(ii) and subsection (q)(5)(B)(ii)(II) and using such certified EHR technology, the eligible professional submits information for such period, in a form and manner specified by the Secretary, on such clinical quality measures and such other measures as selected by the Secretary under subparagraph (B)(i).

The Secretary may provide for the use of alternative means for meeting the requirements of clauses (i), (ii), and (iii) in the case of an eligible professional furnishing covered professional services in a group practice (as defined by the Secretary). The Secretary shall seek to improve the use of electronic health records and health care quality over time by requiring more stringent measures of meaningful use selected under this paragraph.

(B) REPORTING ON MEASURES.—

(i) SELECTION.—The Secretary shall select measures for purposes of subparagraph (A)(iii) but only consistent with the following:

(I) The Secretary shall provide preference to clinical quality measures that have been endorsed by the entity with a contract with the Secretary under section 1890(a).

(II) Prior to any measure being selected under this subparagraph, the Secretary shall publish in the Federal Register such measure and provide for a period of public comment on such measure.

(ii) LIMITATION.—The Secretary may not require the electronic reporting of information on clinical quality measures under subparagraph (A)(iii) unless the Secretary has the capacity to accept the information electronically, which may be on a pilot basis.

(iii) COORDINATION OF REPORTING OF INFORMATION.—In selecting such measures, and in establishing the form and manner for reporting measures under subparagraph (A)(iii), the Secretary shall seek to avoid redundant or duplicative reporting otherwise required, including reporting under subsection (k)(2)(C).

(C) DEMONSTRATION OF MEANINGFUL USE OF CERTIFIED EHR TECHNOLOGY AND INFORMATION EXCHANGE.—

(i) IN GENERAL.—A professional may satisfy the demonstration requirement of clauses (i) and (ii) of

subparagraph (A) through means specified by the Secretary, which may include—

(I) an attestation;

(II) the submission of claims with appropriate coding (such as a code indicating that a patient encounter was documented using certified EHR technology);

(III) a survey response;

(IV) reporting under subparagraph (A)(iii); and

(V) other means specified by the Secretary.

(ii) USE OF PART D DATA.—Notwithstanding sections 1860D–15(d)(2)(B) and 1860D–15(f)(2), the Secretary may use data regarding drug claims submitted for purposes of section 1860D–15 that are necessary for purposes of subparagraph (A).

(D) CONTINUED APPLICATION FOR PURPOSES OF MIPS.—With respect to 2019 and each subsequent payment year, the Secretary shall, for purposes of subsection (q) and in accordance with paragraph (1)(F) of such subsection, determine whether an eligible professional who is a MIPS eligible professional (as defined in subsection (q)(1)(C)) for such year is a meaningful EHR user under this paragraph for the performance period under subsection (q) for such year.

(3) APPLICATION.—

(A) PHYSICIAN REPORTING SYSTEM RULES.—Paragraphs (5), (6), and (8) of subsection (k) shall apply for purposes of this subsection in the same manner as they apply for purposes of such subsection.

(B) COORDINATION WITH OTHER PAYMENTS.—The provisions of this subsection shall not be taken into account in applying the provisions of subsection (m) of this section and of section 1833(m) and any payment under such provisions shall not be taken into account in computing allowable charges under this subsection.

(C) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, of—

(i) the methodology and standards for determining payment amounts under this subsection and payment adjustments under subsection (a)(7)(A), including the limitation under paragraph (1)(B) and coordination under clauses (ii) and (iii) of paragraph (1)(D);

(ii) the methodology and standards for determining a meaningful EHR user under paragraph (2), including selection of measures under paragraph (2)(B), specification of the means of demonstrating meaningful EHR use under paragraph (2)(C), and the hardship exception under subsection (a)(7)(B);

(iii) the methodology and standards for determining a hospital-based eligible professional under paragraph (1)(C); and

(iv) the specification of reporting periods under paragraph (5) and the selection of the form of payment under paragraph (1)(D)(i).

(D) POSTING ON WEBSITE.—The Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services, in an easily understandable format, a list of the names, business addresses, and business phone numbers of the eligible professionals who are meaningful EHR users and, as determined appropriate by the Secretary, of group practices receiving incentive payments under paragraph (1).

(4) CERTIFIED EHR TECHNOLOGY DEFINED.—For purposes of this section, the term "certified EHR technology" means a qualified electronic health record (as defined in section 3000(13) of the Public Health Service Act) that is certified pursuant to section 3001(c)(5) of such Act as meeting standards adopted under section 3004 of such Act that are applicable to the type of record involved (as determined by the Secretary, such as an ambulatory electronic health record for office-based physicians or an inpatient hospital electronic health record for hospitals).

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

(A) COVERED PROFESSIONAL SERVICES.—The term "covered professional services" has the meaning given such term in subsection (k)(3).

(B) EHR REPORTING PERIOD.—The term "EHR reporting period" means, with respect to a payment year, any period (or periods) as specified by the Secretary.

(C) ELIGIBLE PROFESSIONAL.—The term "eligible professional" means a physician, as defined in section 1861(r).

(p) ESTABLISHMENT OF VALUE-BASED PAYMENT MODIFIER.—

(1) IN GENERAL.—The Secretary shall establish a payment modifier that provides for differential payment to a physician or a group of physicians under the fee schedule established under subsection (b) based upon the quality of care furnished compared to cost (as determined under paragraphs (2) and (3), respectively) during a performance period. Such payment modifier shall be separate from the geographic adjustment factors established under subsection (e).

(2) QUALITY.—

(A) IN GENERAL.—For purposes of paragraph (1), quality of care shall be evaluated, to the extent practicable, based on a composite of measures of the quality of care furnished (as established by the Secretary under subparagraph (B)).

(B) MEASURES.—

(i) The Secretary shall establish appropriate measures of the quality of care furnished by a physician or group of physicians to individuals enrolled under this part, such as measures that reflect health outcomes. Such measures shall be risk adjusted as determined appropriate by the Secretary.

(ii) The Secretary shall seek endorsement of the measures established under this subparagraph by the entity with a contract under section 1890(a).

(C) CONTINUED APPLICATION FOR PURPOSES OF MIPS.—The Secretary shall, in accordance with subsection (q)(1)(F), carry out subparagraph (B) for purposes of subsection (q).

(3) COSTS.—For purposes of paragraph (1), costs shall be evaluated, to the extent practicable, based on a composite of appropriate measures of costs established by the Secretary (such as the composite measure under the methodology established under subsection (n)(9)(C)(iii)) that eliminate the effect of geographic adjustments in payment rates (as described in subsection (e)), and take into account risk factors (such as socioeconomic and demographic characteristics, ethnicity, and health status of individuals (such as to recognize that less healthy individuals may require more intensive interventions) and other factors determined appropriate by the Secretary. With respect to 2019 and each subsequent year, the Secretary shall, in accordance with subsection (q)(1)(F), carry out this paragraph for purposes of subsection (q).

(4) IMPLEMENTATION.—

(A) PUBLICATION OF MEASURES, DATES OF IMPLEMENTATION, PERFORMANCE PERIOD.—Not later than January 1, 2012, the Secretary shall publish the following:

(i) The measures of quality of care and costs established under paragraphs (2) and (3), respectively.

(ii) The dates for implementation of the payment modifier (as determined under subparagraph (B)).

(iii) The initial performance period (as specified under subparagraph (B)(ii)).

(B) DEADLINES FOR IMPLEMENTATION.—

(i) INITIAL IMPLEMENTATION.—Subject to the preceding provisions of this subparagraph, the Secretary shall begin implementing the payment modifier established under this subsection through the rulemaking process during 2013 for the physician fee schedule established under subsection (b).

(ii) INITIAL PERFORMANCE PERIOD.—

(I) IN GENERAL.—The Secretary shall specify an initial performance period for application of the payment modifier established under this subsection with respect to 2015.

(II) PROVISION OF INFORMATION DURING INITIAL PERFORMANCE PERIOD.—During the initial performance period, the Secretary shall, to the extent practicable, provide information to physicians and groups of physicians about the quality of care furnished by the physician or group of physicians to individuals enrolled under this part compared to cost (as determined under paragraphs (2) and (3), respectively) with respect to the performance period.

(iii) APPLICATION.—The Secretary shall apply the payment modifier established under this subsection for items and services furnished on or after January 1, 2015, with respect to specific physicians and groups of physicians the Secretary determines appropriate, and for services furnished on or after January 1, 2017, with respect to all physicians and groups of physicians. Such payment modifier shall not be applied for

items and services furnished on or after January 1, 2019.

(C) BUDGET NEUTRALITY.—The payment modifier established under this subsection shall be implemented in a budget neutral manner.

(5) SYSTEMS-BASED CARE.—The Secretary shall, as appropriate, apply the payment modifier established under this subsection in a manner that promotes systems-based care.

(6) CONSIDERATION OF SPECIAL CIRCUMSTANCES OF CERTAIN PROVIDERS.—In applying the payment modifier under this subsection, the Secretary shall, as appropriate, take into account the special circumstances of physicians or groups of physicians in rural areas and other underserved communities.

(7) APPLICATION.—For purposes of the initial application of the payment modifier established under this subsection during the period beginning on January 1, 2015, and ending on December 31, 2016, the term "physician" has the meaning given such term in section 1861(r). On or after January 1, 2017, the Secretary may apply this subsection to eligible professionals (as defined in subsection (k)(3)(B)) as the Secretary determines appropriate.

(8) DEFINITIONS.—For purposes of this subsection:

(A) COSTS.—The term "costs" means expenditures per individual as determined appropriate by the Secretary. In making the determination under the preceding sentence, the Secretary may take into account the amount of growth in expenditures per individual for a physician compared to the amount of such growth for other physicians.

(B) PERFORMANCE PERIOD.—The term "performance period" means a period specified by the Secretary.

(9) COORDINATION WITH OTHER VALUE-BASED PURCHASING REFORMS.—The Secretary shall coordinate the value-based payment modifier established under this subsection with the Physician Feedback Program under subsection (n) and, as the Secretary determines appropriate, other similar provisions of this title.

(10) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of—

(A) the establishment of the value-based payment modifier under this subsection;

(B) the evaluation of quality of care under paragraph (2), including the establishment of appropriate measures of the quality of care under paragraph (2)(B);

(C) the evaluation of costs under paragraph (3), including the establishment of appropriate measures of costs under such paragraph;

(D) the dates for implementation of the value-based payment modifier;

(E) the specification of the initial performance period and any other performance period under paragraphs (4)(B)(ii) and (8)(B), respectively;

(F) the application of the value-based payment modifier under paragraph (7); and

(G) the determination of costs under paragraph (8)(A).

(q) MERIT-BASED INCENTIVE PAYMENT SYSTEM.—

(1) ESTABLISHMENT.—

(A) IN GENERAL.—Subject to the succeeding provisions of this subsection, the Secretary shall establish an eligible professional Merit-based Incentive Payment System (in this subsection referred to as the "MIPS") under which the Secretary shall—

(i) develop a methodology for assessing the total performance of each MIPS eligible professional according to performance standards under paragraph (3) for a performance period (as established under paragraph (4)) for a year;

(ii) using such methodology, provide for a composite performance score in accordance with paragraph (5) for each such professional for each performance period; and

(iii) use such composite performance score of the MIPS eligible professional for a performance period for a year to determine and apply a MIPS adjustment factor (and, as applicable, an additional MIPS adjustment factor) under paragraph (6) to the professional for the year.

Notwithstanding subparagraph (C)(ii), under the MIPS, the Secretary shall permit any eligible professional (as defined in subsection (k)(3)(B)) to report on applicable measures and activities described in paragraph (2)(B).

(B) PROGRAM IMPLEMENTATION.—The MIPS shall apply to payments for items and services furnished on or after January 1, 2019.

(C) MIPS ELIGIBLE PROFESSIONAL DEFINED.—

(i) IN GENERAL.—For purposes of this subsection, subject to clauses (ii) and (iv), the term "MIPS eligible professional" means—

(I) for the first and second years for which the MIPS applies to payments (and for the performance period for such first and second year), a physician (as defined in section 1861(r)), a physician assistant, nurse practitioner, and clinical nurse specialist (as such terms are defined in section 1861(aa)(5)), a certified registered nurse anesthetist (as defined in section 1861(bb)(2)), and a group that includes such professionals; and

(II) for the third year for which the MIPS applies to payments (and for the performance period for such third year) and for each succeeding year (and for the performance period for each such year), the professionals described in subclause (I), such other eligible professionals (as defined in subsection (k)(3)(B)) as specified by the Secretary, and a group that includes such professionals.

(ii) EXCLUSIONS.—For purposes of clause (i), the term "MIPS eligible professional" does not include, with respect to a year, an eligible professional (as defined in subsection (k)(3)(B)) who—

(I) is a qualifying APM participant (as defined in section 1833(z)(2));

(II) subject to clause (vii), is a partial qualifying APM participant (as defined in clause (iii)) for the most recent period for which data are available and who, for the performance period with respect to such year, does not report on applicable measures and activities described in paragraph (2)(B) that are required to be reported by such a professional under the MIPS; or

(III) for the performance period with respect to such year, does not exceed the low-volume threshold measurement selected under clause (iv).

(iii) PARTIAL QUALIFYING APM PARTICIPANT.—For purposes of this subparagraph, the term "partial qualifying APM participant" means, with respect to a year, an eligible professional for whom the Secretary determines the minimum payment percentage (or percentages), as applicable, described in paragraph (2) of section 1833(z) for such year have not been satisfied, but who would be considered a qualifying APM participant (as defined in such paragraph) for such year if—

(I) with respect to 2019 and 2020, the reference in subparagraph (A) of such paragraph to 25 percent was instead a reference to 20 percent;

(II) with respect to 2021 and 2022—

(aa) the reference in subparagraph (B)(i) of such paragraph to 50 percent was instead a reference to 40 percent; and

(bb) the references in subparagraph (B)(ii) of such paragraph to 50 percent and 25 percent of such paragraph were instead references to 40 percent and 20 percent, respectively; and

(III) with respect to 2023 and subsequent years—

(aa) the reference in subparagraph (C)(i) of such paragraph to 75 percent was instead a reference to 50 percent; and

(bb) the references in subparagraph (C)(ii) of such paragraph to 75 percent and 25 percent of such paragraph were instead references to 50 percent and 20 percent, respectively.

(iv) SELECTION OF LOW-VOLUME THRESHOLD MEASUREMENT.—The Secretary shall select a low-volume threshold to apply for purposes of clause (ii)(III), which may include one or more or a combination of the following:

(I) The minimum number (as determined by the Secretary) of individuals enrolled under this part who are treated by the eligible professional for the performance period involved.

(II) The minimum number (as determined by the Secretary) of items and services furnished to

individuals enrolled under this part by such professional for such performance period.

(III) The minimum amount (as determined by the Secretary) of allowed charges billed by such professional under this part for such performance period.

(v) TREATMENT OF NEW MEDICARE ENROLLED ELIGIBLE PROFESSIONALS.—In the case of a professional who first becomes a Medicare enrolled eligible professional during the performance period for a year (and had not previously submitted claims under this title such as a person, an entity, or a part of a physician group or under a different billing number or tax identifier), such professional shall not be treated under this subsection as a MIPS eligible professional until the subsequent year and performance period for such subsequent year.

(vi) CLARIFICATION.—In the case of items and services furnished during a year by an individual who is not a MIPS eligible professional (including pursuant to clauses (ii) and (v)) with respect to a year, in no case shall a MIPS adjustment factor (or additional MIPS adjustment factor) under paragraph (6) apply to such individual for such year.

(vii) PARTIAL QUALIFYING APM PARTICIPANT CLARIFICATIONS.—

(I) TREATMENT AS MIPS ELIGIBLE PROFESSIONAL.—In the case of an eligible professional who is a partial qualifying APM participant, with respect to a year, and who, for the performance period for such year, reports on applicable measures and activities described in paragraph (2)(B) that are required to be reported by such a professional under the MIPS, such eligible professional is considered to be a MIPS eligible professional with respect to such year.

(II) NOT ELIGIBLE FOR QUALIFYING APM PARTICIPANT PAYMENTS.—In no case shall an eligible professional who is a partial qualifying APM participant, with respect to a year, be considered a qualifying APM participant (as defined in paragraph (2) of section 1833(z)) for such year or be eligible for the additional payment under paragraph (1) of such section for such year.

(D) APPLICATION TO GROUP PRACTICES.—

(i) IN GENERAL.—Under the MIPS:

(I) QUALITY PERFORMANCE CATEGORY.—The Secretary shall establish and apply a process that includes features of the provisions of subsection (m)(3)(C) for MIPS eligible professionals in a group practice with respect to assessing performance of such group with respect to the performance category described in clause (i) of paragraph (2)(A).

(II) OTHER PERFORMANCE CATEGORIES.—The Secretary may establish and apply a process that includes features of the provisions of subsection (m)(3)(C) for MIPS eligible professionals in a group practice with respect to assessing the performance of such group with respect to the performance categories described in clauses (ii) through (iv) of such paragraph.

(ii) ENSURING COMPREHENSIVENESS OF GROUP PRACTICE ASSESSMENT.—The process established under clause (i) shall to the extent practicable reflect the range of items and services furnished by the MIPS eligible professionals in the group practice involved.

(E) USE OF REGISTRIES.—Under the MIPS, the Secretary shall encourage the use of qualified clinical data registries pursuant to subsection (m)(3)(E) in carrying out this subsection.

(F) APPLICATION OF CERTAIN PROVISIONS.—In applying a provision of subsection (k), (m), (o), or (p) for purposes of this subsection, the Secretary shall—

(i) adjust the application of such provision to ensure the provision is consistent with the provisions of this subsection; and

(ii) not apply such provision to the extent that the provision is duplicative with a provision of this subsection.

(G) ACCOUNTING FOR RISK FACTORS.—

(i) RISK FACTORS.—Taking into account the relevant studies conducted and recommendations made in reports under section 2(d) of the Improving Medicare Post-Acute Care Transformation Act of 2014, and, as appropriate, other information, including information collected before completion of such studies and recommendations, the Secretary, on an ongoing basis, shall, as the Secretary determines appropriate and based on an individual's health status and other risk factors—

(I) assess appropriate adjustments to quality measures, resource use measures, and other measures used under the MIPS; and

(II) assess and implement appropriate adjustments to payment adjustments, composite performance scores, scores for performance categories, or scores for measures or activities under the MIPS.

(2) MEASURES AND ACTIVITIES UNDER PERFORMANCE CATEGORIES.—

(A) PERFORMANCE CATEGORIES.—Under the MIPS, the Secretary shall use the following performance categories (each of which is referred to in this subsection as a performance category) in determining the composite performance score under paragraph (5):

(i) Quality.

(ii) Resource use.

(iii) Clinical practice improvement activities.

(iv) Meaningful use of certified EHR technology.

(B) MEASURES AND ACTIVITIES SPECIFIED FOR EACH CATEGORY.—For purposes of paragraph (3)(A) and subject to subparagraph (C), measures and activities specified for a performance period (as established under paragraph (4)) for a year are as follows:

(i) QUALITY.—For the performance category described in subparagraph (A)(i), the quality measures included in the final measures list published under subparagraph (D)(i) for such year and the list of quality measures described in subparagraph (D)(vi) used by qualified clinical data registries under subsection (m)(3)(E).

(ii) RESOURCE USE.—For the performance category described in subparagraph (A)(ii), the measurement of resource use for such period under subsection (p)(3), using the methodology under subsection (r) as appropriate, and, as feasible and applicable, accounting for the cost of drugs under part D.

(iii) CLINICAL PRACTICE IMPROVEMENT ACTIVITIES.—For the performance category described in subparagraph (A)(iii), clinical practice improvement activities (as defined in subparagraph (C)(v)(III)) under subcategories specified by the Secretary for such period, which shall include at least the following:

(I) The subcategory of expanded practice access, such as same day appointments for urgent needs and after hours access to clinician advice.

(II) The subcategory of population management, such as monitoring health conditions of individuals to provide timely health care interventions or participation in a qualified clinical data registry.

(III) The subcategory of care coordination, such as timely communication of test results, timely exchange of clinical information to patients and other providers, and use of remote monitoring or telehealth.

(IV) The subcategory of beneficiary engagement, such as the establishment of care plans for individuals with complex care needs, beneficiary self-management assessment and training, and using shared decision-making mechanisms.

(V) The subcategory of patient safety and practice assessment, such as through use of clinical or surgical checklists and practice assessments related to maintaining certification.

(VI) The subcategory of participation in an alternative payment model (as defined in section 1833(z)(3)(C)).

In establishing activities under this clause, the Secretary shall give consideration to the circumstances of small practices (consisting of 15 or fewer professionals) and practices located in rural areas and in health professional shortage areas (as designated under section 332(a)(1)(A) of the Public Health Service Act).

(iv) MEANINGFUL EHR USE.—For the performance category described in subparagraph (A)(iv), the requirements established for such period under subsection (o)(2) for determining whether an eligible professional is a meaningful EHR user.

(C) ADDITIONAL PROVISIONS.—

(i) EMPHASIZING OUTCOME MEASURES UNDER THE QUALITY PERFORMANCE CATEGORY.—In applying subparagraph (B)(i), the Secretary shall, as feasible, emphasize the application of outcome measures.

(ii) APPLICATION OF ADDITIONAL SYSTEM MEASURES.—The Secretary may use measures used for a payment system other than for physicians, such as measures for inpatient hospitals, for purposes of the performance categories described in clauses (i) and (ii) of subparagraph (A). For purposes of the previous sentence, the Secretary may not use measures for hospital outpatient departments, except in the case of items and services furnished by emergency physicians, radiologists, and anesthesiologists.

(iii) GLOBAL AND POPULATION-BASED MEASURES.—The Secretary may use global measures, such as global outcome measures, and population-based measures for purposes of the performance category described in subparagraph (A)(i).

(iv) APPLICATION OF MEASURES AND ACTIVITIES TO NON-PATIENT-FACING PROFESSIONALS.—In carrying out this paragraph, with respect to measures and activities specified in subparagraph (B) for performance categories described in subparagraph (A), the Secretary—

(I) shall give consideration to the circumstances of professional types (or subcategories of those types determined by practice characteristics) who typically furnish services that do not involve face-to-face interaction with a patient; and

(II) may, to the extent feasible and appropriate, take into account such circumstances and apply under this subsection with respect to MIPS eligible professionals of such professional types or subcategories, alternative measures or activities that fulfill the goals of the applicable performance category.

In carrying out the previous sentence, the Secretary shall consult with professionals of such professional types or subcategories.

(v) CLINICAL PRACTICE IMPROVEMENT ACTIVITIES.—

(I) REQUEST FOR INFORMATION.—In initially applying subparagraph (B)(iii), the Secretary shall use a request for information to solicit recommendations from stakeholders to identify activities described in such subparagraph and specifying criteria for such activities.

(II) CONTRACT AUTHORITY FOR CLINICAL PRACTICE IMPROVEMENT ACTIVITIES PERFORMANCE CATEGORY.—In applying subparagraph (B)(iii), the

Secretary may contract with entities to assist the Secretary in—

(aa) identifying activities described in subparagraph (B)(iii);

(bb) specifying criteria for such activities; and

(cc) determining whether a MIPS eligible professional meets such criteria.

(III) CLINICAL PRACTICE IMPROVEMENT ACTIVITIES DEFINED.—For purposes of this subsection, the term "clinical practice improvement activity" means an activity that relevant eligible professional organizations and other relevant stakeholders identify as improving clinical practice or care delivery and that the Secretary determines, when effectively executed, is likely to result in improved outcomes.

(D) ANNUAL LIST OF QUALITY MEASURES AVAILABLE FOR MIPS ASSESSMENT.—

(i) IN GENERAL.—Under the MIPS, the Secretary, through notice and comment rulemaking and subject to the succeeding clauses of this subparagraph, shall, with respect to the performance period for a year, establish an annual final list of quality measures from which MIPS eligible professionals may choose for purposes of assessment under this subsection for such performance period. Pursuant to the previous sentence, the Secretary shall—

(I) not later than November 1 of the year prior to the first day of the first performance period under the MIPS, establish and publish in the Federal Register a final list of quality measures; and

(II) not later than November 1 of the year prior to the first day of each subsequent performance period, update the final list of quality measures from the previous year (and publish such updated final list in the Federal Register), by—

(aa) removing from such list, as appropriate, quality measures, which may include the removal of measures that are no longer meaningful (such as measures that are topped out);

(bb) adding to such list, as appropriate, new quality measures; and

(cc) determining whether or not quality measures on such list that have undergone substantive changes should be included in the updated list.

(ii) CALL FOR QUALITY MEASURES.—

(I) IN GENERAL.—Eligible professional organizations and other relevant stakeholders shall be requested to identify and submit quality measures to be considered for selection under this subparagraph in the annual list of quality measures published under clause (i) and to identify and submit

updates to the measures on such list. For purposes of the previous sentence, measures may be submitted regardless of whether such measures were previously published in a proposed rule or endorsed by an entity with a contract under section 1890(a).

(II) ELIGIBLE PROFESSIONAL ORGANIZATION DEFINED.—In this subparagraph, the term "eligible professional organization" means a professional organization as defined by nationally recognized specialty boards of certification or equivalent certification boards.

(iii) REQUIREMENTS.—In selecting quality measures for inclusion in the annual final list under clause (i), the Secretary shall—

(I) provide that, to the extent practicable, all quality domains (as defined in subsection (s)(1)(B)) are addressed by such measures; and

(II) ensure that such selection is consistent with the process for selection of measures under subsections (k), (m), and (p)(2).

(iv) PEER REVIEW.—Before including a new measure in the final list of measures published under clause (i) for a year, the Secretary shall submit for publication in applicable specialty-appropriate, peer-reviewed journals such measure and the method for developing and selecting such measure, including clinical and other data supporting such measure.

(v) MEASURES FOR INCLUSION.—The final list of quality measures published under clause (i) shall include, as applicable, measures under subsections (k), (m), and (p)(2), including quality measures from among—

(I) measures endorsed by a consensus-based entity;

(II) measures developed under subsection (s); and

(III) measures submitted under clause (ii)(I).

Any measure selected for inclusion in such list that is not endorsed by a consensus-based entity shall have a focus that is evidence-based.

(vi) EXCEPTION FOR QUALIFIED CLINICAL DATA REGISTRY MEASURES.—Measures used by a qualified clinical data registry under subsection (m)(3)(E) shall not be subject to the requirements under clauses (i), (iv), and (v). The Secretary shall publish the list of measures used by such qualified clinical data registries on the Internet website of the Centers for Medicare & Medicaid Services.

(vii) EXCEPTION FOR EXISTING QUALITY MEASURES.—Any quality measure specified by the Secretary under subsection (k) or (m), including under subsection (m)(3)(E), and any measure of quality of care established under subsection (p)(2) for the reporting period or performance period under the respective subsection

beginning before the first performance period under the MIPS—

(I) shall not be subject to the requirements under clause (i) (except under items (aa) and (cc) of subclause (II) of such clause) or to the requirement under clause (iv); and

(II) shall be included in the final list of quality measures published under clause (i) unless removed under clause (i)(II)(aa).

(viii) CONSULTATION WITH RELEVANT ELIGIBLE PROFESSIONAL ORGANIZATIONS AND OTHER RELEVANT STAKEHOLDERS.—Relevant eligible professional organizations and other relevant stakeholders, including State and national medical societies, shall be consulted in carrying out this subparagraph.

(ix) OPTIONAL APPLICATION.—The process under section 1890A is not required to apply to the selection of measures under this subparagraph.

(3) PERFORMANCE STANDARDS.—

(A) ESTABLISHMENT.—Under the MIPS, the Secretary shall establish performance standards with respect to measures and activities specified under paragraph (2)(B) for a performance period (as established under paragraph (4)) for a year.

(B) CONSIDERATIONS IN ESTABLISHING STANDARDS.—In establishing such performance standards with respect to measures and activities specified under paragraph (2)(B), the Secretary shall consider the following:

(i) Historical performance standards.

(ii) Improvement.

(iii) The opportunity for continued improvement.

(4) PERFORMANCE PERIOD.—The Secretary shall establish a performance period (or periods) for a year (beginning with 2019). Such performance period (or periods) shall begin and end prior to the beginning of such year and be as close as possible to such year. In this subsection, such performance period (or periods) for a year shall be referred to as the performance period for the year.

(5) COMPOSITE PERFORMANCE SCORE.—

(A) IN GENERAL.—Subject to the succeeding provisions of this paragraph and taking into account, as available and applicable, paragraph (1)(G), the Secretary shall develop a methodology for assessing the total performance of each MIPS eligible professional according to performance standards under paragraph (3) with respect to applicable measures and activities specified in paragraph (2)(B) with respect to each performance category applicable to such professional for a performance period (as established under paragraph (4)) for a year. Using such methodology, the Secretary shall provide for a composite assessment (using a scoring scale of 0 to 100) for each such professional for the performance period for such year. In this subsection such a composite assessment for such a professional with respect to a performance period shall be referred to as the

"composite performance score" for such professional for such performance period.

(B) INCENTIVE TO REPORT; ENCOURAGING USE OF CERTIFIED EHR TECHNOLOGY FOR REPORTING QUALITY MEASURES.—

(i) INCENTIVE TO REPORT.—Under the methodology established under subparagraph (A), the Secretary shall provide that in the case of a MIPS eligible professional who fails to report on an applicable measure or activity that is required to be reported by the professional, the professional shall be treated as achieving the lowest potential score applicable to such measure or activity.

(ii) ENCOURAGING USE OF CERTIFIED EHR TECHNOLOGY AND QUALIFIED CLINICAL DATA REGISTRIES FOR REPORTING QUALITY MEASURES.—Under the methodology established under subparagraph (A), the Secretary shall—

(I) encourage MIPS eligible professionals to report on applicable measures with respect to the performance category described in paragraph (2)(A)(i) through the use of certified EHR technology and qualified clinical data registries; and

(II) with respect to a performance period, with respect to a year, for which a MIPS eligible professional reports such measures through the use of such EHR technology, treat such professional as satisfying the clinical quality measures reporting requirement described in subsection (o)(2)(A)(iii) for such year.

(C) CLINICAL PRACTICE IMPROVEMENT ACTIVITIES PERFORMANCE SCORE.—

(i) RULE FOR CERTIFICATION.—A MIPS eligible professional who is in a practice that is certified as a patient-centered medical home or comparable specialty practice, as determined by the Secretary, with respect to a performance period shall be given the highest potential score for the performance category described in paragraph (2)(A)(iii) for such period.

(ii) APM PARTICIPATION.—Participation by a MIPS eligible professional in an alternative payment model (as defined in section 1833(z)(3)(C)) with respect to a performance period shall earn such eligible professional a minimum score of one-half of the highest potential score for the performance category described in paragraph (2)(A)(iii) for such performance period.

(iii) SUBCATEGORIES.—A MIPS eligible professional shall not be required to perform activities in each subcategory under paragraph (2)(B)(iii) or participate in an alternative payment model in order to achieve the highest potential score for the performance category described in paragraph (2)(A)(iii).

(D) ACHIEVEMENT AND IMPROVEMENT.—

(i) TAKING INTO ACCOUNT IMPROVEMENT.—Beginning with the second year to which the MIPS applies, in ad-

dition to the achievement of a MIPS eligible professional, if data sufficient to measure improvement is available, the methodology developed under subparagraph (A)—

(I) in the case of the performance score for the performance category described in clauses (i) and (ii) of paragraph (2)(A), shall take into account the improvement of the professional; and

(II) in the case of performance scores for other performance categories, may take into account the improvement of the professional.

(ii) ASSIGNING HIGHER WEIGHT FOR ACHIEVEMENT.—Subject to clause (i), under the methodology developed under subparagraph (A), the Secretary may assign a higher scoring weight under subparagraph (F) with respect to the achievement of a MIPS eligible professional than with respect to any improvement of such professional applied under clause (i) with respect to a measure, activity, or category described in paragraph (2).

(E) WEIGHTS FOR THE PERFORMANCE CATEGORIES.—

(i) IN GENERAL.—Under the methodology developed under subparagraph (A), subject to subparagraph (F)(i) and clause (ii), the composite performance score shall be determined as follows:

(I) QUALITY.—

(aa) IN GENERAL.—Subject to item (bb), thirty percent of such score shall be based on performance with respect to the category described in clause (i) of paragraph (2)(A). In applying the previous sentence, the Secretary shall, as feasible, encourage the application of outcome measures within such category.

(bb) FIRST 2 YEARS.—For the first and second years for which the MIPS applies to payments, the percentage applicable under item (aa) shall be increased in a manner such that the total percentage points of the increase under this item for the respective year equals the total number of percentage points by which the percentage applied under subclause (II)(bb) for the respective year is less than 30 percent.

(II) RESOURCE USE.—

(aa) IN GENERAL.—Subject to item (bb), thirty percent of such score shall be based on performance with respect to the category described in clause (ii) of paragraph (2)(A).

(bb) FIRST 2 YEARS.—For the first year for which the MIPS applies to payments, not more than 10 percent of such score shall be based on performance with respect to the category described in clause (ii) of paragraph (2)(A). For the second year for which the MIPS applies to payments, not more than 15

percent of such score shall be based on performance with respect to the category described in clause (ii) of paragraph (2)(A).

(III) CLINICAL PRACTICE IMPROVEMENT ACTIVITIES.—Fifteen percent of such score shall be based on performance with respect to the category described in clause (iii) of paragraph (2)(A).

(IV) MEANINGFUL USE OF CERTIFIED EHR TECHNOLOGY.—Twenty-five percent of such score shall be based on performance with respect to the category described in clause (iv) of paragraph (2)(A).

(ii) AUTHORITY TO ADJUST PERCENTAGES IN CASE OF HIGH EHR MEANINGFUL USE ADOPTION.—In any year in which the Secretary estimates that the proportion of eligible professionals (as defined in subsection (o)(5)) who are meaningful EHR users (as determined under subsection (o)(2)) is 75 percent or greater, the Secretary may reduce the percent applicable under clause (i)(IV), but not below 15 percent. If the Secretary makes such reduction for a year, subject to subclauses (I)(bb) and (II)(bb) of clause (i), the percentages applicable under one or more of subclauses (I), (II), and (III) of clause (i) for such year shall be increased in a manner such that the total percentage points of the increase under this clause for such year equals the total number of percentage points reduced under the preceding sentence for such year.

(F) CERTAIN FLEXIBILITY FOR WEIGHTING PERFORMANCE CATEGORIES, MEASURES, AND ACTIVITIES.—Under the methodology under subparagraph (A), if there are not sufficient measures and activities (described in paragraph (2)(B)) applicable and available to each type of eligible professional involved, the Secretary shall assign different scoring weights (including a weight of 0)—

(i) which may vary from the scoring weights specified in subparagraph (E), for each performance category based on the extent to which the category is applicable to the type of eligible professional involved; and

(ii) for each measure and activity specified under paragraph (2)(B) with respect to each such category based on the extent to which the measure or activity is applicable and available to the type of eligible professional involved.

(G) RESOURCE USE.—Analysis of the performance category described in paragraph (2)(A)(ii) shall include results from the methodology described in subsection (r)(5), as appropriate.

(H) INCLUSION OF QUALITY MEASURE DATA FROM OTHER PAYERS.—In applying subsections (k), (m), and (p) with respect to measures described in paragraph (2)(B)(i), analysis of the performance category described in paragraph (2)(A)(i) may include data submitted by MIPS eligible professionals with respect to items and services furnished to

individuals who are not individuals entitled to benefits under part A or enrolled under part B.

(I) USE OF VOLUNTARY VIRTUAL GROUPS FOR CERTAIN ASSESSMENT PURPOSES.—

(i) IN GENERAL.—In the case of MIPS eligible professionals electing to be a virtual group under clause (ii) with respect to a performance period for a year, for purposes of applying the methodology under subparagraph (A) with respect to the performance categories described in clauses (i) and (ii) of paragraph (2)(A)—

(I) the assessment of performance provided under such methodology with respect to such performance categories that is to be applied to each such professional in such group for such performance period shall be with respect to the combined performance of all such professionals in such group for such period; and

(II) with respect to the composite performance score provided under this paragraph for such performance period for each such MIPS eligible professional in such virtual group, the components of the composite performance score that assess performance with respect to such performance categories shall be based on the assessment of the combined performance under subclause (I) for such performance categories and performance period.

(ii) ELECTION OF PRACTICES TO BE A VIRTUAL GROUP.—The Secretary shall, in accordance with the requirements under clause (iii), establish and have in place a process to allow an individual MIPS eligible professional or a group practice consisting of not more than 10 MIPS eligible professionals to elect, with respect to a performance period for a year to be a virtual group under this subparagraph with at least one other such individual MIPS eligible professional or group practice. Such a virtual group may be based on appropriate classifications of providers, such as by geographic areas or by provider specialties defined by nationally recognized specialty boards of certification or equivalent certification boards.

(iii) REQUIREMENTS.—The requirements for the process under clause (ii) shall—

(I) provide that an election under such clause, with respect to a performance period, shall be made before the beginning of such performance period and may not be changed during such performance period;

(II) provide that an individual MIPS eligible professional and a group practice described in clause (ii) may elect to be in no more than one virtual group for a performance period and that, in the case of such a group practice that elects to be in such virtual group for such performance period,

such election applies to all MIPS eligible professionals in such group practice;

(III) provide that a virtual group be a combination of tax identification numbers;

(IV) provide for formal written agreements among MIPS eligible professionals electing to be a virtual group under this subparagraph; and

(V) include such other requirements as the Secretary determines appropriate.

(6) MIPS PAYMENTS.—

(A) MIPS ADJUSTMENT FACTOR.—Taking into account paragraph (1)(G), the Secretary shall specify a MIPS adjustment factor for each MIPS eligible professional for a year. Such MIPS adjustment factor for a MIPS eligible professional for a year shall be in the form of a percent and shall be determined—

(i) by comparing the composite performance score of the eligible professional for such year to the performance threshold established under subparagraph (D)(i) for such year;

(ii) in a manner such that the adjustment factors specified under this subparagraph for a year result in differential payments under this paragraph reflecting that—

(I) MIPS eligible professionals with composite performance scores for such year at or above such performance threshold for such year receive zero or positive payment adjustment factors for such year in accordance with clause (iii), with such professionals having higher composite performance scores receiving higher adjustment factors; and

(II) MIPS eligible professionals with composite performance scores for such year below such performance threshold for such year receive negative payment adjustment factors for such year in accordance with clause (iv), with such professionals having lower composite performance scores receiving lower adjustment factors;

(iii) in a manner such that MIPS eligible professionals with composite scores described in clause (ii)(I) for such year, subject to clauses (i) and (ii) of subparagraph (F), receive a zero or positive adjustment factor on a linear sliding scale such that an adjustment factor of 0 percent is assigned for a score at the performance threshold and an adjustment factor of the applicable percent specified in subparagraph (B) is assigned for a score of 100; and

(iv) in a manner such that—

(I) subject to subclause (II), MIPS eligible professionals with composite performance scores described in clause (ii)(II) for such year receive a negative payment adjustment factor on a linear sliding scale such that an adjustment factor of 0 percent is assigned for a score at the performance threshold and an adjustment factor of the nega-

tive of the applicable percent specified in subparagraph (B) is assigned for a score of 0; and

(II) MIPS eligible professionals with composite performance scores that are equal to or greater than 0, but not greater than ¼ of the performance threshold specified under subparagraph (D)(i) for such year, receive a negative payment adjustment factor that is equal to the negative of the applicable percent specified in subparagraph (B) for such year.

(B) APPLICABLE PERCENT DEFINED.—For purposes of this paragraph, the term "applicable percent" means—

(i) for 2019, 4 percent;

(ii) for 2020, 5 percent;

(iii) for 2021, 7 percent; and

(iv) for 2022 and subsequent years, 9 percent.

(C) ADDITIONAL MIPS ADJUSTMENT FACTORS FOR EXCEPTIONAL PERFORMANCE.—For 2019 and each subsequent year through 2024, in the case of a MIPS eligible professional with a composite performance score for a year at or above the additional performance threshold under subparagraph (D)(ii) for such year, in addition to the MIPS adjustment factor under subparagraph (A) for the eligible professional for such year, subject to subparagraph (F)(iv), the Secretary shall specify an additional positive MIPS adjustment factor for such professional and year. Such additional MIPS adjustment factors shall be in the form of a percent and determined by the Secretary in a manner such that professionals having higher composite performance scores above the additional performance threshold receive higher additional MIPS adjustment factors.

(D) ESTABLISHMENT OF PERFORMANCE THRESHOLDS.—

(i) PERFORMANCE THRESHOLD.—For each year of the MIPS, the Secretary shall compute a performance threshold with respect to which the composite performance score of MIPS eligible professionals shall be compared for purposes of determining adjustment factors under subparagraph (A) that are positive, negative, and zero. Such performance threshold for a year shall be the mean or median (as selected by the Secretary) of the composite performance scores for all MIPS eligible professionals with respect to a prior period specified by the Secretary. The Secretary may reassess the selection of the mean or median under the previous sentence every 3 years.

(ii) ADDITIONAL PERFORMANCE THRESHOLD FOR EXCEPTIONAL PERFORMANCE.—In addition to the performance threshold under clause (i), for each year of the MIPS, the Secretary shall compute an additional performance threshold for purposes of determining the additional MIPS adjustment factors under subparagraph (C). For each such year, the Secretary shall apply either of the following methods for computing such additional performance threshold for such a year:

(I) The threshold shall be the score that is equal to the 25th percentile of the range of possible composite performance scores above the performance threshold determined under clause (i).

(II) The threshold shall be the score that is equal to the 25th percentile of the actual composite performance scores for MIPS eligible professionals with composite performance scores at or above the performance threshold with respect to the prior period described in clause (i).

(iii) SPECIAL RULE FOR INITIAL 2 YEARS.—With respect to each of the first two years to which the MIPS applies, the Secretary shall, prior to the performance period for such years, establish a performance threshold for purposes of determining MIPS adjustment factors under subparagraph (A) and a threshold for purposes of determining additional MIPS adjustment factors under subparagraph (C). Each such performance threshold shall—

(I) be based on a period prior to such performance periods; and

(II) take into account—

(aa) data available with respect to performance on measures and activities that may be used under the performance categories under subparagraph (2)(B); and

(bb) other factors determined appropriate by the Secretary.

(E) APPLICATION OF MIPS ADJUSTMENT FACTORS.—In the case of items and services furnished by a MIPS eligible professional during a year (beginning with 2019), the amount otherwise paid under this part with respect to such items and services and MIPS eligible professional for such year, shall be multiplied by—

(i) 1, plus

(ii) the sum of—

(I) the MIPS adjustment factor determined under subparagraph (A) divided by 100, and

(II) as applicable, the additional MIPS adjustment factor determined under subparagraph (C) divided by 100.

(F) AGGREGATE APPLICATION OF MIPS ADJUSTMENT FACTORS.—

(i) APPLICATION OF SCALING FACTOR.—

(I) IN GENERAL.—With respect to positive MIPS adjustment factors under subparagraph (A)(ii)(I) for eligible professionals whose composite performance score is above the performance threshold under subparagraph (D)(i) for such year, subject to subclause (II), the Secretary shall increase or decrease such adjustment factors by a scaling factor in order to ensure that the budget neutrality requirement of clause (ii) is met.

(II) SCALING FACTOR LIMIT.—In no case may the scaling factor applied under this clause exceed 3.0.

(ii) BUDGET NEUTRALITY REQUIREMENT.—

(I) IN GENERAL.—Subject to clause (iii), the Secretary shall ensure that the estimated amount described in subclause (II) for a year is equal to the estimated amount described in subclause (III) for such year.

(II) AGGREGATE INCREASES.—The amount described in this subclause is the estimated increase in the aggregate allowed charges resulting from the application of positive MIPS adjustment factors under subparagraph (A) (after application of the scaling factor described in clause (i)) to MIPS eligible professionals whose composite performance score for a year is above the performance threshold under subparagraph (D)(i) for such year.

(III) AGGREGATE DECREASES.—The amount described in this subclause is the estimated decrease in the aggregate allowed charges resulting from the application of negative MIPS adjustment factors under subparagraph (A) to MIPS eligible professionals whose composite performance score for a year is below the performance threshold under subparagraph (D)(i) for such year.

(iii) EXCEPTIONS.—

(I) In the case that all MIPS eligible professionals receive composite performance scores for a year that are below the performance threshold under subparagraph (D)(i) for such year, the negative MIPS adjustment factors under subparagraph (A) shall apply with respect to such MIPS eligible professionals and the budget neutrality requirement of clause (ii) and the additional adjustment factors under clause (iv) shall not apply for such year.

(II) In the case that, with respect to a year, the application of clause (i) results in a scaling factor equal to the maximum scaling factor specified in clause (i)(II), such scaling factor shall apply and the budget neutrality requirement of clause (ii) shall not apply for such year.

(iv) ADDITIONAL INCENTIVE PAYMENT ADJUSTMENTS.—

(I) IN GENERAL.—Subject to subclause (II), in specifying the MIPS additional adjustment factors under subparagraph (C) for each applicable MIPS eligible professional for a year, the Secretary shall ensure that the estimated aggregate increase in payments under this part resulting from the application of such additional adjustment factors for MIPS eligible professionals in a year shall be equal (as estimated by the Secretary) to $500,000,000 for each year beginning with 2019 and ending with 2024.

(II) LIMITATION ON ADDITIONAL INCENTIVE PAYMENT ADJUSTMENTS.—The MIPS additional ad-

justment factor under subparagraph (C) for a year for an applicable MIPS eligible professional whose composite performance score is above the additional performance threshold under subparagraph (D)(ii) for such year shall not exceed 10 percent. The application of the previous sentence may result in an aggregate amount of additional incentive payments that are less than the amount specified in subclause (I).

(7) ANNOUNCEMENT OF RESULT OF ADJUSTMENTS.—Under the MIPS, the Secretary shall, not later than 30 days prior to January 1 of the year involved, make available to MIPS eligible professionals the MIPS adjustment factor (and, as applicable, the additional MIPS adjustment factor) under paragraph (6) applicable to the eligible professional for items and services furnished by the professional for such year. The Secretary may include such information in the confidential feedback under paragraph (12).

(8) NO EFFECT IN SUBSEQUENT YEARS.—The MIPS adjustment factors and additional MIPS adjustment factors under paragraph (6) shall apply only with respect to the year involved, and the Secretary shall not take into account such adjustment factors in making payments to a MIPS eligible professional under this part in a subsequent year.

(9) PUBLIC REPORTING.—

(A) IN GENERAL.—The Secretary shall, in an easily understandable format, make available on the Physician Compare Internet website of the Centers for Medicare & Medicaid Services the following:

(i) Information regarding the performance of MIPS eligible professionals under the MIPS, which—

(I) shall include the composite score for each such MIPS eligible professional and the performance of each such MIPS eligible professional with respect to each performance category; and

(II) may include the performance of each such MIPS eligible professional with respect to each measure or activity specified in paragraph (2)(B).

(ii) The names of eligible professionals in eligible alternative payment models (as defined in section 1833(z)(3)(D)) and, to the extent feasible, the names of such eligible alternative payment models and performance of such models.

(B) DISCLOSURE.—The information made available under this paragraph shall indicate, where appropriate, that publicized information may not be representative of the eligible professional's entire patient population, the variety of services furnished by the eligible professional, or the health conditions of individuals treated.

(C) OPPORTUNITY TO REVIEW AND SUBMIT CORRECTIONS.—The Secretary shall provide for an opportunity for a professional described in subparagraph (A) to review, and submit corrections for, the information to be made public with respect to the professional under such subparagraph prior to such information being made public.

(D) AGGREGATE INFORMATION.—The Secretary shall periodically post on the Physician Compare Internet website aggregate information on the MIPS, including the range of composite scores for all MIPS eligible professionals and the range of the performance of all MIPS eligible professionals with respect to each performance category.

(10) CONSULTATION.—The Secretary shall consult with stakeholders in carrying out the MIPS, including for the identification of measures and activities under paragraph (2)(B) and the methodologies developed under paragraphs (5)(A) and (6) and regarding the use of qualified clinical data registries. Such consultation shall include the use of a request for information or other mechanisms determined appropriate.

(11) TECHNICAL ASSISTANCE TO SMALL PRACTICES AND PRACTICES IN HEALTH PROFESSIONAL SHORTAGE AREAS.—

(A) IN GENERAL.—The Secretary shall enter into contracts or agreements with appropriate entities (such as quality improvement organizations, regional extension centers (as described in section 3012(c) of the Public Health Service Act), or regional health collaboratives) to offer guidance and assistance to MIPS eligible professionals in practices of 15 or fewer professionals (with priority given to such practices located in rural areas, health professional shortage areas (as designated under in section 332(a)(1)(A) of such Act), and medically underserved areas, and practices with low composite scores) with respect to—

(i) the performance categories described in clauses (i) through (iv) of paragraph (2)(A); or

(ii) how to transition to the implementation of and participation in an alternative payment model as described in section 1833(z)(3)(C).

(B) FUNDING FOR TECHNICAL ASSISTANCE.—For purposes of implementing subparagraph (A), the Secretary shall provide for the transfer from the Federal Supplementary Medical Insurance Trust Fund established under section 1841 to the Centers for Medicare & Medicaid Services Program Management Account of $20,000,000 for each of fiscal years 2016 through 2020. Amounts transferred under this subparagraph for a fiscal year shall be available until expended.

(12) FEEDBACK AND INFORMATION TO IMPROVE PERFORMANCE.—

(A) PERFORMANCE FEEDBACK.—

(i) IN GENERAL.—Beginning July 1, 2017, the Secretary—

(I) shall make available timely (such as quarterly) confidential feedback to MIPS eligible professionals on the performance of such professionals with respect to the performance categories under clauses (i) and (ii) of paragraph (2)(A); and

(II) may make available confidential feedback to such professionals on the performance of such professionals with respect to the performance categories under clauses (iii) and (iv) of such paragraph.

(ii) MECHANISMS.—The Secretary may use one or more mechanisms to make feedback available under clause (i), which may include use of a web-based portal or other mechanisms determined appropriate by the Secretary. With respect to the performance category described in paragraph (2)(A)(i), feedback under this subparagraph shall, to the extent an eligible professional chooses to participate in a data registry for purposes of this subsection (including registries under subsections (k) and (m)), be provided based on performance on quality measures reported through the use of such registries. With respect to any other performance category described in paragraph (2)(A), the Secretary shall encourage provision of feedback through qualified clinical data registries as described in subsection (m)(3)(E)).

(iii) USE OF DATA.—For purposes of clause (i), the Secretary may use data, with respect to a MIPS eligible professional, from periods prior to the current performance period and may use rolling periods in order to make illustrative calculations about the performance of such professional.

(iv) DISCLOSURE EXEMPTION.—Feedback made available under this subparagraph shall be exempt from disclosure under section 552 of title 5, United States Code.

(v) RECEIPT OF INFORMATION.—The Secretary may use the mechanisms established under clause (ii) to receive information from professionals, such as information with respect to this subsection.

(B) ADDITIONAL INFORMATION.—

(i) IN GENERAL.—Beginning July 1, 2018, the Secretary shall make available to MIPS eligible professionals information, with respect to individuals who are patients of such MIPS eligible professionals, about items and services for which payment is made under this title that are furnished to such individuals by other suppliers and providers of services, which may include information described in clause (ii). Such information may be made available under the previous sentence to such MIPS eligible professionals by mechanisms determined appropriate by the Secretary, which may include use of a web-based portal. Such information may be made available in accordance with the same or similar terms as data are made available to accountable care organizations participating in the shared savings program under section 1899.

(ii) TYPE OF INFORMATION.—For purposes of clause (i), the information described in this clause, is the following:

(I) With respect to selected items and services (as determined appropriate by the Secretary) for which payment is made under this title and that are furnished to individuals, who are patients of a MIPS eligible professional, by another supplier or

provider of services during the most recent period for which data are available (such as the most recent three-month period), such as the name of such providers furnishing such items and services to such patients during such period, the types of such items and services so furnished, and the dates such items and services were so furnished.

(II) Historical data, such as averages and other measures of the distribution if appropriate, of the total, and components of, allowed charges (and other figures as determined appropriate by the Secretary).

(13) REVIEW.—

(A) TARGETED REVIEW.—The Secretary shall establish a process under which a MIPS eligible professional may seek an informal review of the calculation of the MIPS adjustment factor (or factors) applicable to such eligible professional under this subsection for a year. The results of a review conducted pursuant to the previous sentence shall not be taken into account for purposes of paragraph (6) with respect to a year (other than with respect to the calculation of such eligible professional's MIPS adjustment factor for such year or additional MIPS adjustment factor for such year) after the factors determined in subparagraph (A) and subparagraph (C) of such paragraph have been determined for such year.

(B) LIMITATION.—Except as provided for in subparagraph (A), there shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the following:

(i) The methodology used to determine the amount of the MIPS adjustment factor under paragraph (6)(A) and the amount of the additional MIPS adjustment factor under paragraph (6)(C) and the determination of such amounts.

(ii) The establishment of the performance standards under paragraph (3) and the performance period under paragraph (4).

(iii) The identification of measures and activities specified under paragraph (2)(B) and information made public or posted on the Physician Compare Internet website of the Centers for Medicare & Medicaid Services under paragraph (9).

(iv) The methodology developed under paragraph (5) that is used to calculate performance scores and the calculation of such scores, including the weighting of measures and activities under such methodology.

(r) COLLABORATING WITH THE PHYSICIAN, PRACTITIONER, AND OTHER STAKEHOLDER COMMUNITIES TO IMPROVE RESOURCE USE MEASUREMENT.—

(1) IN GENERAL.—In order to involve the physician, practitioner, and other stakeholder communities in enhancing the infrastructure for resource use measurement, including for purposes of the Merit-based Incentive Payment System under subsection (q) and alternative payment models under section

1833(z), the Secretary shall undertake the steps described in the succeeding provisions of this subsection.

(2) DEVELOPMENT OF CARE EPISODE AND PATIENT CONDITION GROUPS AND CLASSIFICATION CODES.—

(A) IN GENERAL.—In order to classify similar patients into care episode groups and patient condition groups, the Secretary shall undertake the steps described in the succeeding provisions of this paragraph.

(B) PUBLIC AVAILABILITY OF EXISTING EFFORTS TO DESIGN AN EPISODE GROUPER.—Not later than 180 days after the date of the enactment of this subsection, the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services a list of the episode groups developed pursuant to subsection (n)(9)(A) and related descriptive information.

(C) STAKEHOLDER INPUT.—The Secretary shall accept, through the date that is 120 days after the day the Secretary posts the list pursuant to subparagraph (B), suggestions from physician specialty societies, applicable practitioner organizations, and other stakeholders for episode groups in addition to those posted pursuant to such subparagraph, and specific clinical criteria and patient characteristics to classify patients into—

(i) care episode groups; and

(ii) patient condition groups.

(D) DEVELOPMENT OF PROPOSED CLASSIFICATION CODES.—

(i) IN GENERAL.—Taking into account the information described in subparagraph (B) and the information received under subparagraph (C), the Secretary shall—

(I) establish care episode groups and patient condition groups, which account for a target of an estimated ½ of expenditures under parts A and B (with such target increasing over time as appropriate); and

(II) assign codes to such groups.

(ii) CARE EPISODE GROUPS.—In establishing the care episode groups under clause (i), the Secretary shall take into account—

(I) the patient's clinical problems at the time items and services are furnished during an episode of care, such as the clinical conditions or diagnoses, whether or not inpatient hospitalization occurs, and the principal procedures or services furnished; and

(II) other factors determined appropriate by the Secretary.

(iii) PATIENT CONDITION GROUPS.—In establishing the patient condition groups under clause (i), the Secretary shall take into account—

(I) the patient's clinical history at the time of a medical visit, such as the patient's combination of chronic conditions, current health status, and recent significant history (such as hospitalization

and major surgery during a previous period, such as 3 months); and

(II) other factors determined appropriate by the Secretary, such as eligibility status under this title (including eligibility under section 226(a), 226(b), or 226A, and dual eligibility under this title and title XIX).

(E) DRAFT CARE EPISODE AND PATIENT CONDITION GROUPS AND CLASSIFICATION CODES.—Not later than 270 days after the end of the comment period described in subparagraph (C), the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services a draft list of the care episode and patient condition codes established under subparagraph (D) (and the criteria and characteristics assigned to such code).

(F) SOLICITATION OF INPUT.—The Secretary shall seek, through the date that is 120 days after the Secretary posts the list pursuant to subparagraph (E), comments from physician specialty societies, applicable practitioner organizations, and other stakeholders, including representatives of individuals entitled to benefits under part A or enrolled under this part, regarding the care episode and patient condition groups (and codes) posted under subparagraph (E). In seeking such comments, the Secretary shall use one or more mechanisms (other than notice and comment rulemaking) that may include use of open door forums, town hall meetings, or other appropriate mechanisms.

(G) OPERATIONAL LIST OF CARE EPISODE AND PATIENT CONDITION GROUPS AND CODES.—Not later than 270 days after the end of the comment period described in subparagraph (F), taking into account the comments received under such subparagraph, the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services an operational list of care episode and patient condition codes (and the criteria and characteristics assigned to such code).

(H) SUBSEQUENT REVISIONS.—Not later than November 1 of each year (beginning with 2018), the Secretary shall, through rulemaking, make revisions to the operational lists of care episode and patient condition codes as the Secretary determines may be appropriate. Such revisions may be based on experience, new information developed pursuant to subsection (n)(9)(A), and input from the physician specialty societies, applicable practitioner organizations, and other stakeholders, including representatives of individuals entitled to benefits under part A or enrolled under this part.

(3) ATTRIBUTION OF PATIENTS TO PHYSICIANS OR PRACTITIONERS.—

(A) IN GENERAL.—In order to facilitate the attribution of patients and episodes (in whole or in part) to one or more physicians or applicable practitioners furnishing items and services, the Secretary shall undertake the steps described in the succeeding provisions of this paragraph.

(B) DEVELOPMENT OF PATIENT RELATIONSHIP CATEGORIES AND CODES.—The Secretary shall develop patient relationship categories and codes that define and distinguish the relationship and responsibility of a physician or applicable practitioner with a patient at the time of furnishing an item or service. Such patient relationship categories shall include different relationships of the physician or applicable practitioner to the patient (and the codes may reflect combinations of such categories), such as a physician or applicable practitioner who—

(i) considers themself to have the primary responsibility for the general and ongoing care for the patient over extended periods of time;

(ii) considers themself to be the lead physician or practitioner and who furnishes items and services and coordinates care furnished by other physicians or practitioners for the patient during an acute episode;

(iii) furnishes items and services to the patient on a continuing basis during an acute episode of care, but in a supportive rather than a lead role;

(iv) furnishes items and services to the patient on an occasional basis, usually at the request of another physician or practitioner; or

(v) furnishes items and services only as ordered by another physician or practitioner.

(C) DRAFT LIST OF PATIENT RELATIONSHIP CATEGORIES AND CODES.—Not later than one year after the date of the enactment of this subsection, the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services a draft list of the patient relationship categories and codes developed under subparagraph (B).

(D) STAKEHOLDER INPUT.—The Secretary shall seek, through the date that is 120 days after the Secretary posts the list pursuant to subparagraph (C), comments from physician specialty societies, applicable practitioner organizations, and other stakeholders, including representatives of individuals entitled to benefits under part A or enrolled under this part, regarding the patient relationship categories and codes posted under subparagraph (C). In seeking such comments, the Secretary shall use one or more mechanisms (other than notice and comment rulemaking) that may include open door forums, town hall meetings, web-based forums, or other appropriate mechanisms.

(E) OPERATIONAL LIST OF PATIENT RELATIONSHIP CATEGORIES AND CODES.—Not later than 240 days after the end of the comment period described in subparagraph (D), taking into account the comments received under such subparagraph, the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services an operational list of patient relationship categories and codes.

(F) SUBSEQUENT REVISIONS.—Not later than November 1 of each year (beginning with 2018), the Secretary shall, through rulemaking, make revisions to the operational list

of patient relationship categories and codes as the Secretary determines appropriate. Such revisions may be based on experience, new information developed pursuant to subsection (n)(9)(A), and input from the physician specialty societies, applicable practitioner organizations, and other stakeholders, including representatives of individuals entitled to benefits under part A or enrolled under this part.

(4) REPORTING OF INFORMATION FOR RESOURCE USE MEASUREMENT.—Claims submitted for items and services furnished by a physician or applicable practitioner on or after January 1, 2018, shall, as determined appropriate by the Secretary, include—

(A) applicable codes established under paragraphs (2) and (3); and

(B) the national provider identifier of the ordering physician or applicable practitioner (if different from the billing physician or applicable practitioner).

(5) METHODOLOGY FOR RESOURCE USE ANALYSIS.—

(A) IN GENERAL.—In order to evaluate the resources used to treat patients (with respect to care episode and patient condition groups), the Secretary shall, as the Secretary determines appropriate—

(i) use the patient relationship codes reported on claims pursuant to paragraph (4) to attribute patients (in whole or in part) to one or more physicians and applicable practitioners;

(ii) use the care episode and patient condition codes reported on claims pursuant to paragraph (4) as a basis to compare similar patients and care episodes and patient condition groups; and

(iii) conduct an analysis of resource use (with respect to care episodes and patient condition groups of such patients).

(B) ANALYSIS OF PATIENTS OF PHYSICIANS AND PRACTITIONERS.—In conducting the analysis described in subparagraph (A)(iii) with respect to patients attributed to physicians and applicable practitioners, the Secretary shall, as feasible—

(i) use the claims data experience of such patients by patient condition codes during a common period, such as 12 months; and

(ii) use the claims data experience of such patients by care episode codes—

(I) in the case of episodes without a hospitalization, during periods of time (such as the number of days) determined appropriate by the Secretary; and

(II) in the case of episodes with a hospitalization, during periods of time (such as the number of days) before, during, and after the hospitalization.

(C) MEASUREMENT OF RESOURCE USE.—In measuring such resource use, the Secretary—

(i) shall use per patient total allowed charges for all services under part A and this part (and, if the Secretary determines appropriate, part D) for the analysis of patient resource use, by care episode codes and by patient condition codes; and

(ii) may, as determined appropriate, use other measures of allowed charges (such as subtotals for categories of items and services) and measures of utilization of items and services (such as frequency of specific items and services and the ratio of specific items and services among attributed patients or episodes).

(D) STAKEHOLDER INPUT.—The Secretary shall seek comments from the physician specialty societies, applicable practitioner organizations, and other stakeholders, including representatives of individuals entitled to benefits under part A or enrolled under this part, regarding the resource use methodology established pursuant to this paragraph. In seeking comments the Secretary shall use one or more mechanisms (other than notice and comment rulemaking) that may include open door forums, town hall meetings, web-based forums, or other appropriate mechanisms.

(6) IMPLEMENTATION.—To the extent that the Secretary contracts with an entity to carry out any part of the provisions of this subsection, the Secretary may not contract with an entity or an entity with a subcontract if the entity or subcontracting entity currently makes recommendations to the Secretary on relative values for services under the fee schedule for physicians' services under this section.

(7) LIMITATION.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of—

(A) care episode and patient condition groups and codes established under paragraph (2);

(B) patient relationship categories and codes established under paragraph (3); and

(C) measurement of, and analyses of resource use with respect to, care episode and patient condition codes and patient relationship codes pursuant to paragraph (5).

(8) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to this section.

(9) DEFINITIONS.—In this subsection:

(A) PHYSICIAN.—The term "physician" has the meaning given such term in section 1861(r)(1).

(B) APPLICABLE PRACTITIONER.—The term "applicable practitioner" means—

(i) a physician assistant, nurse practitioner, and clinical nurse specialist (as such terms are defined in section 1861(aa)(5)), and a certified registered nurse anesthetist (as defined in section 1861(bb)(2)); and

(ii) beginning January 1, 2019, such other eligible professionals (as defined in subsection (k)(3)(B)) as specified by the Secretary.

(10) CLARIFICATION.—The provisions of sections 1890(b)(7) and 1890A shall not apply to this subsection.

(s) PRIORITIES AND FUNDING FOR MEASURE DEVELOPMENT.—

(1) PLAN IDENTIFYING MEASURE DEVELOPMENT PRIORITIES AND TIMELINES.—

(A) DRAFT MEASURE DEVELOPMENT PLAN.—Not later than January 1, 2016, the Secretary shall develop, and post on the Internet website of the Centers for Medicare & Medicaid Services, a draft plan for the development of quality measures for application under the applicable provisions (as defined in paragraph (5)). Under such plan the Secretary shall—

(i) address how measures used by private payers and integrated delivery systems could be incorporated under title XVIII;

(ii) describe how coordination, to the extent possible, will occur across organizations developing such measures; and

(iii) take into account how clinical best practices and clinical practice guidelines should be used in the development of quality measures.

(B) QUALITY DOMAINS.—For purposes of this subsection, the term "quality domains" means at least the following domains:

(i) Clinical care.

(ii) Safety.

(iii) Care coordination.

(iv) Patient and caregiver experience.

(v) Population health and prevention.

(C) CONSIDERATION.—In developing the draft plan under this paragraph, the Secretary shall consider—

(i) gap analyses conducted by the entity with a contract under section 1890(a) or other contractors or entities;

(ii) whether measures are applicable across health care settings;

(iii) clinical practice improvement activities submitted under subsection (q)(2)(C)(iv) for identifying possible areas for future measure development and identifying existing gaps with respect to such measures; and

(iv) the quality domains applied under this subsection.

(D) PRIORITIES.—In developing the draft plan under this paragraph, the Secretary shall give priority to the following types of measures:

(i) Outcome measures, including patient reported outcome and functional status measures.

(ii) Patient experience measures.

(iii) Care coordination measures.

(iv) Measures of appropriate use of services, including measures of over use.

(E) STAKEHOLDER INPUT.—The Secretary shall accept through March 1, 2016, comments on the draft plan posted under paragraph (1)(A) from the public, including health care providers, payers, consumers, and other stakeholders.

(F) FINAL MEASURE DEVELOPMENT PLAN.—Not later than May 1, 2016, taking into account the comments received

under this subparagraph, the Secretary shall finalize the plan and post on the Internet website of the Centers for Medicare & Medicaid Services an operational plan for the development of quality measures for use under the applicable provisions. Such plan shall be updated as appropriate.

(2) CONTRACTS AND OTHER ARRANGEMENTS FOR QUALITY MEASURE DEVELOPMENT.—

(A) IN GENERAL.—The Secretary shall enter into contracts or other arrangements with entities for the purpose of developing, improving, updating, or expanding in accordance with the plan under paragraph (1) quality measures for application under the applicable provisions. Such entities shall include organizations with quality measure development expertise.

(B) PRIORITIZATION.—

(i) IN GENERAL.—In entering into contracts or other arrangements under subparagraph (A), the Secretary shall give priority to the development of the types of measures described in paragraph (1)(D).

(ii) CONSIDERATION.—In selecting measures for development under this subsection, the Secretary shall consider—

(I) whether such measures would be electronically specified; and

(II) clinical practice guidelines to the extent that such guidelines exist.

(3) ANNUAL REPORT BY THE SECRETARY.—

(A) IN GENERAL.—Not later than May 1, 2017, and annually thereafter, the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services a report on the progress made in developing quality measures for application under the applicable provisions.

(B) REQUIREMENTS.—Each report submitted pursuant to subparagraph (A) shall include the following:

(i) A description of the Secretary's efforts to implement this paragraph.

(ii) With respect to the measures developed during the previous year—

(I) a description of the total number of quality measures developed and the types of such measures, such as an outcome or patient experience measure;

(II) the name of each measure developed;

(III) the name of the developer and steward of each measure;

(IV) with respect to each type of measure, an estimate of the total amount expended under this title to develop all measures of such type; and

(V) whether the measure would be electronically specified.

(iii) With respect to measures in development at the time of the report—

(I) the information described in clause (ii), if available; and

(II) a timeline for completion of the development of such measures.

(iv) A description of any updates to the plan under paragraph (1) (including newly identified gaps and the status of previously identified gaps) and the inventory of measures applicable under the applicable provisions.

(v) Other information the Secretary determines to be appropriate.

(4) STAKEHOLDER INPUT.—With respect to paragraph (1), the Secretary shall seek stakeholder input with respect to—

(A) the identification of gaps where no quality measures exist, particularly with respect to the types of measures described in paragraph (1)(D);

(B) prioritizing quality measure development to address such gaps; and

(C) other areas related to quality measure development determined appropriate by the Secretary.

(5) DEFINITION OF APPLICABLE PROVISIONS.—In this subsection, the term "applicable provisions" means the following provisions:

(A) Subsection (q)(2)(B)(i).

(B) Section 1833(z)(2)(C).

(6) FUNDING.—For purposes of carrying out this subsection, the Secretary shall provide for the transfer, from the Federal Supplementary Medical Insurance Trust Fund under section 1841, of $15,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for each of fiscal years 2015 through 2019. Amounts transferred under this paragraph shall remain available through the end of fiscal year 2022.

(7) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to the collection of information for the development of quality measures.

PART C—MEDICARE+CHOICE PROGRAM

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CONTRACTS WITH MEDICARE+CHOICE ORGANIZATIONS

SEC. 1857. (a) IN GENERAL.—The Secretary shall not permit the election under section 1851 of a Medicare+Choice plan offered by a Medicare+Choice organization under this part, and no payment shall be made under section 1853 to an organization, unless the Secretary has entered into a contract under this section with the organization with respect to the offering of such plan. Such a contract with an organization may cover more than 1 Medicare+Choice plan. Such contract shall provide that the organization agrees to comply with the applicable requirements and standards of this part and the terms and conditions of payment as provided for in this part.

(b) MINIMUM ENROLLMENT REQUIREMENTS.—

(1) IN GENERAL.—Subject to paragraph (2), the Secretary may not enter into a contract under this section with a Medicare+Choice organization unless the organization has—

(A) at least 5,000 individuals (or 1,500 individuals in the case of an organization that is a provider-sponsored organization) who are receiving health benefits through the organization, or

(B) at least 1,500 individuals (or 500 individuals in the case of an organization that is a provider-sponsored organization) who are receiving health benefits through the organization if the organization primarily serves individuals residing outside of urbanized areas.

(2) APPLICATION TO MSA PLANS.—In applying paragraph (1) in the case of a Medicare+Choice organization that is offering an MSA plan, paragraph (1) shall be applied by substituting covered lives for individuals.

(3) ALLOWING TRANSITION.—The Secretary may waive the requirement of paragraph (1) during the first 3 contract years with respect to an organization.

(c) CONTRACT PERIOD AND EFFECTIVENESS.—

(1) PERIOD.—Each contract under this section shall be for a term of at least 1 year, as determined by the Secretary, and may be made automatically renewable from term to term in the absence of notice by either party of intention to terminate at the end of the current term.

(2) TERMINATION AUTHORITY.—In accordance with procedures established under subsection (h), the Secretary may at any time terminate any such contract if the Secretary determines that the organization—

(A) has failed substantially to carry out the contract;

(B) is carrying out the contract in a manner inconsistent with the efficient and effective administration of this part; or

(C) no longer substantially meets the applicable conditions of this part.

(3) EFFECTIVE DATE OF CONTRACTS.—The effective date of any contract executed pursuant to this section shall be specified in the contract, except that in no case shall a contract under this section which provides for coverage under an MSA plan be effective before January 1999 with respect to such coverage.

(4) PREVIOUS TERMINATIONS.—

(A) IN GENERAL.—The Secretary may not enter into a contract with a Medicare+Choice organization if a previous contract with that organization under this section was terminated at the request of the organization within the preceding 2-year period, except as provided in subparagraph (B) and except in such other circumstances which warrant special consideration, as determined by the Secretary.

(B) EARLIER RE-ENTRY PERMITTED WHERE CHANGE IN PAYMENT POLICY.—Subparagraph (A) shall not apply with respect to the offering by a Medicare+Choice organization of a Medicare+Choice plan in a Medicare+Choice payment area if during the 6-month period beginning on the date the organization notified the Secretary of the intention to terminate the most recent previous contract, there was a legislative change enacted (or a regulatory change adopted) that has the effect of increasing payment amounts

under section 1853 for that Medicare+Choice payment area.

(5) CONTRACTING AUTHORITY.—The authority vested in the Secretary by this part may be performed without regard to such provisions of law or regulations relating to the making, performance, amendment, or modification of contracts of the United States as the Secretary may determine to be inconsistent with the furtherance of the purpose of this title.

(d) PROTECTIONS AGAINST FRAUD AND BENEFICIARY PROTECTIONS.—

(1) PERIODIC AUDITING.—The Secretary shall provide for the annual auditing of the financial records (including data relating to medicare utilization and costs, including allowable costs under section 1858(c)) of at least one-third of the Medicare+Choice organizations offering Medicare+Choice plans under this part. The Comptroller General shall monitor auditing activities conducted under this subsection.

(2) INSPECTION AND AUDIT.—Each contract under this section shall provide that the Secretary, or any person or organization designated by the Secretary—

(A) shall have the right to timely inspect or otherwise evaluate (i) the quality, appropriateness, and timeliness of services performed under the contract, and (ii) the facilities of the organization when there is reasonable evidence of some need for such inspection, and

(B) shall have the right to timely audit and inspect any books and records of the Medicare+Choice organization that pertain (i) to the ability of the organization to bear the risk of potential financial losses, or (ii) to services performed or determinations of amounts payable under the contract.

(3) ENROLLEE NOTICE AT TIME OF TERMINATION.—Each contract under this section shall require the organization to provide (and pay for) written notice in advance of the contract's termination, as well as a description of alternatives for obtaining benefits under this title, to each individual enrolled with the organization under this part.

(4) DISCLOSURE.—

(A) IN GENERAL.—Each Medicare+Choice organization shall, in accordance with regulations of the Secretary, report to the Secretary financial information which shall include the following:

(i) Such information as the Secretary may require demonstrating that the organization has a fiscally sound operation.

(ii) A copy of the report, if any, filed with the Secretary containing the information required to be reported under section 1124 by disclosing entities.

(iii) A description of transactions, as specified by the Secretary, between the organization and a party in interest. Such transactions shall include—

(I) any sale or exchange, or leasing of any property between the organization and a party in interest;

(II) any furnishing for consideration of goods, services (including management services), or facilities between the organization and a party in interest, but not including salaries paid to employees for services provided in the normal course of their employment and health services provided to members by hospitals and other providers and by staff, medical group (or groups), individual practice association (or associations), or any combination thereof; and

(III) any lending of money or other extension of credit between an organization and a party in interest.

The Secretary may require that information reported respecting an organization which controls, is controlled by, or is under common control with, another entity be in the form of a consolidated financial statement for the organization and such entity.

(B) PARTY IN INTEREST DEFINED.—For the purposes of this paragraph, the term "party in interest" means—

(i) any director, officer, partner, or employee responsible for management or administration of a Medicare+Choice organization, any person who is directly or indirectly the beneficial owner of more than 5 percent of the equity of the organization, any person who is the beneficial owner of a mortgage, deed of trust, note, or other interest secured by, and valuing more than 5 percent of the organization, and, in the case of a Medicare+Choice organization organized as a nonprofit corporation, an incorporator or member of such corporation under applicable State corporation law;

(ii) any entity in which a person described in clause (i)—

(I) is an officer or director;

(II) is a partner (if such entity is organized as a partnership);

(III) has directly or indirectly a beneficial interest of more than 5 percent of the equity; or

(IV) has a mortgage, deed of trust, note, or other interest valuing more than 5 percent of the assets of such entity;

(iii) any person directly or indirectly controlling, controlled by, or under common control with an organization; and

(iv) any spouse, child, or parent of an individual described in clause (i).

(C) ACCESS TO INFORMATION.—Each Medicare+Choice organization shall make the information reported pursuant to subparagraph (A) available to its enrollees upon reasonable request.

(5) LOAN INFORMATION.—The contract shall require the organization to notify the Secretary of loans and other special financial arrangements which are made between the organization and subcontractors, affiliates, and related parties.

(6) REVIEW TO ENSURE COMPLIANCE WITH CARE MANAGEMENT REQUIREMENTS FOR SPECIALIZED MEDICARE ADVANTAGE PLANS FOR SPECIAL NEEDS INDIVIDUALS.—In conjunction with the periodic audit of a specialized Medicare Advantage plan for special needs individuals under paragraph (1), the Secretary shall conduct a review to ensure that such organization offering the plan meets the requirements described in section 1859(f)(5).

(e) ADDITIONAL CONTRACT TERMS.—

(1) IN GENERAL.—The contract shall contain such other terms and conditions not inconsistent with this part (including requiring the organization to provide the Secretary with such information) as the Secretary may find necessary and appropriate.

(2) COST-SHARING IN ENROLLMENT-RELATED COSTS.—

(A) IN GENERAL.—A Medicare+Choice organization and a PDP sponsor under part D shall pay the fee established by the Secretary under subparagraph (B).

(B) AUTHORIZATION.—The Secretary is authorized to charge a fee to each Medicare+Choice organization with a contract under this part and each PDP sponsor with a contract under part D that is equal to the organization' or sponsor's pro rata share (as determined by the Secretary) of the aggregate amount of fees which the Secretary is directed to collect in a fiscal year. Any amounts collected shall be available without further appropriation to the Secretary for the purpose of carrying out section 1851 (relating to enrollment and dissemination of information), section 1860D-1(c), and section 4360 of the Omnibus Budget Reconciliation Act of 1990 (relating to the health insurance counseling and assistance program).

(C) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated for the purposes described in subparagraph (B) for each fiscal year beginning with fiscal year 2001 and ending with fiscal year 2005 an amount equal to $100,000,000, and for each fiscal year beginning with fiscal year 2006 an amount equal to $200,000,000, reduced by the amount of fees authorized to be collected under this paragraph and section 1860D–12(b)(3)(D) for the fiscal year.

(D) LIMITATION.—In any fiscal year the fees collected by the Secretary under subparagraph (B) shall not exceed the lesser of—

(i) the estimated costs to be incurred by the Secretary in the fiscal year in carrying out the activities described in section 1851 and section 1860D–1(c) and section 4360 of the Omnibus Budget Reconciliation Act of 1990; or

(ii)(I) $200,000,000 in fiscal year 1998;

(II) $150,000,000 in fiscal year 1999;

(III) $100,000,000 in fiscal year 2000;

(IV) the Medicare+Choice portion (as defined in subparagraph (E)) of $100,000,000 in fiscal year 2001 and each succeeding fiscal year before fiscal year 2006; and

(V) the applicable portion (as defined in subparagraph (F)) of $200,000,000 in fiscal year 2006 and each succeeding fiscal year.

(E) MEDICARE+CHOICE PORTION DEFINED.—In this paragraph, the term "Medicare+Choice portion" means, for a fiscal year, the ratio, as estimated by the Secretary, of—

(i) the average number of individuals enrolled in Medicare+Choice plans during the fiscal year, to

(ii) the average number of individuals entitled to benefits under part A, and enrolled under part B, during the fiscal year.

(F) APPLICABLE PORTION DEFINED.—In this paragraph, the term "applicable portion" means, for a fiscal year—

(i) with respect to MA organizations, the Secretary's estimate of the total proportion of expenditures under this title that are attributable to expenditures made under this part (including payments under part D that are made to such organizations); or

(ii) with respect to PDP sponsors, the Secretary's estimate of the total proportion of expenditures under this title that are attributable to expenditures made to such sponsors under part D.

(3) AGREEMENTS WITH FEDERALLY QUALIFIED HEALTH CENTERS.—

(A) PAYMENT LEVELS AND AMOUNTS.—A contract under this section with an MA organization shall require the organization to provide, in any written agreement described in section 1853(a)(4) between the organization and a federally qualified health center, for a level and amount of payment to the federally qualified health center for services provided by such health center that is not less than the level and amount of payment that the plan would make for such services if the services had been furnished by a entity providing similar services that was not a federally qualified health center.

(B) COST-SHARING.—Under the written agreement referred to in subparagraph (A), a federally qualified health center must accept the payment amount referred to in such subparagraph plus the Federal payment provided for in section 1833(a)(3)(B) as payment in full for services covered by the agreement, except that such a health center may collect any amount of cost-sharing permitted under the contract under this section, so long as the amounts of any deductible, coinsurance, or copayment comply with the requirements under section 1854(e).

(4) REQUIREMENT FOR MINIMUM MEDICAL LOSS RATIO.—If the Secretary determines for a contract year (beginning with 2014) that an MA plan has failed to have a medical loss ratio of at least .85—

(A) the MA plan shall remit to the Secretary an amount equal to the product of—

(i) the total revenue of the MA plan under this part for the contract year; and

(ii) the difference between .85 and the medical loss ratio;

(B) for 3 consecutive contract years, the Secretary shall not permit the enrollment of new enrollees under the plan for coverage during the second succeeding contract year; and

(C) the Secretary shall terminate the plan contract if the plan fails to have such a medical loss ratio for 5 consecutive contract years.

(f) PROMPT PAYMENT BY MEDICARE+CHOICE ORGANIZATION.—

(1) REQUIREMENT.—A contract under this part shall require a Medicare+Choice organization to provide prompt payment (consistent with the provisions of sections 1816(c)(2) and 1842(c)(2)) of claims submitted for services and supplies furnished to enrollees pursuant to the contract, if the services or supplies are not furnished under a contract between the organization and the provider or supplier (or in the case of a Medicare+Choice private fee-for-service plan, if a claim is submitted to such organization by an enrollee).

(2) SECRETARY'S OPTION TO BYPASS NONCOMPLYING ORGANIZATION.—In the case of a Medicare+Choice eligible organization which the Secretary determines, after notice and opportunity for a hearing, has failed to make payments of amounts in compliance with paragraph (1), the Secretary may provide for direct payment of the amounts owed to providers and suppliers (or, in the case of a Medicare+Choice private fee-for-service plan, amounts owed to the enrollees) for covered services and supplies furnished to individuals enrolled under this part under the contract. If the Secretary provides for the direct payments, the Secretary shall provide for an appropriate reduction in the amount of payments otherwise made to the organization under this part to reflect the amount of the Secretary's payments (and the Secretary's costs in making the payments).

(3) INCORPORATION OF CERTAIN PRESCRIPTION DRUG PLAN CONTRACT REQUIREMENTS.—The following provisions shall apply to contracts with a Medicare Advantage organization offering an MA–PD plan in the same manner as they apply to contracts with a PDP sponsor offering a prescription drug plan under part D:

(A) PROMPT PAYMENT.—Section 1860D–12(b)(4).

(B) SUBMISSION OF CLAIMS BY PHARMACIES LOCATED IN OR CONTRACTING WITH LONG-TERM CARE FACILITIES.—Section 1860D–12(b)(5).

(C) REGULAR UPDATE OF PRESCRIPTION DRUG PRICING STANDARD.—Section 1860D–12(b)(6).

(g) INTERMEDIATE SANCTIONS.—

(1) IN GENERAL.—If the Secretary determines that a Medicare+Choice organization with a contract under this section—

(A) fails substantially to provide medically necessary items and services that are required (under law or under the contract) to be provided to an individual covered under the contract, if the failure has adversely affected (or has substantial likelihood of adversely affecting) the individual;

(B) imposes premiums on individuals enrolled under this part in excess of the amount of the Medicare+Choice

monthly basic and supplemental beneficiary premiums permitted under section 1854;

(C) acts to expel or to refuse to re-enroll an individual in violation of the provisions of this part;

(D) engages in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment (except as permitted by this part) by eligible individuals with the organization whose medical condition or history indicates a need for substantial future medical services;

(E) misrepresents or falsifies information that is furnished—

(i) to the Secretary under this part, or

(ii) to an individual or to any other entity under this part;

(F) fails to comply with the applicable requirements of section 1852(j)(3) or 1852(k)(2)(A)(ii);

(G) employs or contracts with any individual or entity that is excluded from participation under this title under section 1128 or 1128A for the provision of health care, utilization review, medical social work, or administrative services or employs or contracts with any entity for the provision (directly or indirectly) through such an excluded individual or entity of such services;

(H) except as provided under subparagraph (C) or (D) of section 1860D–1(b)(1), enrolls an individual in any plan under this part without the prior consent of the individual or the designee of the individual;

(I) transfers an individual enrolled under this part from one plan to another without the prior consent of the individual or the designee of the individual or solely for the purpose of earning a commission;

(J) fails to comply with marketing restrictions described in subsections (h) and (j) of section 1851 or applicable implementing regulations or guidance; or

(K) employs or contracts with any individual or entity who engages in the conduct described in subparagraphs (A) through (J) of this paragraph;

the Secretary may provide, in addition to any other remedies authorized by law, for any of the remedies described in paragraph (2). The Secretary may provide, in addition to any other remedies authorized by law, for any of the remedies described in paragraph (2), if the Secretary determines that any employee or agent of such organization, or any provider or supplier who contracts with such organization, has engaged in any conduct described in subparagraphs (A) through (K) of this paragraph.

(2) REMEDIES.—The remedies described in this paragraph are—

(A) civil money penalties of not more than $25,000 for each determination under paragraph (1) or, with respect to a determination under subparagraph (D) or (E)(i) of such paragraph, of not more than $100,000 for each such determination, except with respect to a determination under subparagraph (E), an assessment of not more than the

amount claimed by such plan or plan sponsor based upon the misrepresentation or falsified information involved, plus, with respect to a determination under paragraph (1)(B), double the excess amount charged in violation of such paragraph (and the excess amount charged shall be deducted from the penalty and returned to the individual concerned), and plus, with respect to a determination under paragraph (1)(D), $15,000 for each individual not enrolled as a result of the practice involved,

(B) suspension of enrollment of individuals under this part after the date the Secretary notifies the organization of a determination under paragraph (1) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur, or

(C) suspension of payment to the organization under this part for individuals enrolled after the date the Secretary notifies the organization of a determination under paragraph (1) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur.

(3) OTHER INTERMEDIATE SANCTIONS.—In the case of a Medicare+Choice organization for which the Secretary makes a determination under subsection (c)(2) the basis of which is not described in paragraph (1), the Secretary may apply the following intermediate sanctions:

(A) Civil money penalties of not more than $25,000 for each determination under subsection (c)(2) if the deficiency that is the basis of the determination has directly adversely affected (or has the substantial likelihood of adversely affecting) an individual covered under the organization's contract.

(B) Civil money penalties of not more than $10,000 for each week beginning after the initiation of civil money penalty procedures by the Secretary during which the deficiency that is the basis of a determination under subsection (c)(2) exists.

(C) Suspension of enrollment of individuals under this part after the date the Secretary notifies the organization of a determination under subsection (c)(2) and until the Secretary is satisfied that the deficiency that is the basis for the determination has been corrected and is not likely to recur.

(D) Civil monetary penalties of not more than $100,000, or such higher amount as the Secretary may establish by regulation, where the finding under subsection (c)(2)(A) is based on the organization's termination of its contract under this section other than at a time and in a manner provided for under subsection (a).

(4) CIVIL MONEY PENALTIES.—The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under paragraph (2) or (3) in the same manner as they apply to a civil money penalty or proceeding under section 1128A(a).

(h) PROCEDURES FOR TERMINATION.—

(1) IN GENERAL.—The Secretary may terminate a contract with a Medicare+Choice organization under this section in accordance with formal investigation and compliance procedures established by the Secretary under which—

(A) the Secretary provides the organization with the reasonable opportunity to develop and implement a corrective action plan to correct the deficiencies that were the basis of the Secretary's determination under subsection (c)(2); and

(B) the Secretary provides the organization with reasonable notice and opportunity for hearing (including the right to appeal an initial decision) before terminating the contract.

(2) EXCEPTION FOR IMMINENT AND SERIOUS RISK TO HEALTH.—Paragraph (1) shall not apply if the Secretary determines that a delay in termination, resulting from compliance with the procedures specified in such paragraph prior to termination, would pose an imminent and serious risk to the health of individuals enrolled under this part with the organization.

(i) MEDICARE+CHOICE PROGRAM COMPATIBILITY WITH EMPLOYER OR UNION GROUP HEALTH PLANS.—

(1) CONTRACTS WITH MA ORGANIZATIONS.—To facilitate the offering of Medicare+Choice plans under contracts between Medicare+Choice organizations and employers, labor organizations, or the trustees of a fund established by one or more employers or labor organizations (or combination thereof) to furnish benefits to the entity's employees, former employees (or combination thereof) or members or former members (or combination thereof) of the labor organizations, the Secretary may waive or modify requirements that hinder the design of, the offering of, or the enrollment in such Medicare+Choice plans.

(2) EMPLOYER SPONSORED MA PLANS.—To facilitate the offering of MA plans by employers, labor organizations, or the trustees of a fund established by one or more employers or labor organizations (or combination thereof) to furnish benefits to the entity's employees, former employees (or combination thereof) or members or former members (or combination thereof) of the labor organizations, the Secretary may waive or modify requirements that hinder the design of, the offering of, or the enrollment in such MA plans. Notwithstanding section 1851(g), an MA plan described in the previous sentence may restrict the enrollment of individuals under this part to individuals who are beneficiaries and participants in such plan.

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PART E—MISCELLANEOUS PROVISIONS

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ADMINISTRATION

SEC. 1874. (a) Except as otherwise provided in this title and in the Railroad Retirement Act of 1974, the insurance programs established by this title shall be administered by the Secretary. The Secretary may perform any of his functions under this title directly, or by contract providing for payment in advance or by way

of reimbursement, and in such installments, as the Secretary may deem necessary.

(b) The Secretary may contract with any person, agency, or institution to secure on a reimbursable basis such special data, actuarial information, and other information as may be necessary in the carrying out of his functions under this title.

(c) In the course of any hearing, investigation, or other proceeding that he is authorized to conduct under this title, the Secretary may administer oaths and affirmations.

(d) INCLUSION OF MEDICARE PROVIDER AND SUPPLIER PAYMENTS IN FEDERAL PAYMENT LEVY PROGRAM.—

(1) IN GENERAL.—The Centers for Medicare & Medicaid Services shall take all necessary steps to participate in the Federal Payment Levy Program under section 6331(h) of the Internal Revenue Code of 1986 as soon as possible and shall ensure that—

(A) at least 50 percent of all payments under parts A and B are processed through such program beginning within 1 year after the date of the enactment of this section;

(B) at least 75 percent of all payments under parts A and B are processed through such program beginning within 2 years after such date; and

(C) all payments under parts A and B are processed through such program beginning not later than September 30, 2011.

(2) ASSISTANCE.—The Financial Management Service and the Internal Revenue Service shall provide assistance to the Centers for Medicare & Medicaid Services to ensure that all payments described in paragraph (1) are included in the Federal Payment Levy Program by the deadlines specified in that subsection.

(e) AVAILABILITY OF DATA.—

(1) IN GENERAL.—Subject to paragraph (4), the Secretary shall make available to qualified entities (as defined in paragraph (2)) data described in paragraph (3) for the evaluation of the performance of providers of services and suppliers.

(2) QUALIFIED ENTITIES.—For purposes of this subsection, the term "qualified entity" means a public or private entity that—

(A) is qualified (as determined by the Secretary) to use claims data to evaluate the performance of providers of services and suppliers on measures of quality, efficiency, effectiveness, and resource use; and

(B) agrees to meet the requirements described in paragraph (4) and meets such other requirements as the Secretary may specify, such as ensuring security of data.

(3) DATA DESCRIBED.—The data described in this paragraph are standardized extracts (as determined by the Secretary) of claims data under parts A, B, and D for items and services furnished under such parts for one or more specified geographic areas and time periods requested by a qualified entity. Beginning July 1, 2016, if the Secretary determines appropriate, the data described in this paragraph may also include standardized extracts (as determined by the Secretary) of claims data under titles XIX and XXI for assistance provided under such

titles for one or more specified geographic areas and time periods requested by a qualified entity. The Secretary shall take such actions as the Secretary deems necessary to protect the identity of individuals entitled to or enrolled for benefits under such parts or under titles XIX or XXI.

(4) REQUIREMENTS.—

(A) FEE.—Data described in paragraph (3) shall be made available to a qualified entity under this subsection at a fee equal to the cost of making such data available. Any fee collected pursuant to the preceding sentence shall be deposited, for periods prior to July 1, 2016, into the Federal Supplementary Medical Insurance Trust Fund under section 1841, and, beginning July 1, 2016, into the Centers for Medicare & Medicaid Services Program Management Account.

(B) SPECIFICATION OF USES AND METHODOLOGIES.—A qualified entity requesting data under this subsection shall—

(i) submit to the Secretary a description of the methodologies that such qualified entity will use to evaluate the performance of providers of services and suppliers using such data;

(ii)(I) except as provided in subclause (II), if available, use standard measures, such as measures endorsed by the entity with a contract under section 1890(a) and measures developed pursuant to section 931 of the Public Health Service Act; or

(II) use alternative measures if the Secretary, in consultation with appropriate stakeholders, determines that use of such alternative measures would be more valid, reliable, responsive to consumer preferences, cost-effective, or relevant to dimensions of quality and resource use not addressed by such standard measures;

(iii) include data made available under this subsection with claims data from sources other than claims data under this title in the evaluation of performance of providers of services and suppliers;

(iv) only include information on the evaluation of performance of providers and suppliers in reports described in subparagraph (C);

(v) make available to providers of services and suppliers, upon their request, data made available under this subsection; and

(vi) prior to their release, submit to the Secretary the format of reports under subparagraph (C).

(C) REPORTS.—Any report by a qualified entity evaluating the performance of providers of services and suppliers using data made available under this subsection shall—

(i) include an understandable description of the measures, which shall include quality measures and the rationale for use of other measures described in subparagraph (B)(ii)(II), risk adjustment methods, physician attribution methods, other applicable meth-

ods, data specifications and limitations, and the sponsors, so that consumers, providers of services and suppliers, health plans, researchers, and other stakeholders can assess such reports;

(ii) be made available confidentially, to any provider of services or supplier to be identified in such report, prior to the public release of such report, and provide an opportunity to appeal and correct errors;

(iii) only include information on a provider of services or supplier in an aggregate form as determined appropriate by the Secretary; and

(iv) except as described in clause (ii), be made available to the public.

(D) APPROVAL AND LIMITATION OF USES.—The Secretary shall not make data described in paragraph (3) available to a qualified entity unless the qualified entity agrees to release the information on the evaluation of performance of providers of services and suppliers. Such entity shall only use such data, and information derived from such evaluation, for the reports under subparagraph (C). Data released to a qualified entity under this subsection shall not be subject to discovery or admission as evidence in judicial or administrative proceedings without consent of the applicable provider of services or supplier.

(f) REQUIREMENT FOR THE SECRETARY TO ESTABLISH POLICIES AND CLAIMS EDITS RELATING TO INCARCERATED INDIVIDUALS, INDIVIDUALS NOT LAWFULLY PRESENT, AND DECEASED INDIVIDUALS.—The Secretary shall establish and maintain procedures, including procedures for using claims processing edits, updating eligibility information to improve provider accessibility, and conducting recoupment activities such as through recovery audit contractors, in order to ensure that payment is not made under this title for items and services furnished to an individual who is one of the following:

(1) An individual who is incarcerated.

(2) An individual who is not lawfully present in the United States and who is not eligible for coverage under this title.

(3) A deceased individual.

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PAYMENT TO HOSPITALS FOR INPATIENT HOSPITAL SERVICES

SEC. 1886. (a)(1)(A)(i) The Secretary, in determining the amount of the payments that may be made under this title with respect to operating costs of inpatient hospital services (as defined in paragraph (4)) shall not recognize as reasonable (in the efficient delivery of health services) costs for the provision of such services by a hospital for a cost reporting period to the extent such costs exceed the applicable percentage (as determined under clause (ii)) of the average of such costs for all hospitals in the same grouping as such hospital for comparable time periods.

(ii) For purposes of clause (i), the applicable percentage for hospital cost reporting periods beginning—

(I) on or after October 1, 1982, and before October 1, 1983, is 120 percent;

(II) on or after October 1, 1983, and before October 1, 1984, is 115 percent; and

(III) on or after October 1, 1984, is 110 percent.

(B)(i) For purposes of subparagraph (A) the Secretary shall establish case mix indexes for all short- term hospitals, and shall set limits for each hospital based upon the general mix of types of medical cases with respect to which such hospital provides services for which payment may be made under this title.

(ii) The Secretary shall set such limits for a cost reporting period of a hospital—

(I) by updating available data for a previous period to the immediate preceding cost reporting period by the estimated average rate of change of hospital costs industry-wide, and

(II) by projecting for the cost reporting period by the applicable percentage increase (as defined in subsection (b)(3)(B)).

(C) The limitation established under subparagraph (A) for any hospital shall in no event be lower than the allowable operating costs of inpatient hospital services (as defined in paragraph (4)) recognized under this title for such hospital for such hospital's last cost reporting period prior to the hospital's first cost reporting period for which this section is in effect.

(D) Subparagraph (A) shall not apply to cost reporting periods beginning on or after October 1, 1983.

(2) The Secretary shall provide for such exemptions from, and exceptions and adjustments to, the limitation established under paragraph (1)(A) as he deems appropriate, including those which he deems necessary to take into account—

(A) the special needs of sole community hospitals, of new hospitals, of risk based health maintenance organizations, and of hospitals which provide atypical services or essential community services, and to take into account extraordinary circumstances beyond the hospital's control, medical and paramedical education costs, significantly fluctuating population in the service area of the hospital, and unusual labor costs,

(B) the special needs of psychiatric hospitals and of public or other hospitals that serve a significantly disproportionate number of patients who have low income or are entitled to benefits under part A of this title, and

(C) a decrease in the inpatient hospital services that a hospital provides and that are customarily provided directly by similar hospitals which results in a significant distortion in the operating costs of inpatient hospital services.

(3) The limitation established under paragraph (1)(A) shall not apply with respect to any hospital which—

(A) is located outside of a standard metropolitan statistical area, and

(B)(i) has less than 50 beds, and

(ii) was in operation and had less than 50 beds on the date of the enactment of this section.

(4) For purposes of this section, the term "operating costs of inpatient hospital services" includes all routine operating costs, ancillary service operating costs, and special care unit operating costs with respect to inpatient hospital services as such costs are determined on an average per admission or per discharge basis (as determined by the Secretary), and includes the costs of all services

for which payment may be made under this title that are provided by the hospital (or by an entity wholly owned or operated by the hospital) to the patient during the 3 days (or, in the case of a hospital that is not a subsection (d) hospital, during the 1 day) immediately preceding the date of the patient's admission if such services are diagnostic services (including clinical diagnostic laboratory tests) or are other services related to the admission (as defined by the Secretary). Such term does not include costs of approved educational activities, a return on equity capital, or, other capital-related costs (as defined by the Secretary for periods before October 1, 1987). In applying the first sentence of this paragraph, the term "other services related to the admission" includes all services that are not diagnostic services (other than ambulance and maintenance renal dialysis services) for which payment may be made under this title that are provided by a hospital (or an entity wholly owned or operated by the hospital) to a patient—

(A) on the date of the patient's inpatient admission; or

(B) during the 3 days (or, in the case of a hospital that is not a subsection (d) hospital, during the 1 day) immediately preceding the date of such admission unless the hospital demonstrates (in a form and manner, and at a time, specified by the Secretary) that such services are not related (as determined by the Secretary) to such admission.

(b)(1) Notwithstanding section 1814(b) but subject to the provisions of section 1813, if the operating costs of inpatient hospital services (as defined in subsection (a)(4)) of a hospital (other than a subsection (d) hospital, as defined in subsection (d)(1)(B) and other than a rehabilitation facility described in subsection (j)(1)) for a cost reporting period subject to this paragraph—

(A) are less than or equal to the target amount (as defined in paragraph (3)) for that hospital for that period, the amount of the payment with respect to such operating costs payable under part A on a per discharge or per admission basis (as the case may be) shall be equal to the amount of such operating costs, plus—

(i) 15 percent of the amount by which the target amount exceeds the amount of the operating costs, or

(ii) 2 percent of the target amount,

whichever is less;

(B) are greater than the target amount but do not exceed 110 percent of the target amount, the amount of the payment with respect to those operating costs payable under part A on a per discharge basis shall equal the target amount; or

(C) are greater than 110 percent of the target amount, the amount of the payment with respect to such operating costs payable under part A on a per discharge or per admission basis (as the case may be) shall be equal to (i) the target amount, plus (ii) in the case of cost reporting periods beginning on or after October 1, 1991, an additional amount equal to 50 percent of the amount by which the operating costs exceed 110 percent of the target amount (except that such additional amount may not exceed 10 percent of the target amount) after any exceptions or adjustments are made to such target amount for the cost reporting period;

plus the amount, if any, provided under paragraph (2), except that in no case may the amount payable under this title (other than on the basis of a DRG prospective payment rate determined under subsection (d)) with respect to operating costs of inpatient hospital services exceed the maximum amount payable with respect to such costs pursuant to subsection (a).

(2)(A) Except as provided in subparagraph (E), in addition to the payment computed under paragraph (1), in the case of an eligible hospital (described in subparagraph (B)) for a cost reporting period beginning on or after October 1, 1997, the amount of payment on a per discharge basis under paragraph (1) shall be increased by the lesser of—

(i) 50 percent of the amount by which the operating costs are less than the expected costs (as defined in subparagraph (D)) for the period; or

(ii) 1 percent of the target amount for the period.

(B) For purposes of this paragraph, an "eligible hospital" means with respect to a cost reporting period, a hospital—

(i) that has received payments under this subsection for at least 3 full cost reporting periods before that cost reporting period, and

(ii) whose operating costs for the period are less than the least of its target amount, its trended costs (as defined in subparagraph (C)), or its expected costs (as defined in subparagraph (D)) for the period.

(C) For purposes of subparagraph (B)(ii), the term "trended costs" means for a hospital cost reporting period ending in a fiscal year—

(i) in the case of a hospital for which its cost reporting period ending in fiscal year 1996 was its third or subsequent full cost reporting period for which it receives payments under this subsection, the lesser of the operating costs or target amount for that hospital for its cost reporting period ending in fiscal year 1996, or

(ii) in the case of any other hospital, the operating costs for that hospital for its third full cost reporting period for which it receives payments under this subsection,

increased (in a compounded manner) for each succeeding fiscal year (through the fiscal year involved) by the market basket percentage increase for the fiscal year.

(D) For purposes of this paragraph, the term "expected costs", with respect to the cost reporting period ending in a fiscal year, means the lesser of the operating costs of inpatient hospital services or target amount per discharge for the previous cost reporting period updated by the market basket percentage increase (as defined in paragraph (3)(B)(iii)) for the fiscal year.

(E)(i) In the case of an eligible hospital that is a hospital or unit that is within a class of hospital described in clause (ii) with a 12-month cost reporting period beginning before the enactment of this subparagraph, in determining the amount of the increase under subparagraph (A), the Secretary shall substitute for the percentage of the target amount applicable under subparagraph (A)(ii)—

(I) for a cost reporting period beginning on or after October 1, 2000, and before September 30, 2001, 1.5 percent; and

(II) for a cost reporting period beginning on or after October 1, 2001, and before September 30, 2002, 2 percent.

(ii) For purposes of clause (i), each of the following shall be treated as a separate class of hospital:

(I) Hospitals described in clause (i) of subsection (d)(1)(B) and psychiatric units described in the matter following clause (v) of such subsection.

(II) Hospitals described in clause (iv) of such subsection.

(3)(A) Except as provided in subparagraph (C) and succeeding subparagraphs and in paragraph (7)(A)(ii), for purposes of this subsection, the term "target amount" means, with respect to a hospital for a particular 12-month cost reporting period—

(i) in the case of the first such reporting period for which this subsection is in effect, the allowable operating costs of inpatient hospital services (as defined in subsection (a)(4)) recognized under this title for such hospital for the preceding 12-month cost reporting period, and

(ii) in the case of a later reporting period, the target amount for the preceding 12-month cost reporting period,

increased by the applicable percentage increase under subparagraph (B) for that particular cost reporting period.

(B)(i) For purposes of subsection (d) and subsection (j) for discharges occurring during a fiscal year, the "applicable percentage increase" shall be—

(I) for fiscal year 1986, ½ percent,

(II) for fiscal year 1987, 1.15 percent,

(III) for fiscal year 1988, 3.0 percent for hospitals located in a rural area, 1.5 percent for hospitals located in a large urban area (as defined in subsection (d)(2)(D)), and 1.0 percent for hospitals located in other urban areas,

(IV) for fiscal year 1989, the market basket percentage increase minus 1.5 percentage points for hospitals located in a rural area, the market basket percentage increase minus 2.0 percentage points for hospitals located in a large urban area, and the market basket percentage increase minus 2.5 percentage points for hospitals located in other urban areas,

(V) for fiscal year 1990, the market basket percentage increase plus 4.22 percentage points for hospitals located in a rural area, the market basket percentage increase plus 0.12 percentage points for hospitals located in a large urban area, and the market basket percentage increase minus 0.53 percentage points for hospitals located in other urban areas,

(VI) for fiscal year 1991, the market basket percentage increase minus 2.0 percentage points for hospitals in a large urban or other urban area, and the market basket percentage increase minus 0.7 percentage point for hospitals located in a rural area,

(VII) for fiscal year 1992, the market basket percentage increase minus 1.6 percentage points for hospitals in a large urban or other urban area, and the market basket percentage increase minus 0.6 percentage point for hospitals located in a rural area,

(VIII) for fiscal year 1993, the market basket percentage increase minus 1.55 percentage point for hospitals in a large urban or other urban area, and the market basket percentage increase minus 0.55 for hospitals located in a rural area,

(IX) for fiscal year 1994, the market basket percentage increase minus 2.5 percentage points for hospitals located in a large urban or other urban area, and the market basket percentage increase minus 1.0 percentage point for hospitals located in a rural area,

(X) for fiscal year 1995, the market basket percentage increase minus 2.5 percentage points for hospitals located in a large urban or other urban area, and such percentage increase for hospitals located in a rural area as will provide for the average standardized amount determined under subsection (d)(3)(A) for hospitals located in a rural area being equal to such average standardized amount for hospitals located in an urban area (other than a large urban area),

(XI) for fiscal year 1996, the market basket percentage increase minus 2.0 percentage points for hospitals in all areas,

(XII) for fiscal year 1997, the market basket percentage increase minus 0.5 percentage point for hospitals in all areas,

(XIII) for fiscal year 1998, 0 percent,

(XIV) for fiscal year 1999, the market basket percentage increase minus 1.9 percentage points for hospitals in all areas,

(XV) for fiscal year 2000, the market basket percentage increase minus 1.8 percentage points for hospitals in all areas,

(XVI) for fiscal year 2001, the market basket percentage increase for hospitals in all areas,

(XVII) for fiscal year 2002, the market basket percentage increase minus 0.55 percentage points for hospitals in all areas,

(XVIII) for fiscal year 2003, the market basket percentage increase minus 0.55 percentage points for hospitals in all areas,

(XIX) for each of fiscal years 2004 through 2006, subject to clause (vii), the market basket percentage increase for hospitals in all areas; and

(XX) for each subsequent fiscal year, subject to clauses (viii), (ix), (xi), and (xii), the market basket percentage increase for hospitals in all areas.

(ii) For purposes of subparagraphs (A) and (E), the "applicable percentage increase" for 12-month cost reporting periods beginning during—

(I) fiscal year 1986, is 0.5 percent,

(II) fiscal year 1987, is 1.15 percent,

(III) fiscal year 1988, is the market basket percentage increase minus 2.0 percentage points,

(IV) a subsequent fiscal year ending on or before September 30, 1993, is the market basket percentage increase,

(V) fiscal years 1994 through 1997, is the market basket percentage increase minus the applicable reduction (as defined in clause (v)(II)), or in the case of a hospital for a fiscal year for which the hospital's update adjustment percentage (as defined in clause (v)(I)) is at least 10 percent, the market basket percentage increase,

(VI) for fiscal year 1998, is 0 percent,

(VII) for fiscal years 1999 through 2002, is the applicable update factor specified under clause (vi) for the fiscal year, and

(VIII) subsequent fiscal years is the market basket percentage increase.

(iii) For purposes of this subparagraph, the term "market basket percentage increase" means, with respect to cost reporting periods and discharges occurring in a fiscal year, the percentage, estimated by the Secretary before the beginning of the period or fiscal year, by which the cost of the mix of goods and services (including personnel costs but excluding nonoperating costs) comprising routine, ancillary, and special care unit inpatient hospital services, based on an index of appropriately weighted indicators of changes in wages and prices which are representative of the mix of goods and services included in such inpatient hospital services, for the period or fiscal year will exceed the cost of such mix of goods and services for the preceding 12-month cost reporting period or fiscal year.

(iv) For purposes of subparagraphs (C) and (D), the "applicable percentage increase" is—

(I) for 12-month cost reporting periods beginning during fiscal years 1986 through 1993, the applicable percentage increase specified in clause (ii),

(II) for fiscal year 1994, the market basket percentage increase minus 2.3 percentage points (adjusted to exclude any portion of a cost reporting period beginning during fiscal year 1993 for which the applicable percentage increase is determined under subparagraph (I)),

(III) for fiscal year 1995, the market basket percentage increase minus 2.2 percentage points, and

(IV) for fiscal year 1996 and each subsequent fiscal year, the applicable percentage increase under clause (i).

(v) For purposes of clause (ii)(V)—

(I) a hospital's "update adjustment percentage" for a fiscal year is the percentage by which the hospital's allowable operating costs of inpatient hospital services recognized under this title for the cost reporting period beginning in fiscal year 1990 exceeds the hospital's target amount (as determined under subparagraph (A)) for such cost reporting period, increased for each fiscal year (beginning with fiscal year 1994) by the sum of any of the hospital's applicable reductions under subclause (V) for previous fiscal years; and

(II) the "applicable reduction" with respect to a hospital for a fiscal year is the lesser of 1 percentage point or the percentage point difference between 10 percent and the hospital's update adjustment percentage for the fiscal year.

(vi) For purposes of clause (ii)(VII) for a fiscal year, if a hospital's allowable operating costs of inpatient hospital services recognized under this title for the most recent cost reporting period for which information is available—

(I) is equal to, or exceeds, 110 percent of the hospital's target amount (as determined under subparagraph (A)) for such cost reporting period, the applicable update factor specified under this clause is the market basket percentage;

(II) exceeds 100 percent, but is less than 110 percent, of such target amount for the hospital, the applicable update factor specified under this clause is 0 percent or, if greater, the market basket percentage minus 0.25 percentage points for each percentage point by which such allowable operating costs (expressed as a percentage of such target amount) is less than 110 percent of such target amount;

(III) is equal to, or less than 100 percent, but exceeds ⅔ of such target amount for the hospital, the applicable update factor specified under this clause is 0 percent or, if greater, the market basket percentage minus 2.5 percentage points; or

(IV) does not exceed ⅔ of such target amount for the hospital, the applicable update factor specified under this clause is 0 percent.

(vii)(I) For purposes of clause (i)(XIX) for fiscal years 2005 and 2006, in a case of a subsection (d) hospital that does not submit data to the Secretary in accordance with subclause (II) with respect to such a fiscal year, the applicable percentage increase under such clause for such fiscal year shall be reduced by 0.4 percentage points. Such reduction shall apply only with respect to the fiscal year involved, and the Secretary shall not take into account such reduction in computing the applicable percentage increase under clause (i)(XIX) for a subsequent fiscal year.

(II) For fiscal years 2005 and 2006, each subsection (d) hospital shall submit to the Secretary quality data (for a set of 10 indicators established by the Secretary as of November 1, 2003) that relate to the quality of care furnished by the hospital in inpatient settings in a form and manner, and at a time, specified by the Secretary for purposes of this clause, but with respect to fiscal year 2005, the Secretary shall provide for a 30-day grace period for the submission of data by a hospital.

(viii)(I) For purposes of clause (i) for fiscal year 2007 and each subsequent fiscal year, in the case of a subsection (d) hospital that does not submit, to the Secretary in accordance with this clause, data required to be submitted on measures selected under this clause with respect to such a fiscal year, the applicable percentage increase under clause (i) for such fiscal year shall be reduced by 2.0 percentage points (or, beginning with fiscal year 2015, by one-quarter of such applicable percentage increase (determined without regard to clause (ix), (xi), or (xii))). Such reduction shall apply only with respect to the fiscal year involved and the Secretary shall not take into account such reduction in computing the applicable percentage increase under clause (i) for a subsequent fiscal year, and the Secretary and the Medicare Payment Advisory Commission shall carry out the requirements under section 5001(b) of the Deficit Reduction Act of 2005.

(II) Each subsection (d) hospital shall submit data on measures selected under this clause to the Secretary in a form and manner, and at a time, specified by the Secretary for purposes of this clause. The Secretary may require hospitals to submit data on measures that are not used for the determination of value-based incentive payments under subsection (o).

(III) The Secretary shall expand, beyond the measures specified under clause (vii)(II) and consistent with the succeeding subclauses, the set of measures that the Secretary determines to be appropriate for the measurement of the quality of care (including medication errors) furnished by hospitals in inpatient settings.

(IV) Effective for payments beginning with fiscal year 2007, in expanding the number of measures under subclause (III), the Secretary shall begin to adopt the baseline set of performance measures as set forth in the November 2005 report by the Institute of Medicine of the National Academy of Sciences under section 238(b)

of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

(V) Effective for payments for fiscal years 2008 through 2012, the Secretary shall add other measures that reflect consensus among affected parties and, to the extent feasible and practicable, shall include measures set forth by one or more national consensus building entities.

(VI) For purposes of this clause and clause (vii), the Secretary may replace any measures or indicators in appropriate cases, such as where all hospitals are effectively in compliance or the measures or indicators have been subsequently shown not to represent the best clinical practice.

(VII) The Secretary shall establish procedures for making information regarding measures submitted under this clause available to the public. Such procedures shall ensure that a hospital has the opportunity to review the data that are to be made public with respect to the hospital prior to such data being made public. The Secretary shall report quality measures of process, structure, outcome, patients' perspectives on care, efficiency, and costs of care that relate to services furnished in inpatient settings in hospitals on the Internet website of the Centers for Medicare & Medicaid Services.

(VIII) Effective for payments beginning with fiscal year 2013, with respect to quality measures for outcomes of care, the Secretary shall provide for such risk adjustment as the Secretary determines to be appropriate to maintain incentives for hospitals to treat patients with severe illnesses or conditions.

(IX)(aa) Subject to item (bb), effective for payments beginning with fiscal year 2013, each measure specified by the Secretary under this clause shall be endorsed by the entity with a contract under section 1890(a).

(bb) 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), the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

(X) To the extent practicable, the Secretary shall, with input from consensus organizations and other stakeholders, take steps to ensure that the measures specified by the Secretary under this clause are coordinated and aligned with quality measures applicable to—

(aa) physicians under section 1848(k); and

(bb) other providers of services and suppliers under this title.

(XI) The Secretary shall establish a process to validate measures specified under this clause as appropriate. Such process shall include the auditing of a number of randomly selected hospitals sufficient to ensure validity of the reporting program under this clause as a whole and shall provide a hospital with an opportunity to appeal the validation of measures reported by such hospital.

(ix)(I) For purposes of clause (i) for fiscal year 2015 and each subsequent fiscal year, in the case of an eligible hospital (as defined in subsection (n)(6)(B)) that is not a meaningful EHR user (as defined in subsection (n)(3)) for an EHR reporting period for such fiscal year, three-quarters of the applicable percentage increase other-

wise applicable under clause (i) (determined without regard to clause (viii), (xi), or (xii)) for such fiscal year shall be reduced by 33⅓ percent for fiscal year 2015, 66⅔ percent for fiscal year 2016, and 100 percent for fiscal year 2017 and each subsequent fiscal year. Such reduction shall apply only with respect to the fiscal year involved and the Secretary shall not take into account such reduction in computing the applicable percentage increase under clause (i) for a subsequent fiscal year.

(II) The Secretary may, on a case-by-case basis (and, with respect to the application of subclause (I) for fiscal year 2017, for categories of subsection (d) hospitals, as established by the Secretary and posted on the Internet website of the Centers for Medicare & Medicaid Services prior to December 15, 2015, an application for which must be submitted to the Secretary by not later than April 1, 2016), exempt an eligible hospital from the application of subclause (I) with respect to a fiscal year if the Secretary determines, subject to annual renewal, that requiring such hospital to be a meaningful EHR user during such fiscal year would result in a significant hardship, such as in the case of a hospital in a rural area without sufficient Internet access. In no case may a hospital be granted an exemption under this subclause for more than 5 years.

(III) For fiscal year 2015 and each subsequent fiscal year, a State in which hospitals are paid for services under section 1814(b)(3) shall adjust the payments to each subsection (d) hospital in the State that is not a meaningful EHR user (as defined in subsection (n)(3)) in a manner that is designed to result in an aggregate reduction in payments to hospitals in the State that is equivalent to the aggregate reduction that would have occurred if payments had been reduced to each subsection (d) hospital in the State in a manner comparable to the reduction under the previous provisions of this clause. The State shall report to the Secretary the methodology it will use to make the payment adjustment under the previous sentence.

(IV) For purposes of this clause, the term "EHR reporting period" means, with respect to a fiscal year, any period (or periods) as specified by the Secretary.

(x)(I) The Secretary shall develop standard Internet website reports tailored to meet the needs of various stakeholders such as hospitals, patients, researchers, and policymakers. The Secretary shall seek input from such stakeholders in determining the type of information that is useful and the formats that best facilitate the use of the information.

(II) The Secretary shall modify the Hospital Compare Internet website to make the use and navigation of that website readily available to individuals accessing it.

(xi)(I) For 2012 and each subsequent fiscal year, after determining the applicable percentage increase described in clause (i) and after application of clauses (viii) and (ix), such percentage increase shall be reduced by the productivity adjustment described in subclause (II).

(II) The productivity adjustment described in this subclause, with respect to a percentage, factor, or update for a fiscal year, year, cost reporting period, or other annual period, is a productivity adjustment equal to the 10-year moving average of changes in annual economy-wide private nonfarm business multi-factor productivity

(as projected by the Secretary for the 10-year period ending with the applicable fiscal year, year, cost reporting period, or other annual period).

(III) The application of subclause (I) may result in the applicable percentage increase described in clause (i) being less than 0.0 for a fiscal year, and may result in payment rates under this section for a fiscal year being less than such payment rates for the preceding fiscal year.

(xii) After determining the applicable percentage increase described in clause (i), and after application of clauses (viii), (ix), and (xi), the Secretary shall reduce such applicable percentage increase—

(I) for each of fiscal years 2010 and 2011, by 0.25 percentage point;

(II) for each of fiscal years 2012 and 2013, by 0.1 percentage point;

(III) for fiscal year 2014, by 0.3 percentage point;

(IV) for each of fiscal years 2015 and 2016, by 0.2 percentage point; and

(V) for each of fiscal years 2017, 2018, and 2019, by 0.75 percentage point.

The application of this clause may result in the applicable percentage increase described in clause (i) being less than 0.0 for a fiscal year, and may result in payment rates under this section for a fiscal year being less than such payment rates for the preceding fiscal year.

(C) In the case of a hospital that is a sole community hospital (as defined in subsection (d)(5)(D)(iii)), subject to subparagraphs (I) and (L), the term "target amount" means—

(i) with respect to the first 12-month cost reporting period in which this subparagraph is applied to the hospital—

(I) the allowable operating costs of inpatient hospital services (as defined in subsection (a)(4)) recognized under this title for the hospital for the 12-month cost reporting period (in this subparagraph referred to as the "base cost reporting period") preceding the first cost reporting period for which this subsection was in effect with respect to such hospital, increased (in a compounded manner) by—

(II) the applicable percentage increases applied to such hospital under this paragraph for cost reporting periods after the base cost reporting period and up to and including such first 12-month cost reporting period,

(ii) with respect to a later cost reporting period beginning before fiscal year 1994, the target amount for the preceding 12-month cost reporting period, increased by the applicable percentage increase under subparagraph (B)(iv) for discharges occurring in the fiscal year in which that later cost reporting period begins,

(iii) with respect to discharges occurring in fiscal year 1994, the target amount for the cost reporting period beginning in fiscal year 1993 increased by the applicable percentage increase under subparagraph (B)(iv), or

(iv) with respect to discharges occurring in fiscal year 1995 and each subsequent fiscal year, the target amount for the pre-

ceding year increased by the applicable percentage increase under subparagraph (B)(iv).

There shall be substituted for the base cost reporting period described in clause (i) a hospital's cost reporting period (if any) beginning during fiscal year 1987 if such substitution results in an increase in the target amount for the hospital.

(D) For cost reporting periods ending on or before September 30, 1994, and for cost reporting periods occurring on or after October 1, 1997, and before October 1, 2017, in the case of a hospital that is a medicare-dependent, small rural hospital (as defined in subsection (d)(5)(G)), subject to subparagraph (K), the term "target amount" means—

(i) with respect to the first 12-month cost reporting period in which this subparagraph is applied to the hospital—

(I) the allowable operating costs of inpatient hospital services (as defined in subsection (a)(4)) recognized under this title for the hospital for the 12-month cost reporting period (in this subparagraph referred to as the "base cost reporting period") preceding the first cost reporting period for which this subsection was in effect with respect to such hospital, increased (in a compounded manner) by—

(II) the applicable percentage increases applied to such hospital under this paragraph for cost reporting periods after the base cost reporting period and up to and including such first 12-month cost reporting period, or

(ii) with respect to a later cost reporting period beginning before fiscal year 1994, the target amount for the preceding 12-month cost reporting period, increased by the applicable percentage increase under subparagraph (B)(iv) for discharges occurring in the fiscal year in which that later cost reporting period begins,

(iii) with respect to discharges occurring in fiscal year 1994, the target amount for the cost reporting period beginning in fiscal year 1993 increased by the applicable percentage increase under subparagraph (B)(iv), and

(iv) with respect to discharges occurring during fiscal year 1998 through fiscal year 2017, the target amount for the preceding year increased by the applicable percentage increase under subparagraph (B)(iv).

There shall be substituted for the base cost reporting period described in clause (i) a hospital's cost reporting period (if any) beginning during fiscal year 1987 if such substitution results in an increase in the target amount for the hospital.

(E) In the case of a hospital described in clause (v) of subsection (d)(1)(B), the term "target amount" means—

(i) with respect to the first 12-month cost reporting period in which this subparagraph is applied to the hospital—

(I) the allowable operating costs of inpatient hospital services (as defined in subsection (a)(4)) recognized under this title for the hospital for the 12-month cost reporting period (in this subparagraph referred to as the "base cost reporting period") preceding the first cost reporting period for which this subsection was in effect with respect to such hospital, increased (in a compounded manner) by—

(II) the sum of the applicable percentage increases applied to such hospital under this paragraph for cost reporting periods after the base cost reporting period and up to and including such first 12-month cost reporting period, or

(ii) with respect to a later cost reporting period, the target amount for the preceding 12-month cost reporting period, increased by the applicable percentage increase under subparagraph (B)(ii) for that later cost reporting period.

There shall be substituted for the base cost reporting period described in clause (i) a hospital's cost reporting period (if any) beginning during fiscal year 1987 if such substitution results in an increase in the target amount for the hospital.

(F)(i) In the case of a hospital (or unit described in the matter following clause (v) of subsection (d)(1)(B)) that received payment under this subsection for inpatient hospital services furnished during cost reporting periods beginning before October 1, 1990, that is within a class of hospital described in clause (iii), and that elects (in a form and manner determined by the Secretary) this subparagraph to apply to the hospital, the target amount for the hospital's 12-month cost reporting period beginning during fiscal year 1998 is equal to the average described in clause (ii).

(ii) The average described in this clause for a hospital or unit shall be determined by the Secretary as follows:

(I) The Secretary shall determine the allowable operating costs for inpatient hospital services for the hospital or unit for each of the 5 cost reporting periods for which the Secretary has the most recent settled cost reports as of the date of the enactment of this subparagraph.

(II) The Secretary shall increase the amount determined under subclause (I) for each cost reporting period by the applicable percentage increase under subparagraph (B)(ii) for each subsequent cost reporting period up to the cost reporting period described in clause (i).

(III) The Secretary shall identify among such 5 cost reporting periods the cost reporting periods for which the amount determined under subclause (II) is the highest, and the lowest.

(IV) The Secretary shall compute the averages of the amounts determined under subclause (II) for the 3 cost reporting periods not identified under subclause (III).

(iii) For purposes of this subparagraph, each of the following shall be treated as a separate class of hospital:

(I) Hospitals described in clause (i) of subsection (d)(1)(B) and psychiatric units described in the matter following clause (v) of such subsection.

(II) Hospitals described in clause (ii) of such subsection and rehabilitation units described in the matter following clause (v) of such subsection.

(III) Hospitals described in clause (iii) of such subsection.

(IV) Hospitals described in clause (iv) of such subsection.

(V) Hospitals described in clause (v) of such subsection.

(G)(i) In the case of a qualified long-term care hospital (as defined in clause (ii)) that elects (in a form and manner determined by the Secretary) this subparagraph to apply to the hospital, the target amount for the hospital's 12-month cost reporting period beginning during fiscal year 1998 is equal to the allowable operating

costs of inpatient hospital services (as defined in subsection (a)(4)) recognized under this title for the hospital for the 12-month cost reporting period beginning during fiscal year 1996, increased by the applicable percentage increase for the cost reporting period beginning during fiscal year 1997.

(ii) In clause (i), a "qualified long-term care hospital" means, with respect to a cost reporting period, a hospital described in clause (iv) of subsection (d)(1)(B) during each of the 2 cost reporting periods for which the Secretary has the most recent settled cost reports as of the date of the enactment of this subparagraph for each of which—

(I) the hospital's allowable operating costs of inpatient hospital services recognized under this title exceeded 115 percent of the hospital's target amount, and

(II) the hospital would have a disproportionate patient percentage of at least 70 percent (as determined by the Secretary under subsection (d)(5)(F)(vi)) if the hospital were a subsection (d) hospital.

(H)(i) In the case of a hospital or unit that is within a class of hospital described in clause (iv), for a cost reporting period beginning during fiscal years 1998 through 2002, the target amount for such a hospital or unit may not exceed the amount as updated up to or for such cost reporting period under clause (ii).

(ii)(I) In the case of a hospital or unit that is within a class of hospital described in clause (iv), the Secretary shall estimate the 75th percentile of the target amounts for such hospitals within such class for cost reporting periods ending during fiscal year 1996, as adjusted under clause (iii).

(II) The Secretary shall update the amount determined under subclause (I), for each cost reporting period after the cost reporting period described in such subclause and up to the first cost reporting period beginning on or after October 1, 1997, by a factor equal to the market basket percentage increase.

(III) For cost reporting periods beginning during each of fiscal years 1999 through 2002, subject to subparagraph (J), the Secretary shall update such amount by a factor equal to the market basket percentage increase.

(iii) In applying clause (ii)(I) in the case of a hospital or unit, the Secretary shall provide for an appropriate adjustment to the labor-related portion of the amount determined under such subparagraph to take into account differences between average wage-related costs in the area of the hospital and the national average of such costs within the same class of hospital.

(iv) For purposes of this subparagraph, each of the following shall be treated as a separate class of hospital:

(I) Hospitals described in clause (i) of subsection (d)(1)(B) and psychiatric units described in the matter following clause (v) of such subsection.

(II) Hospitals described in clause (ii) of such subsection and rehabilitation units described in the matter following clause (v) of such subsection.

(III) Hospitals described in clause (iv) of such subsection.

(I)(i) Subject to subparagraph (L), for cost reporting periods beginning on or after October 1, 2000, in the case of a sole community hospital there shall be substituted for the amount otherwise deter-

mined under subsection (d)(5)(D)(i), if such substitution results in a greater amount of payment under this section for the hospital—

(I) with respect to discharges occurring in fiscal year 2001, 75 percent of the amount otherwise applicable to the hospital under subsection (d)(5)(D)(i) (referred to in this clause as the "subsection (d)(5)(D)(i) amount") and 25 percent of the rebased target amount (as defined in clause (ii));

(II) with respect to discharges occurring in fiscal year 2002, 50 percent of the subsection (d)(5)(D)(i) amount and 50 percent of the rebased target amount;

(III) with respect to discharges occurring in fiscal year 2003, 25 percent of the subsection (d)(5)(D)(i) amount and 75 percent of the rebased target amount; and

(IV) with respect to discharges occurring after fiscal year 2003, 100 percent of the rebased target amount.

(ii) For purposes of this subparagraph, the "rebased target amount" has the meaning given the term "target amount" in subparagraph (C) except that—

(I) there shall be substituted for the base cost reporting period the 12-month cost reporting period beginning during fiscal year 1996;

(II) any reference in subparagraph (C)(i) to the "first cost reporting period" described in such subparagraph is deemed a reference to the first cost reporting period beginning on or after October 1, 2000; and

(III) applicable increase percentage shall only be applied under subparagraph (C)(iv) for discharges occurring in fiscal years beginning with fiscal year 2002.

(iii) In no case shall a hospital be denied treatment as a sole community hospital or payment (on the basis of a target rate as such as a hospital) because data are unavailable for any cost reporting period due to changes in ownership, changes in fiscal intermediaries, or other extraordinary circumstances, so long as data for at least one applicable base cost reporting period is available.

(J) For cost reporting periods beginning during fiscal year 2001, for a hospital described in subsection (d)(1)(B)(iv)—

(i) the limiting or cap amount otherwise determined under subparagraph (H) shall be increased by 2 percent; and

(ii) the target amount otherwise determined under subparagraph (A) shall be increased by 25 percent (subject to the limiting or cap amount determined under subparagraph (H), as increased by clause (i)).

(K)(i) With respect to discharges occurring on or after October 1, 2006, in the case of a medicare-dependent, small rural hospital, for purposes of applying subparagraph (D)—

(I) there shall be substituted for the base cost reporting period described in subparagraph (D)(i) the 12-month cost reporting period beginning during fiscal year 2002; and

(II) any reference in such subparagraph to the "first cost reporting period" described in such subparagraph is deemed a reference to the first cost reporting period beginning on or after October 1, 2006.

(ii) This subparagraph shall only apply to a hospital if the substitution described in clause (i)(I) results in an increase in the target amount under subparagraph (D) for the hospital.

(L)(i) For cost reporting periods beginning on or after January 1, 2009, in the case of a sole community hospital there shall be substituted for the amount otherwise determined under subsection (d)(5)(D)(i) of this section, if such substitution results in a greater amount of payment under this section for the hospital, the subparagraph (L) rebased target amount.

(ii) For purposes of this subparagraph, the term "subparagraph (L) rebased target amount" has the meaning given the term "target amount" in subparagraph (C), except that—

(I) there shall be substituted for the base cost reporting period the 12-month cost reporting period beginning during fiscal year 2006;

(II) any reference in subparagraph (C)(i) to the "first cost reporting period" described in such subparagraph is deemed a reference to the first cost reporting period beginning on or after January 1, 2009; and

(III) the applicable percentage increase shall only be applied under subparagraph (C)(iv) for discharges occurring on or after January 1, 2009.

(4)(A)(i) The Secretary shall provide for an exception and adjustment to (and in the case of a hospital described in subsection (d)(1)(B)(iii), may provide an exemption from) the method under this subsection for determining the amount of payment to a hospital where events beyond the hospital's control or extraordinary circumstances, including changes in the case mix of such hospital, create a distortion in the increase in costs for a cost reporting period (including any distortion in the costs for the base period against which such increase is measured). The Secretary may provide for such other exemptions from, and exceptions and adjustments to, such method as the Secretary deems appropriate, including the assignment of a new base period which is more representative, as determined by the Secretary, of the reasonable and necessary cost of inpatient services and including those which he deems necessary to take into account a decrease in the inpatient hospital services that a hospital provides and that are customarily provided directly by similar hospitals which results in a significant distortion in the operating costs of inpatient hospital services. The Secretary shall announce a decision on any request for an exemption, exception, or adjustment under this paragraph not later than 180 days after receiving a completed application from the intermediary for such exemption, exception, or adjustment, and shall include in such decision a detailed explanation of the grounds on which such request was approved or denied.

(ii) The payment reductions under paragraph (3)(B)(ii)(V) shall not be considered by the Secretary in making adjustments pursuant to clause (i). In making such reductions, the Secretary shall treat the applicable update factor described in paragraph (3)(B)(vi) for a fiscal year as being equal to the market basket percentage for that year.

(B) In determining under subparagraph (A) whether to assign a new base period which is more representative of the reasonable and necessary cost to a hospital of providing inpatient services, the Secretary shall take into consideration—

(i) changes in applicable technologies and medical practices, or differences in the severity of illness among patients, that increase the hospital's costs;

(ii) whether increases in wages and wage-related costs for hospitals located in the geographic area in which the hospital is located exceed the average of the increases in such costs paid by hospitals in the United States; and

(iii) such other factors as the Secretary considers appropriate in determining increases in the hospital's costs of providing inpatient services.

(C) Paragraph (1) shall not apply to payment of hospitals which is otherwise determined under paragraph (3) of section 1814(b).

(5) In the case of any hospital having any cost reporting period of other than a 12-month period, the Secretary shall determine the 12-month period which shall be used for purposes of this section.

(6) In the case of any hospital which becomes subject to the taxes under section 3111 of the Internal Revenue Code of 1954, with respect to any or all of its employees, for part or all of a cost reporting period, and was not subject to such taxes with respect to any or all of its employees for all or part of the 12-month base cost reporting period referred to in subsection (b)(3)(A)(i), the Secretary shall provide for an adjustment by increasing the base period amount described in such subsection for such hospital by an amount equal to the amount of such taxes which would have been paid or accrued by such hospital for such base period if such hospital had been subject to such taxes for all of such base period with respect to all its employees, minus the amount of any such taxes actually paid or accrued for such base period.

(7)(A) Notwithstanding paragraph (1), in the case of a hospital or unit that is within a class of hospital described in subparagraph (B) which first receives payments under this section on or after October 1, 1997—

(i) for each of the first 2 cost reporting periods for which the hospital has a settled cost report, the amount of the payment with respect to operating costs described in paragraph (1) under part A on a per discharge or per admission basis (as the case may be) is equal to the lesser of—

(I) the amount of operating costs for such respective period, or

(II) 110 percent of the national median (as estimated by the Secretary) of the target amount for hospitals in the same class as the hospital for cost reporting periods ending during fiscal year 1996, updated by the hospital market basket increase percentage to the fiscal year in which the hospital first received payments under this section, as adjusted under subparagraph (C); and

(ii) for purposes of computing the target amount for the subsequent cost reporting period, the target amount for the preceding cost reporting period is equal to the amount determined under clause (i) for such preceding period.

(B) For purposes of this paragraph, each of the following shall be treated as a separate class of hospital:

(i) Hospitals described in clause (i) of subsection (d)(1)(B) and psychiatric units described in the matter following clause (v) of such subsection.

(ii) Hospitals described in clause (ii) of such subsection and rehabilitation units described in the matter following clause (v) of such subsection.

(iii) Hospitals described in clause (iv) of such subsection.

(C) In applying subparagraph (A)(i)(II) in the case of a hospital or unit, the Secretary shall provide for an appropriate adjustment to the labor-related portion of the amount determined under such subparagraph to take into account differences between average wage-related costs in the area of the hospital and the national average of such costs within the same class of hospital.

(c)(1) The Secretary may provide, in his discretion, that payment with respect to services provided by a hospital in a State may be made in accordance with a hospital reimbursement control system in a State, rather than in accordance with the other provisions of this title, if the chief executive officer of the State requests such treatment and if—

(A) the Secretary determines that the system, if approved under this subsection, will apply (i) to substantially all non-Federal acute care hospitals (as defined by the Secretary) in the State and (ii) to the review of at least 75 percent of all revenues or expenses in the State for inpatient hospital services and of revenues or expenses for inpatient hospital services provided under the State's plan approved under title XIX;

(B) the Secretary has been provided satisfactory assurances as to the equitable treatment under the system of all entities (including Federal and State programs) that pay hospitals for inpatient hospital services, of hospital employees, and of hospital patients;

(C) the Secretary has been provided satisfactory assurances that under the system, over 36-month periods (the first such period beginning with the first month in which this subsection applies to that system in the State), the amount of payments made under this title under such system will not exceed the amount of payments which would otherwise have been made under this title not using such system;

(D) the Secretary determines that the system will not preclude an eligible organization (as defined in section 1876(b)) from negotiating directly with hospitals with respect to the organization's rate of payment for inpatient hospital services; and

(E) the Secretary determines that the system requires hospitals to meet the requirement of section 1866(a)(1)(G) and the system provides for the exclusion of certain costs in accordance with section 1862(a)(14) (except for such waivers thereof as the Secretary provides by regulation).

The Secretary cannot deny the application of a State under this subsection on the ground that the State's hospital reimbursement control system is based on a payment methodology other than on the basis of a diagnosis-related group or on the ground that the amount of payments made under this title under such system must be less than the amount of payments which would otherwise have been made under this title not using such system. If the Secretary determines that the conditions described in subparagraph (C) are based on maintaining payment amounts at no more than a specified percentage increase above the payment amounts in a base pe-

riod, the State has the option of applying such test (for inpatient hospital services under part A) on an aggregate payment basis or on the basis of the amount of payment per inpatient discharge or admission. If the Secretary determines that the conditions described in subparagraph (C) are based on maintaining aggregate payment amounts below a national average percentage increase in total payments under part A for inpatient hospital services, the Secretary cannot deny the application of a State under this subsection on the ground that the State's rate of increase in such payments for such services must be less than such national average rate of increase.

(2) In determining under paragraph (1)(C) the amount of payment which would otherwise have been made under this title for a State, the Secretary may provide for appropriate adjustment of such amount to take into account previous reductions effected in the amount of payments made under this title in the State due to the operation of the hospital reimbursement control system in the State if the system has resulted in an aggregate rate of increase in operating costs of inpatient hospital services (as defined in subsection (a)(4)) under this title for hospitals in the State which is less than the aggregate rate of increase in such costs under this title for hospitals in the United States.

(3) The Secretary shall discontinue payments under a system described in paragraph (1) if the Secretary—

(A) determines that the system no longer meets the requirements of subparagraphs (A), (D), and (E) of paragraph (1) and, if applicable, the requirements of paragraph (5), or

(B) has reason to believe that the assurances described in subparagraph (B) or (C) of paragraph (1) (or, if applicable, in paragraph (5)) are not being (or will not be) met.

(4) The Secretary shall approve the request of a State under paragraph (1) with respect to a hospital reimbursement control system if—

(A) the requirements of subparagraphs (A), (B), (C), (D), and (E) of paragraph (1) have been met with respect to the system, and

(B) with respect to that system a waiver of certain requirements of title XVIII of the Social Security Act has been approved on or before (and which is in effect as of) the date of the enactment of the Social Security Amendments of 1983, pursuant to section 402(a) of the Social Security Amendments of 1967 or section 222(a) of the Social Security Amendments of 1972.

With respect to a State system described in this paragraph, the Secretary shall judge the effectiveness of such system on the basis of its rate of increase or inflation in inpatient hospital payments for individuals under this title, as compared to the national rate of increase or inflation for such payments, with the State retaining the option to have the test applied on the basis of the aggregate payments under the State system as compared to aggregate payments which would have been made under the national system since October 1, 1984, to the most recent date for which annual data are available.

(5) The Secretary shall approve the request of a State under paragraph (1) with respect to a hospital reimbursement control system if—

(A) the requirements of subparagraphs (A), (B), (C), (D), and (E) of paragraph (1) have been met with respect to the system;

(B) the Secretary determines that the system—

(i) is operated directly by the State or by an entity designated pursuant to State law,

(ii) provides for payment of hospitals covered under the system under a methodology (which sets forth exceptions and adjustments, as well as any method for changes in the methodology) by which rates or amounts to be paid for hospital services during a specified period are established under the system prior to the defined rate period, and

(iii) hospitals covered under the system will make such reports (in lieu of cost and other reports, identified by the Secretary, otherwise required under this title) as the Secretary may require in order to properly monitor assurances provided under this subsection;

(C) the State has provided the Secretary with satisfactory assurances that operation of the system will not result in any change in hospital admission practices which result in—

(i) a significant reduction in the proportion of patients (receiving hospital services covered under the system) who have no third-party coverage and who are unable to pay for hospital services,

(ii) a significant reduction in the proportion of individuals admitted to hospitals for inpatient hospital services for which payment is (or is likely to be) less than the anticipated charges for or costs of such services,

(iii) the refusal to admit patients who would be expected to require unusually costly or prolonged treatment for reasons other than those related to the appropriateness of the care available at the hospital, or

(iv) the refusal to provide emergency services to any person who is in need of emergency services if the hospital provides such services;

(D) any change by the State in the system which has the effect of materially reducing payments to hospitals can only take effect upon 60 days notice to the Secretary and to the hospitals the payment to which is likely to be materially affected by the change; and

(E) the State has provided the Secretary with satisfactory assurances that in the development of the system the State has consulted with local governmental officials concerning the impact of the system on public hospitals.

The Secretary shall respond to requests of States under this paragraph within 60 days of the date the request is submitted to the Secretary.

(6) If the Secretary determines that the assurances described in paragraph (1)(C) have not been met with respect to any 36-month period, the Secretary may reduce payments under this title to hospitals under the system in an amount equal to the amount by which the payment under this title under such system for such pe-

riod exceeded the amount of payments which would otherwise have been made under this title not using such system.

(7) In the case of a State which made a request under paragraph (5) before December 31, 1984, for the approval of a State hospital reimbursement control system and which request was approved—

(A) in applying paragraphs (1)(C) and (6), a reference to a "36-month period" is deemed a reference to a "48-month period", and

(B) in order to allow the State the opportunity to provide the assurances described in paragraph (1)(C) for a 48-month period, the Secretary may not discontinue payments under the system, under the authority of paragraph (3)(A) because the Secretary has reason to believe that such assurances are not being (or will not be) met, before July 1, 1986.

(d)(1)(A) Notwithstanding section 1814(b) but subject to the provisions of section 1813, the amount of the payment with respect to the operating costs of inpatient hospital services (as defined in subsection (a)(4)) of a subsection (d) hospital (as defined in subparagraph (B)) for inpatient hospital discharges in a cost reporting period or in a fiscal year—

(i) beginning on or after October 1, 1983, and before October 1, 1984, is equal to the sum of—

(I) the target percentage (as defined in subparagraph (C)) of the hospital's target amount for the cost reporting period (as defined in subsection (b)(3)(A), but determined without the application of subsection (a)), and

(II) the DRG percentage (as defined in subparagraph (C)) of the regional adjusted DRG prospective payment rate determined under paragraph (2) for such discharges;

(ii) beginning on or after October 1, 1984, and before October 1, 1987, is equal to the sum of—

(I) the target percentage (as defined in subparagraph (C)) of the hospital's target amount for the cost reporting period (as defined in subsection (b)(3)(A), but determined without the application of subsection (a)), and

(II) the DRG percentage (as defined in subparagraph (C)) of the applicable combined adjusted DRG prospective payment rate determined under subparagraph (D) for such discharges; or

(iii) beginning on or after April 1, 1988, is equal to

(I) the national adjusted DRG prospective payment rate determined under paragraph (3) for such discharges, or

(II) for discharges occurring during a fiscal year ending on or before September 30, 1996, the sum of 85 percent of the national adjusted DRG prospective payment rate determined under paragraph (3) for such discharges and 15 percent of the regional adjusted DRG prospective payment rate determined under such paragraph, but only if the average standardized amount (described in clause (i)(I) or clause (ii)(I) of paragraph (3)(D)) for hospitals within the region of, and in the same large urban or other area (or, for discharges occurring during a fiscal year ending on or before September 30, 1994, the same rural, large urban, or other urban area) as, the hospital is greater than the average standardized amount (described in the respective

clause) for hospitals within the United States in that type of area for discharges occurring during such fiscal year.

(B) As used in this section, the term "subsection (d) hospital" means a hospital located in one of the fifty States or the District of Columbia other than—

(i) a psychiatric hospital (as defined in section 1861(f)),

(ii) a rehabilitation hospital (as defined by the Secretary),

(iii) a hospital whose inpatients are predominantly individuals under 18 years of age,

(iv)(I) a hospital which has an average inpatient length of stay (as determined by the Secretary) of greater than 25 days, or

(II) a hospital that first received payment under this subsection in 1986 which has an average inpatient length of stay (as determined by the Secretary) of greater than 20 days and that has 80 percent or more of its annual medicare inpatient discharges with a principal diagnosis that reflects a finding of neoplastic disease in the 12-month cost reporting period ending in fiscal year 1997, or

(v)(I) a hospital that the Secretary has classified, at any time on or before December 31, 1990, (or, in the case of a hospital that, as of the date of the enactment of this clause, is located in a State operating a demonstration project under section 1814(b), on or before December 31, 1991) for purposes of applying exceptions and adjustments to payment amounts under this subsection, as a hospital involved extensively in treatment for or research on cancer,

(II) a hospital that was recognized as a comprehensive cancer center or clinical cancer research center by the National Cancer Institute of the National Institutes of Health as of April 20, 1983, that is located in a State which, as of December 19, 1989, was not operating a demonstration project under section 1814(b), that applied and was denied, on or before December 31, 1990, for classification as a hospital involved extensively in treatment for or research on cancer under this clause (as in effect on the day before the date of the enactment of this subclause), that as of the date of the enactment of this subclause, is licensed for less than 50 acute care beds, and that demonstrates for the 4–year period ending on December 31, 1996, that at least 50 percent of its total discharges have a principal finding of neoplastic disease, as defined in subparagraph (E), or

(III) a hospital that was recognized as a clinical cancer research center by the National Cancer Institute of the National Institutes of Health as of February 18, 1998, that has never been reimbursed for inpatient hospital services pursuant to a reimbursement system under a demonstration project under section 1814(b), that is a freestanding facility organized primarily for treatment of and research on cancer and is not a unit of another hospital, that as of the date of the enactment of this subclause, is licensed for 162 acute care beds, and that demonstrates for the 4-year period ending on June 30, 1999, that at least 50 percent of its total discharges have a principal finding of neoplastic disease, as defined in subparagraph (E);

and, in accordance with regulations of the Secretary, does not include a psychiatric or rehabilitation unit of the hospital which is a distinct part of the hospital (as defined by the Secretary). A hospital that was classified by the Secretary on or before September 30, 1995, as a hospital described in clause (iv) shall continue to be so classified notwithstanding that it is located in the same building as, or on the same campus as, another hospital.

(C) For purposes of this subsection, for cost reporting periods beginning—

(i) on or after October 1, 1983, and before October 1, 1984, the "target percentage" is 75 percent and the "DRG percentage" is 25 percent;

(ii) on or after October 1, 1984, and before October 1, 1985, the "target percentage" is 50 percent and the "DRG percentage" is 50 percent;

(iii) on or after October 1, 1985, and before October 1, 1986, the "target percentage" is 45 percent and the "DRG percentage" is 55 percent; and

(iv) on or after October 1, 1986, and before October 1, 1987, the "target percentage" is 25 percent and the "DRG percentage" is 75 percent.

(D) For purposes of subparagraph (A)(ii)(II), the "applicable combined adjusted DRG prospective payment rate" for discharges occurring—

(i) on or after October 1, 1984, and before October 1, 1986, is a combined rate consisting of 25 percent of the national adjusted DRG prospective payment rate, and 75 percent of the regional adjusted DRG prospective payment rate, determined under paragraph (3) for such discharges; and

(ii) on or after October 1, 1986, and before October 1, 1987, is a combined rate consisting of 50 percent of the national adjusted DRG prospective payment rate, and 50 percent of the regional adjusted DRG prospective payment rate, determined under paragraph (3) for such discharges.

(E) For purposes of subclauses (II) and (III) of subparagraph (B)(v) only, the term "principal finding of neoplastic disease" means the condition established after study to be chiefly responsible for occasioning the admission of a patient to a hospital, except that only discharges with ICD–9–CM principal diagnosis codes of 140 through 239, V58.0, V58.1, V66.1, V66.2, or 990 will be considered to reflect such a principal diagnosis.

(2) The Secretary shall determine a national adjusted DRG prospective payment rate, for each inpatient hospital discharge in fiscal year 1984 involving inpatient hospital services of a subsection (d) hospital in the United States, and shall determine a regional adjusted DRG prospective payment rate for such discharges in each region, for which payment may be made under part A of this title. Each such rate shall be determined for hospitals located in urban or rural areas within the United States or within each such region, respectively, as follows:

(A) DETERMINING ALLOWABLE INDIVIDUAL HOSPITAL COSTS FOR BASE PERIOD.—The Secretary shall determine the allowable operating costs per discharge of inpatient hospital services for the hospital for the most recent cost reporting period for which data are available.

(B) UPDATING FOR FISCAL YEAR 1984.—The Secretary shall update each amount determined under subparagraph (A) for fiscal year 1984 by—

(i) updating for fiscal year 1983 by the estimated average rate of change of hospital costs industry-wide between the cost reporting period used under such subparagraph and fiscal year 1983 and the most recent case-mix data available, and

(ii) projecting for fiscal year 1984 by the applicable percentage increase (as defined in subsection (b)(3)(B)) for fiscal year 1984.

(C) STANDARDIZING AMOUNTS.—The Secretary shall standardize the amount updated under subparagraph (B) for each hospital by—

(i) excluding an estimate of indirect medical education costs (taking into account, for discharges occurring after September 30, 1986, the amendments made by section 9104(a) of the Medicare and Medicaid Budget Reconciliation Amendments of 1985), except that the Secretary shall not take into account any reduction in the amount of additional payments under paragraph (5)(B)(ii) resulting from the amendment made by section 4621(a)(1) of the Balanced Budget Act of 1997 or any additional payments under such paragraph resulting from the application of section 111 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, of section 302 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, or the Medicare Prescription Drug, Improvement, and Modernization Act of 2003,

(ii) adjusting for variations among hospitals by area in the average hospital wage level,

(iii) adjusting for variations in case mix among hospitals, and

(iv) for discharges occurring on or after October 1, 1986, excluding an estimate of the additional payments to certain hospitals to be made under paragraph (5)(F), except that the Secretary shall not exclude additional payments under such paragraph made as a result of the enactment of section 6003(c) of the Omnibus Budget Reconciliation Act of 1989, the enactment of section 4002(b) of the Omnibus Budget Reconciliation Act of 1990, the enactment of section 303 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, or the enactment of section 402(a)(1) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

(D) COMPUTING URBAN AND RURAL AVERAGES.—The Secretary shall compute an average of the standardized amounts determined under subparagraph (C) for the United States and for each region—

(i) for all subsection (d) hospitals located in an urban area within the United States or that region, respectively, and

(ii) for all subsection (d) hospitals located in a rural area within the United States or that region, respectively.

For purposes of this subsection, the term "region" means one of the nine census divisions, comprising the fifty States and the District of Columbia, established by the Bureau of the Census for statistical and reporting purposes; the term "urban area" means an area within a Metropolitan Statistical Area (as defined by the Office of Management and Budget) or within such similar area as the Secretary has recognized under subsection (a) by regulation; the term "large urban area" means, with respect to a fiscal year, such an urban area which the Secretary determines (in the publications described in subsection (e)(5) before the fiscal year) has a population of more than 1,000,000 (as determined by the Secretary based on the most recent available population data published by the Bureau of the Census); and the term "rural area" means any area outside such an area or similar area. A hospital located in a Metropolitan Statistical Area shall be deemed to be located in the region in which the largest number of the hospitals in the same Metropolitan Statistical Area are located, or, at the option of the Secretary, the region in which the majority of the inpatient discharges (with respect to which payments are made under this title) from hospitals in the same Metropolitan Statistical Area are made.

(E) REDUCING FOR VALUE OF OUTLIER PAYMENTS.—The Secretary shall reduce each of the average standardized amounts determined under subparagraph (D) by a proportion equal to the proportion (estimated by the Secretary) of the amount of payments under this subsection based on DRG prospective payment rates which are additional payments described in paragraph (5)(A) (relating to outlier payments).

(F) MAINTAINING BUDGET NEUTRALITY.—The Secretary shall adjust each of such average standardized amounts as may be required under subsection (e)(1)(B) for that fiscal year.

(G) COMPUTING DRG-SPECIFIC RATES FOR URBAN AND RURAL HOSPITALS IN THE UNITED STATES AND IN EACH REGION.—For each discharge classified within a diagnosis-related group, the Secretary shall establish a national DRG prospective payment rate and shall establish a regional DRG prospective payment rate for each region, each of which is equal—

(i) for hospitals located in an urban area in the United States or that region (respectively), to the product of—

(I) the average standardized amount (computed under subparagraph (D), reduced under subparagraph (E), and adjusted under subparagraph (F)) for hospitals located in an urban area in the United States or that region, and

(II) the weighting factor (determined under paragraph (4)(B)) for that diagnosis-related group; and

(ii) for hospitals located in a rural area in the United States or that region (respectively), to the product of—

(I) the average standardized amount (computed under subparagraph (D), reduced under subparagraph (E), and adjusted under subparagraph (F)) for hospitals located in a rural area in the United States or that region, and

(II) the weighting factor (determined under paragraph (4)(B)) for that diagnosis-related group.

(H) ADJUSTING FOR DIFFERENT AREA WAGE LEVELS.—The Secretary shall adjust the proportion, (as estimated by the Secretary from time to time) of hospitals' costs which are attributable to wages and wage-related costs, of the national and regional DRG prospective payment rates computed under subparagraph (G) for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level.

(3) The Secretary shall determine a national adjusted DRG prospective payment rate, for each inpatient hospital discharge in a fiscal year after fiscal year 1984 involving inpatient hospital services of a subsection (d) hospital in the United States, and shall determine, for fiscal years before fiscal year 1997, a regional adjusted DRG prospective payment rate for such discharges in each region for which payment may be made under part A of this title. Each such rate shall be determined for hospitals located in large urban, other urban, or rural areas within the United States and within each such region, respectively, as follows:

(A) UPDATING PREVIOUS STANDARDIZED AMOUNTS.—(i) For discharges occurring in a fiscal year beginning before October 1, 1987, the Secretary shall compute an average standardized amount for hospitals located in an urban area and for hospitals located in a rural area within the United States and for hospitals located in an urban area and for hospitals located in a rural area within each region, equal to the respective average standardized amount computed for the previous fiscal year under paragraph (2)(D) or under this subparagraph, increased for the fiscal year involved by the applicable percentage increase under subsection (b)(3)(B). With respect to discharges occurring on or after October 1, 1987, the Secretary shall compute urban and rural averages on the basis of discharge weighting rather than hospital weighting, making appropriate adjustments to ensure that computation on such basis does not result in total payments under this section that are greater or less than the total payments that would have been made under this section but for this sentence, and making appropriate changes in the manner of determining the reductions under subparagraph (C)(ii).

(ii) For discharges occurring in a fiscal year beginning on or after October 1, 1987, and ending on or before September 30, 1994, the Secretary shall compute an average standardized amount for hospitals located in a large urban area, for hospitals located in a rural area, and for hospitals located in other urban areas, within the United States and within each region, equal to the respective average standardized amount computed for the previous fiscal year under this subparagraph increased by the applicable percentage increase under subsection (b)(3)(B)(i) with respect to hospitals located in the respective areas for the fiscal year involved.

(iii) For discharges occurring in the fiscal year beginning on October 1, 1994, the average standardized amount for hospitals located in a rural area shall be equal to the average standard-

ized amount for hospitals located in an urban area. For discharges occurring on or after October 1, 1994, the Secretary shall adjust the ratio of the labor portion to non-labor portion of each average standardized amount to equal such ratio for the national average of all standardized amounts.

(iv)(I) Subject to subclause (II), for discharges occurring in a fiscal year beginning on or after October 1, 1995, the Secretary shall compute an average standardized amount for hospitals located in a large urban area and for hospitals located in other areas within the United States and within each region equal to the respective average standardized amount computed for the previous fiscal year under this subparagraph increased by the applicable percentage increase under subsection (b)(3)(B)(i) with respect to hospitals located in the respective areas for the fiscal year involved.

(II) For discharges occurring in a fiscal year (beginning with fiscal year 2004), the Secretary shall compute a standardized amount for hospitals located in any area within the United States and within each region equal to the standardized amount computed for the previous fiscal year under this subparagraph for hospitals located in a large urban area (or, beginning with fiscal year 2005, for all hospitals in the previous fiscal year) increased by the applicable percentage increase under subsection (b)(3)(B)(i) for the fiscal year involved.

(v) Average standardized amounts computed under this paragraph shall be adjusted to reflect the most recent case-mix data available.

(vi) Insofar as the Secretary determines that the adjustments under paragraph (4)(C)(i) for a previous fiscal year (or estimates that such adjustments for a future fiscal year) did (or are likely to) result in a change in aggregate payments under this subsection during the fiscal year that are a result of changes in the coding or classification of discharges that do not reflect real changes in case mix, the Secretary may adjust the average standardized amounts computed under this paragraph for subsequent fiscal years so as to eliminate the effect of such coding or classification changes.

(B) REDUCING FOR VALUE OF OUTLIER PAYMENTS.—The Secretary shall reduce each of the average standardized amounts determined under subparagraph (A) by a factor equal to the proportion of payments under this subsection (as estimated by the Secretary) based on DRG prospective payment amounts which are additional payments described in paragraph (5)(A) (relating to outlier payments).

(C)(i) MAINTAINING BUDGET NEUTRALITY FOR FISCAL YEAR 1985.—For discharges occurring in fiscal year 1985, the Secretary shall adjust each of such average standardized amounts as may be required under subsection (e)(1)(B) for that fiscal year.

(ii) REDUCING FOR SAVINGS FROM AMENDMENT TO INDIRECT TEACHING ADJUSTMENT FOR DISCHARGES AFTER SEPTEMBER 30, 1986.—For discharges occurring after September 30, 1986, the Secretary shall further reduce each of the average standardized amounts (in a proportion which takes into account the differing effects of the standardization effected under paragraph

(2)(C)(i)) so as to provide for a reduction in the total of the payments (attributable to this paragraph) made for discharges occurring on or after October 1, 1986, of an amount equal to the estimated reduction in the payment amounts under paragraph (5)(B) that would have resulted from the enactment of the amendments made by section 9104 of the Medicare and Medicaid Budget Reconciliation Amendments of 1985 and by section 4003(a)(1) of the Omnibus Budget Reconciliation Act of 1987 if the factor described in clause (ii)(II) of paragraph (5)(B) (determined without regard to amendments made by the Omnibus Budget Reconciliation Act of 1990) were applied for discharges occurring on or after such date instead of the factor described in clause (ii) of that paragraph.

(D) COMPUTING DRG-SPECIFIC RATES FOR HOSPITALS.—For each discharge classified within a diagnosis-related group, the Secretary shall establish for the fiscal year a national DRG prospective payment rate and shall establish, for fiscal years before fiscal year 1997, a regional DRG prospective payment rate for each region which is equal—

(i) for fiscal years before fiscal year 2004, for hospitals located in a large urban area in the United States or that region (respectively), to the product of—

(I) the average standardized amount (computed under subparagraph (A), reduced under subparagraph (B), and adjusted or reduced under subparagraph (C)) for the fiscal year for hospitals located in such a large urban area in the United States or that region, and

(II) the weighting factor (determined under paragraph (4)(B)) for that diagnosis-related group;

(ii) for fiscal years before fiscal year 2004, for hospitals located in other areas in the United States or that region (respectively), to the product of—

(I) the average standardized amount (computed under subparagraph (A), reduced under subparagraph (B), and adjusted or reduced under subparagraph (C)) for the fiscal year for hospitals located in other areas in the United States or that region, and

(II) the weighting factor (determined under paragraph (4)(B)) for that diagnosis-related group; and

(iii) for a fiscal year beginning after fiscal year 2003, for hospitals located in all areas, to the product of—

(I) the applicable standardized amount (computed under subparagraph (A)), reduced under subparagraph (B), and adjusted or reduced under subparagraph (C) for the fiscal year; and

(II) the weighting factor (determined under paragraph (4)(B)) for that diagnosis-related group.

(E) ADJUSTING FOR DIFFERENT AREA WAGE LEVELS.—

(i) IN GENERAL.—Except as provided in clause (ii) or (iii), the Secretary shall adjust the proportion, (as estimated by the Secretary from time to time) of hospitals' costs which are attributable to wages and wage-related costs, of the DRG prospective payment rates computed under subparagraph (D) for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative

hospital wage level in the geographic area of the hospital compared to the national average hospital wage level. Not later than October 1, 1990, and October 1, 1993 (and at least every 12 months thereafter), the Secretary shall update the factor under the preceding sentence on the basis of a survey conducted by the Secretary (and updated as appropriate) of the wages and wage-related costs of subsection (d) hospitals in the United States. Not less often than once every 3 years the Secretary (through such survey or otherwise) shall measure the earnings and paid hours of employment by occupational category and shall exclude data with respect to the wages and wage-related costs incurred in furnishing skilled nursing facility services. Any adjustments or updates made under this subparagraph for a fiscal year (beginning with fiscal year 1991) shall be made in a manner that assures that the aggregate payments under this subsection in the fiscal year are not greater or less than those that would have been made in the year without such adjustment. The Secretary shall apply the previous sentence for any period as if the amendments made by section 403(a)(1) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and the amendments made by section 10324(a)(1) of the Patient Protection and Affordable Care Act had not been enacted.

(ii) ALTERNATIVE PROPORTION TO BE ADJUSTED BEGINNING IN FISCAL YEAR 2005.—For discharges occurring on or after October 1, 2004, the Secretary shall substitute "62 percent" for the proportion described in the first sentence of clause (i), unless the application of this clause would result in lower payments to a hospital than would otherwise be made.

(iii) FLOOR ON AREA WAGE INDEX FOR HOSPITALS IN FRONTIER STATES.—

(I) IN GENERAL.—Subject to subclause (IV), for discharges occurring on or after October 1, 2010, the area wage index applicable under this subparagraph to any hospital which is located in a frontier State (as defined in subclause (II)) may not be less than 1.00.

(II) FRONTIER STATE DEFINED.—In this clause, the term "frontier State" means a State in which at least 50 percent of the counties in the State are frontier counties.

(III) FRONTIER COUNTY DEFINED.—In this clause, the term "frontier county" means a county in which the population per square mile is less than 6.

(IV) LIMITATION.—This clause shall not apply to any hospital located in a State that receives a non-labor related share adjustment under paragraph (5)(H).

(4)(A) The Secretary shall establish a classification of inpatient hospital discharges by diagnosis-related groups and a methodology for classifying specific hospital discharges within these groups.

(B) For each such diagnosis-related group the Secretary shall assign an appropriate weighting factor which reflects the relative

hospital resources used with respect to discharges classified within that group compared to discharges classified within other groups.

(C)(i) The Secretary shall adjust the classifications and weighting factors established under subparagraphs (A) and (B), for discharges in fiscal year 1988 and at least annually thereafter, to reflect changes in treatment patterns, technology (including a new medical service or technology under paragraph (5)(K)), and other factors which may change the relative use of hospital resources.

(ii) For discharges in fiscal year 1990, the Secretary shall reduce the weighting factor for each diagnosis-related group by 1.22 percent.

(iii) Any such adjustment under clause (i) for discharges in a fiscal year (beginning with fiscal year 1991) shall be made in a manner that assures that the aggregate payments under this subsection for discharges in the fiscal year are not greater or less than those that would have been made for discharges in the year without such adjustment.

(D)(i) For discharges occurring on or after October 1, 2008, the diagnosis-related group to be assigned under this paragraph for a discharge described in clause (ii) shall be a diagnosis-related group that does not result in higher payment based on the presence of a secondary diagnosis code described in clause (iv).

(ii) A discharge described in this clause is a discharge which meets the following requirements:

(I) The discharge includes a condition identified by a diagnosis code selected under clause (iv) as a secondary diagnosis.

(II) But for clause (i), the discharge would have been classified to a diagnosis-related group that results in a higher payment based on the presence of a secondary diagnosis code selected under clause (iv).

(III) At the time of admission, no code selected under clause (iv) was present.

(iii) As part of the information required to be reported by a hospital with respect to a discharge of an individual in order for payment to be made under this subsection, for discharges occurring on or after October 1, 2007, the information shall include the secondary diagnosis of the individual at admission.

(iv) By not later than October 1, 2007, the Secretary shall select diagnosis codes associated with at least two conditions, each of which codes meets all of the following requirements (as determined by the Secretary):

(I) Cases described by such code have a high cost or high volume, or both, under this title.

(II) The code results in the assignment of a case to a diagnosis-related group that has a higher payment when the code is present as a secondary diagnosis.

(III) The code describes such conditions that could reasonably have been prevented through the application of evidence-based guidelines.

The Secretary may from time to time revise (through addition or deletion of codes) the diagnosis codes selected under this clause so long as there are diagnosis codes associated with at least two conditions selected for discharges occurring during any fiscal year.

(v) In selecting and revising diagnosis codes under clause (iv), the Secretary shall consult with the Centers for Disease Control and Prevention and other appropriate entities.

(vi) Any change resulting from the application of this subparagraph shall not be taken into account in adjusting the weighting factors under subparagraph (C)(i) or in applying budget neutrality under subparagraph (C)(iii).

(5)(A)(i) For discharges occurring during fiscal years ending on or before September 30, 1997, the Secretary shall provide for an additional payment for a subsection (d) hospital for any discharge in a diagnosis-related group, the length of stay of which exceeds the mean length of stay for discharges within that group by a fixed number of days, or exceeds such mean length of stay by some fixed number of standard deviations, whichever is the fewer number of days.

(ii) For cases which are not included in clause (i), a subsection (d) hospital may request additional payments in any case where charges, adjusted to cost, exceed a fixed multiple of the applicable DRG prospective payment rate, or exceed such other fixed dollar amount, whichever is greater, or for discharges in fiscal years beginning on or after October 1, 1994, exceed the sum of the applicable DRG prospective payment rate plus any amounts payable under subparagraphs (B) and (F) plus a fixed dollar amount determined by the Secretary.

(iii) The amount of such additional payment under clauses (i) and (ii) shall be determined by the Secretary and shall (except as payments under clause (i) are required to be reduced to take into account the requirements of clause (v)) approximate the marginal cost of care beyond the cutoff point applicable under clause (i) or (ii).

(iv) The total amount of the additional payments made under this subparagraph for discharges in a fiscal year may not be less than 5 percent nor more than 6 percent of the total payments projected or estimated to be made based on DRG prospective payment rates for discharges in that year.

(v) The Secretary shall provide that—

(I) the day outlier percentage for fiscal year 1995 shall be 75 percent of the day outlier percentage for fiscal year 1994;

(II) the day outlier percentage for fiscal year 1996 shall be 50 percent of the day outlier percentage for fiscal year 1994; and

(III) the day outlier percentage for fiscal year 1997 shall be 25 percent of the day outlier percentage for fiscal year 1994.

(vi) For purposes of this subparagraph the term "day outlier percentage" means, for a fiscal year, the percentage of the total additional payments made by the Secretary under this subparagraph for discharges in that fiscal year which are additional payments under clause (i).

(B) The Secretary shall provide for an additional payment amount for subsection (d) hospitals with indirect costs of medical education, in an amount computed in the same manner as the adjustment for such costs under regulations (in effect as of January 1, 1983) under subsection (a)(2), except as follows:

(i) The amount of such additional payment shall be determined by multiplying (I) the sum of the amount determined

under paragraph (1)(A)(ii)(II) (or, if applicable, the amount determined under paragraph (1)(A)(iii)) and, for cases qualifying for additional payment under subparagraph (A)(i), the amount paid to the hospital under subparagraph (A), by (II) the indirect teaching adjustment factor described in clause (ii).

(ii) For purposes of clause (i)(II), the indirect teaching adjustment factor is equal to c × (((1+r) to the nth power) − 1), where "r" is the ratio of the hospital's full-time equivalent interns and residents to beds and "n" equals .405. Subject to clause (ix), for discharges occurring—

(I) on or after October 1, 1988, and before October 1, 1997, "c" is equal to 1.89;

(II) during fiscal year 1998, "c" is equal to 1.72;

(III) during fiscal year 1999, "c" is equal to 1.6;

(IV) during fiscal year 2000, "c" is equal to 1.47;

(V) during fiscal year 2001, "c" is equal to 1.54;

(VI) during fiscal year 2002, "c" is equal to 1.6;

(VII) on or after October 1, 2002, and before April 1, 2004, "c" is equal to 1.35;

(VIII) on or after April 1, 2004, and before October 1, 2004, "c" is equal to 1.47;

(IX) during fiscal year 2005, "c" is equal to 1.42;

(X) during fiscal year 2006, "c" is equal to 1.37;

(XI) during fiscal year 2007, "c" is equal to 1.32; and

(XII) on or after October 1, 2007, "c" is equal to 1.35.

(iii) In determining such adjustment the Secretary shall not distinguish between those interns and residents who are employees of a hospital and those interns and residents who furnish services to a hospital but are not employees of such hospital.

(iv)(I) Effective for discharges occurring on or after October 1, 1997, and before July 1, 2010, all the time spent by an intern or resident in patient care activities under an approved medical residency training program at an entity in a nonhospital setting shall be counted towards the determination of full-time equivalency if the hospital incurs all, or substantially all, of the costs for the training program in that setting.

(II) Effective for discharges occurring on or after July 1, 2010, all the time spent by an intern or resident in patient care activities in a nonprovider setting shall be counted towards the determination of full-time equivalency if a hospital incurs the costs of the stipends and fringe benefits of the intern or resident during the time the intern or resident spends in that setting. If more than one hospital incurs these costs, either directly or through a third party, such hospitals shall count a proportional share of the time, as determined by written agreement between the hospitals, that a resident spends training in that setting.

(v) In determining the adjustment with respect to a hospital for discharges occurring on or after October 1, 1997, the total number of full-time equivalent interns and residents in the fields of allopathic and osteopathic medicine in either a hospital or nonhospital setting may not exceed the number (or, 130 percent of such number in the case of a hospital located in a rural area) of such full-time equivalent interns and resi-

dents in the hospital with respect to the hospital's most recent cost reporting period ending on or before December 31, 1996. Rules similar to the rules of subsection (h)(4)(F)(ii) shall apply for purposes of this clause. The provisions of subsections (h)(4)(H)(vi), (h)(7), and (h)(8) shall apply with respect to the first sentence of this clause in the same manner as they apply with respect to subsection (h)(4)(F)(i).

(vi) For purposes of clause (ii)—

(I) "r" may not exceed the ratio of the number of interns and residents, subject to the limit under clause (v), with respect to the hospital for its most recent cost reporting period to the hospital's available beds (as defined by the Secretary) during that cost reporting period, and

(II) for the hospital's cost reporting periods beginning on or after October 1, 1997, subject to the limits described in clauses (iv) and (v), the total number of full-time equivalent residents for payment purposes shall equal the average of the actual full-time equivalent resident count for the cost reporting period and the preceding two cost reporting periods.

In the case of the first cost reporting period beginning on or after October 1, 1997, subclause (II) shall be applied by using the average for such period and the preceding cost reporting period.

(vii) If any cost reporting period beginning on or after October 1, 1997, is not equal to twelve months, the Secretary shall make appropriate modifications to ensure that the average full-time equivalent residency count pursuant to subclause (II) of clause (vi) is based on the equivalent of full twelve-month cost reporting periods.

(viii) Rules similar to the rules of subsection (h)(4)(H) shall apply for purposes of clauses (v) and (vi).

(ix) For discharges occurring on or after July 1, 2005, insofar as an additional payment amount under this subparagraph is attributable to resident positions redistributed to a hospital under subsection (h)(7)(B), in computing the indirect teaching adjustment factor under clause (ii) the adjustment shall be computed in a manner as if "c" were equal to 0.66 with respect to such resident positions.

(x) For discharges occurring on or after July 1, 2011, insofar as an additional payment amount under this subparagraph is attributable to resident positions distributed to a hospital under subsection (h)(8)(B), the indirect teaching adjustment factor shall be computed in the same manner as provided under clause (ii) with respect to such resident positions.

(x)(I) The provisions of subparagraph (K) of subsection (h)(4) shall apply under this subparagraph in the same manner as they apply under such subsection.

(II) In determining the hospital's number of full-time equivalent residents for purposes of this subparagraph, all the time spent by an intern or resident in an approved medical residency training program in non-patient care activities, such as didactic conferences and seminars, as such time and activities are defined by the Secretary, that occurs in the hospital

shall be counted toward the determination of full-time equivalency if the hospital—

(aa) is recognized as a subsection (d) hospital;

(bb) is recognized as a subsection (d) Puerto Rico hospital;

(cc) is reimbursed under a reimbursement system authorized under section 1814(b)(3); or

(dd) is a provider-based hospital outpatient department.

(III) In determining the hospital's number of full-time equivalent residents for purposes of this subparagraph, all the time spent by an intern or resident in an approved medical residency training program in research activities that are not associated with the treatment or diagnosis of a particular patient, as such time and activities are defined by the Secretary, shall not be counted toward the determination of full-time equivalency.

(C)(i) The Secretary shall provide for such exceptions and adjustments to the payment amounts established under this subsection (other than under paragraph (9)) as the Secretary deems appropriate to take into account the special needs of regional and national referral centers (including those hospitals of 275 or more beds located in rural areas). A hospital which is classified as a rural hospital may appeal to the Secretary to be classified as a rural referral center under this clause on the basis of criteria (established by the Secretary) which shall allow the hospital to demonstrate that it should be so reclassified by reason of certain of its operating characteristics being similar to those of a typical urban hospital located in the same census region and which shall not require a rural osteopathic hospital to have more than 3,000 discharges in a year in order to be classified as a rural referral center. Such characteristics may include wages, scope of services, service area, and the mix of medical specialties. The Secretary shall publish the criteria not later than August 17, 1984, for implementation by October 1, 1984. An appeal allowed under this clause must be submitted to the Secretary (in such form and manner as the Secretary may prescribe) during the quarter before the first quarter of the hospital's cost reporting period (or, in the case of a cost reporting period beginning during October 1984, during the first quarter of that period), and the Secretary must make a final determination with respect to such appeal within 60 days after the date the appeal was submitted. Any payment adjustments necessitated by a reclassification based upon the appeal shall be effective at the beginning of such cost reporting period.

(ii) The Secretary shall provide, under clause (i), for the classification of a rural hospital as a regional referral center if the hospital has a case mix index equal to or greater than the median case mix index for hospitals (other than hospitals with approved teaching programs) located in an urban area in the same region (as defined in paragraph (2)(D)), has at least 5,000 discharges a year or, if less, the median number of discharges in urban hospitals in the region in which the hospital is located (or, in the case of a rural osteopathic hospital, meets the criterion established by the Secretary under clause (i) with respect to the annual number of dis-

charges for such hospitals), and meets any other criteria established by the Secretary under clause (i).

(D)(i) For any cost reporting period beginning on or after April 1, 1990, with respect to a subsection (d) hospital which is a sole community hospital, payment under paragraph (1)(A) shall be—

(I) an amount based on 100 percent of the hospital's target amount for the cost reporting period, as defined in subsection (b)(3)(C), or

(II) the amount determined under paragraph (1)(A)(iii),

whichever results in greater payment to the hospital.

(ii) In the case of a sole community hospital that experiences, in a cost reporting period compared to the previous cost reporting period, a decrease of more than 5 percent in its total number of inpatient cases due to circumstances beyond its control, the Secretary shall provide for such adjustment to the payment amounts under this subsection (other than under paragraph (9)) as may be necessary to fully compensate the hospital for the fixed costs it incurs in the period in providing inpatient hospital services, including the reasonable cost of maintaining necessary core staff and services.

(iii) For purposes of this title, the term "sole community hospital" means any hospital—

(I) that the Secretary determines is located more than 35 road miles from another hospital,

(II) that, by reason of factors such as the time required for an individual to travel to the nearest alternative source of appropriate inpatient care (in accordance with standards promulgated by the Secretary), location, weather conditions, travel conditions, or absence of other like hospitals (as determined by the Secretary), is the sole source of inpatient hospital services reasonably available to individuals in a geographic area who are entitled to benefits under part A, or

(III) that is located in a rural area and designated by the Secretary as an essential access community hospital under section 1820(i)(1) as in effect on September 30, 1997.

(iv) The Secretary shall promulgate a standard for determining whether a hospital meets the criteria for classification as a sole community hospital under clause (iii)(II) because of the time required for an individual to travel to the nearest alternative source of appropriate inpatient care.

(v) If the Secretary determines that, in the case of a hospital located in a rural area and designated by the Secretary as an essential access community hospital under section 1820(i)(1) as in effect on September 30, 1997, the hospital has incurred increases in reasonable costs during a cost reporting period as a result of becoming a member of a rural health network (as defined in section 1820(d)) in the State in which it is located, and in incurring such increases, the hospital will increase its costs for subsequent cost reporting periods, the Secretary shall increase the hospital's target amount under subsection (b)(3)(C) to account for such incurred increases.

(E)(i) The Secretary shall estimate the amount of reimbursement made for services described in section 1862(a)(14) with respect to which payment was made under part B in the base reporting periods referred to in paragraph (2)(A) and with respect to which payment is no longer being made.

(ii) The Secretary shall provide for an adjustment to the payment for subsection (d) hospitals in each fiscal year so as appropriately to reflect the net amount described in clause (i).

(F)(i) Subject to subsection (r), for discharges occurring on or after May 1, 1986, the Secretary shall provide, in accordance with this subparagraph, for an additional payment amount for each subsection (d) hospital which—

(I) serves a significantly disproportionate number of low-income patients (as defined in clause (v)), or

(II) is located in an urban area, has 100 or more beds, and can demonstrate that its net inpatient care revenues (excluding any of such revenues attributable to this title or State plans approved under title XIX), during the cost reporting period in which the discharges occur, for indigent care from State and local government sources exceed 30 percent of its total of such net inpatient care revenues during the period.

(ii) Subject to clause (ix), the amount of such payment for each discharge shall be determined by multiplying (I) the sum of the amount determined under paragraph (1)(A)(ii)(II) (or, if applicable, the amount determined under paragraph (1)(A)(iii)) and, for cases qualifying for additional payment under subparagraph (A)(i), the amount paid to the hospital under subparagraph (A) for that discharge, by (II) the disproportionate share adjustment percentage established under clause (iii) or (iv) for the cost reporting period in which the discharge occurs.

(iii) The disproportionate share adjustment percentage for a cost reporting period for a hospital described in clause (i)(II) is equal to 35 percent.

(iv) The disproportionate share adjustment percentage for a cost reporting period for a hospital that is not described in clause (i)(II) and that—

(I) is located in an urban area and has 100 or more beds or is described in the second sentence of clause (v), is equal to the percent determined in accordance with the applicable formula described in clause (vii);

(II) is located in an urban area and has less than 100 beds, is equal to 5 percent or, subject to clause (xiv) and for discharges occurring on or after April 1, 2001, is equal to the percent determined in accordance with clause (xiii);

(III) is located in a rural area and is not described in subclause (IV) or (V) or in the second sentence of clause (v), is equal to 4 percent or, subject to clause (xiv) and for discharges occurring on or after April 1, 2001, is equal to the percent determined in accordance with clause (xii);

(IV) is located in a rural area, is classified as a rural referral center under subparagraph (C), and is classified as a sole community hospital under subparagraph (D), is equal to 10 percent or, if greater, the percent determined in accordance with the applicable formula described in clause (viii) or, subject to clause (xiv) and for discharges occurring on or after April 1, 2001, the greater of the percentages determined under clause (x) or (xi);

(V) is located in a rural area, is classified as a rural referral center under subparagraph (C), and is not classified as a sole community hospital under subparagraph (D), is equal to the

percent determined in accordance with the applicable formula described in clause (viii) or, subject to clause (xiv) and for discharges occurring on or after April 1, 2001, is equal to the percent determined in accordance with clause (xi); or

(VI) is located in a rural area, is classified as a sole community hospital under subparagraph (D), and is not classified as a rural referral center under subparagraph (C), is 10 percent or, subject to clause (xiv) and for discharges occurring on or after April 1, 2001, is equal to the percent determined in accordance with clause (x).

(v) In this subparagraph, a hospital "serves a significantly disproportionate number of low income patients" for a cost reporting period if the hospital has a disproportionate patient percentage (as defined in clause (vi)) for that period which equals, or exceeds—

(I) 15 percent, if the hospital is located in an urban area and has 100 or more beds,

(II) 30 percent (or 15 percent, for discharges occurring on or after April 1, 2001), if the hospital is located in a rural area and has more than 100 beds, or is located in a rural area and is classified as a sole community hospital under subparagraph (D),

(III) 40 percent (or 15 percent, for discharges occurring on or after April 1, 2001), if the hospital is located in an urban area and has less than 100 beds, or

(IV) 45 percent (or 15 percent, for discharges occurring on or after April 1, 2001), if the hospital is located in a rural area and is not described in subclause (II).

A hospital located in a rural area and with 500 or more beds also "serves a significantly disproportionate number of low income patients" for a cost reporting period if the hospital has a disproportionate patient percentage (as defined in clause (vi)) for that period which equals or exceeds a percentage specified by the Secretary.

(vi) In this subparagraph, the term "disproportionate patient percentage" means, with respect to a cost reporting period of a hospital, the sum of—

(I) the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were entitled to benefits under part A of this title and were entitled to supplementary security income benefits (excluding any State supplementation) under title XVI of this Act, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were entitled to benefits under part A of this title, and

(II) the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under title XIX, but who were not entitled to benefits under part A of this title, and the denominator of which is the total number of the hospital's patient days for such period.

In determining under subclause (II) the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan ap-

proved under title XIX, the Secretary may, to the extent and for the period the Secretary determines appropriate, include patient days of patients not so eligible but who are regarded as such because they receive benefits under a demonstration project approved under title XI.

(vii) The formula used to determine the disproportionate share adjustment percentage for a cost reporting period for a hospital described in clause (iv)(I) is—

(I) in the case of such a hospital with a disproportionate patient percentage (as defined in clause (vi)) greater than 20.2—

(a) for discharges occurring on or after April 1, 1990, and on or before December 31, 1990, (P–20.2)(.65) + 5.62,

(b) for discharges occurring on or after January 1, 1991, and on or before September 30, 1993, (P–20.2)(.7) + 5.62,

(c) for discharges occurring on or after October 1, 1993, and on or before September 30, 1994, (P–20.2)(.8) + 5.88, and

(d) for discharges occurring on or after October 1, 1994, (P–20.2)(.825) + 5.88; or

(II) in the case of any other such hospital—

(a) for discharges occurring on or after April 1, 1990, and on or before December 31, 1990, (P–15)(.6) + 2.5,

(b) for discharges occurring on or after January 1, 1991, and on or before September 30, 1993, (P–15)(.6) + 2.5,

(c) for discharges occurring on or after October 1, 1993, (P–15)(.65) + 2.5,

where "P" is the hospital's disproportionate patient percentage (as defined in clause (vi)).

(viii) Subject to clause (xiv), the formula used to determine the disproportionate share adjustment percentage for a cost reporting period for a hospital described in clause (iv)(IV) or (iv)(V) is the percentage determined in accordance with the following formula:(P–30)(.6) + 4.0, where "P" is the hospital's disproportionate patient percentage (as defined in clause (vi)).

(ix) In the case of discharges occurring—

(I) during fiscal year 1998, the additional payment amount otherwise determined under clause (ii) shall be reduced by 1 percent;

(II) during fiscal year 1999, such additional payment amount shall be reduced by 2 percent;

(III) during fiscal years 2000 and 2001, such additional payment amount shall be reduced by 3 percent and 2 percent, respectively;

(IV) during fiscal year 2002, such additional payment amount shall be reduced by 3 percent; and

(V) during fiscal year 2003 and each subsequent fiscal year, such additional payment amount shall be reduced by 0 percent.

(x) Subject to clause (xiv), for purposes of clause (iv)(VI) (relating to sole community hospitals), in the case of a hospital for a cost reporting period with a disproportionate patient percentage (as defined in clause (vi)) that—

(I) is less than 19.3, the disproportionate share adjustment percentage is determined in accordance with the following formula: (P–15)(.65) + 2.5;

(II) is equal to or exceeds 19.3, but is less than 30.0, such adjustment percentage is equal to 5.25 percent; or

(III) is equal to or exceeds 30, such adjustment percentage is equal to 10 percent,

where "P" is the hospital's disproportionate patient percentage (as defined in clause (vi)).

(xi) Subject to clause (xiv), for purposes of clause (iv)(V) (relating to rural referral centers), in the case of a hospital for a cost reporting period with a disproportionate patient percentage (as defined in clause (vi)) that—

(I) is less than 19.3, the disproportionate share adjustment percentage is determined in accordance with the following formula: (P–15)(.65) + 2.5;

(II) is equal to or exceeds 19.3, but is less than 30.0, such adjustment percentage is equal to 5.25 percent; or

(III) is equal to or exceeds 30, such adjustment percentage is determined in accordance with the following formula: (P–30)(.6) + 5.25,

where "P" is the hospital's disproportionate patient percentage (as defined in clause (vi)).

(xii) Subject to clause (xiv), for purposes of clause (iv)(III) (relating to small rural hospitals generally), in the case of a hospital for a cost reporting period with a disproportionate patient percentage (as defined in clause (vi)) that—

(I) is less than 19.3, the disproportionate share adjustment percentage is determined in accordance with the following formula: (P–15)(.65) + 2.5; or

(II) is equal to or exceeds 19.3, such adjustment percentage is equal to 5.25 percent,

where "P" is the hospital's disproportionate patient percentage (as defined in clause (vi)).

(xiii) Subject to clause (xiv), for purposes of clause (iv)(II) (relating to urban hospitals with less than 100 beds), in the case of a hospital for a cost reporting period with a disproportionate patient percentage (as defined in clause (vi)) that—

(I) is less than 19.3, the disproportionate share adjustment percentage is determined in accordance with the following formula: (P–15)(.65) + 2.5; or

(II) is equal to or exceeds 19.3, such adjustment percentage is equal to 5.25 percent,

where "P" is the hospital's disproportionate patient percentage (as defined in clause (vi)).

(xiv)(I) In the case of discharges occurring on or after April 1, 2004, subject to subclause (II), there shall be substituted for the disproportionate share adjustment percentage otherwise determined under clause (iv) (other than subclause (I)) or under clause (viii), (x), (xi), (xii), or (xiii), the disproportionate share adjustment percentage determined under clause (vii) (relating to large, urban hospitals).

(II) Under subclause (I), the disproportionate share adjustment percentage shall not exceed 12 percent for a hospital that is not classified as a rural referral center under subparagraph (C) or, in the case of discharges occurring on or after October 1, 2006, as a medicare-dependent, small rural hospital under subparagraph (G)(iv).

(G)(i) For any cost reporting period beginning on or after April 1, 1990, and before October 1, 1994, or discharges occurring on or after October 1, 1997, and before October 1, 2017, in the case of a subsection (d) hospital which is a medicare-dependent, small rural hospital, payment under paragraph (1)(A) shall be equal to the sum of the amount determined under clause (ii) and the amount determined under paragraph (1)(A)(iii).

(ii) The amount determined under this clause is—

(I) for discharges occurring during the 36-month period beginning with the first day of the cost reporting period that begins on or after April 1, 1990, the amount by which the hospital's target amount for the cost reporting period (as defined in subsection (b)(3)(D)) exceeds the amount determined under paragraph (1)(A)(iii); and

(II) for discharges occurring during any subsequent cost reporting period (or portion thereof) and before October 1, 1994, or discharges occurring on or after October 1, 1997, and before October 1, 2017, 50 percent (or 75 percent in the case of discharges occurring on or after October 1, 2006) of the amount by which the hospital's target amount for the cost reporting period or for discharges in the fiscal year (as defined in subsection (b)(3)(D)) exceeds the amount determined under paragraph (1)(A)(iii).

(iii) In the case of a medicare dependent, small rural hospital that experiences, in a cost reporting period compared to the previous cost reporting period, a decrease of more than 5 percent in its total number of inpatient cases due to circumstances beyond its control, the Secretary shall provide for such adjustment to the payment amounts under this subsection (other than under paragraph (9)) as may be necessary to fully compensate the hospital for the fixed costs it incurs in the period in providing inpatient hospital services, including the reasonable cost of maintaining necessary core staff and services.

(iv) The term "medicare-dependent, small rural hospital" means, with respect to any cost reporting period to which clause (i) applies, any hospital—

(I) located in a rural area,

(II) that has not more than 100 beds,

(III) that is not classified as a sole community hospital under subparagraph (D), and

(IV) for which not less than 60 percent of its inpatient days or discharges during the cost reporting period beginning in fiscal year 1987, or two of the three most recently audited cost reporting periods for which the Secretary has a settled cost report, were attributable to inpatients entitled to benefits under part A.

(H) The Secretary may provide for such adjustments to the payment amounts under this subsection as the Secretary deems appropriate to take into account the unique circumstances of hospitals located in Alaska and Hawaii.

(I)(i) The Secretary shall provide by regulation for such other exceptions and adjustments to such payment amounts under this subsection as the Secretary deems appropriate.

(ii) In making adjustments under clause (i) for transfer cases (as defined by the Secretary) in a fiscal year, not taking in account the

effect of subparagraph (J), the Secretary may make adjustments to each of the average standardized amounts determined under paragraph (3) to assure that the aggregate payments made under this subsection for such fiscal year are not greater or lesser than those that would have otherwise been made in such fiscal year.

(J)(i) The Secretary shall treat the term "transfer case" (as defined in subparagraph (I)(ii)) as including the case of a qualified discharge (as defined in clause (ii)), which is classified within a diagnosis-related group described in clause (iii), and which occurs on or after October 1, 1998. In the case of a qualified discharge for which a substantial portion of the costs of care are incurred in the early days of the inpatient stay (as defined by the Secretary), in no case may the payment amount otherwise provided under this subsection exceed an amount equal to the sum of—

(I) 50 percent of the amount of payment under this subsection for transfer cases (as established under subparagraph (I)(i)), and

(II) 50 percent of the amount of payment which would have been made under this subsection with respect to the qualified discharge if no transfer were involved.

(ii) For purposes of clause (i), subject to clause (iii), the term "qualified discharge" means a discharge classified with a diagnosis-related group (described in clause (iii)) of an individual from a subsection (d) hospital, if upon such discharge the individual—

(I) is admitted as an inpatient to a hospital or hospital unit that is not a subsection (d) hospital for the provision of inpatient hospital services;

(II) is admitted to a skilled nursing facility;

(III) is provided home health services from a home health agency, if such services relate to the condition or diagnosis for which such individual received inpatient hospital services from the subsection (d) hospital, and if such services are provided within an appropriate period (as determined by the Secretary); or

(IV) for discharges occurring on or after October 1, 2000, the individual receives post discharge services described in clause (iv)(I).

(iii) Subject to clause (iv), a diagnosis-related group described in this clause is—

(I) 1 of 10 diagnosis-related groups selected by the Secretary based upon a high volume of discharges classified within such groups and a disproportionate use of post discharge services described in clause (ii); and

(II) a diagnosis-related group specified by the Secretary under clause (iv)(II).

(iv) The Secretary shall include in the proposed rule published under subsection (e)(5)(A) for fiscal year 2001, a description of the effect of this subparagraph. The Secretary may include in the proposed rule (and in the final rule published under paragraph (6)) for fiscal year 2001 or a subsequent fiscal year, a description of—

(I) post-discharge services not described in subclauses (I), (II), and (III) of clause (ii), the receipt of which results in a qualified discharge; and

(II) diagnosis-related groups described in clause (iii)(I) in addition to the 10 selected under such clause.

(K)(i) Effective for discharges beginning on or after October 1, 2001, the Secretary shall establish a mechanism to recognize the costs of new medical services and technologies under the payment system established under this subsection. Such mechanism shall be established after notice and opportunity for public comment (in the publications required by subsection (e)(5) for a fiscal year or otherwise). Such mechanism shall be modified to meet the requirements of clause (viii).

(ii) The mechanism established pursuant to clause (i) shall—

(I) apply to a new medical service or technology if, based on the estimated costs incurred with respect to discharges involving such service or technology, the DRG prospective payment rate otherwise applicable to such discharges under this subsection is inadequate (applying a threshold specified by the Secretary that is the lesser of 75 percent of the standardized amount (increased to reflect the difference between cost and charges) or 75 percent of one standard deviation for the diagnosis-related group involved);

(II) provide for the collection of data with respect to the costs of a new medical service or technology described in subclause (I) for a period of not less than two years and not more than three years beginning on the date on which an inpatient hospital code is issued with respect to the service or technology;

(III) provide for additional payment to be made under this subsection with respect to discharges involving a new medical service or technology described in subclause (I) that occur during the period described in subclause (II) in an amount that adequately reflects the estimated average cost of such service or technology; and

(IV) provide that discharges involving such a service or technology that occur after the close of the period described in subclause (II) will be classified within a new or existing diagnosis-related group with a weighting factor under paragraph (4)(B) that is derived from cost data collected with respect to discharges occurring during such period.

(iii) For purposes of clause (ii)(II), the term "inpatient hospital code" means any code that is used with respect to inpatient hospital services for which payment may be made under this subsection and includes an alphanumeric code issued under the International Classification of Diseases, 9th Revision, Clinical Modification ("ICD–9–CM") and its subsequent revisions.

(iv) For purposes of clause (ii)(III), the term "additional payment" means, with respect to a discharge for a new medical service or technology described in clause (ii)(I), an amount that exceeds the prospective payment rate otherwise applicable under this subsection to discharges involving such service or technology that would be made but for this subparagraph.

(v) The requirement under clause (ii)(III) for an additional payment may be satisfied by means of a new-technology group (described in subparagraph (L)), an add-on payment, a payment adjustment, or any other similar mechanism for increasing the amount otherwise payable with respect to a discharge under this subsection. The Secretary may not establish a separate fee schedule for such additional payment for such services and technologies, by utilizing a methodology established under subsection (a) or (h)

of section 1834 to determine the amount of such additional payment, or by other similar mechanisms or methodologies.

(vi) For purposes of this subparagraph and subparagraph (L), a medical service or technology will be considered a "new medical service or technology" if the service or technology meets criteria established by the Secretary after notice and an opportunity for public comment.

(vii) Under the mechanism under this subparagraph, the Secretary shall provide for the addition of new diagnosis and procedure codes in April 1 of each year, but the addition of such codes shall not require the Secretary to adjust the payment (or diagnosis-related group classification) under this subsection until the fiscal year that begins after such date.

(viii) The mechanism established pursuant to clause (i) shall be adjusted to provide, before publication of a proposed rule, for public input regarding whether a new service or technology represents an advance in medical technology that substantially improves the diagnosis or treatment of individuals entitled to benefits under part A as follows:

(I) The Secretary shall make public and periodically update a list of all the services and technologies for which an application for additional payment under this subparagraph is pending.

(II) The Secretary shall accept comments, recommendations, and data from the public regarding whether the service or technology represents a substantial improvement.

(III) The Secretary shall provide for a meeting at which organizations representing hospitals, physicians, such individuals, manufacturers, and any other interested party may present comments, recommendations, and data to the clinical staff of the Centers for Medicare & Medicaid Services before publication of a notice of proposed rulemaking regarding whether service or technology represents a substantial improvement.

(ix) Before establishing any add-on payment under this subparagraph with respect to a new technology, the Secretary shall seek to identify one or more diagnosis-related groups associated with such technology, based on similar clinical or anatomical characteristics and the cost of the technology. Within such groups the Secretary shall assign an eligible new technology into a diagnosis-related group where the average costs of care most closely approximate the costs of care of using the new technology. No add-on payment under this subparagraph shall be made with respect to such new technology and this clause shall not affect the application of paragraph (4)(C)(iii).

(L)(i) In establishing the mechanism under subparagraph (K), the Secretary may establish new-technology groups into which a new medical service or technology will be classified if, based on the estimated average costs incurred with respect to discharges involving such service or technology, the DRG prospective payment rate otherwise applicable to such discharges under this subsection is inadequate.

(ii) Such groups—

(I) shall not be based on the costs associated with a specific new medical service or technology; but

(II) shall, in combination with the applicable standardized amounts and the weighting factors assigned to such groups under paragraph (4)(B), reflect such cost cohorts as the Secretary determines are appropriate for all new medical services and technologies that are likely to be provided as inpatient hospital services in a fiscal year.

(iii) The methodology for classifying specific hospital discharges within a diagnosis-related group under paragraph (4)(A) or a new-technology group shall provide that a specific hospital discharge may not be classified within both a diagnosis-related group and a new-technology group.

(6) The Secretary shall provide for publication in the Federal Register, on or before the August 1 before each fiscal year (beginning with fiscal year 1984), of a description of the methodology and data used in computing the adjusted DRG prospective payment rates under this subsection, including any adjustments required under subsection (e)(1)(B).

(7) There shall be no administrative or judicial review under section 1878 or otherwise of—

(A) the determination of the requirement, or the proportional amount, of any adjustment effected pursuant to subsection (e)(1) or the determination of the applicable percentage increase under paragraph (12)(A)(ii),

(B) the establishment of diagnosis-related groups, of the methodology for the classification of discharges within such groups, and of the appropriate weighting factors thereof under paragraph (4), including the selection and revision of codes under paragraph (4)(D), and

(C) the determination of whether services provided prior to a patient's inpatient admission are related to the admission (as described in subsection (a)(4)).

(8)(A) In the case of any hospital which is located in an area which is, at any time after April 20, 1983, reclassified from an urban to a rural area, payments to such hospital for the first two cost reporting periods for which such reclassification is effective shall be made as follows:

(i) For the first such cost reporting period, payment shall be equal to the amount payable to such hospital for such reporting period on the basis of the rural classification, plus an amount equal to two-thirds of the amount (if any) by which—

(I) the amount which would have been payable to such hospital for such reporting period on the basis of an urban classification, exceeds

(II) the amount payable to such hospital for such reporting period on the basis of the rural classification.

(ii) For the second such cost reporting period, payment shall be equal to the amount payable to such hospital for such reporting period on the basis of the rural classification, plus an amount equal to one-third of the amount (if any) by which—

(I) the amount which would have been payable to such hospital for such reporting period on the basis of an urban classification, exceeds

(II) the amount payable to such hospital for such reporting period on the basis of the rural classification.

(B)(i) For purposes of this subsection, the Secretary shall treat a hospital located in a rural county adjacent to one or more urban areas as being located in the urban metropolitan statistical area to which the greatest number of workers in the county commute, if the rural county would otherwise be considered part of an urban area, under the standards for designating Metropolitan Statistical Areas (and for designating New England County Metropolitan Areas) described in clause (ii), if the commuting rates used in determining outlying counties (or, for New England, similar recognized areas) were determined on the basis of the aggregate number of resident workers who commute to (and, if applicable under the standards, from) the central county or counties of all contiguous Metropolitan Statistical Areas (or New England County Metropolitan Areas).

(ii) The standards described in this clause for cost reporting periods beginning in a fiscal year—

(I) before fiscal year 2003, are the standards published in the Federal Register on January 3, 1980, or, at the election of the hospital with respect to fiscal years 2001 and 2002, standards so published on March 30, 1990; and

(II) after fiscal year 2002, are the standards published in the Federal Register by the Director of the Office of Management and Budget based on the most recent available decennial population data.

Subparagraphs (C) and (D) shall not apply with respect to the application of subclause (I).

(C)(i) If the application of subparagraph (B) or a decision of the Medicare Geographic Classification Review Board or the Secretary under paragraph (10), by treating hospitals located in a rural county or counties as being located in an urban area, or by treating hospitals located in one urban area as being located in another urban area—

(I) reduces the wage index for that urban area (as applied under this subsection) by 1 percentage point or less, the Secretary, in calculating such wage index under this subsection, shall exclude those hospitals so treated, or

(II) reduces the wage index for that urban area by more than 1 percentage point (as applied under this subsection), the Secretary shall calculate and apply such wage index under this subsection separately to hospitals located in such urban area (excluding all the hospitals so treated) and to the hospitals so treated (as if such hospitals were located in such urban area).

(ii) If the application of subparagraph (B) or a decision of the Medicare Geographic Classification Review Board or the Secretary under paragraph (10), by treating hospitals located in a rural county or counties as not being located in the rural area in a State, reduces the wage index for that rural area (as applied under this subsection), the Secretary shall calculate and apply such wage index under this subsection as if the hospitals so treated had not been excluded from calculation of the wage index for that rural area.

(iii) The application of subparagraph (B) or a decision of the Medicare Geographic Classification Review Board or the Secretary under paragraph (10) may not result in the reduction of any coun-

ty's wage index to a level below the wage index for rural areas in the State in which the county is located.

(iv) The application of subparagraph (B) or a decision of the Medicare Geographic Classification Review Board or of the Secretary under paragraph (10) may not result in a reduction in an urban area's wage index if—

(I) the urban area has a wage index below the wage index for rural areas in the State in which it is located; or

(II) the urban area is located in a State that is composed of a single urban area.

(v) This subparagraph shall apply with respect to discharges occurring in a fiscal year only if the Secretary uses a method for making adjustments to the DRG prospective payment rate for area differences in hospital wage levels under paragraph (3)(E) for the fiscal year that is based on the use of Metropolitan Statistical Area classifications.

(D) The Secretary shall make a proportional adjustment in the standardized amounts determined under paragraph (3) to assure that the provisions of subparagraphs (B) and (C) or a decision of the Medicare Geographic Classification Review Board or the Secretary under paragraph (10) do not result in aggregate payments under this section that are greater or less than those that would otherwise be made.

(E)(i) For purposes of this subsection, not later than 60 days after the receipt of an application (in a form and manner determined by the Secretary) from a subsection (d) hospital described in clause (ii), the Secretary shall treat the hospital as being located in the rural area (as defined in paragraph (2)(D)) of the State in which the hospital is located.

(ii) For purposes of clause (i), a subsection (d) hospital described in this clause is a subsection (d) hospital that is located in an urban area (as defined in paragraph (2)(D)) and satisfies any of the following criteria:

(I) The hospital is located in a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725)).

(II) The hospital is located in an area designated by any law or regulation of such State as a rural area (or is designated by such State as a rural hospital).

(III) The hospital would qualify as a rural, regional, or national referral center under paragraph (5)(C) or as a sole community hospital under paragraph (5)(D) if the hospital were located in a rural area.

(IV) The hospital meets such other criteria as the Secretary may specify.

(9)(A) Notwithstanding section 1814(b) but subject to the provisions of section 1813, the amount of the payment with respect to the operating costs of inpatient hospital services of a subsection (d) Puerto Rico hospital for inpatient hospital discharges is equal to the sum of—

(i) the applicable Puerto Rico percentage (specified in subparagraph (E)) of the Puerto Rico adjusted DRG prospective

payment rate (determined under subparagraph (B) or (C)) for such discharges,

(ii) the applicable Federal percentage (specified in subparagraph (E)) of—

(I) for discharges beginning in a fiscal year beginning on or after October 1, 1997, and before October 1, 2003, the discharge-weighted average of—

(aa) the national adjusted DRG prospective payment rate (determined under paragraph (3)(D)) for hospitals located in a large urban area,

(bb) such rate for hospitals located in other urban areas, and

(cc) such rate for hospitals located in a rural area, for such discharges, adjusted in the manner provided in paragraph (3)(E) for different area wage levels; and

(II) for discharges in a fiscal year beginning on or after October 1, 2003, the national DRG prospective payment rate determined under paragraph (3)(D)(iii) for hospitals located in any area for such discharges, adjusted in the manner provided in paragraph (3)(E) for different area wage levels.

As used in this section, the term "subsection (d) Puerto Rico hospital" means a hospital that is located in Puerto Rico and that would be a subsection (d) hospital (as defined in paragraph (1)(B)) if it were located in one of the 50 States.

(B) The Secretary shall determine a Puerto Rico adjusted DRG prospective payment rate, for each inpatient hospital discharge in fiscal year 1988 involving inpatient hospital services of a subsection (d) Puerto Rico hospital for which payment may be made under part A of this title. Such rate shall be determined for such hospitals located in urban or rural areas within Puerto Rico, as follows:

(i) The Secretary shall determine the target amount (as defined in subsection (b)(3)(A)) for the hospital for the cost reporting period beginning in fiscal year 1987 and increase such amount by prorating the applicable percentage increase (as defined in subsection (b)(3)(B)) to update the amount to the midpoint in fiscal year 1988.

(ii) The Secretary shall standardize the amount determined under clause (i) for each hospital by—

(I) excluding an estimate of indirect medical education costs,

(II) adjusting for variations among hospitals by area in the average hospital wage level,

(III) adjusting for variations in case mix among hospitals, and

(IV) excluding an estimate of the additional payments to certain subsection (d) Puerto Rico hospitals to be made under subparagraph (D)(iii) (relating to disproportionate share payments).

(iii) The Secretary shall compute a discharge weighted average of the standardized amounts determined under clause (ii) for all hospitals located in an urban area and for all hospitals located in a rural area (as such terms are defined in paragraph (2)(D)).

(iv) The Secretary shall reduce the average standardized amount by a proportion equal to the proportion (estimated by the Secretary) of the amount of payments under this paragraph which are additional payments described in subparagraph (D)(i) (relating to outlier payments).

(v) For each discharge classified within a diagnosis-related group for hospitals located in an urban or rural area, respectively, the Secretary shall establish a Puerto Rico DRG prospective payment rate equal to the product of—

(I) the average standardized amount (computed under clause (iii) and reduced under clause (iv)) for hospitals located in an urban or rural area, respectively, and

(II) the weighting factor (determined under paragraph (4)(B)) for that diagnosis-related group.

(vi) The Secretary shall adjust the proportion (as estimated by the Secretary from time to time) of hospitals' costs which are attributable to wages and wage-related costs, of the Puerto Rico DRG prospective payment rate computed under clause (v) for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the Puerto Rican average hospital wage level.

(C) The Secretary shall determine a Puerto Rico adjusted DRG prospective payment rate, for each inpatient hospital discharge after fiscal year 1988 involving inpatient hospital services of a subsection (d) Puerto Rico hospital for which payment may be made under part A of this title. Such rate shall be determined for hospitals located in urban or rural areas within Puerto Rico as follows:

(i)(I) For discharges in a fiscal year after fiscal year 1988 and before fiscal year 2004, the Secretary shall compute an average standardized amount for hospitals located in an urban area and for hospitals located in a rural area equal to the respective average standardized amount computed for the previous fiscal year under subparagraph (B)(iii) or under this clause, increased for fiscal year 1989 by the applicable percentage increase under subsection (b)(3)(B), and adjusted for subsequent fiscal years in accordance with the final determination of the Secretary under subsection (e)(4), and adjusted to reflect the most recent case-mix data available.

(II) For discharges occurring in a fiscal year (beginning with fiscal year 2004), the Secretary shall compute an average standardized amount for hospitals located in any area of Puerto Rico that is equal to the average standardized amount computed under subclause (I) for fiscal year 2003 for hospitals in a large urban area (or, beginning with fiscal year 2005, for all hospitals in the previous fiscal year) increased by the applicable percentage increase under subsection (b)(3)(B) for the fiscal year involved.

(ii) The Secretary shall reduce each of the average standardized amounts (or for fiscal year 2004 and thereafter, the average standardized amount) by a proportion equal to the proportion (estimated by the Secretary) of the amount of payments under this paragraph which are additional payments described in subparagraph (D)(i) (relating to outlier payments).

(iii) For each discharge classified within a diagnosis-related group for hospitals located in an urban or rural area, respectively, the Secretary shall establish a Puerto Rico DRG prospective payment rate equal to the product of—

(I) the average standardized amount (computed under clause (i) and reduced under clause (ii)), and

(II) the weighting factor (determined under paragraph (4)(B)) for that diagnosis-related group.

(iv)(I) The Secretary shall adjust the proportion (as estimated by the Secretary from time to time) of hospitals' costs which are attributable to wages and wage-related costs, of the Puerto Rico DRG prospective payment rate computed under clause (iii) for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the Puerto Rico average hospital wage level. The second and third sentences of paragraph (3)(E)(i) shall apply to subsection (d) Puerto Rico hospitals under this clause in the same manner as they apply to subsection (d) hospitals under such paragraph and, for purposes of this clause, any reference in such paragraph to a subsection (d) hospital is deemed a reference to a subsection (d) Puerto Rico hospital.

(II) For discharges occurring on or after October 1, 2004, the Secretary shall substitute "62 percent" for the proportion described in the first sentence of clause (i), unless the application of this subclause would result in lower payments to a hospital than would otherwise be made.

(D) The following provisions of paragraph (5) shall apply to subsection (d) Puerto Rico hospitals receiving payment under this paragraph in the same manner and to the extent as they apply to subsection (d) hospitals receiving payment under this subsection:

(i) Subparagraph (A) (relating to outlier payments).

(ii) Subparagraph (B) (relating to payments for indirect medical education costs), except that for this purpose the sum of the amount determined under subparagraph (A) of this paragraph and the amount paid to the hospital under clause (i) of this subparagraph shall be substituted for the sum referred to in paragraph (5)(B)(i)(I).

(iii) Subparagraph (F) (relating to disproportionate share payments), except that for this purpose the sum described in clause (ii) of this subparagraph shall be substituted for the sum referred to in paragraph (5)(F)(ii)(I).

(iv) Subparagraph (H) (relating to exceptions and adjustments).

(E) For purposes of subparagraph (A), for discharges occurring—

(i) on or after October 1, 1987, and before October 1, 1997, the applicable Puerto Rico percentage is 75 percent and the applicable Federal percentage is 25 percent;

(ii) on or after October 1, 1997, and before April 1, 2004, the applicable Puerto Rico percentage is 50 percent and the applicable Federal percentage is 50 percent;

(iii) on or after April 1, 2004, and before October 1, 2004, the applicable Puerto Rico percentage is 37.5 percent and the applicable Federal percentage is 62.5 percent;

(iv) on or after October 1, 2004, and before January 1, 2016, the applicable Puerto Rico percentage is 25 percent and the applicable Federal percentage is 75 percent; and

(v) on or after January 1, 2016, the applicable Puerto Rico percentage is 0 percent and the applicable Federal percentage is 100 percent.

(10)(A) There is hereby established the Medicare Geographic Classification Review Board (hereinafter in this paragraph referred to as the "Board").

(B)(i) The Board shall be composed of 5 members appointed by the Secretary without regard to the provisions of title 5, United States Code, governing appointments in the competitive service. Two of such members shall be representative of subsection (d) hospitals located in a rural area under paragraph (2)(D). At least 1 member shall be knowledgeable in the field of analyzing costs with respect to the provision of inpatient hospital services.

(ii) The Secretary shall make initial appointments to the Board as provided in this paragraph within 180 days after the date of the enactment of this paragraph.

(C)(i) The Board shall consider the application of any subsection (d) hospital requesting that the Secretary change the hospital's geographic classification for purposes of determining for a fiscal year—

(I) the hospital's average standardized amount under paragraph (2)(D), or

(II) the factor used to adjust the DRG prospective payment rate for area differences in hospital wage levels that applies to such hospital under paragraph (3)(E).

(ii) A hospital requesting a change in geographic classification under clause (i) for a fiscal year shall submit its application to the Board not later than the first day of the 13-month period ending on September 30 of the preceding fiscal year.

(iii)(I) The Board shall render a decision on an application submitted under clause (i) not later than 180 days after the deadline referred to in clause (ii).

(II) Appeal of decisions of the Board shall be subject to the provisions of section 557b of title 5, United States Code. The Secretary shall issue a decision on such an appeal not later than 90 days after the date on which the appeal is filed. The decision of the Secretary shall be final and shall not be subject to judicial review.

(D)(i) The Secretary shall publish guidelines to be utilized by the Board in rendering decisions on applications submitted under this paragraph, and shall include in such guidelines the following:

(I) Guidelines for comparing wages, taking into account (to the extent the Secretary determines appropriate) occupational mix, in the area in which the hospital is classified and the area in which the hospital is applying to be classified.

(II) Guidelines for determining whether the county in which the hospital is located should be treated as being a part of a particular Metropolitan Statistical Area.

(III) Guidelines for considering information provided by an applicant with respect to the effects of the hospital's geographic classification on access to inpatient hospital services by medicare beneficiaries.

(IV) Guidelines for considering the appropriateness of the criteria used to define New England County Metropolitan Areas.

(ii) Notwithstanding clause (i), if the Secretary uses a method for making adjustments to the DRG prospective payment rate for area differences in hospital wage levels under paragraph (3)(E) that is not based on the use of Metropolitan Statistical Area classifications, the Secretary may revise the guidelines published under clause (i) to the extent such guidelines are used to determine the appropriateness of the geographic area in which the hospital is determined to be located for purposes of making such adjustments.

(iii) Under the guidelines published by the Secretary under clause (i), in the case of a hospital which has ever been classified by the Secretary as a rural referral center under paragraph (5)(C), the Board may not reject the application of the hospital under this paragraph on the basis of any comparison between the average hourly wage of the hospital and the average hourly wage of hospitals in the area in which it is located.

(iv) The Secretary shall publish the guidelines described in clause (i) by July 1, 1990.

(v) Any decision of the Board to reclassify a subsection (d) hospital for purposes of the adjustment factor described in subparagraph (C)(i)(II) for fiscal year 2001 or any fiscal year thereafter shall be effective for a period of 3 fiscal years, except that the Secretary shall establish procedures under which a subsection (d) hospital may elect to terminate such reclassification before the end of such period.

(vi) Such guidelines shall provide that, in making decisions on applications for reclassification for the purposes described in clause (v) for fiscal year 2003 and any succeeding fiscal year, the Board shall base any comparison of the average hourly wage for the hospital with the average hourly wage for hospitals in an area on—

(I) an average of the average hourly wage amount for the hospital from the most recently published hospital wage survey data of the Secretary (as of the date on which the hospital applies for reclassification) and such amount from each of the two immediately preceding surveys; and

(II) an average of the average hourly wage amount for hospitals in such area from the most recently published hospital wage survey data of the Secretary (as of the date on which the hospital applies for reclassification) and such amount from each of the two immediately preceding surveys.

(E)(i) The Board shall have full power and authority to make rules and establish procedures, not inconsistent with the provisions of this title or regulations of the Secretary, which are necessary or appropriate to carry out the provisions of this paragraph. In the course of any hearing the Board may administer oaths and affirmations. The provisions of subsections (d) and (e) of section 205 with respect to subpenas shall apply to the Board to the same extent as such provisions apply to the Secretary with respect to title II.

(ii) The Board is authorized to engage such technical assistance and to receive such information as may be required to carry out its functions, and the Secretary shall, in addition, make available to the Board such secretarial, clerical, and other assistance as the Board may require to carry out its functions.

(F)(i) Each member of the Board who is not an officer or employee of the Federal Government shall be compensated at a rate equal to the daily equivalent of the annual rate of basic pay prescribed for grade GS–18 of the General Schedule under section 5332 of title 5, United States Code, for each day (including travel time) during which such member is engaged in the performance of the duties of the Board. Each member of the Board who is an officer or employee of the United States shall serve without compensation in addition to that received for service as an officer or employee of the United States.

(ii) Members of the Board shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Board.

(11) ADDITIONAL PAYMENTS FOR MANAGED CARE ENROLLEES.—

(A) IN GENERAL.—For portions of cost reporting periods occurring on or after January 1, 1998, the Secretary shall provide for an additional payment amount for each applicable discharge of any subsection (d) hospital that has an approved medical residency training program.

(B) APPLICABLE DISCHARGE.—For purposes of this paragraph, the term "applicable discharge" means the discharge of any individual who is enrolled under a risk-sharing contract with an eligible organization under section 1876 and who is entitled to benefits under part A or any individual who is enrolled with a Medicare+Choice organization under part C.

(C) DETERMINATION OF AMOUNT.—The amount of the payment under this paragraph with respect to any applicable discharge shall be equal to the applicable percentage (as defined in subsection (h)(3)(D)(ii)) of the estimated average per discharge amount that would otherwise have been paid under paragraph (5)(B) if the individuals had not been enrolled as described in subparagraph (B).

(D) SPECIAL RULE FOR HOSPITALS UNDER REIMBURSEMENT SYSTEM.—The Secretary shall establish rules for the application of this paragraph to a hospital reimbursed under a reimbursement system authorized under section 1814(b)(3) in the same manner as it would apply to the hospital if it were not reimbursed under such section.

(12) PAYMENT ADJUSTMENT FOR LOW-VOLUME HOSPITALS.—

(A) IN GENERAL.—In addition to any payments calculated under this section for a subsection (d) hospital, for discharges occurring during a fiscal year (beginning with fiscal year 2005), the Secretary shall provide for an additional payment amount to each low-volume hospital (as defined in subparagraph (C)(i)) for discharges occurring during that fiscal year that is equal to the applicable percentage increase (determined under subparagraph (B) or (D) for the hospital involved) in the amount paid to such hospital under this section for such discharges (determined without regard to this paragraph).

(B) APPLICABLE PERCENTAGE INCREASE.—For discharges occurring in fiscal years 2005 through 2010 and for discharges occurring in fiscal year 2018 and subsequent fiscal years, the Secretary shall determine an applicable percentage increase for purposes of subparagraph (A) as follows:

(i) The Secretary shall determine the empirical relationship for subsection (d) hospitals between the standardized cost-per-case for such hospitals and the total number of discharges of such hospitals and the amount of the additional incremental costs (if any) that are associated with such number of discharges.

(ii) The applicable percentage increase shall be determined based upon such relationship in a manner that reflects, based upon the number of such discharges for a subsection (d) hospital, such additional incremental costs.

(iii) In no case shall the applicable percentage increase exceed 25 percent.

(C) DEFINITIONS.—

(i) LOW-VOLUME HOSPITAL.—For purposes of this paragraph, the term "low-volume hospital" means, for a fiscal year, a subsection (d) hospital (as defined in paragraph (1)(B)) that the Secretary determines is located more than 25 road miles (or, with respect to fiscal years 2011 through 2017, 15 road miles) from another subsection (d) hospital and has less than 800 discharges (or, with respect to fiscal years 2011 through 2017, 1,600 discharges of individuals entitled to, or enrolled for, benefits under part A) during the fiscal year or portion of fiscal year.

(ii) DISCHARGE.—For purposes of subparagraph (B) and clause (i), the term "discharge" means an inpatient acute care discharge of an individual regardless of whether the individual is entitled to benefits under part A.

(D) TEMPORARY APPLICABLE PERCENTAGE INCREASE.—For discharges occurring in fiscal years 2011 through 2017, the Secretary shall determine an applicable percentage increase for purposes of subparagraph (A) using a continuous linear sliding scale ranging from 25 percent for low-volume hospitals with 200 or fewer discharges of individuals entitled to, or enrolled for, benefits under part A in the fiscal year or the portion of fiscal year to 0 percent for low-volume hospitals with greater than 1,600 discharges of such individuals in the fiscal year.

(13)(A) In order to recognize commuting patterns among geographic areas, the Secretary shall establish a process through application or otherwise for an increase of the wage index applied under paragraph (3)(E) for subsection (d) hospitals located in a qualifying county described in subparagraph (B) in the amount computed under subparagraph (D) based on out-migration of hospital employees who reside in that county to any higher wage index area.

(B) The Secretary shall establish criteria for a qualifying county under this subparagraph based on the out-migration referred to in

subparagraph (A) and differences in the area wage indices. Under such criteria the Secretary shall, utilizing such data as the Secretary determines to be appropriate, establish—

(i) a threshold percentage, established by the Secretary, of the weighted average of the area wage index or indices for the higher wage index areas involved;

(ii) a threshold (of not less than 10 percent) for minimum out-migration to a higher wage index area or areas; and

(iii) a requirement that the average hourly wage of the hospitals in the qualifying county equals or exceeds the average hourly wage of all the hospitals in the area in which the qualifying county is located.

(C) For purposes of this paragraph, the term "higher wage index area" means, with respect to a county, an area with a wage index that exceeds that of the county.

(D) The increase in the wage index under subparagraph (A) for a qualifying county shall be equal to the percentage of the hospital employees residing in the qualifying county who are employed in any higher wage index area multiplied by the sum of the products, for each higher wage index area of—

(i) the difference between—

(I) the wage index for such higher wage index area, and

(II) the wage index of the qualifying county; and

(ii) the number of hospital employees residing in the qualifying county who are employed in such higher wage index area divided by the total number of hospital employees residing in the qualifying county who are employed in any higher wage index area.

(E) The process under this paragraph may be based upon the process used by the Medicare Geographic Classification Review Board under paragraph (10). As the Secretary determines to be appropriate to carry out such process, the Secretary may require hospitals (including subsection (d) hospitals and other hospitals) and critical access hospitals, as required under section 1866(a)(1)(T), to submit data regarding the location of residence, or the Secretary may use data from other sources.

(F) A wage index increase under this paragraph shall be effective for a period of 3 fiscal years, except that the Secretary shall establish procedures under which a subsection (d) hospital may elect to waive the application of such wage index increase.

(G) A hospital in a county that has a wage index increase under this paragraph for a period and that has not waived the application of such an increase under subparagraph (F) is not eligible for reclassification under paragraph (8) or (10) during that period.

(H) Any increase in a wage index under this paragraph for a county shall not be taken into account for purposes of—

(i) computing the wage index for portions of the wage index area (not including the county) in which the county is located; or

(ii) applying any budget neutrality adjustment with respect to such index under paragraph (8)(D).

(I) The thresholds described in subparagraph (B), data on hospital employees used under this paragraph, and any determination of the Secretary under the process described in subparagraph (E) shall be final and shall not be subject to judicial review.

(e)(1)(A) For cost reporting periods of hospitals beginning in fiscal year 1984 or fiscal year 1985, the Secretary shall provide for such proportional adjustment in the applicable percentage increase (otherwise applicable to the periods under subsection (b)(3)(B)) as may be necessary to assure that—

(i) the aggregate payment amounts otherwise provided under subsection (d)(1)(A)(i)(I) for that fiscal year for operating costs of inpatient hospital services of hospitals (excluding payments made under section 1866(a)(1)(F)),

are not greater or less than—

(ii) the target percentage (as defined in subsection (d)(1)(C)) of the payment amounts which would have been payable for such services for those same hospitals for that fiscal year under this section under the law as in effect before the date of the enactment of the Social Security Amendments of 1983 (excluding payments made under section 1866(a)(1)(F));

except that the adjustment made under this subparagraph shall apply only to subsection (d) hospitals and shall not apply for purposes of making computations under subsection (d)(2)(B)(ii) or subsection (d)(3)(A).

(B) For discharges occurring in fiscal year 1984 or fiscal year 1985, the Secretary shall provide under subsections (d)(2)(F) and (d)(3)(C) for such equal proportional adjustment in each of the average standardized amounts otherwise computed for that fiscal year as may be necessary to assure that—

(i) the aggregate payment amounts otherwise provided under subsection (d)(1)(A)(i)(II) and (d)(5) for that fiscal year for operating costs of inpatient hospital services of hospitals (excluding payments made under section 1866(a)(1)(F)),

are not greater or less than—

(ii) the DRG percentage (as defined in subsection (d)(1)(C)) of the payment amounts which would have been payable for such services for those same hospitals for that fiscal year under this section under the law as in effect before the date of the enactment of the Social Security Amendments of 1983 (excluding payments made under section 1866(a)(1)(F)).

(C) For discharges occurring in fiscal year 1988, the Secretary shall provide for such equal proportional adjustment in each of the average standardized amounts otherwise computed under subsection (d)(3) for that fiscal year as may be necessary to assure that—

(i) the aggregate payment amounts otherwise provided under subsections (d)(1)(A)(iii), (d)(5), and (d)(9) for that fiscal year for operating costs of inpatient hospital services of subsection (d) hospitals and subsection (d) Puerto Rico hospitals,

are not greater or less than—

(ii) the payment amounts that would have been payable for such services for those same hospitals for that fiscal year but for the enactment of the amendments made by section 9304 of the Omnibus Budget Reconciliation Act of 1986.

(4)(A) Taking into consideration the recommendations of the Commission, the Secretary shall recommend for each fiscal year (beginning with fiscal year 1988) an appropriate change factor for inpatient hospital services for discharges in that fiscal year which will take into account amounts necessary for the efficient and effec-

tive delivery of medically appropriate and necessary care of high quality. The appropriate change factor may be different for all large urban subsection (d) hospitals, other urban subsection (d) hospitals, urban subsection (d) Puerto Rico hospitals, rural subsection (d) hospitals, and rural subsection (d) Puerto Rico hospitals, and all other hospitals and units not paid under subsection (d), and may vary among such other hospitals and units.

(B) In addition to the recommendation made under subparagraph (A), the Secretary shall, taking into consideration the recommendations of the Commission under paragraph (2)(B), recommend for each fiscal year (beginning with fiscal year 1992) other appropriate changes in each existing reimbursement policy under this title under which payments to an institution are based upon prospectively determined rates.

(5) The Secretary shall cause to have published in the Federal Register, not later than—

(A) the April 1 before each fiscal year (beginning with fiscal year 1986), the Secretary's proposed recommendations under paragraph (4) for that fiscal year for public comment, and

(B) the August 1 before such fiscal year after such consideration of public comment on the proposal as is feasible in the time available, the Secretary's final recommendations under such paragraph for that year.

The Secretary shall include in the publication referred to in subparagraph (A) for a fiscal year the report of the Commission's recommendations submitted under paragraph (3) for that fiscal year. To the extent that the Secretary's recommendations under paragraph (4) differ from the Commission's recommendations for that fiscal year, the Secretary shall include in the publication referred to in subparagraph (A) an explanation of the Secretary's grounds for not following the Commission's recommendations.

(f)(1)(A) The Secretary shall maintain a system for the reporting of costs of hospitals receiving payments computed under subsection (d).

(B)(i) Subject to clause (ii), the Secretary shall place into effect a standardized electronic cost reporting format for hospitals under this title.

(ii) The Secretary may delay or waive the implementation of such format in particular instances where such implementation would result in financial hardship (in particular with respect to hospitals with a small percentage of inpatients entitled to benefits under this title).

(2) If the Secretary determines, based upon information supplied by a quality improvement organization under part B of title XI, that a hospital, in order to circumvent the payment method established under subsection (b) or (d) of this section, has taken an action that results in the admission of individuals entitled to benefits under part A unnecessarily, unnecessary multiple admissions of the same such individuals, or other inappropriate medical or other practices with respect to such individuals, the Secretary may—

(A) deny payment (in whole or in part) under part A with respect to inpatient hospital services provided with respect to such an unnecessary admission (or subsequent admission of the same individual), or

(B) require the hospital to take other corrective action necessary to prevent or correct the inappropriate practice.

(3) The provisions of subsections (c) through (g) of section 1128 shall apply to determinations made under paragraph (2) in the same manner as they apply to exclusions effected under section 1128(b)(13).

(g)(1)(A) Notwithstanding section 1861(v), instead of any amounts that are otherwise payable under this title with respect to the reasonable costs of subsection (d) hospitals and subsection (d) Puerto Rico hospitals for capital-related costs of inpatient hospital services, the Secretary shall, for hospital cost reporting periods beginning on or after October 1, 1991, provide for payments for such costs in accordance with a prospective payment system established by the Secretary. Aggregate payments made under subsection (d) and this subsection during fiscal years 1992 through 1995 shall be reduced in a manner that results in a reduction (as estimated by the Secretary) in the amount of such payments equal to a 10 percent reduction in the amount of payments attributable to capital-related costs that would otherwise have been made during such fiscal year had the amount of such payments been based on reasonable costs (as defined in section 1861(v)). For discharges occurring after September 30, 1993, the Secretary shall reduce by 7.4 percent the unadjusted standard Federal capital payment rate (as described in 42 CFR 412.308(c), as in effect on the date of the enactment of the Omnibus Budget Reconciliation Act of 1993) and shall (for hospital cost reporting periods beginning on or after October 1, 1993) redetermine which payment methodology is applied to the hospital under such system to take into account such reduction. In addition to the reduction described in the preceding sentence, for discharges occurring on or after October 1, 1997, the Secretary shall apply the budget neutrality adjustment factor used to determine the Federal capital payment rate in effect on September 30, 1995 (as described in section 412.352 of title 42 of the Code of Federal Regulations), to (i) the unadjusted standard Federal capital payment rate (as described in section 412.308(c) of that title, as in effect on September 30, 1997), and (ii) the unadjusted hospital-specific rate (as described in section 412.328(e)(1) of that title, as in effect on September 30, 1997), and, for discharges occurring on or after October 1, 1997, and before October 1, 2002, reduce the rates described in clauses (i) and (ii) by 2.1 percent.

(B) Such system—

(i) shall provide for (I) a payment on a per discharge basis, and (II) an appropriate weighting of such payment amount as relates to the classification of the discharge;

(ii) may provide for an adjustment to take into account variations in the relative costs of capital and construction for the different types of facilities or areas in which they are located;

(iii) may provide for such exceptions (including appropriate exceptions to reflect capital obligations) as the Secretary determines to be appropriate, and

(iv) may provide for suitable adjustment to reflect hospital occupancy rate.

(C) In this paragraph, the term "capital-related costs" has the meaning given such term by the Secretary under subsection (a)(4)

as of September 30, 1987, and does not include a return on equity capital.

(2)(A) The Secretary shall provide that the amount which is allowable, with respect to reasonable costs of inpatient hospital services for which payment may be made under this title, for a return on equity capital for hospitals shall, for cost reporting periods beginning on or after the date of the enactment of this subsection, be equal to amounts otherwise allowable under regulations in effect on March 1, 1983, except that the rate of return to be recognized shall be equal to the applicable percentage (described in subparagraph (B)) of the average of the rates of interest, for each of the months any part of which is included in the reporting period, on obligations issued for purchase by the Federal Hospital Insurance Trust Fund.

(B) In this paragraph, the "applicable percentage" is—

(i) 75 percent, for cost reporting periods beginning during fiscal year 1987,

(ii) 50 percent, for cost reporting periods beginning during fiscal year 1988,

(iii) 25 percent, for cost reporting periods beginning during fiscal year 1989, and

(iv) 0 percent, for cost reporting periods beginning on or after October 1, 1989.

(3)(A) Except as provided in subparagraph (B), in determining the amount of the payments that may be made under this title with respect to all the capital-related costs of inpatient hospital services of a subsection (d) hospital and a subsection (d) Puerto Rico hospital, the Secretary shall reduce the amounts of such payments otherwise established under this title by—

(i) 3.5 percent for payments attributable to portions of cost reporting periods occurring during fiscal year 1987,

(ii) 7 percent for payments attributable to portions of cost reporting periods or discharges (as the case may be) occurring during fiscal year 1988 on or after October 1, 1987, and before January 1, 1988,

(iii) 12 percent for payments attributable to portions of cost reporting periods or discharges (as the case may be) in fiscal year 1988, occurring on or after January 1, 1988,

(iv) 15 percent for payments attributable to portions of cost reporting periods or discharges (as the case may be) occurring during fiscal year 1989, and

(v) 15 percent for payments attributable to portions of cost reporting periods or discharges (as the case may be) occurring during the period beginning January 1, 1990, and ending September 30, 1991.

(B) Subparagraph (A) shall not apply to payments with respect to the capital-related costs of any hospital that is a sole community hospital (as defined in subsection (d)(5)(D)(iii)) or a critical access hospital (as defined in section 1861(mm)(1)).

(4) In determining the amount of the payments that are attributable to portions of cost reporting periods occurring during fiscal years 1998 through 2002 and that may be made under this title with respect to capital-related costs of inpatient hospital services of a hospital which is described in clause (i), (ii), or (iv) of subsection (d)(1)(B) or a unit described in the matter after clause (v) of such

subsection, the Secretary shall reduce the amounts of such payments otherwise determined under this title by 15 percent.

(h) PAYMENTS FOR DIRECT GRADUATE MEDICAL EDUCATION COSTS.—

(1) SUBSTITUTION OF SPECIAL PAYMENT RULES.—Notwithstanding section 1861(v), instead of any amounts that are otherwise payable under this title with respect to the reasonable costs of hospitals for direct graduate medical education costs, the Secretary shall provide for payments for such costs in accordance with paragraph (3) of this subsection. In providing for such payments, the Secretary shall provide for an allocation of such payments between part A and part B (and the trust funds established under the respective parts) as reasonably reflects the proportion of direct graduate medical education costs of hospitals associated with the provision of services under each respective part.

(2) DETERMINATION OF HOSPITAL-SPECIFIC APPROVED FTE RESIDENT AMOUNTS.—The Secretary shall determine, for each hospital with an approved medical residency training program, an approved FTE resident amount for each cost reporting period beginning on or after July 1, 1985, as follows:

(A) DETERMINING ALLOWABLE AVERAGE COST PER FTE RESIDENT IN A HOSPITAL'S BASE PERIOD.—The Secretary shall determine, for the hospital's cost reporting period that began during fiscal year 1984, the average amount recognized as reasonable under this title for direct graduate medical education costs of the hospital for each full-time-equivalent resident.

(B) UPDATING TO THE FIRST COST REPORTING PERIOD.—

(i) IN GENERAL.—The Secretary shall update each average amount determined under subparagraph (A) by the percentage increase in the consumer price index during the 12-month cost reporting period described in such subparagraph.

(ii) EXCEPTION.—The Secretary shall not perform an update under clause (i) in the case of a hospital if the hospital's reporting period, described in subparagraph (A), began on or after July 1, 1984, and before October 1, 1984.

(C) AMOUNT FOR FIRST COST REPORTING PERIOD.—For the first cost reporting period of the hospital beginning on or after July 1, 1985, the approved FTE resident amount for the hospital is equal to the amount determined under subparagraph (B) increased by 1 percent.

(D) AMOUNT FOR SUBSEQUENT COST REPORTING PERIODS.—

(i) IN GENERAL.—Except as provided in a subsequent clause, for each subsequent cost reporting period, the approved FTE resident amount for the hospital is equal to the approved FTE resident amount determined under this paragraph for the previous cost reporting period updated, through the midpoint of the period, by projecting the estimated percentage change in the consumer price index during the 12-month period ending at that midpoint, with appropriate adjust-

ments to reflect previous under-or over-estimations under this subparagraph in the projected percentage change in the consumer price index.

(ii) FREEZE IN UPDATE FOR FISCAL YEARS 1994 AND 1995.—For cost reporting periods beginning during fiscal year 1994 or fiscal year 1995, the approved FTE resident amount for a hospital shall not be updated under clause (i) for a resident who is not a primary care resident (as defined in paragraph (5)(H)) or a resident enrolled in an approved medical residency training program in obstetrics and gynecology.

(iii) FLOOR FOR LOCALITY ADJUSTED NATIONAL AVERAGE PER RESIDENT AMOUNT.—The approved FTE resident amount for a hospital for the cost reporting period beginning during fiscal year 2001 shall not be less than 70 percent, and for the cost reporting period beginning during fiscal year 2002 shall not be less than 85 percent, of the locality adjusted national average per resident amount computed under subparagraph (E) for the hospital and period.

(iv) ADJUSTMENT IN RATE OF INCREASE FOR HOSPITALS WITH FTE APPROVED AMOUNT ABOVE 140 PERCENT OF LOCALITY ADJUSTED NATIONAL AVERAGE PER RESIDENT AMOUNT.—

(I) FREEZE FOR FISCAL YEARS 2001 AND 2002 AND 2004 THROUGH 2013.—For a cost reporting period beginning during fiscal year 2001 or fiscal year 2002 or during the period beginning with fiscal year 2004 and ending with fiscal year 2013, if the approved FTE resident amount for a hospital for the preceding cost reporting period exceeds 140 percent of the locality adjusted national average per resident amount computed under subparagraph (E) for that hospital and period, subject to subclause (III), the approved FTE resident amount for the period involved shall be the same as the approved FTE resident amount for the hospital for such preceding cost reporting period.

(II) 2 PERCENT DECREASE IN UPDATE FOR FISCAL YEARS 2003, 2004, AND 2005.—For the cost reporting period beginning during fiscal year 2003, if the approved FTE resident amount for a hospital for the preceding cost reporting period exceeds 140 percent of the locality adjusted national average per resident amount computed under subparagraph (E) for that hospital and preceding period, the approved FTE resident amount for the period involved shall be updated in the manner described in subparagraph (D)(i) except that, subject to subclause (III), the consumer price index applied for a 12-month period shall be reduced (but not below zero) by 2 percentage points.

(III) NO ADJUSTMENT BELOW 140 PERCENT.—In no case shall subclause (I) or (II) reduce an approved FTE resident amount for a hospital for a

cost reporting period below 140 percent of the locality adjusted national average per resident amount computed under subparagraph (E) for such hospital and period.

(E) DETERMINATION OF LOCALITY ADJUSTED NATIONAL AVERAGE PER RESIDENT AMOUNT.—The Secretary shall determine a locality adjusted national average per resident amount with respect to a cost reporting period of a hospital beginning during a fiscal year as follows:

(i) DETERMINING HOSPITAL SINGLE PER RESIDENT AMOUNT.—The Secretary shall compute for each hospital operating an approved graduate medical education program a single per resident amount equal to the average (weighted by number of full-time equivalent residents, as determined under paragraph (4)) of the primary care per resident amount and the non-primary care per resident amount computed under paragraph (2) for cost reporting periods ending during fiscal year 1997.

(ii) STANDARDIZING PER RESIDENT AMOUNTS.—The Secretary shall compute a standardized per resident amount for each such hospital by dividing the single per resident amount computed under clause (i) by an average of the 3 geographic index values (weighted by the national average weight for each of the work, practice expense, and malpractice components) as applied under section 1848(e) for 1999 for the fee schedule area in which the hospital is located.

(iii) COMPUTING OF WEIGHTED AVERAGE.—The Secretary shall compute the average of the standardized per resident amounts computed under clause (ii) for such hospitals, with the amount for each hospital weighted by the average number of full-time equivalent residents at such hospital (as determined under paragraph (4)).

(iv) COMPUTING NATIONAL AVERAGE PER RESIDENT AMOUNT.—The Secretary shall compute the national average per resident amount, for a hospital's cost reporting period that begins during fiscal year 2001, equal to the weighted average computed under clause (iii) increased by the estimated percentage increase in the consumer price index for all urban consumers during the period beginning with the month that represents the midpoint of the cost reporting periods described in clause (i) and ending with the midpoint of the hospital's cost reporting period that begins during fiscal year 2001.

(v) ADJUSTING FOR LOCALITY.—The Secretary shall compute the product of—

(I) the national average per resident amount computed under clause (iv) for the hospital, and

(II) the geographic index value average (described and applied under clause (ii)) for the fee schedule area in which the hospital is located.

(vi) COMPUTING LOCALITY ADJUSTED AMOUNT.—The locality adjusted national per resident amount for a hospital for—

(I) the cost reporting period beginning during fiscal year 2001 is the product computed under clause (v); or

(II) each subsequent cost reporting period is equal to the locality adjusted national per resident amount for the hospital for the previous cost reporting period (as determined under this clause) updated, through the midpoint of the period, by projecting the estimated percentage change in the consumer price index for all urban consumers during the 12-month period ending at that midpoint.

(F) TREATMENT OF CERTAIN HOSPITALS.—In the case of a hospital that did not have an approved medical residency training program or was not participating in the program under this title for a cost reporting period beginning during fiscal year 1984, the Secretary shall, for the first such period for which it has such a residency training program and is participating under this title, provide for such approved FTE resident amount as the Secretary determines to be appropriate, based on approved FTE resident amounts for comparable programs.

(3) HOSPITAL PAYMENT AMOUNT PER RESIDENT.—

(A) IN GENERAL.—The payment amount, for a hospital cost reporting period beginning on or after July 1, 1985, is equal to the product of—

(i) the aggregate approved amount (as defined in subparagraph (B)) for that period, and

(ii) the hospital's medicare patient load (as defined in subparagraph (C)) for that period.

(B) AGGREGATE APPROVED AMOUNT.—As used in subparagraph (A), the term "aggregate approved amount" means, for a hospital cost reporting period, the product of—

(i) the hospital's approved FTE resident amount (determined under paragraph (2)) for that period, and

(ii) the weighted average number of full-time-equivalent residents (as determined under paragraph (4)) in the hospital's approved medical residency training programs in that period.

The Secretary shall reduce the aggregate approved amount to the extent payment is made under subsection (k) for residents included in the hospital's count of full-time equivalent residents.

(C) MEDICARE PATIENT LOAD.—As used in subparagraph (A), the term "medicare patient load" means, with respect to a hospital's cost reporting period, the fraction of the total number of inpatient-bed-days (as established by the Secretary) during the period which are attributable to patients with respect to whom payment may be made under part A.

(D) PAYMENT FOR MANAGED CARE ENROLLEES.—

(i) IN GENERAL.—For portions of cost reporting periods occurring on or after January 1, 1998, the Secretary shall provide for an additional payment amount under this subsection for services furnished to individuals who are enrolled under a risk-sharing contract with an eligible organization under section 1876 and who are entitled to part A or with a Medicare+Choice organization under part C. The amount of such a payment shall equal, subject to clause (iii), the applicable percentage of the product of—

(I) the aggregate approved amount (as defined in subparagraph (B)) for that period; and

(II) the fraction of the total number of inpatient-bed days (as established by the Secretary) during the period which are attributable to such enrolled individuals.

(ii) APPLICABLE PERCENTAGE.—For purposes of clause (i), the applicable percentage is—

(I) 20 percent in 1998,

(II) 40 percent in 1999,

(III) 60 percent in 2000,

(IV) 80 percent in 2001, and

(V) 100 percent in 2002 and subsequent years.

(iii) PROPORTIONAL REDUCTION FOR NURSING AND ALLIED HEALTH EDUCATION.—The Secretary shall estimate a proportional adjustment in payments to all hospitals determined under clauses (i) and (ii) for portions of cost reporting periods beginning in a year (beginning with 2000) such that the proportional adjustment reduces payments in an amount for such year equal to the total additional payment amounts for nursing and allied health education determined under subsection (l) for portions of cost reporting periods occurring in that year.

(iv) SPECIAL RULE FOR HOSPITALS UNDER REIMBURSEMENT SYSTEM.—The Secretary shall establish rules for the application of this subparagraph to a hospital reimbursed under a reimbursement system authorized under section 1814(b)(3) in the same manner as it would apply to the hospital if it were not reimbursed under such section.

(4) DETERMINATION OF FULL-TIME-EQUIVALENT RESIDENTS.—

(A) RULES.—The Secretary shall establish rules consistent with this paragraph for the computation of the number of full-time- equivalent residents in an approved medical residency training program.

(B) ADJUSTMENT FOR PART-YEAR OR PART-TIME RESIDENTS.—Such rules shall take into account individuals who serve as residents for only a portion of a period with a hospital or simultaneously with more than one hospital.

(C) WEIGHTING FACTORS FOR CERTAIN RESIDENTS.—Subject to subparagraph (D), such rules shall provide, in calculating the number of full-time-equivalent residents in an approved residency program—

(i) before July 1, 1986, for each resident the weighting factor is 1.00,

(ii) on or after July 1, 1986, for a resident who is in the resident's initial residency period (as defined in paragraph (5)(F)), the weighting factor is 1.00,

(iii) on or after July 1, 1986, and before July 1, 1987, for a resident who is not in the resident's initial residency period (as defined in paragraph (5)(F)), the weighting factor is .75, and

(iv) on or after July 1, 1987, for a resident who is not in the resident's initial residency period (as defined in paragraph (5)(F)), the weighting factor is .50.

(D) FOREIGN MEDICAL GRADUATES REQUIRED TO PASS FMGEMS EXAMINATION.—

(i) IN GENERAL.—Except as provided in clause (ii), such rules shall provide that, in the case of an individual who is a foreign medical graduate (as defined in paragraph (5)(D)), the individual shall not be counted as a resident on or after July 1, 1986, unless—

(I) the individual has passed the FMGEMS examination (as defined in paragraph (5)(E)), or

(II) the individual has previously received certification from, or has previously passed the examination of, the Educational Commission for Foreign Medical Graduates.

(ii) TRANSITION FOR CURRENT FMGS.—On or after July 1, 1986, but before July 1, 1987, in the case of a foreign medical graduate who—

(I) has served as a resident before July 1, 1986, and is serving as a resident after that date, but

(II) has not passed the FMGEMS examination or a previous examination of the Educational Commission for Foreign Medical Graduates before July 1, 1986,

the individual shall be counted as a resident at a rate equal to one-half of the rate at which the individual would otherwise be counted.

(E) COUNTING TIME SPENT IN OUTPATIENT SETTINGS.—Subject to subparagraphs (J) and (K), such rules shall provide that only time spent in activities relating to patient care shall be counted and that—

(i) effective for cost reporting periods beginning before July 1, 2010, all the time;

(ii) effective for cost reporting periods beginning on or after July 1, 2010, all the time so spent by a resident shall be counted towards the determination of full-time equivalency, without regard to the setting in which the activities are performed, if a hospital incurs the costs of the stipends and fringe benefits of the resident during the time the resident spends in that setting. If more than one hospital incurs these costs, either directly or through a third party, such hospitals shall count a proportional share of the time, as determined by written agreement between the hospitals, that a resident spends training in that setting.

so spent by a resident under an approved medical residency training program shall be counted towards the determination of full-time equivalency, without regard to the setting in which the activities are performed, if the hospital incurs all, or substantially all, of the costs for the training program in that setting.

Any hospital claiming under this subparagraph for time spent in a nonprovider setting shall maintain and make available to the Secretary records regarding the amount of such time and such amount in comparison with amounts of such time in such base year as the Secretary shall specify.

(F) LIMITATION ON NUMBER OF RESIDENTS IN ALLOPATHIC AND OSTEOPATHIC MEDICINE.—

(i) IN GENERAL.—Such rules shall provide that for purposes of a cost reporting period beginning on or after October 1, 1997, subject to paragraphs (7) and (8), the total number of full-time equivalent residents before application of weighting factors (as determined under this paragraph) with respect to a hospital's approved medical residency training program in the fields of allopathic medicine and osteopathic medicine may not exceed the number (or, 130 percent of such number in the case of a hospital located in a rural area) of such full-time equivalent residents for the hospital's most recent cost reporting period ending on or before December 31, 1996.

(ii) COUNTING PRIMARY CARE RESIDENTS ON CERTAIN APPROVED LEAVES OF ABSENCE IN BASE YEAR FTE COUNT.—

(I) IN GENERAL.—In determining the number of such full-time equivalent residents for a hospital's most recent cost reporting period ending on or before December 31, 1996, for purposes of clause (i), the Secretary shall count an individual to the extent that the individual would have been counted as a primary care resident for such period but for the fact that the individual, as determined by the Secretary, was on maternity or disability leave or a similar approved leave of absence.

(II) LIMITATION TO 3 FTE RESIDENTS FOR ANY HOSPITAL.—The total number of individuals counted under subclause (I) for a hospital may not exceed 3 full-time equivalent residents.

(G) COUNTING INTERNS AND RESIDENTS FOR FY 1998 AND SUBSEQUENT YEARS.—

(i) IN GENERAL.—For cost reporting periods beginning during fiscal years beginning on or after October 1, 1997, subject to the limit described in subparagraph (F), the total number of full-time equivalent residents for determining a hospital's graduate medical education payment shall equal the average of the actual full-time equivalent resident counts for the cost reporting period and the preceding two cost reporting periods.

(ii) ADJUSTMENT FOR SHORT PERIODS.—If any cost reporting period beginning on or after October 1, 1997, is not equal to twelve months, the Secretary shall make appropriate modifications to ensure that the average full-time equivalent resident counts pursuant to clause (i) are based on the equivalent of full twelve-month cost reporting periods.

(iii) TRANSITION RULE FOR 1998.—In the case of a hospital's first cost reporting period beginning on or after October 1, 1997, clause (i) shall be applied by using the average for such period and the preceding cost reporting period.

(H) SPECIAL RULES FOR APPLICATION OF SUBPARAGRAPHS (F) AND (G).—

(i) NEW FACILITIES.—The Secretary shall, consistent with the principles of subparagraphs (F) and (G) and subject to paragraphs (7) and (8), prescribe rules for the application of such subparagraphs in the case of medical residency training programs established on or after January 1, 1995. In promulgating such rules for purposes of subparagraph (F), the Secretary shall give special consideration to facilities that meet the needs of underserved rural areas.

(ii) AGGREGATION.—The Secretary may prescribe rules which allow institutions which are members of the same affiliated group (as defined by the Secretary) to elect to apply the limitation of subparagraph (F) on an aggregate basis.

(iii) DATA COLLECTION.—The Secretary may require any entity that operates a medical residency training program and to which subparagraphs (F) and (G) apply to submit to the Secretary such additional information as the Secretary considers necessary to carry out such subparagraphs.

(iv) NONRURAL HOSPITALS OPERATING TRAINING PROGRAMS IN RURAL AREAS.—In the case of a hospital that is not located in a rural area but establishes separately accredited approved medical residency training programs (or rural tracks) in an rural area or has an accredited training program with an integrated rural track, the Secretary shall adjust the limitation under subparagraph (F) in an appropriate manner insofar as it applies to such programs in such rural areas in order to encourage the training of physicians in rural areas.

(v) SPECIAL PROVIDER AGREEMENT.—If an entity enters into a provider agreement pursuant to section 1866(a) to provide hospital services on the same physical site previously used by Medicare Provider No. 05–0578—

(I) the limitation on the number of total full time equivalent residents under subparagraph (F) and clauses (v) and (vi)(I) of subsection (d)(5)(B) applicable to such provider shall be equal to the limitation applicable under such provisions to Pro-

vider No. 05–0578 for its cost reporting period ending on June 30, 2006; and

(II) the provisions of subparagraph (G) and subsection (d)(5)(B)(vi)(II) shall not be applicable to such provider for the first three cost reporting years in which such provider trains residents under any approved medical residency training program.

(vi) REDISTRIBUTION OF RESIDENCY SLOTS AFTER A HOSPITAL CLOSES.—

(I) IN GENERAL.—Subject to the succeeding provisions of this clause, the Secretary shall, by regulation, establish a process under which, in the case where a hospital (other than a hospital described in clause (v)) with an approved medical residency program closes on or after a date that is 2 years before the date of enactment of this clause, the Secretary shall increase the otherwise applicable resident limit under this paragraph for other hospitals in accordance with this clause.

(II) PRIORITY FOR HOSPITALS IN CERTAIN AREAS.—Subject to the succeeding provisions of this clause, in determining for which hospitals the increase in the otherwise applicable resident limit is provided under such process, the Secretary shall distribute the increase to hospitals in the following priority order (with preference given within each category to hospitals that are members of the same affiliated group (as defined by the Secretary under clause (ii)) as the closed hospital):

(aa) First, to hospitals located in the same core-based statistical area as, or a core-based statistical area contiguous to, the hospital that closed.

(bb) Second, to hospitals located in the same State as the hospital that closed.

(cc) Third, to hospitals located in the same region of the country as the hospital that closed.

(dd) Fourth, only if the Secretary is not able to distribute the increase to hospitals described in item (cc), to qualifying hospitals in accordance with the provisions of paragraph (8).

(III) REQUIREMENT HOSPITAL LIKELY TO FILL POSITION WITHIN CERTAIN TIME PERIOD.—The Secretary may only increase the otherwise applicable resident limit of a hospital under such process if the Secretary determines the hospital has demonstrated a likelihood of filling the positions made available under this clause within 3 years.

(IV) LIMITATION.—The aggregate number of increases in the otherwise applicable resident limits for hospitals under this clause shall be equal to the number of resident positions in the approved

medical residency programs that closed on or after the date described in subclause (I).

(V) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to the implementation of this clause.

(J) TREATMENT OF CERTAIN NONPROVIDER AND DIDACTIC ACTIVITIES.—Such rules shall provide that all time spent by an intern or resident in an approved medical residency training program in a nonprovider setting that is primarily engaged in furnishing patient care (as defined in paragraph (5)(K)) in non-patient care activities, such as didactic conferences and seminars, but not including research not associated with the treatment or diagnosis of a particular patient, as such time and activities are defined by the Secretary, shall be counted toward the determination of full-time equivalency.

(K) TREATMENT OF CERTAIN OTHER ACTIVITIES.—In determining the hospital's number of full-time equivalent residents for purposes of this subsection, all the time that is spent by an intern or resident in an approved medical residency training program on vacation, sick leave, or other approved leave, as such time is defined by the Secretary, and that does not prolong the total time the resident is participating in the approved program beyond the normal duration of the program shall be counted toward the determination of full-time equivalency.

(5) DEFINITIONS AND SPECIAL RULES.—As used in this subsection:

(A) APPROVED MEDICAL RESIDENCY TRAINING PROGRAM.—The term "approved medical residency training program" means a residency or other postgraduate medical training program participation in which may be counted toward certification in a specialty or subspecialty and includes formal postgraduate training programs in geriatric medicine approved by the Secretary.

(B) CONSUMER PRICE INDEX.—The term "consumer price index" refers to the Consumer Price Index for All Urban Consumers (United States city average), as published by the Secretary of Commerce.

(C) DIRECT GRADUATE MEDICAL EDUCATION COSTS.—The term "direct graduate medical education costs" means direct costs of approved educational activities for approved medical residency training programs.

(D) FOREIGN MEDICAL GRADUATE.—The term "foreign medical graduate" means a resident who is not a graduate of—

(i) a school of medicine accredited by the Liaison Committee on Medical Education of the American Medical Association and the Association of American Medical Colleges (or approved by such Committee as meeting the standards necessary for such accreditation),

(ii) a school of osteopathy accredited by the American Osteopathic Association, or approved by such As-

sociation as meeting the standards necessary for such accreditation, or

(iii) a school of dentistry or podiatry which is accredited (or meets the standards for accreditation) by an organization recognized by the Secretary for such purpose.

(E) FMGEMS EXAMINATION.—The term "FMGEMS examination" means parts I and II of the Foreign Medical Graduate Examination in the Medical Sciences or any successor examination recognized by the Secretary for this purpose.

(F) INITIAL RESIDENCY PERIOD.—The term "initial residency period" means the period of board eligibility, except that—

(i) except as provided in clause (ii), in no case shall the initial period of residency exceed an aggregate period of formal training of more than five years for any individual, and

(ii) a period, of not more than two years, during which an individual is in a geriatric residency or fellowship program or a preventive medicine residency or fellowship program which meets such criteria as the Secretary may establish, shall be treated as part of the initial residency period, but shall not be counted against any limitation on the initial residency period.

Subject to subparagraph (G)(v), the initial residency period shall be determined, with respect to a resident, as of the time the resident enters the residency training program.

(G) PERIOD OF BOARD ELIGIBILITY.—

(i) GENERAL RULE.—Subject to clauses (ii), (iii), (iv), and (v), the term "period of board eligibility" means, for a resident, the minimum number of years of formal training necessary to satisfy the requirements for initial board eligibility in the particular specialty for which the resident is training.

(ii) APPLICATION OF 1985–1986 DIRECTORY.—Except as provided in clause (iii), the period of board eligibility shall be such period specified in the 1985–1986 Directory of Residency Training Programs published by the Accreditation Council on Graduate Medical Education.

(iii) CHANGES IN PERIOD OF BOARD ELIGIBILITY.—On or after July 1, 1989, if the Accreditation Council on Graduate Medical Education, in its Directory of Residency Training Programs—

(I) increases the minimum number of years of formal training necessary to satisfy the requirements for a specialty, above the period specified in its 1985–1986 Directory, the Secretary may increase the period of board eligibility for that specialty, but not to exceed the period of board eligibility specified in that later Directory, or

(II) decreases the minimum number of years of formal training necessary to satisfy the requirements for a specialty, below the period specified in its 1985–1986 Directory, the Secretary may de-

crease the period of board eligibility for that specialty, but not below the period of board eligibility specified in that later Directory.

(iv) SPECIAL RULE FOR CERTAIN PRIMARY CARE COMBINED RESIDENCY PROGRAMS.—(I) In the case of a resident enrolled in a combined medical residency training program in which all of the individual programs (that are combined) are for training a primary care resident (as defined in subparagraph (H)), the period of board eligibility shall be the minimum number of years of formal training required to satisfy the requirements for initial board eligibility in the longest of the individual programs plus one additional year.

(II) A resident enrolled in a combined medical residency training program that includes an obstetrics and gynecology program shall qualify for the period of board eligibility under subclause (I) if the other programs such resident combines with such obstetrics and gynecology program are for training a primary care resident.

(v) CHILD NEUROLOGY TRAINING PROGRAMS.—In the case of a resident enrolled in a child neurology residency training program, the period of board eligibility and the initial residency period shall be the period of board eligibility for pediatrics plus 2 years.

(H) PRIMARY CARE RESIDENT.—The term "primary care resident" means a resident enrolled in an approved medical residency training program in family medicine, general internal medicine, general pediatrics, preventive medicine, geriatric medicine, or osteopathic general practice.

(I) RESIDENT.—The term "resident" includes an intern or other participant in an approved medical residency training program.

(J) ADJUSTMENTS FOR CERTAIN FAMILY PRACTICE RESIDENCY PROGRAMS.—

(i) IN GENERAL.—In the case of an approved medical residency training program (meeting the requirements of clause (ii)) of a hospital which received funds from the United States, a State, or a political subdivision of a State or an instrumentality of such a State or political subdivision (other than payments under this title or a State plan under title XIX) for the program during the cost reporting period that began during fiscal year 1984, the Secretary shall—

(I) provide for an average amount under paragraph (2)(A) that takes into account the Secretary's estimate of the amount that would have been recognized as reasonable under this title if the hospital had not received such funds, and

(II) reduce the payment amount otherwise provided under this subsection in an amount equal to the proportion of such program funds received during the cost reporting period involved that is allocable to this title.

(ii) ADDITIONAL REQUIREMENTS.—A hospital's approved medical residency program meets the requirements of this clause if—

(I) the program is limited to training for family and community medicine;

(II) the program is the only approved medical residency program of the hospital; and

(III) the average amount determined under paragraph (2)(A) for the hospital (as determined without regard to the increase in such amount described in clause (i)(I)) does not exceed $10,000.

(K) NONPROVIDER SETTING THAT IS PRIMARILY ENGAGED IN FURNISHING PATIENT CARE.—The term "nonprovider setting that is primarily engaged in furnishing patient care" means a nonprovider setting in which the primary activity is the care and treatment of patients, as defined by the Secretary.

(6) INCENTIVE PAYMENT UNDER PLANS FOR VOLUNTARY REDUCTION IN NUMBER OF RESIDENTS.—

(A) IN GENERAL.—In the case of a voluntary residency reduction plan for which an application is approved under subparagraph (B), subject to subparagraph (F), each hospital which is part of the qualifying entity submitting the plan shall be paid an applicable hold harmless percentage (as specified in subparagraph (E)) of the sum of—

(i) the amount (if any) by which—

(I) the amount of payment which would have been made under this subsection if there had been a 5-percent reduction in the number of full-time equivalent residents in the approved medical education training programs of the hospital as of June 30, 1997, exceeds

(II) the amount of payment which is made under this subsection, taking into account the reduction in such number effected under the reduction plan; and

(ii) the amount of the reduction in payment under subsection (d)(5)(B) for the hospital that is attributable to the reduction in number of residents effected under the plan below 95 percent of the number of full-time equivalent residents in such programs of the hospital as of June 30, 1997.

The determination of the amounts under clauses (i) and (ii) for any year shall be made on the basis of the provisions of this title in effect on the application deadline date for the first calendar year to which the reduction plan applies.

(B) APPROVAL OF PLAN APPLICATIONS.—The Secretary may not approve the application of an qualifying entity unless—

(i) the application is submitted in a form and manner specified by the Secretary and by not later than November 1, 1999,

(ii) the application provides for the operation of a plan for the reduction in the number of full-time equivalent residents in the approved medical residency

training programs of the entity consistent with the requirements of subparagraph (D);

(iii) the entity elects in the application the period of residency training years (not greater than 5) over which the reduction will occur;

(iv) the entity will not reduce the proportion of its residents in primary care (to the total number of residents) below such proportion as in effect as of the applicable time described in subparagraph (D)(v); and

(v) the Secretary determines that the application and the entity and such plan meet such other requirements as the Secretary specifies in regulations.

(C) QUALIFYING ENTITY.—For purposes of this paragraph, any of the following may be a qualifying entity:

(i) Individual hospitals operating one or more approved medical residency training programs.

(ii) Two or more hospitals that operate such programs and apply for treatment under this paragraph as a single qualifying entity.

(iii) A qualifying consortium (as described in section 4628 of the Balanced Budget Act of 1997).

(D) RESIDENCY REDUCTION REQUIREMENTS.—

(i) INDIVIDUAL HOSPITAL APPLICANTS.—In the case of a qualifying entity described in subparagraph (C)(i), the number of full-time equivalent residents in all the approved medical residency training programs operated by or through the entity shall be reduced as follows:

(I) If the base number of residents exceeds 750 residents, by a number equal to at least 20 percent of such base number.

(II) Subject to subclause (IV), if the base number of residents exceeds 600 but is less than 750 residents, by 150 residents.

(III) Subject to subclause (IV), if the base number of residents does not exceed 600 residents, by a number equal to at least 25 percent of such base number.

(IV) In the case of a qualifying entity which is described in clause (v) and which elects treatment under this subclause, by a number equal to at least 20 percent of the base number.

(ii) JOINT APPLICANTS.—In the case of a qualifying entity described in subparagraph (C)(ii), the number of full-time equivalent residents in the aggregate for all the approved medical residency training programs operated by or through the entity shall be reduced as follows:

(I) Subject to subclause (II), by a number equal to at least 25 percent of the base number.

(II) In the case of such a qualifying entity which is described in clause (v) and which elects treatment under this subclause, by a number equal to at least 20 percent of the base number.

(iii) CONSORTIA.—In the case of a qualifying entity described in subparagraph (C)(iii), the number of full-time equivalent residents in the aggregate for all the approved medical residency training programs operated by or through the entity shall be reduced by a number equal to at least 20 percent of the base number.

(iv) MANNER OF REDUCTION.—The reductions specified under the preceding provisions of this subparagraph for a qualifying entity shall be below the base number of residents for that entity and shall be fully effective not later than the 5th residency training year in which the application under subparagraph (B) is effective.

(v) ENTITIES PROVIDING ASSURANCE OF INCREASE IN PRIMARY CARE RESIDENTS.—An entity is described in this clause if—

(I) the base number of residents for the entity is less than 750 or the entity is described in subparagraph (C)(ii); and

(II) the entity represents in its application under subparagraph (B) that it will increase the number of full-time equivalent residents in primary care by at least 20 percent (from such number included in the base number of residents) by not later than the 5th residency training year in which the application under subparagraph (B) is effective.

If a qualifying entity fails to comply with the representation described in subclause (II) by the end of such 5th residency training year, the entity shall be subject to repayment of all amounts paid under this paragraph, in accordance with procedures established to carry out subparagraph (F).

(vi) BASE NUMBER OF RESIDENTS DEFINED.—For purposes of this paragraph, the term "base number of residents" means, with respect to a qualifying entity (or its participating hospitals) operating approved medical residency training programs, the number of full-time equivalent residents in such programs (before application of weighting factors) of the entity as of the most recent residency training year ending before June 30, 1997, or, if less, for any subsequent residency training year that ends before the date the entity makes application under this paragraph.

(E) APPLICABLE HOLD HARMLESS PERCENTAGE.—For purposes of subparagraph (A), the "applicable hold harmless percentage" for the—

(i) first and second residency training years in which the reduction plan is in effect, 100 percent,

(ii) third such year, 75 percent,

(iii) fourth such year, 50 percent, and

(iv) fifth such year, 25 percent.

(F) PENALTY FOR NONCOMPLIANCE.—

(i) IN GENERAL.—No payment may be made under this paragraph to a hospital for a residency training year if the hospital has failed to reduce the number of full-time equivalent residents (in the manner required under subparagraph (D)) to the number agreed to by the Secretary and the qualifying entity in approving the application under this paragraph with respect to such year.

(ii) INCREASE IN NUMBER OF RESIDENTS IN SUBSEQUENT YEARS.—If payments are made under this paragraph to a hospital, and if the hospital increases the number of full-time equivalent residents above the number of such residents permitted under the reduction plan as of the completion of the plan, then, as specified by the Secretary, the entity is liable for repayment to the Secretary of the total amounts paid under this paragraph to the entity.

(G) TREATMENT OF ROTATING RESIDENTS.—In applying this paragraph, the Secretary shall establish rules regarding the counting of residents who are assigned to institutions the medical residency training programs in which are not covered under approved applications under this paragraph.

(7) REDISTRIBUTION OF UNUSED RESIDENT POSITIONS.—

(A) REDUCTION IN LIMIT BASED ON UNUSED POSITIONS.—

(i) PROGRAMS SUBJECT TO REDUCTION.—

(I) IN GENERAL.—Except as provided in subclause (II), if a hospital's reference resident level (specified in clause (ii)) is less than the otherwise applicable resident limit (as defined in subparagraph (C)(ii)), effective for portions of cost reporting periods occurring on or after July 1, 2005, the otherwise applicable resident limit shall be reduced by 75 percent of the difference between such otherwise applicable resident limit and such reference resident level.

(II) EXCEPTION FOR SMALL RURAL HOSPITALS.—This subparagraph shall not apply to a hospital located in a rural area (as defined in subsection (d)(2)(D)(ii)) with fewer than 250 acute care inpatient beds.

(ii) REFERENCE RESIDENT LEVEL.—

(I) IN GENERAL.—Except as otherwise provided in subclauses (II) and (III), the reference resident level specified in this clause for a hospital is the resident level for the most recent cost reporting period of the hospital ending on or before September 30, 2002, for which a cost report has been settled (or, if not, submitted (subject to audit)), as determined by the Secretary.

(II) USE OF MOST RECENT ACCOUNTING PERIOD TO RECOGNIZE EXPANSION OF EXISTING PROGRAMS.—If a hospital submits a timely request to increase its resident level due to an expansion of

an existing residency training program that is not reflected on the most recent settled cost report, after audit and subject to the discretion of the Secretary, the reference resident level for such hospital is the resident level for the cost reporting period that includes July 1, 2003, as determined by the Secretary.

(III) EXPANSIONS UNDER NEWLY APPROVED PROGRAMS.—Upon the timely request of a hospital, the Secretary shall adjust the reference resident level specified under subclause (I) or (II) to include the number of medical residents that were approved in an application for a medical residency training program that was approved by an appropriate accrediting organization (as determined by the Secretary) before January 1, 2002, but which was not in operation during the cost reporting period used under subclause (I) or (II), as the case may be, as determined by the Secretary.

(iii) AFFILIATION.—The provisions of clause (i) shall be applied to hospitals which are members of the same affiliated group (as defined by the Secretary under paragraph (4)(H)(ii)) as of July 1, 2003.

(B) REDISTRIBUTION.—

(i) IN GENERAL.—The Secretary is authorized to increase the otherwise applicable resident limit for each qualifying hospital that submits a timely application under this subparagraph by such number as the Secretary may approve for portions of cost reporting periods occurring on or after July 1, 2005. The aggregate number of increases in the otherwise applicable resident limits under this subparagraph may not exceed the Secretary's estimate of the aggregate reduction in such limits attributable to subparagraph (A).

(ii) CONSIDERATIONS IN REDISTRIBUTION.—In determining for which hospitals the increase in the otherwise applicable resident limit is provided under clause (i), the Secretary shall take into account the demonstrated likelihood of the hospital filling the positions within the first 3 cost reporting periods beginning on or after July 1, 2005, made available under this subparagraph, as determined by the Secretary.

(iii) PRIORITY FOR RURAL AND SMALL URBAN AREAS.—In determining for which hospitals and residency training programs an increase in the otherwise applicable resident limit is provided under clause (i), the Secretary shall distribute the increase to programs of hospitals located in the following priority order:

(I) First, to hospitals located in rural areas (as defined in subsection (d)(2)(D)(ii)).

(II) Second, to hospitals located in urban areas that are not large urban areas (as defined for purposes of subsection (d)).

(III) Third, to other hospitals in a State if the residency training program involved is in a spe-

cialty for which there are not other residency training programs in the State.

Increases of residency limits within the same priority category under this clause shall be determined by the Secretary.

(iv) LIMITATION.—In no case shall more than 25 full-time equivalent additional residency positions be made available under this subparagraph with respect to any hospital.

(v) APPLICATION OF LOCALITY ADJUSTED NATIONAL AVERAGE PER RESIDENT AMOUNT.—With respect to additional residency positions in a hospital attributable to the increase provided under this subparagraph, notwithstanding any other provision of this subsection, the approved FTE resident amount is deemed to be equal to the locality adjusted national average per resident amount computed under paragraph (4)(E) for that hospital.

(vi) CONSTRUCTION.—Nothing in this subparagraph shall be construed as permitting the redistribution of reductions in residency positions attributable to voluntary reduction programs under paragraph (6), under a demonstration project approved as of October 31, 2003, under the authority of section 402 of Public Law 90–248, or as affecting the ability of a hospital to establish new medical residency training programs under paragraph (4)(H).

(C) RESIDENT LEVEL AND LIMIT DEFINED.—In this paragraph:

(i) RESIDENT LEVEL.—The term "resident level" means, with respect to a hospital, the total number of full-time equivalent residents, before the application of weighting factors (as determined under paragraph (4)), in the fields of allopathic and osteopathic medicine for the hospital.

(ii) OTHERWISE APPLICABLE RESIDENT LIMIT.—The term "otherwise applicable resident limit" means, with respect to a hospital, the limit otherwise applicable under subparagraphs (F)(i) and (H) of paragraph (4) on the resident level for the hospital determined without regard to this paragraph.

(D) ADJUSTMENT BASED ON SETTLED COST REPORT.—In the case of a hospital with a dual accredited osteopathic and allopathic family practice program for which—

(i) the otherwise applicable resident limit was reduced under subparagraph (A)(i)(I); and

(ii) such reduction was based on a reference resident level that was determined using a cost report and where a revised or corrected notice of program reimbursement was issued for such cost report between September 1, 2006 and September 15, 2006, whether as a result of an appeal or otherwise, and the reference resident level under such settled cost report is higher than the level used for the reduction under subparagraph (A)(i)(I);

the Secretary shall apply subparagraph (A)(i)(I) using the higher resident reference level and make any necessary adjustments to such reduction. Any such necessary adjustments shall be effective for portions of cost reporting periods occurring on or after July 1, 2005.

(E) JUDICIAL REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise, with respect to determinations made under this this paragraph, paragraph (8), or paragraph (4)(H)(vi).

(8) DISTRIBUTION OF ADDITIONAL RESIDENCY POSITIONS.—

(A) REDUCTIONS IN LIMIT BASED ON UNUSED POSITIONS.—

(i) IN GENERAL.—Except as provided in clause (ii), if a hospital's reference resident level (as defined in subparagraph (H)(i)) is less than the otherwise applicable resident limit (as defined in subparagraph (H)(iii)), effective for portions of cost reporting periods occurring on or after July 1, 2011, the otherwise applicable resident limit shall be reduced by 65 percent of the difference between such otherwise applicable resident limit and such reference resident level.

(ii) EXCEPTIONS.—This subparagraph shall not apply to—

(I) a hospital located in a rural area (as defined in subsection (d)(2)(D)(ii)) with fewer than 250 acute care inpatient beds;

(II) a hospital that was part of a qualifying entity which had a voluntary residency reduction plan approved under paragraph (6)(B) or under the authority of section 402 of Public Law 90–248, if the hospital demonstrates to the Secretary that it has a specified plan in place for filling the unused positions by not later than 2 years after the date of enactment of this paragraph; or

(III) a hospital described in paragraph (4)(H)(v).

(B) DISTRIBUTION.—

(i) IN GENERAL.—The Secretary shall increase the otherwise applicable resident limit for each qualifying hospital that submits an application under this subparagraph by such number as the Secretary may approve for portions of cost reporting periods occurring on or after July 1, 2011. The aggregate number of increases in the otherwise applicable resident limit under this subparagraph shall be equal to the aggregate reduction in such limits attributable to subparagraph (A) (as estimated by the Secretary).

(ii) REQUIREMENTS.—Subject to clause (iii), a hospital that receives an increase in the otherwise applicable resident limit under this subparagraph shall ensure, during the 5-year period beginning on the date of such increase, that—

(I) the number of full-time equivalent primary care residents, as defined in paragraph (5)(H) (as determined by the Secretary), excluding any additional positions under subclause (II), is not less than the average number of full-time equivalent

primary care residents (as so determined) during the 3 most recent cost reporting periods ending prior to the date of enactment of this paragraph; and

(II) not less than 75 percent of the positions attributable to such increase are in a primary care or general surgery residency (as determined by the Secretary).

The Secretary may determine whether a hospital has met the requirements under this clause during such 5-year period in such manner and at such time as the Secretary determines appropriate, including at the end of such 5-year period.

(iii) REDISTRIBUTION OF POSITIONS IF HOSPITAL NO LONGER MEETS CERTAIN REQUIREMENTS.—In the case where the Secretary determines that a hospital described in clause (ii) does not meet either of the requirements under subclause (I) or (II) of such clause, the Secretary shall—

(I) reduce the otherwise applicable resident limit of the hospital by the amount by which such limit was increased under this paragraph; and

(II) provide for the distribution of positions attributable to such reduction in accordance with the requirements of this paragraph.

(C) CONSIDERATIONS IN REDISTRIBUTION.—In determining for which hospitals the increase in the otherwise applicable resident limit is provided under subparagraph (B), the Secretary shall take into account—

(i) the demonstration likelihood of the hospital filling the positions made available under this paragraph within the first 3 cost reporting periods beginning on or after July 1, 2011, as determined by the Secretary; and

(ii) whether the hospital has an accredited rural training track (as described in paragraph (4)(H)(iv)).

(D) PRIORITY FOR CERTAIN AREAS.—In determining for which hospitals the increase in the otherwise applicable resident limit is provided under subparagraph (B), subject to subparagraph (E), the Secretary shall distribute the increase to hospitals based on the following factors:

(i) Whether the hospital is located in a State with a resident-to-population ratio in the lowest quartile (as determined by the Secretary).

(ii) Whether the hospital is located in a State, a territory of the United States, or the District of Columbia that is among the top 10 States, territories, or Districts in terms of the ratio of—

(I) the total population of the State, territory, or District living in an area designated (under such section 332(a)(1)(A)) as a health professional shortage area (as of the date of enactment of this paragraph); to

(II) the total population of the State, territory, or District (as determined by the Secretary based

on the most recent available population data published by the Bureau of the Census).

(iii) Whether the hospital is located in a rural area (as defined in subsection (d)(2)(D)(ii)).

(E) RESERVATION OF POSITIONS FOR CERTAIN HOSPITALS.—

(i) IN GENERAL.—Subject to clause (ii), the Secretary shall reserve the positions available for distribution under this paragraph as follows:

(I) 70 percent of such positions for distribution to hospitals described in clause (i) of subparagraph (D).

(II) 30 percent of such positions for distribution to hospitals described in clause (ii) and (iii) of such subparagraph.

(ii) EXCEPTION IF POSITIONS NOT REDISTRIBUTED BY JULY 1, 2011.—In the case where the Secretary does not distribute positions to hospitals in accordance with clause (i) by July 1, 2011, the Secretary shall distribute such positions to other hospitals in accordance with the considerations described in subparagraph (C) and the priority described in subparagraph (D).

(F) LIMITATION.—A hospital may not receive more than 75 full-time equivalent additional residency positions under this paragraph.

(G) APPLICATION OF PER RESIDENT AMOUNTS FOR PRIMARY CARE AND NONPRIMARY CARE.—With respect to additional residency positions in a hospital attributable to the increase provided under this paragraph, the approved FTE per resident amounts are deemed to be equal to the hospital per resident amounts for primary care and nonprimary care computed under paragraph (2)(D) for that hospital.

(H) DEFINITIONS.—In this paragraph:

(i) REFERENCE RESIDENT LEVEL.—The term "reference resident level" means, with respect to a hospital, the highest resident level for any of the 3 most recent cost reporting periods (ending before the date of the enactment of this paragraph) of the hospital for which a cost report has been settled (or, if not, submitted (subject to audit)), as determined by the Secretary.

(ii) RESIDENT LEVEL.—The term "resident level" has the meaning given such term in paragraph (7)(C)(i).

(iii) OTHERWISE APPLICABLE RESIDENT LIMIT.—The term "otherwise applicable resident limit" means, with respect to a hospital, the limit otherwise applicable under subparagraphs (F)(i) and (H) of paragraph (4) on the resident level for the hospital determined without regard to this paragraph but taking into account paragraph (7)(A).

(I) AFFILIATION.—The provisions of this paragraph shall be applied to hospitals which are members of the same affiliated group (as defined by the Secretary under paragraph (4)(H)(ii)) and the reference resident level for each

such hospital shall be the reference resident level with respect to the cost reporting period that results in the smallest difference between the reference resident level and the otherwise applicable resident limit.

(i) AVOIDING DUPLICATIVE PAYMENTS TO HOSPITALS PARTICIPATING IN RURAL DEMONSTRATION PROGRAMS.—The Secretary shall reduce any payment amounts otherwise determined under this section to the extent necessary to avoid duplication of any payment made under section 4005(e) of the Omnibus Budget Reconciliation Act of 1987.

(j) PROSPECTIVE PAYMENT FOR INPATIENT REHABILITATION SERVICES.—

(1) PAYMENT DURING TRANSITION PERIOD.—

(A) IN GENERAL.—Notwithstanding section 1814(b), but subject to the provisions of section 1813, the amount of the payment with respect to the operating and capital costs of inpatient hospital services of a rehabilitation hospital or a rehabilitation unit (in this subsection referred to as a "rehabilitation facility"), other than a facility making an election under subparagraph (F) in a cost reporting period beginning on or after October 1, 2000, and before October 1, 2002, is equal to the sum of—

(i) the TEFRA percentage (as defined in subparagraph (C)) of the amount that would have been paid under part A with respect to such costs if this subsection did not apply, and

(ii) the prospective payment percentage (as defined in subparagraph (C)) of the product of (I) the per unit payment rate established under this subsection for the fiscal year in which the payment unit of service occurs, and (II) the number of such payment units occurring in the cost reporting period.

(B) FULLY IMPLEMENTED SYSTEM.—Notwithstanding section 1814(b), but subject to the provisions of section 1813, the amount of the payment with respect to the operating and capital costs of inpatient hospital services of a rehabilitation facility for a payment unit in a cost reporting period beginning on or after October 1, 2002, or, in the case of a facility making an election under subparagraph (F), for any cost reporting period described in such subparagraph, is equal to the per unit payment rate established under this subsection for the fiscal year in which the payment unit of service occurs.

(C) TEFRA AND PROSPECTIVE PAYMENT PERCENTAGES SPECIFIED.—For purposes of subparagraph (A), for a cost reporting period beginning—

(i) on or after October 1, 2000, and before October 1, 2001, the "TEFRA percentage" is 66⅔ percent and the "prospective payment percentage" is 33⅓ percent; and

(ii) on or after October 1, 2001, and before October 1, 2002, the "TEFRA percentage" is 33⅓ percent and the "prospective payment percentage" is 66⅔ percent.

(D) PAYMENT UNIT.—For purposes of this subsection, the term "payment unit" means a discharge.

(E) CONSTRUCTION RELATING TO TRANSFER AUTHORITY.—Nothing in this subsection shall be construed as preventing the Secretary from providing for an adjustment to payments to take into account the early transfer of a patient from a rehabilitation facility to another site of care.

(F) ELECTION TO APPLY FULL PROSPECTIVE PAYMENT SYSTEM.—A rehabilitation facility may elect, not later than 30 days before its first cost reporting period for which the payment methodology under this subsection applies to the facility, to have payment made to the facility under this subsection under the provisions of subparagraph (B) (rather than subparagraph (A)) for each cost reporting period to which such payment methodology applies.

(2) PATIENT CASE MIX GROUPS.—

(A) ESTABLISHMENT.—The Secretary shall establish—

(i) classes of patient discharges of rehabilitation facilities by functional-related groups (each in this subsection referred to as a "case mix group"), based on impairment, age, comorbidities, and functional capability of the patient and such other factors as the Secretary deems appropriate to improve the explanatory power of functional independence measure-function related groups; and

(ii) a method of classifying specific patients in rehabilitation facilities within these groups.

(B) WEIGHTING FACTORS.—For each case mix group the Secretary shall assign an appropriate weighting which reflects the relative facility resources used with respect to patients classified within that group compared to patients classified within other groups.

(C) ADJUSTMENTS FOR CASE MIX.—

(i) IN GENERAL.—The Secretary shall from time to time adjust the classifications and weighting factors established under this paragraph as appropriate to reflect changes in treatment patterns, technology, case mix, number of payment units for which payment is made under this title, and other factors which may affect the relative use of resources. Such adjustments shall be made in a manner so that changes in aggregate payments under the classification system are a result of real changes and are not a result of changes in coding that are unrelated to real changes in case mix.

(ii) ADJUSTMENT.—Insofar as the Secretary determines that such adjustments for a previous fiscal year (or estimates that such adjustments for a future fiscal year) did (or are likely to) result in a change in aggregate payments under the classification system during the fiscal year that are a result of changes in the coding or classification of patients that do not reflect real changes in case mix, the Secretary shall adjust the per payment unit payment rate for subsequent years so as to eliminate the effect of such coding or classification changes.

(D) DATA COLLECTION.—The Secretary is authorized to require rehabilitation facilities that provide inpatient hospital services to submit such data as the Secretary deems necessary to establish and administer the prospective payment system under this subsection.

(3) PAYMENT RATE.—

(A) IN GENERAL.—The Secretary shall determine a prospective payment rate for each payment unit for which such rehabilitation facility is entitled to receive payment under this title. Subject to subparagraph (B), such rate for payment units occurring during a fiscal year shall be based on the average payment per payment unit under this title for inpatient operating and capital costs of rehabilitation facilities using the most recent data available (as estimated by the Secretary as of the date of establishment of the system) adjusted—

(i) by updating such per-payment-unit amount to the fiscal year involved by the weighted average of the applicable percentage increases provided under subsection (b)(3)(B)(ii) (for cost reporting periods beginning during the fiscal year) covering the period from the midpoint of the period for such data through the midpoint of fiscal year 2000 and by an increase factor (described in subparagraph (C)) specified by the Secretary for subsequent fiscal years up to the fiscal year involved;

(ii) by reducing such rates by a factor equal to the proportion of payments under this subsection (as estimated by the Secretary) based on prospective payment amounts which are additional payments described in paragraph (4) (relating to outlier and related payments);

(iii) for variations among rehabilitation facilities by area under paragraph (6);

(iv) by the weighting factors established under paragraph (2)(B); and

(v) by such other factors as the Secretary determines are necessary to properly reflect variations in necessary costs of treatment among rehabilitation facilities.

(B) BUDGET NEUTRAL RATES.—The Secretary shall establish the prospective payment amounts under this subsection for payment units during fiscal years 2001 and 2002 at levels such that, in the Secretary's estimation, the amount of total payments under this subsection for such fiscal years (including any payment adjustments pursuant to paragraphs (4) and (6) but not taking into account any payment adjustment resulting from an election permitted under paragraph (1)(F)) shall be equal to 98 percent for fiscal year 2001 and 100 percent for fiscal year 2002 of the amount of payments that would have been made under this title during the fiscal years for operating and capital costs of rehabilitation facilities had this subsection not been enacted. In establishing such payment amounts, the Secretary shall consider the effects of the prospective pay-

ment system established under this subsection on the total number of payment units from rehabilitation facilities and other factors described in subparagraph (A).

(C) INCREASE FACTOR.—

(i) IN GENERAL.—For purposes of this subsection for payment units in each fiscal year (beginning with fiscal year 2001), the Secretary shall establish an increase factor subject to clauses (ii) and (iii). Such factor shall be based on an appropriate percentage increase in a market basket of goods and services comprising services for which payment is made under this subsection, which may be the market basket percentage increase described in subsection (b)(3)(B)(iii). The increase factor to be applied under this subparagraph for each of fiscal years 2008 and 2009 shall be 0 percent.

(ii) PRODUCTIVITY AND OTHER ADJUSTMENT.—Subject to clause (iii), after establishing the increase factor described in clause (i) for a fiscal year, the Secretary shall reduce such increase factor—

(I) for fiscal year 2012 and each subsequent fiscal year, by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II); and

(II) for each of fiscal years 2010 through 2019, by the other adjustment described in subparagraph (D).

The application of this clause may result in the increase factor under this subparagraph being less than 0.0 for a fiscal year, and may result in payment rates under this subsection for a fiscal year being less than such payment rates for the preceding fiscal year.

(iii) SPECIAL RULE FOR FISCAL YEAR 2018.—The increase factor to be applied under this subparagraph for fiscal year 2018, after the application of clause (ii), shall be 1 percent.

(D) OTHER ADJUSTMENT.—For purposes of subparagraph (C)(ii)(II), the other adjustment described in this subparagraph is—

(i) for each of fiscal years 2010 and 2011, 0.25 percentage point;

(ii) for each of fiscal years 2012 and 2013, 0.1 percentage point;

(iii) for fiscal year 2014, 0.3 percentage point;

(iv) for each of fiscal years 2015 and 2016, 0.2 percentage point; and

(v) for each of fiscal years 2017, 2018, and 2019, 0.75 percentage point.

(4) OUTLIER AND SPECIAL PAYMENTS.—

(A) OUTLIERS.—

(i) IN GENERAL.—The Secretary may provide for an additional payment to a rehabilitation facility for patients in a case mix group, based upon the patient being classified as an outlier based on an unusual length of stay, costs, or other factors specified by the Secretary.

(ii) PAYMENT BASED ON MARGINAL COST OF CARE.—The amount of such additional payment under clause (i) shall be determined by the Secretary and shall approximate the marginal cost of care beyond the cutoff point applicable under clause (i).

(iii) TOTAL PAYMENTS.—The total amount of the additional payments made under this subparagraph for payment units in a fiscal year may not exceed 5 percent of the total payments projected or estimated to be made based on prospective payment rates for payment units in that year.

(B) ADJUSTMENT.—The Secretary may provide for such adjustments to the payment amounts under this subsection as the Secretary deems appropriate to take into account the unique circumstances of rehabilitation facilities located in Alaska and Hawaii.

(5) PUBLICATION.—The Secretary shall provide for publication in the Federal Register, on or before August 1 before each fiscal year (beginning with fiscal year 2001), of the classification and weighting factors for case mix groups under paragraph (2) for such fiscal year and a description of the methodology and data used in computing the prospective payment rates under this subsection for that fiscal year.

(6) AREA WAGE ADJUSTMENT.—The Secretary shall adjust the proportion (as estimated by the Secretary from time to time) of rehabilitation facilities' costs which are attributable to wages and wage-related costs, of the prospective payment rates computed under paragraph (3) for area differences in wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the rehabilitation facility compared to the national average wage level for such facilities. Not later than October 1, 2001 (and at least every 36 months thereafter), the Secretary shall update the factor under the preceding sentence on the basis of information available to the Secretary (and updated as appropriate) of the wages and wage-related costs incurred in furnishing rehabilitation services. Any adjustments or updates made under this paragraph for a fiscal year shall be made in a manner that assures that the aggregated payments under this subsection in the fiscal year are not greater or less than those that would have been made in the year without such adjustment.

(7) QUALITY REPORTING.—

(A) REDUCTION IN UPDATE FOR FAILURE TO REPORT.—

(i) IN GENERAL.—For purposes of fiscal year 2014 and each subsequent fiscal year, in the case of a rehabilitation facility that does not submit data to the Secretary in accordance with subparagraphs (C) and (F) with respect to such a fiscal year, after determining the increase factor described in paragraph (3)(C), and after application of subparagraphs (C)(iii) and (D) of paragraph (3), the Secretary shall reduce such increase factor for payments for discharges occurring during such fiscal year by 2 percentage points.

(ii) SPECIAL RULE.—The application of this subparagraph may result in the increase factor described in

paragraph (3)(C) being less than 0.0 for a fiscal year, and may result in payment rates under this subsection for a fiscal year being less than such payment rates for the preceding fiscal year.

(B) NONCUMULATIVE APPLICATION.—Any reduction under subparagraph (A) shall apply only with respect to the fiscal year involved and the Secretary shall not take into account such reduction in computing the payment amount under this subsection for a subsequent fiscal year.

(C) SUBMISSION OF QUALITY DATA.—Subject to subparagraph (G), for fiscal year 2014 and each subsequent fiscal year, each rehabilitation facility shall submit to the Secretary data on quality measures specified under subparagraph (D). Such data shall be submitted in a form and manner, and at a time, specified by the Secretary for purposes of this subparagraph.

(D) QUALITY MEASURES.—

(i) IN GENERAL.—Subject to clause (ii), any measure specified by the Secretary under this subparagraph must have been endorsed by the entity with a contract under section 1890(a).

(ii) EXCEPTION.—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), the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

(iii) TIME FRAME.—Not later than October 1, 2012, the Secretary shall publish the measures selected under this subparagraph that will be applicable with respect to fiscal year 2014.

(E) PUBLIC AVAILABILITY OF DATA SUBMITTED.—The Secretary shall establish procedures for making data submitted under subparagraph (C) and subparagraph (F)(i) available to the public. Such procedures shall ensure that a rehabilitation facility has the opportunity to review the data that is to be made public with respect to the facility prior to such data being made public. The Secretary shall report quality measures that relate to services furnished in inpatient settings in rehabilitation facilities on the Internet website of the Centers for Medicare & Medicaid Services.

(F) SUBMISSION OF ADDITIONAL DATA.—

(i) IN GENERAL.—For the fiscal year beginning on the specified application date (as defined in subsection (a)(2)(E) of section 1899B), as applicable with respect to inpatient rehabilitation facilities and quality measures under subsection (c)(1) of such section and measures under subsection (d)(1) of such section, and each subsequent fiscal year, in addition to such data on the quality measures described in subparagraph (C), each rehabilitation facility shall submit to the Secretary

data on the quality measures under such subsection (c)(1) and any necessary data specified by the Secretary under such subsection (d)(1).

(ii) STANDARDIZED PATIENT ASSESSMENT DATA.—For fiscal year 2019 and each subsequent fiscal year, in addition to such data described in clause (i), each rehabilitation facility shall submit to the Secretary standardized patient assessment data required under subsection (b)(1) of section 1899B.

(iii) SUBMISSION.—Such data shall be submitted in the form and manner, and at the time, specified by the Secretary for purposes of this subparagraph.

(G) NON-DUPLICATION.—To the extent data submitted under subparagraph (F) duplicates other data required to be submitted under subparagraph (C), the submission of such data under subparagraph (F) shall be in lieu of the submission of such data under subparagraph (C). The previous sentence shall not apply insofar as the Secretary determines it is necessary to avoid a delay in the implementation of section 1899B, taking into account the different specified application dates under subsection (a)(2)(E) of such section.

(8) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise of the establishment of—

(A) case mix groups, of the methodology for the classification of patients within such groups, and of the appropriate weighting factors thereof under paragraph (2),

(B) the prospective payment rates under paragraph (3),

(C) outlier and special payments under paragraph (4), and

(D) area wage adjustments under paragraph (6).

(k) PAYMENT TO NONHOSPITAL PROVIDERS.—

(1) IN GENERAL.—For cost reporting periods beginning on or after October 1, 1997, the Secretary may establish rules for payment to qualified nonhospital providers for their direct costs of medical education, if those costs are incurred in the operation of an approved medical residency training program described in subsection (h). Such rules shall specify the amounts, form, and manner in which such payments will be made and the portion of such payments that will be made from each of the trust funds under this title.

(2) QUALIFIED NONHOSPITAL PROVIDERS.—For purposes of this subsection, the term "qualified nonhospital providers" means—

(A) a Federally qualified health center, as defined in section 1861(aa)(4);

(B) a rural health clinic, as defined in section 1861(aa)(2);

(C) Medicare+Choice organizations; and

(D) such other providers (other than hospitals) as the Secretary determines to be appropriate.

(l) PAYMENT FOR NURSING AND ALLIED HEALTH EDUCATION FOR MANAGED CARE ENROLLEES.—

(1) IN GENERAL.—For portions of cost reporting periods occurring in a year (beginning with 2000), the Secretary shall provide for an additional payment amount for any hospital that receives payments for the costs of approved educational activities for nurse and allied health professional training under section 1861(v)(1).

(2) PAYMENT AMOUNT.—The additional payment amount under this subsection for each hospital for portions of cost reporting periods occurring in a year shall be an amount specified by the Secretary in a manner consistent with the following:

(A) DETERMINATION OF MANAGED CARE ENROLLEE PAYMENT RATIO FOR GRADUATE MEDICAL EDUCATION PAYMENTS.—The Secretary shall estimate the ratio of payments for all hospitals for portions of cost reporting periods occurring in the year under subsection (h)(3)(D) to total direct graduate medical education payments estimated for such portions of periods under subsection (h)(3).

(B) APPLICATION TO FEE-FOR-SERVICE NURSING AND ALLIED HEALTH EDUCATION PAYMENTS.—Such ratio shall be applied to the Secretary's estimate of total payments for nursing and allied health education determined under section 1861(v) for portions of cost reporting periods occurring in the year to determine a total amount of additional payments for nursing and allied health education to be distributed to hospitals under this subsection for portions of cost reporting periods occurring in the year; except that in no case shall such total amount exceed $60,000,000 in any year.

(C) APPLICATION TO HOSPITAL.—The amount of payment under this subsection to a hospital for portions of cost reporting periods occurring in a year is equal to the total amount of payments determined under subparagraph (B) for the year multiplied by the ratio of—

(i) the product of (I) the Secretary's estimate of the ratio of the amount of payments made under section 1861(v) to the hospital for nursing and allied health education activities for the hospital's cost reporting period ending in the second preceding fiscal year, to the hospital's total inpatient days for such period, and (II) the total number of inpatient days (as established by the Secretary) for such period which are attributable to services furnished to individuals who are enrolled under a risk sharing contract with an eligible organization under section 1876 and who are entitled to benefits under part A or who are enrolled with a Medicare+Choice organization under part C; to

(ii) the sum of the products determined under clause (i) for such cost reporting periods.

(m) PROSPECTIVE PAYMENT FOR LONG-TERM CARE HOSPITALS.—

(1) REFERENCE TO ESTABLISHMENT AND IMPLEMENTATION OF SYSTEM.—For provisions related to the establishment and implementation of a prospective payment system for payments under this title for inpatient hospital services furnished by a long-term care hospital described in subsection (d)(1)(B)(iv), see

section 123 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 and section 307(b) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000.

(2) UPDATE FOR RATE YEAR 2008.—In implementing the system described in paragraph (1) for discharges occurring during the rate year ending in 2008 for a hospital, the base rate for such discharges for the hospital shall be the same as the base rate for discharges for the hospital occurring during the rate year ending in 2007.

(3) IMPLEMENTATION FOR RATE YEAR 2010 AND SUBSEQUENT YEARS.—

(A) IN GENERAL.—Subject to subparagraph (C), in implementing the system described in paragraph (1) for rate year 2010 and each subsequent rate year, any annual update to a standard Federal rate for discharges for the hospital during the rate year, shall be reduced—

(i) for rate year 2012 and each subsequent rate year, by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II); and

(ii) for each of rate years 2010 through 2019, by the other adjustment described in paragraph (4).

(B) SPECIAL RULE.—The application of this paragraph may result in such annual update being less than 0.0 for a rate year, and may result in payment rates under the system described in paragraph (1) for a rate year being less than such payment rates for the preceding rate year.

(C) ADDITIONAL SPECIAL RULE.—For fiscal year 2018, the annual update under subparagraph (A) for the fiscal year, after application of clauses (i) and (ii) of subparagraph (A), shall be 1 percent.

(4) OTHER ADJUSTMENT.—For purposes of paragraph (3)(A)(ii), the other adjustment described in this paragraph is—

(A) for rate year 2010, 0.25 percentage point;

(B) for rate year 2011, 0.50 percentage point;

(C) for each of the rate years beginning in 2012 and 2013, 0.1 percentage point;

(D) for rate year 2014, 0.3 percentage point;

(E) for each of rate years 2015 and 2016, 0.2 percentage point; and

(F) for each of rate years 2017, 2018, and 2019, 0.75 percentage point.

(5) QUALITY REPORTING.—

(A) REDUCTION IN UPDATE FOR FAILURE TO REPORT.—

(i) IN GENERAL.—Under the system described in paragraph (1), for rate year 2014 and each subsequent rate year, in the case of a long-term care hospital that does not submit data to the Secretary in accordance with subparagraphs (C) and (F) with respect to such a rate year, any annual update to a standard Federal rate for discharges for the hospital during the rate year, and after application of paragraph (3), shall be reduced by 2 percentage points.

(ii) SPECIAL RULE.—The application of this subparagraph may result in such annual update being less

than 0.0 for a rate year, and may result in payment rates under the system described in paragraph (1) for a rate year being less than such payment rates for the preceding rate year.

(B) NONCUMULATIVE APPLICATION.—Any reduction under subparagraph (A) shall apply only with respect to the rate year involved and the Secretary shall not take into account such reduction in computing the payment amount under the system described in paragraph (1) for a subsequent rate year.

(C) SUBMISSION OF QUALITY DATA.—Subject to subparagraph (G), for rate year 2014 and each subsequent rate year, each long-term care hospital shall submit to the Secretary data on quality measures specified under subparagraph (D). Such data shall be submitted in a form and manner, and at a time, specified by the Secretary for purposes of this subparagraph.

(D) QUALITY MEASURES.—

(i) IN GENERAL.—Subject to clause (ii), any measure specified by the Secretary under this subparagraph must have been endorsed by the entity with a contract under section 1890(a).

(ii) EXCEPTION.—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), the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

(iii) TIME FRAME.—Not later than October 1, 2012, the Secretary shall publish the measures selected under this subparagraph that will be applicable with respect to rate year 2014.

(iv) ADDITIONAL QUALITY MEASURES.—Not later than October 1, 2015, the Secretary shall establish a functional status quality measure for change in mobility among inpatients requiring ventilator support.

(E) PUBLIC AVAILABILITY OF DATA SUBMITTED.—The Secretary shall establish procedures for making data submitted under subparagraph (C) and subparagraph (F)(i) available to the public. Such procedures shall ensure that a long-term care hospital has the opportunity to review the data that is to be made public with respect to the hospital prior to such data being made public. The Secretary shall report quality measures that relate to services furnished in inpatient settings in long-term care hospitals on the Internet website of the Centers for Medicare & Medicaid Services.

(F) SUBMISSION OF ADDITIONAL DATA.—

(i) IN GENERAL.—For the rate year beginning on the specified application date (as defined in subsection (a)(2)(E) of section 1899B), as applicable with respect to long-term care hospitals and quality measures

under subsection (c)(1) of such section and measures under subsection (d)(1) of such section, and each subsequent rate year, in addition to the data on the quality measures described in subparagraph (C), each long-term care hospital (other than a hospital classified under subsection (d)(1)(B)(iv)(II)) shall submit to the Secretary data on the quality measures under such subsection (c)(1) and any necessary data specified by the Secretary under such subsection (d)(1).

(ii) STANDARDIZED PATIENT ASSESSMENT DATA.—For rate year 2019 and each subsequent rate year, in addition to such data described in clause (i), each long-term care hospital (other than a hospital classified under subsection (d)(1)(B)(iv)(II)) shall submit to the Secretary standardized patient assessment data required under subsection (b)(1) of section 1899B.

(iii) SUBMISSION.—Such data shall be submitted in the form and manner, and at the time, specified by the Secretary for purposes of this subparagraph.

(G) NON-DUPLICATION.—To the extent data submitted under subparagraph (F) duplicates other data required to be submitted under subparagraph (C), the submission of such data under subparagraph (F) shall be in lieu of the submission of such data under subparagraph (C). The previous sentence shall not apply insofar as the Secretary determines it is necessary to avoid a delay in the implementation of section 1899B, taking into account the different specified application dates under subsection (a)(2)(E) of such section.

(6) APPLICATION OF SITE NEUTRAL IPPS PAYMENT RATE IN CERTAIN CASES.—

(A) GENERAL APPLICATION OF SITE NEUTRAL IPPS PAYMENT AMOUNT FOR DISCHARGES FAILING TO MEET APPLICABLE CRITERIA.—

(i) IN GENERAL.—For a discharge in cost reporting periods beginning on or after October 1, 2015, except as provided in clause (ii) and subparagraphs (C) and (E), payment under this title to a long-term care hospital for inpatient hospital services shall be made at the applicable site neutral payment rate (as defined in subparagraph (B)).

(ii) EXCEPTION FOR CERTAIN DISCHARGES MEETING CRITERIA.—Clause (i) shall not apply (and payment shall be made to a long-term care hospital without regard to this paragraph) for a discharge if—

(I) the discharge meets the ICU criterion under clause (iii) or the ventilator criterion under clause (iv); and

(II) the discharge does not have a principal diagnosis relating to a psychiatric diagnosis or to rehabilitation.

(iii) INTENSIVE CARE UNIT (ICU) CRITERION.—

(I) IN GENERAL.—The criterion specified in this clause (in this paragraph referred to as the "ICU criterion"), for a discharge from a long-term care

hospital, is that the stay in the long-term care hospital ending with such discharge was immediately preceded by a discharge from a stay in a subsection (d) hospital that included at least 3 days in an intensive care unit (ICU), as determined by the Secretary.

(II) DETERMINING ICU DAYS.—In determining intensive care unit days under subclause (I), the Secretary shall use data from revenue center codes 020x or 021x (or such successor codes as the Secretary may establish).

(iv) VENTILATOR CRITERION.—The criterion specified in this clause (in this paragraph referred to as the "ventilator criterion"), for a discharge from a long-term care hospital, is that—

(I) the stay in the long-term care hospital ending with such discharge was immediately preceded by a discharge from a stay in a subsection (d) hospital; and

(II) the individual discharged was assigned to a Medicare-Severity-Long-Term-Care-Diagnosis-Related-Group (MS–LTC–DRG) based on the receipt of ventilator services of at least 96 hours.

(B) APPLICABLE SITE NEUTRAL PAYMENT RATE DEFINED.—

(i) IN GENERAL.—In this paragraph, the term "applicable site neutral payment rate" means—

(I) for discharges in cost reporting periods beginning during fiscal year 2016 or fiscal year 2017, the blended payment rate specified in clause (iii); and

(II) for discharges in cost reporting periods beginning during fiscal year 2018 or a subsequent fiscal year, the site neutral payment rate (as defined in clause (ii)).

(ii) SITE NEUTRAL PAYMENT RATE DEFINED.—In this paragraph, the term "site neutral payment rate" means the lower of—

(I) the IPPS comparable per diem amount determined under paragraph (d)(4) of section 412.529 of title 42, Code of Federal Regulations, including any applicable outlier payments under section 412.525 of such title; or

(II) 100 percent of the estimated cost for the services involved.

(iii) BLENDED PAYMENT RATE.—The blended payment rate specified in this clause, for a long-term care hospital for inpatient hospital services for a discharge, is comprised of—

(I) half of the site neutral payment rate (as defined in clause (ii)) for the discharge; and

(II) half of the payment rate that would otherwise be applicable to such discharge without regard to this paragraph, as determined by the Secretary.

(C) LIMITING PAYMENT FOR ALL HOSPITAL DISCHARGES TO SITE NEUTRAL PAYMENT RATE FOR HOSPITALS FAILING TO MEET APPLICABLE LTCH DISCHARGE THRESHOLDS.—

(i) NOTICE OF LTCH DISCHARGE PAYMENT PERCENTAGE.—For cost reporting periods beginning during or after fiscal year 2016, the Secretary shall inform each long-term care hospital of its LTCH discharge payment percentage (as defined in clause (iv)) for such period.

(ii) LIMITATION.—For cost reporting periods beginning during or after fiscal year 2020, if the Secretary determines for a long-term care hospital that its LTCH discharge payment percentage for the period is not at least 50 percent—

(I) the Secretary shall inform the hospital of such fact; and

(II) subject to clause (iii), for all discharges in the hospital in each succeeding cost reporting period, the payment amount under this subsection shall be the payment amount that would apply under subsection (d) for the discharge if the hospital were a subsection (d) hospital.

(iii) PROCESS FOR REINSTATEMENT.—The Secretary shall establish a process whereby a long-term care hospital may seek to and have the provisions of subclause (II) of clause (ii) discontinued with respect to that hospital.

(iv) LTCH DISCHARGE PAYMENT PERCENTAGE.—In this subparagraph, the term "LTCH discharge payment percentage" means, with respect to a long-term care hospital for a cost reporting period beginning during or after fiscal year 2020, the ratio (expressed as a percentage) of—

(I) the number of Medicare fee-for-service discharges for such hospital and period for which payment is not made at the site neutral payment rate, to

(II) the total number of Medicare fee-for-service discharges for such hospital and period.

(D) INCLUSION OF SUBSECTION (d) PUERTO RICO HOSPITALS.—In this paragraph, any reference in this paragraph to a subsection (d) hospital shall be deemed to include a reference to a subsection (d) Puerto Rico hospital.

(E) TEMPORARY EXCEPTION FOR CERTAIN SEVERE WOUND DISCHARGES FROM CERTAIN LONG-TERM CARE HOSPITALS.—

(i) IN GENERAL.—In the case of a discharge occurring prior to January 1, 2017, subparagraph (A)(i) shall not apply (and payment shall be made to a long-term care hospital without regard to this paragraph) if such discharge—

(I) is from a long-term care hospital that is—

(aa) identified by the amendment made by section 4417(a) of the Balanced Budget Act of 1997 (42 U.S.C. 1395ww note, Public Law 105–33); and

(bb) located in a rural area (as defined in subsection (d)(2)(D)) or treated as being so located pursuant to subsection (d)(8)(E); and

(II) the individual discharged has a severe wound.

(ii) SEVERE WOUND DEFINED.—In this subparagraph, the term "severe wound" means a stage 3 wound, stage 4 wound, unstageable wound, non-healing surgical wound, infected wound, fistula, osteomyelitis, or wound with morbid obesity, as identified in the claim from the long-term care hospital.

(n) INCENTIVES FOR ADOPTION AND MEANINGFUL USE OF CERTIFIED EHR TECHNOLOGY.—

(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, with respect to inpatient hospital services furnished by an eligible hospital during a payment year (as defined in paragraph (2)(G)), if the eligible hospital is a meaningful EHR user (as determined under paragraph (3)) for the EHR reporting period with respect to such year, in addition to the amount otherwise paid under this section, there also shall be paid to the eligible hospital, from the Federal Hospital Insurance Trust Fund established under section 1817, an amount equal to the applicable amount specified in paragraph (2)(A) for the hospital for such payment year.

(2) PAYMENT AMOUNT.—

(A) IN GENERAL.—Subject to the succeeding subparagraphs of this paragraph, the applicable amount specified in this subparagraph for an eligible hospital for a payment year is equal to the product of the following:

(i) INITIAL AMOUNT.—The sum of—

(I) the base amount specified in subparagraph (B); plus

(II) the discharge related amount specified in subparagraph (C) for a 12-month period selected by the Secretary with respect to such payment year.

(ii) MEDICARE SHARE.—The Medicare share as specified in subparagraph (D) for the eligible hospital for a period selected by the Secretary with respect to such payment year.

(iii) TRANSITION FACTOR.—The transition factor specified in subparagraph (E) for the eligible hospital for the payment year.

(B) BASE AMOUNT.—The base amount specified in this subparagraph is $2,000,000.

(C) DISCHARGE RELATED AMOUNT.—The discharge related amount specified in this subparagraph for a 12-month period selected by the Secretary shall be determined as the sum of the amount, estimated based upon total discharges for the eligible hospital (regardless of any source of payment) for the period, for each discharge up to the 23,000th discharge as follows:

(i) For the first through 1,149th discharge, $0.

(ii) For the 1,150th through the 23,000th discharge, $200.

(iii) For any discharge greater than the 23,000th, $0.

(D) MEDICARE SHARE.—The Medicare share specified under this subparagraph for an eligible hospital for a period selected by the Secretary for a payment year is equal to the fraction—

(i) the numerator of which is the sum (for such period and with respect to the eligible hospital) of—

(I) the estimated number of inpatient-bed-days (as established by the Secretary) which are attributable to individuals with respect to whom payment may be made under part A; and

(II) the estimated number of inpatient-bed-days (as so established) which are attributable to individuals who are enrolled with a Medicare Advantage organization under part C; and

(ii) the denominator of which is the product of—

(I) the estimated total number of inpatient-bed-days with respect to the eligible hospital during such period; and

(II) the estimated total amount of the eligible hospital's charges during such period, not including any charges that are attributable to charity care (as such term is used for purposes of hospital cost reporting under this title), divided by the estimated total amount of the hospital's charges during such period.

Insofar as the Secretary determines that data are not available on charity care necessary to calculate the portion of the formula specified in clause (ii)(II), the Secretary shall use data on uncompensated care and may adjust such data so as to be an appropriate proxy for charity care including a downward adjustment to eliminate bad debt data from uncompensated care data. In the absence of the data necessary, with respect to a hospital, for the Secretary to compute the amount described in clause (ii)(II), the amount under such clause shall be deemed to be 1. In the absence of data, with respect to a hospital, necessary to compute the amount described in clause (i)(II), the amount under such clause shall be deemed to be 0.

(E) TRANSITION FACTOR SPECIFIED.—

(i) IN GENERAL.—Subject to clause (ii), the transition factor specified in this subparagraph for an eligible hospital for a payment year is as follows:

(I) For the first payment year for such hospital, 1.

(II) For the second payment year for such hospital, ¾.

(III) For the third payment year for such hospital, ½.

(IV) For the fourth payment year for such hospital, ¼.

(V) For any succeeding payment year for such hospital, 0.

(ii) PHASE DOWN FOR ELIGIBLE HOSPITALS FIRST ADOPTING EHR AFTER 2013.—If the first payment year

for an eligible hospital is after 2013, then the transition factor specified in this subparagraph for a payment year for such hospital is the same as the amount specified in clause (i) for such payment year for an eligible hospital for which the first payment year is 2013. If the first payment year for an eligible hospital is after 2015 then the transition factor specified in this subparagraph for such hospital and for such year and any subsequent year shall be 0.

(F) FORM OF PAYMENT.—The payment under this subsection for a payment year may be in the form of a single consolidated payment or in the form of such periodic installments as the Secretary may specify.

(G) PAYMENT YEAR DEFINED.—

(i) IN GENERAL.—For purposes of this subsection, the term "payment year" means a fiscal year beginning with fiscal year 2011.

(ii) FIRST, SECOND, ETC. PAYMENT YEAR.—The term "first payment year" means, with respect to inpatient hospital services furnished by an eligible hospital, the first fiscal year for which an incentive payment is made for such services under this subsection. The terms "second payment year", "third payment year", and "fourth payment year" mean, with respect to an eligible hospital, each successive year immediately following the first payment year for that hospital.

(3) MEANINGFUL EHR USER.—

(A) IN GENERAL.—For purposes of paragraph (1), an eligible hospital shall be treated as a meaningful EHR user for an EHR reporting period for a payment year (or, for purposes of subsection (b)(3)(B)(ix), for an EHR reporting period under such subsection for a fiscal year) if each of the following requirements are met:

(i) MEANINGFUL USE OF CERTIFIED EHR TECHNOLOGY.—The eligible hospital demonstrates to the satisfaction of the Secretary, in accordance with subparagraph (C)(i), that during such period the hospital is using certified EHR technology in a meaningful manner.

(ii) INFORMATION EXCHANGE.—The eligible hospital demonstrates to the satisfaction of the Secretary, in accordance with subparagraph (C)(i), that during such period such certified EHR technology is connected in a manner that provides, in accordance with law and standards applicable to the exchange of information, for the electronic exchange of health information to improve the quality of health care, such as promoting care coordination, and the hospital demonstrates (through a process specified by the Secretary, such as the use of an attestation) that the hospital has not knowingly and willfully taken action (such as to disable functionality) to limit or restrict the compatibility or interoperability of the certified EHR technology.

(iii) REPORTING ON MEASURES USING EHR.—Subject to subparagraph (B)(ii) and using such certified EHR

technology, the eligible hospital submits information for such period, in a form and manner specified by the Secretary, on such clinical quality measures and such other measures as selected by the Secretary under subparagraph (B)(i).

The Secretary shall seek to improve the use of electronic health records and health care quality over time by requiring more stringent measures of meaningful use selected under this paragraph.

(B) REPORTING ON MEASURES.—

(i) SELECTION.—The Secretary shall select measures for purposes of subparagraph (A)(iii) but only consistent with the following:

(I) The Secretary shall provide preference to clinical quality measures that have been selected for purposes of applying subsection (b)(3)(B)(viii) or that have been endorsed by the entity with a contract with the Secretary under section 1890(a).

(II) Prior to any measure (other than a clinical quality measure that has been selected for purposes of applying subsection (b)(3)(B)(viii)) being selected under this subparagraph, the Secretary shall publish in the Federal Register such measure and provide for a period of public comment on such measure.

(ii) LIMITATIONS.—The Secretary may not require the electronic reporting of information on clinical quality measures under subparagraph (A)(iii) unless the Secretary has the capacity to accept the information electronically, which may be on a pilot basis.

(iii) COORDINATION OF REPORTING OF INFORMATION.—In selecting such measures, and in establishing the form and manner for reporting measures under subparagraph (A)(iii), the Secretary shall seek to avoid redundant or duplicative reporting with reporting otherwise required, including reporting under subsection (b)(3)(B)(viii).

(C) DEMONSTRATION OF MEANINGFUL USE OF CERTIFIED EHR TECHNOLOGY AND INFORMATION EXCHANGE.—

(i) IN GENERAL.—An eligible hospital may satisfy the demonstration requirement of clauses (i) and (ii) of subparagraph (A) through means specified by the Secretary, which may include—

(I) an attestation;

(II) the submission of claims with appropriate coding (such as a code indicating that inpatient care was documented using certified EHR technology);

(III) a survey response;

(IV) reporting under subparagraph (A)(iii); and

(V) other means specified by the Secretary.

(ii) USE OF PART D DATA.—Notwithstanding sections 1860D–15(d)(2)(B) and 1860D–15(f)(2), the Secretary may use data regarding drug claims submitted for

purposes of section 1860D–15 that are necessary for purposes of subparagraph (A).

(4) APPLICATION.—

(A) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, of—

(i) the methodology and standards for determining payment amounts under this subsection and payment adjustments under subsection (b)(3)(B)(ix), including selection of periods under paragraph (2) for determining, and making estimates or using proxies of, discharges under paragraph (2)(C) and inpatient-bed-days, hospital charges, charity charges, and Medicare share under paragraph (2)(D);

(ii) the methodology and standards for determining a meaningful EHR user under paragraph (3), including selection of measures under paragraph (3)(B), specification of the means of demonstrating meaningful EHR use under paragraph (3)(C), and the hardship exception under subsection (b)(3)(B)(ix)(II); and

(iii) the specification of EHR reporting periods under paragraph (6)(B) and the selection of the form of payment under paragraph (2)(F).

(B) POSTING ON WEBSITE.—The Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services, in an easily understandable format, a list of the names of the eligible hospitals that are meaningful EHR users under this subsection or subsection (b)(3)(B)(ix) (and a list of the names of critical access hospitals to which paragraph (3) or (4) of section 1814(l) applies), and other relevant data as determined appropriate by the Secretary. The Secretary shall ensure that an eligible hospital (or critical access hospital) has the opportunity to review the other relevant data that are to be made public with respect to the hospital (or critical access hospital) prior to such data being made public.

(5) CERTIFIED EHR TECHNOLOGY DEFINED.—The term "certified EHR technology" has the meaning given such term in section 1848(o)(4).

(6) DEFINITIONS.—For purposes of this subsection:

(A) EHR REPORTING PERIOD.—The term "EHR reporting period" means, with respect to a payment year, any period (or periods) as specified by the Secretary.

(B) ELIGIBLE HOSPITAL.—The term "eligible hospital" means a hospital that is a subsection (d) hospital or a subsection (d) Puerto Rico hospital.

(o) HOSPITAL VALUE-BASED PURCHASING PROGRAM.—

(1) ESTABLISHMENT.—

(A) IN GENERAL.—Subject to the succeeding provisions of this subsection, the Secretary shall establish a hospital value-based purchasing program (in this subsection referred to as the "Program") under which value-based incentive payments are made in a fiscal year to hospitals that meet the performance standards under paragraph (3)

for the performance period for such fiscal year (as established under paragraph (4)).

(B) PROGRAM TO BEGIN IN FISCAL YEAR 2013.—The Program shall apply to payments for discharges occurring on or after October 1, 2012.

(C) APPLICABILITY OF PROGRAM TO HOSPITALS.—

(i) IN GENERAL.—For purposes of this subsection, subject to clause (ii), the term "hospital" means a subsection (d) hospital (as defined in subsection (d)(1)(B)).

(ii) EXCLUSIONS.—The term "hospital" shall not include, with respect to a fiscal year, a hospital—

(I) that is subject to the payment reduction under subsection (b)(3)(B)(viii)(I) for such fiscal year;

(II) for which, during the performance period for such fiscal year, the Secretary has cited deficiencies that pose immediate jeopardy to the health or safety of patients;

(III) for which there are not a minimum number (as determined by the Secretary) of measures that apply to the hospital for the performance period for such fiscal year; or

(IV) for which there are not a minimum number (as determined by the Secretary) of cases for the measures that apply to the hospital for the performance period for such fiscal year.

(iii) INDEPENDENT ANALYSIS.—For purposes of determining the minimum numbers under subclauses (III) and (IV) of clause (ii), the Secretary shall have conducted an independent analysis of what numbers are appropriate.

(iv) EXEMPTION.—In the case of a hospital that is paid under section 1814(b)(3), the Secretary may exempt such hospital from the application of this subsection if the State which is paid under such section submits 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 under this subsection.

(2) MEASURES.—

(A) IN GENERAL.—The Secretary shall select measures, other than measures of readmissions, for purposes of the Program. Such measures shall be selected from the measures specified under subsection (b)(3)(B)(viii).

(B) REQUIREMENTS.—

(i) FOR FISCAL YEAR 2013.—For value-based incentive payments made with respect to discharges occurring during fiscal year 2013, the Secretary shall ensure the following:

(I) CONDITIONS OR PROCEDURES.—Measures are selected under subparagraph (A) that cover at least the following 5 specific conditions or procedures:

(aa) Acute myocardial infarction (AMI).

(bb) Heart failure.

(cc) Pneumonia.

(dd) Surgeries, as measured by the Surgical Care Improvement Project (formerly referred to as "Surgical Infection Prevention" for discharges occurring before July 2006).

(ee) Healthcare-associated infections, as measured by the prevention metrics and targets established in the HHS Action Plan to Prevent Healthcare-Associated Infections (or any successor plan) of the Department of Health and Human Services.

(II) HCAHPS.—Measures selected under subparagraph (A) shall be related to the Hospital Consumer Assessment of Healthcare Providers and Systems survey (HCAHPS).

(ii) INCLUSION OF EFFICIENCY MEASURES.—For value-based incentive payments made with respect to discharges occurring during fiscal year 2014 or a subsequent fiscal year, the Secretary shall ensure that measures selected under subparagraph (A) include efficiency measures, including measures of "Medicare spending per beneficiary". Such measures shall be adjusted for factors such as age, sex, race, severity of illness, and other factors that the Secretary determines appropriate.

(C) LIMITATIONS.—

(i) TIME REQUIREMENT FOR PRIOR REPORTING AND NOTICE.—The Secretary may not select a measure under subparagraph (A) for use under the Program with respect to a performance period for a fiscal year (as established under paragraph (4)) unless such measure has been specified under subsection (b)(3)(B)(viii) and included on the Hospital Compare Internet website for at least 1 year prior to the beginning of such performance period.

(ii) MEASURE NOT APPLICABLE UNLESS HOSPITAL FURNISHES SERVICES APPROPRIATE TO THE MEASURE.—A measure selected under subparagraph (A) shall not apply to a hospital if such hospital does not furnish services appropriate to such measure.

(D) REPLACING MEASURES.—Subclause (VI) of subsection (b)(3)(B)(viii) shall apply to measures selected under subparagraph (A) in the same manner as such subclause applies to measures selected under such subsection.

(3) PERFORMANCE STANDARDS.—

(A) ESTABLISHMENT.—The Secretary shall establish performance standards with respect to measures selected under paragraph (2) for a performance period for a fiscal year (as established under paragraph (4)).

(B) ACHIEVEMENT AND IMPROVEMENT.—The performance standards established under subparagraph (A) shall include levels of achievement and improvement.

(C) TIMING.—The Secretary shall establish and announce the performance standards under subparagraph (A)

not later than 60 days prior to the beginning of the performance period for the fiscal year involved.

(D) CONSIDERATIONS IN ESTABLISHING STANDARDS.—In establishing performance standards with respect to measures under this paragraph, the Secretary shall take into account appropriate factors, such as—

(i) practical experience with the measures involved, including whether a significant proportion of hospitals failed to meet the performance standard during previous performance periods;

(ii) historical performance standards;

(iii) improvement rates; and

(iv) the opportunity for continued improvement.

(4) PERFORMANCE PERIOD.—For purposes of the Program, the Secretary shall establish the performance period for a fiscal year. Such performance period shall begin and end prior to the beginning of such fiscal year.

(5) HOSPITAL PERFORMANCE SCORE.—

(A) IN GENERAL.—Subject to subparagraph (B), the Secretary shall develop a methodology for assessing the total performance of each hospital based on performance standards with respect to the measures selected under paragraph (2) for a performance period (as established under paragraph (4)). Using such methodology, the Secretary shall provide for an assessment (in this subsection referred to as the "hospital performance score") for each hospital for each performance period.

(B) APPLICATION.—

(i) APPROPRIATE DISTRIBUTION.—The Secretary shall ensure that the application of the methodology developed under subparagraph (A) results in an appropriate distribution of value-based incentive payments under paragraph (6) among hospitals achieving different levels of hospital performance scores, with hospitals achieving the highest hospital performance scores receiving the largest value-based incentive payments.

(ii) HIGHER OF ACHIEVEMENT OR IMPROVEMENT.—The methodology developed under subparagraph (A) shall provide that the hospital performance score is determined using the higher of its achievement or improvement score for each measure.

(iii) WEIGHTS.—The methodology developed under subparagraph (A) shall provide for the assignment of weights for categories of measures as the Secretary determines appropriate.

(iv) NO MINIMUM PERFORMANCE STANDARD.—The Secretary shall not set a minimum performance standard in determining the hospital performance score for any hospital.

(v) REFLECTION OF MEASURES APPLICABLE TO THE HOSPITAL.—The hospital performance score for a hospital shall reflect the measures that apply to the hospital.

(6) CALCULATION OF VALUE-BASED INCENTIVE PAYMENTS.—

(A) IN GENERAL.—In the case of a hospital that the Secretary determines meets (or exceeds) the performance standards under paragraph (3) for the performance period for a fiscal year (as established under paragraph (4)), the Secretary shall increase the base operating DRG payment amount (as defined in paragraph (7)(D)), as determined after application of paragraph (7)(B)(i), for a hospital for each discharge occurring in such fiscal year by the value-based incentive payment amount.

(B) VALUE-BASED INCENTIVE PAYMENT AMOUNT.—The value-based incentive payment amount for each discharge of a hospital in a fiscal year shall be equal to the product of—

(i) the base operating DRG payment amount (as defined in paragraph (7)(D)) for the discharge for the hospital for such fiscal year; and

(ii) the value-based incentive payment percentage specified under subparagraph (C) for the hospital for such fiscal year.

(C) VALUE-BASED INCENTIVE PAYMENT PERCENTAGE.—

(i) IN GENERAL.—The Secretary shall specify a value-based incentive payment percentage for a hospital for a fiscal year.

(ii) REQUIREMENTS.—In specifying the value-based incentive payment percentage for each hospital for a fiscal year under clause (i), the Secretary shall ensure that—

(I) such percentage is based on the hospital performance score of the hospital under paragraph (5); and

(II) the total amount of value-based incentive payments under this paragraph to all hospitals in such fiscal year is equal to the total amount available for value-based incentive payments for such fiscal year under paragraph (7)(A), as estimated by the Secretary.

(7) FUNDING FOR VALUE-BASED INCENTIVE PAYMENTS.—

(A) AMOUNT.—The total amount available for value-based incentive payments under paragraph (6) for all hospitals for a fiscal year shall be equal to the total amount of reduced payments for all hospitals under subparagraph (B) for such fiscal year, as estimated by the Secretary.

(B) ADJUSTMENT TO PAYMENTS.—

(i) IN GENERAL.—The Secretary shall reduce the base operating DRG payment amount (as defined in subparagraph (D)) for a hospital for each discharge in a fiscal year (beginning with fiscal year 2013) by an amount equal to the applicable percent (as defined in subparagraph (C)) of the base operating DRG payment amount for the discharge for the hospital for such fiscal year. The Secretary shall make such reductions for all hospitals in the fiscal year involved, regardless of whether or not the hospital has been determined by the Secretary to have earned a value-based incentive payment under paragraph (6) for such fiscal year.

(ii) NO EFFECT ON OTHER PAYMENTS.—Payments described in items (aa) and (bb) of subparagraph (D)(i)(II) for a hospital shall be determined as if this subsection had not been enacted.

(C) APPLICABLE PERCENT DEFINED.—For purposes of subparagraph (B), the term "applicable percent" means—

(i) with respect to fiscal year 2013, 1.0 percent;

(ii) with respect to fiscal year 2014, 1.25 percent;

(iii) with respect to fiscal year 2015, 1.5 percent;

(iv) with respect to fiscal year 2016, 1.75 percent; and

(v) with respect to fiscal year 2017 and succeeding fiscal years, 2 percent.

(D) BASE OPERATING DRG PAYMENT AMOUNT DEFINED.—

(i) IN GENERAL.—Except as provided in clause (ii), 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 (q)) for a discharge if this subsection did not apply; reduced by

(II) any portion of such payment amount that is attributable to—

(aa) payments under paragraphs (5)(A), (5)(B), (5)(F), and (12) of subsection (d); and

(bb) such other payments under subsection (d) determined appropriate by the Secretary.

(ii) 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 year 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 term "base operating DRG payment amount" means the payment amount under such section.

(8) ANNOUNCEMENT OF NET RESULT OF ADJUSTMENTS.—Under the Program, the Secretary shall, not later than 60 days prior to the fiscal year involved, inform each hospital of the adjustments to payments to the hospital for discharges occurring in such fiscal year under paragraphs (6) and (7)(B)(i).

(9) NO EFFECT IN SUBSEQUENT FISCAL YEARS.—The value-based incentive payment under paragraph (6) and the payment reduction under paragraph (7)(B)(i) shall each apply only with respect to the fiscal year involved, and the Secretary shall not take into account such value-based incentive payment or pay-

ment reduction in making payments to a hospital under this section in a subsequent fiscal year.

(10) PUBLIC REPORTING.—

(A) HOSPITAL SPECIFIC INFORMATION.—

(i) IN GENERAL.—The Secretary shall make information available to the public regarding the performance of individual hospitals under the Program, including—

(I) the performance of the hospital with respect to each measure that applies to the hospital;

(II) the performance of the hospital with respect to each condition or procedure; and

(III) the hospital performance score assessing the total performance of the hospital.

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

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

(B) AGGREGATE INFORMATION.—The Secretary shall periodically post on the Hospital Compare Internet website aggregate information on the Program, including—

(i) the number of hospitals receiving value-based incentive payments under paragraph (6) and the range and total amount of such value-based incentive payments; and

(ii) the number of hospitals receiving less than the maximum value-based incentive payment available to the hospital for the fiscal year involved and the range and amount of such payments.

(11) IMPLEMENTATION.—

(A) APPEALS.—The Secretary shall establish a process by which hospitals may appeal the calculation of a hospital's performance assessment with respect to the performance standards established under paragraph (3)(A) and the hospital performance score under paragraph (5). The Secretary shall ensure that such process provides for resolution of such appeals in a timely manner.

(B) LIMITATION ON REVIEW.—Except as provided in subparagraph (A), there shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the following:

(i) The methodology used to determine the amount of the value-based incentive payment under paragraph (6) and the determination of such amount.

(ii) The determination of the amount of funding available for such value-based incentive payments under paragraph (7)(A) and the payment reduction under paragraph (7)(B)(i).

(iii) The establishment of the performance standards under paragraph (3) and the performance period under paragraph (4).

(iv) The measures specified under subsection (b)(3)(B)(viii) and the measures selected under paragraph (2).

(v) The methodology developed under paragraph (5) that is used to calculate hospital performance scores and the calculation of such scores.

(vi) The validation methodology specified in subsection (b)(3)(B)(viii)(XI).

(C) CONSULTATION WITH SMALL HOSPITALS.—The Secretary shall consult with small rural and urban hospitals on the application of the Program to such hospitals.

(12) PROMULGATION OF REGULATIONS.—The Secretary shall promulgate regulations to carry out the Program, including the selection of measures under paragraph (2), the methodology developed under paragraph (5) that is used to calculate hospital performance scores, and the methodology used to determine the amount of value-based incentive payments under paragraph (6).

(p) ADJUSTMENT TO HOSPITAL PAYMENTS FOR HOSPITAL ACQUIRED CONDITIONS.—

(1) IN GENERAL.—In order to provide an incentive for applicable hospitals to reduce hospital acquired conditions under this title, with respect to discharges from an applicable hospital occurring during fiscal year 2015 or a subsequent fiscal year, the amount of payment under this section or section 1814(b)(3), as applicable, for such discharges during the fiscal year shall be equal to 99 percent of the amount of payment that would otherwise apply to such discharges under this section or section 1814(b)(3) (determined after the application of subsections (o) and (q) and section 1814(l)(4) but without regard to this subsection).

(2) APPLICABLE HOSPITALS.—

(A) IN GENERAL.—For purposes of this subsection, the term "applicable hospital" means a subsection (d) hospital that meets the criteria described in subparagraph (B).

(B) CRITERIA DESCRIBED.—

(i) IN GENERAL.—The criteria described in this subparagraph, with respect to a subsection (d) hospital, is that the subsection (d) hospital is in the top quartile of all subsection (d) hospitals, relative to the national average, of hospital acquired conditions during the applicable period, as determined by the Secretary.

(ii) RISK ADJUSTMENT.—In carrying out clause (i), the Secretary shall establish and apply an appropriate risk adjustment methodology.

(C) EXEMPTION.—In the case of a hospital that is paid under section 1814(b)(3), the Secretary may exempt such hospital from the application of this subsection if the State which is paid under such section submits 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 under this subsection.

(3) HOSPITAL ACQUIRED CONDITIONS.—For purposes of this subsection, the term "hospital acquired condition" means a condition identified for purposes of subsection (d)(4)(D)(iv) and any other condition determined appropriate by the Secretary that an individual acquires during a stay in an applicable hospital, as determined by the Secretary.

(4) APPLICABLE PERIOD.—In this subsection, the term "applicable period" means, with respect to a fiscal year, a period specified by the Secretary.

(5) REPORTING TO HOSPITALS.—Prior to fiscal year 2015 and each subsequent fiscal year, the Secretary shall provide confidential reports to applicable hospitals with respect to hospital acquired conditions of the applicable hospital during the applicable period.

(6) REPORTING HOSPITAL SPECIFIC INFORMATION.—

(A) IN GENERAL.—The Secretary shall make information available to the public regarding hospital acquired conditions of each applicable hospital.

(B) OPPORTUNITY TO REVIEW AND SUBMIT CORRECTIONS.—The Secretary shall ensure that an applicable 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 criteria described in paragraph (2)(A).

(B) The specification of hospital acquired conditions under paragraph (3).

(C) The specification of the applicable period under paragraph (4).

(D) The provision of reports to applicable hospitals under paragraph (5) and the information made available to the public under paragraph (6).

(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—

(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 pay-

ment 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.

(r) ADJUSTMENTS TO MEDICARE DSH PAYMENTS.—

(1) EMPIRICALLY JUSTIFIED DSH PAYMENTS.—For fiscal year 2014 and each subsequent fiscal year, instead of the amount of disproportionate share hospital payment that would otherwise be made under subsection (d)(5)(F) to a subsection (d) hospital for the fiscal year, the Secretary shall pay to the subsection (d) hospital 25 percent of such amount (which represents the empirically justified amount for such payment, as determined by the Medicare Payment Advisory Commission in its March 2007 Report to the Congress).

(2) ADDITIONAL PAYMENT.—In addition to the payment made to a subsection (d) hospital under paragraph (1), for fiscal year 2014 and each subsequent fiscal year, the Secretary shall pay to such subsection (d) hospitals an additional amount equal to the product of the following factors:

(A) FACTOR ONE.—A factor equal to the difference between—

(i) the aggregate amount of payments that would be made to subsection (d) hospitals under subsection (d)(5)(F) if this subsection did not apply for such fiscal year (as estimated by the Secretary); and

(ii) the aggregate amount of payments that are made to subsection (d) hospitals under paragraph (1) for such fiscal year (as so estimated).

(B) FACTOR TWO.—

(i) FISCAL YEARS 2014, 2015, 2016, AND 2017.—For each of fiscal years 2014, 2015, 2016, and 2017, a factor equal to 1 minus the percent change in the percent of individuals under the age of 65 who are uninsured, as determined by comparing the percent of such individuals—

(I) who are uninsured in 2013, the last year before coverage expansion under the Patient Protection and Affordable Care Act (as calculated by the Secretary based on the most recent estimates available from the Director of the Congressional Budget Office before a vote in either House on the Health Care and Education Reconciliation Act of 2010 that, if determined in the affirmative, would clear such Act for enrollment); and

(II) who are uninsured in the most recent period for which data is available (as so calculated),

minus 0.1 percentage points for fiscal year 2014 and minus 0.2 percentage points for each of fiscal years 2015, 2016, and 2017.

(ii) 2018 AND SUBSEQUENT YEARS.—For fiscal year 2018 and each subsequent fiscal year, a factor equal to 1 minus the percent change in the percent of individuals who are uninsured, as determined by comparing the percent of individuals—

(I) who are uninsured in 2013 (as estimated by the Secretary, based on data from the Census Bureau or other sources the Secretary determines appropriate, and certified by the Chief Actuary of the Centers for Medicare & Medicaid Services); and

(II) who are uninsured in the most recent period for which data is available (as so estimated and certified),

minus 0.2 percentage points for each of fiscal years 2018 and 2019.

(C) FACTOR THREE.—A factor equal to the percent, for each subsection (d) hospital, that represents the quotient of—

(i) the amount of uncompensated care for such hospital for a period selected by the Secretary (as estimated by the Secretary, based on appropriate data (including, in the case where the Secretary determines that alternative data is available which is a better proxy for the costs of subsection (d) hospitals for treating the uninsured, the use of such alternative data)); and

(ii) the aggregate amount of uncompensated care for all subsection (d) hospitals that receive a payment under this subsection for such period (as so estimated, based on such data).

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

(A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).

(B) Any period selected by the Secretary for such purposes.

(s) PROSPECTIVE PAYMENT FOR PSYCHIATRIC HOSPITALS.—

(1) REFERENCE TO ESTABLISHMENT AND IMPLEMENTATION OF SYSTEM.—For provisions related to the establishment and implementation of a prospective payment system for payments under this title for inpatient hospital services furnished by psychiatric hospitals (as described in clause (i) of subsection (d)(1)(B)) and psychiatric units (as described in the matter following clause (v) of such subsection), see section 124 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999.

(2) IMPLEMENTATION FOR RATE YEAR BEGINNING IN 2010 AND SUBSEQUENT RATE YEARS.—

(A) IN GENERAL.—In implementing the system described in paragraph (1) for the rate year beginning in 2010 and any subsequent rate year, any update to a base rate for days during the rate year for a psychiatric hospital or unit, respectively, shall be reduced—

(i) for the rate year beginning in 2012 and each subsequent rate year, by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II); and

(ii) for each of the rate years beginning in 2010 through 2019, by the other adjustment described in paragraph (3).

(B) SPECIAL RULE.—The application of this paragraph may result in such update being less than 0.0 for a rate year, and may result in payment rates under the system described in paragraph (1) for a rate year being less than such payment rates for the preceding rate year.

(3) OTHER ADJUSTMENT.—For purposes of paragraph (2)(A)(ii), the other adjustment described in this paragraph is—

(A) for each of the rate years beginning in 2010 and 2011, 0.25 percentage point;

(B) for each of the rate years beginning in 2012 and 2013, 0.1 percentage point;

(C) for the rate year beginning in 2014, 0.3 percentage point;

(D) for each of the rate years beginning in 2015 and 2016, 0.2 percentage point; and

(E) for each of the rate years beginning in 2017, 2018, and 2019, 0.75 percentage point.

(4) QUALITY REPORTING.—

(A) REDUCTION IN UPDATE FOR FAILURE TO REPORT.—

(i) IN GENERAL.—Under the system described in paragraph (1), for rate year 2014 and each subsequent rate year, in the case of a psychiatric hospital or psychiatric unit that does not submit data to the Secretary in accordance with subparagraph (C) with respect to such a rate year, any annual update to a standard Federal rate for discharges for the hospital during the rate year, and after application of paragraph (2), shall be reduced by 2 percentage points.

(ii) SPECIAL RULE.—The application of this subparagraph may result in such annual update being less than 0.0 for a rate year, and may result in payment rates under the system described in paragraph (1) for a rate year being less than such payment rates for the preceding rate year.

(B) NONCUMULATIVE APPLICATION.—Any reduction under subparagraph (A) shall apply only with respect to the rate year involved and the Secretary shall not take into account such reduction in computing the payment amount under the system described in paragraph (1) for a subsequent rate year.

(C) SUBMISSION OF QUALITY DATA.—For rate year 2014 and each subsequent rate year, each psychiatric hospital and psychiatric unit shall submit to the Secretary data on quality measures specified under subparagraph (D). Such data shall be submitted in a form and manner, and at a time, specified by the Secretary for purposes of this subparagraph.

(D) QUALITY MEASURES.—

(i) IN GENERAL.—Subject to clause (ii), any measure specified by the Secretary under this subparagraph must have been endorsed by the entity with a contract under section 1890(a).

(ii) EXCEPTION.—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), the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted

by a consensus organization identified by the Secretary.

(iii) TIME FRAME.—Not later than October 1, 2012, the Secretary shall publish the measures selected under this subparagraph that will be applicable with respect to rate year 2014.

(E) PUBLIC AVAILABILITY OF DATA SUBMITTED.—The Secretary shall establish procedures for making data submitted under subparagraph (C) available to the public. Such procedures shall ensure that a psychiatric hospital and a psychiatric unit has the opportunity to review the data that is to be made public with respect to the hospital or unit prior to such data being made public. The Secretary shall report quality measures that relate to services furnished in inpatient settings in psychiatric hospitals and psychiatric units on the Internet website of the Centers for Medicare & Medicaid Services.

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MEDICARE PRESCRIPTION DRUG, IMPROVEMENT, AND MODERNIZATION ACT OF 2003

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TITLE IV—RURAL PROVISIONS

Subtitle A—Provisions Relating to Part A Only

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SEC. 410A. RURAL COMMUNITY HOSPITAL DEMONSTRATION PROGRAM.

(a) ESTABLISHMENT OF RURAL COMMUNITY HOSPITAL (RCH) DEMONSTRATION PROGRAM.—

(1) IN GENERAL.—The Secretary shall establish a demonstration program to test the feasibility and advisability of the establishment of rural community hospitals (as defined in subsection (f)(1)) to furnish covered inpatient hospital services (as defined in subsection (f)(2)) to medicare beneficiaries.

(2) DEMONSTRATION AREAS.—The program shall be conducted in rural areas selected by the Secretary in States with low population densities, as determined by the Secretary.

(3) APPLICATION.—Each rural community hospital that is located in a demonstration area selected under paragraph (2) that desires to participate in the demonstration program under this section shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

(4) SELECTION OF HOSPITALS.—The Secretary shall select from among rural community hospitals submitting applications under paragraph (3) not more than 15 of such hospitals to participate in the demonstration program under this section.

(5) DURATION.—The Secretary shall conduct the demonstration program under this section for a 5-year period (in this section referred to as the "initial 5-year period") and, as provided in subsection (g), for the 5-year extension period.

(6) IMPLEMENTATION.—The Secretary shall implement the demonstration program not later than January 1, 2005, but may not implement the program before October 1, 2004.

(b) PAYMENT.—

(1) IN GENERAL.—The amount of payment under the demonstration program for covered inpatient hospital services furnished in a rural community hospital, other than such services furnished in a psychiatric or rehabilitation unit of the hospital which is a distinct part, is—

(A) for discharges occurring in the first cost reporting period beginning on or after the implementation of the demonstration program, the reasonable costs of providing such services; and

(B) for discharges occurring in a subsequent cost reporting period under the demonstration program, the lesser of—

(i) the reasonable costs of providing such services in the cost reporting period involved; or

(ii) the target amount (as defined in paragraph (2)), applicable to the cost reporting period involved.

(2) TARGET AMOUNT.—For purposes of paragraph (1)(B)(ii), the term "target amount" means, with respect to a rural community hospital for a particular 12-month cost reporting period—

(A) in the case of the second such cost reporting period for which this subsection is in effect, the reasonable costs of providing such covered inpatient hospital services as determined under paragraph (1)(A), and

(B) in the case of a later cost reporting period, the target amount for the preceding 12-month cost reporting period, increased by the applicable percentage increase (under clause (i) of section 1886(b)(3)(B) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B))) in the market basket percentage increase (as defined in clause (iii) of such section) for that particular cost reporting period.

(c) FUNDING.—

(1) IN GENERAL.—The Secretary shall provide for the transfer from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) of such funds as are necessary for the costs of carrying out the demonstration program under this section.

(2) BUDGET NEUTRALITY.—In conducting the demonstration program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration program under this section was not implemented.

(d) WAIVER AUTHORITY.—The Secretary may waive such requirements of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) as may be necessary for the purpose of carrying out the demonstration program under this section.

(e) REPORT.—Not later than 6 months after the completion of the demonstration program under this section, the Secretary shall submit to Congress a report on such program, together with recommendations for such legislation and administrative action as the Secretary determines to be appropriate.

(f) DEFINITIONS.—In this section:

(1) RURAL COMMUNITY HOSPITAL DEFINED.—

(A) IN GENERAL.—The term "rural community hospital" means a hospital (as defined in section 1861(e) of the Social Security Act (42 U.S.C. 1395x(e))) that—

(i) is located in a rural area (as defined in section 1886(d)(2)(D) of such Act (42 U.S.C. 1395ww(d)(2)(D))) or treated as being so located pursuant to section 1886(d)(8)(E) of such Act (42 U.S.C. 1395ww(d)(8)(E));

(ii) subject to subparagraph (B), has fewer than 51 acute care inpatient beds, as reported in its most recent cost report;

(iii) makes available 24-hour emergency care services; and

(iv) is not eligible for designation, or has not been designated, as a critical access hospital under section 1820.

(B) TREATMENT OF PSYCHIATRIC AND REHABILITATION UNITS.—For purposes of subparagraph (A)(ii), beds in a psychiatric or rehabilitation unit of the hospital which is a distinct part of the hospital shall not be counted.

(2) COVERED INPATIENT HOSPITAL SERVICES.—The term "covered inpatient hospital services" means inpatient hospital services, and includes extended care services furnished under an agreement under section 1883 of the Social Security Act (42 U.S.C. 1395tt).

(g) FIVE-YEAR EXTENSION OF DEMONSTRATION PROGRAM.—

(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, the Secretary shall conduct the demonstration program under this section for an additional 5-year period (in this section referred to as the "5-year extension period") that begins on the date immediately following the last day of the initial 5-year period under subsection (a)(5).

(2) EXPANSION OF DEMONSTRATION STATES.—Notwithstanding subsection (a)(2), during the 5-year extension period, the Secretary shall expand the number of States with low population densities determined by the Secretary under such subsection to 20. In determining which States to include in such expansion, the Secretary shall use the same criteria and data that the Secretary used to determine the States under such subsection for purposes of the initial 5-year period.

(3) INCREASE IN MAXIMUM NUMBER OF HOSPITALS PARTICIPATING IN THE DEMONSTRATION PROGRAM.—Notwithstanding subsection (a)(4), during the 5-year extension period, not more than 30 rural community hospitals may participate in the demonstration program under this section.

(4) HOSPITALS IN DEMONSTRATION PROGRAM ON DATE OF ENACTMENT.—In the case of a rural community hospital that is participating in the demonstration program under this section as of the last day of the initial 5-year period, the Secretary—

(A) shall provide for the continued participation of such rural community hospital in the demonstration program during the 5-year extension period unless the rural community hospital makes an election, in such form and manner as the Secretary may specify, to discontinue such participation; and

(B) in calculating the amount of payment under subsection (b) to the rural community hospital for covered inpatient hospital services furnished by the hospital during such 5-year extension period, shall substitute, under paragraph (1)(A) of such subsection—

(i) the reasonable costs of providing such services for discharges occurring in the first cost reporting period beginning on or after the first day of the 5-year extension period, for

(ii) the reasonable costs of providing such services for discharges occurring in the first cost reporting period beginning on or after the implementation of the demonstration program.

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MEDICARE, MEDICAID, AND SCHIP EXTENSION ACT OF 2007

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TITLE I—MEDICARE

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SEC. 114. LONG-TERM CARE HOSPITALS.

(a) [Omitted—Amends other Act]

(b) STUDY AND REPORT ON LONG-TERM CARE HOSPITAL FACILITY AND PATIENT CRITERIA.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the "Secretary") shall conduct a study on the establishment of national long-term care hospital facility and patient criteria for purposes of determining medical necessity, appropriateness of admission, and continued stay at, and discharge from, long-term care hospitals.

(2) REPORT.—Not later than 18 months after the date of the enactment of this Act, the Secretary shall submit to Congress a report on the study conducted under paragraph (1), together with recommendations for such legislation and administrative actions, including timelines for implementation of patient criteria or other actions, as the Secretary determines appropriate.

(3) CONSIDERATIONS.—In conducting the study and preparing the report under this subsection, the Secretary shall consider—

(A) recommendations contained in a report to Congress by the Medicare Payment Advisory Commission in June 2004 for long-term care hospital-specific facility and patient criteria to ensure that patients admitted to long-term

care hospitals are medically complex and appropriate to receive long-term care hospital services; and

(B) ongoing work by the Secretary to evaluate and determine the feasibility of such recommendations.

(c) PAYMENT FOR LONG-TERM CARE HOSPITAL SERVICES.—

(1) DELAY IN APPLICATION OF 25 PERCENT PATIENT THRESHOLD PAYMENT ADJUSTMENT.—The Secretary shall not apply, for cost reporting periods beginning on or after July 1, 2007,—

(A) for a 9-year period, section 412.536 of title 42, Code of Federal Regulations, or any similar provision, to free-standing long-term care hospitals or to a long-termcare hospital, or satellite facility, that as of December29, 2007, was co-located with an entity that is a provider-based, off-campus location of a subsection (d) hospital whichdid not provide services payable under section 1886(d) ofthe Social Security Act at the off-campus location; and

(B) such section or section 412.534 of title 42, Code of Federal Regulations, or any similar provisions, to a long-term care hospital identified by the amendment made by section 4417(a) of the Balanced Budget Act of 1997 (Public Law 105–33).

(2) PAYMENT FOR HOSPITALS-WITHIN-HOSPITALS.—

(A) IN GENERAL.—Payment to an applicable long-term care hospital or satellite facility which is located in a rural area or which is co-located with an urban single or MSA dominant hospital under paragraphs (d)(1), (e)(1), and (e)(4) of section 412.534 of title 42, Code of Federal Regulations, shall not be subject to any payment adjustment under such section if no more than 75 percent of the hospital's Medicare discharges (other than discharges described in paragraph (d)(2) or (e)(3) of such section) are admitted from a co-located hospital.

(B) CO-LOCATED LONG-TERM CARE HOSPITALS AND SATELLITE FACILITIES.—

(i) IN GENERAL.—Payment to an applicable long-term care hospital or satellite facility which is co-located with another hospital shall not be subject to any payment adjustment under section 412.534 of title 42, Code of Federal Regulations, if no more than 50 percent of the hospital's Medicare discharges (other than discharges described in paragraph (c)(3) of such section) are admitted from a co-located hospital.

(ii) APPLICABLE LONG-TERM CARE HOSPITAL OR SATELLITE FACILITY DEFINED.—In this paragraph, the term "applicable long-term care hospital or satellite facility" means a hospital or satellite facility that is subject to the transition rules under section 412.534(g) of title 42, Code of Federal Regulations or that isdescribed in section 412.22(h)(3)(i) of such title.

(C) EFFECTIVE DATE.—Subparagraphs (A) and (B) shall apply to cost reporting periods beginning on or after October 1, 2007 (or July 1, 2007, in the case of a satellite facility described in section 412.22(h)(3)(i) of title 42, Code of Federal Regulations) for a 9-year period.

(3) NO APPLICATION OF VERY SHORT-STAY OUTLIER POLICY.—The Secretary shall not apply, for the 5-year period beginning on the date of the enactment of this Act, the amendments finalized on May 11, 2007 (72 Federal Register 26904, 26992) made to the short-stay outlier payment provision for long-term care hospitals contained in section 412.529(c)(3)(i) of title 42, Code of Federal Regulations, or any similar provision.

(4) NO APPLICATION OF ONE-TIME ADJUSTMENT TO STANDARD AMOUNT.—The Secretary shall not, for the 5-year period beginning on the date of the enactment of this Act, make the one-time prospective adjustment to long-term care hospital prospective payment rates provided for in section 412.523(d)(3) of title 42, Code of Federal Regulations, or any similar provision.

(d) MORATORIUM ON THE ESTABLISHMENT OF LONG-TERM CARE HOSPITALS, LONG-TERM CARE SATELLITE FACILITIES AND ON THE INCREASE OF LONG-TERM CARE HOSPITAL BEDS IN EXISTING LONG-TERM CARE HOSPITALS OR SATELLITE FACILITIES.—

(1) IN GENERAL.—During the 5-year period (and for the period beginning on the date of the enactment of paragraph (7) of this subsection and ending September 30, 2017) beginning on the date of the enactment of this Act, the Secretary shall impose a moratorium for purposes of the Medicare program under title XVIII of the Social Security Act—

(A) subject to paragraph (2), on the establishment and classification of a long-term care hospital or satellite facility, other than an existing long-term care hospital or facility; and

(B) subject to paragraph (3), on an increase of long-term care hospital beds in existing long-term care hospitals or satellite facilities.

(2) EXCEPTION FOR CERTAIN LONG-TERM CARE HOSPITALS.—The moratorium under paragraph (1)(A) shall not apply to a long-term care hospital that as of the date of the enactment of this Act—

(A) began its qualifying period for payment as a long-term care hospital under section 412.23(e) of title 42, Code of Federal Regulations, on or before the date of the enactment of this Act;

(B) has a binding written agreement with an outside, unrelated party for the actual construction, renovation, lease, or demolition for a long-term care hospital, and has expended, before the date of the enactment of this Act, at least 10 percent of the estimated cost of the project (or, if less, $2,500,000); or

(C) has obtained an approved certificate of need in a State where one is required on or before the date of the enactment of this Act.

(3) EXCEPTION FOR BED INCREASES DURING MORATORIUM.—

(A) IN GENERAL.—Subject to subparagraph (B), the moratorium under paragraph (1)(B) shall not apply to an increase in beds in an existing hospital or satellite facility if the hospital or facility obtained a certificate of need for an increase in beds that is in a State for which such certificate of need is required and that was issued on or after

April 1, 2005, and before December 29, 2007, or if the hospital or facility—

(i) is located in a State where there is only one other long-term care hospital; and

(ii) requests an increase in beds following the closure or the decrease in the number of beds of another long-term care hospital in the State.

(B) NO EFFECT ON CERTAIN LIMITATION.—The exception under subparagraph (A) shall not effect the limitation on increasing beds under sections 412.22(h)(3) and 412.22(f) of title 42, Code of Federal Regulations.

(4) EXISTING HOSPITAL OR SATELLITE FACILITY DEFINED.—For purposes of this subsection, the term "existing" means, with respect to a hospital or satellite facility, a hospital or satellite facility that received payment under the provisions of subpart O of part 412 of title 42, Code of Federal Regulations, as of the date of the enactment of this Act.

(5) JUDICIAL REVIEW.—There shall be no administrative or judicial review under section 1869 of the Social Security Act (42 U.S.C. 1395ff), section 1878 of such Act (42 U.S.C. 1395oo), or otherwise, of the application of this subsection by the Secretary.

(6) LIMITATION ON APPLICATION OF EXCEPTIONS.—Paragraphs (2) and (3) shall not apply during the period beginning on the date of the enactment of paragraph (7) of this subsection and ending September 30, 2017.

(7) ADDITIONAL EXCEPTION FOR CERTAIN LONG-TERM CARE HOSPITALS.—The moratorium under paragraph (1)(A) shall not apply to a long-term care hospital that—

(A) began its qualifying period for payment as a long-term care hospital under section 412.23(e) of title 42, Code of Federal Regulations, on or before the date of enactment of this paragraph;

(B) has a binding written agreement as of the date of the enactment of this paragraph with an outside, unrelated party for the actual construction, renovation, lease, or demolition for a long-term care hospital, and has expended, before such date of enactment, at least 10 percent of the estimated cost of the project (or, if less, $2,500,000); or

(C) has obtained an approved certificate of need in a State where one is required on or before such date of enactment.

(e) LONG-TERM CARE HOSPITAL PAYMENT UPDATE.—

(1) [Omitted—amends other Act]

(2) DELAYED EFFECTIVE DATE.—Subsection (m)(2) of section 1886 of the Social Security Act, as added by paragraph (1), shall not apply to discharges occurring on or after July 1, 2007, and before April 1, 2008.

(f) EXPANDED REVIEW OF MEDICAL NECESSITY.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall provide, under contracts with one or more appropriate fiscal intermediaries or medicare administrative contractors under section 1874A(a)(4)(G) of the Social Security Act (42 U.S.C. 1395kk–1(a)(4)(G)), for reviews of the medical necessity

of admissions to long-term care hospitals (described in section 1886(d)(1)(B)(iv) of such Act) and continued stay at such hospitals, of individuals entitled to, or enrolled for, benefits under part A of title XVIII of such Act consistent with this subsection. Such reviews shall be made for discharges occurring on or after October 1, 2007.

(2) REVIEW METHODOLOGY.—The medical necessity reviews under paragraph (1) shall be conducted on an annual basis in accordance with rules specified by the Secretary. Such reviews shall—

(A) provide for a statistically valid and representative sample of admissions of such individuals sufficient to provide results at a 95 percent confidence interval; and

(B) guarantee that at least 75 percent of overpayments received by long-term care hospitals for medically unnecessary admissions and continued stays of individuals in long-term care hospitals will be identified and recovered and that related days of care will not be counted toward the length of stay requirement contained in section 1886(d)(1)(B)(iv) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)(iv)).

(3) CONTINUATION OF REVIEWS.—Under contracts under this subsection, the Secretary shall establish an error rate with respect to such reviews that could require further review of the medical necessity of admissions and continued stay in the hospital involved and other actions as determined by the Secretary.

(4) TERMINATION OF REQUIRED REVIEWS.—

(A) IN GENERAL.—Subject to subparagraph (B), the previous provisions of this subsection shall cease to apply for discharges occurring on or after October 1, 2010.

(B) CONTINUATION.—As of the date specified in subparagraph (A), the Secretary shall determine whether to continue to guarantee, through continued medical review and sampling under this paragraph, recovery of at least 75 percent of overpayments received by long-term care hospitals due to medically unnecessary admissions and continued stays.

(5) FUNDING.—The costs to fiscal intermediaries or medicare administrative contractors conducting the medical necessity reviews under paragraph (1) shall be funded from the aggregate overpayments recouped by the Secretary of Health and Human Services from long-term care hospitals due to medically unnecessary admissions and continued stays. The Secretary may use an amount not in excess of 40 percent of the overpayments recouped under this paragraph to compensate the fiscal intermediaries or Medicare administrative contractors for the costs of services performed.

(g) IMPLEMENTATION.—For purposes of carrying out the provisions of, and amendments made by, this title, in addition to any amounts otherwise provided in this title, there are appropriated to the Centers for Medicare & Medicaid Services Program Management Account, out of any money in the Treasury not otherwise ap-

propriated, $35,000,000 for the period of fiscal years 2008 and 2009.

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TMA, ABSTINENCE EDUCATION, AND QI PROGRAMS EXTENSION ACT OF 2007

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SEC. 7. DOCUMENTATION AND CODING ADJUSTMENTS IN RESPONSE TO THE IMPLEMENTATION OF THE MEDICARE SEVERITY DIAGNOSIS RELATED GROUP (MS-DRG) SYSTEM UNDER THE MEDICARE PROSPECTIVE PAYMENT SYSTEM FOR INPATIENT HOSPITAL SERVICES.

(a) IN GENERAL.—In implementing the final rule published on August 22, 2007, on pages 47130 through 48175 of volume 72 of the Federal Register, the Secretary of Health and Human Services (in this section referred to as the "Secretary") shall apply prospective documentation and coding adjustments (made in response to the implementation of a Medicare Severity Diagnosis Related Group (MS-DRG) system under the hospital inpatient prospective payment system under section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)) of—

(1) for discharges occurring during fiscal year 2008, 0.6 percent rather than the 1.2 percent specified in such final rule; and

(2) for discharges occurring during fiscal year 2009, 0.9 percent rather than the 1.8 percent specified in such final rule.

(b) SUBSEQUENT ADJUSTMENTS.—

(1) IN GENERAL.—Notwithstanding any other provision of law, if the Secretary determines that implementation of such Medicare Severity Diagnosis Related Group (MS-DRG) system resulted in changes in coding and classification that did not reflect real changes in case mix under section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)) for discharges occurring during fiscal year 2008 or 2009 that are different than the prospective documentation and coding adjustments applied under subsection (a) or otherwise applied for such year, the Secretary shall—

(A) make an appropriate adjustment under paragraph (3)(A)(vi) of such section 1886(d); and

(B)(i) make an additional adjustment to the standardized amounts under such section 1886(d) for discharges occurring only during fiscal years 2010, 2011, and 2012 to offset the estimated amount of the increase in aggregate payments (including interest as determined by the Secretary) determined, based upon a retrospective evaluation of claims data submitted under such Medicare Severity Diagnosis Related Group (MS-DRG) system, by the Secretary with respect to discharges occurring during fiscal years 2008 and 2009;

(ii) make an additional adjustment to the standardized amounts under such section 1886(d) based upon the Secretary's estimates for discharges occurring only during fiscal years 2014, 2015, 2016, and 2017 to fully offset $11,000,000,000 (which represents the amount of the in-

crease in aggregate payments from fiscal years 2008 through 2013 for which an adjustment was not previously applied); and

(iii) make an additional adjustment to the standardized amounts under such section 1886(d) of an increase of 0.5 percentage points for discharges occurring during each of fiscal years 2018 through 2023 and not make the adjustment (estimated to be an increase of 3.2 percent) that would otherwise apply for discharges occurring during fiscal year 2018 by reason of the completion of the adjustments required under clause (ii).

(2) REQUIREMENT.—Any adjustment under paragraph (1)(B) shall reflect the difference between the amount the Secretary estimates that implementation of such Medicare Severity Diagnosis Related Group (MS-DRG) system resulted in changes in coding and classification that did not reflect real changes in case mix and the prospective documentation and coding adjustments applied under subsection (a). An adjustment made under paragraph (1)(B) for discharges occurring in a year shall not be included in the determination of standardized amounts for discharges occurring in a subsequent year.

(3) PROHIBITION.—The Secretary shall not make an additional prospective adjustment (estimated to be a decrease of 0.55 percent) to the standardized amounts under such section 1886(d) to offset the amount of the increase in aggregate payments related to documentation and coding changes for discharges occurring during fiscal year 2010.

(4) RULE OF CONSTRUCTION.—Nothing in this section shall be construed as providing authority to apply the adjustment under paragraph (1)(B) other than for discharges occurring during fiscal years 2010, 2011, 2012, 2014, 2015, 2016, and 2017 and each succeeding fiscal year through fiscal year 2023.

(5) JUDICIAL REVIEW.—There shall be no administrative or judicial review under section 1878 of the Social Security Act (42 U.S.C. 1395oo) or otherwise of any determination or adjustments made under this subsection.

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B. CHANGES IN EXISTING LAW PROPOSED BY THE BILL, AS REPORTED

In compliance with clause 3(e)(1)(B) of rule XIII of the Rules of the House of Representatives, changes in existing law proposed by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italics, existing law in which no change is proposed is shown in roman):

CHANGES IN EXISTING LAW PROPOSED BY THE BILL, AS REPORTED

In compliance with clause 3(e)(1)(B) of rule XIII of the Rules of the House of Representatives, changes in existing law proposed by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italics, existing law in which no change is proposed is shown in roman):

SOCIAL SECURITY ACT

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TITLE XVIII—HEALTH INSURANCE FOR THE AGED AND DISABLED

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PART B—SUPPLEMENTARY MEDICAL INSURANCE BENEFITS FOR THE AGED AND DISABLED

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PAYMENT OF BENEFITS

SEC. 1833. (a) Except as provided in section 1876, and subject to the succeeding provisions of this section, there shall be paid from the Federal Supplementary Medical Insurance Trust Fund, in the case of each individual who is covered under the insurance program established by this part and incurs expenses for services with respect to which benefits are payable under this part, amounts equal to—(1) in the case of services described in section 1832(a)(1)—80 percent of the reasonable charges for the services; except that (A) an organization which provides medical and other health services (or arranges for their availability) on a prepayment basis (and either is sponsored by a union or employer, or does not provide, or arrange for the provision of, any inpatient hospital services) may elect to be paid 80 percent of the reasonable cost of services for which payment may be made under this part on behalf of individuals enrolled in such organization in lieu of 80 percent of the reasonable charges for such services if the organization undertakes to charge such individuals no more than 20 percent of such reasonable cost plus any amounts payable by them as a result of subsection (b), (B) with respect to items and services described in section 1861(s)(10)(A), the amounts paid shall be 100 percent of the reasonable charges for such items and services, (C) with respect to expenses incurred for those physicians' services for which payment may be made under this part that are described in section 1862(a)(4), the amounts paid shall be subject to such limitations as may be prescribed by regulations, (D) with respect to clinical diagnostic laboratory tests for which payment is made under this part (i)(I) on the basis of a fee schedule under subsection (h)(1) (for tests furnished before January 1, 2017) or section 1834(d)(1), the amount paid shall be equal to 80 percent (or 100 percent, in the case of such tests for which payment is made on an assignment-related basis) of the lesser of the amount determined under such fee schedule, the limitation amount for that test determined under subsection (h)(4)(B), or the amount of the charges billed for the tests, or (II) under section 1834A (for tests furnished on or after January1, 2017), the amount paid shall be equal to 80 percent(or 100 percent, in the case of such tests for which payment is made on an assignment-related basis) of the lesser of the amount determined under such section or the amount of the charges billed for the tests, or (ii) for tests furnished before January 1, 2017,on the basis of a negotiated rate established under subsection (h)(6), the amount paid shall be equal to 100 percent of such negotiated rate,,(E) with respect to services furnished to individuals who have

been determined to have end stage renal disease, the amounts paid shall be determined subject to the provisions of section 1881,(F) with respect to clinical social worker services under section 1861(s)(2)(N), the amounts paid shall be 80 percent of the lesser of (i) the actual charge for the services or (ii) 75 percent of the amount determined for payment of a psychologist under clause (L),

(G) with respect to facility services furnished in connection with a surgical procedure specified pursuant to subsection (i)(1)(A) and furnished to an individual in an ambulatory surgical center described in such subsection, for services furnished beginning with the implementation date of a revised payment system for such services in such facilities specified in subsection (i)(2)(D), the amounts paid shall be 80 percent of the lesser of the actual charge for the services or the amount determined by the Secretary under such revised payment system,

(H) with respect to services of a certified registered nurse anesthetist under section 1861(s)(11), the amounts paid shall be 80 percent of the least of the actual charge, the prevailing charge that would be recognized (or, for services furnished on or after January 1, 1992, the fee schedule amount provided under section 1848) if the services had been performed by an anesthesiologist, or the fee schedule for such services established by the Secretary in accordance with subsection (l), (I) with respect to covered items (described in section 1834(a)(13)), the amounts paid shall be the amounts described in section 1834(a)(1), and(J) with respect to expenses incurred for radiologist services (as defined in section 1834(b)(6)), subject to section 1848, the amounts paid shall be 80 percent of the lesser of the actual charge for the services or the amount provided under the fee schedule established under section 1834(b), (K) with respect to certified nurse-midwife services under section 1861(s)(2)(L), the amounts paid shall be 80 percent of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary for the purposes of this subparagraph (but in no event shall such fee schedule exceed 65 percent of the prevailing charge that would be allowed for the same service performed by a physician, or, for services furnished on or after January 1, 1992, 65 percent (or 100 percent for services furnished on or after January 1, 2011) of the fee schedule amount provided under section 1848 for the same service performed by a physician), (L) with respect to qualified psychologist services under section 1861(s)(2)(M), the amounts paid shall be 80 percent of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary for the purposes of this subparagraph, (M) with respect to prosthetic devices and orthotics and prosthetics (as defined in section 1834(h)(4)), the amounts paid shall be the amounts described in section 1834(h)(1), (N) with respect to expenses incurred for physicians' services (as defined in section 1848(j)(3)) other than personalized prevention plan services (as defined in section 1861(hhh)(1)), the amounts paid shall be 80 percent of the payment basis determined under section 1848(a)(1), (O) with respect to services described in section 1861(s)(2)(K) (relating to

services furnished by physician assistants, nurse practitioners, or clinic nurse specialists), the amounts paid shall be equal to 80 percent of (i) the lesser of the actual charge or 85 percent of the fee schedule amount provided under section 1848, or (ii) in the case of services as an assistant at surgery, the lesser of the actual charge or 85 percent of the amount that would otherwise be recognized if performed by a physician who is serving as an assistant at surgery, (P) with respect to surgical dressings, the amounts paid shall be the amounts determined under section 1834(i), (Q) with respect to items or services for which fee schedules are established pursuant to section 1842(s), the amounts paid shall be 80 percent of the lesser of the actual charge or the fee schedule established in such section, (R) with respect to ambulance services, (i) the amounts paid shall be 80 percent of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary under section 1834(l) and (ii) with respect to ambulance services described in section 1834(l)(8), the amounts paid shall be the amounts determined under section 1834(g) for outpatient critical access hospital services, (S) with respect to drugs and biologicals (including intravenous immune globulin (as defined in section 1861(zz))) not paid on a cost or prospective payment basis as otherwise provided in this part (other than items and services described in subparagraph (B)), the amounts paid shall be 80 percent of the lesser of the actual charge or the payment amount established in section 1842(o) (or, if applicable, under section 1847, 1847A, or 1847B), (T) with respect to medical nutrition therapy services (as defined in section 1861(vv)), the amount paid shall be 80 percent (or 100 percent if such services are recommended with a grade of A or B by the United States Preventive Services Task Force for any indication or population and are appropriate for the individual) of the lesser of the actual charge for the services or 85 percent of the amount determined under the fee schedule established under section 1848(b) for the same services if furnished by a physician, (U) with respect to facility fees described in section 1834(m)(2)(B), the amounts paid shall be 80 percent of the lesser of the actual charge or the amounts specified in such section, (V) notwithstanding subparagraphs (I) (relating to durable medical equipment), (M) (relating to prosthetic devices and orthotics and prosthetics), and (Q) (relating to 1842(s) items), with respect to competitively priced items and services (described in section 1847(a)(2)) that are furnished in a competitive area, the amounts paid shall be the amounts described in section 1847(b)(5), (W) with respect to additional preventive services (as defined in section 1861(ddd)(1)), the amount paid shall be (i) in the case of such services which are clinical diagnostic laboratory tests, the amount determined under subparagraph (D) (if such subparagraph were applied, by substituting "100 percent" for "80 percent"), and (ii) in the case of all other such services, 100 percent of the lesser of the actual charge for the service or the amount determined under a fee schedule established by the Secretary for purposes of this subparagraph, (X) with respect to personalized prevention plan services (as defined in section

1861(hhh)(1)), the amount paid shall be 100 percent of the lesser of the actual charge for the services or the amount determined under the payment basis determined under section 1848, (Y) with respect to preventive services described in subparagraphs (A) and (B) of section 1861(ddd)(3) that are appropriate for the individual and, in the case of such services described in subparagraph (A), are recommended with a grade of A or B by the United States Preventive Services Task Force for any indication or population, the amount paid shall be 100 percent of (i) except as provided in clause (ii), the lesser of the actual charge for the services or the amount determined under the fee schedule that applies to such services under this part, and (ii) in the case of such services that are covered OPD services (as defined in subsection (t)(1)(B)), the amount determined under subsection (t), (Z) with respect to Federally qualified health center services for which payment is made under section 1834(o), the amounts paid shall be 80 percent of the lesser of the actual charge or the amount determined under such section, and (AA) with respect to an applicable disposable device (as defined in paragraph (2) of section 1834(s)) furnished to an individual pursuant to paragraph (1) of such section, the amount paid shall be equal to 80 percent of the lesser of the actual charge or the amount determined under paragraph (3) of such section;

(2) in the case of services described in section 1832(a)(2) (except those services described in subparagraphs (C), (D), (E), (F), (G), (H), and (I) of such section and unless otherwise specified in section 1881)—

(A) with respect to home health services (other than a covered osteoporosis drug) (as defined in section 1861(kk)), the amount determined under the prospective payment system under section 1895;

(B) with respect to other items and services (except those described in subparagraph (C), (D), or (E) of this paragraph and except as may be provided in section 1886 or section 1888(e)(9))—

(i) furnished before January 1, 1999, the lesser of—

(I) the reasonable cost of such services, as determined under section 1861(v), or

(II) the customary charges with respect to such services,—less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A), but in no case may the payment for such other services exceed 80 percent of such reasonable cost, or

(ii) if such services are furnished before January 1, 1999, by a public provider of services, or by another provider which demonstrates to the satisfaction of the Secretary that a significant portion of its patients are low-income (and requests that payment be made under this clause), free of charge or at nominal charges to the public, 80 percent of the amount determined in accordance with section 1814(b)(2), or

(iii) if such services are furnished on or after January 1, 1999, the amount determined under subsection (t), or

(iv) if (and for so long as) the conditions described in section 1814(b)(3) are met, the amounts determined under the reimbursement system described in such section;

(C) with respect to services described in the second sentence of section 1861(p), 80 percent of the reasonable charges for such services;

(D) with respect to clinical diagnostic laboratory tests for which payment is made under this part (i)(I)on the basis of a fee schedule determined under subsection(h)(1) (for tests furnished before January 1, 2017) or section 1834(d)(1), the amount paid shall be equal to 80 percent (or 100 percent, in the case of such tests for which payment is made on an assignment-related basis or to a provider having an agreement under section 1866) of the lesser of the amount determined under such fee schedule, the limitation amount for that test determined under subsection (h)(4)(B), or the amount of the charges billed for the tests, or (II) under section 1834A (for tests furnished on or after January 1, 2017), the amount paid shall be equal to 80 percent (or 100 percent, in the case of such tests for which payment is made on an assignment-related basis or to a provider having an agreement under section 1866) of the lesser of the amount determined under such section or the amount of the charges billed for the tests, or (ii) for tests furnished before January 1, 2017, on the basis of a negotiated rate established under subsection (h)(6), the amount paid shall be equal to 100 percent of such negotiated rate for such tests;

(E) with respect to—

(i) outpatient hospital radiology services (including diagnostic and therapeutic radiology, nuclear medicine and CAT scan procedures, magnetic resonance imaging, and ultrasound and other imaging services, but excluding screening mammography and, for services furnished on or after January 1, 2005, diagnostic mammography), and

(ii) effective for procedures performed on or after October 1, 1989, diagnostic procedures (as defined by the Secretary) described in section 1861(s)(3) (other than diagnostic x-ray tests and diagnostic laboratory tests),

the amount determined under subsection (n) or, for services or procedures performed on or after January 1, 1999, subsection (t);

(F) with respect to a covered osteoporosis drug (as defined in section 1861(kk)) furnished by a home health agency, 80 percent of the reasonable cost of such service, as determined under section 1861(v);

(G) with respect to items and services described in section 1861(s)(10)(A), the lesser of—

(i) the reasonable cost of such services, as determined under section 1861(v), or

(ii) the customary charges with respect to such services; and

(H) with respect to personalized prevention plan services (as defined in section 1861(hhh)(1)) furnished by an outpatient department of a hospital, the amount determined under paragraph (1)(X),

or, if such services are furnished by a public provider of services, or by another provider which demonstrates to the satisfaction of the Secretary that a significant portion of its patients are low-income (and requests that payment be made under this provision), free of charge or at nominal charges to the public, the amount determined in accordance with section 1814(b)(2);

(3) in the case of services described in section 1832(a)(2)(D)—

(A) except as provided in subparagraph (B), the costs which are reasonable and related to the cost of furnishing such services or which are based on such other tests of reasonableness as the Secretary may prescribe in regulations, including those authorized under section 1861(v)(1)(A), less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A), but in no case may the payment for such services (other than for items and services described in section 1861(s)(10)(A)) exceed 80 percent of such costs; or

(B) with respect to the services described in clause (ii) of section 1832(a)(2)(D) that are furnished to an individual enrolled with a MA plan under part C pursuant to a written agreement described in section 1853(a)(4), the amount (if any) by which—

(i) the amount of payment that would have otherwise been provided (I) under subparagraph (A) (calculated as if "100 percent" were substituted for "80 percent" in such subparagraph) for such services if the individual had not been so enrolled, or (II) in the case of such services furnished on or after the implementation date of the prospective payment system under section 1834(o), under such section (calculated as if "100 percent" were substituted for "80 percent" in such section) for such services if the individual had not been so enrolled; exceeds

(ii) the amount of the payments received under such written agreement for such services (not including any financial incentives provided for in such agreement such as risk pool payments, bonuses, or withholds),

less the amount the federally qualified health center may charge as described in section 1857(e)(3)(B);

(4) in the case of facility services described in section 1832(a)(2)(F), and outpatient hospital facility services furnished in connection with surgical procedures specified by the Secretary pursuant to section 1833(i)(1)(A), the applicable amount as determined under paragraph (2) or (3) of subsection (i) or subsection (t);

(5) in the case of covered items (described in section 1834(a)(13)) the amounts described in section 1834(a)(1);

(6) in the case of outpatient critical access hospital services, the amounts described in section 1834(g);

(7) in the case of prosthetic devices and orthotics and prosthetics (as described in section 1834(h)(4)), the amounts described in section 1834(h);

(8) in the case of—

(A) outpatient physical therapy services, outpatient speech-language pathology services, and outpatient occupational therapy services furnished—

(i) by a rehabilitation agency, public health agency, clinic, comprehensive outpatient rehabilitation facility, or skilled nursing facility,

(ii) by a home health agency to an individual who is not homebound, or

(iii) by another entity under an arrangement with an entity described in clause (i) or (ii); and

(B) outpatient physical therapy services, outpatient speech-language pathology services, and outpatient occupational therapy services furnished—

(i) by a hospital to an outpatient or to a hospital inpatient who is entitled to benefits under part A but has exhausted benefits for inpatient hospital services during a spell of illness or is not so entitled to benefits under part A, or

(ii) by another entity under an arrangement with a hospital described in clause (i),

the amounts described in section 1834(k); and

(9) in the case of services described in section 1832(a)(2)(E) that are not described in paragraph (8), the amounts described in section 1834(k).

Paragraph (3)(A) shall not apply to Federally qualified health center services furnished on or after the implementation date of the prospective payment system under section 1834(0).

(b) Before applying subsection (a) with respect to expenses incurred by an individual during any calendar year, the total amount of the expenses incurred by such individual during such year (which would, except for this subsection, constitute incurred expenses from which benefits payable under subsection (a) are determinable) shall be reduced by a deductible of $75 for calendar years before 1991, $100 for 1991 through 2004, $110 for 2005, and for a subsequent year the amount of such deductible for the previous year increased by the annual percentage increase in the monthly actuarial rate under section 1839(a)(1) ending with such subsequent year (rounded to the nearest $1); except that (1) such total amount shall not include expenses incurred for preventive services described in subparagraph (A) of section 1861(ddd)(3) that are recommended with a grade of A or B by the United States Preventive Services Task Force for any indication or population and are appropriate for the individual., (2) such deductible shall not apply with respect to home health services (other than a covered osteoporosis drug (as defined in section 1861(kk))), (3) such deductible shall not apply with respect to clinical diagnostic laboratory tests for which payment is made under this part (A) under subsection (a)(1)(D)(i) or (a)(2)(D)(i) on an assignment-related basis, or to a provider having an agreement under section 1866, or (B) for tests furnished be-

fore January 1, 2017,on the basis of a negotiated rate determined under subsection (h)(6), (4) such deductible shall not apply to Federally qualified health center services, (5) such deductible shall not apply with respect to screening mammography (as described in section 1861(jj)), (6) such deductible shall not apply with respect to screening pap smear and screening pelvic exam (as described in section 1861(nn)), (7) such deductible shall not apply with respect to ultrasound screening for abdominal aortic aneurysm (as defined in section 1861(bbb)), (8) such deductible shall not apply with respect to colorectal cancer screening tests (as described in section 1861(pp)(1)), (9) such deductible shall not apply with respect to an initial preventive physical examination (as defined in section 1861(ww)), and (10) such deductible shall not apply with respect to personalized prevention plan services (as defined in section 1861(hhh)(1)). The total amount of the expenses incurred by an individual as determined under the preceding sentence shall, after the reduction specified in such sentence, be further reduced by an amount equal to the expenses incurred for the first three pints of whole blood (or equivalent quantities of packed red blood cells, as defined under regulations) furnished to the individual during the calendar year, except that such deductible for such blood shall in accordance with regulations be appropriately reduced to the extent that there has been a replacement of such blood (or equivalent quantities of packed red blood cells, as so defined); and for such purposes blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual shall be deemed replaced when the institution or other person furnishing such blood (or such equivalent quantities of packed red blood cells, as so defined) is given one pint of blood for each pint of blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual with respect to which a deduction is made under this sentence. The deductible under the previous sentence for blood or blood cells furnished an individual in a year shall be reduced to the extent that a deductible has been imposed under section 1813(a)(2) to blood or blood cells furnished the individual in the year. Paragraph (1) of the first sentence of this subsection shall apply with respect to a colorectal cancer screening test regardless of the code that is billed for the establishment of a diagnosis as a result of the test, or for the removal of tissue or other matter or other procedure that is furnished in connection with, as a result of, and in the same clinical encounter as the screening test.

(c)(1) Notwithstanding any other provision of this part, with respect to expenses incurred in a calendar year in connection with the treatment of mental, psychoneurotic, and personality disorders of an individual who is not an inpatient of a hospital at the time such expenses are incurred, there shall be considered as incurred expenses for purposes of subsections (a) and (b)—

(A) for expenses incurred in years prior to 2010, only 62½ percent of such expenses;

(B) for expenses incurred in 2010 or 2011, only 68¾ percent of such expenses;

(C) for expenses incurred in 2012, only 75 percent of such expenses;

(D) for expenses incurred in 2013, only 81¼ percent of such expenses; and

(E) for expenses incurred in 2014 or any subsequent calendar year, 100 percent of such expenses.

(2) For purposes of subparagraphs (A) through (D) of paragraph (1), the term "treatment" does not include brief office visits (as defined by the Secretary) for the sole purpose of monitoring or changing drug prescriptions used in the treatment of such disorders or partial hospitalization services that are not directly provided by a physician

(d) No payment may be made under this part with respect to any services furnished an individual to the extent that such individual is entitled (or would be entitled except for section 1813) to have payment made with respect to such services under part A.

(e) No payment shall be made to any provider of services or other person under this part unless there has been furnished such information as may be necessary in order to determine the amounts due such provider or other person under this part for the period with respect to which the amounts are being paid or for any prior period.

(f) In establishing limits under subsection (a) on payment for rural health clinic services provided by rural health clinics (other than such clinics in hospitals with less than 50 beds), the Secretary shall establish such limit, for services provided—

(1) in 1988, after March 31, at $46 per visit, and

(2) in a subsequent year, at the limit established under this subsection for the previous year increased by the percentage increase in the MEI (as defined in section 1842(i)(3)) applicable to primary care services (as defined in section 1842(i)(4)) furnished as of the first day of that year.

(g)(1) Subject to paragraphs (4) and (5), in the case of physical therapy services of the type described in section 1861(p) and speech-language pathology services of the type described in such section through the application of section 1861(ll)(2), but (except as provided in paragraph (6)) not described in subsection (a)(8)(B), and physical therapy services and speech-language pathology services of such type which are furnished by a physician or as incident to physicians' services, with respect to expenses incurred in any calendar year, no more than the amount specified in paragraph (2) for the year shall be considered as incurred expenses for purposes of subsections (a) and (b).

(2) The amount specified in this paragraph—

(A) for 1999, 2000, and 2001, is $1,500, and

(B) for a subsequent year is the amount specified in this paragraph for the preceding year increased by the percentage increase in the MEI (as defined in section 1842(i)(3)) for such subsequent year;

except that if an increase under subparagraph (B) for a year is not a multiple of $10, it shall be rounded to the nearest multiple of $10.

(3) Subject to paragraphs (4) and (5), in the case of occupational therapy services (of the type that are described in section 1861(p) (but (except as provided in paragraph (6)) not described in subsection (a)(8)(B)) through the operation of section 1861(g) and of such type which are furnished by a physician or as incident to physicians' services), with respect to expenses incurred in any calendar year, no more than the amount specified in paragraph (2) for the

year shall be considered as incurred expenses for purposes of subsections (a) and (b).

(4) This subsection shall not apply to expenses incurred with respect to services furnished during 2000, 2001, 2002, 2004, and 2005.

(5)(A) With respect to expenses incurred during the period beginning on January 1, 2006, and ending on December 31, 2017, for services, the Secretary shall implement a process under which an individual enrolled under this part may, upon request of the individual or a person on behalf of the individual, obtain an exception from the uniform dollar limitation specified in paragraph (2), for services described in paragraphs (1) and (3) if the provision of such services is determined to be medically necessary and if the requirement of subparagraph (B) is met. Under such process, if the Secretary does not make a decision on such a request for an exception within 10 business days of the date of the Secretary's receipt of the request made in accordance with such requirement, the Secretary shall be deemed to have found the services to be medically necessary.

(B) In the case of outpatient therapy services for which an exception is requested under the first sentence of subparagraph (A), the claim for such services shall contain an appropriate modifier (such as the KX modifier used as of the date of the enactment of this subparagraph) indicating that such services are medically necessary as justified by appropriate documentation in the medical record involved.

(C)(i) In applying this paragraph with respect to a request for an exception with respect to expenses that would be incurred for outpatient therapy services (including services described in subsection (a)(8)(B)) that would exceed the threshold described in clause (ii) for a year, the request for such an exception, for services furnished on or after October 1, 2012, shall be subject to a manual medical review process that, subject to subparagraph (E), is similar to the manual medical review process used for certain exceptions under this paragraph in 2006.

(ii) The threshold under this clause for a year is $3,700. Such threshold shall be applied separately—

(I) for physical therapy services and speech-language pathology services; and

(II) for occupational therapy services.

(D) With respect to services furnished on or after January 1, 2013, where payment may not be made as a result of application of paragraphs (1) and (3), section 1879 shall apply in the same manner as such section applies to a denial that is made by reason of section 1862(a)(1).

(E)(i) In place of the manual medical review process under subparagraph (C)(i), the Secretary shall implement a process for medical review under this subparagraph under which the Secretary shall identify and conduct medical review for services described in subparagraph (C)(i) furnished by a provider of services or supplier (in this subparagraph referred to as a "therapy provider") using such factors as the Secretary determines to be appropriate.

(ii) Such factors may include the following:

(I) The therapy provider has had a high claims denial percentage for therapy services under this part or is less compliant with applicable requirements under this title.

(II) The therapy provider has a pattern of billing for therapy services under this part that is aberrant compared to peers or otherwise has questionable billing practices for such services, such as billing medically unlikely units of services in a day.

(III) The therapy provider is newly enrolled under this title or has not previously furnished therapy services under this part.

(IV) The services are furnished to treat a type of medical condition.

(V) The therapy provider is part of group that includes another therapy provider identified using the factors determined under this subparagraph.

(iii) For purposes of carrying out this subparagraph, the Secretary shall provide for the transfer, from the Federal Supplementary Medical Insurance Trust Fund under section 1841, of $5,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for fiscal years 2015 and 2016, to remain available until expended. Such funds may not be used by a contractor under section 1893(h) for medical reviews under this subparagraph.

(iv) The targeted review process under this subparagraph shall not apply to services for which expenses are incurred beyond the period for which the exceptions process under subparagraph (A) is implemented.

(6)(A) In applying paragraphs (1) and (3) to services furnished during the period beginning not later than October 1, 2012, and ending on December 31, 2017, the exclusion of services described in subsection (a)(8)(B) from the uniform dollar limitation specified in paragraph (2) shall not apply to such services furnished during 2012 through 2017.

(B)(i) With respect to outpatient therapy services furnished beginning on or after January 1, 2013, and before January 1, 2014, for which payment is made under section 1834(g), the Secretary shall count toward the uniform dollar limitations described in paragraphs (1) and (3) and the threshold described in paragraph (5)(C) the amount that would be payable under this part if such services were paid under section 1834(k)(1)(B) instead of being paid under section 1834(g).

(ii) Nothing in clause (i) shall be construed as changing the method of payment for outpatient therapy services under section 1834(g).

(h)(1)(A) Subject to section 1834(d)(1), the Secretary shall establish fee schedules for clinical diagnostic laboratory tests (including prostate cancer screening tests under section 1861(oo) consisting of prostate-specific antigen blood tests) for which payment is made under this part, other than such tests performed by a provider of services for an inpatient of such provider.

(B) In the case of clinical diagnostic laboratory tests performed by a physician or by a laboratory (other than tests performed by a qualified hospital laboratory (as defined in subparagraph (D)) for outpatients of such hospital), the fee schedules established under subparagraph (A) shall be established on a regional, statewide, or

carrier service area basis (as the Secretary may determine to be appropriate) for tests furnished on or after July 1, 1984.

(C) In the case of clinical diagnostic laboratory tests performed by a qualified hospital laboratory (as defined in subparagraph (D)) for outpatients of such hospital, the fee schedules established under subparagraph (A) shall be established on a regional, statewide, or carrier service area basis (as the Secretary may determine to be appropriate) for tests furnished on or after July 1, 1984.

(D) In this subsection, the term "qualified hospital laboratory" means a hospital laboratory, in a sole community hospital (as defined in section 1886(d)(5)(D)(iii)), which provides some clinical diagnostic laboratory tests 24 hours a day in order to serve a hospital emergency room which is available to provide services 24 hours a day and 7 days a week.

(2)(A)(i) Except as provided in clause (v), subparagraph (B), and paragraph (4), the Secretary shall set the fee schedules at 60 percent (or, in the case of a test performed by a qualified hospital laboratory (as defined in paragraph (1)(D)) for outpatients of such hospital, 62 percent) of the prevailing charge level determined pursuant to the third and fourth sentences of section 1842(b)(3) for similar clinical diagnostic laboratory tests for the applicable region, State, or area for the 12-month period beginning July 1, 1984, adjusted annually (to become effective on January 1 of each year) by, subject to clause (iv), a percentage increase or decrease equal to the percentage increase or decrease in the Consumer Price Index for All Urban Consumers (United States city average) minus, for each of the years 2009 and 2010, 0.5 percentage points, and, for tests furnished before the dateof enactment of section 1834A, subject to such other adjustments as the Secretary determines are justified by technological changes.

(ii) Notwithstanding clause (i)—

(I) any change in the fee schedules which would have become effective under this subsection for tests furnished on or after January 1, 1988, shall not be effective for tests furnished during the 3-month period beginning on January 1, 1988,

(II) the Secretary shall not adjust the fee schedules under clause (i) to take into account any increase in the consumer price index for 1988,

(III) the annual adjustment in the fee schedules determined under clause (i) for each of the years 1991, 1992, and 1993 shall be 2 percent, and

(IV) the annual adjustment in the fee schedules determined under clause (i) for each of the years 1994 and 1995, 1998 through 2002, and 2004 through 2008 shall be 0 percent.

(iii) In establishing fee schedules under clause (i) with respect to automated tests and tests (other than cytopathology tests) which before July 1, 1984, the Secretary made subject to a limit based on lowest charge levels under the sixth sentence of section 1842(b)(3) performed after March 31, 1988, the Secretary shall reduce by 8.3 percent the fee schedules otherwise established for 1988, and such reduced fee schedules shall serve as the base for 1989 and subsequent years.

(iv) After determining the adjustment to the fee schedules under clause (i), the Secretary shall reduce such adjustment—

(I) for 2011 and each subsequent year, by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II); and

(II) for each of 2011 through 2015, by 1.75 percentage points. Subclause (I) shall not apply in a year where the adjustment to the fee schedules determined under clause (i) is 0.0 or a percentage decrease for a year. The application of the productivity adjustment under subclause (I) shall not result in an adjustment to the fee schedules under clause (i) being less than 0.0 for a year. The application of subclause (II) may result in an adjustment to the fee schedules under clause (i) being less than 0.0 for a year, and may result in payment rates for a year being less than such payment rates for the preceding year.

(v) The Secretary shall reduce by 2 percent the fee schedules otherwise determined under clause (i) for 2013, and such reduced fee schedules shall serve as the base for 2014 and subsequent years.

(B) The Secretary may make further adjustments or exceptions to the fee schedules to assure adequate reimbursement of (i) emergency laboratory tests needed for the provision of bona fide emergency services, and (ii) certain low volume high-cost tests where highly sophisticated equipment or extremely skilled personnel are necessary to assure quality.

(3) In addition to the amounts provided under the fee schedules (for tests furnished before January 1, 2017)or under section 1834A (for tests furnished on or afterJanuary 1, 2017), subject to subsection (b)(5) of such section, the Secretary shall provide for and establish (A) a nominal fee to cover the appropriate costs in collecting the sample on which a clinical diagnostic laboratory test was performed and for which payment is made under this part, except that not more than one such fee may be provided under this paragraph with respect to samples collected in the same encounter, and (B) a fee to cover the transportation and personnel expenses for trained personnel to travel to the location of an individual to collect the sample, except that such a fee may be provided only with respect to an individual who is homebound or an inpatient in an inpatient facility (other than a hospital). In establishing a fee to cover the transportation and personnel expenses for trained personnel to travel to the location of an individual to collect a sample, the Secretary shall provide a method for computing the fee based on the number of miles traveled and the personnel costs associated with the collection of each individual sample, but the Secretary shall only be required to apply such method in the case of tests furnished during the period beginning on April 1, 1989, and ending on December 31, 1990, by a laboratory that establishes to the satisfaction of the Secretary (based on data for the 12-month period ending June 30, 1988) that (i) the laboratory is dependent upon payments under this title for at least 80 percent of its collected revenues for clinical diagnostic laboratory tests, (ii) at least 85 percent of its gross revenues for such tests are attributable to tests performed with respect to individuals who are homebound or who are residents in a nursing facility, and (iii) the laboratory provided such tests for residents in nursing facilities representing at least 20 percent of the number of such facilities in the State in which the laboratory is located.

(4)(A) In establishing any fee schedule under this subsection, the Secretary may provide for an adjustment to take into account, with

respect to the portion of the expenses of clinical diagnostic laboratory tests attributable to wages, the relative difference between a region's or local area's wage rates and the wage rate presumed in the data on which the schedule is based.

(B) For purposes of subsections (a)(1)(D)(i) and (a)(2)(D)(i), the limitation amount for a clinical diagnostic laboratory test performed—

(i) on or after July 1, 1986, and before April 1, 1988, is equal to 115 percent of the median of all the fee schedules established for that test for that laboratory setting under paragraph (1),

(ii) after March 31, 1988, and before January 1, 1990, is equal to the median of all the fee schedules established for that test for that laboratory setting under paragraph (1),

(iii) after December 31, 1989, and before January 1, 1991, is equal to 93 percent of the median of all the fee schedules established for that test for that laboratory setting under paragraph (1),

(iv) after December 31, 1990, and before January 1, 1994, is equal to 88 percent of such median,

(v) after December 31, 1993, and before January 1, 1995, is equal to 84 percent of such median,

(vi) after December 31, 1994, and before January 1, 1996, is equal to 80 percent of such median,

(vii) after December 31, 1995, and before January 1, 1998, is equal to 76 percent of such median, and

(viii) after December 31, 1997, is equal to 74 percent of such median (or 100 percent of such median in the case of a clinical diagnostic laboratory test performed on or after January 1, 2001, that the Secretary determines is a new test for which no limitation amount has previously been established under this subparagraph).

(5)(A) In the case of a bill or request for payment for a clinical diagnostic laboratory test for which payment may otherwise be made under this part on an assignment-related basis or under a provider agreement under section 1866, payment may be made only to the person or entity which performed or supervised the performance of such test; except that—

(i) if a physician performed or supervised the performance of such test, payment may be made to another physician with whom he shares his practice,

(ii) in the case of a test performed at the request of a laboratory by another laboratory, payment may be made to the referring laboratory but only if—

(I) the referring laboratory is located in, or is part of, a rural hospital,

(II) the referring laboratory is wholly owned by the entity performing such test, the referring laboratory wholly owns the entity performing such test, or both the referring laboratory and the entity performing such test are wholly-owned by a third entity, or

(III) not more than 30 percent of the clinical diagnostic laboratory tests for which such referring laboratory (but not including a laboratory described in subclause (II)), re-

ceives requests for testing during the year in which the test is performed are performed by another laboratory, and

(iii) in the case of a clinical diagnostic laboratory test provided under an arrangement (as defined in section 1861(w)(1)) made by a hospital, critical access hospital, or skilled nursing facility, payment shall be made to the hospital or skilled nursing facility.

(B) In the case of such a bill or request for payment for a clinical diagnostic laboratory test for which payment may otherwise be made under this part, and which is not described in subparagraph (A), payment may be made to the beneficiary only on the basis of the itemized bill of the person or entity which performed or supervised the performance of the test.

(C) Payment for a clinical diagnostic laboratory test, including a test performed in a physician's office but excluding a test performed by a rural health clinic may only be made on an assignment-related basis or to a provider of services with an agreement in effect under section 1866.

(D) A person may not bill for a clinical diagnostic laboratory test, including a test performed in a physician's office but excluding a test performed by a rural health clinic, other than on an assignment-related basis. If a person knowingly and willfully and on a repeated basis bills for a clinical diagnostic laboratory test in violation of the previous sentence, the Secretary may apply sanctions against the person in the same manner as the Secretary may apply sanctions against a physician in accordance with paragraph (2) of section 1842(j) in the same manner such paragraphs apply with respect to a physician. Paragraph (4) of such section shall apply in this subparagraph in the same manner as such paragraph applies to such section.

(6) For tests furnished before January 1, 2017, inthe case of any diagnostic laboratory test payment for which is not made on the basis of a fee schedule under paragraph (1), the Secretary may establish a payment rate which is acceptable to the person or entity performing the test and which would be considered the full charge for such tests. Such negotiated rate shall be limited to an amount not in excess of the total payment that would have been made for the services in the absence of such rate.

(7) Notwithstanding paragraphs (1) and (4)and section 1834A, the Secretary shall establish a national minimum payment amount under this part for a diagnostic or screening pap smear laboratory test (including all cervical cancer screening technologies that have been approved by the Food and Drug Administration as a primary screening method for detection of cervical cancer) equal to $14.60 for tests furnished in 2000. For such tests furnished in subsequent years, such national minimum payment amount shall be adjusted annually as provided in paragraph (2).

(8)(A) The Secretary shall establish by regulation procedures for determining the basis for, and amount of, payment under this subsection for any clinical diagnostic laboratory test with respect to which a new or substantially revised HCPCS code is assigned on or after January 1, 2005 (in this paragraph referred to as "new tests").

(B) Determinations under subparagraph (A) shall be made only after the Secretary—

(i) makes available to the public (through an Internet website and other appropriate mechanisms) a list that includes any such test for which establishment of a payment amount under this subsection is being considered for a year;

(ii) on the same day such list is made available, causes to have published in the Federal Register notice of a meeting to receive comments and recommendations (and data on which recommendations are based) from the public on the appropriate basis under this subsection for establishing payment amounts for the tests on such list;

(iii) not less than 30 days after publication of such notice convenes a meeting, that includes representatives of officials of the Centers for Medicare & Medicaid Services involved in determining payment amounts, to receive such comments and recommendations (and data on which the recommendations are based);

(iv) taking into account the comments and recommendations (and accompanying data) received at such meeting, develops and makes available to the public (through an Internet website and other appropriate mechanisms) a list of proposed determinations with respect to the appropriate basis for establishing a payment amount under this subsection for each such code, together with an explanation of the reasons for each such determination, the data on which the determinations are based, and a request for public written comments on the proposed determination; and

(v) taking into account the comments received during the public comment period, develops and makes available to the public (through an Internet website and other appropriate mechanisms) a list of final determinations of the payment amounts for such tests under this subsection, together with the rationale for each such determination, the data on which the determinations are based, and responses to comments and suggestions received from the public.

(C) Under the procedures established pursuant to subparagraph (A), the Secretary shall—

(i) set forth the criteria for making determinations under subparagraph (A); and

(ii) make available to the public the data (other than proprietary data) considered in making such determinations.

(D) The Secretary may convene such further public meetings to receive public comments on payment amounts for new tests under this subsection as the Secretary deems appropriate.

(E) For purposes of this paragraph:

(i) The term "HCPCS" refers to the Health Care Procedure Coding System.

(ii) A code shall be considered to be "substantially revised" if there is a substantive change to the definition of the test or procedure to which the code applies (such as a new analyte or a new methodology for measuring an existing analyte-specific test).

(9) Notwithstanding any other provision in this part, in the case of any diagnostic laboratory test for HbA1c that is labeled by the Food and Drug Administration for home use and is furnished on or after April 1, 2008, the payment rate for such test shall be the

payment rate established under this part for a glycated hemoglobin test (identified as of October 1, 2007, by HCPCS code 83036 (and any succeeding codes)).

(i)(1) The Secretary shall, in consultation with appropriate medical organizations—

(A) specify those surgical procedures which are appropriately (when considered in terms of the proper utilization of hospital inpatient facilities) performed on an inpatient basis in a hospital but which also can be performed safely on an ambulatory basis in an ambulatory surgical center (meeting the standards specified under section 1832(a)(2)(F)(i)), critical access hospital, or hospital outpatient department, and

(B) specify those surgical procedures which are appropriately (when considered in terms of the proper utilization of hospital inpatient facilities) performed on an inpatient basis in a hospital but which also can be performed safely on an ambulatory basis in a physician's office.

The lists of procedures established under subparagraphs (A) and (B) shall be reviewed and updated not less often than every 2 years, in consultation with appropriate trade and professional organizations.

(2)(A) For services furnished prior to the implementation of the system described in subparagraph (D), subject to subparagraph (E), the amount of payment to be made for facility services furnished in connection with a surgical procedure specified pursuant to paragraph (1)(A) and furnished to an individual in an ambulatory surgical center described in such paragraph shall be equal to 80 percent of a standard overhead amount established by the Secretary (with respect to each such procedure) on the basis of the Secretary's estimate of a fair fee which—

(i) takes into account the costs incurred by such centers, or classes of centers, generally in providing services furnished in connection with the performance of such procedure, as determined in accordance with a survey (based upon a representative sample of procedures and facilities) of the actual audited costs incurred by such centers in providing such services,

(ii) takes such costs into account in such a manner as will assure that the performance of the procedure in such a center will result in substantially less amounts paid under this title than would have been paid if the procedure had been performed on an inpatient basis in a hospital, and

(iii) in the case of insertion of an intraocular lens during or subsequent to cataract surgery includes payment which is reasonable and related to the cost of acquiring the class of lens involved.

Each amount so established shall be reviewed and updated not later than July 1, 1987, and annually thereafter to take account of varying conditions in different areas.

(B) The amount of payment to be made under this part for facility services furnished, in connection with a surgical procedure specified pursuant to paragraph (1)(B), in a physician's office shall be equal to 80 percent of a standard overhead amount established by the Secretary (with respect to each such procedure) on the basis of the Secretary's estimate of a fair fee which—

(i) takes into account additional costs, not usually included in the professional fee, incurred by physicians in securing, maintaining, and staffing the facilities and ancillary services appropriate for the performance of such procedure in the physician's office, and

(ii) takes such items into account in such a manner which will assure that the performance of such procedure in the physician's office will result in substantially less amounts paid under this title than would have been paid if the services had been furnished on an inpatient basis in a hospital.

Each amount so established shall be reviewed and updated not later than July 1, 1987, and annually thereafter to take account of varying conditions in different areas.

(C)(i) Notwithstanding the second sentence of each of subparagraphs (A) and (B), except as otherwise specified in clauses (ii), (iii), and (iv), if the Secretary has not updated amounts established under such subparagraphs or under subparagraph (D), with respect to facility services furnished during a fiscal year (beginning with fiscal year 1986 or a calendar year (beginning with 2006)), such amounts shall be increased by the percentage increase in the Consumer Price Index for all urban consumers (U.S. city average) as estimated by the Secretary for the 12-month period ending with the midpoint of the year involved.

(ii) In each of the fiscal years 1998 through 2002, the increase under this subparagraph shall be reduced (but not below zero) by 2.0 percentage points.

(iii) In fiscal year 2004, beginning with April 1, 2004, the increase under this subparagraph shall be the Consumer Price Index for all urban consumers (U.S. city average) as estimated by the Secretary for the 12-month period ending with March 31, 2003, minus 3.0 percentage points.

(iv) In fiscal year 2005, the last quarter of calendar year 2005, and each of calendar years 2006 through 2009, the increase under this subparagraph shall be 0 percent.

(D)(i) Taking into account the recommendations in the report under section 626(d) of Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the Secretary shall implement a revised payment system for payment of surgical services furnished in ambulatory surgical centers.

(ii) In the year the system described in clause (i) is implemented, such system shall be designed to result in the same aggregate amount of expenditures for such services as would be made if this subparagraph did not apply, as estimated by the Secretary and taking into account reduced expenditures that would apply if subparagraph (E) were to continue to apply, as estimated by the Secretary.

(iii) The Secretary shall implement the system described in clause (i) for periods in a manner so that it is first effective beginning on or after January 1, 2006, and not later than January 1, 2008.

(iv) The Secretary may implement such system in a manner so as to provide for a reduction in any annual update for failure to report on quality measures in accordance with paragraph (7).

(v) In implementing the system described in clause (i) for 2011 and each subsequent year, any annual update under such

system for the year, after application of clause (iv), shall be reduced by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II). The application of the preceding sentence may result in such update being less than 0.0 for a year, and may result in payment rates under the system described in clause (i) for a year being less than such payment rates for the preceding year.

(vi) There shall be no administrative or judicial review under section 1869, 1878, or otherwise, of the classification system, the relative weights, payment amounts, and the geographic adjustment factor, if any, under this subparagraph.

(E) With respect to surgical procedures furnished on or after January 1, 2007, and before the effective date of the implementation of a revised payment system under subparagraph (D), if—

(i) the standard overhead amount under subparagraph (A) for a facility service for such procedure, without the application of any geographic adjustment, exceeds

(ii) the Medicare OPD fee schedule amount established under the prospective payment system for hospital outpatient department services under paragraph (3)(D) of section 1833(t) for such service for such year, determined without regard to geographic adjustment under paragraph (2)(D) of such section,

the Secretary shall substitute under subparagraph (A) the amount described in clause (ii) for the standard overhead amount for such service referred to in clause (i).

(3)(A) The aggregate amount of the payments to be made under this part for outpatient hospital facility services or critical access hospital services furnished before January 1, 1999, in connection with surgical procedures specified under paragraph (1)(A) shall be equal to the lesser of—

(i) the amount determined with respect to such services under subsection (a)(2)(B); or

(ii) the blend amount (described in subparagraph (B)).

(B)(i) The blend amount for a cost reporting period is the sum of—

(I) the cost proportion (as defined in clause (ii)(I)) of the amount described in subparagraph (A)(i), and

(II) the ASC proportion (as defined in clause (ii)(II)) of the standard overhead amount payable with respect to the same surgical procedure as if it were provided in an ambulatory surgical center in the same area, as determined under paragraph (2)(A), less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A).

(ii) Subject to paragraph (4), in this paragraph:

(I) The term "cost proportion" means 75 percent for cost reporting periods beginning in fiscal year 1988, 50 percent for portions of cost reporting periods beginning on or after October 1, 1988, and ending on or before December 31, 1990, and 42 percent for portions of cost reporting periods beginning on or after January 1, 1991.

(II) The term "ASC proportion" means 25 percent for cost reporting periods beginning in fiscal year 1988, 50 percent for portions of cost reporting periods beginning on or after October 1, 1988, and ending on or before December 31, 1990, and 58

percent for portions of cost reporting periods beginning on or after January 1, 1991.

(4)(A) In the case of a hospital that—

(i) makes application to the Secretary and demonstrates that it specializes in eye services or eye and ear services (as determined by the Secretary),

(ii) receives more than 30 percent of its total revenues from outpatient services, and

(iii) on October 1, 1987—

(I) was an eye specialty hospital or an eye and ear specialty hospital, or

(II) was operated as an eye or eye and ear unit (as defined in subparagraph (B)) of a general acute care hospital which, on the date of the application described in clause (i), operates less than 20 percent of the beds that the hospital operated on October 1, 1987, and has sold or otherwise disposed of a substantial portion of the hospital's other acute care operations,

the cost proportion and ASC proportion in effect under subclauses (I) and (II) of paragraph (3)(B)(ii) for cost reporting periods beginning in fiscal year 1988 shall remain in effect for cost reporting periods beginning on or after October 1, 1988, and before January 1, 1995.

(B) For purposes of this subparagraph (A)(iii)(II), the term "eye or eye and ear unit" means a physically separate or distinct unit containing separate surgical suites devoted solely to eye or eye and ear services.

(5)(A) The Secretary is authorized to provide by regulations that in the case of a surgical procedure, specified by the Secretary pursuant to paragraph (1)(A), performed in an ambulatory surgical center described in such paragraph, there shall be paid (in lieu of any amounts otherwise payable under this part) with respect to the facility services furnished by such center and with respect to all related services (including physicians' services, laboratory, X-ray, and diagnostic services) a single all-inclusive fee established pursuant to subparagraph (B), if all parties furnishing all such services agree to accept such fee (to be divided among the parties involved in such manner as they shall have previously agreed upon) as full payment for the services furnished.

(B) In implementing this paragraph, the Secretary shall establish with respect to each surgical procedure specified pursuant to paragraph (1)(A) the amount of the all-inclusive fee for such procedure, taking into account such factors as may be appropriate. The amount so established with respect to any surgical procedure shall be reviewed periodically and may be adjusted by the Secretary, when appropriate, to take account of varying conditions in different areas.

(6) Any person, including a facility having an agreement under section 1832(a)(2)(F)(i), who knowingly and willfully presents, or causes to be presented, a bill or request for payment, for an intraocular lens inserted during or subsequent to cataract surgery for which payment may be made under paragraph (2)(A)(iii), is subject to a civil money penalty of not to exceed $2,000. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same man-

ner as such provisions apply to a penalty or proceeding under section 1128A(a).

(7)(A) For purposes of paragraph (2)(D)(iv), the Secretary may provide, in the case of an ambulatory surgical center that does not submit, to the Secretary in accordance with this paragraph, data required to be submitted on measures selected under this paragraph with respect to a year, any annual increase provided under the system established under paragraph (2)(D) for such year shall be reduced by 2.0 percentage points. A reduction under this subparagraph shall apply only with respect to the year involved and the Secretary shall not take into account such reduction in computing any annual increase factor for a subsequent year.

(B) Except as the Secretary may otherwise provide, the provisions of subparagraphs (B), (C), (D), and (E) of paragraph (17) of section 1833(t) shall apply with respect to services of ambulatory surgical centers under this paragraph in a similar manner to the manner in which they apply under such paragraph and, for purposes of this subparagraph, any reference to a hospital, outpatient setting, or outpatient hospital services is deemed a reference to an ambulatory surgical center, the setting of such a center, or services of such a center, respectively.

(j) Whenever a final determination is made that the amount of payment made under this part either to a provider of services or to another person pursuant to an assignment under section 1842(b)(3)(B)(ii) was in excess of or less than the amount of payment that is due, and payment of such excess or deficit is not made (or effected by offset) within 30 days of the date of the determination, interest shall accrue on the balance of such excess or deficit not paid or offset (to the extent that the balance is owed by or owing to the provider) at a rate determined in accordance with the regulations of the Secretary of the Treasury applicable to charges for late payments.

(k) With respect to services described in section 1861(s)(10)(B), the Secretary may provide, instead of the amount of payment otherwise provided under this part, for payment of such an amount or amounts as reasonably reflects the general cost of efficiently providing such services.

(l)(1)(A) The Secretary shall establish a fee schedule for services of certified registered nurse anesthetists under section 1861(s)(11).

(B) In establishing the fee schedule under this paragraph the Secretary may utilize a system of time units, a system of base and time units, or any appropriate methodology.

(C) The provisions of this subsection shall not apply to certain services furnished in certain hospitals in rural areas under the provisions of section 9320(k) of the Omnibus Budget Reconciliation Act of 1986, as amended by section 6132 of the Omnibus Budget Reconciliation Act of 1989.

(2) Except as provided in paragraph (3), the fee schedule established under paragraph (1) shall be initially based on audited data from cost reporting periods ending in fiscal year 1985 and such other data as the Secretary determines necessary.

(3)(A) In establishing the initial fee schedule for those services, the Secretary shall adjust the fee schedule to the extent necessary to ensure that the estimated total amount which will be paid under this title for those services plus applicable coinsurance in 1989 will

equal the estimated total amount which would be paid under this title for those services in 1989 if the services were included as inpatient hospital services and payment for such services was made under part A in the same manner as payment was made in fiscal year 1987, adjusted to take into account changes in prices and technology relating to the administration of anesthesia.

(B) The Secretary shall also reduce the prevailing charge of physicians for medical direction of a certified registered nurse anesthetist, or the fee schedule for services of certified registered nurse anesthetists, or both, to the extent necessary to ensure that the estimated total amount which will be paid under this title plus applicable coinsurance for such medical direction and such services in 1989 and 1990 will not exceed the estimated total amount which would have been paid plus applicable coinsurance but for the enactment of the amendments made by section 9320 of the Omnibus Budget Reconciliation Act of 1986. A reduced prevailing charge under this subparagraph shall become the prevailing charge but for subsequent years for purposes of applying the economic index under the fourth sentence of section 1842(b)(3).

(4)(A) Except as provided in subparagraphs (C) and (D), in determining the amount paid under the fee schedule under this subsection for services furnished on or after January 1, 1991, by a certified registered nurse anesthetist who is not medically directed—

(i) the conversion factor shall be—

(I) for services furnished in 1991, $15.50,

(II) for services furnished in 1992, $15.75,

(III) for services furnished in 1993, $16.00,

(IV) for services furnished in 1994, $16.25,

(V) for services furnished in 1995, $16.50,

(VI) for services furnished in 1996, $16.75, and

(VII) for services furnished in calendar years after 1996, the previous year's conversion factor increased by the update determined under section 1848(d) for physician anesthesia services for that year;

(ii) the payment areas to be used shall be the fee schedule areas used under section 1848 (or, in the case of services furnished during 1991, the localities used under section 1842(b)) for purposes of computing payments for physicians' services that are anesthesia services;

(iii) the geographic adjustment factors to be applied to the conversion factor under clause (i) for services in a fee schedule area or locality is—

(I) in the case of services furnished in 1991, the geographic work index value and the geographic practice cost index value specified in section 1842(q)(1)(B) for physicians' services that are anesthesia services furnished in the area or locality, and

(II) in the case of services furnished after 1991, the geographic work index value, the geographic practice cost index value, and the geographic malpractice index value used for determining payments for physicians' services that are anesthesia services under section 1848,

with 70 percent of the conversion factor treated as attributable to work and 30 percent as attributable to overhead for services furnished in 1991 (and the portions attributable to work, prac-

tice expenses, and malpractice expenses in 1992 and thereafter being the same as is applied under section 1848).

(B)(i) Except as provided in clause (ii) and subparagraph (D), in determining the amount paid under the fee schedule under this subsection for services furnished on or after January 1, 1991, and before January 1, 1994, by a certified registered nurse anesthetist who is medically directed, the Secretary shall apply the same methodology specified in subparagraph (A).

(ii) The conversion factor used under clause (i) shall be—

(I) for services furnished in 1991, $10.50,

(II) for services furnished in 1992, $10.75, and

(III) for services furnished in 1993, $11.00.

(iii) In the case of services of a certified registered nurse anesthetist who is medically directed or medically supervised by a physician which are furnished on or after January 1, 1994, the fee schedule amount shall be one-half of the amount described in section 1848(a)(5)(B) with respect to the physician.

(C) Notwithstanding subclauses (I) through (V) of subparagraph (A)(i)—

(i) in the case of a 1990 conversion factor that is greater than $16.50, the conversion factor for a calendar year after 1990 and before 1996 shall be the 1990 conversion factor reduced by the product of the last digit of the calendar year and one-fifth of the amount by which the 1990 conversion factor exceeds $16.50; and

(ii) in the case of a 1990 conversion factor that is greater than $15.49 but less than $16.51, the conversion factor for a calendar year after 1990 and before 1996 shall be the greater of—

(I) the 1990 conversion factor, or

(II) the conversion factor specified in subparagraph (A)(i) for the year involved.

(D) Notwithstanding subparagraph (C), in no case may the conversion factor used to determine payment for services in a fee schedule area or locality under this subsection, as adjusted by the adjustment factors specified in subparagraphs (A)(iii), exceed the conversion factor used to determine the amount paid for physicians' services that are anesthesia services in the area or locality.

(5)(A) Payment for the services of a certified registered nurse anesthetist (for which payment may otherwise be made under this part) may be made on the basis of a claim or request for payment presented by the certified registered nurse anesthetist furnishing such services, or by a hospital, critical access hospital, physician, group practice, or ambulatory surgical center with which the certified registered nurse anesthetist furnishing such services has an employment or contractual relationship that provides for payment to be made under this part for such services to such hospital, critical access hospital, physician, group practice, or ambulatory surgical center.

(B) No hospital or critical access hospital that presents a claim or request for payment for services of a certified nurse anesthetist under this part may treat any uncollected coinsurance amount imposed under this part with respect to such services as a bad debt of such hospital or critical access hospital for purposes of this title.

(6) If an adjustment under paragraph (3)(B) results in a reduction in the reasonable charge for a physicians' service and a nonparticipating physician furnishes the service to an individual entitled to benefits under this part after the effective date of the reduction, the physician's actual charge is subject to a limit under section 1842(j)(1)(D).

(m)(1) In the case of physicians' services furnished in a year to an individual, who is covered under the insurance program established by this part and who incurs expenses for such services, in an area that is designated (under section 332(a)(1)(A) of the Public Health Service Act) as a health professional shortage area as identified by the Secretary prior to the beginning of such year, in addition to the amount otherwise paid under this part, there also shall be paid to the physician (or to an employer or facility in the cases described in clause (A) of section 1842(b)(6)) (on a monthly or quarterly basis) from the Federal Supplementary Medical Insurance Trust Fund an amount equal to 10 percent of the payment amount for the service under this part.

(2) For each health professional shortage area identified in paragraph (1) that consists of an entire county, the Secretary shall provide for the additional payment under paragraph (1) without any requirement on the physician to identify the health professional shortage area involved. The Secretary may implement the previous sentence using the method specified in subsection (u)(4)(C).

(3) The Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services a list of the health professional shortage areas identified in paragraph (1) that consist of a partial county to facilitate the additional payment under paragraph (1) in such areas.

(4) There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, respecting—

(A) the identification of a county or area;

(B) the assignment of a specialty of any physician under this paragraph;

(C) the assignment of a physician to a county under this subsection; or

(D) the assignment of a postal ZIP Code to a county or other area under this subsection.

(n)(1)(A) The aggregate amount of the payments to be made for all or part of a cost reporting period for services described in subsection (a)(2)(E)(i) furnished under this part on or after October 1, 1988, and before January 1, 1999, and for services described in subsection (a)(2)(E)(ii) furnished under this part on or after October 1, 1989, and before January 1, 1999, shall be equal to the lesser of—

(i) the amount determined with respect to such services under subsection (a)(2)(B), or

(ii) the blend amount for radiology services and diagnostic procedures determined in accordance with subparagraph (B).

(B)(i) The blend amount for radiology services and diagnostic procedures for a cost reporting period is the sum of—

(I) the cost proportion (as defined in clause (ii)) of the amount described in subparagraph (A)(i); and

(II) the charge proportion (as defined in clause (ii)(II)) of 62 percent (for services described in subsection (a)(2)(E)(i)), or (for

procedures described in subsection (a)(2)(E)(ii)), 42 percent or such other percent established by the Secretary (or carriers acting pursuant to guidelines issued by the Secretary) based on prevailing charges established with actual charge data, of the prevailing charge or (for services described in subsection (a)(2)(E)(i) furnished on or after January 1, 1989) the fee schedule amount established for participating physicians for the same services as if they were furnished in a physician's office in the same locality as determined under section 1842(b), less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A).

(ii) In this subparagraph:

(I) The term "cost proportion" means 50 percent, except that such term means 65 percent in the case of outpatient radiology services for portions of cost reporting periods which occur in fiscal year 1989 and in the case of diagnostic procedures described in subsection (a)(2)(E)(ii) for portions of cost reporting periods which occur in fiscal year 1990, and such term means 42 percent in the case of outpatient radiology services for portions of cost reporting periods beginning on or after January 1, 1991.

(II) The term "charge proportion" means 100 percent minus the cost proportion.

(o)(1) In the case of shoes described in section 1861(s)(12)—

(A) no payment may be made under this part, with respect to any individual for any year, for the furnishing of—

(i) more than one pair of custom molded shoes (including inserts provided with such shoes) and 2 additional pairs of inserts for such shoes, or

(ii) more than one pair of extra-depth shoes (not including inserts provided with such shoes) and 3 pairs of inserts for such shoes, and

(B) with respect to expenses incurred in any calendar year, no more than the amount of payment applicable under paragraph (2) shall be considered as incurred expenses for purposes of subsections (a) and (b).

Payment for shoes (or inserts) under this part shall be considered to include payment for any expenses for the fitting of such shoes (or inserts).

(2)(A) Except as provided by the Secretary under subparagraphs (B) and (C), the amount of payment under this paragraph for custom molded shoes, extra-depth shoes, and inserts shall be the amount determined for such items by the Secretary under section 1834(h).

(B) The Secretary may establish payment amounts for shoes and inserts that are lower than the amount established under section 1834(h) if the Secretary finds that shoes and inserts of an appropriate quality are readily available at or below the amount established under such section.

(C) In accordance with procedures established by the Secretary, an individual entitled to benefits with respect to shoes described in section 1861(s)(12) may substitute modification of such shoes instead of obtaining one (or more, as specified by the Secretary) pair of inserts (other than the original pair of inserts with respect to such shoes). In such case, the Secretary shall substitute, for the

payment amount established under section 1834(h), a payment amount that the Secretary estimates will assure that there is no net increase in expenditures under this subsection as a result of this subparagraph.

(3) In this title, the term "shoes" includes, except for purposes of subparagraphs (A)(ii) and (B) of paragraph (2), inserts for extra-depth shoes.

(q)(1) Each request for payment, or bill submitted, for an item or service furnished by an entity for which payment may be made under this part and for which the entity knows or has reason to believe there has been a referral by a referring physician (within the meaning of section 1877) shall include the name and unique physician identification number for the referring physician.

(2)(A) In the case of a request for payment for an item or service furnished by an entity under this part on an assignment-related basis and for which information is required to be provided under paragraph (1) but not included, payment may be denied under this part.

(B) In the case of a request for payment for an item or service furnished by an entity under this part not submitted on an assignment-related basis and for which information is required to be provided under paragraph (1) but not included—

(i) if the entity knowingly and willfully fails to provide such information promptly upon request of the Secretary or a carrier, the entity may be subject to a civil money penalty in an amount not to exceed $2,000, and

(ii) if the entity knowingly, willfully, and in repeated cases fails, after being notified by the Secretary of the obligations and requirements of this subsection to provide the information required under paragraph (1), the entity may be subject to exclusion from participation in the programs under this Act for a period not to exceed 5 years, in accordance with the procedures of subsections (c), (f), and (g) of section 1128.

The provisions of section 1128A (other than subsections (a) and (b)) shall apply to civil money penalties under clause (i) in the same manner as they apply to a penalty or proceeding under section 1128A(a).

(r)(1) With respect to services described in section 1861(s)(2)(K)(ii) (relating to nurse practitioner or clinical nurse specialist services), payment may be made on the basis of a claim or request for payment presented by the nurse practitioner or clinical nurse specialist furnishing such services, or by a hospital, critical access hospital, skilled nursing facility or nursing facility (as defined in section 1919(a)), physician, group practice, or ambulatory surgical center with which the nurse practitioner or clinical nurse specialist has an employment or contractual relationship that provides for payment to be made under this part for such services to such hospital, physician, group practice, or ambulatory surgical center.

(2) No hospital or critical access hospital that presents a claim or request for payment under this part for services described in section 1861(s)(2)(K)(ii) may treat any uncollected coinsurance amount imposed under this part with respect to such services as a bad debt of such hospital for purposes of this title.

(s) The Secretary may not provide for payment under subsection (a)(1)(A) with respect to an organization unless the organization provides assurances satisfactory to the Secretary that the organization meets the requirement of section 1866(f) (relating to maintaining written policies and procedures respecting advance directives).

(t) PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES.—

(1) AMOUNT OF PAYMENT.—

(A) IN GENERAL.—With respect to covered OPD services (as defined in subparagraph (B)) furnished during a year beginning with 1999, the amount of payment under this part shall be determined under a prospective payment system established by the Secretary in accordance with this subsection.

(B) DEFINITION OF COVERED OPD SERVICES.—For purposes of this subsection, the term "covered OPD services"—

(i) means hospital outpatient services designated by the Secretary;

(ii) subject to clause (iv), includes inpatient hospital services designated by the Secretary that are covered under this part and furnished to a hospital inpatient who (I) is entitled to benefits under part A but has exhausted benefits for inpatient hospital services during a spell of illness, or (II) is not so entitled;

(iii) includes implantable items described in paragraph (3), (6), or (8) of section 1861(s);

(iv) does not include any therapy services described in subsection (a)(8) or ambulance services, for which payment is made under a fee schedule described in section 1834(k) or section 1834(l) and does not include screening mammography (as defined in section 1861(jj)), diagnostic mammography, or personalized prevention plan services (as defined in section 1861(hhh)(1)); and

(v) does not include applicable items and services (as defined in subparagraph (A) of paragraph (21)) that are furnished on or after January 1, 2017, by an off-campus outpatient department of a provider (as defined in subparagraph (B) of such paragraph).

(2) SYSTEM REQUIREMENTS.—Under the payment system—

(A) the Secretary shall develop a classification system for covered OPD services;

(B) the Secretary may establish groups of covered OPD services, within the classification system described in subparagraph (A), so that services classified within each group are comparable clinically and with respect to the use of resources and so that an implantable item is classified to the group that includes the service to which the item relates;

(C) the Secretary shall, using data on claims from 1996 and using data from the most recent available cost reports, establish relative payment weights for covered OPD services (and any groups of such services described in subparagraph (B)) based on median (or, at the election of the Sec-

retary, mean) hospital costs and shall determine projections of the frequency of utilization of each such service (or group of services) in 1999;

(D) subject to paragraph (19), the Secretary shall determine a wage adjustment factor to adjust the portion of payment and coinsurance attributable to labor-related costs for relative differences in labor and labor-related costs across geographic regions in a budget neutral manner;

(E) the Secretary shall establish, in a budget neutral manner, outlier adjustments under paragraph (5) and transitional pass-through payments under paragraph (6) and other adjustments as determined to be necessary to ensure equitable payments, such as adjustments for certain classes of hospitals;

(F) the Secretary shall develop a method for controlling unnecessary increases in the volume of covered OPD services;

(G) the Secretary shall create additional groups of covered OPD services that classify separately those procedures that utilize contrast agents from those that do not; and

(H) with respect to devices of brachytherapy consisting of a seed or seeds (or radioactive source), the Secretary shall create additional groups of covered OPD services that classify such devices separately from the other services (or group of services) paid for under this subsection in a manner reflecting the number, isotope, and radioactive intensity of such devices furnished, including separate groups for palladium-103 and iodine-125 devices and for stranded and non-stranded devices furnished on or after July 1, 2007.

For purposes of subparagraph (B), items and services within a group shall not be treated as "comparable with respect to the use of resources" if the highest median cost (or mean cost, if elected by the Secretary under subparagraph (C)) for an item or service within the group is more than 2 times greater than the lowest median cost (or mean cost, if so elected) for an item or service within the group; except that the Secretary may make exceptions in unusual cases, such as low volume items and services, but may not make such an exception in the case of a drug or biological that has been designated as an orphan drug under section 526 of the Federal Food, Drug and Cosmetic Act.

(3) CALCULATION OF BASE AMOUNTS.—

(A) AGGREGATE AMOUNTS THAT WOULD BE PAYABLE IF DEDUCTIBLES WERE DISREGARDED.—The Secretary shall estimate the sum of—

(i) the total amounts that would be payable from the Trust Fund under this part for covered OPD services in 1999, determined without regard to this subsection, as though the deductible under section 1833(b) did not apply, and

(ii) the total amounts of copayments estimated to be paid under this subsection by beneficiaries to hospitals

for covered OPD services in 1999, as though the deductible under section 1833(b) did not apply.

(B) UNADJUSTED COPAYMENT AMOUNT.—

(i) IN GENERAL.—For purposes of this subsection, subject to clause (ii), the "unadjusted copayment amount" applicable to a covered OPD service (or group of such services) is 20 percent of the national median of the charges for the service (or services within the group) furnished during 1996, updated to 1999 using the Secretary's estimate of charge growth during the period.

(ii) ADJUSTED TO BE 20 PERCENT WHEN FULLY PHASED IN.—If the pre-deductible payment percentage for a covered OPD service (or group of such services) furnished in a year would be equal to or exceed 80 percent, then the unadjusted copayment amount shall be 20 percent of amount determined under subparagraph (D).

(iii) RULES FOR NEW SERVICES.—The Secretary shall establish rules for establishment of an unadjusted copayment amount for a covered OPD service not furnished during 1996, based upon its classification within a group of such services.

(C) CALCULATION OF CONVERSION FACTORS.—

(i) FOR 1999.—

(I) IN GENERAL.—The Secretary shall establish a 1999 conversion factor for determining the medicare OPD fee schedule amounts for each covered OPD service (or group of such services) furnished in 1999. Such conversion factor shall be established on the basis of the weights and frequencies described in paragraph (2)(C) and in such a manner that the sum for all services and groups of the products (described in subclause (II) for each such service or group) equals the total projected amount described in subparagraph (A).

(II) PRODUCT DESCRIBED.—The Secretary shall determine for each service or group the product of the medicare OPD fee schedule amounts (taking into account appropriate adjustments described in paragraphs (2)(D) and (2)(E)) and the estimated frequencies for such service or group.

(ii) SUBSEQUENT YEARS.—Subject to paragraph (8)(B), the Secretary shall establish a conversion factor for covered OPD services furnished in subsequent years in an amount equal to the conversion factor established under this subparagraph and applicable to such services furnished in the previous year increased by the OPD fee schedule increase factor specified under clause (iv) for the year involved.

(iii) ADJUSTMENT FOR SERVICE MIX CHANGES.—Insofar as the Secretary determines that the adjustments for service mix under paragraph (2) for a previous year (or estimates that such adjustments for a future year) did (or are likely to) result in a change in aggre-

gate payments under this subsection during the year that are a result of changes in the coding or classification of covered OPD services that do not reflect real changes in service mix, the Secretary may adjust the conversion factor computed under this subparagraph for subsequent years so as to eliminate the effect of such coding or classification changes.

(iv) OPD FEE SCHEDULE INCREASE FACTOR.—For purposes of this subparagraph, subject to paragraph (17) and subparagraph (F) of this paragraph, the "OPD fee schedule increase factor" for services furnished in a year is equal to the market basket percentage increase applicable under section 1886(b)(3)(B)(iii) to hospital discharges occurring during the fiscal year ending in such year, reduced by 1 percentage point for such factor for services furnished in each of 2000 and 2002. In applying the previous sentence for years beginning with 2000, the Secretary may substitute for the market basket percentage increase an annual percentage increase that is computed and applied with respect to covered OPD services furnished in a year in the same manner as the market basket percentage increase is determined and applied to inpatient hospital services for discharges occurring in a fiscal year.

(D) CALCULATION OF MEDICARE OPD FEE SCHEDULE AMOUNTS.—The Secretary shall compute a medicare OPD fee schedule amount for each covered OPD service (or group of such services) furnished in a year, in an amount equal to the product of—

(i) the conversion factor computed under subparagraph (C) for the year, and

(ii) the relative payment weight (determined under paragraph (2)(C)) for the service or group.

(E) PRE-DEDUCTIBLE PAYMENT PERCENTAGE.—The pre-deductible payment percentage for a covered OPD service (or group of such services) furnished in a year is equal to the ratio of—

(i) the medicare OPD fee schedule amount established under subparagraph (D) for the year, minus the unadjusted copayment amount determined under subparagraph (B) for the service or group, to

(ii) the medicare OPD fee schedule amount determined under subparagraph (D) for the year for such service or group.

(F) PRODUCTIVITY AND OTHER ADJUSTMENT.—After determining the OPD fee schedule increase factor under subparagraph (C)(iv), the Secretary shall reduce such increase factor—

(i) for 2012 and subsequent years, by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II); and

(ii) for each of 2010 through 2019, by the adjustment described in subparagraph (G).

The application of this subparagraph may result in the increase factor under subparagraph (C)(iv) being less than

0.0 for a year, and may result in payment rates under the payment system under this subsection for a year being less than such payment rates for the preceding year.

(G) OTHER ADJUSTMENT.—For purposes of subparagraph (F)(ii), the adjustment described in this subparagraph is—

(i) for each of 2010 and 2011, 0.25 percentage point;

(ii) for each of 2012 and 2013, 0.1 percentage point;

(iii) for 2014, 0.3 percentage point;

(iv) for each of 2015 and 2016, 0.2 percentage point; and

(v) for each of 2017, 2018, and 2019, 0.75 percentage point.

(4) MEDICARE PAYMENT AMOUNT.—The amount of payment made from the Trust Fund under this part for a covered OPD service (and such services classified within a group) furnished in a year is determined, subject to paragraph (7), as follows:

(A) FEE SCHEDULE ADJUSTMENTS.—The medicare OPD fee schedule amount (computed under paragraph (3)(D)) for the service or group and year is adjusted for relative differences in the cost of labor and other factors determined by the Secretary, as computed under paragraphs (2)(D) and (2)(E).

(B) SUBTRACT APPLICABLE DEDUCTIBLE.—Reduce the adjusted amount determined under subparagraph (A) by the amount of the deductible under section 1833(b), to the extent applicable.

(C) APPLY PAYMENT PROPORTION TO REMAINDER.—The amount of payment is the amount so determined under subparagraph (B) multiplied by the pre-deductible payment percentage (as determined under paragraph (3)(E)) for the service or group and year involved, plus the amount of any reduction in the copayment amount attributable to paragraph (8)(C).

(5) OUTLIER ADJUSTMENT.—

(A) IN GENERAL.—Subject to subparagraph (D), the Secretary shall provide for an additional payment for each covered OPD service (or group of services) for which a hospital's charges, adjusted to cost, exceed—

(i) a fixed multiple of the sum of—

(I) the applicable medicare OPD fee schedule amount determined under paragraph (3)(D), as adjusted under paragraph (4)(A) (other than for adjustments under this paragraph or paragraph (6)); and

(II) any transitional pass-through payment under paragraph (6); and

(ii) at the option of the Secretary, such fixed dollar amount as the Secretary may establish.

(B) AMOUNT OF ADJUSTMENT.—The amount of the additional payment under subparagraph (A) shall be determined by the Secretary and shall approximate the marginal cost of care beyond the applicable cutoff point under such subparagraph.

(C) LIMIT ON AGGREGATE OUTLIER ADJUSTMENTS.—

(i) IN GENERAL.—The total of the additional payments made under this paragraph for covered OPD services furnished in a year (as estimated by the Secretary before the beginning of the year) may not exceed the applicable percentage (specified in clause (ii)) of the total program payments estimated to be made under this subsection for all covered OPD services furnished in that year. If this paragraph is first applied to less than a full year, the previous sentence shall apply only to the portion of such year.

(ii) APPLICABLE PERCENTAGE.—For purposes of clause (i), the term "applicable percentage" means a percentage specified by the Secretary up to (but not to exceed)—

(I) for a year (or portion of a year) before 2004, 2.5 percent; and

(II) for 2004 and thereafter, 3.0 percent.

(D) TRANSITIONAL AUTHORITY.—In applying subparagraph (A) for covered OPD services furnished before January 1, 2002, the Secretary may—

(i) apply such subparagraph to a bill for such services related to an outpatient encounter (rather than for a specific service or group of services) using OPD fee schedule amounts and transitional pass-through payments covered under the bill; and

(ii) use an appropriate cost-to-charge ratio for the hospital involved (as determined by the Secretary), rather than for specific departments within the hospital.

(E) EXCLUSION OF SEPARATE DRUG AND BIOLOGICAL APCS FROM OUTLIER PAYMENTS.—No additional payment shall be made under subparagraph (A) in the case of ambulatory payment classification groups established separately for drugs or biologicals.

(6) TRANSITIONAL PASS-THROUGH FOR ADDITIONAL COSTS OF INNOVATIVE MEDICAL DEVICES, DRUGS, AND BIOLOGICALS.—

(A) IN GENERAL.—The Secretary shall provide for an additional payment under this paragraph for any of the following that are provided as part of a covered OPD service (or group of services):

(i) CURRENT ORPHAN DRUGS.—A drug or biological that is used for a rare disease or condition with respect to which the drug or biological has been designated as an orphan drug under section 526 of the Federal Food, Drug and Cosmetic Act if payment for the drug or biological as an outpatient hospital service under this part was being made on the first date that the system under this subsection is implemented.

(ii) CURRENT CANCER THERAPY DRUGS AND BIOLOGICALS AND BRACHYTHERAPY.—A drug or biological that is used in cancer therapy, including (but not limited to) a chemotherapeutic agent, an antiemetic, a hematopoietic growth factor, a colony stimulating factor, a biological response modifier, a bisphosphonate, and a device of brachytherapy or temperature mon-

itored cryoablation, if payment for such drug, biological, or device as an outpatient hospital service under this part was being made on such first date.

(iii) CURRENT RADIOPHARMACEUTICAL DRUGS AND BIOLOGICAL PRODUCTS.—A radiopharmaceutical drug or biological product used in diagnostic, monitoring, and therapeutic nuclear medicine procedures if payment for the drug or biological as an outpatient hospital service under this part was being made on such first date.

(iv) NEW MEDICAL DEVICES, DRUGS, AND BIOLOGICALS.—A medical device, drug, or biological not described in clause (i), (ii), or (iii) if—

(I) payment for the device, drug, or biological as an outpatient hospital service under this part was not being made as of December 31, 1996; and

(II) the cost of the drug or biological or the average cost of the category of devices is not insignificant in relation to the OPD fee schedule amount (as calculated under paragraph (3)(D)) payable for the service (or group of services) involved.

(B) USE OF CATEGORIES IN DETERMINING ELIGIBILITY OF A DEVICE FOR PASS-THROUGH PAYMENTS.—The following provisions apply for purposes of determining whether a medical device qualifies for additional payments under clause (ii) or (iv) of subparagraph (A):

(i) ESTABLISHMENT OF INITIAL CATEGORIES.—

(I) IN GENERAL.—The Secretary shall initially establish under this clause categories of medical devices based on type of device by April 1, 2001. Such categories shall be established in a manner such that each medical device that meets the requirements of clause (ii) or (iv) of subparagraph (A) as of January 1, 2001, is included in such a category and no such device is included in more than one category. For purposes of the preceding sentence, whether a medical device meets such requirements as of such date shall be determined on the basis of the program memoranda issued before such date.

(II) AUTHORIZATION OF IMPLEMENTATION OTHER THAN THROUGH REGULATIONS.—The categories may be established under this clause by program memorandum or otherwise, after consultation with groups representing hospitals, manufacturers of medical devices, and other affected parties.

(ii) ESTABLISHING CRITERIA FOR ADDITIONAL CATEGORIES.—

(I) IN GENERAL.—The Secretary shall establish criteria that will be used for creation of additional categories (other than those established under clause (i)) through rulemaking (which may include use of an interim final rule with comment period).

(II) STANDARD.—Such categories shall be established under this clause in a manner such that no

medical device is described by more than one category. Such criteria shall include a test of whether the average cost of devices that would be included in a category and are in use at the time the category is established is not insignificant, as described in subparagraph (A)(iv)(II).

(III) DEADLINE.—Criteria shall first be established under this clause by July 1, 2001. The Secretary may establish in compelling circumstances categories under this clause before the date such criteria are established.

(IV) ADDING CATEGORIES.—The Secretary shall promptly establish a new category of medical devices under this clause for any medical device that meets the requirements of subparagraph (A)(iv) and for which none of the categories in effect (or that were previously in effect) is appropriate.

(iii) PERIOD FOR WHICH CATEGORY IS IN EFFECT.—A category of medical devices established under clause (i) or (ii) shall be in effect for a period of at least 2 years, but not more than 3 years, that begins—

(I) in the case of a category established under clause (i), on the first date on which payment was made under this paragraph for any device described by such category (including payments made during the period before April 1, 2001); and

(II) in the case of any other category, on the first date on which payment is made under this paragraph for any medical device that is described by such category.

(iv) REQUIREMENTS TREATED AS MET.—A medical device shall be treated as meeting the requirements of subparagraph (A)(iv), regardless of whether the device meets the requirement of subclause (I) of such subparagraph, if—

(I) the device is described by a category established and in effect under clause (i); or

(II) the device is described by a category established and in effect under clause (ii) and an application under section 515 of the Federal Food, Drug, and Cosmetic Act has been approved with respect to the device, or the device has been cleared for market under section 510(k) of such Act, or the device is exempt from the requirements of section 510(k) of such Act pursuant to subsection (l) or (m) of section 510 of such Act or section 520(g) of such Act.

Nothing in this clause shall be construed as requiring an application or prior approval (other than that described in subclause (II)) in order for a covered device described by a category to qualify for payment under this paragraph.

(C) LIMITED PERIOD OF PAYMENT.—

(i) DRUGS AND BIOLOGICALS.—The payment under this paragraph with respect to a drug or biological

shall only apply during a period of at least 2 years, but not more than 3 years, that begins—

(I) on the first date this subsection is implemented in the case of a drug or biological described in clause (i), (ii), or (iii) of subparagraph (A) and in the case of a drug or biological described in subparagraph (A)(iv) and for which payment under this part is made as an outpatient hospital service before such first date; or

(II) in the case of a drug or biological described in subparagraph (A)(iv) not described in subclause (I), on the first date on which payment is made under this part for the drug or biological as an outpatient hospital service.

(ii) MEDICAL DEVICES.—Payment shall be made under this paragraph with respect to a medical device only if such device—

(I) is described by a category of medical devices established and in effect under subparagraph (B); and

(II) is provided as part of a service (or group of services) paid for under this subsection and provided during the period for which such category is in effect under such subparagraph.

(D) AMOUNT OF ADDITIONAL PAYMENT.—Subject to subparagraph (E)(iii), the amount of the payment under this paragraph with respect to a device, drug, or biological provided as part of a covered OPD service is—

(i) in the case of a drug or biological, the amount by which the amount determined under section 1842(o) (or if the drug or biological is covered under a competitive acquisition contract under section 1847B, an amount determined by the Secretary equal to the average price for the drug or biological for all competitive acquisition areas and year established under such section as calculated and adjusted by the Secretary for purposes of this paragraph) for the drug or biological exceeds the portion of the otherwise applicable medicare OPD fee schedule that the Secretary determines is associated with the drug or biological; or

(ii) in the case of a medical device, the amount by which the hospital's charges for the device, adjusted to cost, exceeds the portion of the otherwise applicable medicare OPD fee schedule that the Secretary determines is associated with the device.

(E) LIMIT ON AGGREGATE ANNUAL ADJUSTMENT.—

(i) IN GENERAL.—The total of the additional payments made under this paragraph for covered OPD services furnished in a year (as estimated by the Secretary before the beginning of the year) may not exceed the applicable percentage (specified in clause (ii)) of the total program payments estimated to be made under this subsection for all covered OPD services furnished in that year. If this paragraph is first applied

to less than a full year, the previous sentence shall apply only to the portion of such year.

(ii) APPLICABLE PERCENTAGE.—For purposes of clause (i), the term "applicable percentage" means—

(I) for a year (or portion of a year) before 2004, 2.5 percent; and

(II) for 2004 and thereafter, a percentage specified by the Secretary up to (but not to exceed) 2.0 percent.

(iii) UNIFORM PROSPECTIVE REDUCTION IF AGGREGATE LIMIT PROJECTED TO BE EXCEEDED.—If the Secretary estimates before the beginning of a year that the amount of the additional payments under this paragraph for the year (or portion thereof) as determined under clause (i) without regard to this clause will exceed the limit established under such clause, the Secretary shall reduce pro rata the amount of each of the additional payments under this paragraph for that year (or portion thereof) in order to ensure that the aggregate additional payments under this paragraph (as so estimated) do not exceed such limit.

(F) LIMITATION OF APPLICATION OF FUNCTIONAL EQUIVALENCE STANDARD.—

(i) IN GENERAL.—The Secretary may not publish regulations that apply a functional equivalence standard to a drug or biological under this paragraph.

(ii) APPLICATION.—Clause (i) shall apply to the application of a functional equivalence standard to a drug or biological on or after the date of enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 unless—

(I) such application was being made to such drug or biological prior to such date of enactment; and

(II) the Secretary applies such standard to such drug or biological only for the purpose of determining eligibility of such drug or biological for additional payments under this paragraph and not for the purpose of any other payments under this title.

(iii) RULE OF CONSTRUCTION.—Nothing in this subparagraph shall be construed to effect the Secretary's authority to deem a particular drug to be identical to another drug if the 2 products are pharmaceutically equivalent and bioequivalent, as determined by the Commissioner of Food and Drugs.

(7) TRANSITIONAL ADJUSTMENT TO LIMIT DECLINE IN PAYMENT.—

(A) BEFORE 2002.—Subject to subparagraph (D), for covered OPD services furnished before January 1, 2002, for which the PPS amount (as defined in subparagraph (E)) is—

(i) at least 90 percent, but less than 100 percent, of the pre-BBA amount (as defined in subparagraph (F)), the amount of payment under this subsection shall be

increased by 80 percent of the amount of such difference;

(ii) at least 80 percent, but less than 90 percent, of the pre-BBA amount, the amount of payment under this subsection shall be increased by the amount by which (I) the product of 0.71 and the pre-BBA amount, exceeds (II) the product of 0.70 and the PPS amount;

(iii) at least 70 percent, but less than 80 percent, of the pre-BBA amount, the amount of payment under this subsection shall be increased by the amount by which (I) the product of 0.63 and the pre-BBA amount, exceeds (II) the product of 0.60 and the PPS amount; or

(iv) less than 70 percent of the pre-BBA amount, the amount of payment under this subsection shall be increased by 21 percent of the pre-BBA amount.

(B) 2002.—Subject to subparagraph (D), for covered OPD services furnished during 2002, for which the PPS amount is—

(i) at least 90 percent, but less than 100 percent, of the pre-BBA amount, the amount of payment under this subsection shall be increased by 70 percent of the amount of such difference;

(ii) at least 80 percent, but less than 90 percent, of the pre-BBA amount, the amount of payment under this subsection shall be increased by the amount by which (I) the product of 0.61 and the pre-BBA amount, exceeds (II) the product of 0.60 and the PPS amount; or

(iii) less than 80 percent of the pre-BBA amount, the amount of payment under this subsection shall be increased by 13 percent of the pre-BBA amount.

(C) 2003.—Subject to subparagraph (D), for covered OPD services furnished during 2003, for which the PPS amount is—

(i) at least 90 percent, but less than 100 percent, of the pre-BBA amount, the amount of payment under this subsection shall be increased by 60 percent of the amount of such difference; or

(ii) less than 90 percent of the pre-BBA amount, the amount of payment under this subsection shall be increased by 6 percent of the pre-BBA amount.

(D) HOLD HARMLESS PROVISIONS.—

(i) TEMPORARY TREATMENT FOR CERTAIN RURAL HOSPITALS.—(I) In the case of a hospital located in a rural area and that has not more than 100 beds or a sole community hospital (as defined in section 1886(d)(5)(D)(iii)) located in a rural area, for covered OPD services furnished before January 1, 2006, for which the PPS amount is less than the pre-BBA amount, the amount of payment under this subsection shall be increased by the amount of such difference.

(II) In the case of a hospital located in a rural area and that has not more than 100 beds and that is not a sole community hospital (as defined in section

1886(d)(5)(D)(iii)), for covered OPD services furnished on or after January 1, 2006, and before January 1, 2013, for which the PPS amount is less than the pre-BBA amount, the amount of payment under this subsection shall be increased by the applicable percentage of the amount of such difference. For purposes of the preceding sentence, the applicable percentage shall be 95 percent with respect to covered OPD services furnished in 2006, 90 percent with respect to such services furnished in 2007, and 85 percent with respect to such services furnished in 2008, 2009, 2010, 2011, or 2012.

(III) In the case of a sole community hospital (as defined in section 1886(d)(5)(D)(iii)) that has not more than 100 beds, for covered OPD services furnished on or after January 1, 2009, and before January 1, 2013, for which the PPS amount is less than the pre-BBA amount, the amount of payment under this subsection shall be increased by 85 percent of the amount of such difference. In the case of covered OPD services furnished on or after January 1, 2010, and before March 1, 2012, the preceding sentence shall be applied without regard to the 100-bed limitation.

(ii) PERMANENT TREATMENT FOR CANCER HOSPITALS AND CHILDREN'S HOSPITALS.—In the case of a hospital described in clause (iii) or (v) of section 1886(d)(1)(B), for covered OPD services for which the PPS amount is less than the pre-BBA amount, the amount of payment under this subsection shall be increased by the amount of such difference.

(E) PPS AMOUNT DEFINED.—In this paragraph, the term "PPS amount" means, with respect to covered OPD services, the amount payable under this title for such services (determined without regard to this paragraph), including amounts payable as copayment under paragraph (8), coinsurance under section 1866(a)(2)(A)(ii), and the deductible under section 1833(b).

(F) PRE-BBA AMOUNT DEFINED.—

(i) IN GENERAL.—In this paragraph, the "pre-BBA amount" means, with respect to covered OPD services furnished by a hospital in a year, an amount equal to the product of the reasonable cost of the hospital for such services for the portions of the hospital's cost reporting period (or periods) occurring in the year and the base OPD payment-to-cost ratio for the hospital (as defined in clause (ii)).

(ii) BASE PAYMENT-TO-COST-RATIO DEFINED.—For purposes of this subparagraph, the "base payment-to-cost ratio" for a hospital means the ratio of—

(I) the hospital's reimbursement under this part for covered OPD services furnished during the cost reporting period ending in 1996 (or in the case of a hospital that did not submit a cost report for such period, during the first subsequent cost reporting period ending before 2001 for which the

hospital submitted a cost report), including any reimbursement for such services through cost-sharing described in subparagraph (E), to

(II) the reasonable cost of such services for such period.

The Secretary shall determine such ratios as if the amendments made by section 4521 of the Balanced Budget Act of 1997 were in effect in 1996.

(G) INTERIM PAYMENTS.—The Secretary shall make payments under this paragraph to hospitals on an interim basis, subject to retrospective adjustments based on settled cost reports.

(H) NO EFFECT ON COPAYMENTS.—Nothing in this paragraph shall be construed to affect the unadjusted copayment amount described in paragraph (3)(B) or the copayment amount under paragraph (8).

(I) APPLICATION WITHOUT REGARD TO BUDGET NEUTRALITY.—The additional payments made under this paragraph—

(i) shall not be considered an adjustment under paragraph (2)(E); and

(ii) shall not be implemented in a budget neutral manner.

(8) COPAYMENT AMOUNT.—

(A) IN GENERAL.—Except as provided in subparagraphs (B) and (C), the copayment amount under this subsection is the amount by which the amount described in paragraph (4)(B) exceeds the amount of payment determined under paragraph (4)(C).

(B) ELECTION TO OFFER REDUCED COPAYMENT AMOUNT.—The Secretary shall establish a procedure under which a hospital, before the beginning of a year (beginning with 1999), may elect to reduce the copayment amount otherwise established under subparagraph (A) for some or all covered OPD services to an amount that is not less than 20 percent of the medicare OPD fee schedule amount (computed under paragraph (3)(D)) for the service involved. Under such procedures, such reduced copayment amount may not be further reduced or increased during the year involved and the hospital may disseminate information on the reduction of copayment amount effected under this subparagraph.

(C) LIMITATION ON COPAYMENT AMOUNT.—

(i) TO INPATIENT HOSPITAL DEDUCTIBLE AMOUNT.—In no case shall the copayment amount for a procedure performed in a year exceed the amount of the inpatient hospital deductible established under section 1813(b) for that year.

(ii) TO SPECIFIED PERCENTAGE.—The Secretary shall reduce the national unadjusted copayment amount for a covered OPD service (or group of such services) furnished in a year in a manner so that the effective copayment rate (determined on a national unadjusted basis) for that service in the year does not exceed the following percentage:

(I) For procedures performed in 2001, on or after April 1, 2001, 57 percent.

(II) For procedures performed in 2002 or 2003, 55 percent.

(III) For procedures performed in 2004, 50 percent.

(IV) For procedures performed in 2005, 45 percent.

(V) For procedures performed in 2006 and thereafter, 40 percent.

(D) NO IMPACT ON DEDUCTIBLES.—Nothing in this paragraph shall be construed as affecting a hospital's authority to waive the charging of a deductible under section 1833(b).

(E) COMPUTATION IGNORING OUTLIER AND PASS-THROUGH ADJUSTMENTS.—The copayment amount shall be computed under subparagraph (A) as if the adjustments under paragraphs (5) and (6) (and any adjustment made under paragraph (2)(E) in relation to such adjustments) had not occurred.

(9) PERIODIC REVIEW AND ADJUSTMENTS COMPONENTS OF PROSPECTIVE PAYMENT SYSTEM.—

(A) PERIODIC REVIEW.—The Secretary shall review not less often than annually and revise the groups, the relative payment weights, and the wage and other adjustments described in paragraph (2) to take into account changes in medical practice, changes in technology, the addition of new services, new cost data, and other relevant information and factors. The Secretary shall consult with an expert outside advisory panel composed of an appropriate selection of representatives of providers to review (and advise the Secretary concerning) the clinical integrity of the groups and weights. Such panel may use data collected or developed by entities and organizations (other than the Department of Health and Human Services) in conducting such review.

(B) BUDGET NEUTRALITY ADJUSTMENT.—If the Secretary makes adjustments under subparagraph (A), then the adjustments for a year may not cause the estimated amount of expenditures under this part for the year to increase or decrease from the estimated amount of expenditures under this part that would have been made if the adjustments had not been made. In determining adjustments under the preceding sentence for 2004 and 2005, the Secretary shall not take into account under this subparagraph or paragraph (2)(E) any expenditures that would not have been made but for the application of paragraph (14).

(C) UPDATE FACTOR.—If the Secretary determines under methodologies described in paragraph (2)(F) that the volume of services paid for under this subsection increased beyond amounts established through those methodologies, the Secretary may appropriately adjust the update to the conversion factor otherwise applicable in a subsequent year.

(10) SPECIAL RULE FOR AMBULANCE SERVICES.—The Secretary shall pay for hospital outpatient services that are ambulance services on the basis described in section 1861(v)(1)(U), or, if applicable, the fee schedule established under section 1834(l).

(11) SPECIAL RULES FOR CERTAIN HOSPITALS.—In the case of hospitals described in clause (iii) or (v) of section 1886(d)(1)(B)—

(A) the system under this subsection shall not apply to covered OPD services furnished before January 1, 2000; and

(B) the Secretary may establish a separate conversion factor for such services in a manner that specifically takes into account the unique costs incurred by such hospitals by virtue of their patient population and service intensity.

(12) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise of—

(A) the development of the classification system under paragraph (2), including the establishment of groups and relative payment weights for covered OPD services, of wage adjustment factors, other adjustments, and methods described in paragraph (2)(F);

(B) the calculation of base amounts under paragraph (3);

(C) periodic adjustments made under paragraph (6);

(D) the establishment of a separate conversion factor under paragraph (8)(B); and

(E) the determination of the fixed multiple, or a fixed dollar cutoff amount, the marginal cost of care, or applicable percentage under paragraph (5) or the determination of insignificance of cost, the duration of the additional payments, the determination and deletion of initial and new categories (consistent with subparagraphs (B) and (C) of paragraph (6)), the portion of the medicare OPD fee schedule amount associated with particular devices, drugs, or biologicals, and the application of any pro rata reduction under paragraph (6).

(13) AUTHORIZATION OF ADJUSTMENT FOR RURAL HOSPITALS.—

(A) STUDY.—The Secretary shall conduct a study to determine if, under the system under this subsection, costs incurred by hospitals located in rural areas by ambulatory payment classification groups (APCs) exceed those costs incurred by hospitals located in urban areas.

(B) AUTHORIZATION OF ADJUSTMENT.—Insofar as the Secretary determines under subparagraph (A) that costs incurred by hospitals located in rural areas exceed those costs incurred by hospitals located in urban areas, the Secretary shall provide for an appropriate adjustment under paragraph (2)(E) to reflect those higher costs by January 1, 2006.

(14) DRUG APC PAYMENT RATES.—

(A) IN GENERAL.—The amount of payment under this subsection for a specified covered outpatient drug (defined in subparagraph (B)) that is furnished as part of a covered OPD service (or group of services)—

(i) in 2004, in the case of—

(I) a sole source drug shall in no case be less than 88 percent, or exceed 95 percent, of the reference average wholesale price for the drug;

(II) an innovator multiple source drug shall in no case exceed 68 percent of the reference average wholesale price for the drug; or

(III) a noninnovator multiple source drug shall in no case exceed 46 percent of the reference average wholesale price for the drug;

(ii) in 2005, in the case of—

(I) a sole source drug shall in no case be less than 83 percent, or exceed 95 percent, of the reference average wholesale price for the drug;

(II) an innovator multiple source drug shall in no case exceed 68 percent of the reference average wholesale price for the drug; or

(III) a noninnovator multiple source drug shall in no case exceed 46 percent of the reference average wholesale price for the drug; or

(iii) in a subsequent year, shall be equal, subject to subparagraph (E)—

(I) to the average acquisition cost for the drug for that year (which, at the option of the Secretary, may vary by hospital group (as defined by the Secretary based on volume of covered OPD services or other relevant characteristics)), as determined by the Secretary taking into account the hospital acquisition cost survey data under subparagraph (D); or

(II) if hospital acquisition cost data are not available, the average price for the drug in the year established under section 1842(o), section 1847A, or section 1847B, as the case may be, as calculated and adjusted by the Secretary as necessary for purposes of this paragraph.

(B) SPECIFIED COVERED OUTPATIENT DRUG DEFINED.—

(i) IN GENERAL.—In this paragraph, the term "specified covered outpatient drug" means, subject to clause (ii), a covered outpatient drug (as defined in section 1927(k)(2)) for which a separate ambulatory payment classification group (APC) has been established and that is—

(I) a radiopharmaceutical; or

(II) a drug or biological for which payment was made under paragraph (6) (relating to pass-through payments) on or before December 31, 2002.

(ii) EXCEPTION.—Such term does not include—

(I) a drug or biological for which payment is first made on or after January 1, 2003, under paragraph (6);

(II) a drug or biological for which a temporary HCPCS code has not been assigned; or

(III) during 2004 and 2005, an orphan drug (as designated by the Secretary).

(C) PAYMENT FOR DESIGNATED ORPHAN DRUGS DURING 2004 AND 2005.—The amount of payment under this subsection for an orphan drug designated by the Secretary under subparagraph (B)(ii)(III) that is furnished as part of a covered OPD service (or group of services) during 2004 and 2005 shall equal such amount as the Secretary may specify.

(D) ACQUISITION COST SURVEY FOR HOSPITAL OUTPATIENT DRUGS.—

(i) ANNUAL GAO SURVEYS IN 2004 AND 2005.—

(I) IN GENERAL.—The Comptroller General of the United States shall conduct a survey in each of 2004 and 2005 to determine the hospital acquisition cost for each specified covered outpatient drug. Not later than April 1, 2005, the Comptroller General shall furnish data from such surveys to the Secretary for use in setting the payment rates under subparagraph (A) for 2006.

(II) RECOMMENDATIONS.—Upon the completion of such surveys, the Comptroller General shall recommend to the Secretary the frequency and methodology of subsequent surveys to be conducted by the Secretary under clause (ii).

(ii) SUBSEQUENT SECRETARIAL SURVEYS.—The Secretary, taking into account such recommendations, shall conduct periodic subsequent surveys to determine the hospital acquisition cost for each specified covered outpatient drug for use in setting the payment rates under subparagraph (A).

(iii) SURVEY REQUIREMENTS.—The surveys conducted under clauses (i) and (ii) shall have a large sample of hospitals that is sufficient to generate a statistically significant estimate of the average hospital acquisition cost for each specified covered outpatient drug. With respect to the surveys conducted under clause (i), the Comptroller General shall report to Congress on the justification for the size of the sample used in order to assure the validity of such estimates.

(iv) DIFFERENTIATION IN COST.—In conducting surveys under clause (i), the Comptroller General shall determine and report to Congress if there is (and the extent of any) variation in hospital acquisition costs for drugs among hospitals based on the volume of covered OPD services performed by such hospitals or other relevant characteristics of such hospitals (as defined by the Comptroller General).

(v) COMMENT ON PROPOSED RATES.—Not later than 30 days after the date the Secretary promulgated proposed rules setting forth the payment rates under subparagraph (A) for 2006, the Comptroller General shall evaluate such proposed rates and submit to Congress a report regarding the appropriateness of such rates

based on the surveys the Comptroller General has conducted under clause (i).

(E) ADJUSTMENT IN PAYMENT RATES FOR OVERHEAD COSTS.—

(i) MEDPAC REPORT ON DRUG APC DESIGN.—The Medicare Payment Advisory Commission shall submit to the Secretary, not later than July 1, 2005, a report on adjustment of payment for ambulatory payment classifications for specified covered outpatient drugs to take into account overhead and related expenses, such as pharmacy services and handling costs. Such report shall include—

(I) a description and analysis of the data available with regard to such expenses;

(II) a recommendation as to whether such a payment adjustment should be made; and

(III) if such adjustment should be made, a recommendation regarding the methodology for making such an adjustment.

(ii) ADJUSTMENT AUTHORIZED.—The Secretary may adjust the weights for ambulatory payment classifications for specified covered outpatient drugs to take into account the recommendations contained in the report submitted under clause (i).

(F) CLASSES OF DRUGS.—For purposes of this paragraph:

(i) SOLE SOURCE DRUGS.—The term "sole source drug" means—

(I) a biological product (as defined under section 1861(t)(1)); or

(II) a single source drug (as defined in section 1927(k)(7)(A)(iv)).

(ii) INNOVATOR MULTIPLE SOURCE DRUGS.—The term "innovator multiple source drug" has the meaning given such term in section 1927(k)(7)(A)(ii).

(iii) NONINNOVATOR MULTIPLE SOURCE DRUGS.—The term "noninnovator multiple source drug" has the meaning given such term in section 1927(k)(7)(A)(iii).

(G) REFERENCE AVERAGE WHOLESALE PRICE.—The term "reference average wholesale price" means, with respect to a specified covered outpatient drug, the average wholesale price for the drug as determined under section 1842(o) as of May 1, 2003.

(H) INAPPLICABILITY OF EXPENDITURES IN DETERMINING CONVERSION, WEIGHTING, AND OTHER ADJUSTMENT FACTORS.—Additional expenditures resulting from this paragraph shall not be taken into account in establishing the conversion, weighting, and other adjustment factors for 2004 and 2005 under paragraph (9), but shall be taken into account for subsequent years.

(15) PAYMENT FOR NEW DRUGS AND BIOLOGICALS UNTIL HCPCS CODE ASSIGNED.—With respect to payment under this part for an outpatient drug or biological that is covered under this part and is furnished as part of covered OPD services for which a HCPCS code has not been assigned, the amount provided for payment for such drug or biological under this part shall be

equal to 95 percent of the average wholesale price for the drug or biological.

(16) MISCELLANEOUS PROVISIONS.—

(A) APPLICATION OF RECLASSIFICATION OF CERTAIN HOSPITALS.—If a hospital is being treated as being located in a rural area under section 1886(d)(8)(E), that hospital shall be treated under this subsection as being located in that rural area.

(B) THRESHOLD FOR ESTABLISHMENT OF SEPARATE APCS FOR DRUGS.—The Secretary shall reduce the threshold for the establishment of separate ambulatory payment classification groups (APCs) with respect to drugs or biologicals to $50 per administration for drugs and biologicals furnished in 2005 and 2006.

(C) PAYMENT FOR DEVICES OF BRACHYTHERAPY AND THERAPEUTIC RADIOPHARMACEUTICALS AT CHARGES ADJUSTED TO COST.—Notwithstanding the preceding provisions of this subsection, for a device of brachytherapy consisting of a seed or seeds (or radioactive source) furnished on or after January 1, 2004, and before January 1, 2010, and for therapeutic radiopharmaceuticals furnished on or after January 1, 2008, and before January 1, 2010, the payment basis for the device or therapeutic radiopharmaceutical under this subsection shall be equal to the hospital's charges for each device or therapeutic radiopharmaceutical furnished, adjusted to cost. Charges for such devices or therapeutic radiopharmaceuticals shall not be included in determining any outlier payment under this subsection.

(D) SPECIAL PAYMENT RULE.—

(i) IN GENERAL.—In the case of covered OPD services furnished on or after April 1, 2013, in a hospital described in clause (ii), if—

(I) the payment rate that would otherwise apply under this subsection for stereotactic radiosurgery, complete course of treatment of cranial lesion(s) consisting of 1 session that is multisource Cobalt 60 based (identified as of January 1, 2013, by HCPCS code 77371 (and any succeeding code) and reimbursed as of such date under APC 0127 (and any succeeding classification group)); exceeds

(II) the payment rate that would otherwise apply under this subsection for linear accelerator based stereotactic radiosurgery, complete course of therapy in one session (identified as of January 1, 2013, by HCPCS code G0173 (and any succeeding code) and reimbursed as of such date under APC 0067 (and any succeeding classification group)),

the payment rate for the service described in subclause (I) shall be reduced to an amount equal to the payment rate for the service described in subclause (II).

(ii) HOSPITAL DESCRIBED.—A hospital described in this clause is a hospital that is not—

(I) located in a rural area (as defined in section 1886(d)(2)(D));

(II) classified as a rural referral center under section 1886(d)(5)(C); or

(III) a sole community hospital (as defined in section 1886(d)(5)(D)(iii)).

(iii) NOT BUDGET NEUTRAL.—In making any budget neutrality adjustments under this subsection for 2013 (with respect to covered OPD services furnished on or after April 1, 2013, and before January 1, 2014) or a subsequent year, the Secretary shall not take into account the reduced expenditures that result from the application of this subparagraph.

(E) APPLICATION OF APPROPRIATE USE CRITERIA FOR CERTAIN IMAGING SERVICES.—For provisions relating to the application of appropriate use criteria for certain imaging services, see section 1834(q).

(F) PAYMENT INCENTIVE FOR THE TRANSITION FROM TRADITIONAL X-RAY IMAGING TO DIGITAL RADIOGRAPHY.—Notwithstanding the previous provisions of this subsection:

(i) LIMITATION ON PAYMENT FOR FILM X-RAY IMAGING SERVICES.—In the case of an imaging service that is an X-ray taken using film and that is furnished during 2017 or a subsequent year, the payment amount for such service (including the X-ray component of a packaged service) that would otherwise be determined under this section (without application of this paragraph and before application of any other adjustment under this subsection) for such year shall be reduced by 20 percent.

(ii) PHASED-IN LIMITATION ON PAYMENT FOR COMPUTED RADIOGRAPHY IMAGING SERVICES.—In the case of an imaging service that is an X-ray taken using computed radiography technology (as defined in section 1848(b)(9)(C))—

(I) in the case of such a service furnished during 2018, 2019, 2020, 2021, or 2022, the payment amount for such service (including the X-ray component of a packaged service) that would otherwise be determined under this section (without application of this paragraph and before application of any other adjustment under this subsection) for such year shall be reduced by 7 percent; and

(II) in the case of such a service furnished during 2023 or a subsequent year, the payment amount for such service (including the X-ray component of a packaged service) that would otherwise be determined under this section (without application of this paragraph and before application of any other adjustment under this subsection) for such year shall be reduced by 10 percent.

(iii) APPLICATION WITHOUT REGARD TO BUDGET NEUTRALITY.—The reductions made under this subparagraph—

(I) shall not be considered an adjustment under paragraph (2)(E); and

(II) shall not be implemented in a budget neutral manner.

(iv) IMPLEMENTATION.—In order to implement this subparagraph, the Secretary shall adopt appropriate mechanisms which may include use of modifiers.

(17) QUALITY REPORTING.—

(A) REDUCTION IN UPDATE FOR FAILURE TO REPORT.—

(i) IN GENERAL.—For purposes of paragraph (3)(C)(iv) for 2009 and each subsequent year, in the case of a subsection (d) hospital (as defined in section 1886(d)(1)(B)) that does not submit, to the Secretary in accordance with this paragraph, data required to be submitted on measures selected under this paragraph with respect to such a year, the OPD fee schedule increase factor under paragraph (3)(C)(iv) for such year shall be reduced by 2.0 percentage points.

(ii) NON-CUMULATIVE APPLICATION.—A reduction under this subparagraph shall apply only with respect to the year involved and the Secretary shall not take into account such reduction in computing the OPD fee schedule increase factor for a subsequent year.

(B) FORM AND MANNER OF SUBMISSION.—Each subsection (d) hospital shall submit data on measures selected under this paragraph to the Secretary in a form and manner, and at a time, specified by the Secretary for purposes of this paragraph.

(C) DEVELOPMENT OF OUTPATIENT MEASURES.—

(i) IN GENERAL.—The Secretary shall develop measures that the Secretary determines to be appropriate for the measurement of the quality of care (including medication errors) furnished by hospitals in outpatient settings and that reflect consensus among affected parties and, to the extent feasible and practicable, shall include measures set forth by one or more national consensus building entities.

(ii) CONSTRUCTION.—Nothing in this paragraph shall be construed as preventing the Secretary from selecting measures that are the same as (or a subset of) the measures for which data are required to be submitted under section 1886(b)(3)(B)(viii).

(D) REPLACEMENT OF MEASURES.—For purposes of this paragraph, the Secretary may replace any measures or indicators in appropriate cases, such as where all hospitals are effectively in compliance or the measures or indicators have been subsequently shown not to represent the best clinical practice.

(E) AVAILABILITY OF DATA.—The Secretary shall establish procedures for making data submitted under this paragraph available to the public. Such procedures shall ensure that a hospital has the opportunity to review the

data that are to be made public with respect to the hospital prior to such data being made public. The Secretary shall report quality measures of process, structure, outcome, patients' perspectives on care, efficiency, and costs of care that relate to services furnished in outpatient settings in hospitals on the Internet website of the Centers for Medicare & Medicaid Services.

(18) AUTHORIZATION OF ADJUSTMENT FOR CANCER HOSPITALS.—

(A) STUDY.—The Secretary shall conduct a study to determine if, under the system under this subsection, costs incurred by hospitals described in section 1886(d)(1)(B)(v) with respect to ambulatory payment classification groups exceed those costs incurred by other hospitals furnishing services under this subsection (as determined appropriate by the Secretary). In conducting the study under this subparagraph, the Secretary shall take into consideration the cost of drugs and biologicals incurred by such hospitals.

(B) AUTHORIZATION OF ADJUSTMENT.—Insofar as the Secretary determines under subparagraph (A) that costs incurred by hospitals described in section 1886(d)(1)(B)(v) exceed those costs incurred by other hospitals furnishing services under this subsection, the Secretary shall*, subject to subparagraph (C),* provide for an appropriate adjustment under paragraph (2)(E) to reflect those higher costs effective for services furnished on or after January 1, 2011.

(C) TARGET PCR ADJUSTMENT.—In applying section 419.43(i) of title 42 of the Code of Federal Regulations to implement the appropriate adjustment under this paragraph for services furnished on or after January 1, 2018, the Secretary shall use a target PCR that is 1.0 percentage points less than the target PCR that would otherwise apply. In addition to the percentage point reduction under the previous sentence, the Secretary may consider making an additional percentage point reduction to such target PCR that takes into account payment rates for applicable items and services described in paragraph (21)(C) other than for services furnished by hospitals described in section 1886(d)(1)(B)(v). In making any budget neutrality adjustments under this subsection for 2018 or a subsequent year, the Secretary shall not take into account the reduced expenditures that result from the application of this subparagraph.

(19) FLOOR ON AREA WAGE ADJUSTMENT FACTOR FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES IN FRONTIER STATES.—

(A) IN GENERAL.—Subject to subparagraph (B), with respect to covered OPD services furnished on or after January 1, 2011, the area wage adjustment factor applicable under the payment system established under this subsection to any hospital outpatient department which is located in a frontier State (as defined in section 1886(d)(3)(E)(iii)(II)) may not be less than 1.00. The preceding sentence shall not be applied in a budget neutral manner.

(B) LIMITATION.—This paragraph shall not apply to any hospital outpatient department located in a State that receives a non-labor related share adjustment under section 1886(d)(5)(H).

(20) NOT BUDGET NEUTRAL APPLICATION OF REDUCED EXPENDITURES RESULTING FROM QUALITY INCENTIVES FOR COMPUTED TOMOGRAPHY.—The Secretary shall not take into account the reduced expenditures that result from the application of section 1834(p) in making any budget neutrality adjustments this subsection.

(21) SERVICES FURNISHED BY AN OFF-CAMPUS OUTPATIENT DEPARTMENT OF A PROVIDER.—

(A) APPLICABLE ITEMS AND SERVICES.—For purposes of paragraph (1)(B)(v) and this paragraph, the term "applicable items and services" means items and services other than items and services furnished by a dedicated emergency department (as defined in section 489.24(b) of title 42 of the Code of Federal Regulations).

(B) OFF-CAMPUS OUTPATIENT DEPARTMENT OF A PROVIDER.—

(i) IN GENERAL.—For purposes of paragraph (1)(B)(v) and this paragraph, subject to [clause (ii)] *the subsequent provisions of this subparagraph*, the term "off-campus outpatient department of a provider" means a department of a provider (as defined in section 413.65(a)(2) of title 42 of the Code of Federal Regulations, as in effect as of the date of the enactment of this paragraph) that is not located—

(I) on the campus (as defined in such section 413.65(a)(2)) of such provider; or

(II) within the distance (described in such definition of campus) from a remote location of a hospital facility (as defined in such section 413.65(a)(2)).

(ii) EXCEPTION.—For purposes of paragraph (1)(B)(v) and this paragraph, the term "off-campus outpatient department of a provider" shall not include a department of a provider (as so defined) that was billing under this subsection with respect to covered OPD services furnished prior to the date of the enactment of this paragraph.

(iii) DEEMED TREATMENT FOR 2017.—For purposes of applying clause (ii) with respect to applicable items and services furnished during 2017, a department of a provider (as so defined) not described in such clause is deemed to be billing under this subsection with respect to covered OPD services furnished prior to November 2, 2015, if the Secretary received from the provider prior to December 2, 2015, an attestation (pursuant to section 413.65(b)(3) of title 42 of the Code of Federal Regulations) that such department was a department of a provider (as so defined).

(iv) ALTERNATIVE EXCEPTION BEGINNING WITH 2018.—For purposes of paragraph (1)(B)(v) and this paragraph with respect to applicable items and services fur-

nished during 2018 or a subsequent year, the term "off-campus outpatient department of a provider" also shall not include a department of a provider (as so defined) that is not described in clause (ii) if—

(I) the Secretary receives from the provider an attestation (pursuant to such section 413.65(b)(3)) not later than December 31, 2016 (or, if later, 60 days after the date of the enactment of this clause), that such department met the requirements of a department of a provider specified in section 413.65 of title 42 of the Code of Federal Regulations;

(II) the provider includes such department as part of the provider on its enrollment form in accordance with the enrollment process under section 1866(j); and

(III) the department met the mid-build requirement of clause (v) and the Secretary receives, not later than 60 days after the date of the enactment of this clause, from the chief executive officer or chief operating officer of the provider a written certification that the department met such requirement.

(v) MID-BUILD REQUIREMENT DESCRIBED.—The mid-build requirement of this clause is, with respect to a department of a provider, that before November 2, 2015, the provider had a binding written agreement with an outside unrelated party for the actual construction of such department.

(vi) EXCLUSION FOR CERTAIN CANCER HOSPITALS.—For purposes of paragraph (1)(B)(v) and this paragraph with respect to applicable items and services furnished during 2017 or a subsequent year, the term "off-campus outpatient department of a provider" also shall not include a department of a provider (as so defined) that is not described in clause (ii) if the provider is a hospital described in section 1886(d)(1)(B)(v) and—

(I) in the case of a department that met the requirements of section 413.65 of title 42 of the Code of Federal Regulations after November 1, 2015, and before the date of the enactment of this clause, the Secretary receives from the provider an attestation that such department met such requirements not later than 60 days after such date of enactment; or

(II) in the case of a department that meets such requirements after such date of enactment, the Secretary receives from the provider an attestation that such department meets such requirements not later than 60 days after the date such requirements are first met with respect to such department.

(vii) AUDIT.—Not later than December 31, 2018, the Secretary shall audit the compliance with requirements of clause (iv) with respect to each department of a pro-

vider to which such clause applies. Not later than 2 years after the date the Secretary receives an attestation under clause (vi) relating to compliance of a department of a provider with requirements referred to in such clause, the Secretary shall audit the compliance with such requirements with respect to the department. If the Secretary finds as a result of an audit under this clause that the applicable requirements were not met with respect to such department, the department shall not be excluded from the term "off-campus outpatient department of a provider" under such clause.

(viii) IMPLEMENTATION.—For purposes of implementing clauses (iii) through (vii):

(I) Notwithstanding any other provision of law, the Secretary may implement such clauses by program instruction or otherwise.

(II) Subchapter I of chapter 35 of title 44, United States Code, shall not apply.

(III) For purposes of carrying out this subparagraph with respect to clauses (iii) and (iv) (and clause (vii) insofar as it relates to clause (iv)), the Secretary shall provide for the transfer from the Supplementary Medical Insurance Trust Fund under section 1841, of $10,000,000 to the Centers for Medicare & Medicaid Services Program Management Account to remain available until December 31, 2018. For purposes of carrying out this subparagraph with respect to clause (vi) (and clause (vii) insofar as it relates to such clause), the Secretary shall provide for the transfer from the Supplementary Medical Insurance Trust Fund under section 1841, of $2,000,000 to the Centers for Medicare & Medicaid Services Program Management Account to remain available until expended.

(C) AVAILABILITY OF PAYMENT UNDER OTHER PAYMENT SYSTEMS.—Payments for applicable items and services furnished by an off-campus outpatient department of a provider that are described in paragraph (1)(B)(v) shall be made under the applicable payment system under this part (other than under this subsection) if the requirements for such payment are otherwise met.

(D) INFORMATION NEEDED FOR IMPLEMENTATION.—Each hospital shall provide to the Secretary such information as the Secretary determines appropriate to implement this paragraph and paragraph (1)(B)(v) (which may include reporting of information on a hospital claim using a code or modifier and reporting information about off-campus outpatient departments of a provider on the enrollment form described in section 1866(j)).

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

(i) The determination of the applicable items and services under subparagraph (A) and applicable payment systems under subparagraph (C).

(ii) The determination of whether a department of a provider meets the term described in subparagraph (B).

(iii) Any information that hospitals are required to report pursuant to subparagraph (D).

(iv) The determination of an audit under subparagraph (B)(vii).

(u) INCENTIVE PAYMENTS FOR PHYSICIAN SCARCITY AREAS.—

(1) IN GENERAL.—In the case of physicians' services furnished on or after January 1, 2005, and before July 1, 2008—

(A) by a primary care physician in a primary care scarcity county (identified under paragraph (4)); or

(B) by a physician who is not a primary care physician in a specialist care scarcity county (as so identified),

in addition to the amount of payment that would otherwise be made for such services under this part, there also shall be paid an amount equal to 5 percent of the payment amount for the service under this part.

(2) DETERMINATION OF RATIOS OF PHYSICIANS TO MEDICARE BENEFICIARIES IN AREA.—Based upon available data, the Secretary shall establish for each county or equivalent area in the United States, the following:

(A) NUMBER OF PHYSICIANS PRACTICING IN THE AREA.—The number of physicians who furnish physicians' services in the active practice of medicine or osteopathy in that county or area, other than physicians whose practice is exclusively for the Federal Government, physicians who are retired, or physicians who only provide administrative services. Of such number, the number of such physicians who are—

(i) primary care physicians; or

(ii) physicians who are not primary care physicians.

(B) NUMBER OF MEDICARE BENEFICIARIES RESIDING IN THE AREA.—The number of individuals who are residing in the county and are entitled to benefits under part A or enrolled under this part, or both (in this subsection referred to as "individuals").

(C) DETERMINATION OF RATIOS.—

(i) PRIMARY CARE RATIO.—The ratio (in this paragraph referred to as the "primary care ratio") of the number of primary care physicians (determined under subparagraph (A)(i)), to the number of individuals determined under subparagraph (B).

(ii) SPECIALIST CARE RATIO.—The ratio (in this paragraph referred to as the "specialist care ratio") of the number of other physicians (determined under subparagraph (A)(ii)), to the number of individuals determined under subparagraph (B).

(3) RANKING OF COUNTIES.—The Secretary shall rank each such county or area based separately on its primary care ratio and its specialist care ratio.

(4) IDENTIFICATION OF COUNTIES.—

(A) IN GENERAL.—The Secretary shall identify—

(i) those counties and areas (in this paragraph referred to as "primary care scarcity counties") with the lowest primary care ratios that represent, if each such county or area were weighted by the number of individuals determined under paragraph (2)(B), an aggregate total of 20 percent of the total of the individuals determined under such paragraph; and

(ii) those counties and areas (in this subsection referred to as "specialist care scarcity counties") with the lowest specialist care ratios that represent, if each such county or area were weighted by the number of individuals determined under paragraph (2)(B), an aggregate total of 20 percent of the total of the individuals determined under such paragraph.

(B) PERIODIC REVISIONS.—The Secretary shall periodically revise the counties or areas identified in subparagraph (A) (but not less often than once every three years) unless the Secretary determines that there is no new data available on the number of physicians practicing in the county or area or the number of individuals residing in the county or area, as identified in paragraph (2).

(C) IDENTIFICATION OF COUNTIES WHERE SERVICE IS FURNISHED.—For purposes of paying the additional amount specified in paragraph (1), if the Secretary uses the 5-digit postal ZIP Code where the service is furnished, the dominant county of the postal ZIP Code (as determined by the United States Postal Service, or otherwise) shall be used to determine whether the postal ZIP Code is in a scarcity county identified in subparagraph (A) or revised in subparagraph (B).

(D) SPECIAL RULE.—With respect to physicians' services furnished on or after January 1, 2008, and before July 1, 2008, for purposes of this subsection, the Secretary shall use the primary care scarcity counties and the specialty care scarcity counties (as identified under the preceding provisions of this paragraph) that the Secretary was using under this subsection with respect to physicians' services furnished on December 31, 2007.

(E) JUDICIAL REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise, respecting—

116.(i) the identification of a county or area;

(ii) the assignment of a specialty of any physician under this paragraph;

(iii) the assignment of a physician to a county under paragraph (2); or

(iv) the assignment of a postal ZIP Code to a county or other area under this subsection.

(5) RURAL CENSUS TRACTS.—To the extent feasible, the Secretary shall treat a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725)), as an equivalent area for purposes of qualifying as a primary care

scarcity county or specialist care scarcity county under this subsection.

(6) PHYSICIAN DEFINED.—For purposes of this paragraph, the term "physician" means a physician described in section 1861(r)(1) and the term "primary care physician" means a physician who is identified in the available data as a general practitioner, family practice practitioner, general internist, or obstetrician or gynecologist.

(7) PUBLICATION OF LIST OF COUNTIES; POSTING ON WEBSITE.—With respect to a year for which a county or area is identified or revised under paragraph (4), the Secretary shall identify such counties or areas as part of the proposed and final rule to implement the physician fee schedule under section 1848 for the applicable year. The Secretary shall post the list of counties identified or revised under paragraph (4) on the Internet website of the Centers for Medicare & Medicaid Services.

(v) INCREASE OF FQHC PAYMENT LIMITS.—In the case of services furnished by Federally qualified health centers (as defined in section 1861(aa)(4)), the Secretary shall establish payment limits with respect to such services under this part for services furnished—

(1) in 2010, at the limits otherwise established under this part for such year increased by $5; and

(2) in a subsequent year, at the limits established under this subsection for the previous year increased by the percentage increase in the MEI (as defined in section 1842(i)(3)) for such subsequent year.

(w) METHODS OF PAYMENT.—The Secretary may develop alternative methods of payment for items and services provided under clinical trials and comparative effectiveness studies sponsored or supported by an agency of the Department of Health and Human Services, as determined by the Secretary, to those that would otherwise apply under this section, to the extent such alternative methods are necessary to preserve the scientific validity of such trials or studies, such as in the case where masking the identity of interventions from patients and investigators is necessary to comply with the particular trial or study design.

(x) INCENTIVE PAYMENTS FOR PRIMARY CARE SERVICES.—

(1) IN GENERAL.—In the case of primary care services furnished on or after January 1, 2011, and before January 1, 2016, by a primary care practitioner, in addition to the amount of payment that would otherwise be made for such services under this part, there also shall be paid (on a monthly or quarterly basis) an amount equal to 10 percent of the payment amount for the service under this part.

(2) DEFINITIONS.—In this subsection:

(A) PRIMARY CARE PRACTITIONER.—The term "primary care practitioner" means an individual—

(i) who—

(I) is a physician (as described in section 1861(r)(1)) who has a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine; or

(II) is a nurse practitioner, clinical nurse specialist, or physician assistant (as those terms are defined in section 1861(aa)(5)); and

(ii) for whom primary care services accounted for at least 60 percent of the allowed charges under this part for such physician or practitioner in a prior period as determined appropriate by the Secretary.

(B) PRIMARY CARE SERVICES.—The term "primary care services" means services identified, as of January 1, 2009, by the following HCPCS codes (and as subsequently modified by the Secretary):

(i) 99201 through 99215.

(ii) 99304 through 99340.

(iii) 99341 through 99350.

(3) COORDINATION WITH OTHER PAYMENTS.—The amount of the additional payment for a service under this subsection and subsection (m) shall be determined without regard to any additional payment for the service under subsection (m) and this subsection, respectively. The amount of the additional payment for a service under this subsection and subsection (z) shall be determined without regard to any additional payment for the service under subsection (z) and this subsection, respectively.

(4) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise, respecting the identification of primary care practitioners under this subsection.

(y) INCENTIVE PAYMENTS FOR MAJOR SURGICAL PROCEDURES FURNISHED IN HEALTH PROFESSIONAL SHORTAGE AREAS.—

(1) IN GENERAL.—In the case of major surgical procedures furnished on or after January 1, 2011, and before January 1, 2016, by a general surgeon in an area that is designated (under section 332(a)(1)(A) of the Public Health Service Act) as a health professional shortage area as identified by the Secretary prior to the beginning of the year involved, in addition to the amount of payment that would otherwise be made for such services under this part, there also shall be paid (on a monthly or quarterly basis) an amount equal to 10 percent of the payment amount for the service under this part.

(2) DEFINITIONS.—In this subsection:

(A) GENERAL SURGEON.—In this subsection, the term "general surgeon" means a physician (as described in section 1861(r)(1)) who has designated CMS specialty code 02–General Surgery as their primary specialty code in the physician's enrollment under section 1866(j).

(B) MAJOR SURGICAL PROCEDURES.—The term "major surgical procedures" means physicians' services which are surgical procedures for which a 10-day or 90-day global period is used for payment under the fee schedule under section 1848(b).

(3) COORDINATION WITH OTHER PAYMENTS.—The amount of the additional payment for a service under this subsection and subsection (m) shall be determined without regard to any additional payment for the service under subsection (m) and this subsection, respectively. The amount of the additional payment for a service under this subsection and subsection (z) shall be

determined without regard to any additional payment for the service under subsection (z) and this subsection, respectively.

(4) APPLICATION.—The provisions of paragraph (2) and (4) of subsection (m) shall apply to the determination of additional payments under this subsection in the same manner as such provisions apply to the determination of additional payments under subsection (m).

(z) INCENTIVE PAYMENTS FOR PARTICIPATION IN ELIGIBLE ALTERNATIVE PAYMENT MODELS.—

(1) PAYMENT INCENTIVE.—

(A) IN GENERAL.—In the case of covered professional services furnished by an eligible professional during a year that is in the period beginning with 2019 and ending with 2024 and for which the professional is a qualifying APM participant with respect to such year, in addition to the amount of payment that would otherwise be made for such covered professional services under this part for such year, there also shall be paid to such professional an amount equal to 5 percent of the estimated aggregate payment amounts for such covered professional services under this part for the preceding year. For purposes of the previous sentence, the payment amount for the preceding year may be an estimation for the full preceding year based on a period of such preceding year that is less than the full year. The Secretary shall establish policies to implement this subparagraph in cases in which payment for covered professional services furnished by a qualifying APM participant in an alternative payment model—

(i) is made to an eligible alternative payment entity rather than directly to the qualifying APM participant; or

(ii) is made on a basis other than a fee-for-service basis (such as payment on a capitated basis).

(B) FORM OF PAYMENT.—Payments under this subsection shall be made in a lump sum, on an annual basis, as soon as practicable.

(C) TREATMENT OF PAYMENT INCENTIVE.—Payments under this subsection shall not be taken into account for purposes of determining actual expenditures under an alternative payment model and for purposes of determining or rebasing any benchmarks used under the alternative payment model.

(D) COORDINATION.—The amount of the additional payment under this subsection or subsection (m) shall be determined without regard to any additional payment under subsection (m) and this subsection, respectively. The amount of the additional payment under this subsection or subsection (x) shall be determined without regard to any additional payment under subsection (x) and this subsection, respectively. The amount of the additional payment under this subsection or subsection (y) shall be determined without regard to any additional payment under subsection (y) and this subsection, respectively.

(2) QUALIFYING APM PARTICIPANT.—For purposes of this subsection, the term "qualifying APM participant" means the following:

(A) 2019 AND 2020.—With respect to 2019 and 2020, an eligible professional for whom the Secretary determines that at least 25 percent of payments under this part for covered professional services furnished by such professional during the most recent period for which data are available (which may be less than a year) were attributable to such services furnished under this part through an eligible alternative payment entity.

(B) 2021 AND 2022.—With respect to 2021 and 2022, an eligible professional described in either of the following clauses:

(i) MEDICARE PAYMENT THRESHOLD OPTION.—An eligible professional for whom the Secretary determines that at least 50 percent of payments under this part for covered professional services furnished by such professional during the most recent period for which data are available (which may be less than a year) were attributable to such services furnished under this part through an eligible alternative payment entity.

(ii) COMBINATION ALL-PAYER AND MEDICARE PAYMENT THRESHOLD OPTION.—An eligible professional—

(I) for whom the Secretary determines, with respect to items and services furnished by such professional during the most recent period for which data are available (which may be less than a year), that at least 50 percent of the sum of—

(aa) payments described in clause (i); and

(bb) all other payments, regardless of payer (other than payments made by the Secretary of Defense or the Secretary of Veterans Affairs and other than payments made under title XIX in a State in which no medical home or alternative payment model is available under the State program under that title),

meet the requirement described in clause (iii)(I) with respect to payments described in item (aa) and meet the requirement described in clause (iii)(II) with respect to payments described in item (bb);

(II) for whom the Secretary determines at least 25 percent of payments under this part for covered professional services furnished by such professional during the most recent period for which data are available (which may be less than a year) were attributable to such services furnished under this part through an eligible alternative payment entity; and

(III) who provides to the Secretary such information as is necessary for the Secretary to make a determination under subclause (I), with respect to such professional.

(iii) REQUIREMENT.—For purposes of clause (ii)(I)—

(I) the requirement described in this subclause, with respect to payments described in item (aa) of such clause, is that such payments are made to an eligible alternative payment entity; and

(II) the requirement described in this subclause, with respect to payments described in item (bb) of such clause, is that such payments are made under arrangements in which—

(aa) quality measures comparable to measures under the performance category described in section 1848(q)(2)(B)(i) apply;

(bb) certified EHR technology is used; and

(cc) the eligible professional participates in an entity that—

(AA) bears more than nominal financial risk if actual aggregate expenditures exceeds expected aggregate expenditures; or

(BB) with respect to beneficiaries under title XIX, is a medical home that meets criteria comparable to medical homes expanded under section 1115A(c).

(C) BEGINNING IN 2023.—With respect to 2023 and each subsequent year, an eligible professional described in either of the following clauses:

(i) MEDICARE PAYMENT THRESHOLD OPTION.—An eligible professional for whom the Secretary determines that at least 75 percent of payments under this part for covered professional services furnished by such professional during the most recent period for which data are available (which may be less than a year) were attributable to such services furnished under this part through an eligible alternative payment entity.

(ii) COMBINATION ALL-PAYER AND MEDICARE PAYMENT THRESHOLD OPTION.—An eligible professional—

(I) for whom the Secretary determines, with respect to items and services furnished by such professional during the most recent period for which data are available (which may be less than a year), that at least 75 percent of the sum of—

(aa) payments described in clause (i); and

(bb) all other payments, regardless of payer (other than payments made by the Secretary of Defense or the Secretary of Veterans Affairs and other than payments made under title XIX in a State in which no medical home or alternative payment model is available under the State program under that title),

meet the requirement described in clause (iii)(I) with respect to payments described in item (aa) and meet the requirement described in clause (iii)(II) with respect to payments described in item (bb);

(II) for whom the Secretary determines at least 25 percent of payments under this part for covered professional services furnished by such pro-

fessional during the most recent period for which data are available (which may be less than a year) were attributable to such services furnished under this part through an eligible alternative payment entity; and

(III) who provides to the Secretary such information as is necessary for the Secretary to make a determination under subclause (I), with respect to such professional.

(iii) REQUIREMENT.—For purposes of clause (ii)(I)—

(I) the requirement described in this subclause, with respect to payments described in item (aa) of such clause, is that such payments are made to an eligible alternative payment entity; and

(II) the requirement described in this subclause, with respect to payments described in item (bb) of such clause, is that such payments are made under arrangements in which—

(aa) quality measures comparable to measures under the performance category described in section 1848(q)(2)(B)(i) apply;

(bb) certified EHR technology is used; and

(cc) the eligible professional participates in an entity that—

(AA) bears more than nominal financial risk if actual aggregate expenditures exceeds expected aggregate expenditures; or

(BB) with respect to beneficiaries under title XIX, is a medical home that meets criteria comparable to medical homes expanded under section 1115A(c).

(D) USE OF PATIENT APPROACH.—The Secretary may base the determination of whether an eligible professional is a qualifying APM participant under this subsection and the determination of whether an eligible professional is a partial qualifying APM participant under section 1848(q)(1)(C)(iii) by using counts of patients in lieu of using payments and using the same or similar percentage criteria (as specified in this subsection and such section, respectively), as the Secretary determines appropriate.

(3) ADDITIONAL DEFINITIONS.—In this subsection:

(A) COVERED PROFESSIONAL SERVICES.—The term "covered professional services" has the meaning given that term in section 1848(k)(3)(A).

(B) ELIGIBLE PROFESSIONAL.—The term "eligible professional" has the meaning given that term in section 1848(k)(3)(B) and includes a group that includes such professionals.

(C) ALTERNATIVE PAYMENT MODEL (APM).—The term "alternative payment model" means, other than for purposes of subparagraphs (B)(ii)(I)(bb) and (C)(ii)(I)(bb) of paragraph (2), any of the following:

(i) A model under section 1115A (other than a health care innovation award).

(ii) The shared savings program under section 1899.

(iii) A demonstration under section 1866C.

(iv) A demonstration required by Federal law.

(D) ELIGIBLE ALTERNATIVE PAYMENT ENTITY.—The term "eligible alternative payment entity" means, with respect to a year, an entity that—

(i) participates in an alternative payment model that—

(I) requires participants in such model to use certified EHR technology (as defined in subsection (o)(4)); and

(II) provides for payment for covered professional services based on quality measures comparable to measures under the performance category described in section 1848(q)(2)(B)(i); and

(ii)(I) bears financial risk for monetary losses under such alternative payment model that are in excess of a nominal amount; or

(II) is a medical home expanded under section 1115A(c).

(4) LIMITATION.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise, of the following:

(A) The determination that an eligible professional is a qualifying APM participant under paragraph (2) and the determination that an entity is an eligible alternative payment entity under paragraph (3)(D).

(B) The determination of the amount of the 5 percent payment incentive under paragraph (1)(A), including any estimation as part of such determination.

(z) MEDICAL REVIEW OF SPINAL SUBLUXATION SERVICES.—

(1) IN GENERAL.—The Secretary shall implement a process for the medical review (as described in paragraph (2)) of treatment by a chiropractor described in section 1861(r)(5) by means of manual manipulation of the spine to correct a subluxation (as described in such section) of an individual who is enrolled under this part and apply such process to such services furnished on or after January 1, 2017, focusing on services such as—

(A) services furnished by a such a chiropractor whose pattern of billing is aberrant compared to peers; and

(B) services furnished by such a chiropractor who, in a prior period, has a services denial percentage in the 85th percentile or greater, taking into consideration the extent that service denials are overturned on appeal.

(2) MEDICAL REVIEW.—

(A) PRIOR AUTHORIZATION MEDICAL REVIEW.—

(i) IN GENERAL.—Subject to clause (ii), the Secretary shall use prior authorization medical review for services described in paragraph (1) that are furnished to an individual by a chiropractor described in section 1861(r)(5) that are part of an episode of treatment that includes more than 12 services. For purposes of the preceding sentence, an episode of treatment shall be determined by the underlying cause that justifies the need for services, such as a diagnosis code.

(ii) ENDING APPLICATION OF PRIOR AUTHORIZATION MEDICAL REVIEW.—The Secretary shall end the application of prior authorization medical review under clause (i) to services described in paragraph (1) by such a chiropractor if the Secretary determines that the chiropractor has a low denial rate under such prior authorization medical review. The Secretary may subsequently reapply prior authorization medical review to such chiropractor if the Secretary determines it to be appropriate and the chiropractor has, in the time period subsequent to the determination by the Secretary of a low denial rate with respect to the chiropractor, furnished such services described in paragraph (1).

(iii) EARLY REQUEST FOR PRIOR AUTHORIZATION REVIEW PERMITTED.—Nothing in this subsection shall be construed to prevent such a chiropractor from requesting prior authorization for services described in paragraph (1) that are to be furnished to an individual before the chiropractor furnishes the twelfth such service to such individual for an episode of treatment.

(B) TYPE OF REVIEW.—The Secretary may use pre-payment review or post-payment review of services described in section 1861(r)(5) that are not subject to prior authorization medical review under subparagraph (A).

(C) RELATIONSHIP TO LAW ENFORCEMENT ACTIVITIES.—The Secretary may determine that medical review under this subsection does not apply in the case where potential fraud may be involved.

(3) NO PAYMENT WITHOUT PRIOR AUTHORIZATION.—With respect to a service described in paragraph (1) for which prior authorization medical review under this subsection applies, the following shall apply:

(A) PRIOR AUTHORIZATION DETERMINATION.—The Secretary shall make a determination, prior to the service being furnished, of whether the service would or would not meet the applicable requirements of section 1862(a)(1)(A).

(B) DENIAL OF PAYMENT.—Subject to paragraph (5), no payment may be made under this part for the service unless the Secretary determines pursuant to subparagraph (A) that the service would meet the applicable requirements of such section 1862(a)(1)(A).

(4) SUBMISSION OF INFORMATION.—A chiropractor described in section 1861(r)(5) may submit the information necessary for medical review by fax, by mail, or by electronic means. The Secretary shall make available the electronic means described in the preceding sentence as soon as practicable.

(5) TIMELINESS.—If the Secretary does not make a prior authorization determination under paragraph (3)(A) within 14 business days of the date of the receipt of medical documentation needed to make such determination, paragraph (3)(B) shall not apply.

(6) APPLICATION OF LIMITATION ON BENEFICIARY LIABILITY.—Where payment may not be made as a result of the application of paragraph (2)(B), section 1879 shall apply in the same man-

ner as such section applies to a denial that is made by reason of section 1862(a)(1).

(7) REVIEW BY CONTRACTORS.—The medical review described in paragraph (2) may be conducted by medicare administrative contractors pursuant to section 1874A(a)(4)(G) or by any other contractor determined appropriate by the Secretary that is not a recovery audit contractor.

(8) MULTIPLE SERVICES.—The Secretary shall, where practicable, apply the medical review under this subsection in a manner so as to allow an individual described in paragraph (1) to obtain, at a single time rather than on a service-by-service basis, an authorization in accordance with paragraph (3)(A) for multiple services.

(9) CONSTRUCTION.—With respect to a service described in paragraph (1) that has been affirmed by medical review under this subsection, nothing in this subsection shall be construed to preclude the subsequent denial of a claim for such service that does not meet other applicable requirements under this Act.

(10) IMPLEMENTATION.—

(A) AUTHORITY.—The Secretary may implement the provisions of this subsection by interim final rule with comment period.

(B) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to medical review under this subsection.

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PAYMENT FOR PHYSICIANS' SERVICES

SEC. 1848. (a) PAYMENT BASED ON FEE SCHEDULE.—

(1) IN GENERAL.—Effective for all physicians' services (as defined in subsection (j)(3)) furnished under this part during a year (beginning with 1992) for which payment is otherwise made on the basis of a reasonable charge or on the basis of a fee schedule under section 1834(b), payment under this part shall instead be based on the lesser of—

(A) the actual charge for the service, or

(B) subject to the succeeding provisions of this subsection, the amount determined under the fee schedule established under subsection (b) for services furnished during that year (in this subsection referred to as the "fee schedule amount").

(2) TRANSITION TO FULL FEE SCHEDULE.—

(A) LIMITING REDUCTIONS AND INCREASES TO 15 PERCENT IN 1992.—

(i) LIMIT ON INCREASE.—In the case of a service in a fee schedule area (as defined in subsection (j)(2)) for which the adjusted historical payment basis (as defined in subparagraph (D)) is less than 85 percent of the fee schedule amount for services furnished in 1992, there shall be substituted for the fee schedule amount an amount equal to the adjusted historical payment basis plus 15 percent of the fee schedule

amount otherwise established (without regard to this paragraph).

(ii) LIMIT IN REDUCTION.—In the case of a service in a fee schedule area for which the adjusted historical payment basis exceeds 115 percent of the fee schedule amount for services furnished in 1992, there shall be substituted for the fee schedule amount an amount equal to the adjusted historical payment basis minus 15 percent of the fee schedule amount otherwise established (without regard to this paragraph).

(B) SPECIAL RULE FOR 1993, 1994, AND 1995.—If a physicians' service in a fee schedule area is subject to the provisions of subparagraph (A) in 1992, for physicians' services furnished in the area—

(i) during 1993, there shall be substituted for the fee schedule amount an amount equal to the sum of—

(I) 75 percent of the fee schedule amount determined under subparagraph (A), adjusted by the update established under subsection (d)(3) for 1993, and

(II) 25 percent of the fee schedule amount determined under paragraph (1) for 1993 without regard to this paragraph;

(ii) during 1994, there shall be substituted for the fee schedule amount an amount equal to the sum of—

(I) 67 percent of the fee schedule amount determined under clause (i), adjusted by the update established under subsection (d)(3) for 1994 and as adjusted under subsection (c)(2)(F)(ii) and under section 13515(b) of the Omnibus Budget Reconciliation Act of 1993, and

(II) 33 percent of the fee schedule amount determined under paragraph (1) for 1994 without regard to this paragraph; and

(iii) during 1995, there shall be substituted for the fee schedule amount an amount equal to the sum of—

(I) 50 percent of the fee schedule amount determined under clause (ii) adjusted by the update established under subsection (d)(3) for 1995, and

(II) 50 percent of the fee schedule amount determined under paragraph (1) for 1995 without regard to this paragraph.

(C) SPECIAL RULE FOR ANESTHESIA AND RADIOLOGY SERVICES.—With respect to physicians' services which are anesthesia services, the Secretary shall provide for a transition in the same manner as a transition is provided for other services under subparagraph (B). With respect to radiology services, "109 percent" and "9 percent" shall be substituted for "115 percent" and "15 percent", respectively, in subparagraph (A)(ii).

(D) ADJUSTED HISTORICAL PAYMENT BASIS DEFINED.—

(i) IN GENERAL.—In this paragraph, the term "adjusted historical payment basis" means, with respect to a physicians' service furnished in a fee schedule area, the weighted average prevailing charge applied

in the area for the service in 1991 (as determined by the Secretary without regard to physician specialty and as adjusted to reflect payments for services with customary charges below the prevailing charge or other payment limitations imposed by law or regulation) adjusted by the update established under subsection (d)(3) for 1992.

(ii) APPLICATION TO RADIOLOGY SERVICES.—In applying clause (i) in the case of physicians' services which are radiology services (including radiologist services, as defined in section 1834(b)(6)), but excluding nuclear medicine services that are subject to section 6105(b) of the Omnibus Budget Reconciliation Act of 1989, there shall be substituted for the weighted average prevailing charge the amount provided under the fee schedule established for the service for the fee schedule area under section 1834(b).

(iii) NUCLEAR MEDICINE SERVICES.—In applying clause (i) in the case of physicians' services which are nuclear medicine services, there shall be substituted for the weighted average prevailing charge the amount provided under section 6105(b) of the Omnibus Budget Reconciliation Act of 1989.

(3) INCENTIVES FOR PARTICIPATING PHYSICIANS AND SUPPLIERS.—In applying paragraph (1)(B) in the case of a nonparticipating physician or a nonparticipating supplier or other person, the fee schedule amount shall be 95 percent of such amount otherwise applied under this subsection (without regard to this paragraph). In the case of physicians' services (including services which the Secretary excludes pursuant to subsection (j)(3)) of a nonparticipating physician, supplier, or other person for which payment is made under this part on a basis other than the fee schedule amount, the payment shall be based on 95 percent of the payment basis for such services furnished by a participating physician, supplier, or other person.

(4) SPECIAL RULE FOR MEDICAL DIRECTION.—

(A) IN GENERAL.—With respect to physicians' services furnished on or after January 1, 1994, and consisting of medical direction of two, three, or four concurrent anesthesia cases, except as provided in paragraph (5), the fee schedule amount to be applied shall be equal to one-half of the amount described in subparagraph (B).

(B) AMOUNT.—The amount described in this subparagraph, for a physician's medical direction of the performance of anesthesia services, is the following percentage of the fee schedule amount otherwise applicable under this section if the anesthesia services were personally performed by the physician alone:

(i) For services furnished during 1994, 120 percent.

(ii) For services furnished during 1995, 115 percent.

(iii) For services furnished during 1996, 110 percent.

(iv) For services furnished during 1997, 105 percent.

(v) For services furnished after 1997, 100 percent.

(5) INCENTIVES FOR ELECTRONIC PRESCRIBING.—

(A) ADJUSTMENT.—

(i) IN GENERAL.—Subject to subparagraph (B) and subsection (m)(2)(B), with respect to covered professional services furnished by an eligible professional during 2012, 2013 or 2014, if the eligible professional is not a successful electronic prescriber for the reporting period for the year (as determined under subsection (m)(3)(B)), the fee schedule amount for such services furnished by such professional during the year (including the fee schedule amount for purposes of determining a payment based on such amount) shall be equal to the applicable percent of the fee schedule amount that would otherwise apply to such services under this subsection (determined after application of paragraph (3) but without regard to this paragraph).

(ii) APPLICABLE PERCENT.—For purposes of clause (i), the term "applicable percent" means—

(I) for 2012, 99 percent;

(II) for 2013, 98.5 percent; and

(III) for 2014, 98 percent.

(B) SIGNIFICANT HARDSHIP EXCEPTION.—The Secretary may, on a case-by-case basis, exempt an eligible professional from the application of the payment adjustment under subparagraph (A) if the Secretary determines, subject to annual renewal, that compliance with the requirement for being a successful electronic prescriber would result in a significant hardship, such as in the case of an eligible professional who practices in a rural area without sufficient Internet access.

(C) APPLICATION.—

(i) PHYSICIAN REPORTING SYSTEM RULES.—Paragraphs (5), (6), and (8) of subsection (k) shall apply for purposes of this paragraph in the same manner as they apply for purposes of such subsection.

(ii) INCENTIVE PAYMENT VALIDATION RULES.—Clauses (ii) and (iii) of subsection (m)(5)(D) shall apply for purposes of this paragraph in a similar manner as they apply for purposes of such subsection.

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

(i) ELIGIBLE PROFESSIONAL; COVERED PROFESSIONAL SERVICES.—The terms "eligible professional" and "covered professional services" have the meanings given such terms in subsection (k)(3).

(ii) PHYSICIAN REPORTING SYSTEM.—The term "physician reporting system" means the system established under subsection (k).

(iii) REPORTING PERIOD.—The term "reporting period" means, with respect to a year, a period specified by the Secretary.

(6) SPECIAL RULE FOR TEACHING ANESTHESIOLOGISTS.—With respect to physicians' services furnished on or after January 1, 2010, in the case of teaching anesthesiologists involved in the training of physician residents in a single anesthesia case or two concurrent anesthesia cases, the fee schedule amount to be applied shall be 100 percent of the fee schedule amount other-

wise applicable under this section if the anesthesia services were personally performed by the teaching anesthesiologist alone and paragraph (4) shall not apply if—

(A) the teaching anesthesiologist is present during all critical or key portions of the anesthesia service or procedure involved; and

(B) the teaching anesthesiologist (or another anesthesiologist with whom the teaching anesthesiologist has entered into an arrangement) is immediately available to furnish anesthesia services during the entire procedure.

(7) INCENTIVES FOR MEANINGFUL USE OF CERTIFIED EHR TECHNOLOGY.—

(A) ADJUSTMENT.—

(i) IN GENERAL.—Subject to subparagraphs (B) and (D), with respect to covered professional services furnished by an eligible professional during each of 2015 through 2018, if the eligible professional is not a meaningful EHR user (as determined under subsection (o)(2)) for an EHR reporting period for the year, the fee schedule amount for such services furnished by such professional during the year (including the fee schedule amount for purposes of determining a payment based on such amount) shall be equal to the applicable percent of the fee schedule amount that would otherwise apply to such services under this subsection (determined after application of paragraph (3) but without regard to this paragraph).

(ii) APPLICABLE PERCENT.—Subject to clause (iii), for purposes of clause (i), the term "applicable percent" means—

(I) for 2015, 99 percent (or, in the case of an eligible professional who was subject to the application of the payment adjustment under section 1848(a)(5) for 2014, 98 percent);

(II) for 2016, 98 percent; and

(III) for 2017 and 2018, 97 percent.

(iii) AUTHORITY TO DECREASE APPLICABLE PERCENTAGE FOR 2018.—For 2018, if the Secretary finds that the proportion of eligible professionals who are meaningful EHR users (as determined under subsection (o)(2)) is less than 75 percent, the applicable percent shall be decreased by 1 percentage point from the applicable percent in the preceding year.

(B) SIGNIFICANT HARDSHIP EXCEPTION.—The Secretary may, on a case-by-case basis (and, with respect to the payment adjustment under subparagraph (A) for 2017, for categories of eligible professionals, as established by the Secretary and posted on the Internet website of the Centers for Medicare & Medicaid Services prior to December 15, 2015, an application for which must be submitted to the Secretary by not later than March 15, 2016), exempt an eligible professional from the application of the payment adjustment under subparagraph (A) if the Secretary determines, subject to annual renewal, that compliance with the requirement for being a meaningful EHR user would re-

sult in a significant hardship, such as in the case of an eligible professional who practices in a rural area without sufficient Internet access. In no case may an eligible professional be granted an exemption under this subparagraph for more than 5 years.

(C) APPLICATION OF PHYSICIAN REPORTING SYSTEM RULES.—Paragraphs (5), (6), and (8) of subsection (k) shall apply for purposes of this paragraph in the same manner as they apply for purposes of such subsection.

(D) NON-APPLICATION TO [HOSPITAL-BASED ELIGIBLE PROFESSIONALS] *HOSPITAL-BASED AND AMBULATORY SURGICAL CENTER-BASED ELIGIBLE PROFESSIONALS*.—[No payment]

(i) HOSPITAL-BASED.—No payment adjustment may be made under subparagraph (A) in the case of hospital-based eligible professionals (as defined in subsection (o)(1)(C)(ii)).

(ii) AMBULATORY SURGICAL CENTER-BASED.—Subject to clause (iv), no payment adjustment may be made under subparagraph (A) for 2017 and 2018 in the case of an eligible professional with respect to whom substantially all of the covered professional services furnished by such professional are furnished in an ambulatory surgical center.

(iii) DETERMINATION.—The determination of whether an eligible professional is an eligible professional described in clause (ii) may be made on the basis of—

(I) the site of service (as defined by the Secretary); or

(II) an attestation submitted by the eligible professional.

Determinations made under subclauses (I) and (II) shall be made without regard to any employment or billing arrangement between the eligible professional and any other supplier or provider of services.

(iv) SUNSET.—Clause (ii) shall no longer apply as of the first year that begins more than 3 years after the date on which the Secretary determines, through notice and comment rulemaking, that certified EHR technology applicable to the ambulatory surgical center setting is available.

(E) DEFINITIONS.—For purposes of this paragraph:

(i) COVERED PROFESSIONAL SERVICES.—The term "covered professional services" has the meaning given such term in subsection (k)(3).

(ii) EHR REPORTING PERIOD.—The term "EHR reporting period" means, with respect to a year, a period (or periods) specified by the Secretary.

(iii) ELIGIBLE PROFESSIONAL.—The term "eligible professional" means a physician, as defined in section 1861(r).

(8) INCENTIVES FOR QUALITY REPORTING.—

(A) ADJUSTMENT.—

(i) IN GENERAL.—With respect to covered professional services furnished by an eligible professional during each of 2015 through 2018, if the eligible pro-

fessional does not satisfactorily submit data on quality measures for covered professional services for the quality reporting period for the year (as determined under subsection (m)(3)(A)), the fee schedule amount for such services furnished by such professional during the year (including the fee schedule amount for purposes of determining a payment based on such amount) shall be equal to the applicable percent of the fee schedule amount that would otherwise apply to such services under this subsection (determined after application of paragraphs (3), (5), and (7), but without regard to this paragraph).

(ii) APPLICABLE PERCENT.—For purposes of clause (i), the term "applicable percent" means—

(I) for 2015, 98.5 percent; and

(II) for 2016, 2017, and 2018, 98 percent.

(B) APPLICATION.—

(i) PHYSICIAN REPORTING SYSTEM RULES.—Paragraphs (5), (6), and (8) of subsection (k) shall apply for purposes of this paragraph in the same manner as they apply for purposes of such subsection.

(ii) INCENTIVE PAYMENT VALIDATION RULES.—Clauses (ii) and (iii) of subsection (m)(5)(D) shall apply for purposes of this paragraph in a similar manner as they apply for purposes of such subsection.

(C) DEFINITIONS.—For purposes of this paragraph:

(i) ELIGIBLE PROFESSIONAL; COVERED PROFESSIONAL SERVICES.—The terms "eligible professional" and "covered professional services" have the meanings given such terms in subsection (k)(3).

(ii) PHYSICIAN REPORTING SYSTEM.—The term "physician reporting system" means the system established under subsection (k).

(iii) QUALITY REPORTING PERIOD.—The term "quality reporting period" means, with respect to a year, a period specified by the Secretary.

(9) INFORMATION REPORTING ON SERVICES INCLUDED IN GLOBAL SURGICAL PACKAGES.—With respect to services for which a physician is required to report information in accordance with subsection (c)(8)(B)(i), the Secretary may through rulemaking delay payment of 5 percent of the amount that would otherwise be payable under the physician fee schedule under this section for such services until the information so required is reported.

(b) ESTABLISHMENT OF FEE SCHEDULES.—

(1) IN GENERAL.—Before November 1 of the preceding year, for each year beginning with 1998, subject to subsection (p), the Secretary shall establish, by regulation, fee schedules that establish payment amounts for all physicians' services furnished in all fee schedule areas (as defined in subsection (j)(2)) for the year. Except as provided in paragraph (2), each such payment amount for a service shall be equal to the product of—

(A) the relative value for the service (as determined in subsection (c)(2)),

(B) the conversion factor (established under subsection (d)) for the year, and

(C) the geographic adjustment factor (established under subsection (e)(2)) for the service for the fee schedule area.

(2) TREATMENT OF RADIOLOGY SERVICES AND ANESTHESIA SERVICES.—

(A) RADIOLOGY SERVICES.—With respect to radiology services (including radiologist services, as defined in section 1834(b)(6)), the Secretary shall base the relative values on the relative value scale developed under section 1834(b)(1)(A), with appropriate modifications of the relative values to assure that the relative values established for radiology services which are similar or related to other physicians' services are consistent with the relative values established for those similar or related services.

(B) ANESTHESIA SERVICES.—In establishing the fee schedule for anesthesia services for which a relative value guide has been established under section 4048(b) of the Omnibus Budget Reconciliation Act of 1987, the Secretary shall use, to the extent practicable, such relative value guide, with appropriate adjustment of the conversion factor, in a manner to assure that the fee schedule amounts for anesthesia services are consistent with the fee schedule amounts for other services determined by the Secretary to be of comparable value. In applying the previous sentence, the Secretary shall adjust the conversion factor by geographic adjustment factors in the same manner as such adjustment is made under paragraph (1)(C).

(C) CONSULTATION.—The Secretary shall consult with the Physician Payment Review Commission and organizations representing physicians or suppliers who furnish radiology services and anesthesia services in applying subparagraphs (A) and (B).

(3) TREATMENT OF INTERPRETATION OF ELECTROCARDIOGRAMS.—The Secretary—

(A) shall make separate payment under this section for the interpretation of electrocardiograms performed or ordered to be performed as part of or in conjunction with a visit to or a consultation with a physician, and

(B) shall adjust the relative values established for visits and consultations under subsection (c) so as not to include relative value units for interpretations of electrocardiograms in the relative value for visits and consultations.

(4) SPECIAL RULE FOR IMAGING SERVICES.—

(A) IN GENERAL.—In the case of imaging services described in subparagraph (B) furnished on or after January 1, 2007, if—

(i) the technical component (including the technical component portion of a global fee) of the service established for a year under the fee schedule described in paragraph (1) without application of the geographic adjustment factor described in paragraph (1)(C), exceeds

(ii) the Medicare OPD fee schedule amount established under the prospective payment system for hos-

pital outpatient department services under paragraph (3)(D) of section 1833(t) for such service for such year, determined without regard to geographic adjustment under paragraph (2)(D) of such section,

the Secretary shall substitute the amount described in clause (ii), adjusted by the geographic adjustment factor described in paragraph (1)(C), for the fee schedule amount for such technical component for such year.

(B) IMAGING SERVICES DESCRIBED.—For purposes of this paragraph, imaging services described in this subparagraph are imaging and computer-assisted imaging services, including X-ray, ultrasound (including echocardiography), nuclear medicine (including positron emission tomography), magnetic resonance imaging, computed tomography, and fluoroscopy, but excluding diagnostic and screening mammography, and for 2010, 2011, and the first 2 months of 2012, dual-energy x-ray absorptiometry services (as described in paragraph (6)).

(C) ADJUSTMENT IN IMAGING UTILIZATION RATE.—With respect to fee schedules established for 2011, 2012, and 2013, in the methodology for determining practice expense relative value units for expensive diagnostic imaging equipment under the final rule published by the Secretary in the Federal Register on November 25, 2009 (42 CFR 410 et al.), the Secretary shall use a 75 percent assumption instead of the utilization rates otherwise established in such final rule. With respect to fee schedules established for 2014 and subsequent years, in such methodology, the Secretary shall use a 90 percent utilization rate.

(D) ADJUSTMENT IN TECHNICAL COMPONENT DISCOUNT ON SINGLE-SESSION IMAGING INVOLVING CONSECUTIVE BODY PARTS.—For services furnished on or after July 1, 2010, the Secretary shall increase the reduction in payments attributable to the multiple procedure payment reduction applicable to the technical component for imaging under the final rule published by the Secretary in the Federal Register on November 21, 2005 (part 405 of title 42, Code of Federal Regulations) from 25 percent to 50 percent.

(5) TREATMENT OF INTENSIVE CARDIAC REHABILITATION PROGRAM.—

(A) IN GENERAL.—In the case of an intensive cardiac rehabilitation program described in section 1861(eee)(4), the Secretary shall substitute the Medicare OPD fee schedule amount established under the prospective payment system for hospital outpatient department service under paragraph (3)(D) of section 1833(t) for cardiac rehabilitation (under HCPCS codes 93797 and 93798 for calendar year 2007, or any succeeding HCPCS codes for cardiac rehabilitation).

(B) DEFINITION OF SESSION.—Each of the services described in subparagraphs (A) through (E) of section 1861(eee)(3), when furnished for one hour, is a separate session of intensive cardiac rehabilitation.

(C) MULTIPLE SESSIONS PER DAY.—Payment may be made for up to 6 sessions per day of the series of 72 one-

hour sessions of intensive cardiac rehabilitation services described in section 1861(eee)(4)(B).

(6) TREATMENT OF BONE MASS SCANS.—For dual-energy x-ray absorptiometry services (identified in 2006 by HCPCS codes 76075 and 76077 (and any succeeding codes)) furnished during 2010, 2011, and the first 2 months of 2012, instead of the payment amount that would otherwise be determined under this section for such years, the payment amount shall be equal to 70 percent of the product of—

(A) the relative value for the service (as determined in subsection (c)(2)) for 2006;

(B) the conversion factor (established under subsection (d)) for 2006; and

(C) the geographic adjustment factor (established under subsection (e)(2)) for the service for the fee schedule area for 2010, 2011, and the first 2 months of 2012, respectively.

(7) ADJUSTMENT IN DISCOUNT FOR CERTAIN MULTIPLE THERAPY SERVICES.—In the case of therapy services furnished on or after January 1, 2011, and before April 1, 2013, and for which payment is made under fee schedules established under this section, instead of the 25 percent multiple procedure payment reduction specified in the final rule published by the Secretary in the Federal Register on November 29, 2010, the reduction percentage shall be 20 percent. In the case of such services furnished on or after April 1, 2013, and for which payment is made under such fee schedules, instead of the 25 percent multiple procedure payment reduction specified in such final rule, the reduction percentage shall be 50 percent.

(8) ENCOURAGING CARE MANAGEMENT FOR INDIVIDUALS WITH CHRONIC CARE NEEDS.—

(A) IN GENERAL.—In order to encourage the management of care for individuals with chronic care needs the Secretary shall, subject to subparagraph (B), make payment (as the Secretary determines to be appropriate) under this section for chronic care management services furnished on or after January 1, 2015, by a physician (as defined in section 1861(r)(1)), physician assistant or nurse practitioner (as defined in section 1861(aa)(5)(A)), clinical nurse specialist (as defined in section 1861(aa)(5)(B)), or certified nurse midwife (as defined in section 1861(gg)(2)).

(B) POLICIES RELATING TO PAYMENT.—In carrying out this paragraph, with respect to chronic care management services, the Secretary shall—

(i) make payment to only one applicable provider for such services furnished to an individual during a period;

(ii) not make payment under subparagraph (A) if such payment would be duplicative of payment that is otherwise made under this title for such services; and

(iii) not require that an annual wellness visit (as defined in section 1861(hhh)) or an initial preventive physical examination (as defined in section 1861(ww)) be furnished as a condition of payment for such management services.

(9) SPECIAL RULE TO INCENTIVIZE TRANSITION FROM TRADITIONAL X-RAY IMAGING TO DIGITAL RADIOGRAPHY.—

(A) LIMITATION ON PAYMENT FOR FILM X-RAY IMAGING SERVICES.—In the case of an imaging service (including the imaging portion of a service) that is an X-ray taken using film and that is furnished during 2017 or a subsequent year, the payment amount for the technical component (including the technical component portion of a global service) of such service that would otherwise be determined under this section (without application of this paragraph and before application of any other adjustment under this section) for such year shall be reduced by 20 percent.

(B) PHASED-IN LIMITATION ON PAYMENT FOR COMPUTED RADIOGRAPHY IMAGING SERVICES.—In the case of an imaging service (including the imaging portion of a service) that is an X-ray taken using computed radiography technology—

(i) in the case of such a service furnished during 2018, 2019, 2020, 2021, or 2022, the payment amount for the technical component (including the technical component portion of a global service) of such service that would otherwise be determined under this section (without application of this paragraph and before application of any other adjustment under this section) for such year shall be reduced by 7 percent; and

(ii) in the case of such a service furnished during 2023 or a subsequent year, the payment amount for the technical component (including the technical component portion of a global service) of such service that would otherwise be determined under this section (without application of this paragraph and before application of any other adjustment under this section) for such year shall be reduced by 10 percent.

(C) COMPUTED RADIOGRAPHY TECHNOLOGY DEFINED.—For purposes of this paragraph, the term "computed radiography technology" means cassette-based imaging which utilizes an imaging plate to create the image involved.

(D) IMPLEMENTATION.—In order to implement this paragraph, the Secretary shall adopt appropriate mechanisms which may include use of modifiers.

(10) REDUCTION OF DISCOUNT IN PAYMENT FOR PROFESSIONAL COMPONENT OF MULTIPLE IMAGING SERVICES.—In the case of the professional component of imaging services furnished on or after January 1, 2017, instead of the 25 percent reduction for multiple procedures specified in the final rule published by the Secretary in the Federal Register on November 28, 2011, as amended in the final rule published by the Secretary in the Federal Register on November 16, 2012, the reduction percentage shall be 5 percent.

(11) SPECIAL RULE FOR CERTAIN RADIATION THERAPY SERVICES.—The code definitions, the work relative value units under subsection (c)(2)(C)(i), and the direct inputs for the practice expense relative value units under subsection (c)(2)(C)(ii) for radiation treatment delivery and related imaging services (identified in 2016 by HCPCS G-codes G6001 through G6015)

for the fee schedule established under this subsection for services furnished in 2017 and 2018 shall be the same as such definitions, units, and inputs for such services for the fee schedule established for services furnished in 2016.

(c) DETERMINATION OF RELATIVE VALUES FOR PHYSICIANS' SERVICES.—

(1) DIVISION OF PHYSICIANS' SERVICES INTO COMPONENTS.—In this section, with respect to a physicians' service:

(A) WORK COMPONENT DEFINED.—The term "work component" means the portion of the resources used in furnishing the service that reflects physician time and intensity in furnishing the service. Such portion shall—

(i) include activities before and after direct patient contact, and

(ii) be defined, with respect to surgical procedures, to reflect a global definition including pre-operative and post-operative physicians' services.

(B) PRACTICE EXPENSE COMPONENT DEFINED.—The term "practice expense component" means the portion of the resources used in furnishing the service that reflects the general categories of expenses (such as office rent and wages of personnel, but excluding malpractice expenses) comprising practice expenses.

(C) MALPRACTICE COMPONENT DEFINED.—The term "malpractice component" means the portion of the resources used in furnishing the service that reflects malpractice expenses in furnishing the service.

(2) DETERMINATION OF RELATIVE VALUES.—

(A) IN GENERAL.—

(i) COMBINATION OF UNITS FOR COMPONENTS.—The Secretary shall develop a methodology for combining the work, practice expense, and malpractice relative value units, determined under subparagraph (C), for each service in a manner to produce a single relative value for that service. Such relative values are subject to adjustment under subparagraph (F)(i) and section 13515(b) of the Omnibus Budget Reconciliation Act of 1993.

(ii) EXTRAPOLATION.—The Secretary may use extrapolation and other techniques to determine the number of relative value units for physicians' services for which specific data are not available and shall take into account recommendations of the Physician Payment Review Commission and the results of consultations with organizations representing physicians who provide such services.

(B) PERIODIC REVIEW AND ADJUSTMENTS IN RELATIVE VALUES.—

(i) PERIODIC REVIEW.—The Secretary, not less often than every 5 years, shall review the relative values established under this paragraph for all physicians' services.

(ii) ADJUSTMENTS.—

(I) IN GENERAL.—The Secretary shall, to the extent the Secretary determines to be necessary and

subject to subclause (II) and paragraph (7), adjust the number of such units to take into account changes in medical practice, coding changes, new data on relative value components, or the addition of new procedures. The Secretary shall publish an explanation of the basis for such adjustments.

(II) LIMITATION ON ANNUAL ADJUSTMENTS.—Subject to clauses (iv) and (v), the adjustments under subclause (I) for a year may not cause the amount of expenditures under this part for the year to differ by more than $20,000,000 from the amount of expenditures under this part that would have been made if such adjustments had not been made.

(iii) CONSULTATION.—The Secretary, in making adjustments under clause (ii), shall consult with the Medicare Payment Advisory Commission and organizations representing physicians.

(iv) EXEMPTION OF CERTAIN ADDITIONAL EXPENDITURES FROM BUDGET NEUTRALITY.—The additional expenditures attributable to—

(I) subparagraph (H) shall not be taken into account in applying clause (ii)(II) for 2004;

(II) subparagraph (I) insofar as it relates to a physician fee schedule for 2005 or 2006 shall not be taken into account in applying clause (ii)(II) for drug administration services under the fee schedule for such year for a specialty described in subparagraph (I)(ii)(II);

(III) subparagraph (J) insofar as it relates to a physician fee schedule for 2005 or 2006 shall not be taken into account in applying clause (ii)(II) for drug administration services under the fee schedule for such year; and

(IV) subsection (b)(6) shall not be taken into account in applying clause (ii)(II) for 2010, 2011, or the first 2 months of 2012.

(v) EXEMPTION OF CERTAIN REDUCED EXPENDITURES FROM BUDGET-NEUTRALITY CALCULATION.—The following reduced expenditures, as estimated by the Secretary, shall not be taken into account in applying clause (ii)(II):

(I) REDUCED PAYMENT FOR MULTIPLE IMAGING PROCEDURES.—Effective for fee schedules established beginning with 2007, reduced expenditures attributable to the multiple procedure payment reduction for imaging under the final rule published by the Secretary in the Federal Register on November 21, 2005 (42 CFR 405, et al.) insofar as it relates to the physician fee schedules for 2006 and 2007.

(II) OPD PAYMENT CAP FOR IMAGING SERVICES.—Effective for fee schedules established beginning with 2007, reduced expenditures attributable to subsection (b)(4).

(III) CHANGE IN UTILIZATION RATE FOR CERTAIN IMAGING SERVICES.—Effective for fee schedules established beginning with 2011, reduced expenditures attributable to the changes in the utilization rate applicable to 2011 and 2014, as described in the first and second sentence, respectively, of subsection (b)(4)(C).

(VI) ADDITIONAL REDUCED PAYMENT FOR MULTIPLE IMAGING PROCEDURES.—Effective for fee schedules established beginning with 2010 (but not applied for services furnished prior to July 1, 2010), reduced expenditures attributable to the increase in the multiple procedure payment reduction from 25 to 50 percent (as described in subsection (b)(4)(D)).

(VII) REDUCED EXPENDITURES FOR MULTIPLE THERAPY SERVICES.—Effective for fee schedules established beginning with 2011, reduced expenditures attributable to the multiple procedure payment reduction for therapy services (as described in subsection (b)(7)).

(VIII) REDUCED EXPENDITURES ATTRIBUTABLE TO APPLICATION OF QUALITY INCENTIVES FOR COMPUTED TOMOGRAPHY.—Effective for fee schedules established beginning with 2016, reduced expenditures attributable to the application of the quality incentives for computed tomography under section 1834(p)

(IX) REDUCTIONS FOR MISVALUED SERVICES IF TARGET NOT MET.—Effective for fee schedules beginning with 2016, reduced expenditures attributable to the application of the target recapture amount described in subparagraph (O)(iii).

(X) REDUCED EXPENDITURES ATTRIBUTABLE TO INCENTIVES TO TRANSITION TO DIGITAL RADIOGRAPHY.—Effective for fee schedules established beginning with 2017, reduced expenditures attributable to subparagraph (A) of subsection (b)(9) and effective for fee schedules established beginning with 2018, reduced expenditures attributable to subparagraph (B) of such subsection.

(XI) DISCOUNT IN PAYMENT FOR PROFESSIONAL COMPONENT OF IMAGING SERVICES.—Effective for fee schedules established beginning with 2017, reduced expenditures attributable to subsection (b)(10).

(vi) ALTERNATIVE APPLICATION OF BUDGET-NEUTRALITY ADJUSTMENT.—Notwithstanding subsection (d)(9)(A), effective for fee schedules established beginning with 2009, with respect to the 5-year review of work relative value units used in fee schedules for 2007 and 2008, in lieu of continuing to apply budget-neutrality adjustments required under clause (ii) for 2007 and 2008 to work relative value units, the Secretary shall apply such budget-neutrality adjustments

to the conversion factor otherwise determined for years beginning with 2009.

(C) COMPUTATION OF RELATIVE VALUE UNITS FOR COMPONENTS.—For purposes of this section for each physicians' service—

(i) WORK RELATIVE VALUE UNITS.—The Secretary shall determine a number of work relative value units for the service or group of services based on the relative resources incorporating physician time and intensity required in furnishing the service or group of services.

(ii) PRACTICE EXPENSE RELATIVE VALUE UNITS.—The Secretary shall determine a number of practice expense relative value units for the service for years before 1999 equal to the product of—

(I) the base allowed charges (as defined in subparagraph (D)) for the service, and

(II) the practice expense percentage for the service (as determined under paragraph (3)(C)(ii)),

and for years beginning with 1999 based on the relative practice expense resources involved in furnishing the service or group of services. For 1999, such number of units shall be determined based 75 percent on such product and based 25 percent on the relative practice expense resources involved in furnishing the service. For 2000, such number of units shall be determined based 50 percent on such product and based 50 percent on such relative practice expense resources. For 2001, such number of units shall be determined based 25 percent on such product and based 75 percent on such relative practice expense resources. For a subsequent year, such number of units shall be determined based entirely on such relative practice expense resources.

(iii) MALPRACTICE RELATIVE VALUE UNITS.—The Secretary shall determine a number of malpractice relative value units for the service or group of services for years before 2000 equal to the product of—

(I) the base allowed charges (as defined in subparagraph (D)) for the service or group of services, and

(II) the malpractice percentage for the service or group of services (as determined under paragraph (3)(C)(iii)),

and for years beginning with 2000 based on the malpractice expense resources involved in furnishing the service or group of services.

(D) BASE ALLOWED CHARGES DEFINED.—In this paragraph, the term "base allowed charges" means, with respect to a physician's service, the national average allowed charges for the service under this part for services furnished during 1991, as estimated by the Secretary using the most recent data available.

(E) REDUCTION IN PRACTICE EXPENSE RELATIVE VALUE UNITS FOR CERTAIN SERVICES.—

(i) IN GENERAL.—Subject to clause (ii), the Secretary shall reduce the practice expense relative value units applied to services described in clause (iii) furnished in—

(I) 1994, by 25 percent of the number by which the number of practice expense relative value units (determined for 1994 without regard to this subparagraph) exceeds the number of work relative value units determined for 1994,

(II) 1995, by an additional 25 percent of such excess, and

(III) 1996, by an additional 25 percent of such excess.

(ii) FLOOR ON REDUCTIONS.—The practice expense relative value units for a physician's service shall not be reduced under this subparagraph to a number less than 128 percent of the number of work relative value units.

(iii) Services covered.—For purposes of clause (i), the services described in this clause are physicians' services that are not described in clause (iv) and for which—

(I) there are work relative value units, and

(II) the number of practice expense relative value units (determined for 1994) exceeds 128 percent of the number of work relative value units (determined for such year).

(iv) EXCLUDED SERVICES.—For purposes of clause (iii), the services described in this clause are services which the Secretary determines at least 75 percent of which are provided under this title in an office setting.

(F) BUDGET NEUTRALITY ADJUSTMENTS.—The Secretary—

(i) shall reduce the relative values for all services (other than anesthesia services) established under this paragraph (and in the case of anesthesia services, the conversion factor established by the Secretary for such services) by such percentage as the Secretary determines to be necessary so that, beginning in 1996, the amendment made by section 13514(a) of the Omnibus Budget Reconciliation Act of 1993 would not result in expenditures under this section that exceed the amount of such expenditures that would have been made if such amendment had not been made, and

(ii) shall reduce the amounts determined under subsection (a)(2)(B)(ii)(I) by such percentage as the Secretary determines to be required to assure that, taking into account the reductions made under clause (i), the amendment made by section 13514(a) of the Omnibus Budget Reconciliation Act of 1993 would not result in expenditures under this section in 1994 that exceed the amount of such expenditures that would have been made if such amendment had not been made.

(G) ADJUSTMENTS IN RELATIVE VALUE UNITS FOR 1998.—

(i) IN GENERAL.—The Secretary shall—

(I) subject to clauses (iv) and (v), reduce the practice expense relative value units applied to any services described in clause (ii) furnished in 1998 to a number equal to 110 percent of the number of work relative value units, and

(II) increase the practice expense relative value units for office visit procedure codes during 1998 by a uniform percentage which the Secretary estimates will result in an aggregate increase in payments for such services equal to the aggregate decrease in payments by reason of subclause (I).

(ii) SERVICES COVERED.—For purposes of clause (i), the services described in this clause are physicians' services that are not described in clause (iii) and for which—

(I) there are work relative value units, and

(II) the number of practice expense relative value units (determined for 1998) exceeds 110 percent of the number of work relative value units (determined for such year).

(iii) EXCLUDED SERVICES.—For purposes of clause (ii), the services described in this clause are services which the Secretary determines at least 75 percent of which are provided under this title in an office setting.

(iv) LIMITATION ON AGGREGATE REALLOCATION.—If the application of clause (i)(I) would result in an aggregate amount of reductions under such clause in excess of $390,000,000, such clause shall be applied by substituting for 110 percent such greater percentage as the Secretary estimates will result in the aggregate amount of such reductions equaling $390,000,000.

(v) NO REDUCTION FOR CERTAIN SERVICES.—Practice expense relative value units for a procedure performed in an office or in a setting out of an office shall not be reduced under clause (i) if the in-office or out-of-office practice expense relative value, respectively, for the procedure would increase under the proposed rule on resource-based practice expenses issued by the Secretary on June 18, 1997 (62 Federal Register 33158 et seq.).

(H) ADJUSTMENTS IN PRACTICE EXPENSE RELATIVE VALUE UNITS FOR CERTAIN DRUG ADMINISTRATION SERVICES BEGINNING IN 2004.—

(i) USE OF SURVEY DATA.—In establishing the physician fee schedule under subsection (b) with respect to payments for services furnished on or after January 1, 2004, the Secretary shall, in determining practice expense relative value units under this subsection, utilize a survey submitted to the Secretary as of January 1, 2003, by a physician specialty organization pursuant to section 212 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 if the survey—

(I) covers practice expenses for oncology drug administration services; and

(II) meets criteria established by the Secretary for acceptance of such surveys.

(ii) PRICING OF CLINICAL ONCOLOGY NURSES IN PRACTICE EXPENSE METHODOLOGY.—If the survey described in clause (i) includes data on wages, salaries, and compensation of clinical oncology nurses, the Secretary shall utilize such data in the methodology for determining practice expense relative value units under subsection (c).

(iii) WORK RELATIVE VALUE UNITS FOR CERTAIN DRUG ADMINISTRATION SERVICES.—In establishing the relative value units under this paragraph for drug administration services described in clause (iv) furnished on or after January 1, 2004, the Secretary shall establish work relative value units equal to the work relative value units for a level 1 office medical visit for an established patient.

(iv) DRUG ADMINISTRATION SERVICES DESCRIBED.—The drug administration services described in this clause are physicians' services—

(I) which are classified as of October 1, 2003, within any of the following groups of procedures: therapeutic or diagnostic infusions (excluding chemotherapy); chemotherapy administration services; and therapeutic, prophylactic, or diagnostic injections;

(II) for which there are no work relative value units assigned under this subsection as of such date; and

(III) for which national relative value units have been assigned under this subsection as of such date.

(I) ADJUSTMENTS IN PRACTICE EXPENSE RELATIVE VALUE UNITS FOR CERTAIN DRUG ADMINISTRATION SERVICES BEGINNING WITH 2005.—

(i) IN GENERAL.—In establishing the physician fee schedule under subsection (b) with respect to payments for services furnished on or after January 1, 2005 or 2006, the Secretary shall adjust the practice expense relative value units for such year consistent with clause (ii).

(ii) USE OF SUPPLEMENTAL SURVEY DATA.—

(I) IN GENERAL.—Subject to subclause (II), if a specialty submits to the Secretary by not later than March 1, 2004, for 2005, or March 1, 2005, for 2006, data that includes expenses for the administration of drugs and biologicals for which the payment amount is determined pursuant to section 1842(o), the Secretary shall use such supplemental survey data in carrying out this subparagraph for the years involved insofar as they are collected and provided by entities and organizations consistent with the criteria established by the Secretary pursuant to section 212(a) of the

Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999.

(II) LIMITATION ON SPECIALTY.—Subclause (I) shall apply to a specialty only insofar as not less than 40 percent of payments for the specialty under this title in 2002 are attributable to the administration of drugs and biologicals, as determined by the Secretary.

(III) APPLICATION.—This clause shall not apply with respect to a survey to which subparagraph (H)(i) applies.

(J) PROVISIONS FOR APPROPRIATE REPORTING AND BILLING FOR PHYSICIANS' SERVICES ASSOCIATED WITH THE ADMINISTRATION OF COVERED OUTPATIENT DRUGS AND BIOLOGICALS.—

(i) EVALUATION OF CODES.—The Secretary shall promptly evaluate existing drug administration codes for physicians' services to ensure accurate reporting and billing for such services, taking into account levels of complexity of the administration and resource consumption.

(ii) USE OF EXISTING PROCESSES.—In carrying out clause (i), the Secretary shall use existing processes for the consideration of coding changes and, to the extent coding changes are made, shall use such processes in establishing relative values for such services.

(iii) IMPLEMENTATION.—In carrying out clause (i), the Secretary shall consult with representatives of physician specialties affected by the implementation of section 1847A or section 1847B, and shall take such steps within the Secretary's authority to expedite such considerations under clause (ii).

(iv) SUBSEQUENT, BUDGET NEUTRAL ADJUSTMENTS PERMITTED.—Nothing in subparagraph (H) or (I) or this subparagraph shall be construed as preventing the Secretary from providing for adjustments in practice expense relative value units under (and consistent with) subparagraph (B) for years after 2004, 2005, or 2006, respectively.

(K) POTENTIALLY MISVALUED CODES.—

(i) IN GENERAL.—The Secretary shall—

(I) periodically identify services as being potentially misvalued using criteria specified in clause (ii); and

(II) review and make appropriate adjustments to the relative values established under this paragraph for services identified as being potentially misvalued under subclause (I).

(ii) IDENTIFICATION OF POTENTIALLY MISVALUED CODES.—For purposes of identifying potentially misvalued codes pursuant to clause (i)(I), the Secretary shall examine codes (and families of codes as appropriate) based on any or all of the following criteria:

(I) Codes that have experienced the fastest growth.

(II) Codes that have experienced substantial changes in practice expenses.

(III) Codes that describe new technologies or services within an appropriate time period (such as 3 years) after the relative values are initially established for such codes.

(IV) Codes which are multiple codes that are frequently billed in conjunction with furnishing a single service.

(V) Codes with low relative values, particularly those that are often billed multiple times for a single treatment.

(VI) Codes that have not been subject to review since implementation of the fee schedule.

(VII) Codes that account for the majority of spending under the physician fee schedule.

(VIII) Codes for services that have experienced a substantial change in the hospital length of stay or procedure time.

(IX) Codes for which there may be a change in the typical site of service since the code was last valued.

(X) Codes for which there is a significant difference in payment for the same service between different sites of service.

(XI) Codes for which there may be anomalies in relative values within a family of codes.

(XII) Codes for services where there may be efficiencies when a service is furnished at the same time as other services.

(XIII) Codes with high intra-service work per unit of time.

(XIV) Codes with high practice expense relative value units.

(XV) Codes with high cost supplies.

(XVI) Codes as determined appropriate by the Secretary.

(iii) REVIEW AND ADJUSTMENTS.—

(I) The Secretary may use existing processes to receive recommendations on the review and appropriate adjustment of potentially misvalued services described in clause (i)(II).

(II) The Secretary may conduct surveys, other data collection activities, studies, or other analyses as the Secretary determines to be appropriate to facilitate the review and appropriate adjustment described in clause (i)(II).

(III) The Secretary may use analytic contractors to identify and analyze services identified under clause (i)(I), conduct surveys or collect data, and make recommendations on the review and appropriate adjustment of services described in clause (i)(II).

(IV) The Secretary may coordinate the review and appropriate adjustment described in clause (i)(II) with the periodic review described in subparagraph (B).

(V) As part of the review and adjustment described in clause (i)(II), including with respect to codes with low relative values described in clause (ii), the Secretary may make appropriate coding revisions (including using existing processes for consideration of coding changes) which may include consolidation of individual services into bundled codes for payment under the fee schedule under subsection (b).

(VI) The provisions of subparagraph (B)(ii)(II) and paragraph (7) shall apply to adjustments to relative value units made pursuant to this subparagraph in the same manner as such provisions apply to adjustments under subparagraph (B)(ii)(I).

(iv) TREATMENT OF CERTAIN RADIATION THERAPY SERVICES.—Radiation treatment delivery and related imaging services identified under subsection (b)(11) shall not be considered as potentially misvalued services for purposes of this subparagraph and subparagraph (O) for 2017 and 2018.

(L) VALIDATING RELATIVE VALUE UNITS.—

(i) IN GENERAL.—The Secretary shall establish a process to validate relative value units under the fee schedule under subsection (b).

(ii) COMPONENTS AND ELEMENTS OF WORK.—The process described in clause (i) may include validation of work elements (such as time, mental effort and professional judgment, technical skill and physical effort, and stress due to risk) involved with furnishing a service and may include validation of the pre-, post-, and intra-service components of work.

(iii) SCOPE OF CODES.—The validation of work relative value units shall include a sampling of codes for services that is the same as the codes listed under subparagraph (K)(ii).

(iv) METHODS.—The Secretary may conduct the validation under this subparagraph using methods described in subclauses (I) through (V) of subparagraph (K)(iii) as the Secretary determines to be appropriate.

(v) ADJUSTMENTS.—The Secretary shall make appropriate adjustments to the work relative value units under the fee schedule under subsection (b). The provisions of subparagraph (B)(ii)(II) shall apply to adjustments to relative value units made pursuant to this subparagraph in the same manner as such provisions apply to adjustments under subparagraph (B)(ii)(II).

(M) AUTHORITY TO COLLECT AND USE INFORMATION ON PHYSICIANS' SERVICES IN THE DETERMINATION OF RELATIVE VALUES.—

(i) COLLECTION OF INFORMATION.—Notwithstanding any other provision of law, the Secretary may collect or obtain information on the resources directly or indirectly related to furnishing services for which payment is made under the fee schedule established under subsection (b). Such information may be collected or obtained from any eligible professional or any other source.

(ii) USE OF INFORMATION.—Notwithstanding any other provision of law, subject to clause (v), the Secretary may (as the Secretary determines appropriate) use information collected or obtained pursuant to clause (i) in the determination of relative values for services under this section.

(iii) TYPES OF INFORMATION.—The types of information described in clauses (i) and (ii) may, at the Secretary's discretion, include any or all of the following:

(I) Time involved in furnishing services.

(II) Amounts and types of practice expense inputs involved with furnishing services.

(III) Prices (net of any discounts) for practice expense inputs, which may include paid invoice prices or other documentation or records.

(IV) Overhead and accounting information for practices of physicians and other suppliers.

(V) Any other element that would improve the valuation of services under this section.

(iv) INFORMATION COLLECTION MECHANISMS.—Information may be collected or obtained pursuant to this subparagraph from any or all of the following:

(I) Surveys of physicians, other suppliers, providers of services, manufacturers, and vendors.

(II) Surgical logs, billing systems, or other practice or facility records.

(III) Electronic health records.

(IV) Any other mechanism determined appropriate by the Secretary.

(v) TRANSPARENCY OF USE OF INFORMATION.—

(I) IN GENERAL.—Subject to subclauses (II) and (III), if the Secretary uses information collected or obtained under this subparagraph in the determination of relative values under this subsection, the Secretary shall disclose the information source and discuss the use of such information in such determination of relative values through notice and comment rulemaking.

(II) THRESHOLDS FOR USE.—The Secretary may establish thresholds in order to use such information, including the exclusion of information collected or obtained from eligible professionals who use very high resources (as determined by the Secretary) in furnishing a service.

(III) DISCLOSURE OF INFORMATION.—The Secretary shall make aggregate information available under this subparagraph but shall not disclose in-

formation in a form or manner that identifies an eligible professional or a group practice, or information collected or obtained pursuant to a nondisclosure agreement.

(vi) INCENTIVE TO PARTICIPATE.—The Secretary may provide for such payments under this part to an eligible professional that submits such solicited information under this subparagraph as the Secretary determines appropriate in order to compensate such eligible professional for such submission. Such payments shall be provided in a form and manner specified by the Secretary.

(vii) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to information collected or obtained under this subparagraph.

(viii) DEFINITION OF ELIGIBLE PROFESSIONAL.—In this subparagraph, the term "eligible professional" has the meaning given such term in subsection (k)(3)(B).

(ix) FUNDING.—For purposes of carrying out this subparagraph, in addition to funds otherwise appropriated, the Secretary shall provide for the transfer, from the Federal Supplementary Medical Insurance Trust Fund under section 1841, of $2,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for each fiscal year beginning with fiscal year 2014. Amounts transferred under the preceding sentence for a fiscal year shall be available until expended.

(N) AUTHORITY FOR ALTERNATIVE APPROACHES TO ESTABLISHING PRACTICE EXPENSE RELATIVE VALUES.—The Secretary may establish or adjust practice expense relative values under this subsection using cost, charge, or other data from suppliers or providers of services, including information collected or obtained under subparagraph (M).

(O) TARGET FOR RELATIVE VALUE ADJUSTMENTS FOR MISVALUED SERVICES.—With respect to fee schedules established for each of 2016 through 2018, the following shall apply:

(i) DETERMINATION OF NET REDUCTION IN EXPENDITURES.—For each year, the Secretary shall determine the estimated net reduction in expenditures under the fee schedule under this section with respect to the year as a result of adjustments to the relative values established under this paragraph for misvalued codes.

(ii) BUDGET NEUTRAL REDISTRIBUTION OF FUNDS IF TARGET MET AND COUNTING OVERAGES TOWARDS THE TARGET FOR THE SUCCEEDING YEAR.—If the estimated net reduction in expenditures determined under clause (i) for the year is equal to or greater than the target for the year—

(I) reduced expenditures attributable to such adjustments shall be redistributed for the year in a budget neutral manner in accordance with subparagraph (B)(ii)(II); and

(II) the amount by which such reduced expenditures exceeds the target for the year shall be treated as a reduction in expenditures described in clause (i) for the succeeding year, for purposes of determining whether the target has or has not been met under this subparagraph with respect to that year.

(iii) EXEMPTION FROM BUDGET NEUTRALITY IF TARGET NOT MET.—If the estimated net reduction in expenditures determined under clause (i) for the year is less than the target for the year, reduced expenditures in an amount equal to the target recapture amount shall not be taken into account in applying subparagraph (B)(ii)(II) with respect to fee schedules beginning with 2016.

(iv) TARGET RECAPTURE AMOUNT.—For purposes of clause (iii), the target recapture amount is, with respect to a year, an amount equal to the difference between—

(I) the target for the year; and

(II) the estimated net reduction in expenditures determined under clause (i) for the year.

(v) TARGET.—For purposes of this subparagraph, with respect to a year, the target is calculated as 0.5 percent (or, for 2016, 1.0 percent) of the estimated amount of expenditures under the fee schedule under this section for the year.

(3) COMPONENT PERCENTAGES.—For purposes of paragraph (2), the Secretary shall determine a work percentage, a practice expense percentage, and a malpractice percentage for each physician's service as follows:

(A) DIVISION OF SERVICES BY SPECIALTY.—For each physician's service or class of physicians' services, the Secretary shall determine the average percentage of each such service or class of services that is performed, nationwide, under this part by physicians in each of the different physician specialties (as identified by the Secretary).

(B) DIVISION OF SPECIALTY BY COMPONENT.—The Secretary shall determine the average percentage division of resources, among the work component, the practice expense component, and the malpractice component, used by physicians in each of such specialties in furnishing physicians' services. Such percentages shall be based on national data that describe the elements of physician practice costs and revenues, by physician specialty. The Secretary may use extrapolation and other techniques to determine practice costs and revenues for specialties for which adequate data are not available.

(C) DETERMINATION OF COMPONENT PERCENTAGES.—

(i) WORK PERCENTAGE.—The work percentage for a service (or class of services) is equal to the sum (for all physician specialties) of—

(I) the average percentage division for the work component for each physician specialty (determined under subparagraph (B)), multiplied by

(II) the proportion (determined under subparagraph (A)) of such service (or services) performed by physicians in that specialty.

(ii) PRACTICE EXPENSE PERCENTAGE.—For years before 2002, the practice expense percentage for a service (or class of services) is equal to the sum (for all physician specialties) of—

(I) the average percentage division for the practice expense component for each physician specialty (determined under subparagraph (B)), multiplied by

(II) the proportion (determined under subparagraph (A)) of such service (or services) performed by physicians in that specialty.

(iii) MALPRACTICE PERCENTAGE.—For years before 1999, the malpractice percentage for a service (or class of services) is equal to the sum (for all physician specialties) of—

(I) the average percentage division for the malpractice component for each physician specialty (determined under subparagraph (B)), multiplied by

(II) the proportion (determined under subparagraph (A)) of such service (or services) performed by physicians in that specialty.

(D) PERIODIC RECOMPUTATION.—The Secretary may, from time to time, provide for the recomputation of work percentages, practice expense percentages, and malpractice percentages determined under this paragraph.

(4) ANCILLARY POLICIES.—The Secretary may establish ancillary policies (with respect to the use of modifiers, local codes, and other matters) as may be necessary to implement this section.

(5) CODING.—The Secretary shall establish a uniform procedure coding system for the coding of all physicians' services. The Secretary shall provide for an appropriate coding structure for visits and consultations. The Secretary may incorporate the use of time in the coding for visits and consultations. The Secretary, in establishing such coding system, shall consult with the Physician Payment Review Commission and other organizations representing physicians.

(6) NO VARIATION FOR SPECIALISTS.—The Secretary may not vary the conversion factor or the number of relative value units for a physicians' service based on whether the physician furnishing the service is a specialist or based on the type of specialty of the physician.

(7) PHASE-IN OF SIGNIFICANT RELATIVE VALUE UNIT (RVU) REDUCTIONS.—Effective for fee schedules established beginning with 2016, for services that are not new or revised codes, if the total relative value units for a service for a year would otherwise be decreased by an estimated amount equal to or greater than 20 percent as compared to the total relative value units for the previous year, the applicable adjustments in work, practice expense, and malpractice relative value units shall be phased-in over a 2-year period.

(8) GLOBAL SURGICAL PACKAGES.—

(A) PROHIBITION OF IMPLEMENTATION OF RULE REGARDING GLOBAL SURGICAL PACKAGES.—

(i) IN GENERAL.—The Secretary shall not implement the policy established in the final rule published on November 13, 2014 (79 Fed. Reg. 67548 et seq.), that requires the transition of all 10-day and 90-day global surgery packages to 0-day global periods.

(ii) CONSTRUCTION.—Nothing in clause (i) shall be construed to prevent the Secretary from revaluing misvalued codes for specific surgical services or assigning values to new or revised codes for surgical services.

(B) COLLECTION OF DATA ON SERVICES INCLUDED IN GLOBAL SURGICAL PACKAGES.—

(i) IN GENERAL.—Subject to clause (ii), the Secretary shall through rulemaking develop and implement a process to gather, from a representative sample of physicians, beginning not later than January 1, 2017, information needed to value surgical services. Such information shall include the number and level of medical visits furnished during the global period and other items and services related to the surgery and furnished during the global period, as appropriate. Such information shall be reported on claims at the end of the global period or in another manner specified by the Secretary. For purposes of carrying out this paragraph (other than clause (iii)), the Secretary shall transfer from the Federal Supplemental Medical Insurance Trust Fund under section 1841 $2,000,000 to the Center for Medicare & Medicaid Services Program Management Account for fiscal year 2015. Amounts transferred under the previous sentence shall remain available until expended.

(ii) REASSESSMENT AND POTENTIAL SUNSET.—Every 4 years, the Secretary shall reassess the value of the information collected pursuant to clause (i). Based on such a reassessment and by regulation, the Secretary may discontinue the requirement for collection of information under such clause if the Secretary determines that the Secretary has adequate information from other sources, such as qualified clinical data registries, surgical logs, billing systems or other practice or facility records, and electronic health records, in order to accurately value global surgical services under this section.

(iii) INSPECTOR GENERAL AUDIT.—The Inspector General of the Department of Health and Human Services shall audit a sample of the information reported under clause (i) to verify the accuracy of the information so reported.

(C) IMPROVING ACCURACY OF PRICING FOR SURGICAL SERVICES.—For years beginning with 2019, the Secretary shall use the information reported under subparagraph (B)(i) as appropriate and other available data for the pur-

pose of improving the accuracy of valuation of surgical services under the physician fee schedule under this section.

(d) CONVERSION FACTORS.—

(1) ESTABLISHMENT.—

(A) IN GENERAL.—The conversion factor for each year shall be the conversion factor established under this subsection for the previous year (or, in the case of 1992, specified in subparagraph (B)) adjusted by the update (established under paragraph (3)) for the year involved (for years before 2001) and, for years beginning with 2001 and ending with 2025, multiplied by the update (established under paragraph (4) or a subsequent paragraph) for the year involved. There shall be two separate conversion factors for each year beginning with 2026, one for items and services furnished by a qualifying APM participant (as defined in section 1833(z)(2)) (referred to in this subsection as the "qualifying APM conversion factor") and the other for other items and services (referred to in this subsection as the "nonqualifying APM conversion factor"), equal to the respective conversion factor for the previous year (or, in the case of 2026, equal to the single conversion factor for 2025) multiplied by the update established under paragraph (20) for such respective conversion factor for such year.

(B) SPECIAL PROVISION FOR 1992.—For purposes of subparagraph (A), the conversion factor specified in this subparagraph is a conversion factor (determined by the Secretary) which, if this section were to apply during 1991 using such conversion factor, would result in the same aggregate amount of payments under this part for physicians' services as the estimated aggregate amount of the payments under this part for such services in 1991.

(C) SPECIAL RULES FOR 1998.—Except as provided in subparagraph (D), the single conversion factor for 1998 under this subsection shall be the conversion factor for primary care services for 1997, increased by the Secretary's estimate of the weighted average of the three separate updates that would otherwise occur were it not for the enactment of chapter 1 of subtitle F of title IV of the Balanced Budget Act of 1997.

(D) SPECIAL RULES FOR ANESTHESIA SERVICES.—The separate conversion factor for anesthesia services for a year shall be equal to 46 percent of the single conversion factor (or, beginning with 2026, applicable conversion factor) established for other physicians' services, except as adjusted for changes in work, practice expense, or malpractice relative value units.

(E) PUBLICATION AND DISSEMINATION OF INFORMATION.—The Secretary shall—

(i) cause to have published in the Federal Register not later than November 1 of each year (beginning with 2000) the conversion factor which will apply to physicians' services for the succeeding year, the update determined under paragraph (4) for such suc-

ceeding year, and the allowed expenditures under such paragraph for such succeeding year; and

(ii) make available to the Medicare Payment Advisory Commission and the public by March 1 of each year (beginning with 2000) an estimate of the sustainable growth rate and of the conversion factor which will apply to physicians' services for the succeeding year and data used in making such estimate.

(3) UPDATE FOR 1999 AND 2000.—

(A) IN GENERAL.—Unless otherwise provided by law, subject to subparagraph (D) and the budget-neutrality factor determined by the Secretary under subsection (c)(2)(B)(ii), the update to the single conversion factor established in paragraph (1)(C) for 1999 and 2000 is equal to the product of—

(i) 1 plus the Secretary's estimate of the percentage increase in the MEI (as defined in section 1842(i)(3)) for the year (divided by 100), and

(ii) 1 plus the Secretary's estimate of the update adjustment factor for the year (divided by 100),

minus 1 and multiplied by 100.

(B) UPDATE ADJUSTMENT FACTOR.—For purposes of subparagraph (A)(ii), the "update adjustment factor" for a year is equal (as estimated by the Secretary) to—

(i) the difference between (I) the sum of the allowed expenditures for physicians' services (as determined under subparagraph (C)) for the period beginning April 1, 1997, and ending on March 31 of the year involved, and (II) the amount of actual expenditures for physicians' services furnished during the period beginning April 1, 1997, and ending on March 31 of the preceding year; divided by

(ii) the actual expenditures for physicians' services for the 12-month period ending on March 31 of the preceding year, increased by the sustainable growth rate under subsection (f) for the fiscal year which begins during such 12-month period.

(C) DETERMINATION OF ALLOWED EXPENDITURES.—For purposes of this paragraph and paragraph (4), the allowed expenditures for physicians' services for the 12-month period ending with March 31 of—

(i) 1997 is equal to the actual expenditures for physicians' services furnished during such 12-month period, as estimated by the Secretary; or

(ii) a subsequent year is equal to the allowed expenditures for physicians' services for the previous year, increased by the sustainable growth rate under subsection (f) for the fiscal year which begins during such 12-month period.

(D) RESTRICTION ON VARIATION FROM MEDICARE ECONOMIC INDEX.—Notwithstanding the amount of the update adjustment factor determined under subparagraph (B) for a year, the update in the conversion factor under this paragraph for the year may not be—

(i) greater than 100 times the following amount: (1.03 + (MEI percentage/100)) − 1; or

(ii) less than 100 times the following amount: (0.93 + (MEI percentage/100)) − 1,

where "MEI percentage" means the Secretary's estimate of the percentage increase in the MEI (as defined in section 1842(i)(3)) for the year involved.

(4) UPDATE FOR YEARS BEGINNING WITH 2001 AND ENDING WITH 2014.—

(A) IN GENERAL.—Unless otherwise provided by law, subject to the budget-neutrality factor determined by the Secretary under subsection (c)(2)(B)(ii) and subject to adjustment under subparagraph (F), the update to the single conversion factor established in paragraph (1)(C) for a year beginning with 2001 and ending with 2014 is equal to the product of—

(i) 1 plus the Secretary's estimate of the percentage increase in the MEI (as defined in section 1842(i)(3)) for the year (divided by 100); and

(ii) 1 plus the Secretary's estimate of the update adjustment factor under subparagraph (B) for the year.

(B) UPDATE ADJUSTMENT FACTOR.—For purposes of subparagraph (A)(ii), subject to subparagraph (D) and the succeeding paragraphs of this subsection, the "update adjustment factor" for a year is equal (as estimated by the Secretary) to the sum of the following:

(i) PRIOR YEAR ADJUSTMENT COMPONENT.—An amount determined by—

(I) computing the difference (which may be positive or negative) between the amount of the allowed expenditures for physicians' services for the prior year (as determined under subparagraph (C)) and the amount of the actual expenditures for such services for that year;

(II) dividing that difference by the amount of the actual expenditures for such services for that year; and

(III) multiplying that quotient by 0.75.

(ii) CUMULATIVE ADJUSTMENT COMPONENT.—An amount determined by—

(I) computing the difference (which may be positive or negative) between the amount of the allowed expenditures for physicians' services (as determined under subparagraph (C)) from April 1, 1996, through the end of the prior year and the amount of the actual expenditures for such services during that period;

(II) dividing that difference by actual expenditures for such services for the prior year as increased by the sustainable growth rate under subsection (f) for the year for which the update adjustment factor is to be determined; and

(III) multiplying that quotient by 0.33.

(C) DETERMINATION OF ALLOWED EXPENDITURES.—For purposes of this paragraph:

(i) PERIOD UP TO APRIL 1, 1999.—The allowed expenditures for physicians' services for a period before April 1, 1999, shall be the amount of the allowed expenditures for such period as determined under paragraph (3)(C).

(ii) TRANSITION TO CALENDAR YEAR ALLOWED EXPENDITURES.—Subject to subparagraph (E), the allowed expenditures for—

(I) the 9-month period beginning April 1, 1999, shall be the Secretary's estimate of the amount of the allowed expenditures that would be permitted under paragraph (3)(C) for such period; and

(II) the year of 1999, shall be the Secretary's estimate of the amount of the allowed expenditures that would be permitted under paragraph (3)(C) for such year.

(iii) YEARS BEGINNING WITH 2000.—The allowed expenditures for a year (beginning with 2000) is equal to the allowed expenditures for physicians' services for the previous year, increased by the sustainable growth rate under subsection (f) for the year involved.

(D) RESTRICTION ON UPDATE ADJUSTMENT FACTOR.—The update adjustment factor determined under subparagraph (B) for a year may not be less than −0.07 or greater than 0.03.

(E) RECALCULATION OF ALLOWED EXPENDITURES FOR UPDATES BEGINNING WITH 2001.—For purposes of determining the update adjustment factor for a year beginning with 2001, the Secretary shall recompute the allowed expenditures for previous periods beginning on or after April 1, 1999, consistent with subsection (f)(3).

(F) TRANSITIONAL ADJUSTMENT DESIGNED TO PROVIDE FOR BUDGET NEUTRALITY.—Under this subparagraph the Secretary shall provide for an adjustment to the update under subparagraph (A)—

(i) for each of 2001, 2002, 2003, and 2004, of −0.2 percent; and

(ii) for 2005 of +0.8 percent.

(5) UPDATE FOR 2004 AND 2005.—The update to the single conversion factor established in paragraph (1)(C) for each of 2004 and 2005 shall be not less than 1.5 percent.

(6) UPDATE FOR 2006.—The update to the single conversion factor established in paragraph (1)(C) for 2006 shall be 0 percent.

(7) CONVERSION FACTOR FOR 2007.—

(A) IN GENERAL.—The conversion factor that would otherwise be applicable under this subsection for 2007 shall be the amount of such conversion factor divided by the product of—

(i) 1 plus the Secretary's estimate of the percentage increase in the MEI (as defined in section 1842(i)(3)) for 2007 (divided by 100); and

(ii) 1 plus the Secretary's estimate of the update adjustment factor under paragraph (4)(B) for 2007.

(B) NO EFFECT ON COMPUTATION OF CONVERSION FACTOR FOR 2008.—The conversion factor under this subsection shall be computed under paragraph (1)(A) for 2008 as if subparagraph (A) had never applied.

(8) UPDATE FOR 2008.—

(A) IN GENERAL.—Subject to paragraph (7)(B), in lieu of the update to the single conversion factor established in paragraph (1)(C) that would otherwise apply for 2008, the update to the single conversion factor shall be 0.5 percent.

(B) NO EFFECT ON COMPUTATION OF CONVERSION FACTOR FOR 2009.—The conversion factor under this subsection shall be computed under paragraph (1)(A) for 2009 and subsequent years as if subparagraph (A) had never applied.

(9) UPDATE FOR 2009.—

(A) IN GENERAL.—Subject to paragraphs (7)(B) and (8)(B), in lieu of the update to the single conversion factor established in paragraph (1)(C) that would otherwise apply for 2009, the update to the single conversion factor shall be 1.1 percent.

(B) NO EFFECT ON COMPUTATION OF CONVERSION FACTOR FOR 2010 AND SUBSEQUENT YEARS.—The conversion factor under this subsection shall be computed under paragraph (1)(A) for 2010 and subsequent years as if subparagraph (A) had never applied.

(10) UPDATE FOR JANUARY THROUGH MAY OF 2010.—

(A) IN GENERAL.—Subject to paragraphs (7)(B), (8)(B), and (9)(B), in lieu of the update to the single conversion factor established in paragraph (1)(C) that would otherwise apply for 2010 for the period beginning on January 1, 2010, and ending on May 31, 2010, the update to the single conversion factor shall be 0 percent for 2010.

(B) NO EFFECT ON COMPUTATION OF CONVERSION FACTOR FOR REMAINING PORTION OF 2010 AND SUBSEQUENT YEARS.—The conversion factor under this subsection shall be computed under paragraph (1)(A) for the period beginning on June 1, 2010, and ending on December 31, 2010, and for 2011 and subsequent years as if subparagraph (A) had never applied.

(11) UPDATE FOR JUNE THROUGH DECEMBER OF 2010.—

(A) IN GENERAL.—Subject to paragraphs (7)(B), (8)(B), (9)(B), and (10)(B), in lieu of the update to the single conversion factor established in paragraph (1)(C) that would otherwise apply for 2010 for the period beginning on June 1, 2010, and ending on December 31, 2010, the update to the single conversion factor shall be 2.2 percent.

(B) NO EFFECT ON COMPUTATION OF CONVERSION FACTOR FOR 2011 AND SUBSEQUENT YEARS.—The conversion factor under this subsection shall be computed under paragraph (1)(A) for 2011 and subsequent years as if subparagraph (A) had never applied.

(12) UPDATE FOR 2011.—

(A) IN GENERAL.—Subject to paragraphs (7)(B), (8)(B), (9)(B), (10)(B), and (11)(B), in lieu of the update to the single conversion factor established in paragraph (1)(C) that

would otherwise apply for 2011, the update to the single conversion factor shall be 0 percent.

(B) NO EFFECT ON COMPUTATION OF CONVERSION FACTOR FOR 2012 AND SUBSEQUENT YEARS.—The conversion factor under this subsection shall be computed under paragraph (1)(A) for 2012 and subsequent years as if subparagraph (A) had never applied.

(13) UPDATE FOR 2012.—

(A) IN GENERAL.—Subject to paragraphs (7)(B), (8)(B), (9)(B), (10)(B), (11)(B), and (12)(B), in lieu of the update to the single conversion factor established in paragraph (1)(C) that would otherwise apply for 2012, the update to the single conversion factor shall be zero percent.

(B) NO EFFECT ON COMPUTATION OF CONVERSION FACTOR FOR 2013 AND SUBSEQUENT YEARS.—The conversion factor under this subsection shall be computed under paragraph (1)(A) for 2013 and subsequent years as if subparagraph (A) had never applied.

(14) UPDATE FOR 2013.—

(A) IN GENERAL.—Subject to paragraphs (7)(B), (8)(B), (9)(B), (10)(B), (11)(B), (12)(B), and (13)(B), in lieu of the update to the single conversion factor established in paragraph (1)(C) that would otherwise apply for 2013, the update to the single conversion factor for such year shall be zero percent.

(B) NO EFFECT ON COMPUTATION OF CONVERSION FACTOR FOR 2014 AND SUBSEQUENT YEARS.—The conversion factor under this subsection shall be computed under paragraph (1)(A) for 2014 and subsequent years as if subparagraph (A) had never applied.

(15) UPDATE FOR 2014.—

(A) IN GENERAL.—Subject to paragraphs (7)(B), (8)(B), (9)(B), (10)(B), (11)(B), (12)(B), (13)(B), and (14)(B), in lieu of the update to the single conversion factor established in paragraph (1)(C) that would otherwise apply for 2014, the update to the single conversion factor shall be 0.5 percent.

(B) NO EFFECT ON COMPUTATION OF CONVERSION FACTOR FOR SUBSEQUENT YEARS.—The conversion factor under this subsection shall be computed under paragraph (1)(A) for 2015 and subsequent years as if subparagraph (A) had never applied.

(16) UPDATE FOR JANUARY THROUGH JUNE OF 2015.—Subject to paragraphs (7)(B), (8)(B), (9)(B), (10)(B), (11)(B), (12)(B), (13)(B), (14)(B), and (15)(B), in lieu of the update to the single conversion factor established in paragraph (1)(C) that would otherwise apply for 2015 for the period beginning on January 1, 2015, and ending on June 30, 2015, the update to the single conversion factor shall be 0.0 percent.

(17) UPDATE FOR JULY THROUGH DECEMBER OF 2015.—The update to the single conversion factor established in paragraph (1)(C) for the period beginning on July 1, 2015, and ending on December 31, 2015, shall be 0.5 percent.

(18) UPDATE FOR 2016 THROUGH 2019.—The update to the single conversion factor established in paragraph (1)(C) for 2016 and each subsequent year through 2019 shall be 0.5 percent.

(19) UPDATE FOR 2020 THROUGH 2025.—The update to the single conversion factor established in paragraph (1)(C) for 2020 and each subsequent year through 2025 shall be 0.0 percent.

(20) UPDATE FOR 2026 AND SUBSEQUENT YEARS.—For 2026 and each subsequent year, the update to the qualifying APM conversion factor established under paragraph (1)(A) is 0.75 percent, and the update to the nonqualifying APM conversion factor established under such paragraph is 0.25 percent.

(e) GEOGRAPHIC ADJUSTMENT FACTORS.—

(1) ESTABLISHMENT OF GEOGRAPHIC INDICES.—

(A) IN GENERAL.—Subject to subparagraphs (B), (C), (E), (G), (H), and (I), the Secretary shall establish—

(i) an index which reflects the relative costs of the mix of goods and services comprising practice expenses (other than malpractice expenses) in the different fee schedule areas compared to the national average of such costs,

(ii) an index which reflects the relative costs of malpractice expenses in the different fee schedule areas compared to the national average of such costs, and

(iii) an index which reflects ¼ of the difference between the relative value of physicians' work effort in each of the different fee schedule areas and the national average of such work effort.

(B) CLASS-SPECIFIC GEOGRAPHIC COST-OF-PRACTICE INDICES.—The Secretary may establish more than one index under subparagraph (A)(i) in the case of classes of physicians' services, if, because of differences in the mix of goods and services comprising practice expenses for the different classes of services, the application of a single index under such clause to different classes of such services would be substantially inequitable.

(C) PERIODIC REVIEW AND ADJUSTMENTS IN GEOGRAPHIC ADJUSTMENT FACTORS.—The Secretary, not less often than every 3 years, shall, in consultation with appropriate representatives of physicians, review the indices established under subparagraph (A) and the geographic index values applied under this subsection for all fee schedule areas. Based on such review, the Secretary may revise such index and adjust such index values, except that, if more than 1 year has elapsed since the date of the last previous adjustment, the adjustment to be applied in the first year of the next adjustment shall be ½ of the adjustment that otherwise would be made.

(D) USE OF RECENT DATA.—In establishing indices and index values under this paragraph, the Secretary shall use the most recent data available relating to practice expenses, malpractice expenses, and physician work effort in different fee schedule areas.

(E) FLOOR AT 1.0 ON WORK GEOGRAPHIC INDEX.—After calculating the work geographic index in subparagraph (A)(iii), for purposes of payment for services furnished on or after January 1, 2004, and before January 1, 2018, the Secretary shall increase the work geographic index to 1.00

for any locality for which such work geographic index is less than 1.00.

(G) FLOOR FOR PRACTICE EXPENSE, MALPRACTICE, AND WORK GEOGRAPHIC INDICES FOR SERVICES FURNISHED IN ALASKA.—For purposes of payment for services furnished in Alaska on or after January 1, 2004, and before January 1, 2006, after calculating the practice expense, malpractice, and work geographic indices in clauses (i), (ii), and (iii) of subparagraph (A) and in subparagraph (B), the Secretary shall increase any such index to 1.67 if such index would otherwise be less than 1.67. For purposes of payment for services furnished in the State described in the preceding sentence on or after January 1, 2009, after calculating the work geographic index in subparagraph (A)(iii), the Secretary shall increase the work geographic index to 1.5 if such index would otherwise be less than 1.5

(H) PRACTICE EXPENSE GEOGRAPHIC ADJUSTMENT FOR 2010 AND SUBSEQUENT YEARS.—

(i) FOR 2010.—Subject to clause (iii), for services furnished during 2010, the employee wage and rent portions of the practice expense geographic index described in subparagraph (A)(i) shall reflect ½ of the difference between the relative costs of employee wages and rents in each of the different fee schedule areas and the national average of such employee wages and rents.

(ii) FOR 2011.—Subject to clause (iii), for services furnished during 2011, the employee wage and rent portions of the practice expense geographic index described in subparagraph (A)(i) shall reflect ½ of the difference between the relative costs of employee wages and rents in each of the different fee schedule areas and the national average of such employee wages and rents.

(iii) HOLD HARMLESS.—The practice expense portion of the geographic adjustment factor applied in a fee schedule area for services furnished in 2010 or 2011 shall not, as a result of the application of clause (i) or (ii), be reduced below the practice expense portion of the geographic adjustment factor under subparagraph (A)(i) (as calculated prior to the application of such clause (i) or (ii), respectively) for such area for such year.

(iv) ANALYSIS.—The Secretary shall analyze current methods of establishing practice expense geographic adjustments under subparagraph (A)(i) and evaluate data that fairly and reliably establishes distinctions in the costs of operating a medical practice in the different fee schedule areas. Such analysis shall include an evaluation of the following:

(I) The feasibility of using actual data or reliable survey data developed by medical organizations on the costs of operating a medical practice, including office rents and non-physician staff wages, in different fee schedule areas.

(II) The office expense portion of the practice expense geographic adjustment described in subparagraph (A)(i), including the extent to which types of office expenses are determined in local markets instead of national markets.

(III) The weights assigned to each of the categories within the practice expense geographic adjustment described in subparagraph (A)(i).

(v) REVISION FOR 2012 AND SUBSEQUENT YEARS.—As a result of the analysis described in clause (iv), the Secretary shall, not later than January 1, 2012, make appropriate adjustments to the practice expense geographic adjustment described in subparagraph (A)(i) to ensure accurate geographic adjustments across fee schedule areas, including—

(I) basing the office rents component and its weight on office expenses that vary among fee schedule areas; and

(II) considering a representative range of professional and non-professional personnel employed in a medical office based on the use of the American Community Survey data or other reliable data for wage adjustments.

Such adjustments shall be made without regard to adjustments made pursuant to clauses (i) and (ii) and shall be made in a budget neutral manner.

(I) FLOOR FOR PRACTICE EXPENSE INDEX FOR SERVICES FURNISHED IN FRONTIER STATES.—

(i) IN GENERAL.—Subject to clause (ii), for purposes of payment for services furnished in a frontier State (as defined in section 1886(d)(3)(E)(iii)(II)) on or after January 1, 2011, after calculating the practice expense index in subparagraph (A)(i), the Secretary shall increase any such index to 1.00 if such index would otherwise be less that 1.00. The preceding sentence shall not be applied in a budget neutral manner.

(ii) LIMITATION.—This subparagraph shall not apply to services furnished in a State that receives a nonlabor related share adjustment under section 1886(d)(5)(H).

(2) COMPUTATION OF GEOGRAPHIC ADJUSTMENT FACTOR.—For purposes of subsection (b)(1)(C), for all physicians' services for each fee schedule area the Secretary shall establish a geographic adjustment factor equal to the sum of the geographic cost-of-practice adjustment factor (specified in paragraph (3)), the geographic malpractice adjustment factor (specified in paragraph (4)), and the geographic physician work adjustment factor (specified in paragraph (5)) for the service and the area.

(3) GEOGRAPHIC COST-OF-PRACTICE ADJUSTMENT FACTOR.—For purposes of paragraph (2), the "geographic cost-of-practice adjustment factor", for a service for a fee schedule area, is the product of—

(A) the proportion of the total relative value for the service that reflects the relative value units for the practice expense component, and

(B) the geographic cost-of-practice index value for the area for the service, based on the index established under paragraph (1)(A)(i) or (1)(B) (as the case may be).

(4) GEOGRAPHIC MALPRACTICE ADJUSTMENT FACTOR.—For purposes of paragraph (2), the "geographic malpractice adjustment factor", for a service for a fee schedule area, is the product of—

(A) the proportion of the total relative value for the service that reflects the relative value units for the malpractice component, and

(B) the geographic malpractice index value for the area, based on the index established under paragraph (1)(A)(ii).

(5) GEOGRAPHIC PHYSICIAN WORK ADJUSTMENT FACTOR.—For purposes of paragraph (2), the "geographic physician work adjustment factor", for a service for a fee schedule area, is the product of—

(A) the proportion of the total relative value for the service that reflects the relative value units for the work component, and

(B) the geographic physician work index value for the area, based on the index established under paragraph (1)(A)(iii).

(6) USE OF MSAS AS FEE SCHEDULE AREAS IN CALIFORNIA.—

(A) IN GENERAL.—Subject to the succeeding provisions of this paragraph and notwithstanding the previous provisions of this subsection, for services furnished on or after January 1, 2017, the fee schedule areas used for payment under this section applicable to California shall be the following:

(i) Each Metropolitan Statistical Area (each in this paragraph referred to as an "MSA"), as defined by the Director of the Office of Management and Budget as of December 31 of the previous year, shall be a fee schedule area.

(ii) All areas not included in an MSA shall be treated as a single rest-of-State fee schedule area.

(B) TRANSITION FOR MSAS PREVIOUSLY IN REST-OF-STATE PAYMENT LOCALITY OR IN LOCALITY 3.—

(i) IN GENERAL.—For services furnished in California during a year beginning with 2017 and ending with 2021 in an MSA in a transition area (as defined in subparagraph (D)), subject to subparagraph (C), the geographic index values to be applied under this subsection for such year shall be equal to the sum of the following:

(I) CURRENT LAW COMPONENT.—The old weighting factor (described in clause (ii)) for such year multiplied by the geographic index values under this subsection for the fee schedule area that included such MSA that would have applied in such area (as estimated by the Secretary) if this paragraph did not apply.

(II) MSA-BASED COMPONENT.—The MSA-based weighting factor (described in clause (iii)) for such year multiplied by the geographic index values

computed for the fee schedule area under subparagraph (A) for the year (determined without regard to this subparagraph).

(ii) OLD WEIGHTING FACTOR.—The old weighting factor described in this clause—

(I) for 2017, is 5/6; and

(II) for each succeeding year, is the old weighting factor described in this clause for the previous year minus 1/6.

(iii) MSA-BASED WEIGHTING FACTOR.—The MSA-based weighting factor described in this clause for a year is 1 minus the old weighting factor under clause (ii) for that year.

(C) HOLD HARMLESS.—For services furnished in a transition area in California during a year beginning with 2017, the geographic index values to be applied under this subsection for such year shall not be less than the corresponding geographic index values that would have applied in such transition area (as estimated by the Secretary) if this paragraph did not apply.

(D) TRANSITION AREA DEFINED.—In this paragraph, the term "transition area" means each of the following fee schedule areas for 2013:

(i) The rest-of-State payment locality.

(ii) Payment locality 3.

(E) REFERENCES TO FEE SCHEDULE AREAS.—Effective for services furnished on or after January 1, 2017, for California, any reference in this section to a fee schedule area shall be deemed a reference to a fee schedule area established in accordance with this paragraph.

(f) SUSTAINABLE GROWTH RATE.—

(1) PUBLICATION.—The Secretary shall cause to have published in the Federal Register not later than—

(A) November 1, 2000, the sustainable growth rate for 2000 and 2001; and

(B) November 1 of each succeeding year through 2014 the sustainable growth rate for such succeeding year and each of the preceding 2 years.

(2) SPECIFICATION OF GROWTH RATE.—The sustainable growth rate for all physicians' services for a fiscal year (beginning with fiscal year 1998 and ending with fiscal year 2000) and a year beginning with 2000 and ending with 2014 shall be equal to the product of—

(A) 1 plus the Secretary's estimate of the weighted average percentage increase (divided by 100) in the fees for all physicians' services in the applicable period involved,

(B) 1 plus the Secretary's estimate of the percentage change (divided by 100) in the average number of individuals enrolled under this part (other than Medicare+Choice plan enrollees) from the previous applicable period to the applicable period involved,

(C) 1 plus the Secretary's estimate of the annual average percentage growth in real gross domestic product per capita (divided by 100) during the 10-year period ending with the applicable period involved, and

(D) 1 plus the Secretary's estimate of the percentage change (divided by 100) in expenditures for all physicians' services in the applicable period (compared with the previous applicable period) which will result from changes in law and regulations, determined without taking into account estimated changes in expenditures resulting from the update adjustment factor determined under subsection (d)(3)(B) or (d)(4)(B), as the case may be,

minus 1 and multiplied by 100.

(3) DATA TO BE USED.—For purposes of determining the update adjustment factor under subsection (d)(4)(B) for a year beginning with 2001, the sustainable growth rates taken into consideration in the determination under paragraph (2) shall be determined as follows:

(A) FOR 2001.—For purposes of such calculations for 2001, the sustainable growth rates for fiscal year 2000 and the years 2000 and 2001 shall be determined on the basis of the best data available to the Secretary as of September 1, 2000.

(B) FOR 2002.—For purposes of such calculations for 2002, the sustainable growth rates for fiscal year 2000 and for years 2000, 2001, and 2002 shall be determined on the basis of the best data available to the Secretary as of September 1, 2001.

(C) FOR 2003 AND SUCCEEDING YEARS.—For purposes of such calculations for a year after 2002—

(i) the sustainable growth rates for that year and the preceding 2 years shall be determined on the basis of the best data available to the Secretary as of September 1 of the year preceding the year for which the calculation is made; and

(ii) the sustainable growth rate for any year before a year described in clause (i) shall be the rate as most recently determined for that year under this subsection.

Nothing in this paragraph shall be construed as affecting the sustainable growth rates established for fiscal year 1998 or fiscal year 1999.

(4) DEFINITIONS.—In this subsection:

(A) SERVICES INCLUDED IN PHYSICIANS' SERVICES.—The term "physicians' services" includes other items and services (such as clinical diagnostic laboratory tests and radiology services), specified by the Secretary, that are commonly performed or furnished by a physician or in a physician's office, but does not include services furnished to a Medicare+Choice plan enrollee.

(B) MEDICARE+CHOICE PLAN ENROLLEE.—The term "Medicare+Choice plan enrollee" means, with respect to a fiscal year, an individual enrolled under this part who has elected to receive benefits under this title for the fiscal year through a Medicare+Choice plan offered under part C, and also includes an individual who is receiving benefits under this part through enrollment with an eligible organization with a risk-sharing contract under section 1876.

(C) APPLICABLE PERIOD.—The term "applicable period" means—

(i) a fiscal year, in the case of fiscal year 1998, fiscal year 1999, and fiscal year 2000; or

(ii) a calendar year with respect to a year beginning with 2000;

as the case may be.

(g) LIMITATION ON BENEFICIARY LIABILITY.—

(1) LIMITATION ON ACTUAL CHARGES.—

(A) IN GENERAL.—In the case of a nonparticipating physician or nonparticipating supplier or other person (as defined in section 1842(i)(2)) who does not accept payment on an assignment-related basis for a physician's service furnished with respect to an individual enrolled under this part, the following rules apply:

(i) APPLICATION OF LIMITING CHARGE.—No person may bill or collect an actual charge for the service in excess of the limiting charge described in paragraph (2) for such service.

(ii) NO LIABILITY FOR EXCESS CHARGES.—No person is liable for payment of any amounts billed for the service in excess of such limiting charge.

(iii) CORRECTION OF EXCESS CHARGES.—If such a physician, supplier, or other person bills, but does not collect, an actual charge for a service in violation of clause (i), the physician, supplier, or other person shall reduce on a timely basis the actual charge billed for the service to an amount not to exceed the limiting charge for the service.

(iv) REFUND OF EXCESS COLLECTIONS.—If such a physician, supplier, or other person collects an actual charge for a service in violation of clause (i), the physician, supplier, or other person shall provide on a timely basis a refund to the individual charged in the amount by which the amount collected exceeded the limiting charge for the service. The amount of such a refund shall be reduced to the extent the individual has an outstanding balance owed by the individual to the physician.

(B) SANCTIONS.—If a physician, supplier, or other person—

(i) knowingly and willfully bills or collects for services in violation of subparagraph (A)(i) on a repeated basis, or

(ii) fails to comply with clause (iii) or (iv) of subparagraph (A) on a timely basis,

the Secretary may apply sanctions against the physician, supplier, or other person in accordance with paragraph (2) of section 1842(j). In applying this subparagraph, paragraph (4) of such section applies in the same manner as such paragraph applies to such section and any reference in such section to a physician is deemed also to include a reference to a supplier or other person under this subparagraph.

(C) TIMELY BASIS.—For purposes of this paragraph, a correction of a bill for an excess charge or refund of an amount with respect to a violation of subparagraph (A)(i) in the case of a service is considered to be provided "on a timely basis", if the reduction or refund is made not later than 30 days after the date the physician, supplier, or other person is notified by the carrier under this part of such violation and of the requirements of subparagraph (A).

(2) LIMITING CHARGE DEFINED.—

(A) FOR 1991.—For physicians' services of a physician furnished during 1991, other than radiologist services subject to section 1834(b), the "limiting charge" shall be the same percentage (or, if less, 25 percent) above the recognized payment amount under this part with respect to the physician (as a nonparticipating physician) as the percentage by which—

(i) the maximum allowable actual charge (as determined under section 1842(j)(1)(C) as of December 31, 1990, or, if less, the maximum actual charge otherwise permitted for the service under this part as of such date) for the service of the physician, exceeds

(ii) the recognized payment amount for the service of the physician (as a nonparticipating physician) as of such date.

In the case of evaluation and management services (as specified in section 1842(b)(16)(B)(ii)), the preceding sentence shall be applied by substituting "40 percent" for "25 percent".

(B) FOR 1992.—For physicians' services furnished during 1992, other than radiologist services subject to section 1834(b), the "limiting charge" shall be the same percentage (or, if less, 20 percent) above the recognized payment amount under this part for nonparticipating physicians as the percentage by which—

(i) the limiting charge (as determined under subparagraph (A) as of December 31, 1991) for the service, exceeds

(ii) the recognized payment amount for the service for nonparticipating physicians as of such date.

(C) AFTER 1992.—For physicians' services furnished in a year after 1992, the "limiting charge" shall be 115 percent of the recognized payment amount under this part for nonparticipating physicians or for nonparticipating suppliers or other persons.

(D) RECOGNIZED PAYMENT AMOUNT.—In this section, the term "recognized payment amount" means, for services furnished on or after January 1, 1992, the fee schedule amount determined under subsection (a) (or, if payment under this part is made on a basis other than the fee schedule under this section, 95 percent of the other payment basis), and, for services furnished during 1991, the applicable percentage (as defined in section 1842(b)(4)(A)(iv)) of the prevailing charge (or fee schedule amount) for nonparticipating physicians for that year.

(3) LIMITATION ON CHARGES FOR MEDICARE BENEFICIARIES ELIGIBLE FOR MEDICAID BENEFITS.—

(A) IN GENERAL.—Payment for physicians' services furnished on or after April 1, 1990, to an individual who is enrolled under this part and eligible for any medical assistance (including as a qualified medicare beneficiary, as defined in section 1905(p)(1)) with respect to such services under a State plan approved under title XIX may only be made on an assignment-related basis and the provisions of section 1902(n)(3)(A) apply to further limit permissible charges under this section.

(B) PENALTY.—A person may not bill for physicians' services subject to subparagraph (A) other than on an assignment-related basis. No person is liable for payment of any amounts billed for such a service in violation of the previous sentence. If a person knowingly and willfully bills for physicians' services in violation of the first sentence, the Secretary may apply sanctions against the person in accordance with section 1842(j)(2).

(4) PHYSICIAN SUBMISSION OF CLAIMS.—

(A) IN GENERAL.—For services furnished on or after September 1, 1990, within 1 year after the date of providing a service for which payment is made under this part on a reasonable charge or fee schedule basis, a physician, supplier, or other person (or an employer or facility in the cases described in section 1842(b)(6)(A))—

(i) shall complete and submit a claim for such service on a standard claim form specified by the Secretary to the carrier on behalf of a beneficiary, and

(ii) may not impose any charge relating to completing and submitting such a form.

(B) PENALTY.—(i) With respect to an assigned claim wherever a physician, provider, supplier or other person (or an employer or facility in the cases described in section 1842(b)(6)(A)) fails to submit such a claim as required in subparagraph (A), the Secretary shall reduce by 10 percent the amount that would otherwise be paid for such claim under this part.

(ii) If a physician, supplier, or other person (or an employer or facility in the cases described in section 1842(b)(6)(A)) fails to submit a claim required to be submitted under subparagraph (A) or imposes a charge in violation of such subparagraph, the Secretary shall apply the sanction with respect to such a violation in the same manner as a sanction may be imposed under section 1842(p)(3) for a violation of section 1842(p)(1).

(5) ELECTRONIC BILLING; DIRECT DEPOSIT.—The Secretary shall encourage and develop a system providing for expedited payment for claims submitted electronically. The Secretary shall also encourage and provide incentives allowing for direct deposit as payments for services furnished by participating physicians. The Secretary shall provide physicians with such technical information as necessary to enable such physicians to submit claims electronically. The Secretary shall submit a plan to Congress on this paragraph by May 1, 1990.

(6) MONITORING OF CHARGES.—

(A) IN GENERAL.—The Secretary shall monitor—

(i) the actual charges of nonparticipating physicians for physicians' services furnished on or after January 1, 1991, to individuals enrolled under this part, and

(ii) changes (by specialty, type of service, and geographic area) in (I) the proportion of expenditures for physicians' services provided under this part by participating physicians, (II) the proportion of expenditures for such services for which payment is made under this part on an assignment-related basis, and (III) the amounts charged above the recognized payment amounts under this part.

(B) REPORT.—The Secretary shall, by not later than April 15 of each year (beginning in 1992), report to the Congress information on the extent to which actual charges exceed limiting charges, the number and types of services involved, and the average amount of excess charges and information regarding the changes described in subparagraph (A)(ii).

(C) PLAN.—If the Secretary finds that there has been a significant decrease in the proportions described in subclauses (I) and (II) of subparagraph (A)(ii) or an increase in the amounts described in subclause (III) of that subparagraph, the Secretary shall develop a plan to address such a problem and transmit to Congress recommendations regarding the plan. The Medicare Payment Advisory Commission shall review the Secretary's plan and recommendations and transmit to Congress its comments regarding such plan and recommendations.

(7) MONITORING OF UTILIZATION AND ACCESS.—

(A) IN GENERAL.—The Secretary shall monitor—

(i) changes in the utilization of and access to services furnished under this part within geographic, population, and service related categories,

(ii) possible sources of inappropriate utilization of services furnished under this part which contribute to the overall level of expenditures under this part, and

(iii) factors underlying these changes and their interrelationships.

(B) REPORT.—The Secretary shall by not later than April 15, of each year (beginning with 1991) report to the Congress on the changes described in subparagraph (A)(i) and shall include in the report an examination of the factors (including factors relating to different services and specific categories and groups of services and geographic and demographic variations in utilization) which may contribute to such changes.

(C) RECOMMENDATIONS.—The Secretary shall include in each annual report under subparagraph (B) recommendations—

(i) addressing any identified patterns of inappropriate utilization,

(ii) on utilization review,

(iii) on physician education or patient education,

(iv) addressing any problems of beneficiary access to care made evident by the monitoring process, and

(v) on such other matters as the Secretary deems appropriate.

The Medicare Payment Advisory Commission shall comment on the Secretary's recommendations and in developing its comments, the Commission shall convene and consult a panel of physician experts to evaluate the implications of medical utilization patterns for the quality of and access to patient care.

(h) SENDING INFORMATION TO PHYSICIANS.—Before the beginning of each year (beginning with 1992), the Secretary shall send to each physician or nonparticipating supplier or other person furnishing physicians' services (as defined in section 1848(j)(3)) furnishing physicians' services under this part, for services commonly performed by the physician, supplier, or other person, information on fee schedule amounts that apply for the year in the fee schedule area for participating and non-participating physicians, and the maximum amount that may be charged consistent with subsection (g)(2). Such information shall be transmitted in conjunction with notices to physicians, suppliers, and other persons under section 1842(h) (relating to the participating physician program) for a year.

(i) MISCELLANEOUS PROVISIONS.—

(1) RESTRICTION ON ADMINISTRATIVE AND JUDICIAL REVIEW.—There shall be no administrative or judicial review under section 1869 or otherwise of—

(A) the determination of the adjusted historical payment basis (as defined in subsection (a)(2)(D)(i)),

(B) the determination of relative values and relative value units under subsection (c), including adjustments under subsections (c)(2)(F), (c)(2)(H), and (c)(2)(I) and section 13515(b) of the Omnibus Budget Reconciliation Act of 1993,

(C) the determination of conversion factors under subsection (d), including without limitation a prospective redetermination of the sustainable growth rates for any or all previous fiscal years,

(D) the establishment of geographic adjustment factors under subsection (e),

(E) the establishment of the system for the coding of physicians' services under this section, and

(F) the collection and use of information in the determination of relative values under subsection (c)(2)(M).

(2) ASSISTANTS-AT-SURGERY.—

(A) IN GENERAL.—Subject to subparagraph (B), in the case of a surgical service furnished by a physician, if payment is made separately under this part for the services of a physician serving as an assistant-at-surgery, the fee schedule amount shall not exceed 16 percent of the fee schedule amount otherwise determined under this section for the global surgical service involved.

(B) DENIAL OF PAYMENT IN CERTAIN CASES.—If the Secretary determines, based on the most recent data available, that for a surgical procedure (or class of surgical procedures) the national average percentage of such procedure

performed under this part which involve the use of a physician as an assistant at surgery is less than 5 percent, no payment may be made under this part for services of an assistant at surgery involved in the procedure.

(3) NO COMPARABILITY ADJUSTMENT.—For physicians' services for which payment under this part is determined under this section—

(A) a carrier may not make any adjustment in the payment amount under section 1842(b)(3)(B) on the basis that the payment amount is higher than the charge applicable, for comparable services and under comparable circumstances, to the policyholders and subscribers of the carrier,

(B) no payment adjustment may be made under section 1842(b)(8), and

(C) section 1842(b)(9) shall not apply.

(j) DEFINITIONS.—In this section:

(1) CATEGORY.—For services furnished before January 1, 1998, the term "category" means, with respect to physicians' services, surgical services (as defined by the Secretary and including anesthesia services), primary care services (as defined in section 1842(i)(4)), and all other physicians' services. The Secretary shall define surgical services and publish such definitions in the Federal Register no later than May 1, 1990, after consultation with organizations representing physicians.

(2) FEE SCHEDULE AREA.—Except as provided in subsection (e)(6)(D), the term "fee schedule area" means a locality used under section 1842(b) for purposes of computing payment amounts for physicians' services.

(3) PHYSICIANS' SERVICES.—The term "physicians' services" includes items and services described in paragraphs (1), (2)(A), (2)(D), (2)(G), (2)(P) (with respect to services described in subparagraphs (A) and (C) of section 1861(oo)(2)), (2)(R) (with respect to services described in suparagraphs (B), (C), and (D) of section 1861(pp)(1)), (2)(S), (2)(W), (2)(AA), (2)(DD), (2)(EE), (2)(FF) (including administration of the health risk assessment), (3), (4), (13), (14) (with respect to services described in section 1861(nn)(2)), and (15) of section 1861(s) (other than clinical diagnostic laboratory tests and, except for purposes of subsection (a)(3), (g), and (h) such other items and services as the Secretary may specify).

(4) PRACTICE EXPENSES.—The term "practice expenses" includes all expenses for furnishing physicians' services, excluding malpractice expenses, physician compensation, and other physician fringe benefits.

(k) QUALITY REPORTING SYSTEM.—

(1) IN GENERAL.—The Secretary shall implement a system for the reporting by eligible professionals of data on quality measures specified under paragraph (2). Such data shall be submitted in a form and manner specified by the Secretary (by program instruction or otherwise), which may include submission of such data on claims under this part.

(2) USE OF CONSENSUS-BASED QUALITY MEASURES.—

(A) FOR 2007.—

(i) IN GENERAL.—For purposes of applying this subsection for the reporting of data on quality measures for covered professional services furnished during the period beginning July 1, 2007, and ending December 31, 2007, the quality measures specified under this paragraph are the measures identified as 2007 physician quality measures under the Physician Voluntary Reporting Program as published on the public website of the Centers for Medicare & Medicaid Services as of the date of the enactment of this subsection, except as may be changed by the Secretary based on the results of a consensus-based process in January of 2007, if such change is published on such website by not later than April 1, 2007.

(ii) SUBSEQUENT REFINEMENTS IN APPLICATION PERMITTED.—The Secretary may, from time to time (but not later than July 1, 2007), publish on such website (without notice or opportunity for public comment) modifications or refinements (such as code additions, corrections, or revisions) for the application of quality measures previously published under clause (i), but may not, under this clause, change the quality measures under the reporting system.

(iii) IMPLEMENTATION.—Notwithstanding any other provision of law, the Secretary may implement by program instruction or otherwise this subsection for 2007.

(B) FOR 2008 AND 2009.—

(i) IN GENERAL.—For purposes of reporting data on quality measures for covered professional services furnished during 2008 and 2009, the quality measures specified under this paragraph for covered professional services shall be measures that have been adopted or endorsed by a consensus organization (such as the National Quality Forum or AQA), that include measures that have been submitted by a physician specialty, and that the Secretary identifies as having used a consensus-based process for developing such measures. Such measures shall include structural measures, such as the use of electronic health records and electronic prescribing technology.

(ii) PROPOSED SET OF MEASURES.—Not later than August 15 of each of 2007 and 2008, the Secretary shall publish in the Federal Register a proposed set of quality measures that the Secretary determines are described in clause (i) and would be appropriate for eligible professionals to use to submit data to the Secretary in 2008 or 2009, as applicable. The Secretary shall provide for a period of public comment on such set of measures.

(iii) FINAL SET OF MEASURES.—Not later than November 15 of each of 2007 and 2008, the Secretary shall publish in the Federal Register a final set of quality measures that the Secretary determines are described in clause (i) and would be appropriate for el-

igible professionals to use to submit data to the Secretary in 2008 or 2009, as applicable.

(C) FOR 2010 AND SUBSEQUENT YEARS.—

(i) IN GENERAL.—Subject to clause (ii), for purposes of reporting data on quality measures for covered professional services furnished during 2010 and each subsequent year, subject to subsection (m)(3)(C), the quality measures (including electronic prescribing quality measures) specified under this paragraph shall be such measures selected by the Secretary from measures that have been endorsed by the entity with a contract with the Secretary under section 1890(a).

(ii) EXCEPTION.—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), the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary, such as the AQA alliance.

(D) OPPORTUNITY TO PROVIDE INPUT ON MEASURES FOR 2009 AND SUBSEQUENT YEARS.—For each quality measure (including an electronic prescribing quality measure) adopted by the Secretary under subparagraph (B) (with respect to 2009) or subparagraph (C), the Secretary shall ensure that eligible professionals have the opportunity to provide input during the development, endorsement, or selection of measures applicable to services they furnish.

(3) COVERED PROFESSIONAL SERVICES AND ELIGIBLE PROFESSIONALS DEFINED.—For purposes of this subsection:

(A) COVERED PROFESSIONAL SERVICES.—The term "covered professional services" means services for which payment is made under, or is based on, the fee schedule established under this section and which are furnished by an eligible professional.

(B) ELIGIBLE PROFESSIONAL.—The term "eligible professional" means any of the following:

(i) A physician.

(ii) A practitioner described in section 1842(b)(18)(C).

(iii) A physical or occupational therapist or a qualified speech-language pathologist.

(iv) Beginning with 2009, a qualified audiologist (as defined in section 1861(ll)(3)(B)).

(4) USE OF REGISTRY-BASED REPORTING.—As part of the publication of proposed and final quality measures for 2008 under clauses (ii) and (iii) of paragraph (2)(B), the Secretary shall address a mechanism whereby an eligible professional may provide data on quality measures through an appropriate medical registry (such as the Society of Thoracic Surgeons National Database) or through a Maintenance of Certification program operated by a specialty body of the American Board of Medical Specialties that meets the criteria for such a registry, as identified by the Secretary.

(5) IDENTIFICATION UNITS.—For purposes of applying this subsection, the Secretary may identify eligible professionals through billing units, which may include the use of the Provider Identification Number, the unique physician identification number (described in section 1833(q)(1)), the taxpayer identification number, or the National Provider Identifier. For purposes of applying this subsection for 2007, the Secretary shall use the taxpayer identification number as the billing unit.

(6) EDUCATION AND OUTREACH.—The Secretary shall provide for education and outreach to eligible professionals on the operation of this subsection.

(7) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, of the development and implementation of the reporting system under paragraph (1), including identification of quality measures under paragraph (2) and the application of paragraphs (4) and (5).

(8) IMPLEMENTATION.—The Secretary shall carry out this subsection acting through the Administrator of the Centers for Medicare & Medicaid Services.

(9) CONTINUED APPLICATION FOR PURPOSES OF MIPS AND FOR CERTAIN PROFESSIONALS VOLUNTEERING TO REPORT.—The Secretary shall, in accordance with subsection (q)(1)(F), carry out the provisions of this subsection—

(A) for purposes of subsection (q); and

(B) for eligible professionals who are not MIPS eligible professionals (as defined in subsection (q)(1)(C)) for the year involved.

(l) PHYSICIAN ASSISTANCE AND QUALITY INITIATIVE FUND.—

(1) ESTABLISHMENT.—The Secretary shall establish under this subsection a Physician Assistance and Quality Initiative Fund (in this subsection referred to as the "Fund") which shall be available to the Secretary for physician payment and quality improvement initiatives, which may include application of an adjustment to the update of the conversion factor under subsection (d).

(2) FUNDING.—

(A) AMOUNT AVAILABLE.—

(i) IN GENERAL.—Subject to clause (ii), there shall be available to the Fund the following amounts:

(I) For expenditures during 2008, an amount equal to $150,500,000.

(II) For expenditures during 2009, an amount equal to $24,500,000.

(ii) LIMITATIONS ON EXPENDITURES.—

(I) 2008.—The amount available for expenditures during 2008 shall be reduced as provided by subparagraph (A) of section 225(c)(1) and section 524 of the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2008 (division G of the Consolidated Appropriations Act, 2008).

(II) 2009.—The amount available for expenditures during 2009 shall be reduced as provided by subparagraph (B) of such section 225(c)(1).

(B) TIMELY OBLIGATION OF ALL AVAILABLE FUNDS FOR SERVICES.—The Secretary shall provide for expenditures from the Fund in a manner designed to provide (to the maximum extent feasible) for the obligation of the entire amount available for expenditures, after application of subparagraph (A)(ii), during—

(i) 2008 for payment with respect to physicians' services furnished during 2008; and

(ii) 2009 for payment with respect to physicians' services furnished during 2009.

(C) PAYMENT FROM TRUST FUND.—The amount specified in subparagraph (A) shall be available to the Fund, as expenditures are made from the Fund, from the Federal Supplementary Medical Insurance Trust Fund under section 1841.

(D) FUNDING LIMITATION.—Amounts in the Fund shall be available in advance of appropriations in accordance with subparagraph (B) but only if the total amount obligated from the Fund does not exceed the amount available to the Fund under subparagraph (A). The Secretary may obligate funds from the Fund only if the Secretary determines (and the Chief Actuary of the Centers for Medicare & Medicaid Services and the appropriate budget officer certify) that there are available in the Fund sufficient amounts to cover all such obligations incurred consistent with the previous sentence.

(E) CONSTRUCTION.—In the case that expenditures from the Fund are applied to, or otherwise affect, a conversion factor under subsection (d) for a year, the conversion factor under such subsection shall be computed for a subsequent year as if such application or effect had never occurred.

(m) INCENTIVE PAYMENTS FOR QUALITY REPORTING.—

(1) INCENTIVE PAYMENTS.—

(A) IN GENERAL.—For 2007 through 2014, with respect to covered professional services furnished during a reporting period by an eligible professional, if—

(i) there are any quality measures that have been established under the physician reporting system that are applicable to any such services furnished by such professional for such reporting period;

(ii) the eligible professional satisfactorily submits (as determined under this subsection) to the Secretary data on such quality measures in accordance with such reporting system for such reporting period,

in addition to the amount otherwise paid under this part, there also shall be paid to the eligible professional (or to an employer or facility in the cases described in clause (A) of section 1842(b)(6)) or, in the case of a group practice under paragraph (3)(C), to the group practice, from the Federal Supplementary Medical Insurance Trust Fund established under section 1841 an amount equal to the applicable quality percent of the Secretary's estimate (based on

claims submitted not later than 2 months after the end of the reporting period) of the allowed charges under this part for all such covered professional services furnished by the eligible professional (or, in the case of a group practice under paragraph (3)(C), by the group practice) during the reporting period.

(B) APPLICABLE QUALITY PERCENT.—For purposes of subparagraph (A), the term "applicable quality percent" means—

(i) for 2007 and 2008, 1.5 percent; and

(ii) for 2009 and 2010, 2.0 percent;

(iii) for 2011, 1.0 percent; and

(iv) for 2012, 2013, and 2014, 0.5 percent.

(2) INCENTIVE PAYMENTS FOR ELECTRONIC PRESCRIBING.—

(A) IN GENERAL.—Subject to subparagraph (D), for 2009 through 2013, with respect to covered professional services furnished during a reporting period by an eligible professional, if the eligible professional is a successful electronic prescriber for such reporting period, in addition to the amount otherwise paid under this part, there also shall be paid to the eligible professional (or to an employer or facility in the cases described in clause (A) of section 1842(b)(6)) or, in the case of a group practice under paragraph (3)(C), to the group practice, from the Federal Supplementary Medical Insurance Trust Fund established under section 1841 an amount equal to the applicable electronic prescribing percent of the Secretary's estimate (based on claims submitted not later than 2 months after the end of the reporting period) of the allowed charges under this part for all such covered professional services furnished by the eligible professional (or, in the case of a group practice under paragraph (3)(C), by the group practice) during the reporting period.

(B) LIMITATION WITH RESPECT TO ELECTRONIC PRESCRIBING QUALITY MEASURES.—The provisions of this paragraph and subsection (a)(5) shall not apply to an eligible professional (or, in the case of a group practice under paragraph (3)(C), to the group practice) if, for the reporting period (or, for purposes of subsection (a)(5), for the reporting period for a year)—

(i) the allowed charges under this part for all covered professional services furnished by the eligible professional (or group, as applicable) for the codes to which the electronic prescribing quality measure applies (as identified by the Secretary and published on the Internet website of the Centers for Medicare & Medicaid Services as of January 1, 2008, and as subsequently modified by the Secretary) are less than 10 percent of the total of the allowed charges under this part for all such covered professional services furnished by the eligible professional (or the group, as applicable); or

(ii) if determined appropriate by the Secretary, the eligible professional does not submit (including both electronically and nonelectronically) a sufficient num-

ber (as determined by the Secretary) of prescriptions under part D.

If the Secretary makes the determination to apply clause (ii) for a period, then clause (i) shall not apply for such period.

(C) APPLICABLE ELECTRONIC PRESCRIBING PERCENT.—For purposes of subparagraph (A), the term "applicable electronic prescribing percent" means—

(i) for 2009 and 2010, 2.0 percent;

(ii) for 2011 and 2012, 1.0 percent; and

(iii) for 2013, 0.5 percent.

(D) LIMITATION WITH RESPECT TO EHR INCENTIVE PAYMENTS.—The provisions of this paragraph shall not apply to an eligible professional (or, in the case of a group practice under paragraph (3)(C), to the group practice) if, for the EHR reporting period the eligible professional (or group practice) receives an incentive payment under subsection (o)(1)(A) with respect to a certified EHR technology (as defined in subsection (o)(4)) that has the capability of electronic prescribing.

(3) SATISFACTORY REPORTING AND SUCCESSFUL ELECTRONIC PRESCRIBER AND DESCRIBED.—

(A) IN GENERAL.—For purposes of paragraph (1), an eligible professional shall be treated as satisfactorily submitting data on quality measures for covered professional services for a reporting period (or, for purposes of subsection (a)(8), for the quality reporting period for the year) if quality measures have been reported as follows:

(i) THREE OR FEWER QUALITY MEASURES APPLICABLE.—If there are no more than 3 quality measures that are provided under the physician reporting system and that are applicable to such services of such professional furnished during the period, each such quality measure has been reported under such system in at least 80 percent of the cases in which such measure is reportable under the system.

(ii) FOUR OR MORE QUALITY MEASURES APPLICABLE.—If there are 4 or more quality measures that are provided under the physician reporting system and that are applicable to such services of such professional furnishedduring the period, at least 3 such quality measures have been reported under such system in at least 80 percent of the cases in which the respective measure is reportable under the system.

For years after 2008, quality measures for purposes of this subparagraph shall not include electronic prescribing quality measures.

(B) SUCCESSFUL ELECTRONIC PRESCRIBER.—

(i) IN GENERAL.—For purposes of paragraph (2) and subsection (a)(5), an eligible professional shall be treated as a successful electronic prescriber for a reporting period (or, for purposes of subsection (a)(5), for the reporting period for a year) if the eligible professional meets the requirement described in clause (ii), or, if the Secretary determines appropriate, the re-

quirement described in clause (iii). If the Secretary makes the determination under the preceding sentence to apply the requirement described in clause (iii) for a period, then the requirement described in clause (ii) shall not apply for such period.

(ii) REQUIREMENT FOR SUBMITTING DATA ON ELECTRONIC PRESCRIBING QUALITY MEASURES.—The requirement described in this clause is that, with respect to covered professional services furnished by an eligible professional during a reporting period (or, for purposes of subsection (a)(5), for the reporting period for a year), if there are any electronic prescribing quality measures that have been established under the physician reporting system and are applicable to any such services furnished by such professional for the period, such professional reported each such measure under such system in at least 50 percent of the cases in which such measure is reportable by such professional under such system.

(iii) REQUIREMENT FOR ELECTRONICALLY PRESCRIBING UNDER PART D.—The requirement described in this clause is that the eligible professional electronically submitted a sufficient number (as determined by the Secretary) of prescriptions under part D during the reporting period (or, for purposes of subsection (a)(5), for the reporting period for a year).

(iv) USE OF PART D DATA.—Notwithstanding sections 1860D-15(d)(2)(B) and 1860D-15(f)(2), the Secretary may use data regarding drug claims submitted for purposes of section 1860D-15 that are necessary for purposes of clause (iii), paragraph (2)(B)(ii), and paragraph (5)(G).

(v) STANDARDS FOR ELECTRONIC PRESCRIBING.—To the extent practicable, in determining whether eligible professionals meet the requirements under clauses (ii) and (iii) for purposes of clause (i), the Secretary shall ensure that eligible professionals utilize electronic prescribing systems in compliance with standards established for such systems pursuant to the Part D Electronic Prescribing Program under section 1860D–4(e).

(C) SATISFACTORY REPORTING MEASURES FOR GROUP PRACTICES.—

(i) IN GENERAL.—By January 1, 2010, the Secretary shall establish and have in place a process under which eligible professionals in a group practice (as defined by the Secretary) shall be treated as satisfactorily submitting data on quality measures under subparagraph (A) and as meeting the requirement described in subparagraph (B)(ii) for covered professional services for a reporting period (or, for purposes of subsection (a)(5), for a reporting period for a year, or, for purposes of subsection (a)(8), for a quality reporting period for the year) if, in lieu of reporting measures under subsection (k)(2)(C), the group practice reports measures determined appropriate by the Secretary,

such as measures that target high-cost chronic conditions and preventive care, in a form and manner, and at a time, specified by the Secretary.

(ii) STATISTICAL SAMPLING MODEL.—The process under clause (i) shall provide and, for 2016 and subsequent years, may provide for the use of a statistical sampling model to submit data on measures, such as the model used under the Physician Group Practice demonstration project under section 1866A.

(iii) NO DOUBLE PAYMENTS.—Payments to a group practice under this subsection by reason of the process under clause (i) shall be in lieu of the payments that would otherwise be made under this subsection to eligible professionals in the group practice for satisfactorily submitting data on quality measures.

(D) SATISFACTORY REPORTING MEASURES THROUGH PARTICIPATION IN A QUALIFIED CLINICAL DATA REGISTRY.—For 2014 and subsequent years, the Secretary shall treat an eligible professional as satisfactorily submitting data on quality measures under subparagraph (A) and, for 2016 and subsequent years, subparagraph (A) or (C) if, in lieu of reporting measures under subsection (k)(2)(C), the eligible professional is satisfactorily participating, as determined by the Secretary, in a qualified clinical data registry (as described in subparagraph (E)) for the year.

(E) QUALIFIED CLINICAL DATA REGISTRY.—

(i) IN GENERAL.—The Secretary shall establish requirements for an entity to be considered a qualified clinical data registry. Such requirements shall include a requirement that the entity provide the Secretary with such information, at such times, and in such manner, as the Secretary determines necessary to carry out this subsection.

(ii) CONSIDERATIONS.—In establishing the requirements under clause (i), the Secretary shall consider whether an entity—

(I) has in place mechanisms for the transparency of data elements and specifications, risk models, and measures;

(II) requires the submission of data from participants with respect to multiple payers;

(III) provides timely performance reports to participants at the individual participant level; and

(IV) supports quality improvement initiatives for participants.

(iii) MEASURES.—With respect to measures used by a qualified clinical data registry—

(I) sections 1890(b)(7) and 1890A(a) shall not apply; and

(II) measures endorsed by the entity with a contract with the Secretary under section 1890(a) may be used.

(iv) CONSULTATION.—In carrying out this subparagraph, the Secretary shall consult with interested parties.

(v) DETERMINATION.—The Secretary shall establish a process to determine whether or not an entity meets the requirements established under clause (i). Such process may involve one or both of the following:

(I) A determination by the Secretary.

(II) A designation by the Secretary of one or more independent organizations to make such determination.

(F) AUTHORITY TO REVISE SATISFACTORILY REPORTING DATA.—For years after 2009, the Secretary, in consultation with stakeholders and experts, may revise the criteria under this subsection for satisfactorily submitting data on quality measures under subparagraph (A) and the criteria for submitting data on electronic prescribing quality measures under subparagraph (B)(ii).

(4) FORM OF PAYMENT.—The payment under this subsection shall be in the form of a single consolidated payment.

(5) APPLICATION.—

(A) PHYSICIAN REPORTING SYSTEM RULES.—Paragraphs (5), (6),and (8) of subsection (k) shall apply for purposes of this subsection in the same manner as they apply for purposes of such subsection.

(B) COORDINATION WITH OTHER BONUS PAYMENTS.—The provisions of this subsection shall not be taken into account in applying subsections (m) and (u) of section 1833 and any payment under such subsections shall not be taken into account in computing allowable charges under this subsection.

(C) IMPLEMENTATION.—Notwithstanding any other provision of law, for 2007, 2008, and 2009, the Secretary may implement by program instruction or otherwise this subsection.

(D) VALIDATION.—

(i) IN GENERAL.—Subject to the succeeding provisions of this subparagraph, for purposes of determining whether a measure is applicable to the covered professional services of an eligible professional under this subsection for 2007 and 288, the Secretary shall presume that if an eligible professional submits data for a measure, such measure is applicable to such professional.

(ii) METHOD.—The Secretary may establish procedures to validate (by sampling or other means as the Secretary determines to be appropriate) whether measures applicable to covered professional services of an eligible professional have been reported.

(iii) DENIAL OF PAYMENT AUTHORITY.—If the Secretary determines that an eligible professional (or, in the case of a group practice under paragraph (3)(C), the group practice) has not reported measures applicable to covered professional services of such professional, the Secretary shall not pay the incentive payment under this subsection. If such payments for such period have already been made, the Secretary shall re-

coup such payments from the eligible professional (or the group practice).

(E) LIMITATIONS ON REVIEW.—

Except as provided in subparagraph (I), there shall be no administrative or judicial review under 1869, section 1878, or otherwise of

(i) the determination of measures applicable to services furnished by eligible professionals under this subsection;

(ii) the determination of satisfactory reporting under this subsection;

(iii) the determination of a successful electronic prescriber under paragraph (3), the limitation under paragraph (2)(B), and the exception under subsection (a)(5)(B); and

(iv) the determination of any incentive payment under this subsection and the payment adjustment under paragraphs (5)(A) and (8)(A) of subsection (a).

(F) EXTENSION.—For 2008 through reporting periods occurring in 2015, the Secretary shall establish and, for reporting periods occurring in 2016 and subsequent years, the Secretary may establish alternative criteria for satisfactorily reporting under this subsection and alternative reporting periods under paragraph (6)(C) for reporting groups of measures under subsection (k)(2)(B) and for reporting using the method specified in subsection (k)(4).

(G) POSTING ON WEBSITE.—The Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services, in an easily understandable format, a list of the names of the following:

(i) The eligible professionals (or, in the case of reporting under paragraph (3)(C), the group practices) who satisfactorily submitted data on quality measures under this subsection.

(ii) The eligible professionals (or, in the case of reporting under paragraph (3)(C), the group practices) who are successful electronic prescribers.

(H) FEEDBACK.—The Secretary shall provide timely feedback to eligible professionals on the performance of the eligible professional with respect to satisfactorily submitting data on quality measures under this subsection.

(I) INFORMAL APPEALS PROCESS.—The Secretary shall, by not later than January 1, 2011, establish and have in place an informal process for eligible professionals to seek a review of the determination that an eligible professional did not satisfactorily submit data on quality measures under this subsection.

(6) DEFINITIONS.—For purposes of this subsection:

(A) ELIGIBLE PROFESSIONAL; COVERED PROFESSIONAL SERVICES.—The terms "eligible professional" and "covered professional services" have the meanings given such termsin subsection (k)(3).

(B) PHYSICIAN REPORTING SYSTEM.—The term "physician reporting system" means the system established under subsection (k).

(C) REPORTING PERIOD.—

(i) IN GENERAL.—Subject to clauses (ii) and (iii), the term "reporting period" means—

(I) for 2007, the period beginning on July 1, 2007, and ending on December 31, 2007; and

(II) for 2008 and subsequent years, the entire year.

(ii) AUTHORITY TO REVISE REPORTING PERIOD.—For years after 2009, the Secretary may revise the reporting period under clause (i) if the Secretary determines such revision is appropriate, produces valid results on measures reported, and is consistent with the goals of maximizing scientific validity and reducing administrative burden. If the Secretary revises such period pursuant to the preceding sentence, the term "reporting period" shall mean such revised period.

(iii) REFERENCE.—Any reference in this subsection to a reporting period with respect to the application of subsection (a)(5) (a)(8) shall be deemed a reference to the reporting period under subsection (a)(5)(D)(iii) or the quality reporting period under subsection (a)(8)(D)(iii), respectively.

(7) INTEGRATION OF PHYSICIAN QUALITY REPORTING AND EHR REPORTING.—Not later than January 1, 2012, the Secretary shall develop a plan to integrate reporting on quality measures under this subsection with reporting requirements under subsection (o) relating to the meaningful use of electronic health records. Such integration shall consist of the following:

(A) The selection of measures, the reporting of which would both demonstrate—

(i) meaningful use of an electronic health record for purposes of subsection (o); and

(ii) quality of care furnished to an individual.

(B) Such other activities as specified by the Secretary.

(8) ADDITIONAL INCENTIVE PAYMENT.—

(A) IN GENERAL.—For 2011 through 2014, if an eligible professional meets the requirements described in subparagraph (B), the applicable quality percent for such year, as described in clauses (iii) and (iv) of paragraph (1)(B), shall be increased by 0.5 percentage points.

(B) REQUIREMENTS DESCRIBED.—In order to qualify for the additional incentive payment described in subparagraph (A), an eligible professional shall meet the following requirements:

(i) The eligible professional shall—

(I) satisfactorily submit data on quality measures for purposes of paragraph (1) for a year; and

(II) have such data submitted on their behalf through a Maintenance of Certification Program (as defined in subparagraph (C)(i)) that meets—

(aa) the criteria for a registry (as described in subsection (k)(4)); or

(bb) an alternative form and manner determined appropriate by the Secretary.

(ii) The eligible professional, more frequently than is required to qualify for or maintain board certification status—

(I) participates in such a Maintenance of Certification program for a year; and

(II) successfully completes a qualified Maintenance of Certification Program practice assessment (as defined in subparagraph (C)(ii)) for such year.

(iii) A Maintenance of Certification program submits to the Secretary, on behalf of the eligible professional, information—

(I) in a form and manner specified by the Secretary, that the eligible professional has successfully met the requirements of clause (ii) (which may be in the form of a structural measure);

(II) if requested by the Secretary, on the survey of patient experience with care (as described in subparagraph (C)(ii)(II)); and

(III) as the Secretary may require, on the methods, measures, and data used under the Maintenance of Certification Program and the qualified Maintenance of Certification Program practice assessment.

(C) DEFINITIONS.—For purposes of this paragraph:

(i) The term "Maintenance of Certification Program" means a continuous assessment program, such as qualified American Board of Medical Specialties Maintenance of Certification program or an equivalent program (as determined by the Secretary), that advances quality and the lifelong learning and self-assessment of board certified specialty physicians by focusing on the competencies of patient care, medical knowledge, practice-based learning, interpersonal and communication skills and professionalism. Such a program shall include the following:

(I) The program requires the physician to maintain a valid, unrestricted medical license in the United States.

(II) The program requires a physician to participate in educational and self-assessment programs that require an assessment of what was learned.

(III) The program requires a physician to demonstrate, through a formalized, secure examination, that the physician has the fundamental diagnostic skills, medical knowledge, and clinical judgment to provide quality care in their respective specialty.

(IV) The program requires successful completion of a qualified Maintenance of Certification Program practice assessment as described in clause (ii).

(ii) The term "qualified Maintenance of Certification Program practice assessment" means an assessment of a physician's practice that—

(I) includes an initial assessment of an eligible professional's practice that is designed to demonstrate the physician's use of evidence-based medicine;

(II) includes a survey of patient experience with care; and

(III) requires a physician to implement a quality improvement intervention to address a practice weakness identified in the initial assessment under subclause (I) and then to remeasure to assess performance improvement after such intervention.

(9) CONTINUED APPLICATION FOR PURPOSES OF MIPS AND FOR CERTAIN PROFESSIONALS VOLUNTEERING TO REPORT.—The Secretary shall, in accordance with subsection (q)(1)(F), carry out the processes under this subsection—

(A) for purposes of subsection (q); and

(B) for eligible professionals who are not MIPS eligible professionals (as defined in subsection (q)(1)(C)) for the year involved.

(n) PHYSICIAN FEEDBACK PROGRAM.—

(1) ESTABLISHMENT.—

(A) IN GENERAL.—

(i) ESTABLISHMENT.—The Secretary shall establish a Physician Feedback Program (in this subsection referred to as the "Program").

(ii) REPORTS ON RESOURCES.—The Secretary shall use claims data under this title (and may use other data) to provide confidential reports to physicians (and, as determined appropriate by the Secretary, to groups of physicians) that measure the resources involved in furnishing care to individuals under this title.

(iii) INCLUSION OF CERTAIN INFORMATION.—If determined appropriate by the Secretary, the Secretary may include information on the quality of care furnished to individuals under this title by the physician (or group of physicians) in such reports.

(B) RESOURCE USE.—The resources described in subparagraph (A)(ii) may be measured—

(i) on an episode basis;

(ii) on a per capita basis; or

(iii) on both an episode and a per capita basis.

(2) IMPLEMENTATION.—The Secretary shall implement the Program by not later than January 1, 2009.

(3) DATA FOR REPORTS.—To the extent practicable, reports under the Program shall be based on the most recent data available.

(4) AUTHORITY TO FOCUS INITIAL APPLICATION.—The Secretary may focus the initial application of the Program as appropriate, such as focusing the Program on—

(A) physician specialties that account for a certain percentage of all spending for physicians' services under this title;

(B) physicians who treat conditions that have a high cost or a high volume, or both, under this title;

(C) physicians who use a high amount of resources compared to other physicians;

(D) physicians practicing in certain geographic areas; or

(E) physicians who treat a minimum number of individuals under this title.

(5) AUTHORITY TO EXCLUDE CERTAIN INFORMATION IF INSUFFICIENT INFORMATION.—The Secretary may exclude certain information regarding a service from a report under the Program with respect to a physician (or group of physicians) if the Secretary determines that there is insufficient information relating to that service to provide a valid report on that service.

(6) ADJUSTMENT OF DATA.—To the extent practicable, the Secretary shall make appropriate adjustments to the data used in preparing reports under the Program, such as adjustments to take into account variations in health status and other patient characteristics. For adjustments for reports on utilization under paragraph (9), see subparagraph (D) of such paragraph.

(7) EDUCATION AND OUTREACH.—The Secretary shall provide for education and outreach activities to physicians on the operation of, and methodologies employed under, the Program.

(8) DISCLOSURE EXEMPTION.—Reports under the Program shall be exempt from disclosure under section 552 of title 5, United States Code.

(9) REPORTS ON UTILIZATION.—

(A) DEVELOPMENT OF EPISODE GROUPER.—

(i) IN GENERAL.—The Secretary shall develop an episode grouper that combines separate but clinically related items and services into an episode of care for an individual, as appropriate.

(ii) TIMELINE FOR DEVELOPMENT.—The episode grouper described in subparagraph (A) shall be developed by not later than January 1, 2012.

(iii) PUBLIC AVAILABILITY.—The Secretary shall make the details of the episode grouper described in subparagraph (A) available to the public.

(iv) ENDORSEMENT.—The Secretary shall seek endorsement of the episode grouper described in subparagraph (A) by the entity with a contract under section 1890(a).

(B) REPORTS ON UTILIZATION.—Effective beginning with 2012, the Secretary shall provide reports to physicians that compare, as determined appropriate by the Secretary, patterns of resource use of the individual physician to such patterns of other physicians.

(C) ANALYSIS OF DATA.—The Secretary shall, for purposes of preparing reports under this paragraph, establish methodologies as appropriate, such as to—

(i) attribute episodes of care, in whole or in part, to physicians;

(ii) identify appropriate physicians for purposes of comparison under subparagraph (B); and

(iii) aggregate episodes of care attributed to a physician under clause (i) into a composite measure per individual.

(D) DATA ADJUSTMENT.—In preparing reports under this paragraph, the Secretary shall make appropriate adjustments, including adjustments—

(i) to account for differences in socioeconomic and demographic characteristics, ethnicity, and health status of individuals (such as to recognize that less healthy individuals may require more intensive interventions); and

(ii) to eliminate the effect of geographic adjustments in payment rates (as described in subsection (e)).

(E) PUBLIC AVAILABILITY OF METHODOLOGY.—The Secretary shall make available to the public—

(i) the methodologies established under subparagraph (C);

(ii) information regarding any adjustments made to data under subparagraph (D); and

(iii) aggregate reports with respect to physicians.

(F) DEFINITION OF PHYSICIAN.—In this paragraph:

(i) IN GENERAL.—The term "physician" has the meaning given that term in section 1861(r)(1).

(ii) TREATMENT OF GROUPS.—Such term includes, as the Secretary determines appropriate, a group of physicians.

(G) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the establishment of the methodology under subparagraph (C), including the determination of an episode of care under such methodology.

(10) COORDINATION WITH OTHER VALUE-BASED PURCHASING REFORMS.—The Secretary shall coordinate the Program with the value-based payment modifier established under subsection (p) and, as the Secretary determines appropriate, other similar provisions of this title.

(11) REPORTS ENDING WITH 2017.—Reports under the Program shall not be provided after December 31, 2017. See subsection (q)(12) for reports under the eligible professionals Merit-based Incentive Payment System.

(o) INCENTIVES FOR ADOPTION AND MEANINGFUL USE OF CERTIFIED EHR TECHNOLOGY.—

(1) INCENTIVE PAYMENTS.—

(A) IN GENERAL.—

(i) IN GENERAL.—Subject to the succeeding subparagraphs of this paragraph, with respect to covered professional services furnished by an eligible professional during a payment year (as defined in subparagraph (E)), if the eligible professional is a meaningful EHR user (as determined under paragraph (2)) for the EHR reporting period with respect to such year, in addition to the amount otherwise paid under this part, there also shall be paid to the eligible professional (or to an employer or facility in the cases described in clause (A) of section 1842(b)(6)), from the Federal Supplementary

Medical Insurance Trust Fund established under section 1841 an amount equal to 75 percent of the Secretary's estimate (based on claims submitted not later than 2 months after the end of the payment year) of the allowed charges under this part for all such covered professional services furnished by the eligible professional during such year.

(ii) NO INCENTIVE PAYMENTS WITH RESPECT TO YEARS AFTER 2016.—No incentive payments may be made under this subsection with respect to a year after 2016.

(B) LIMITATIONS ON AMOUNTS OF INCENTIVE PAYMENTS.—

(i) IN GENERAL.—In no case shall the amount of the incentive payment provided under this paragraph for an eligible professional for a payment year exceed the applicable amount specified under this subparagraph with respect to such eligible professional and such year.

(ii) AMOUNT.—Subject to clauses (iii) through (v), the applicable amount specified in this subparagraph for an eligible professional is as follows:

(I) For the first payment year for such professional, $15,000 (or, if the first payment year for such eligible professional is 2011 or 2012, $18,000).

(II) For the second payment year for such professional, $12,000.

(III) For the third payment year for such professional, $8,000.

(IV) For the fourth payment year for such professional, $4,000.

(V) For the fifth payment year for such professional, $2,000.

(VI) For any succeeding payment year for such professional, $0.

(iii) PHASE DOWN FOR ELIGIBLE PROFESSIONALS FIRST ADOPTING EHR AFTER 2013.—If the first payment year for an eligible professional is after 2013, then the amount specified in this subparagraph for a payment year for such professional is the same as the amount specified in clause (ii) for such payment year for an eligible professional whose first payment year is 2013.

(iv) INCREASE FOR CERTAIN ELIGIBLE PROFESSIONALS.—In the case of an eligible professional who predominantly furnishes services under this part in an area that is designated by the Secretary (under section 332(a)(1)(A) of the Public Health Service Act) as a health professional shortage area, the amount that would otherwise apply for a payment year for such professional under subclauses (I) through (V) of clause (ii) shall be increased by 10 percent. In implementing the preceding sentence, the Secretary may, as determined appropriate, apply provisions of subsections (m) and (u) of section 1833 in a similar manner as such provisions apply under such subsection.

(v) NO INCENTIVE PAYMENT IF FIRST ADOPTING AFTER 2014.—If the first payment year for an eligible professional is after 2014 then the applicable amount specified in this subparagraph for such professional for such year and any subsequent year shall be $0.

(C) NON-APPLICATION TO HOSPITAL-BASED ELIGIBLE PROFESSIONALS.—

(i) IN GENERAL.—No incentive payment may be made under this paragraph in the case of a hospital-based eligible professional.

(ii) HOSPITAL-BASED ELIGIBLE PROFESSIONAL.—For purposes of clause (i), the term "hospital-based eligible professional" means, with respect to covered professional services furnished by an eligible professional during the EHR reporting period for a payment year, an eligible professional, such as a pathologist, anesthesiologist, or emergency physician, who furnishes substantially all of such services in a hospital inpatient or emergency room setting and through the use of the facilities and equipment, including qualified electronic health records, of the hospital. The determination of whether an eligible professional is a hospital-based eligible professional shall be made on the basis of the site of service (as defined by the Secretary) and without regard to any employment or billing arrangement between the eligible professional and any other provider.

(D) PAYMENT.—

(i) FORM OF PAYMENT.—The payment under this paragraph may be in the form of a single consolidated payment or in the form of such periodic installments as the Secretary may specify.

(ii) COORDINATION OF APPLICATION OF LIMITATION FOR PROFESSIONALS IN DIFFERENT PRACTICES.—In the case of an eligible professional furnishing covered professional services in more than one practice (as specified by the Secretary), the Secretary shall establish rules to coordinate the incentive payments, including the application of the limitation on amounts of such incentive payments under this paragraph, among such practices.

(iii) COORDINATION WITH MEDICAID.—The Secretary shall seek, to the maximum extent practicable, to avoid duplicative requirements from Federal and State governments to demonstrate meaningful use of certified EHR technology under this title and title XIX. The Secretary may also adjust the reporting periods under such title and such subsections in order to carry out this clause.

(E) PAYMENT YEAR DEFINED.—

(i) IN GENERAL.—For purposes of this subsection, the term "payment year" means a year beginning with 2011.

(ii) FIRST, SECOND, ETC. PAYMENT YEAR.—The term "first payment year" means, with respect to covered

professional services furnished by an eligible professional, the first year for which an incentive payment is made for such services under this subsection. The terms "second payment year", "third payment year", "fourth payment year", and "fifth payment year" mean, with respect to covered professional services furnished by such eligible professional, each successive year immediately following the first payment year for such professional.

(2) MEANINGFUL EHR USER.—

(A) IN GENERAL.—An eligible professional shall be treated as a meaningful EHR user for an EHR reporting period for a payment year (or, for purposes of subsection (a)(7), for an EHR reporting period under such subsection for a year, or pursuant to subparagraph (D) for purposes of subsection (q), for a performance period under such subsection for a year) if each of the following requirements is met:

(i) MEANINGFUL USE OF CERTIFIED EHR TECHNOLOGY.—The eligible professional demonstrates to the satisfaction of the Secretary, in accordance with subparagraph (C)(i), that during such period the professional is using certified EHR technology in a meaningful manner, which shall include the use of electronic prescribing as determined to be appropriate by the Secretary.

(ii) INFORMATION EXCHANGE.—The eligible professional demonstrates to the satisfaction of the Secretary, in accordance with subparagraph (C)(i), that during such period such certified EHR technology is connected in a manner that provides, in accordance with law and standards applicable to the exchange of information, for the electronic exchange of health information to improve the quality of health care, such as promoting care coordination, and the professional demonstrates (through a process specified by the Secretary, such as the use of an attestation) that the professional has not knowingly and willfully taken action (such as to disable functionality) to limit or restrict the compatibility or interoperability of the certified EHR technology.

(iii) REPORTING ON MEASURES USING EHR.—Subject to subparagraph (B)(ii) and subsection (q)(5)(B)(ii)(II) and using such certified EHR technology, the eligible professional submits information for such period, in a form and manner specified by the Secretary, on such clinical quality measures and such other measures as selected by the Secretary under subparagraph (B)(i).

The Secretary may provide for the use of alternative means for meeting the requirements of clauses (i), (ii), and (iii) in the case of an eligible professional furnishing covered professional services in a group practice (as defined by the Secretary). The Secretary shall seek to improve the use of electronic health records and health care quality over time by requiring more stringent measures of meaningful use selected under this paragraph.

(B) REPORTING ON MEASURES.—

(i) SELECTION.—The Secretary shall select measures for purposes of subparagraph (A)(iii) but only consistent with the following:

(I) The Secretary shall provide preference to clinical quality measures that have been endorsed by the entity with a contract with the Secretary under section 1890(a).

(II) Prior to any measure being selected under this subparagraph, the Secretary shall publish in the Federal Register such measure and provide for a period of public comment on such measure.

(ii) LIMITATION.—The Secretary may not require the electronic reporting of information on clinical quality measures under subparagraph (A)(iii) unless the Secretary has the capacity to accept the information electronically, which may be on a pilot basis.

(iii) COORDINATION OF REPORTING OF INFORMATION.—In selecting such measures, and in establishing the form and manner for reporting measures under subparagraph (A)(iii), the Secretary shall seek to avoid redundant or duplicative reporting otherwise required, including reporting under subsection (k)(2)(C).

(C) DEMONSTRATION OF MEANINGFUL USE OF CERTIFIED EHR TECHNOLOGY AND INFORMATION EXCHANGE.—

(i) IN GENERAL.—A professional may satisfy the demonstration requirement of clauses (i) and (ii) of subparagraph (A) through means specified by the Secretary, which may include—

(I) an attestation;

(II) the submission of claims with appropriate coding (such as a code indicating that a patient encounter was documented using certified EHR technology);

(III) a survey response;

(IV) reporting under subparagraph (A)(iii); and

(V) other means specified by the Secretary.

(ii) USE OF PART D DATA.—Notwithstanding sections 1860D–15(d)(2)(B) and 1860D–15(f)(2), the Secretary may use data regarding drug claims submitted for purposes of section 1860D–15 that are necessary for purposes of subparagraph (A).

(D) CONTINUED APPLICATION FOR PURPOSES OF MIPS.—With respect to 2019 and each subsequent payment year, the Secretary shall, for purposes of subsection (q) and in accordance with paragraph (1)(F) of such subsection, determine whether an eligible professional who is a MIPS eligible professional (as defined in subsection (q)(1)(C)) for such year is a meaningful EHR user under this paragraph for the performance period under subsection (q) for such year. *The provisions of subparagraphs (B) and (D) of subsection (a)(7), including the application of clause (iv) of such subparagraph (D), shall apply to assessments of MIPS eligible professionals under subsection (q) with respect to the performance category described in subsection (q)(2)(A)(iv) in a*

manner similar to the manner in which such provisions apply with respect to payment adjustments made under subsection (a)(7)(A).

(3) APPLICATION.—

(A) PHYSICIAN REPORTING SYSTEM RULES.—Paragraphs (5), (6), and (8) of subsection (k) shall apply for purposes of this subsection in the same manner as they apply for purposes of such subsection.

(B) COORDINATION WITH OTHER PAYMENTS.—The provisions of this subsection shall not be taken into account in applying the provisions of subsection (m) of this section and of section 1833(m) and any payment under such provisions shall not be taken into account in computing allowable charges under this subsection.

(C) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, of—

(i) the methodology and standards for determining payment amounts under this subsection and payment adjustments under subsection (a)(7)(A), including the limitation under paragraph (1)(B) and coordination under clauses (ii) and (iii) of paragraph (1)(D);

(ii) the methodology and standards for determining a meaningful EHR user under paragraph (2), including selection of measures under paragraph (2)(B), specification of the means of demonstrating meaningful EHR use under paragraph (2)(C), and the hardship exception under subsection (a)(7)(B);

(iii) the methodology and standards for determining a hospital-based eligible professional under paragraph (1)(C); and

(iv) the specification of reporting periods under paragraph (5) and the selection of the form of payment under paragraph (1)(D)(i).

(D) POSTING ON WEBSITE.—The Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services, in an easily understandable format, a list of the names, business addresses, and business phone numbers of the eligible professionals who are meaningful EHR users and, as determined appropriate by the Secretary, of group practices receiving incentive payments under paragraph (1).

(4) CERTIFIED EHR TECHNOLOGY DEFINED.—For purposes of this section, the term "certified EHR technology" means a qualified electronic health record (as defined in section 3000(13) of the Public Health Service Act) that is certified pursuant to section 3001(c)(5) of such Act as meeting standards adopted under section 3004 of such Act that are applicable to the type of record involved (as determined by the Secretary, such as an ambulatory electronic health record for office-based physicians or an inpatient hospital electronic health record for hospitals).

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

(A) COVERED PROFESSIONAL SERVICES.—The term "covered professional services" has the meaning given such term in subsection (k)(3).

(B) EHR REPORTING PERIOD.—The term "EHR reporting period" means, with respect to a payment year, any period (or periods) as specified by the Secretary.

(C) ELIGIBLE PROFESSIONAL.—The term "eligible professional" means a physician, as defined in section 1861(r).

(p) ESTABLISHMENT OF VALUE-BASED PAYMENT MODIFIER.—

(1) IN GENERAL.—The Secretary shall establish a payment modifier that provides for differential payment to a physician or a group of physicians under the fee schedule established under subsection (b) based upon the quality of care furnished compared to cost (as determined under paragraphs (2) and (3), respectively) during a performance period. Such payment modifier shall be separate from the geographic adjustment factors established under subsection (e).

(2) QUALITY.—

(A) IN GENERAL.—For purposes of paragraph (1), quality of care shall be evaluated, to the extent practicable, based on a composite of measures of the quality of care furnished (as established by the Secretary under subparagraph (B)).

(B) MEASURES.—

(i) The Secretary shall establish appropriate measures of the quality of care furnished by a physician or group of physicians to individuals enrolled under this part, such as measures that reflect health outcomes. Such measures shall be risk adjusted as determined appropriate by the Secretary.

(ii) The Secretary shall seek endorsement of the measures established under this subparagraph by the entity with a contract under section 1890(a).

(C) CONTINUED APPLICATION FOR PURPOSES OF MIPS.—The Secretary shall, in accordance with subsection (q)(1)(F), carry out subparagraph (B) for purposes of subsection (q).

(3) COSTS.—For purposes of paragraph (1), costs shall be evaluated, to the extent practicable, based on a composite of appropriate measures of costs established by the Secretary (such as the composite measure under the methodology established under subsection (n)(9)(C)(iii)) that eliminate the effect of geographic adjustments in payment rates (as described in subsection (e)), and take into account risk factors (such as socioeconomic and demographic characteristics, ethnicity, and health status of individuals (such as to recognize that less healthy individuals may require more intensive interventions) and other factors determined appropriate by the Secretary. With respect to 2019 and each subsequent year, the Secretary shall, in accordance with subsection (q)(1)(F), carry out this paragraph for purposes of subsection (q).

(4) IMPLEMENTATION.—

(A) PUBLICATION OF MEASURES, DATES OF IMPLEMENTATION, PERFORMANCE PERIOD.—Not later than January 1, 2012, the Secretary shall publish the following:

(i) The measures of quality of care and costs established under paragraphs (2) and (3), respectively.

(ii) The dates for implementation of the payment modifier (as determined under subparagraph (B)).

(iii) The initial performance period (as specified under subparagraph (B)(ii)).

(B) DEADLINES FOR IMPLEMENTATION.—

(i) INITIAL IMPLEMENTATION.—Subject to the preceding provisions of this subparagraph, the Secretary shall begin implementing the payment modifier established under this subsection through the rulemaking process during 2013 for the physician fee schedule established under subsection (b).

(ii) INITIAL PERFORMANCE PERIOD.—

(I) IN GENERAL.—The Secretary shall specify an initial performance period for application of the payment modifier established under this subsection with respect to 2015.

(II) PROVISION OF INFORMATION DURING INITIAL PERFORMANCE PERIOD.—During the initial performance period, the Secretary shall, to the extent practicable, provide information to physicians and groups of physicians about the quality of care furnished by the physician or group of physicians to individuals enrolled under this part compared to cost (as determined under paragraphs (2) and (3), respectively) with respect to the performance period.

(iii) APPLICATION.—The Secretary shall apply the payment modifier established under this subsection for items and services furnished on or after January 1, 2015, with respect to specific physicians and groups of physicians the Secretary determines appropriate, and for services furnished on or after January 1, 2017, with respect to all physicians and groups of physicians. Such payment modifier shall not be applied for items and services furnished on or after January 1, 2019.

(C) BUDGET NEUTRALITY.—The payment modifier established under this subsection shall be implemented in a budget neutral manner.

(5) SYSTEMS-BASED CARE.—The Secretary shall, as appropriate, apply the payment modifier established under this subsection in a manner that promotes systems-based care.

(6) CONSIDERATION OF SPECIAL CIRCUMSTANCES OF CERTAIN PROVIDERS.—In applying the payment modifier under this subsection, the Secretary shall, as appropriate, take into account the special circumstances of physicians or groups of physicians in rural areas and other underserved communities.

(7) APPLICATION.—For purposes of the initial application of the payment modifier established under this subsection during the period beginning on January 1, 2015, and ending on December 31, 2016, the term "physician" has the meaning given such term in section 1861(r). On or after January 1, 2017, the Secretary may apply this subsection to eligible professionals

(as defined in subsection (k)(3)(B)) as the Secretary determines appropriate.

(8) DEFINITIONS.—For purposes of this subsection:

(A) COSTS.—The term "costs" means expenditures per individual as determined appropriate by the Secretary. In making the determination under the preceding sentence, the Secretary may take into account the amount of growth in expenditures per individual for a physician compared to the amount of such growth for other physicians.

(B) PERFORMANCE PERIOD.—The term "performance period" means a period specified by the Secretary.

(9) COORDINATION WITH OTHER VALUE-BASED PURCHASING REFORMS.—The Secretary shall coordinate the value-based payment modifier established under this subsection with the Physician Feedback Program under subsection (n) and, as the Secretary determines appropriate, other similar provisions of this title.

(10) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of—

(A) the establishment of the value-based payment modifier under this subsection;

(B) the evaluation of quality of care under paragraph (2), including the establishment of appropriate measures of the quality of care under paragraph (2)(B);

(C) the evaluation of costs under paragraph (3), including the establishment of appropriate measures of costs under such paragraph;

(D) the dates for implementation of the value-based payment modifier;

(E) the specification of the initial performance period and any other performance period under paragraphs (4)(B)(ii) and (8)(B), respectively;

(F) the application of the value-based payment modifier under paragraph (7); and

(G) the determination of costs under paragraph (8)(A).

(q) MERIT-BASED INCENTIVE PAYMENT SYSTEM.—

(1) ESTABLISHMENT.—

(A) IN GENERAL.—Subject to the succeeding provisions of this subsection, the Secretary shall establish an eligible professional Merit-based Incentive Payment System (in this subsection referred to as the "MIPS") under which the Secretary shall—

(i) develop a methodology for assessing the total performance of each MIPS eligible professional according to performance standards under paragraph (3) for a performance period (as established under paragraph (4)) for a year;

(ii) using such methodology, provide for a composite performance score in accordance with paragraph (5) for each such professional for each performance period; and

(iii) use such composite performance score of the MIPS eligible professional for a performance period for a year to determine and apply a MIPS adjustment fac-

tor (and, as applicable, an additional MIPS adjustment factor) under paragraph (6) to the professional for the year.

Notwithstanding subparagraph (C)(ii), under the MIPS, the Secretary shall permit any eligible professional (as defined in subsection (k)(3)(B)) to report on applicable measures and activities described in paragraph (2)(B).

(B) PROGRAM IMPLEMENTATION.—The MIPS shall apply to payments for items and services furnished on or after January 1, 2019.

(C) MIPS ELIGIBLE PROFESSIONAL DEFINED.—

(i) IN GENERAL.—For purposes of this subsection, subject to clauses (ii) and (iv), the term "MIPS eligible professional" means—

(I) for the first and second years for which the MIPS applies to payments (and for the performance period for such first and second year), a physician (as defined in section 1861(r)), a physician assistant, nurse practitioner, and clinical nurse specialist (as such terms are defined in section 1861(aa)(5)), a certified registered nurse anesthetist (as defined in section 1861(bb)(2)), and a group that includes such professionals; and

(II) for the third year for which the MIPS applies to payments (and for the performance period for such third year) and for each succeeding year (and for the performance period for each such year), the professionals described in subclause (I), such other eligible professionals (as defined in subsection (k)(3)(B)) as specified by the Secretary, and a group that includes such professionals.

(ii) EXCLUSIONS.—For purposes of clause (i), the term "MIPS eligible professional" does not include, with respect to a year, an eligible professional (as defined in subsection (k)(3)(B)) who—

(I) is a qualifying APM participant (as defined in section 1833(z)(2));

(II) subject to clause (vii), is a partial qualifying APM participant (as defined in clause (iii)) for the most recent period for which data are available and who, for the performance period with respect to such year, does not report on applicable measures and activities described in paragraph (2)(B) that are required to be reported by such a professional under the MIPS; or

(III) for the performance period with respect to such year, does not exceed the low-volume threshold measurement selected under clause (iv).

(iii) PARTIAL QUALIFYING APM PARTICIPANT.—For purposes of this subparagraph, the term "partial qualifying APM participant" means, with respect to a year, an eligible professional for whom the Secretary determines the minimum payment percentage (or percentages), as applicable, described in paragraph (2) of section 1833(z) for such year have not been satisfied, but

who would be considered a qualifying APM participant (as defined in such paragraph) for such year if—

(I) with respect to 2019 and 2020, the reference in subparagraph (A) of such paragraph to 25 percent was instead a reference to 20 percent;

(II) with respect to 2021 and 2022—

(aa) the reference in subparagraph (B)(i) of such paragraph to 50 percent was instead a reference to 40 percent; and

(bb) the references in subparagraph (B)(ii) of such paragraph to 50 percent and 25 percent of such paragraph were instead references to 40 percent and 20 percent, respectively; and

(III) with respect to 2023 and subsequent years—

(aa) the reference in subparagraph (C)(i) of such paragraph to 75 percent was instead a reference to 50 percent; and

(bb) the references in subparagraph (C)(ii) of such paragraph to 75 percent and 25 percent of such paragraph were instead references to 50 percent and 20 percent, respectively.

(iv) SELECTION OF LOW-VOLUME THRESHOLD MEASUREMENT.—The Secretary shall select a low-volume threshold to apply for purposes of clause (ii)(III), which may include one or more or a combination of the following:

(I) The minimum number (as determined by the Secretary) of individuals enrolled under this part who are treated by the eligible professional for the performance period involved.

(II) The minimum number (as determined by the Secretary) of items and services furnished to individuals enrolled under this part by such professional for such performance period.

(III) The minimum amount (as determined by the Secretary) of allowed charges billed by such professional under this part for such performance period.

(v) TREATMENT OF NEW MEDICARE ENROLLED ELIGIBLE PROFESSIONALS.—In the case of a professional who first becomes a Medicare enrolled eligible professional during the performance period for a year (and had not previously submitted claims under this title such as a person, an entity, or a part of a physician group or under a different billing number or tax identifier), such professional shall not be treated under this subsection as a MIPS eligible professional until the subsequent year and performance period for such subsequent year.

(vi) CLARIFICATION.—In the case of items and services furnished during a year by an individual who is not a MIPS eligible professional (including pursuant to

clauses (ii) and (v)) with respect to a year, in no case shall a MIPS adjustment factor (or additional MIPS adjustment factor) under paragraph (6) apply to such individual for such year.

(vii) PARTIAL QUALIFYING APM PARTICIPANT CLARIFICATIONS.—

(I) TREATMENT AS MIPS ELIGIBLE PROFESSIONAL.—In the case of an eligible professional who is a partial qualifying APM participant, with respect to a year, and who, for the performance period for such year, reports on applicable measures and activities described in paragraph (2)(B) that are required to be reported by such a professional under the MIPS, such eligible professional is considered to be a MIPS eligible professional with respect to such year.

(II) NOT ELIGIBLE FOR QUALIFYING APM PARTICIPANT PAYMENTS.—In no case shall an eligible professional who is a partial qualifying APM participant, with respect to a year, be considered a qualifying APM participant (as defined in paragraph (2) of section 1833(z)) for such year or be eligible for the additional payment under paragraph (1) of such section for such year.

(D) APPLICATION TO GROUP PRACTICES.—

(i) IN GENERAL.—Under the MIPS:

(I) QUALITY PERFORMANCE CATEGORY.—The Secretary shall establish and apply a process that includes features of the provisions of subsection (m)(3)(C) for MIPS eligible professionals in a group practice with respect to assessing performance of such group with respect to the performance category described in clause (i) of paragraph (2)(A).

(II) OTHER PERFORMANCE CATEGORIES.—The Secretary may establish and apply a process that includes features of the provisions of subsection (m)(3)(C) for MIPS eligible professionals in a group practice with respect to assessing the performance of such group with respect to the performance categories described in clauses (ii) through (iv) of such paragraph.

(ii) ENSURING COMPREHENSIVENESS OF GROUP PRACTICE ASSESSMENT.—The process established under clause (i) shall to the extent practicable reflect the range of items and services furnished by the MIPS eligible professionals in the group practice involved.

(E) USE OF REGISTRIES.—Under the MIPS, the Secretary shall encourage the use of qualified clinical data registries pursuant to subsection (m)(3)(E) in carrying out this subsection.

(F) APPLICATION OF CERTAIN PROVISIONS.—In applying a provision of subsection (k), (m), (o), or (p) for purposes of this subsection, the Secretary shall—

(i) adjust the application of such provision to ensure the provision is consistent with the provisions of this subsection; and

(ii) not apply such provision to the extent that the provision is duplicative with a provision of this subsection.

(G) ACCOUNTING FOR RISK FACTORS.—

(i) RISK FACTORS.—Taking into account the relevant studies conducted and recommendations made in reports under section 2(d) of the Improving Medicare Post-Acute Care Transformation Act of 2014, and, as appropriate, other information, including information collected before completion of such studies and recommendations, the Secretary, on an ongoing basis, shall, as the Secretary determines appropriate and based on an individual's health status and other risk factors—

(I) assess appropriate adjustments to quality measures, resource use measures, and other measures used under the MIPS; and

(II) assess and implement appropriate adjustments to payment adjustments, composite performance scores, scores for performance categories, or scores for measures or activities under the MIPS.

(2) MEASURES AND ACTIVITIES UNDER PERFORMANCE CATEGORIES.—

(A) PERFORMANCE CATEGORIES.—Under the MIPS, the Secretary shall use the following performance categories (each of which is referred to in this subsection as a performance category) in determining the composite performance score under paragraph (5):

(i) Quality.

(ii) Resource use.

(iii) Clinical practice improvement activities.

(iv) Meaningful use of certified EHR technology.

(B) MEASURES AND ACTIVITIES SPECIFIED FOR EACH CATEGORY.—For purposes of paragraph (3)(A) and subject to subparagraph (C), measures and activities specified for a performance period (as established under paragraph (4)) for a year are as follows:

(i) QUALITY.—For the performance category described in subparagraph (A)(i), the quality measures included in the final measures list published under subparagraph (D)(i) for such year and the list of quality measures described in subparagraph (D)(vi) used by qualified clinical data registries under subsection (m)(3)(E).

(ii) RESOURCE USE.—For the performance category described in subparagraph (A)(ii), the measurement of resource use for such period under subsection (p)(3), using the methodology under subsection (r) as appropriate, and, as feasible and applicable, accounting for the cost of drugs under part D.

(iii) CLINICAL PRACTICE IMPROVEMENT ACTIVITIES.—For the performance category described in subparagraph (A)(iii), clinical practice improvement activities (as defined in subparagraph (C)(v)(III)) under subcategories specified by the Secretary for such period, which shall include at least the following:

(I) The subcategory of expanded practice access, such as same day appointments for urgent needs and after hours access to clinician advice.

(II) The subcategory of population management, such as monitoring health conditions of individuals to provide timely health care interventions or participation in a qualified clinical data registry.

(III) The subcategory of care coordination, such as timely communication of test results, timely exchange of clinical information to patients and other providers, and use of remote monitoring or telehealth.

(IV) The subcategory of beneficiary engagement, such as the establishment of care plans for individuals with complex care needs, beneficiary self-management assessment and training, and using shared decision-making mechanisms.

(V) The subcategory of patient safety and practice assessment, such as through use of clinical or surgical checklists and practice assessments related to maintaining certification.

(VI) The subcategory of participation in an alternative payment model (as defined in section 1833(z)(3)(C)).

In establishing activities under this clause, the Secretary shall give consideration to the circumstances of small practices (consisting of 15 or fewer professionals) and practices located in rural areas and in health professional shortage areas (as designated under section 332(a)(1)(A) of the Public Health Service Act).

(iv) MEANINGFUL EHR USE.—For the performance category described in subparagraph (A)(iv), the requirements established for such period under subsection (o)(2) for determining whether an eligible professional is a meaningful EHR user.

(C) ADDITIONAL PROVISIONS.—

(i) EMPHASIZING OUTCOME MEASURES UNDER THE QUALITY PERFORMANCE CATEGORY.—In applying subparagraph (B)(i), the Secretary shall, as feasible, emphasize the application of outcome measures.

(ii) APPLICATION OF ADDITIONAL SYSTEM MEASURES.—The Secretary may use measures used for a payment system other than for physicians, such as measures for inpatient hospitals, for purposes of the performance categories described in clauses (i) and (ii) of subparagraph (A). For purposes of the previous sentence, the Secretary may not use measures for hospital outpatient departments, except in the case of items

and services furnished by emergency physicians, radiologists, and anesthesiologists.

(iii) GLOBAL AND POPULATION-BASED MEASURES.—The Secretary may use global measures, such as global outcome measures, and population-based measures for purposes of the performance category described in subparagraph (A)(i).

(iv) APPLICATION OF MEASURES AND ACTIVITIES TO NON-PATIENT-FACING PROFESSIONALS.—In carrying out this paragraph, with respect to measures and activities specified in subparagraph (B) for performance categories described in subparagraph (A), the Secretary—

(I) shall give consideration to the circumstances of professional types (or subcategories of those types determined by practice characteristics) who typically furnish services that do not involve face-to-face interaction with a patient; and

(II) may, to the extent feasible and appropriate, take into account such circumstances and apply under this subsection with respect to MIPS eligible professionals of such professional types or subcategories, alternative measures or activities that fulfill the goals of the applicable performance category.

In carrying out the previous sentence, the Secretary shall consult with professionals of such professional types or subcategories.

(v) CLINICAL PRACTICE IMPROVEMENT ACTIVITIES.—

(I) REQUEST FOR INFORMATION.—In initially applying subparagraph (B)(iii), the Secretary shall use a request for information to solicit recommendations from stakeholders to identify activities described in such subparagraph and specifying criteria for such activities.

(II) CONTRACT AUTHORITY FOR CLINICAL PRACTICE IMPROVEMENT ACTIVITIES PERFORMANCE CATEGORY.—In applying subparagraph (B)(iii), the Secretary may contract with entities to assist the Secretary in—

(aa) identifying activities described in subparagraph (B)(iii);

(bb) specifying criteria for such activities; and

(cc) determining whether a MIPS eligible professional meets such criteria.

(III) CLINICAL PRACTICE IMPROVEMENT ACTIVITIES DEFINED.—For purposes of this subsection, the term "clinical practice improvement activity" means an activity that relevant eligible professional organizations and other relevant stakeholders identify as improving clinical practice or care delivery and that the Secretary determines, when effectively executed, is likely to result in improved outcomes.

(D) ANNUAL LIST OF QUALITY MEASURES AVAILABLE FOR MIPS ASSESSMENT.—

(i) IN GENERAL.—Under the MIPS, the Secretary, through notice and comment rulemaking and subject to the succeeding clauses of this subparagraph, shall, with respect to the performance period for a year, establish an annual final list of quality measures from which MIPS eligible professionals may choose for purposes of assessment under this subsection for such performance period. Pursuant to the previous sentence, the Secretary shall—

(I) not later than November 1 of the year prior to the first day of the first performance period under the MIPS, establish and publish in the Federal Register a final list of quality measures; and

(II) not later than November 1 of the year prior to the first day of each subsequent performance period, update the final list of quality measures from the previous year (and publish such updated final list in the Federal Register), by—

(aa) removing from such list, as appropriate, quality measures, which may include the removal of measures that are no longer meaningful (such as measures that are topped out);

(bb) adding to such list, as appropriate, new quality measures; and

(cc) determining whether or not quality measures on such list that have undergone substantive changes should be included in the updated list.

(ii) CALL FOR QUALITY MEASURES.—

(I) IN GENERAL.—Eligible professional organizations and other relevant stakeholders shall be requested to identify and submit quality measures to be considered for selection under this subparagraph in the annual list of quality measures published under clause (i) and to identify and submit updates to the measures on such list. For purposes of the previous sentence, measures may be submitted regardless of whether such measures were previously published in a proposed rule or endorsed by an entity with a contract under section 1890(a).

(II) ELIGIBLE PROFESSIONAL ORGANIZATION DEFINED.—In this subparagraph, the term "eligible professional organization" means a professional organization as defined by nationally recognized specialty boards of certification or equivalent certification boards.

(iii) REQUIREMENTS.—In selecting quality measures for inclusion in the annual final list under clause (i), the Secretary shall—

(I) provide that, to the extent practicable, all quality domains (as defined in subsection (s)(1)(B)) are addressed by such measures; and

(II) ensure that such selection is consistent with the process for selection of measures under subsections (k), (m), and (p)(2).

(iv) PEER REVIEW.—Before including a new measure in the final list of measures published under clause (i) for a year, the Secretary shall submit for publication in applicable specialty-appropriate, peer-reviewed journals such measure and the method for developing and selecting such measure, including clinical and other data supporting such measure.

(v) MEASURES FOR INCLUSION.—The final list of quality measures published under clause (i) shall include, as applicable, measures under subsections (k), (m), and (p)(2), including quality measures from among—

(I) measures endorsed by a consensus-based entity;

(II) measures developed under subsection (s); and

(III) measures submitted under clause (ii)(I).

Any measure selected for inclusion in such list that is not endorsed by a consensus-based entity shall have a focus that is evidence-based.

(vi) EXCEPTION FOR QUALIFIED CLINICAL DATA REGISTRY MEASURES.—Measures used by a qualified clinical data registry under subsection (m)(3)(E) shall not be subject to the requirements under clauses (i), (iv), and (v). The Secretary shall publish the list of measures used by such qualified clinical data registries on the Internet website of the Centers for Medicare & Medicaid Services.

(vii) EXCEPTION FOR EXISTING QUALITY MEASURES.—Any quality measure specified by the Secretary under subsection (k) or (m), including under subsection (m)(3)(E), and any measure of quality of care established under subsection (p)(2) for the reporting period or performance period under the respective subsection beginning before the first performance period under the MIPS—

(I) shall not be subject to the requirements under clause (i) (except under items (aa) and (cc) of subclause (II) of such clause) or to the requirement under clause (iv); and

(II) shall be included in the final list of quality measures published under clause (i) unless removed under clause (i)(II)(aa).

(viii) CONSULTATION WITH RELEVANT ELIGIBLE PROFESSIONAL ORGANIZATIONS AND OTHER RELEVANT STAKEHOLDERS.—Relevant eligible professional organizations and other relevant stakeholders, including State and national medical societies, shall be consulted in carrying out this subparagraph.

(ix) OPTIONAL APPLICATION.—The process under section 1890A is not required to apply to the selection of measures under this subparagraph.

(3) PERFORMANCE STANDARDS.—

(A) ESTABLISHMENT.—Under the MIPS, the Secretary shall establish performance standards with respect to measures and activities specified under paragraph (2)(B) for a performance period (as established under paragraph (4)) for a year.

(B) CONSIDERATIONS IN ESTABLISHING STANDARDS.—In establishing such performance standards with respect to measures and activities specified under paragraph (2)(B), the Secretary shall consider the following:

(i) Historical performance standards.

(ii) Improvement.

(iii) The opportunity for continued improvement.

(4) PERFORMANCE PERIOD.—The Secretary shall establish a performance period (or periods) for a year (beginning with 2019). Such performance period (or periods) shall begin and end prior to the beginning of such year and be as close as possible to such year. In this subsection, such performance period (or periods) for a year shall be referred to as the performance period for the year.

(5) COMPOSITE PERFORMANCE SCORE.—

(A) IN GENERAL.—Subject to the succeeding provisions of this paragraph and taking into account, as available and applicable, paragraph (1)(G), the Secretary shall develop a methodology for assessing the total performance of each MIPS eligible professional according to performance standards under paragraph (3) with respect to applicable measures and activities specified in paragraph (2)(B) with respect to each performance category applicable to such professional for a performance period (as established under paragraph (4)) for a year. Using such methodology, the Secretary shall provide for a composite assessment (using a scoring scale of 0 to 100) for each such professional for the performance period for such year. In this subsection such a composite assessment for such a professional with respect to a performance period shall be referred to as the "composite performance score" for such professional for such performance period.

(B) INCENTIVE TO REPORT; ENCOURAGING USE OF CERTIFIED EHR TECHNOLOGY FOR REPORTING QUALITY MEASURES.—

(i) INCENTIVE TO REPORT.—Under the methodology established under subparagraph (A), the Secretary shall provide that in the case of a MIPS eligible professional who fails to report on an applicable measure or activity that is required to be reported by the professional, the professional shall be treated as achieving the lowest potential score applicable to such measure or activity.

(ii) ENCOURAGING USE OF CERTIFIED EHR TECHNOLOGY AND QUALIFIED CLINICAL DATA REGISTRIES FOR REPORTING QUALITY MEASURES.—Under the method-

ology established under subparagraph (A), the Secretary shall—

(I) encourage MIPS eligible professionals to report on applicable measures with respect to the performance category described in paragraph (2)(A)(i) through the use of certified EHR technology and qualified clinical data registries; and

(II) with respect to a performance period, with respect to a year, for which a MIPS eligible professional reports such measures through the use of such EHR technology, treat such professional as satisfying the clinical quality measures reporting requirement described in subsection (o)(2)(A)(iii) for such year.

(C) CLINICAL PRACTICE IMPROVEMENT ACTIVITIES PERFORMANCE SCORE.—

(i) RULE FOR CERTIFICATION.—A MIPS eligible professional who is in a practice that is certified as a patient-centered medical home or comparable specialty practice, as determined by the Secretary, with respect to a performance period shall be given the highest potential score for the performance category described in paragraph (2)(A)(iii) for such period.

(ii) APM PARTICIPATION.—Participation by a MIPS eligible professional in an alternative payment model (as defined in section 1833(z)(3)(C)) with respect to a performance period shall earn such eligible professional a minimum score of one-half of the highest potential score for the performance category described in paragraph (2)(A)(iii) for such performance period.

(iii) SUBCATEGORIES.—A MIPS eligible professional shall not be required to perform activities in each subcategory under paragraph (2)(B)(iii) or participate in an alternative payment model in order to achieve the highest potential score for the performance category described in paragraph (2)(A)(iii).

(D) ACHIEVEMENT AND IMPROVEMENT.—

(i) TAKING INTO ACCOUNT IMPROVEMENT.—Beginning with the second year to which the MIPS applies, in addition to the achievement of a MIPS eligible professional, if data sufficient to measure improvement is available, the methodology developed under subparagraph (A)—

(I) in the case of the performance score for the performance category described in clauses (i) and (ii) of paragraph (2)(A), shall take into account the improvement of the professional; and

(II) in the case of performance scores for other performance categories, may take into account the improvement of the professional.

(ii) ASSIGNING HIGHER WEIGHT FOR ACHIEVEMENT.—Subject to clause (i), under the methodology developed under subparagraph (A), the Secretary may assign a higher scoring weight under subparagraph (F) with respect to the achievement of a MIPS eligible profes-

sional than with respect to any improvement of such professional applied under clause (i) with respect to a measure, activity, or category described in paragraph (2).

(E) WEIGHTS FOR THE PERFORMANCE CATEGORIES.—

(i) IN GENERAL.—Under the methodology developed under subparagraph (A), subject to subparagraph (F)(i) and clause (ii), the composite performance score shall be determined as follows:

(I) QUALITY.—

(aa) IN GENERAL.—Subject to item (bb), thirty percent of such score shall be based on performance with respect to the category described in clause (i) of paragraph (2)(A). In applying the previous sentence, the Secretary shall, as feasible, encourage the application of outcome measures within such category.

(bb) FIRST 2 YEARS.—For the first and second years for which the MIPS applies to payments, the percentage applicable under item (aa) shall be increased in a manner such that the total percentage points of the increase under this item for the respective year equals the total number of percentage points by which the percentage applied under subclause (II)(bb) for the respective year is less than 30 percent.

(II) RESOURCE USE.—

(aa) IN GENERAL.—Subject to item (bb), thirty percent of such score shall be based on performance with respect to the category described in clause (ii) of paragraph (2)(A).

(bb) FIRST 2 YEARS.—For the first year for which the MIPS applies to payments, not more than 10 percent of such score shall be based on performance with respect to the category described in clause (ii) of paragraph (2)(A). For the second year for which the MIPS applies to payments, not more than 15 percent of such score shall be based on performance with respect to the category described in clause (ii) of paragraph (2)(A).

(III) CLINICAL PRACTICE IMPROVEMENT ACTIVITIES.—Fifteen percent of such score shall be based on performance with respect to the category described in clause (iii) of paragraph (2)(A).

(IV) MEANINGFUL USE OF CERTIFIED EHR TECHNOLOGY.—Twenty-five percent of such score shall be based on performance with respect to the category described in clause (iv) of paragraph (2)(A).

(ii) AUTHORITY TO ADJUST PERCENTAGES IN CASE OF HIGH EHR MEANINGFUL USE ADOPTION.—In any year in which the Secretary estimates that the proportion of eligible professionals (as defined in subsection (o)(5)) who are meaningful EHR users (as determined under

subsection (o)(2)) is 75 percent or greater, the Secretary may reduce the percent applicable under clause (i)(IV), but not below 15 percent. If the Secretary makes such reduction for a year, subject to subclauses (I)(bb) and (II)(bb) of clause (i), the percentages applicable under one or more of subclauses (I), (II), and (III) of clause (i) for such year shall be increased in a manner such that the total percentage points of the increase under this clause for such year equals the total number of percentage points reduced under the preceding sentence for such year.

(F) CERTAIN FLEXIBILITY FOR WEIGHTING PERFORMANCE CATEGORIES, MEASURES, AND ACTIVITIES.—Under the methodology under subparagraph (A), if there are not sufficient measures and activities (described in paragraph (2)(B)) applicable and available to each type of eligible professional involved, the Secretary shall assign different scoring weights (including a weight of 0)—

(i) which may vary from the scoring weights specified in subparagraph (E), for each performance category based on the extent to which the category is applicable to the type of eligible professional involved; and

(ii) for each measure and activity specified under paragraph (2)(B) with respect to each such category based on the extent to which the measure or activity is applicable and available to the type of eligible professional involved.

(G) RESOURCE USE.—Analysis of the performance category described in paragraph (2)(A)(ii) shall include results from the methodology described in subsection (r)(5), as appropriate.

(H) INCLUSION OF QUALITY MEASURE DATA FROM OTHER PAYERS.—In applying subsections (k), (m), and (p) with respect to measures described in paragraph (2)(B)(i), analysis of the performance category described in paragraph (2)(A)(i) may include data submitted by MIPS eligible professionals with respect to items and services furnished to individuals who are not individuals entitled to benefits under part A or enrolled under part B.

(I) USE OF VOLUNTARY VIRTUAL GROUPS FOR CERTAIN ASSESSMENT PURPOSES.—

(i) IN GENERAL.—In the case of MIPS eligible professionals electing to be a virtual group under clause (ii) with respect to a performance period for a year, for purposes of applying the methodology under subparagraph (A) with respect to the performance categories described in clauses (i) and (ii) of paragraph (2)(A)—

(I) the assessment of performance provided under such methodology with respect to such performance categories that is to be applied to each such professional in such group for such performance period shall be with respect to the combined performance of all such professionals in such group for such period; and

(II) with respect to the composite performance score provided under this paragraph for such performance period for each such MIPS eligible professional in such virtual group, the components of the composite performance score that assess performance with respect to such performance categories shall be based on the assessment of the combined performance under subclause (I) for such performance categories and performance period.

(ii) ELECTION OF PRACTICES TO BE A VIRTUAL GROUP.—The Secretary shall, in accordance with the requirements under clause (iii), establish and have in place a process to allow an individual MIPS eligible professional or a group practice consisting of not more than 10 MIPS eligible professionals to elect, with respect to a performance period for a year to be a virtual group under this subparagraph with at least one other such individual MIPS eligible professional or group practice. Such a virtual group may be based on appropriate classifications of providers, such as by geographic areas or by provider specialties defined by nationally recognized specialty boards of certification or equivalent certification boards.

(iii) REQUIREMENTS.—The requirements for the process under clause (ii) shall—

(I) provide that an election under such clause, with respect to a performance period, shall be made before the beginning of such performance period and may not be changed during such performance period;

(II) provide that an individual MIPS eligible professional and a group practice described in clause (ii) may elect to be in no more than one virtual group for a performance period and that, in the case of such a group practice that elects to be in such virtual group for such performance period, such election applies to all MIPS eligible professionals in such group practice;

(III) provide that a virtual group be a combination of tax identification numbers;

(IV) provide for formal written agreements among MIPS eligible professionals electing to be a virtual group under this subparagraph; and

(V) include such other requirements as the Secretary determines appropriate.

(6) MIPS PAYMENTS.—

(A) MIPS ADJUSTMENT FACTOR.—Taking into account paragraph (1)(G), the Secretary shall specify a MIPS adjustment factor for each MIPS eligible professional for a year. Such MIPS adjustment factor for a MIPS eligible professional for a year shall be in the form of a percent and shall be determined—

(i) by comparing the composite performance score of the eligible professional for such year to the perform-

ance threshold established under subparagraph (D)(i) for such year;

(ii) in a manner such that the adjustment factors specified under this subparagraph for a year result in differential payments under this paragraph reflecting that—

(I) MIPS eligible professionals with composite performance scores for such year at or above such performance threshold for such year receive zero or positive payment adjustment factors for such year in accordance with clause (iii), with such professionals having higher composite performance scores receiving higher adjustment factors; and

(II) MIPS eligible professionals with composite performance scores for such year below such performance threshold for such year receive negative payment adjustment factors for such year in accordance with clause (iv), with such professionals having lower composite performance scores receiving lower adjustment factors;

(iii) in a manner such that MIPS eligible professionals with composite scores described in clause (ii)(I) for such year, subject to clauses (i) and (ii) of subparagraph (F), receive a zero or positive adjustment factor on a linear sliding scale such that an adjustment factor of 0 percent is assigned for a score at the performance threshold and an adjustment factor of the applicable percent specified in subparagraph (B) is assigned for a score of 100; and

(iv) in a manner such that—

(I) subject to subclause (II), MIPS eligible professionals with composite performance scores described in clause (ii)(II) for such year receive a negative payment adjustment factor on a linear sliding scale such that an adjustment factor of 0 percent is assigned for a score at the performance threshold and an adjustment factor of the negative of the applicable percent specified in subparagraph (B) is assigned for a score of 0; and

(II) MIPS eligible professionals with composite performance scores that are equal to or greater than 0, but not greater than ¼ of the performance threshold specified under subparagraph (D)(i) for such year, receive a negative payment adjustment factor that is equal to the negative of the applicable percent specified in subparagraph (B) for such year.

(B) APPLICABLE PERCENT DEFINED.—For purposes of this paragraph, the term "applicable percent" means—

(i) for 2019, 4 percent;

(ii) for 2020, 5 percent;

(iii) for 2021, 7 percent; and

(iv) for 2022 and subsequent years, 9 percent.

(C) ADDITIONAL MIPS ADJUSTMENT FACTORS FOR EXCEPTIONAL PERFORMANCE.—For 2019 and each subsequent

year through 2024, in the case of a MIPS eligible professional with a composite performance score for a year at or above the additional performance threshold under subparagraph (D)(ii) for such year, in addition to the MIPS adjustment factor under subparagraph (A) for the eligible professional for such year, subject to subparagraph (F)(iv), the Secretary shall specify an additional positive MIPS adjustment factor for such professional and year. Such additional MIPS adjustment factors shall be in the form of a percent and determined by the Secretary in a manner such that professionals having higher composite performance scores above the additional performance threshold receive higher additional MIPS adjustment factors.

(D) ESTABLISHMENT OF PERFORMANCE THRESHOLDS.—

(i) PERFORMANCE THRESHOLD.—For each year of the MIPS, the Secretary shall compute a performance threshold with respect to which the composite performance score of MIPS eligible professionals shall be compared for purposes of determining adjustment factors under subparagraph (A) that are positive, negative, and zero. Such performance threshold for a year shall be the mean or median (as selected by the Secretary) of the composite performance scores for all MIPS eligible professionals with respect to a prior period specified by the Secretary. The Secretary may reassess the selection of the mean or median under the previous sentence every 3 years.

(ii) ADDITIONAL PERFORMANCE THRESHOLD FOR EXCEPTIONAL PERFORMANCE.—In addition to the performance threshold under clause (i), for each year of the MIPS, the Secretary shall compute an additional performance threshold for purposes of determining the additional MIPS adjustment factors under subparagraph (C). For each such year, the Secretary shall apply either of the following methods for computing such additional performance threshold for such a year:

(I) The threshold shall be the score that is equal to the 25th percentile of the range of possible composite performance scores above the performance threshold determined under clause (i).

(II) The threshold shall be the score that is equal to the 25th percentile of the actual composite performance scores for MIPS eligible professionals with composite performance scores at or above the performance threshold with respect to the prior period described in clause (i).

(iii) SPECIAL RULE FOR INITIAL 2 YEARS.—With respect to each of the first two years to which the MIPS applies, the Secretary shall, prior to the performance period for such years, establish a performance threshold for purposes of determining MIPS adjustment factors under subparagraph (A) and a threshold for purposes of determining additional MIPS adjustment factors under subparagraph (C). Each such performance threshold shall—

(I) be based on a period prior to such performance periods; and

(II) take into account—

(aa) data available with respect to performance on measures and activities that may be used under the performance categories under subparagraph (2)(B); and

(bb) other factors determined appropriate by the Secretary.

(E) APPLICATION OF MIPS ADJUSTMENT FACTORS.—In the case of items and services furnished by a MIPS eligible professional during a year (beginning with 2019), the amount otherwise paid under this part with respect to such items and services and MIPS eligible professional for such year, shall be multiplied by—

(i) 1, plus

(ii) the sum of—

(I) the MIPS adjustment factor determined under subparagraph (A) divided by 100, and

(II) as applicable, the additional MIPS adjustment factor determined under subparagraph (C) divided by 100.

(F) AGGREGATE APPLICATION OF MIPS ADJUSTMENT FACTORS.—

(i) APPLICATION OF SCALING FACTOR.—

(I) IN GENERAL.—With respect to positive MIPS adjustment factors under subparagraph (A)(ii)(I) for eligible professionals whose composite performance score is above the performance threshold under subparagraph (D)(i) for such year, subject to subclause (II), the Secretary shall increase or decrease such adjustment factors by a scaling factor in order to ensure that the budget neutrality requirement of clause (ii) is met.

(II) SCALING FACTOR LIMIT.—In no case may the scaling factor applied under this clause exceed 3.0.

(ii) BUDGET NEUTRALITY REQUIREMENT.—

(I) IN GENERAL.—Subject to clause (iii), the Secretary shall ensure that the estimated amount described in subclause (II) for a year is equal to the estimated amount described in subclause (III) for such year.

(II) AGGREGATE INCREASES.—The amount described in this subclause is the estimated increase in the aggregate allowed charges resulting from the application of positive MIPS adjustment factors under subparagraph (A) (after application of the scaling factor described in clause (i)) to MIPS eligible professionals whose composite performance score for a year is above the performance threshold under subparagraph (D)(i) for such year.

(III) AGGREGATE DECREASES.—The amount described in this subclause is the estimated decrease in the aggregate allowed charges resulting from the application of negative MIPS adjustment fac-

tors under subparagraph (A) to MIPS eligible professionals whose composite performance score for a year is below the performance threshold under subparagraph (D)(i) for such year.

(iii) EXCEPTIONS.—

(I) In the case that all MIPS eligible professionals receive composite performance scores for a year that are below the performance threshold under subparagraph (D)(i) for such year, the negative MIPS adjustment factors under subparagraph (A) shall apply with respect to such MIPS eligible professionals and the budget neutrality requirement of clause (ii) and the additional adjustment factors under clause (iv) shall not apply for such year.

(II) In the case that, with respect to a year, the application of clause (i) results in a scaling factor equal to the maximum scaling factor specified in clause (i)(II), such scaling factor shall apply and the budget neutrality requirement of clause (ii) shall not apply for such year.

(iv) ADDITIONAL INCENTIVE PAYMENT ADJUSTMENTS.—

(I) IN GENERAL.—Subject to subclause (II), in specifying the MIPS additional adjustment factors under subparagraph (C) for each applicable MIPS eligible professional for a year, the Secretary shall ensure that the estimated aggregate increase in payments under this part resulting from the application of such additional adjustment factors for MIPS eligible professionals in a year shall be equal (as estimated by the Secretary) to $500,000,000 for each year beginning with 2019 and ending with 2024.

(II) LIMITATION ON ADDITIONAL INCENTIVE PAYMENT ADJUSTMENTS.—The MIPS additional adjustment factor under subparagraph (C) for a year for an applicable MIPS eligible professional whose composite performance score is above the additional performance threshold under subparagraph (D)(ii) for such year shall not exceed 10 percent. The application of the previous sentence may result in an aggregate amount of additional incentive payments that are less than the amount specified in subclause (I).

(7) ANNOUNCEMENT OF RESULT OF ADJUSTMENTS.—Under the MIPS, the Secretary shall, not later than 30 days prior to January 1 of the year involved, make available to MIPS eligible professionals the MIPS adjustment factor (and, as applicable, the additional MIPS adjustment factor) under paragraph (6) applicable to the eligible professional for items and services furnished by the professional for such year. The Secretary may include such information in the confidential feedback under paragraph (12).

(8) NO EFFECT IN SUBSEQUENT YEARS.—The MIPS adjustment factors and additional MIPS adjustment factors under paragraph (6) shall apply only with respect to the year involved, and the Secretary shall not take into account such adjustment factors in making payments to a MIPS eligible professional under this part in a subsequent year.

(9) PUBLIC REPORTING.—

(A) IN GENERAL.—The Secretary shall, in an easily understandable format, make available on the Physician Compare Internet website of the Centers for Medicare & Medicaid Services the following:

(i) Information regarding the performance of MIPS eligible professionals under the MIPS, which—

(I) shall include the composite score for each such MIPS eligible professional and the performance of each such MIPS eligible professional with respect to each performance category; and

(II) may include the performance of each such MIPS eligible professional with respect to each measure or activity specified in paragraph (2)(B).

(ii) The names of eligible professionals in eligible alternative payment models (as defined in section 1833(z)(3)(D)) and, to the extent feasible, the names of such eligible alternative payment models and performance of such models.

(B) DISCLOSURE.—The information made available under this paragraph shall indicate, where appropriate, that publicized information may not be representative of the eligible professional's entire patient population, the variety of services furnished by the eligible professional, or the health conditions of individuals treated.

(C) OPPORTUNITY TO REVIEW AND SUBMIT CORRECTIONS.—The Secretary shall provide for an opportunity for a professional described in subparagraph (A) to review, and submit corrections for, the information to be made public with respect to the professional under such subparagraph prior to such information being made public.

(D) AGGREGATE INFORMATION.—The Secretary shall periodically post on the Physician Compare Internet website aggregate information on the MIPS, including the range of composite scores for all MIPS eligible professionals and the range of the performance of all MIPS eligible professionals with respect to each performance category.

(10) CONSULTATION.—The Secretary shall consult with stakeholders in carrying out the MIPS, including for the identification of measures and activities under paragraph (2)(B) and the methodologies developed under paragraphs (5)(A) and (6) and regarding the use of qualified clinical data registries. Such consultation shall include the use of a request for information or other mechanisms determined appropriate.

(11) TECHNICAL ASSISTANCE TO SMALL PRACTICES AND PRACTICES IN HEALTH PROFESSIONAL SHORTAGE AREAS.—

(A) IN GENERAL.—The Secretary shall enter into contracts or agreements with appropriate entities (such as quality improvement organizations, regional extension cen-

ters (as described in section 3012(c) of the Public Health Service Act), or regional health collaboratives) to offer guidance and assistance to MIPS eligible professionals in practices of 15 or fewer professionals (with priority given to such practices located in rural areas, health professional shortage areas (as designated under in section 332(a)(1)(A) of such Act), and medically underserved areas, and practices with low composite scores) with respect to—

(i) the performance categories described in clauses (i) through (iv) of paragraph (2)(A); or

(ii) how to transition to the implementation of and participation in an alternative payment model as described in section 1833(z)(3)(C).

(B) FUNDING FOR TECHNICAL ASSISTANCE.—For purposes of implementing subparagraph (A), the Secretary shall provide for the transfer from the Federal Supplementary Medical Insurance Trust Fund established under section 1841 to the Centers for Medicare & Medicaid Services Program Management Account of $20,000,000 for each of fiscal years 2016 through 2020. Amounts transferred under this subparagraph for a fiscal year shall be available until expended.

(12) FEEDBACK AND INFORMATION TO IMPROVE PERFORMANCE.—

(A) PERFORMANCE FEEDBACK.—

(i) IN GENERAL.—Beginning July 1, 2017, the Secretary—

(I) shall make available timely (such as quarterly) confidential feedback to MIPS eligible professionals on the performance of such professionals with respect to the performance categories under clauses (i) and (ii) of paragraph (2)(A); and

(II) may make available confidential feedback to such professionals on the performance of such professionals with respect to the performance categories under clauses (iii) and (iv) of such paragraph.

(ii) MECHANISMS.—The Secretary may use one or more mechanisms to make feedback available under clause (i), which may include use of a web-based portal or other mechanisms determined appropriate by the Secretary. With respect to the performance category described in paragraph (2)(A)(i), feedback under this subparagraph shall, to the extent an eligible professional chooses to participate in a data registry for purposes of this subsection (including registries under subsections (k) and (m)), be provided based on performance on quality measures reported through the use of such registries. With respect to any other performance category described in paragraph (2)(A), the Secretary shall encourage provision of feedback through qualified clinical data registries as described in subsection (m)(3)(E)).

(iii) USE OF DATA.—For purposes of clause (i), the Secretary may use data, with respect to a MIPS eligi-

ble professional, from periods prior to the current performance period and may use rolling periods in order to make illustrative calculations about the performance of such professional.

(iv) DISCLOSURE EXEMPTION.—Feedback made available under this subparagraph shall be exempt from disclosure under section 552 of title 5, United States Code.

(v) RECEIPT OF INFORMATION.—The Secretary may use the mechanisms established under clause (ii) to receive information from professionals, such as information with respect to this subsection.

(B) ADDITIONAL INFORMATION.—

(i) IN GENERAL.—Beginning July 1, 2018, the Secretary shall make available to MIPS eligible professionals information, with respect to individuals who are patients of such MIPS eligible professionals, about items and services for which payment is made under this title that are furnished to such individuals by other suppliers and providers of services, which may include information described in clause (ii). Such information may be made available under the previous sentence to such MIPS eligible professionals by mechanisms determined appropriate by the Secretary, which may include use of a web-based portal. Such information may be made available in accordance with the same or similar terms as data are made available to accountable care organizations participating in the shared savings program under section 1899.

(ii) TYPE OF INFORMATION.—For purposes of clause (i), the information described in this clause, is the following:

(I) With respect to selected items and services (as determined appropriate by the Secretary) for which payment is made under this title and that are furnished to individuals, who are patients of a MIPS eligible professional, by another supplier or provider of services during the most recent period for which data are available (such as the most recent three-month period), such as the name of such providers furnishing such items and services to such patients during such period, the types of such items and services so furnished, and the dates such items and services were so furnished.

(II) Historical data, such as averages and other measures of the distribution if appropriate, of the total, and components of, allowed charges (and other figures as determined appropriate by the Secretary).

(13) REVIEW.—

(A) TARGETED REVIEW.—The Secretary shall establish a process under which a MIPS eligible professional may seek an informal review of the calculation of the MIPS adjustment factor (or factors) applicable to such eligible professional under this subsection for a year. The results of a re-

view conducted pursuant to the previous sentence shall not be taken into account for purposes of paragraph (6) with respect to a year (other than with respect to the calculation of such eligible professional's MIPS adjustment factor for such year or additional MIPS adjustment factor for such year) after the factors determined in subparagraph (A) and subparagraph (C) of such paragraph have been determined for such year.

(B) LIMITATION.—Except as provided for in subparagraph (A), there shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the following:

(i) The methodology used to determine the amount of the MIPS adjustment factor under paragraph (6)(A) and the amount of the additional MIPS adjustment factor under paragraph (6)(C) and the determination of such amounts.

(ii) The establishment of the performance standards under paragraph (3) and the performance period under paragraph (4).

(iii) The identification of measures and activities specified under paragraph (2)(B) and information made public or posted on the Physician Compare Internet website of the Centers for Medicare & Medicaid Services under paragraph (9).

(iv) The methodology developed under paragraph (5) that is used to calculate performance scores and the calculation of such scores, including the weighting of measures and activities under such methodology.

(r) COLLABORATING WITH THE PHYSICIAN, PRACTITIONER, AND OTHER STAKEHOLDER COMMUNITIES TO IMPROVE RESOURCE USE MEASUREMENT.—

(1) IN GENERAL.—In order to involve the physician, practitioner, and other stakeholder communities in enhancing the infrastructure for resource use measurement, including for purposes of the Merit-based Incentive Payment System under subsection (q) and alternative payment models under section 1833(z), the Secretary shall undertake the steps described in the succeeding provisions of this subsection.

(2) DEVELOPMENT OF CARE EPISODE AND PATIENT CONDITION GROUPS AND CLASSIFICATION CODES.—

(A) IN GENERAL.—In order to classify similar patients into care episode groups and patient condition groups, the Secretary shall undertake the steps described in the succeeding provisions of this paragraph.

(B) PUBLIC AVAILABILITY OF EXISTING EFFORTS TO DESIGN AN EPISODE GROUPER.—Not later than 180 days after the date of the enactment of this subsection, the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services a list of the episode groups developed pursuant to subsection (n)(9)(A) and related descriptive information.

(C) STAKEHOLDER INPUT.—The Secretary shall accept, through the date that is 120 days after the day the Secretary posts the list pursuant to subparagraph (B), sugges-

tions from physician specialty societies, applicable practitioner organizations, and other stakeholders for episode groups in addition to those posted pursuant to such subparagraph, and specific clinical criteria and patient characteristics to classify patients into—

(i) care episode groups; and

(ii) patient condition groups.

(D) DEVELOPMENT OF PROPOSED CLASSIFICATION CODES.—

(i) IN GENERAL.—Taking into account the information described in subparagraph (B) and the information received under subparagraph (C), the Secretary shall—

(I) establish care episode groups and patient condition groups, which account for a target of an estimated ½ of expenditures under parts A and B (with such target increasing over time as appropriate); and

(II) assign codes to such groups.

(ii) CARE EPISODE GROUPS.—In establishing the care episode groups under clause (i), the Secretary shall take into account—

(I) the patient's clinical problems at the time items and services are furnished during an episode of care, such as the clinical conditions or diagnoses, whether or not inpatient hospitalization occurs, and the principal procedures or services furnished; and

(II) other factors determined appropriate by the Secretary.

(iii) PATIENT CONDITION GROUPS.—In establishing the patient condition groups under clause (i), the Secretary shall take into account—

(I) the patient's clinical history at the time of a medical visit, such as the patient's combination of chronic conditions, current health status, and recent significant history (such as hospitalization and major surgery during a previous period, such as 3 months); and

(II) other factors determined appropriate by the Secretary, such as eligibility status under this title (including eligibility under section 226(a), 226(b), or 226A, and dual eligibility under this title and title XIX).

(E) DRAFT CARE EPISODE AND PATIENT CONDITION GROUPS AND CLASSIFICATION CODES.—Not later than 270 days after the end of the comment period described in subparagraph (C), the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services a draft list of the care episode and patient condition codes established under subparagraph (D) (and the criteria and characteristics assigned to such code).

(F) SOLICITATION OF INPUT.—The Secretary shall seek, through the date that is 120 days after the Secretary posts the list pursuant to subparagraph (E), comments from

physician specialty societies, applicable practitioner organizations, and other stakeholders, including representatives of individuals entitled to benefits under part A or enrolled under this part, regarding the care episode and patient condition groups (and codes) posted under subparagraph (E). In seeking such comments, the Secretary shall use one or more mechanisms (other than notice and comment rulemaking) that may include use of open door forums, town hall meetings, or other appropriate mechanisms.

(G) OPERATIONAL LIST OF CARE EPISODE AND PATIENT CONDITION GROUPS AND CODES.—Not later than 270 days after the end of the comment period described in subparagraph (F), taking into account the comments received under such subparagraph, the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services an operational list of care episode and patient condition codes (and the criteria and characteristics assigned to such code).

(H) SUBSEQUENT REVISIONS.—Not later than November 1 of each year (beginning with 2018), the Secretary shall, through rulemaking, make revisions to the operational lists of care episode and patient condition codes as the Secretary determines may be appropriate. Such revisions may be based on experience, new information developed pursuant to subsection (n)(9)(A), and input from the physician specialty societies, applicable practitioner organizations, and other stakeholders, including representatives of individuals entitled to benefits under part A or enrolled under this part.

(3) ATTRIBUTION OF PATIENTS TO PHYSICIANS OR PRACTITIONERS.—

(A) IN GENERAL.—In order to facilitate the attribution of patients and episodes (in whole or in part) to one or more physicians or applicable practitioners furnishing items and services, the Secretary shall undertake the steps described in the succeeding provisions of this paragraph.

(B) DEVELOPMENT OF PATIENT RELATIONSHIP CATEGORIES AND CODES.—The Secretary shall develop patient relationship categories and codes that define and distinguish the relationship and responsibility of a physician or applicable practitioner with a patient at the time of furnishing an item or service. Such patient relationship categories shall include different relationships of the physician or applicable practitioner to the patient (and the codes may reflect combinations of such categories), such as a physician or applicable practitioner who—

(i) considers themself to have the primary responsibility for the general and ongoing care for the patient over extended periods of time;

(ii) considers themself to be the lead physician or practitioner and who furnishes items and services and coordinates care furnished by other physicians or practitioners for the patient during an acute episode;

(iii) furnishes items and services to the patient on a continuing basis during an acute episode of care, but in a supportive rather than a lead role;

(iv) furnishes items and services to the patient on an occasional basis, usually at the request of another physician or practitioner; or

(v) furnishes items and services only as ordered by another physician or practitioner.

(C) DRAFT LIST OF PATIENT RELATIONSHIP CATEGORIES AND CODES.—Not later than one year after the date of the enactment of this subsection, the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services a draft list of the patient relationship categories and codes developed under subparagraph (B).

(D) STAKEHOLDER INPUT.—The Secretary shall seek, through the date that is 120 days after the Secretary posts the list pursuant to subparagraph (C), comments from physician specialty societies, applicable practitioner organizations, and other stakeholders, including representatives of individuals entitled to benefits under part A or enrolled under this part, regarding the patient relationship categories and codes posted under subparagraph (C). In seeking such comments, the Secretary shall use one or more mechanisms (other than notice and comment rulemaking) that may include open door forums, town hall meetings, web-based forums, or other appropriate mechanisms.

(E) OPERATIONAL LIST OF PATIENT RELATIONSHIP CATEGORIES AND CODES.—Not later than 240 days after the end of the comment period described in subparagraph (D), taking into account the comments received under such subparagraph, the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services an operational list of patient relationship categories and codes.

(F) SUBSEQUENT REVISIONS.—Not later than November 1 of each year (beginning with 2018), the Secretary shall, through rulemaking, make revisions to the operational list of patient relationship categories and codes as the Secretary determines appropriate. Such revisions may be based on experience, new information developed pursuant to subsection (n)(9)(A), and input from the physician specialty societies, applicable practitioner organizations, and other stakeholders, including representatives of individuals entitled to benefits under part A or enrolled under this part.

(4) REPORTING OF INFORMATION FOR RESOURCE USE MEASUREMENT.—Claims submitted for items and services furnished by a physician or applicable practitioner on or after January 1, 2018, shall, as determined appropriate by the Secretary, include—

(A) applicable codes established under paragraphs (2) and (3); and

(B) the national provider identifier of the ordering physician or applicable practitioner (if different from the billing physician or applicable practitioner).

(5) METHODOLOGY FOR RESOURCE USE ANALYSIS.—

(A) IN GENERAL.—In order to evaluate the resources used to treat patients (with respect to care episode and patient condition groups), the Secretary shall, as the Secretary determines appropriate—

(i) use the patient relationship codes reported on claims pursuant to paragraph (4) to attribute patients (in whole or in part) to one or more physicians and applicable practitioners;

(ii) use the care episode and patient condition codes reported on claims pursuant to paragraph (4) as a basis to compare similar patients and care episodes and patient condition groups; and

(iii) conduct an analysis of resource use (with respect to care episodes and patient condition groups of such patients).

(B) ANALYSIS OF PATIENTS OF PHYSICIANS AND PRACTITIONERS.—In conducting the analysis described in subparagraph (A)(iii) with respect to patients attributed to physicians and applicable practitioners, the Secretary shall, as feasible—

(i) use the claims data experience of such patients by patient condition codes during a common period, such as 12 months; and

(ii) use the claims data experience of such patients by care episode codes—

(I) in the case of episodes without a hospitalization, during periods of time (such as the number of days) determined appropriate by the Secretary; and

(II) in the case of episodes with a hospitalization, during periods of time (such as the number of days) before, during, and after the hospitalization.

(C) MEASUREMENT OF RESOURCE USE.—In measuring such resource use, the Secretary—

(i) shall use per patient total allowed charges for all services under part A and this part (and, if the Secretary determines appropriate, part D) for the analysis of patient resource use, by care episode codes and by patient condition codes; and

(ii) may, as determined appropriate, use other measures of allowed charges (such as subtotals for categories of items and services) and measures of utilization of items and services (such as frequency of specific items and services and the ratio of specific items and services among attributed patients or episodes).

(D) STAKEHOLDER INPUT.—The Secretary shall seek comments from the physician specialty societies, applicable practitioner organizations, and other stakeholders, including representatives of individuals entitled to benefits under part A or enrolled under this part, regarding the re-

source use methodology established pursuant to this paragraph. In seeking comments the Secretary shall use one or more mechanisms (other than notice and comment rulemaking) that may include open door forums, town hall meetings, web-based forums, or other appropriate mechanisms.

(6) IMPLEMENTATION.—To the extent that the Secretary contracts with an entity to carry out any part of the provisions of this subsection, the Secretary may not contract with an entity or an entity with a subcontract if the entity or subcontracting entity currently makes recommendations to the Secretary on relative values for services under the fee schedule for physicians' services under this section.

(7) LIMITATION.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of—

(A) care episode and patient condition groups and codes established under paragraph (2);

(B) patient relationship categories and codes established under paragraph (3); and

(C) measurement of, and analyses of resource use with respect to, care episode and patient condition codes and patient relationship codes pursuant to paragraph (5).

(8) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to this section.

(9) DEFINITIONS.—In this subsection:

(A) PHYSICIAN.—The term "physician" has the meaning given such term in section 1861(r)(1).

(B) APPLICABLE PRACTITIONER.—The term "applicable practitioner" means—

(i) a physician assistant, nurse practitioner, and clinical nurse specialist (as such terms are defined in section 1861(aa)(5)), and a certified registered nurse anesthetist (as defined in section 1861(bb)(2)); and

(ii) beginning January 1, 2019, such other eligible professionals (as defined in subsection (k)(3)(B)) as specified by the Secretary.

(10) CLARIFICATION.—The provisions of sections 1890(b)(7) and 1890A shall not apply to this subsection.

(s) PRIORITIES AND FUNDING FOR MEASURE DEVELOPMENT.—

(1) PLAN IDENTIFYING MEASURE DEVELOPMENT PRIORITIES AND TIMELINES.—

(A) DRAFT MEASURE DEVELOPMENT PLAN.—Not later than January 1, 2016, the Secretary shall develop, and post on the Internet website of the Centers for Medicare & Medicaid Services, a draft plan for the development of quality measures for application under the applicable provisions (as defined in paragraph (5)). Under such plan the Secretary shall—

(i) address how measures used by private payers and integrated delivery systems could be incorporated under title XVIII;

(ii) describe how coordination, to the extent possible, will occur across organizations developing such measures; and

(iii) take into account how clinical best practices and clinical practice guidelines should be used in the development of quality measures.

(B) QUALITY DOMAINS.—For purposes of this subsection, the term "quality domains" means at least the following domains:

(i) Clinical care.

(ii) Safety.

(iii) Care coordination.

(iv) Patient and caregiver experience.

(v) Population health and prevention.

(C) CONSIDERATION.—In developing the draft plan under this paragraph, the Secretary shall consider—

(i) gap analyses conducted by the entity with a contract under section 1890(a) or other contractors or entities;

(ii) whether measures are applicable across health care settings;

(iii) clinical practice improvement activities submitted under subsection (q)(2)(C)(iv) for identifying possible areas for future measure development and identifying existing gaps with respect to such measures; and

(iv) the quality domains applied under this subsection.

(D) PRIORITIES.—In developing the draft plan under this paragraph, the Secretary shall give priority to the following types of measures:

(i) Outcome measures, including patient reported outcome and functional status measures.

(ii) Patient experience measures.

(iii) Care coordination measures.

(iv) Measures of appropriate use of services, including measures of over use.

(E) STAKEHOLDER INPUT.—The Secretary shall accept through March 1, 2016, comments on the draft plan posted under paragraph (1)(A) from the public, including health care providers, payers, consumers, and other stakeholders.

(F) FINAL MEASURE DEVELOPMENT PLAN.—Not later than May 1, 2016, taking into account the comments received under this subparagraph, the Secretary shall finalize the plan and post on the Internet website of the Centers for Medicare & Medicaid Services an operational plan for the development of quality measures for use under the applicable provisions. Such plan shall be updated as appropriate.

(2) CONTRACTS AND OTHER ARRANGEMENTS FOR QUALITY MEASURE DEVELOPMENT.—

(A) IN GENERAL.—The Secretary shall enter into contracts or other arrangements with entities for the purpose of developing, improving, updating, or expanding in accordance with the plan under paragraph (1) quality measures for application under the applicable provisions. Such entities shall include organizations with quality measure development expertise.

(B) PRIORITIZATION.—

(i) IN GENERAL.—In entering into contracts or other arrangements under subparagraph (A), the Secretary shall give priority to the development of the types of measures described in paragraph (1)(D).

(ii) CONSIDERATION.—In selecting measures for development under this subsection, the Secretary shall consider—

(I) whether such measures would be electronically specified; and

(II) clinical practice guidelines to the extent that such guidelines exist.

(3) ANNUAL REPORT BY THE SECRETARY.—

(A) IN GENERAL.—Not later than May 1, 2017, and annually thereafter, the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services a report on the progress made in developing quality measures for application under the applicable provisions.

(B) REQUIREMENTS.—Each report submitted pursuant to subparagraph (A) shall include the following:

(i) A description of the Secretary's efforts to implement this paragraph.

(ii) With respect to the measures developed during the previous year—

(I) a description of the total number of quality measures developed and the types of such measures, such as an outcome or patient experience measure;

(II) the name of each measure developed;

(III) the name of the developer and steward of each measure;

(IV) with respect to each type of measure, an estimate of the total amount expended under this title to develop all measures of such type; and

(V) whether the measure would be electronically specified.

(iii) With respect to measures in development at the time of the report—

(I) the information described in clause (ii), if available; and

(II) a timeline for completion of the development of such measures.

(iv) A description of any updates to the plan under paragraph (1) (including newly identified gaps and the status of previously identified gaps) and the inventory of measures applicable under the applicable provisions.

(v) Other information the Secretary determines to be appropriate.

(4) STAKEHOLDER INPUT.—With respect to paragraph (1), the Secretary shall seek stakeholder input with respect to—

(A) the identification of gaps where no quality measures exist, particularly with respect to the types of measures described in paragraph (1)(D);

(B) prioritizing quality measure development to address such gaps; and

(C) other areas related to quality measure development determined appropriate by the Secretary.

(5) DEFINITION OF APPLICABLE PROVISIONS.—In this subsection, the term "applicable provisions" means the following provisions:

(A) Subsection (q)(2)(B)(i).

(B) Section 1833(z)(2)(C).

(6) FUNDING.—For purposes of carrying out this subsection, the Secretary shall provide for the transfer, from the Federal Supplementary Medical Insurance Trust Fund under section 1841, of $15,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for each of fiscal years 2015 through 2019. Amounts transferred under this paragraph shall remain available through the end of fiscal year 2022.

(7) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to the collection of information for the development of quality measures.

PART C—MEDICARE+CHOICE PROGRAM

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CONTRACTS WITH MEDICARE+CHOICE ORGANIZATIONS

SEC. 1857. (a) IN GENERAL.—The Secretary shall not permit the election under section 1851 of a Medicare+Choice plan offered by a Medicare+Choice organization under this part, and no payment shall be made under section 1853 to an organization, unless the Secretary has entered into a contract under this section with the organization with respect to the offering of such plan. Such a contract with an organization may cover more than 1 Medicare+Choice plan. Such contract shall provide that the organization agrees to comply with the applicable requirements and standards of this part and the terms and conditions of payment as provided for in this part.

(b) MINIMUM ENROLLMENT REQUIREMENTS.—

(1) IN GENERAL.—Subject to paragraph (2), the Secretary may not enter into a contract under this section with a Medicare+Choice organization unless the organization has—

(A) at least 5,000 individuals (or 1,500 individuals in the case of an organization that is a provider-sponsored organization) who are receiving health benefits through the organization, or

(B) at least 1,500 individuals (or 500 individuals in the case of an organization that is a provider-sponsored organization) who are receiving health benefits through the organization if the organization primarily serves individuals residing outside of urbanized areas.

(2) APPLICATION TO MSA PLANS.—In applying paragraph (1) in the case of a Medicare+Choice organization that is offering an MSA plan, paragraph (1) shall be applied by substituting covered lives for individuals.

(3) ALLOWING TRANSITION.—The Secretary may waive the requirement of paragraph (1) during the first 3 contract years with respect to an organization.

(c) CONTRACT PERIOD AND EFFECTIVENESS.—

(1) PERIOD.—Each contract under this section shall be for a term of at least 1 year, as determined by the Secretary, and may be made automatically renewable from term to term in the absence of notice by either party of intention to terminate at the end of the current term.

(2) TERMINATION AUTHORITY.—In accordance with procedures established under subsection (h), the Secretary may at any time terminate any such contract if the Secretary determines that the organization—

(A) has failed substantially to carry out the contract;

(B) is carrying out the contract in a manner inconsistent with the efficient and effective administration of this part; or

(C) no longer substantially meets the applicable conditions of this part.

(3) EFFECTIVE DATE OF CONTRACTS.—The effective date of any contract executed pursuant to this section shall be specified in the contract, except that in no case shall a contract under this section which provides for coverage under an MSA plan be effective before January 1999 with respect to such coverage.

(4) PREVIOUS TERMINATIONS.—

(A) IN GENERAL.—The Secretary may not enter into a contract with a Medicare+Choice organization if a previous contract with that organization under this section was terminated at the request of the organization within the preceding 2-year period, except as provided in subparagraph (B) and except in such other circumstances which warrant special consideration, as determined by the Secretary.

(B) EARLIER RE-ENTRY PERMITTED WHERE CHANGE IN PAYMENT POLICY.—Subparagraph (A) shall not apply with respect to the offering by a Medicare+Choice organization of a Medicare+Choice plan in a Medicare+Choice payment area if during the 6-month period beginning on the date the organization notified the Secretary of the intention to terminate the most recent previous contract, there was a legislative change enacted (or a regulatory change adopted) that has the effect of increasing payment amounts under section 1853 for that Medicare+Choice payment area.

(5) CONTRACTING AUTHORITY.—The authority vested in the Secretary by this part may be performed without regard to such provisions of law or regulations relating to the making, performance, amendment, or modification of contracts of the United States as the Secretary may determine to be inconsistent with the furtherance of the purpose of this title.

(d) PROTECTIONS AGAINST FRAUD AND BENEFICIARY PROTECTIONS.—

(1) PERIODIC AUDITING.—The Secretary shall provide for the annual auditing of the financial records (including data relating to medicare utilization and costs, including allowable costs

under section 1858(c)) of at least one-third of the Medicare+Choice organizations offering Medicare+Choice plans under this part. The Comptroller General shall monitor auditing activities conducted under this subsection.

(2) INSPECTION AND AUDIT.—Each contract under this section shall provide that the Secretary, or any person or organization designated by the Secretary—

(A) shall have the right to timely inspect or otherwise evaluate (i) the quality, appropriateness, and timeliness of services performed under the contract, and (ii) the facilities of the organization when there is reasonable evidence of some need for such inspection, and

(B) shall have the right to timely audit and inspect any books and records of the Medicare+Choice organization that pertain (i) to the ability of the organization to bear the risk of potential financial losses, or (ii) to services performed or determinations of amounts payable under the contract.

(3) ENROLLEE NOTICE AT TIME OF TERMINATION.—Each contract under this section shall require the organization to provide (and pay for) written notice in advance of the contract's termination, as well as a description of alternatives for obtaining benefits under this title, to each individual enrolled with the organization under this part.

(4) DISCLOSURE.—

(A) IN GENERAL.—Each Medicare+Choice organization shall, in accordance with regulations of the Secretary, report to the Secretary financial information which shall include the following:

(i) Such information as the Secretary may require demonstrating that the organization has a fiscally sound operation.

(ii) A copy of the report, if any, filed with the Secretary containing the information required to be reported under section 1124 by disclosing entities.

(iii) A description of transactions, as specified by the Secretary, between the organization and a party in interest. Such transactions shall include—

(I) any sale or exchange, or leasing of any property between the organization and a party in interest;

(II) any furnishing for consideration of goods, services (including management services), or facilities between the organization and a party in interest, but not including salaries paid to employees for services provided in the normal course of their employment and health services provided to members by hospitals and other providers and by staff, medical group (or groups), individual practice association (or associations), or any combination thereof; and

(III) any lending of money or other extension of credit between an organization and a party in interest.

The Secretary may require that information reported respecting an organization which controls, is controlled by, or is under common control with, another entity be in the form of a consolidated financial statement for the organization and such entity.

(B) PARTY IN INTEREST DEFINED.—For the purposes of this paragraph, the term "party in interest" means—

(i) any director, officer, partner, or employee responsible for management or administration of a Medicare+Choice organization, any person who is directly or indirectly the beneficial owner of more than 5 percent of the equity of the organization, any person who is the beneficial owner of a mortgage, deed of trust, note, or other interest secured by, and valuing more than 5 percent of the organization, and, in the case of a Medicare+Choice organization organized as a nonprofit corporation, an incorporator or member of such corporation under applicable State corporation law;

(ii) any entity in which a person described in clause (i)—

(I) is an officer or director;

(II) is a partner (if such entity is organized as a partnership);

(III) has directly or indirectly a beneficial interest of more than 5 percent of the equity; or

(IV) has a mortgage, deed of trust, note, or other interest valuing more than 5 percent of the assets of such entity;

(iii) any person directly or indirectly controlling, controlled by, or under common control with an organization; and

(iv) any spouse, child, or parent of an individual described in clause (i).

(C) ACCESS TO INFORMATION.—Each Medicare+Choice organization shall make the information reported pursuant to subparagraph (A) available to its enrollees upon reasonable request.

(5) LOAN INFORMATION.—The contract shall require the organization to notify the Secretary of loans and other special financial arrangements which are made between the organization and subcontractors, affiliates, and related parties.

(6) REVIEW TO ENSURE COMPLIANCE WITH CARE MANAGEMENT REQUIREMENTS FOR SPECIALIZED MEDICARE ADVANTAGE PLANS FOR SPECIAL NEEDS INDIVIDUALS.—In conjunction with the periodic audit of a specialized Medicare Advantage plan for special needs individuals under paragraph (1), the Secretary shall conduct a review to ensure that such organization offering the plan meets the requirements described in section 1859(f)(5).

(e) ADDITIONAL CONTRACT TERMS.—

(1) IN GENERAL.—The contract shall contain such other terms and conditions not inconsistent with this part (including requiring the organization to provide the Secretary with such information) as the Secretary may find necessary and appropriate.

(2) COST-SHARING IN ENROLLMENT-RELATED COSTS.—

(A) IN GENERAL.—A Medicare+Choice organization and a PDP sponsor under part D shall pay the fee established by the Secretary under subparagraph (B).

(B) AUTHORIZATION.—The Secretary is authorized to charge a fee to each Medicare+Choice organization with a contract under this part and each PDP sponsor with a contract under part D that is equal to the organization' or sponsor's pro rata share (as determined by the Secretary) of the aggregate amount of fees which the Secretary is directed to collect in a fiscal year. Any amounts collected shall be available without further appropriation to the Secretary for the purpose of carrying out section 1851 (relating to enrollment and dissemination of information), section 1860D-1(c), and section 4360 of the Omnibus Budget Reconciliation Act of 1990 (relating to the health insurance counseling and assistance program).

(C) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated for the purposes described in subparagraph (B) for each fiscal year beginning with fiscal year 2001 and ending with fiscal year 2005 an amount equal to $100,000,000, and for each fiscal year beginning with fiscal year 2006 an amount equal to $200,000,000, reduced by the amount of fees authorized to be collected under this paragraph and section 1860D–12(b)(3)(D) for the fiscal year.

(D) LIMITATION.—In any fiscal year the fees collected by the Secretary under subparagraph (B) shall not exceed the lesser of—

(i) the estimated costs to be incurred by the Secretary in the fiscal year in carrying out the activities described in section 1851 and section 1860D–1(c) and section 4360 of the Omnibus Budget Reconciliation Act of 1990; or

(ii)(I) $200,000,000 in fiscal year 1998;

(II) $150,000,000 in fiscal year 1999;

(III) $100,000,000 in fiscal year 2000;

(IV) the Medicare+Choice portion (as defined in subparagraph (E)) of $100,000,000 in fiscal year 2001 and each succeeding fiscal year before fiscal year 2006; and

(V) the applicable portion (as defined in subparagraph (F)) of $200,000,000 in fiscal year 2006 and each succeeding fiscal year.

(E) MEDICARE+CHOICE PORTION DEFINED.—In this paragraph, the term "Medicare+Choice portion" means, for a fiscal year, the ratio, as estimated by the Secretary, of—

(i) the average number of individuals enrolled in Medicare+Choice plans during the fiscal year, to

(ii) the average number of individuals entitled to benefits under part A, and enrolled under part B, during the fiscal year.

(F) APPLICABLE PORTION DEFINED.—In this paragraph, the term "applicable portion" means, for a fiscal year—

(i) with respect to MA organizations, the Secretary's estimate of the total proportion of expenditures under

this title that are attributable to expenditures made under this part (including payments under part D that are made to such organizations); or

(ii) with respect to PDP sponsors, the Secretary's estimate of the total proportion of expenditures under this title that are attributable to expenditures made to such sponsors under part D.

(3) AGREEMENTS WITH FEDERALLY QUALIFIED HEALTH CENTERS.—

(A) PAYMENT LEVELS AND AMOUNTS.—A contract under this section with an MA organization shall require the organization to provide, in any written agreement described in section 1853(a)(4) between the organization and a federally qualified health center, for a level and amount of payment to the federally qualified health center for services provided by such health center that is not less than the level and amount of payment that the plan would make for such services if the services had been furnished by a entity providing similar services that was not a federally qualified health center.

(B) COST-SHARING.—Under the written agreement referred to in subparagraph (A), a federally qualified health center must accept the payment amount referred to in such subparagraph plus the Federal payment provided for in section 1833(a)(3)(B) as payment in full for services covered by the agreement, except that such a health center may collect any amount of cost-sharing permitted under the contract under this section, so long as the amounts of any deductible, coinsurance, or copayment comply with the requirements under section 1854(e).

(4) REQUIREMENT FOR MINIMUM MEDICAL LOSS RATIO.—If the Secretary determines for a contract year (beginning with 2014) that an MA plan has failed to have a medical loss ratio of at least .85—

(A) the MA plan shall remit to the Secretary an amount equal to the product of—

(i) the total revenue of the MA plan under this part for the contract year; and

(ii) the difference between .85 and the medical loss ratio;

(B) for 3 consecutive contract years, the Secretary shall not permit the enrollment of new enrollees under the plan for coverage during the second succeeding contract year; and

(C) the Secretary shall terminate the plan contract if the plan fails to have such a medical loss ratio for 5 consecutive contract years.

(f) PROMPT PAYMENT BY MEDICARE+CHOICE ORGANIZATION.—

(1) REQUIREMENT.—A contract under this part shall require a Medicare+Choice organization to provide prompt payment (consistent with the provisions of sections 1816(c)(2) and 1842(c)(2)) of claims submitted for services and supplies furnished to enrollees pursuant to the contract, if the services or supplies are not furnished under a contract between the organization and the provider or supplier (or in the case of a

Medicare+Choice private fee-for-service plan, if a claim is submitted to such organization by an enrollee).

(2) SECRETARY'S OPTION TO BYPASS NONCOMPLYING ORGANIZATION.—In the case of a Medicare+Choice eligible organization which the Secretary determines, after notice and opportunity for a hearing, has failed to make payments of amounts in compliance with paragraph (1), the Secretary may provide for direct payment of the amounts owed to providers and suppliers (or, in the case of a Medicare+Choice private fee-for-service plan, amounts owed to the enrollees) for covered services and supplies furnished to individuals enrolled under this part under the contract. If the Secretary provides for the direct payments, the Secretary shall provide for an appropriate reduction in the amount of payments otherwise made to the organization under this part to reflect the amount of the Secretary's payments (and the Secretary's costs in making the payments).

(3) INCORPORATION OF CERTAIN PRESCRIPTION DRUG PLAN CONTRACT REQUIREMENTS.—The following provisions shall apply to contracts with a Medicare Advantage organization offering an MA–PD plan in the same manner as they apply to contracts with a PDP sponsor offering a prescription drug plan under part D:

(A) PROMPT PAYMENT.—Section 1860D–12(b)(4).

(B) SUBMISSION OF CLAIMS BY PHARMACIES LOCATED IN OR CONTRACTING WITH LONG-TERM CARE FACILITIES.—Section 1860D–12(b)(5).

(C) REGULAR UPDATE OF PRESCRIPTION DRUG PRICING STANDARD.—Section 1860D–12(b)(6).

(g) INTERMEDIATE SANCTIONS.—

(1) IN GENERAL.—If the Secretary determines that a Medicare+Choice organization with a contract under this section—

(A) fails substantially to provide medically necessary items and services that are required (under law or under the contract) to be provided to an individual covered under the contract, if the failure has adversely affected (or has substantial likelihood of adversely affecting) the individual;

(B) imposes premiums on individuals enrolled under this part in excess of the amount of the Medicare+Choice monthly basic and supplemental beneficiary premiums permitted under section 1854;

(C) acts to expel or to refuse to re-enroll an individual in violation of the provisions of this part;

(D) engages in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment (except as permitted by this part) by eligible individuals with the organization whose medical condition or history indicates a need for substantial future medical services;

(E) misrepresents or falsifies information that is furnished—

(i) to the Secretary under this part, or

(ii) to an individual or to any other entity under this part;

(F) fails to comply with the applicable requirements of section 1852(j)(3) or 1852(k)(2)(A)(ii);

(G) employs or contracts with any individual or entity that is excluded from participation under this title under section 1128 or 1128A for the provision of health care, utilization review, medical social work, or administrative services or employs or contracts with any entity for the provision (directly or indirectly) through such an excluded individual or entity of such services;

(H) except as provided under subparagraph (C) or (D) of section 1860D–1(b)(1), enrolls an individual in any plan under this part without the prior consent of the individual or the designee of the individual;

(I) transfers an individual enrolled under this part from one plan to another without the prior consent of the individual or the designee of the individual or solely for the purpose of earning a commission;

(J) fails to comply with marketing restrictions described in subsections (h) and (j) of section 1851 or applicable implementing regulations or guidance; or

(K) employs or contracts with any individual or entity who engages in the conduct described in subparagraphs (A) through (J) of this paragraph;

the Secretary may provide, in addition to any other remedies authorized by law, for any of the remedies described in paragraph (2). The Secretary may provide, in addition to any other remedies authorized by law, for any of the remedies described in paragraph (2), if the Secretary determines that any employee or agent of such organization, or any provider or supplier who contracts with such organization, has engaged in any conduct described in subparagraphs (A) through (K) of this paragraph.

(2) REMEDIES.—The remedies described in this paragraph are—

(A) civil money penalties of not more than $25,000 for each determination under paragraph (1) or, with respect to a determination under subparagraph (D) or (E)(i) of such paragraph, of not more than $100,000 for each such determination, except with respect to a determination under subparagraph (E), an assessment of not more than the amount claimed by such plan or plan sponsor based upon the misrepresentation or falsified information involved, plus, with respect to a determination under paragraph (1)(B), double the excess amount charged in violation of such paragraph (and the excess amount charged shall be deducted from the penalty and returned to the individual concerned), and plus, with respect to a determination under paragraph (1)(D), $15,000 for each individual not enrolled as a result of the practice involved,

(B) suspension of enrollment of individuals under this part after the date the Secretary notifies the organization of a determination under paragraph (1) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur, or

(C) suspension of payment to the organization under this part for individuals enrolled after the date the Secretary notifies the organization of a determination under paragraph (1) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur.

(3) OTHER INTERMEDIATE SANCTIONS.—In the case of a Medicare+Choice organization for which the Secretary makes a determination under subsection (c)(2) the basis of which is not described in paragraph (1), the Secretary may apply the following intermediate sanctions:

(A) Civil money penalties of not more than $25,000 for each determination under subsection (c)(2) if the deficiency that is the basis of the determination has directly adversely affected (or has the substantial likelihood of adversely affecting) an individual covered under the organization's contract.

(B) Civil money penalties of not more than $10,000 for each week beginning after the initiation of civil money penalty procedures by the Secretary during which the deficiency that is the basis of a determination under subsection (c)(2) exists.

(C) Suspension of enrollment of individuals under this part after the date the Secretary notifies the organization of a determination under subsection (c)(2) and until the Secretary is satisfied that the deficiency that is the basis for the determination has been corrected and is not likely to recur.

(D) Civil monetary penalties of not more than $100,000, or such higher amount as the Secretary may establish by regulation, where the finding under subsection (c)(2)(A) is based on the organization's termination of its contract under this section other than at a time and in a manner provided for under subsection (a).

(4) CIVIL MONEY PENALTIES.—The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under paragraph (2) or (3) in the same manner as they apply to a civil money penalty or proceeding under section 1128A(a).

(h) PROCEDURES FOR TERMINATION.—

(1) IN GENERAL.—The Secretary may terminate a contract with a Medicare+Choice organization under this section in accordance with formal investigation and compliance procedures established by the Secretary under which—

(A) the Secretary provides the organization with the reasonable opportunity to develop and implement a corrective action plan to correct the deficiencies that were the basis of the Secretary's determination under subsection (c)(2); and

(B) the Secretary provides the organization with reasonable notice and opportunity for hearing (including the right to appeal an initial decision) before terminating the contract.

(2) EXCEPTION FOR IMMINENT AND SERIOUS RISK TO HEALTH.—Paragraph (1) shall not apply if the Secretary deter-

mines that a delay in termination, resulting from compliance with the procedures specified in such paragraph prior to termination, would pose an imminent and serious risk to the health of individuals enrolled under this part with the organization.

(3) DELAY IN CONTRACT TERMINATION AUTHORITY FOR PLANS FAILING TO ACHIEVE MINIMUM QUALITY RATING.—During the period beginning on the date of the enactment of this paragraph and through the end of plan year 2018, the Secretary may not terminate a contract under this section with respect to the offering of an MA plan by a Medicare Advantage organization solely because the MA plan has failed to achieve a minimum quality rating under the 5-star rating system under section 1853(o)(4).

(i) MEDICARE+CHOICE PROGRAM COMPATIBILITY WITH EMPLOYER OR UNION GROUP HEALTH PLANS.—

(1) CONTRACTS WITH MA ORGANIZATIONS.—To facilitate the offering of Medicare+Choice plans under contracts between Medicare+Choice organizations and employers, labor organizations, or the trustees of a fund established by one or more employers or labor organizations (or combination thereof) to furnish benefits to the entity's employees, former employees (or combination thereof) or members or former members (or combination thereof) of the labor organizations, the Secretary may waive or modify requirements that hinder the design of, the offering of, or the enrollment in such Medicare+Choice plans.

(2) EMPLOYER SPONSORED MA PLANS.—To facilitate the offering of MA plans by employers, labor organizations, or the trustees of a fund established by one or more employers or labor organizations (or combination thereof) to furnish benefits to the entity's employees, former employees (or combination thereof) or members or former members (or combination thereof) of the labor organizations, the Secretary may waive or modify requirements that hinder the design of, the offering of, or the enrollment in such MA plans. Notwithstanding section 1851(g), an MA plan described in the previous sentence may restrict the enrollment of individuals under this part to individuals who are beneficiaries and participants in such plan.

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PART E—MISCELLANEOUS PROVISIONS

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ADMINISTRATION

SEC. 1874. (a) Except as otherwise provided in this title and in the Railroad Retirement Act of 1974, the insurance programs established by this title shall be administered by the Secretary. The Secretary may perform any of his functions under this title directly, or by contract providing for payment in advance or by way of reimbursement, and in such installments, as the Secretary may deem necessary.

(b) The Secretary may contract with any person, agency, or institution to secure on a reimbursable basis such special data, actuarial information, and other information as may be necessary in the carrying out of his functions under this title.

(c) In the course of any hearing, investigation, or other proceeding that he is authorized to conduct under this title, the Secretary may administer oaths and affirmations.

(d) INCLUSION OF MEDICARE PROVIDER AND SUPPLIER PAYMENTS IN FEDERAL PAYMENT LEVY PROGRAM.—

(1) IN GENERAL.—The Centers for Medicare & Medicaid Services shall take all necessary steps to participate in the Federal Payment Levy Program under section 6331(h) of the Internal Revenue Code of 1986 as soon as possible and shall ensure that—

(A) at least 50 percent of all payments under parts A and B are processed through such program beginning within 1 year after the date of the enactment of this section;

(B) at least 75 percent of all payments under parts A and B are processed through such program beginning within 2 years after such date; and

(C) all payments under parts A and B are processed through such program beginning not later than September 30, 2011.

(2) ASSISTANCE.—The Financial Management Service and the Internal Revenue Service shall provide assistance to the Centers for Medicare & Medicaid Services to ensure that all payments described in paragraph (1) are included in the Federal Payment Levy Program by the deadlines specified in that subsection.

(e) AVAILABILITY OF DATA.—

(1) IN GENERAL.—Subject to paragraph (4), the Secretary shall make available to qualified entities (as defined in paragraph (2)) data described in paragraph (3) for the evaluation of the performance of providers of services and suppliers.

(2) QUALIFIED ENTITIES.—For purposes of this subsection, the term "qualified entity" means a public or private entity that—

(A) is qualified (as determined by the Secretary) to use claims data to evaluate the performance of providers of services and suppliers on measures of quality, efficiency, effectiveness, and resource use; and

(B) agrees to meet the requirements described in paragraph (4) and meets such other requirements as the Secretary may specify, such as ensuring security of data.

(3) DATA DESCRIBED.—The data described in this paragraph are standardized extracts (as determined by the Secretary) of claims data under parts A, B, and D for items and services furnished under such parts for one or more specified geographic areas and time periods requested by a qualified entity. Beginning July 1, 2016, if the Secretary determines appropriate, the data described in this paragraph may also include standardized extracts (as determined by the Secretary) of claims data under titles XIX and XXI for assistance provided under such titles for one or more specified geographic areas and time periods requested by a qualified entity. The Secretary shall take such actions as the Secretary deems necessary to protect the identity of individuals entitled to or enrolled for benefits under such parts or under titles XIX or XXI.

(4) REQUIREMENTS.—

(A) FEE.—Data described in paragraph (3) shall be made available to a qualified entity under this subsection at a fee equal to the cost of making such data available. Any fee collected pursuant to the preceding sentence shall be deposited, for periods prior to July 1, 2016, into the Federal Supplementary Medical Insurance Trust Fund under section 1841, and, beginning July 1, 2016, into the Centers for Medicare & Medicaid Services Program Management Account.

(B) SPECIFICATION OF USES AND METHODOLOGIES.—A qualified entity requesting data under this subsection shall—

(i) submit to the Secretary a description of the methodologies that such qualified entity will use to evaluate the performance of providers of services and suppliers using such data;

(ii)(I) except as provided in subclause (II), if available, use standard measures, such as measures endorsed by the entity with a contract under section 1890(a) and measures developed pursuant to section 931 of the Public Health Service Act; or

(II) use alternative measures if the Secretary, in consultation with appropriate stakeholders, determines that use of such alternative measures would be more valid, reliable, responsive to consumer preferences, cost-effective, or relevant to dimensions of quality and resource use not addressed by such standard measures;

(iii) include data made available under this subsection with claims data from sources other than claims data under this title in the evaluation of performance of providers of services and suppliers;

(iv) only include information on the evaluation of performance of providers and suppliers in reports described in subparagraph (C);

(v) make available to providers of services and suppliers, upon their request, data made available under this subsection; and

(vi) prior to their release, submit to the Secretary the format of reports under subparagraph (C).

(C) REPORTS.—Any report by a qualified entity evaluating the performance of providers of services and suppliers using data made available under this subsection shall—

(i) include an understandable description of the measures, which shall include quality measures and the rationale for use of other measures described in subparagraph (B)(ii)(II), risk adjustment methods, physician attribution methods, other applicable methods, data specifications and limitations, and the sponsors, so that consumers, providers of services and suppliers, health plans, researchers, and other stakeholders can assess such reports;

(ii) be made available confidentially, to any provider of services or supplier to be identified in such report,

prior to the public release of such report, and provide an opportunity to appeal and correct errors;

(iii) only include information on a provider of services or supplier in an aggregate form as determined appropriate by the Secretary; and

(iv) except as described in clause (ii), be made available to the public.

(D) APPROVAL AND LIMITATION OF USES.—The Secretary shall not make data described in paragraph (3) available to a qualified entity unless the qualified entity agrees to release the information on the evaluation of performance of providers of services and suppliers. Such entity shall only use such data, and information derived from such evaluation, for the reports under subparagraph (C). Data released to a qualified entity under this subsection shall not be subject to discovery or admission as evidence in judicial or administrative proceedings without consent of the applicable provider of services or supplier.

(f) REQUIREMENT FOR THE SECRETARY TO ESTABLISH POLICIES AND CLAIMS EDITS RELATING TO INCARCERATED INDIVIDUALS, INDIVIDUALS NOT LAWFULLY PRESENT, AND DECEASED INDIVIDUALS.—The Secretary shall establish and maintain procedures, including procedures for using claims processing edits, updating eligibility information to improve provider accessibility, and conducting recoupment activities such as through recovery audit contractors, in order to ensure that payment is not made under this title for items and services furnished to an individual who is one of the following:

(1) An individual who is incarcerated.

(2) An individual who is not lawfully present in the United States and who is not eligible for coverage under this title.

(3) A deceased individual.

(g) REQUIREMENT FOR ENROLLMENT DATA REPORTING.—

(1) IN GENERAL.—Each year (beginning with 2016), the Secretary shall submit to the Committees on Ways and Means and Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate a report on Medicare enrollment data (and, in the case of part A, on data on individuals receiving benefits under such part) as of a date in such year specified by the Secretary. Such data shall be presented—

(A) by Congressional district and State; and

(B) in a manner that provides for such data based on—

(i) fee-for-service enrollment (as defined in paragraph (2));

(ii) enrollment under part C (including separate for aggregate enrollment in MA–PD plans and aggregate enrollment in MA plans that are not MA–PD plans); and

(iii) enrollment under part D.

(2) FEE-FOR-SERVICE ENROLLMENT DEFINED.—For purpose of paragraph (1)(B)(i), the term "fee-for-service enrollment" means aggregate enrollment (including receipt of benefits other than through enrollment) under—

(A) part A only;

(B) part B only; and

(C) both part A and part B.

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PAYMENT TO HOSPITALS FOR INPATIENT HOSPITAL SERVICES

SEC. 1886. (a)(1)(A)(i) The Secretary, in determining the amount of the payments that may be made under this title with respect to operating costs of inpatient hospital services (as defined in paragraph (4)) shall not recognize as reasonable (in the efficient delivery of health services) costs for the provision of such services by a hospital for a cost reporting period to the extent such costs exceed the applicable percentage (as determined under clause (ii)) of the average of such costs for all hospitals in the same grouping as such hospital for comparable time periods.

(ii) For purposes of clause (i), the applicable percentage for hospital cost reporting periods beginning—

(I) on or after October 1, 1982, and before October 1, 1983, is 120 percent;

(II) on or after October 1, 1983, and before October 1, 1984, is 115 percent; and

(III) on or after October 1, 1984, is 110 percent.

(B)(i) For purposes of subparagraph (A) the Secretary shall establish case mix indexes for all short- term hospitals, and shall set limits for each hospital based upon the general mix of types of medical cases with respect to which such hospital provides services for which payment may be made under this title.

(ii) The Secretary shall set such limits for a cost reporting period of a hospital—

(I) by updating available data for a previous period to the immediate preceding cost reporting period by the estimated average rate of change of hospital costs industry-wide, and

(II) by projecting for the cost reporting period by the applicable percentage increase (as defined in subsection (b)(3)(B)).

(C) The limitation established under subparagraph (A) for any hospital shall in no event be lower than the allowable operating costs of inpatient hospital services (as defined in paragraph (4)) recognized under this title for such hospital for such hospital's last cost reporting period prior to the hospital's first cost reporting period for which this section is in effect.

(D) Subparagraph (A) shall not apply to cost reporting periods beginning on or after October 1, 1983.

(2) The Secretary shall provide for such exemptions from, and exceptions and adjustments to, the limitation established under paragraph (1)(A) as he deems appropriate, including those which he deems necessary to take into account—

(A) the special needs of sole community hospitals, of new hospitals, of risk based health maintenance organizations, and of hospitals which provide atypical services or essential community services, and to take into account extraordinary circumstances beyond the hospital's control, medical and paramedical education costs, significantly fluctuating population in the service area of the hospital, and unusual labor costs,

(B) the special needs of psychiatric hospitals and of public or other hospitals that serve a significantly disproportionate num-

ber of patients who have low income or are entitled to benefits under part A of this title, and

(C) a decrease in the inpatient hospital services that a hospital provides and that are customarily provided directly by similar hospitals which results in a significant distortion in the operating costs of inpatient hospital services.

(3) The limitation established under paragraph (1)(A) shall not apply with respect to any hospital which—

(A) is located outside of a standard metropolitan statistical area, and

(B)(i) has less than 50 beds, and

(ii) was in operation and had less than 50 beds on the date of the enactment of this section.

(4) For purposes of this section, the term "operating costs of inpatient hospital services" includes all routine operating costs, ancillary service operating costs, and special care unit operating costs with respect to inpatient hospital services as such costs are determined on an average per admission or per discharge basis (as determined by the Secretary), and includes the costs of all services for which payment may be made under this title that are provided by the hospital (or by an entity wholly owned or operated by the hospital) to the patient during the 3 days (or, in the case of a hospital that is not a subsection (d) hospital, during the 1 day) immediately preceding the date of the patient's admission if such services are diagnostic services (including clinical diagnostic laboratory tests) or are other services related to the admission (as defined by the Secretary). Such term does not include costs of approved educational activities, a return on equity capital, or, other capital-related costs (as defined by the Secretary for periods before October 1, 1987). In applying the first sentence of this paragraph, the term "other services related to the admission" includes all services that are not diagnostic services (other than ambulance and maintenance renal dialysis services) for which payment may be made under this title that are provided by a hospital (or an entity wholly owned or operated by the hospital) to a patient—

(A) on the date of the patient's inpatient admission; or

(B) during the 3 days (or, in the case of a hospital that is not a subsection (d) hospital, during the 1 day) immediately preceding the date of such admission unless the hospital demonstrates (in a form and manner, and at a time, specified by the Secretary) that such services are not related (as determined by the Secretary) to such admission.

(b)(1) Notwithstanding section 1814(b) but subject to the provisions of section 1813, if the operating costs of inpatient hospital services (as defined in subsection (a)(4)) of a hospital (other than a subsection (d) hospital, as defined in subsection (d)(1)(B) and other than a rehabilitation facility described in subsection (j)(1)) for a cost reporting period subject to this paragraph—

(A) are less than or equal to the target amount (as defined in paragraph (3)) for that hospital for that period, the amount of the payment with respect to such operating costs payable under part A on a per discharge or per admission basis (as the case may be) shall be equal to the amount of such operating costs, plus—

(i) 15 percent of the amount by which the target amount exceeds the amount of the operating costs, or

(ii) 2 percent of the target amount,

whichever is less;

(B) are greater than the target amount but do not exceed 110 percent of the target amount, the amount of the payment with respect to those operating costs payable under part A on a per discharge basis shall equal the target amount; or

(C) are greater than 110 percent of the target amount, the amount of the payment with respect to such operating costs payable under part A on a per discharge or per admission basis (as the case may be) shall be equal to (i) the target amount, plus (ii) in the case of cost reporting periods beginning on or after October 1, 1991, an additional amount equal to 50 percent of the amount by which the operating costs exceed 110 percent of the target amount (except that such additional amount may not exceed 10 percent of the target amount) after any exceptions or adjustments are made to such target amount for the cost reporting period;

plus the amount, if any, provided under paragraph (2), except that in no case may the amount payable under this title (other than on the basis of a DRG prospective payment rate determined under subsection (d)) with respect to operating costs of inpatient hospital services exceed the maximum amount payable with respect to such costs pursuant to subsection (a).

(2)(A) Except as provided in subparagraph (E), in addition to the payment computed under paragraph (1), in the case of an eligible hospital (described in subparagraph (B)) for a cost reporting period beginning on or after October 1, 1997, the amount of payment on a per discharge basis under paragraph (1) shall be increased by the lesser of—

(i) 50 percent of the amount by which the operating costs are less than the expected costs (as defined in subparagraph (D)) for the period; or

(ii) 1 percent of the target amount for the period.

(B) For purposes of this paragraph, an "eligible hospital" means with respect to a cost reporting period, a hospital—

(i) that has received payments under this subsection for at least 3 full cost reporting periods before that cost reporting period, and

(ii) whose operating costs for the period are less than the least of its target amount, its trended costs (as defined in subparagraph (C)), or its expected costs (as defined in subparagraph (D)) for the period.

(C) For purposes of subparagraph (B)(ii), the term "trended costs" means for a hospital cost reporting period ending in a fiscal year—

(i) in the case of a hospital for which its cost reporting period ending in fiscal year 1996 was its third or subsequent full cost reporting period for which it receives payments under this subsection, the lesser of the operating costs or target amount for that hospital for its cost reporting period ending in fiscal year 1996, or

(ii) in the case of any other hospital, the operating costs for that hospital for its third full cost reporting period for which it receives payments under this subsection,

increased (in a compounded manner) for each succeeding fiscal year (through the fiscal year involved) by the market basket percentage increase for the fiscal year.

(D) For purposes of this paragraph, the term "expected costs", with respect to the cost reporting period ending in a fiscal year, means the lesser of the operating costs of inpatient hospital services or target amount per discharge for the previous cost reporting period updated by the market basket percentage increase (as defined in paragraph (3)(B)(iii)) for the fiscal year.

(E)(i) In the case of an eligible hospital that is a hospital or unit that is within a class of hospital described in clause (ii) with a 12-month cost reporting period beginning before the enactment of this subparagraph, in determining the amount of the increase under subparagraph (A), the Secretary shall substitute for the percentage of the target amount applicable under subparagraph (A)(ii)—

(I) for a cost reporting period beginning on or after October 1, 2000, and before September 30, 2001, 1.5 percent; and

(II) for a cost reporting period beginning on or after October 1, 2001, and before September 30, 2002, 2 percent.

(ii) For purposes of clause (i), each of the following shall be treated as a separate class of hospital:

(I) Hospitals described in clause (i) of subsection (d)(1)(B) and psychiatric units described in the matter following clause (v) of such subsection.

(II) Hospitals described in clause (iv) of such subsection.

(3)(A) Except as provided in subparagraph (C) and succeeding subparagraphs and in paragraph (7)(A)(ii), for purposes of this subsection, the term "target amount" means, with respect to a hospital for a particular 12-month cost reporting period—

(i) in the case of the first such reporting period for which this subsection is in effect, the allowable operating costs of inpatient hospital services (as defined in subsection (a)(4)) recognized under this title for such hospital for the preceding 12-month cost reporting period, and

(ii) in the case of a later reporting period, the target amount for the preceding 12-month cost reporting period,

increased by the applicable percentage increase under subparagraph (B) for that particular cost reporting period.

(B)(i) For purposes of subsection (d) and subsection (j) for discharges occurring during a fiscal year, the "applicable percentage increase" shall be—

(I) for fiscal year 1986, ½ percent,

(II) for fiscal year 1987, 1.15 percent,

(III) for fiscal year 1988, 3.0 percent for hospitals located in a rural area, 1.5 percent for hospitals located in a large urban area (as defined in subsection (d)(2)(D)), and 1.0 percent for hospitals located in other urban areas,

(IV) for fiscal year 1989, the market basket percentage increase minus 1.5 percentage points for hospitals located in a rural area, the market basket percentage increase minus 2.0 percentage points for hospitals located in a large urban area, and the market basket percentage increase minus 2.5 percentage points for hospitals located in other urban areas,

(V) for fiscal year 1990, the market basket percentage increase plus 4.22 percentage points for hospitals located in a

rural area, the market basket percentage increase plus 0.12 percentage points for hospitals located in a large urban area, and the market basket percentage increase minus 0.53 percentage points for hospitals located in other urban areas,

(VI) for fiscal year 1991, the market basket percentage increase minus 2.0 percentage points for hospitals in a large urban or other urban area, and the market basket percentage increase minus 0.7 percentage point for hospitals located in a rural area,

(VII) for fiscal year 1992, the market basket percentage increase minus 1.6 percentage points for hospitals in a large urban or other urban area, and the market basket percentage increase minus 0.6 percentage point for hospitals located in a rural area,

(VIII) for fiscal year 1993, the market basket percentage increase minus 1.55 percentage point for hospitals in a large urban or other urban area, and the market basket percentage increase minus 0.55 for hospitals located in a rural area,

(IX) for fiscal year 1994, the market basket percentage increase minus 2.5 percentage points for hospitals located in a large urban or other urban area, and the market basket percentage increase minus 1.0 percentage point for hospitals located in a rural area,

(X) for fiscal year 1995, the market basket percentage increase minus 2.5 percentage points for hospitals located in a large urban or other urban area, and such percentage increase for hospitals located in a rural area as will provide for the average standardized amount determined under subsection (d)(3)(A) for hospitals located in a rural area being equal to such average standardized amount for hospitals located in an urban area (other than a large urban area),

(XI) for fiscal year 1996, the market basket percentage increase minus 2.0 percentage points for hospitals in all areas,

(XII) for fiscal year 1997, the market basket percentage increase minus 0.5 percentage point for hospitals in all areas,

(XIII) for fiscal year 1998, 0 percent,

(XIV) for fiscal year 1999, the market basket percentage increase minus 1.9 percentage points for hospitals in all areas,

(XV) for fiscal year 2000, the market basket percentage increase minus 1.8 percentage points for hospitals in all areas,

(XVI) for fiscal year 2001, the market basket percentage increase for hospitals in all areas,

(XVII) for fiscal year 2002, the market basket percentage increase minus 0.55 percentage points for hospitals in all areas,

(XVIII) for fiscal year 2003, the market basket percentage increase minus 0.55 percentage points for hospitals in all areas,

(XIX) for each of fiscal years 2004 through 2006, subject to clause (vii), the market basket percentage increase for hospitals in all areas; and

(XX) for each subsequent fiscal year, subject to clauses (viii), (ix), (xi), and (xii), the market basket percentage increase for hospitals in all areas.

(ii) For purposes of subparagraphs (A) and (E), the "applicable percentage increase" for 12-month cost reporting periods beginning during—

(I) fiscal year 1986, is 0.5 percent,

(II) fiscal year 1987, is 1.15 percent,

(III) fiscal year 1988, is the market basket percentage increase minus 2.0 percentage points,

(IV) a subsequent fiscal year ending on or before September 30, 1993, is the market basket percentage increase,

(V) fiscal years 1994 through 1997, is the market basket percentage increase minus the applicable reduction (as defined in clause (v)(II)), or in the case of a hospital for a fiscal year for which the hospital's update adjustment percentage (as defined in clause (v)(I)) is at least 10 percent, the market basket percentage increase,

(VI) for fiscal year 1998, is 0 percent,

(VII) for fiscal years 1999 through 2002, is the applicable update factor specified under clause (vi) for the fiscal year, and

(VIII) subsequent fiscal years is the market basket percentage increase.

(iii) For purposes of this subparagraph, the term "market basket percentage increase" means, with respect to cost reporting periods and discharges occurring in a fiscal year, the percentage, estimated by the Secretary before the beginning of the period or fiscal year, by which the cost of the mix of goods and services (including personnel costs but excluding nonoperating costs) comprising routine, ancillary, and special care unit inpatient hospital services, based on an index of appropriately weighted indicators of changes in wages and prices which are representative of the mix of goods and services included in such inpatient hospital services, for the period or fiscal year will exceed the cost of such mix of goods and services for the preceding 12-month cost reporting period or fiscal year.

(iv) For purposes of subparagraphs (C) and (D), the "applicable percentage increase" is—

(I) for 12-month cost reporting periods beginning during fiscal years 1986 through 1993, the applicable percentage increase specified in clause (ii),

(II) for fiscal year 1994, the market basket percentage increase minus 2.3 percentage points (adjusted to exclude any portion of a cost reporting period beginning during fiscal year 1993 for which the applicable percentage increase is determined under subparagraph (I)),

(III) for fiscal year 1995, the market basket percentage increase minus 2.2 percentage points, and

(IV) for fiscal year 1996 and each subsequent fiscal year, the applicable percentage increase under clause (i).

(v) For purposes of clause (ii)(V)—

(I) a hospital's "update adjustment percentage" for a fiscal year is the percentage by which the hospital's allowable operating costs of inpatient hospital services recognized under this title for the cost reporting period beginning in fiscal year 1990 exceeds the hospital's target amount (as determined under subparagraph (A)) for such cost reporting period, increased for each fiscal year (beginning with fiscal year 1994) by the sum of any of the hospital's applicable reductions under subclause (V) for previous fiscal years; and

(II) the "applicable reduction" with respect to a hospital for a fiscal year is the lesser of 1 percentage point or the percent-

age point difference between 10 percent and the hospital's update adjustment percentage for the fiscal year.

(vi) For purposes of clause (ii)(VII) for a fiscal year, if a hospital's allowable operating costs of inpatient hospital services recognized under this title for the most recent cost reporting period for which information is available—

(I) is equal to, or exceeds, 110 percent of the hospital's target amount (as determined under subparagraph (A)) for such cost reporting period, the applicable update factor specified under this clause is the market basket percentage;

(II) exceeds 100 percent, but is less than 110 percent, of such target amount for the hospital, the applicable update factor specified under this clause is 0 percent or, if greater, the market basket percentage minus 0.25 percentage points for each percentage point by which such allowable operating costs (expressed as a percentage of such target amount) is less than 110 percent of such target amount;

(III) is equal to, or less than 100 percent, but exceeds ⅔ of such target amount for the hospital, the applicable update factor specified under this clause is 0 percent or, if greater, the market basket percentage minus 2.5 percentage points; or

(IV) does not exceed ⅔ of such target amount for the hospital, the applicable update factor specified under this clause is 0 percent.

(vii)(I) For purposes of clause (i)(XIX) for fiscal years 2005 and 2006, in a case of a subsection (d) hospital that does not submit data to the Secretary in accordance with subclause (II) with respect to such a fiscal year, the applicable percentage increase under such clause for such fiscal year shall be reduced by 0.4 percentage points. Such reduction shall apply only with respect to the fiscal year involved, and the Secretary shall not take into account such reduction in computing the applicable percentage increase under clause (i)(XIX) for a subsequent fiscal year.

(II) For fiscal years 2005 and 2006, each subsection (d) hospital shall submit to the Secretary quality data (for a set of 10 indicators established by the Secretary as of November 1, 2003) that relate to the quality of care furnished by the hospital in inpatient settings in a form and manner, and at a time, specified by the Secretary for purposes of this clause, but with respect to fiscal year 2005, the Secretary shall provide for a 30-day grace period for the submission of data by a hospital.

(viii)(I) For purposes of clause (i) for fiscal year 2007 and each subsequent fiscal year, in the case of a subsection (d) hospital that does not submit, to the Secretary in accordance with this clause, data required to be submitted on measures selected under this clause with respect to such a fiscal year, the applicable percentage increase under clause (i) for such fiscal year shall be reduced by 2.0 percentage points (or, beginning with fiscal year 2015, by one-quarter of such applicable percentage increase (determined without regard to clause (ix), (xi), or (xii))). Such reduction shall apply only with respect to the fiscal year involved and the Secretary shall not take into account such reduction in computing the applicable percentage increase under clause (i) for a subsequent fiscal year, and the Secretary and the Medicare Payment Advisory Commission

shall carry out the requirements under section 5001(b) of the Deficit Reduction Act of 2005.

(II) Each subsection (d) hospital shall submit data on measures selected under this clause to the Secretary in a form and manner, and at a time, specified by the Secretary for purposes of this clause. The Secretary may require hospitals to submit data on measures that are not used for the determination of value-based incentive payments under subsection (o).

(III) The Secretary shall expand, beyond the measures specified under clause (vii)(II) and consistent with the succeeding subclauses, the set of measures that the Secretary determines to be appropriate for the measurement of the quality of care (including medication errors) furnished by hospitals in inpatient settings.

(IV) Effective for payments beginning with fiscal year 2007, in expanding the number of measures under subclause (III), the Secretary shall begin to adopt the baseline set of performance measures as set forth in the November 2005 report by the Institute of Medicine of the National Academy of Sciences under section 238(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

(V) Effective for payments for fiscal years 2008 through 2012, the Secretary shall add other measures that reflect consensus among affected parties and, to the extent feasible and practicable, shall include measures set forth by one or more national consensus building entities.

(VI) For purposes of this clause and clause (vii), the Secretary may replace any measures or indicators in appropriate cases, such as where all hospitals are effectively in compliance or the measures or indicators have been subsequently shown not to represent the best clinical practice.

(VII) The Secretary shall establish procedures for making information regarding measures submitted under this clause available to the public. Such procedures shall ensure that a hospital has the opportunity to review the data that are to be made public with respect to the hospital prior to such data being made public. The Secretary shall report quality measures of process, structure, outcome, patients' perspectives on care, efficiency, and costs of care that relate to services furnished in inpatient settings in hospitals on the Internet website of the Centers for Medicare & Medicaid Services.

(VIII) Effective for payments beginning with fiscal year 2013, with respect to quality measures for outcomes of care, the Secretary shall provide for such risk adjustment as the Secretary determines to be appropriate to maintain incentives for hospitals to treat patients with severe illnesses or conditions.

(IX)(aa) Subject to item (bb), effective for payments beginning with fiscal year 2013, each measure specified by the Secretary under this clause shall be endorsed by the entity with a contract under section 1890(a).

(bb) 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), the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

(X) To the extent practicable, the Secretary shall, with input from consensus organizations and other stakeholders, take steps to ensure that the measures specified by the Secretary under this clause are coordinated and aligned with quality measures applicable to—

(aa) physicians under section 1848(k); and

(bb) other providers of services and suppliers under this title.

(XI) The Secretary shall establish a process to validate measures specified under this clause as appropriate. Such process shall include the auditing of a number of randomly selected hospitals sufficient to ensure validity of the reporting program under this clause as a whole and shall provide a hospital with an opportunity to appeal the validation of measures reported by such hospital.

(ix)(I) For purposes of clause (i) for fiscal year 2015 and each subsequent fiscal year, in the case of an eligible hospital (as defined in subsection (n)(6)(B)) that is not a meaningful EHR user (as defined in subsection (n)(3)) for an EHR reporting period for such fiscal year, three-quarters of the applicable percentage increase otherwise applicable under clause (i) (determined without regard to clause (viii), (xi), or (xii)) for such fiscal year shall be reduced by 33⅓ percent for fiscal year 2015, 66⅔ percent for fiscal year 2016, and 100 percent for fiscal year 2017 and each subsequent fiscal year. Such reduction shall apply only with respect to the fiscal year involved and the Secretary shall not take into account such reduction in computing the applicable percentage increase under clause (i) for a subsequent fiscal year.

(II) The Secretary may, on a case-by-case basis (and, with respect to the application of subclause (I) for fiscal year 2017, for categories of subsection (d) hospitals, as established by the Secretary and posted on the Internet website of the Centers for Medicare & Medicaid Services prior to December 15, 2015, an application for which must be submitted to the Secretary by not later than April 1, 2016), exempt an eligible hospital from the application of subclause (I) with respect to a fiscal year if the Secretary determines, subject to annual renewal, that requiring such hospital to be a meaningful EHR user during such fiscal year would result in a significant hardship, such as in the case of a hospital in a rural area without sufficient Internet access. In no case may a hospital be granted an exemption under this subclause for more than 5 years.

(III) For fiscal year 2015 and each subsequent fiscal year, a State in which hospitals are paid for services under section 1814(b)(3) shall adjust the payments to each subsection (d) hospital in the State that is not a meaningful EHR user (as defined in subsection (n)(3)) in a manner that is designed to result in an aggregate reduction in payments to hospitals in the State that is equivalent to the aggregate reduction that would have occurred if payments had been reduced to each subsection (d) hospital in the State in a manner comparable to the reduction under the previous provisions of this clause. The State shall report to the Secretary the methodology it will use to make the payment adjustment under the previous sentence.

(IV) For purposes of this clause, the term "EHR reporting period" means, with respect to a fiscal year, any period (or periods) as specified by the Secretary.

(x)(I) The Secretary shall develop standard Internet website reports tailored to meet the needs of various stakeholders such as hospitals, patients, researchers, and policymakers. The Secretary shall seek input from such stakeholders in determining the type of information that is useful and the formats that best facilitate the use of the information.

(II) The Secretary shall modify the Hospital Compare Internet website to make the use and navigation of that website readily available to individuals accessing it.

(xi)(I) For 2012 and each subsequent fiscal year, after determining the applicable percentage increase described in clause (i) and after application of clauses (viii) and (ix), such percentage increase shall be reduced by the productivity adjustment described in subclause (II).

(II) The productivity adjustment described in this subclause, with respect to a percentage, factor, or update for a fiscal year, year, cost reporting period, or other annual period, is a productivity adjustment equal to the 10-year moving average of changes in annual economy-wide private nonfarm business multi-factor productivity (as projected by the Secretary for the 10-year period ending with the applicable fiscal year, year, cost reporting period, or other annual period).

(III) The application of subclause (I) may result in the applicable percentage increase described in clause (i) being less than 0.0 for a fiscal year, and may result in payment rates under this section for a fiscal year being less than such payment rates for the preceding fiscal year.

(xii) After determining the applicable percentage increase described in clause (i), and after application of clauses (viii), (ix), and (xi), the Secretary shall reduce such applicable percentage increase—

(I) for each of fiscal years 2010 and 2011, by 0.25 percentage point;

(II) for each of fiscal years 2012 and 2013, by 0.1 percentage point;

(III) for fiscal year 2014, by 0.3 percentage point;

(IV) for each of fiscal years 2015 and 2016, by 0.2 percentage point; and

(V) for each of fiscal years 2017, 2018, and 2019, by 0.75 percentage point.

The application of this clause may result in the applicable percentage increase described in clause (i) being less than 0.0 for a fiscal year, and may result in payment rates under this section for a fiscal year being less than such payment rates for the preceding fiscal year.

(C) In the case of a hospital that is a sole community hospital (as defined in subsection (d)(5)(D)(iii)), subject to subparagraphs (I) and (L), the term "target amount" means—

(i) with respect to the first 12-month cost reporting period in which this subparagraph is applied to the hospital—

(I) the allowable operating costs of inpatient hospital services (as defined in subsection (a)(4)) recognized under this title for the hospital for the 12-month cost reporting period (in this subparagraph referred to as the "base cost reporting period") preceding the first cost reporting period

for which this subsection was in effect with respect to such hospital, increased (in a compounded manner) by—

(II) the applicable percentage increases applied to such hospital under this paragraph for cost reporting periods after the base cost reporting period and up to and including such first 12-month cost reporting period,

(ii) with respect to a later cost reporting period beginning before fiscal year 1994, the target amount for the preceding 12-month cost reporting period, increased by the applicable percentage increase under subparagraph (B)(iv) for discharges occurring in the fiscal year in which that later cost reporting period begins,

(iii) with respect to discharges occurring in fiscal year 1994, the target amount for the cost reporting period beginning in fiscal year 1993 increased by the applicable percentage increase under subparagraph (B)(iv), or

(iv) with respect to discharges occurring in fiscal year 1995 and each subsequent fiscal year, the target amount for the preceding year increased by the applicable percentage increase under subparagraph (B)(iv).

There shall be substituted for the base cost reporting period described in clause (i) a hospital's cost reporting period (if any) beginning during fiscal year 1987 if such substitution results in an increase in the target amount for the hospital.

(D) For cost reporting periods ending on or before September 30, 1994, and for cost reporting periods occurring on or after October 1, 1997, and before October 1, 2017, in the case of a hospital that is a medicare-dependent, small rural hospital (as defined in subsection (d)(5)(G)), subject to subparagraph (K), the term "target amount" means—

(i) with respect to the first 12-month cost reporting period in which this subparagraph is applied to the hospital—

(I) the allowable operating costs of inpatient hospital services (as defined in subsection (a)(4)) recognized under this title for the hospital for the 12-month cost reporting period (in this subparagraph referred to as the "base cost reporting period") preceding the first cost reporting period for which this subsection was in effect with respect to such hospital, increased (in a compounded manner) by—

(II) the applicable percentage increases applied to such hospital under this paragraph for cost reporting periods after the base cost reporting period and up to and including such first 12-month cost reporting period, or

(ii) with respect to a later cost reporting period beginning before fiscal year 1994, the target amount for the preceding 12-month cost reporting period, increased by the applicable percentage increase under subparagraph (B)(iv) for discharges occurring in the fiscal year in which that later cost reporting period begins,

(iii) with respect to discharges occurring in fiscal year 1994, the target amount for the cost reporting period beginning in fiscal year 1993 increased by the applicable percentage increase under subparagraph (B)(iv), and

(iv) with respect to discharges occurring during fiscal year 1998 through fiscal year 2017, the target amount for the pre-

ceding year increased by the applicable percentage increase under subparagraph (B)(iv).

There shall be substituted for the base cost reporting period described in clause (i) a hospital's cost reporting period (if any) beginning during fiscal year 1987 if such substitution results in an increase in the target amount for the hospital.

(E) In the case of a hospital described in clause (v) of subsection (d)(1)(B), the term "target amount" means—

(i) with respect to the first 12-month cost reporting period in which this subparagraph is applied to the hospital—

(I) the allowable operating costs of inpatient hospital services (as defined in subsection (a)(4)) recognized under this title for the hospital for the 12-month cost reporting period (in this subparagraph referred to as the "base cost reporting period") preceding the first cost reporting period for which this subsection was in effect with respect to such hospital, increased (in a compounded manner) by—

(II) the sum of the applicable percentage increases applied to such hospital under this paragraph for cost reporting periods after the base cost reporting period and up to and including such first 12-month cost reporting period, or

(ii) with respect to a later cost reporting period, the target amount for the preceding 12-month cost reporting period, increased by the applicable percentage increase under subparagraph (B)(ii) for that later cost reporting period.

There shall be substituted for the base cost reporting period described in clause (i) a hospital's cost reporting period (if any) beginning during fiscal year 1987 if such substitution results in an increase in the target amount for the hospital.

(F)(i) In the case of a hospital (or unit described in the matter following clause (v) of subsection (d)(1)(B)) that received payment under this subsection for inpatient hospital services furnished during cost reporting periods beginning before October 1, 1990, that is within a class of hospital described in clause (iii), and that elects (in a form and manner determined by the Secretary) this subparagraph to apply to the hospital, the target amount for the hospital's 12-month cost reporting period beginning during fiscal year 1998 is equal to the average described in clause (ii).

(ii) The average described in this clause for a hospital or unit shall be determined by the Secretary as follows:

(I) The Secretary shall determine the allowable operating costs for inpatient hospital services for the hospital or unit for each of the 5 cost reporting periods for which the Secretary has the most recent settled cost reports as of the date of the enactment of this subparagraph.

(II) The Secretary shall increase the amount determined under subclause (I) for each cost reporting period by the applicable percentage increase under subparagraph (B)(ii) for each subsequent cost reporting period up to the cost reporting period described in clause (i).

(III) The Secretary shall identify among such 5 cost reporting periods the cost reporting periods for which the amount determined under subclause (II) is the highest, and the lowest.

(IV) The Secretary shall compute the averages of the amounts determined under subclause (II) for the 3 cost reporting periods not identified under subclause (III).

(iii) For purposes of this subparagraph, each of the following shall be treated as a separate class of hospital:

(I) Hospitals described in clause (i) of subsection (d)(1)(B) and psychiatric units described in the matter following clause (v) of such subsection.

(II) Hospitals described in clause (ii) of such subsection and rehabilitation units described in the matter following clause (v) of such subsection.

(III) Hospitals described in clause (iii) of such subsection.

(IV) Hospitals described in clause (iv) of such subsection.

(V) Hospitals described in clause (v) of such subsection.

(G)(i) In the case of a qualified long-term care hospital (as defined in clause (ii)) that elects (in a form and manner determined by the Secretary) this subparagraph to apply to the hospital, the target amount for the hospital's 12-month cost reporting period beginning during fiscal year 1998 is equal to the allowable operating costs of inpatient hospital services (as defined in subsection (a)(4)) recognized under this title for the hospital for the 12-month cost reporting period beginning during fiscal year 1996, increased by the applicable percentage increase for the cost reporting period beginning during fiscal year 1997.

(ii) In clause (i), a "qualified long-term care hospital" means, with respect to a cost reporting period, a hospital described in clause (iv) of subsection (d)(1)(B) during each of the 2 cost reporting periods for which the Secretary has the most recent settled cost reports as of the date of the enactment of this subparagraph for each of which—

(I) the hospital's allowable operating costs of inpatient hospital services recognized under this title exceeded 115 percent of the hospital's target amount, and

(II) the hospital would have a disproportionate patient percentage of at least 70 percent (as determined by the Secretary under subsection (d)(5)(F)(vi)) if the hospital were a subsection (d) hospital.

(H)(i) In the case of a hospital or unit that is within a class of hospital described in clause (iv), for a cost reporting period beginning during fiscal years 1998 through 2002, the target amount for such a hospital or unit may not exceed the amount as updated up to or for such cost reporting period under clause (ii).

(ii)(I) In the case of a hospital or unit that is within a class of hospital described in clause (iv), the Secretary shall estimate the 75th percentile of the target amounts for such hospitals within such class for cost reporting periods ending during fiscal year 1996, as adjusted under clause (iii).

(II) The Secretary shall update the amount determined under subclause (I), for each cost reporting period after the cost reporting period described in such subclause and up to the first cost reporting period beginning on or after October 1, 1997, by a factor equal to the market basket percentage increase.

(III) For cost reporting periods beginning during each of fiscal years 1999 through 2002, subject to subparagraph (J), the Sec-

retary shall update such amount by a factor equal to the market basket percentage increase.

(iii) In applying clause (ii)(I) in the case of a hospital or unit, the Secretary shall provide for an appropriate adjustment to the labor-related portion of the amount determined under such subparagraph to take into account differences between average wage-related costs in the area of the hospital and the national average of such costs within the same class of hospital.

(iv) For purposes of this subparagraph, each of the following shall be treated as a separate class of hospital:

(I) Hospitals described in clause (i) of subsection (d)(1)(B) and psychiatric units described in the matter following clause (v) of such subsection.

(II) Hospitals described in clause (ii) of such subsection and rehabilitation units described in the matter following clause (v) of such subsection.

(III) Hospitals described in clause (iv) of such subsection.

(I)(i) Subject to subparagraph (L), for cost reporting periods beginning on or after October 1, 2000, in the case of a sole community hospital there shall be substituted for the amount otherwise determined under subsection (d)(5)(D)(i), if such substitution results in a greater amount of payment under this section for the hospital—

(I) with respect to discharges occurring in fiscal year 2001, 75 percent of the amount otherwise applicable to the hospital under subsection (d)(5)(D)(i) (referred to in this clause as the "subsection (d)(5)(D)(i) amount") and 25 percent of the rebased target amount (as defined in clause (ii));

(II) with respect to discharges occurring in fiscal year 2002, 50 percent of the subsection (d)(5)(D)(i) amount and 50 percent of the rebased target amount;

(III) with respect to discharges occurring in fiscal year 2003, 25 percent of the subsection (d)(5)(D)(i) amount and 75 percent of the rebased target amount; and

(IV) with respect to discharges occurring after fiscal year 2003, 100 percent of the rebased target amount.

(ii) For purposes of this subparagraph, the "rebased target amount" has the meaning given the term "target amount" in subparagraph (C) except that—

(I) there shall be substituted for the base cost reporting period the 12-month cost reporting period beginning during fiscal year 1996;

(II) any reference in subparagraph (C)(i) to the "first cost reporting period" described in such subparagraph is deemed a reference to the first cost reporting period beginning on or after October 1, 2000; and

(III) applicable increase percentage shall only be applied under subparagraph (C)(iv) for discharges occurring in fiscal years beginning with fiscal year 2002.

(iii) In no case shall a hospital be denied treatment as a sole community hospital or payment (on the basis of a target rate as such as a hospital) because data are unavailable for any cost reporting period due to changes in ownership, changes in fiscal intermediaries, or other extraordinary circumstances, so long as data for at least one applicable base cost reporting period is available.

(J) For cost reporting periods beginning during fiscal year 2001, for a hospital described in subsection (d)(1)(B)(iv)—

(i) the limiting or cap amount otherwise determined under subparagraph (H) shall be increased by 2 percent; and

(ii) the target amount otherwise determined under subparagraph (A) shall be increased by 25 percent (subject to the limiting or cap amount determined under subparagraph (H), as increased by clause (i)).

(K)(i) With respect to discharges occurring on or after October 1, 2006, in the case of a medicare-dependent, small rural hospital, for purposes of applying subparagraph (D)—

(I) there shall be substituted for the base cost reporting period described in subparagraph (D)(i) the 12-month cost reporting period beginning during fiscal year 2002; and

(II) any reference in such subparagraph to the "first cost reporting period" described in such subparagraph is deemed a reference to the first cost reporting period beginning on or after October 1, 2006.

(ii) This subparagraph shall only apply to a hospital if the substitution described in clause (i)(I) results in an increase in the target amount under subparagraph (D) for the hospital.

(L)(i) For cost reporting periods beginning on or after January 1, 2009, in the case of a sole community hospital there shall be substituted for the amount otherwise determined under subsection (d)(5)(D)(i) of this section, if such substitution results in a greater amount of payment under this section for the hospital, the subparagraph (L) rebased target amount.

(ii) For purposes of this subparagraph, the term "subparagraph (L) rebased target amount" has the meaning given the term "target amount" in subparagraph (C), except that—

(I) there shall be substituted for the base cost reporting period the 12-month cost reporting period beginning during fiscal year 2006;

(II) any reference in subparagraph (C)(i) to the "first cost reporting period" described in such subparagraph is deemed a reference to the first cost reporting period beginning on or after January 1, 2009; and

(III) the applicable percentage increase shall only be applied under subparagraph (C)(iv) for discharges occurring on or after January 1, 2009.

(4)(A)(i) The Secretary shall provide for an exception and adjustment to (and in the case of a hospital described in subsection (d)(1)(B)(iii), may provide an exemption from) the method under this subsection for determining the amount of payment to a hospital where events beyond the hospital's control or extraordinary circumstances, including changes in the case mix of such hospital, create a distortion in the increase in costs for a cost reporting period (including any distortion in the costs for the base period against which such increase is measured). The Secretary may provide for such other exemptions from, and exceptions and adjustments to, such method as the Secretary deems appropriate, including the assignment of a new base period which is more representative, as determined by the Secretary, of the reasonable and necessary cost of inpatient services and including those which he deems necessary to take into account a decrease in the inpatient

hospital services that a hospital provides and that are customarily provided directly by similar hospitals which results in a significant distortion in the operating costs of inpatient hospital services. The Secretary shall announce a decision on any request for an exemption, exception, or adjustment under this paragraph not later than 180 days after receiving a completed application from the intermediary for such exemption, exception, or adjustment, and shall include in such decision a detailed explanation of the grounds on which such request was approved or denied.

(ii) The payment reductions under paragraph (3)(B)(ii)(V) shall not be considered by the Secretary in making adjustments pursuant to clause (i). In making such reductions, the Secretary shall treat the applicable update factor described in paragraph (3)(B)(vi) for a fiscal year as being equal to the market basket percentage for that year.

(B) In determining under subparagraph (A) whether to assign a new base period which is more representative of the reasonable and necessary cost to a hospital of providing inpatient services, the Secretary shall take into consideration—

(i) changes in applicable technologies and medical practices, or differences in the severity of illness among patients, that increase the hospital's costs;

(ii) whether increases in wages and wage-related costs for hospitals located in the geographic area in which the hospital is located exceed the average of the increases in such costs paid by hospitals in the United States; and

(iii) such other factors as the Secretary considers appropriate in determining increases in the hospital's costs of providing inpatient services.

(C) Paragraph (1) shall not apply to payment of hospitals which is otherwise determined under paragraph (3) of section 1814(b).

(5) In the case of any hospital having any cost reporting period of other than a 12-month period, the Secretary shall determine the 12-month period which shall be used for purposes of this section.

(6) In the case of any hospital which becomes subject to the taxes under section 3111 of the Internal Revenue Code of 1954, with respect to any or all of its employees, for part or all of a cost reporting period, and was not subject to such taxes with respect to any or all of its employees for all or part of the 12-month base cost reporting period referred to in subsection (b)(3)(A)(i), the Secretary shall provide for an adjustment by increasing the base period amount described in such subsection for such hospital by an amount equal to the amount of such taxes which would have been paid or accrued by such hospital for such base period if such hospital had been subject to such taxes for all of such base period with respect to all its employees, minus the amount of any such taxes actually paid or accrued for such base period.

(7)(A) Notwithstanding paragraph (1), in the case of a hospital or unit that is within a class of hospital described in subparagraph (B) which first receives payments under this section on or after October 1, 1997—

(i) for each of the first 2 cost reporting periods for which the hospital has a settled cost report, the amount of the payment with respect to operating costs described in paragraph (1)

under part A on a per discharge or per admission basis (as the case may be) is equal to the lesser of—

(I) the amount of operating costs for such respective period, or

(II) 110 percent of the national median (as estimated by the Secretary) of the target amount for hospitals in the same class as the hospital for cost reporting periods ending during fiscal year 1996, updated by the hospital market basket increase percentage to the fiscal year in which the hospital first received payments under this section, as adjusted under subparagraph (C); and

(ii) for purposes of computing the target amount for the subsequent cost reporting period, the target amount for the preceding cost reporting period is equal to the amount determined under clause (i) for such preceding period.

(B) For purposes of this paragraph, each of the following shall be treated as a separate class of hospital:

(i) Hospitals described in clause (i) of subsection (d)(1)(B) and psychiatric units described in the matter following clause (v) of such subsection.

(ii) Hospitals described in clause (ii) of such subsection and rehabilitation units described in the matter following clause (v) of such subsection.

(iii) Hospitals described in clause (iv) of such subsection.

(C) In applying subparagraph (A)(i)(II) in the case of a hospital or unit, the Secretary shall provide for an appropriate adjustment to the labor-related portion of the amount determined under such subparagraph to take into account differences between average wage-related costs in the area of the hospital and the national average of such costs within the same class of hospital.

(c)(1) The Secretary may provide, in his discretion, that payment with respect to services provided by a hospital in a State may be made in accordance with a hospital reimbursement control system in a State, rather than in accordance with the other provisions of this title, if the chief executive officer of the State requests such treatment and if—

(A) the Secretary determines that the system, if approved under this subsection, will apply (i) to substantially all non-Federal acute care hospitals (as defined by the Secretary) in the State and (ii) to the review of at least 75 percent of all revenues or expenses in the State for inpatient hospital services and of revenues or expenses for inpatient hospital services provided under the State's plan approved under title XIX;

(B) the Secretary has been provided satisfactory assurances as to the equitable treatment under the system of all entities (including Federal and State programs) that pay hospitals for inpatient hospital services, of hospital employees, and of hospital patients;

(C) the Secretary has been provided satisfactory assurances that under the system, over 36-month periods (the first such period beginning with the first month in which this subsection applies to that system in the State), the amount of payments made under this title under such system will not exceed the amount of payments which would otherwise have been made under this title not using such system;

(D) the Secretary determines that the system will not preclude an eligible organization (as defined in section 1876(b)) from negotiating directly with hospitals with respect to the organization's rate of payment for inpatient hospital services; and

(E) the Secretary determines that the system requires hospitals to meet the requirement of section 1866(a)(1)(G) and the system provides for the exclusion of certain costs in accordance with section 1862(a)(14) (except for such waivers thereof as the Secretary provides by regulation).

The Secretary cannot deny the application of a State under this subsection on the ground that the State's hospital reimbursement control system is based on a payment methodology other than on the basis of a diagnosis-related group or on the ground that the amount of payments made under this title under such system must be less than the amount of payments which would otherwise have been made under this title not using such system. If the Secretary determines that the conditions described in subparagraph (C) are based on maintaining payment amounts at no more than a specified percentage increase above the payment amounts in a base period, the State has the option of applying such test (for inpatient hospital services under part A) on an aggregate payment basis or on the basis of the amount of payment per inpatient discharge or admission. If the Secretary determines that the conditions described in subparagraph (C) are based on maintaining aggregate payment amounts below a national average percentage increase in total payments under part A for inpatient hospital services, the Secretary cannot deny the application of a State under this subsection on the ground that the State's rate of increase in such payments for such services must be less than such national average rate of increase.

(2) In determining under paragraph (1)(C) the amount of payment which would otherwise have been made under this title for a State, the Secretary may provide for appropriate adjustment of such amount to take into account previous reductions effected in the amount of payments made under this title in the State due to the operation of the hospital reimbursement control system in the State if the system has resulted in an aggregate rate of increase in operating costs of inpatient hospital services (as defined in subsection (a)(4)) under this title for hospitals in the State which is less than the aggregate rate of increase in such costs under this title for hospitals in the United States.

(3) The Secretary shall discontinue payments under a system described in paragraph (1) if the Secretary—

(A) determines that the system no longer meets the requirements of subparagraphs (A), (D), and (E) of paragraph (1) and, if applicable, the requirements of paragraph (5), or

(B) has reason to believe that the assurances described in subparagraph (B) or (C) of paragraph (1) (or, if applicable, in paragraph (5)) are not being (or will not be) met.

(4) The Secretary shall approve the request of a State under paragraph (1) with respect to a hospital reimbursement control system if—

(A) the requirements of subparagraphs (A), (B), (C), (D), and (E) of paragraph (1) have been met with respect to the system, and

(B) with respect to that system a waiver of certain requirements of title XVIII of the Social Security Act has been approved on or before (and which is in effect as of) the date of the enactment of the Social Security Amendments of 1983, pursuant to section 402(a) of the Social Security Amendments of 1967 or section 222(a) of the Social Security Amendments of 1972.

With respect to a State system described in this paragraph, the Secretary shall judge the effectiveness of such system on the basis of its rate of increase or inflation in inpatient hospital payments for individuals under this title, as compared to the national rate of increase or inflation for such payments, with the State retaining the option to have the test applied on the basis of the aggregate payments under the State system as compared to aggregate payments which would have been made under the national system since October 1, 1984, to the most recent date for which annual data are available.

(5) The Secretary shall approve the request of a State under paragraph (1) with respect to a hospital reimbursement control system if—

(A) the requirements of subparagraphs (A), (B), (C), (D), and (E) of paragraph (1) have been met with respect to the system;

(B) the Secretary determines that the system—

(i) is operated directly by the State or by an entity designated pursuant to State law,

(ii) provides for payment of hospitals covered under the system under a methodology (which sets forth exceptions and adjustments, as well as any method for changes in the methodology) by which rates or amounts to be paid for hospital services during a specified period are established under the system prior to the defined rate period, and

(iii) hospitals covered under the system will make such reports (in lieu of cost and other reports, identified by the Secretary, otherwise required under this title) as the Secretary may require in order to properly monitor assurances provided under this subsection;

(C) the State has provided the Secretary with satisfactory assurances that operation of the system will not result in any change in hospital admission practices which result in—

(i) a significant reduction in the proportion of patients (receiving hospital services covered under the system) who have no third-party coverage and who are unable to pay for hospital services,

(ii) a significant reduction in the proportion of individuals admitted to hospitals for inpatient hospital services for which payment is (or is likely to be) less than the anticipated charges for or costs of such services,

(iii) the refusal to admit patients who would be expected to require unusually costly or prolonged treatment for reasons other than those related to the appropriateness of the care available at the hospital, or

(iv) the refusal to provide emergency services to any person who is in need of emergency services if the hospital provides such services;

(D) any change by the State in the system which has the effect of materially reducing payments to hospitals can only take effect upon 60 days notice to the Secretary and to the hospitals the payment to which is likely to be materially affected by the change; and

(E) the State has provided the Secretary with satisfactory assurances that in the development of the system the State has consulted with local governmental officials concerning the impact of the system on public hospitals.

The Secretary shall respond to requests of States under this paragraph within 60 days of the date the request is submitted to the Secretary.

(6) If the Secretary determines that the assurances described in paragraph (1)(C) have not been met with respect to any 36-month period, the Secretary may reduce payments under this title to hospitals under the system in an amount equal to the amount by which the payment under this title under such system for such period exceeded the amount of payments which would otherwise have been made under this title not using such system.

(7) In the case of a State which made a request under paragraph (5) before December 31, 1984, for the approval of a State hospital reimbursement control system and which request was approved—

(A) in applying paragraphs (1)(C) and (6), a reference to a "36-month period" is deemed a reference to a "48-month period", and

(B) in order to allow the State the opportunity to provide the assurances described in paragraph (1)(C) for a 48-month period, the Secretary may not discontinue payments under the system, under the authority of paragraph (3)(A) because the Secretary has reason to believe that such assurances are not being (or will not be) met, before July 1, 1986.

(d)(1)(A) Notwithstanding section 1814(b) but subject to the provisions of section 1813, the amount of the payment with respect to the operating costs of inpatient hospital services (as defined in subsection (a)(4)) of a subsection (d) hospital (as defined in subparagraph (B)) for inpatient hospital discharges in a cost reporting period or in a fiscal year—

(i) beginning on or after October 1, 1983, and before October 1, 1984, is equal to the sum of—

(I) the target percentage (as defined in subparagraph (C)) of the hospital's target amount for the cost reporting period (as defined in subsection (b)(3)(A), but determined without the application of subsection (a)), and

(II) the DRG percentage (as defined in subparagraph (C)) of the regional adjusted DRG prospective payment rate determined under paragraph (2) for such discharges;

(ii) beginning on or after October 1, 1984, and before October 1, 1987, is equal to the sum of—

(I) the target percentage (as defined in subparagraph (C)) of the hospital's target amount for the cost reporting period (as defined in subsection (b)(3)(A), but determined without the application of subsection (a)), and

(II) the DRG percentage (as defined in subparagraph (C)) of the applicable combined adjusted DRG prospective payment rate determined under subparagraph (D) for such discharges; or

(iii) beginning on or after April 1, 1988, is equal to

(I) the national adjusted DRG prospective payment rate determined under paragraph (3) for such discharges, or

(II) for discharges occurring during a fiscal year ending on or before September 30, 1996, the sum of 85 percent of the national adjusted DRG prospective payment rate determined under paragraph (3) for such discharges and 15 percent of the regional adjusted DRG prospective payment rate determined under such paragraph, but only if the average standardized amount (described in clause (i)(I) or clause (ii)(I) of paragraph (3)(D)) for hospitals within the region of, and in the same large urban or other area (or, for discharges occurring during a fiscal year ending on or before September 30, 1994, the same rural, large urban, or other urban area) as, the hospital is greater than the average standardized amount (described in the respective clause) for hospitals within the United States in that type of area for discharges occurring during such fiscal year.

(B) As used in this section, the term "subsection (d) hospital" means a hospital located in one of the fifty States or the District of Columbia other than—

(i) a psychiatric hospital (as defined in section 1861(f)),

(ii) a rehabilitation hospital (as defined by the Secretary),

(iii) a hospital whose inpatients are predominantly individuals under 18 years of age,

(iv)(I) a hospital which has an average inpatient length of stay (as determined by the Secretary) of greater than 25 days, or

(II) a hospital that first received payment under this subsection in 1986 which has an average inpatient length of stay (as determined by the Secretary) of greater than 20 days and that has 80 percent or more of its annual medicare inpatient discharges with a principal diagnosis that reflects a finding of neoplastic disease in the 12-month cost reporting period ending in fiscal year 1997, or

(v)(I) a hospital that the Secretary has classified, at any time on or before December 31, 1990, (or, in the case of a hospital that, as of the date of the enactment of this clause, is located in a State operating a demonstration project under section 1814(b), on or before December 31, 1991) for purposes of applying exceptions and adjustments to payment amounts under this subsection, as a hospital involved extensively in treatment for or research on cancer,

(II) a hospital that was recognized as a comprehensive cancer center or clinical cancer research center by the National Cancer Institute of the National Institutes of Health as of April 20, 1983, that is located in a State which, as of December 19, 1989, was not operating a demonstration project under section 1814(b), that applied and was denied, on or before December 31, 1990, for classification as a hospital involved extensively in treatment for or research on cancer under this clause

(as in effect on the day before the date of the enactment of this subclause), that as of the date of the enactment of this subclause, is licensed for less than 50 acute care beds, and that demonstrates for the 4–year period ending on December 31, 1996, that at least 50 percent of its total discharges have a principal finding of neoplastic disease, as defined in subparagraph (E), or

(III) a hospital that was recognized as a clinical cancer research center by the National Cancer Institute of the National Institutes of Health as of February 18, 1998, that has never been reimbursed for inpatient hospital services pursuant to a reimbursement system under a demonstration project under section 1814(b), that is a freestanding facility organized primarily for treatment of and research on cancer and is not a unit of another hospital, that as of the date of the enactment of this subclause, is licensed for 162 acute care beds, and that demonstrates for the 4-year period ending on June 30, 1999, that at least 50 percent of its total discharges have a principal finding of neoplastic disease, as defined in subparagraph (E);

and, in accordance with regulations of the Secretary, does not include a psychiatric or rehabilitation unit of the hospital which is a distinct part of the hospital (as defined by the Secretary). A hospital that was classified by the Secretary on or before September 30, 1995, as a hospital described in clause (iv) shall continue to be so classified notwithstanding that it is located in the same building as, or on the same campus as, another hospital.

(C) For purposes of this subsection, for cost reporting periods beginning—

(i) on or after October 1, 1983, and before October 1, 1984, the "target percentage" is 75 percent and the "DRG percentage" is 25 percent;

(ii) on or after October 1, 1984, and before October 1, 1985, the "target percentage" is 50 percent and the "DRG percentage" is 50 percent;

(iii) on or after October 1, 1985, and before October 1, 1986, the "target percentage" is 45 percent and the "DRG percentage" is 55 percent; and

(iv) on or after October 1, 1986, and before October 1, 1987, the "target percentage" is 25 percent and the "DRG percentage" is 75 percent.

(D) For purposes of subparagraph (A)(ii)(II), the "applicable combined adjusted DRG prospective payment rate" for discharges occurring—

(i) on or after October 1, 1984, and before October 1, 1986, is a combined rate consisting of 25 percent of the national adjusted DRG prospective payment rate, and 75 percent of the regional adjusted DRG prospective payment rate, determined under paragraph (3) for such discharges; and

(ii) on or after October 1, 1986, and before October 1, 1987, is a combined rate consisting of 50 percent of the national adjusted DRG prospective payment rate, and 50 percent of the regional adjusted DRG prospective payment rate, determined under paragraph (3) for such discharges.

(E) For purposes of subclauses (II) and (III) of subparagraph (B)(v) only, the term "principal finding of neoplastic disease" means

the condition established after study to be chiefly responsible for occasioning the admission of a patient to a hospital, except that only discharges with ICD–9–CM principal diagnosis codes of 140 through 239, V58.0, V58.1, V66.1, V66.2, or 990 will be considered to reflect such a principal diagnosis.

(2) The Secretary shall determine a national adjusted DRG prospective payment rate, for each inpatient hospital discharge in fiscal year 1984 involving inpatient hospital services of a subsection (d) hospital in the United States, and shall determine a regional adjusted DRG prospective payment rate for such discharges in each region, for which payment may be made under part A of this title. Each such rate shall be determined for hospitals located in urban or rural areas within the United States or within each such region, respectively, as follows:

(A) DETERMINING ALLOWABLE INDIVIDUAL HOSPITAL COSTS FOR BASE PERIOD.—The Secretary shall determine the allowable operating costs per discharge of inpatient hospital services for the hospital for the most recent cost reporting period for which data are available.

(B) UPDATING FOR FISCAL YEAR 1984.—The Secretary shall update each amount determined under subparagraph (A) for fiscal year 1984 by—

(i) updating for fiscal year 1983 by the estimated average rate of change of hospital costs industry-wide between the cost reporting period used under such subparagraph and fiscal year 1983 and the most recent case-mix data available, and

(ii) projecting for fiscal year 1984 by the applicable percentage increase (as defined in subsection (b)(3)(B)) for fiscal year 1984.

(C) STANDARDIZING AMOUNTS.—The Secretary shall standardize the amount updated under subparagraph (B) for each hospital by—

(i) excluding an estimate of indirect medical education costs (taking into account, for discharges occurring after September 30, 1986, the amendments made by section 9104(a) of the Medicare and Medicaid Budget Reconciliation Amendments of 1985), except that the Secretary shall not take into account any reduction in the amount of additional payments under paragraph (5)(B)(ii) resulting from the amendment made by section 4621(a)(1) of the Balanced Budget Act of 1997 or any additional payments under such paragraph resulting from the application of section 111 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, of section 302 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, or the Medicare Prescription Drug, Improvement, and Modernization Act of 2003,

(ii) adjusting for variations among hospitals by area in the average hospital wage level,

(iii) adjusting for variations in case mix among hospitals, and

(iv) for discharges occurring on or after October 1, 1986, excluding an estimate of the additional payments to certain hospitals to be made under paragraph (5)(F), except

that the Secretary shall not exclude additional payments under such paragraph made as a result of the enactment of section 6003(c) of the Omnibus Budget Reconciliation Act of 1989, the enactment of section 4002(b) of the Omnibus Budget Reconciliation Act of 1990, the enactment of section 303 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, or the enactment of section 402(a)(1) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

(D) COMPUTING URBAN AND RURAL AVERAGES.—The Secretary shall compute an average of the standardized amounts determined under subparagraph (C) for the United States and for each region—

(i) for all subsection (d) hospitals located in an urban area within the United States or that region, respectively, and

(ii) for all subsection (d) hospitals located in a rural area within the United States or that region, respectively.

For purposes of this subsection, the term "region" means one of the nine census divisions, comprising the fifty States and the District of Columbia, established by the Bureau of the Census for statistical and reporting purposes; the term "urban area" means an area within a Metropolitan Statistical Area (as defined by the Office of Management and Budget) or within such similar area as the Secretary has recognized under subsection (a) by regulation; the term "large urban area" means, with respect to a fiscal year, such an urban area which the Secretary determines (in the publications described in subsection (e)(5) before the fiscal year) has a population of more than 1,000,000 (as determined by the Secretary based on the most recent available population data published by the Bureau of the Census); and the term "rural area" means any area outside such an area or similar area. A hospital located in a Metropolitan Statistical Area shall be deemed to be located in the region in which the largest number of the hospitals in the same Metropolitan Statistical Area are located, or, at the option of the Secretary, the region in which the majority of the inpatient discharges (with respect to which payments are made under this title) from hospitals in the same Metropolitan Statistical Area are made.

(E) REDUCING FOR VALUE OF OUTLIER PAYMENTS.—The Secretary shall reduce each of the average standardized amounts determined under subparagraph (D) by a proportion equal to the proportion (estimated by the Secretary) of the amount of payments under this subsection based on DRG prospective payment rates which are additional payments described in paragraph (5)(A) (relating to outlier payments).

(F) MAINTAINING BUDGET NEUTRALITY.—The Secretary shall adjust each of such average standardized amounts as may be required under subsection (e)(1)(B) for that fiscal year.

(G) COMPUTING DRG-SPECIFIC RATES FOR URBAN AND RURAL HOSPITALS IN THE UNITED STATES AND IN EACH REGION.—For each discharge classified within a diagnosis-related group, the Secretary shall establish a national DRG prospective payment

rate and shall establish a regional DRG prospective payment rate for each region, each of which is equal—

(i) for hospitals located in an urban area in the United States or that region (respectively), to the product of—

(I) the average standardized amount (computed under subparagraph (D), reduced under subparagraph (E), and adjusted under subparagraph (F)) for hospitals located in an urban area in the United States or that region, and

(II) the weighting factor (determined under paragraph (4)(B)) for that diagnosis-related group; and

(ii) for hospitals located in a rural area in the United States or that region (respectively), to the product of—

(I) the average standardized amount (computed under subparagraph (D), reduced under subparagraph (E), and adjusted under subparagraph (F)) for hospitals located in a rural area in the United States or that region, and

(II) the weighting factor (determined under paragraph (4)(B)) for that diagnosis-related group.

(H) ADJUSTING FOR DIFFERENT AREA WAGE LEVELS.—The Secretary shall adjust the proportion, (as estimated by the Secretary from time to time) of hospitals' costs which are attributable to wages and wage-related costs, of the national and regional DRG prospective payment rates computed under subparagraph (G) for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level.

(3) The Secretary shall determine a national adjusted DRG prospective payment rate, for each inpatient hospital discharge in a fiscal year after fiscal year 1984 involving inpatient hospital services of a subsection (d) hospital in the United States, and shall determine, for fiscal years before fiscal year 1997, a regional adjusted DRG prospective payment rate for such discharges in each region for which payment may be made under part A of this title. Each such rate shall be determined for hospitals located in large urban, other urban, or rural areas within the United States and within each such region, respectively, as follows:

(A) UPDATING PREVIOUS STANDARDIZED AMOUNTS.—(i) For discharges occurring in a fiscal year beginning before October 1, 1987, the Secretary shall compute an average standardized amount for hospitals located in an urban area and for hospitals located in a rural area within the United States and for hospitals located in an urban area and for hospitals located in a rural area within each region, equal to the respective average standardized amount computed for the previous fiscal year under paragraph (2)(D) or under this subparagraph, increased for the fiscal year involved by the applicable percentage increase under subsection (b)(3)(B). With respect to discharges occurring on or after October 1, 1987, the Secretary shall compute urban and rural averages on the basis of discharge weighting rather than hospital weighting, making appropriate adjustments to ensure that computation on such basis does not result in total payments under this section that are greater or

less than the total payments that would have been made under this section but for this sentence, and making appropriate changes in the manner of determining the reductions under subparagraph (C)(ii).

(ii) For discharges occurring in a fiscal year beginning on or after October 1, 1987, and ending on or before September 30, 1994, the Secretary shall compute an average standardized amount for hospitals located in a large urban area, for hospitals located in a rural area, and for hospitals located in other urban areas, within the United States and within each region, equal to the respective average standardized amount computed for the previous fiscal year under this subparagraph increased by the applicable percentage increase under subsection (b)(3)(B)(i) with respect to hospitals located in the respective areas for the fiscal year involved.

(iii) For discharges occurring in the fiscal year beginning on October 1, 1994, the average standardized amount for hospitals located in a rural area shall be equal to the average standardized amount for hospitals located in an urban area. For discharges occurring on or after October 1, 1994, the Secretary shall adjust the ratio of the labor portion to non-labor portion of each average standardized amount to equal such ratio for the national average of all standardized amounts.

(iv)(I) Subject to subclause (II), for discharges occurring in a fiscal year beginning on or after October 1, 1995, the Secretary shall compute an average standardized amount for hospitals located in a large urban area and for hospitals located in other areas within the United States and within each region equal to the respective average standardized amount computed for the previous fiscal year under this subparagraph increased by the applicable percentage increase under subsection (b)(3)(B)(i) with respect to hospitals located in the respective areas for the fiscal year involved.

(II) For discharges occurring in a fiscal year (beginning with fiscal year 2004), the Secretary shall compute a standardized amount for hospitals located in any area within the United States and within each region equal to the standardized amount computed for the previous fiscal year under this subparagraph for hospitals located in a large urban area (or, beginning with fiscal year 2005, for all hospitals in the previous fiscal year) increased by the applicable percentage increase under subsection (b)(3)(B)(i) for the fiscal year involved.

(v) Average standardized amounts computed under this paragraph shall be adjusted to reflect the most recent case-mix data available.

(vi) Insofar as the Secretary determines that the adjustments under paragraph (4)(C)(i) for a previous fiscal year (or estimates that such adjustments for a future fiscal year) did (or are likely to) result in a change in aggregate payments under this subsection during the fiscal year that are a result of changes in the coding or classification of discharges that do not reflect real changes in case mix, the Secretary may adjust the average standardized amounts computed under this paragraph for subsequent fiscal years so as to eliminate the effect of such coding or classification changes.

(B) REDUCING FOR VALUE OF OUTLIER PAYMENTS.—The Secretary shall reduce each of the average standardized amounts determined under subparagraph (A) by a factor equal to the proportion of payments under this subsection (as estimated by the Secretary) based on DRG prospective payment amounts which are additional payments described in paragraph (5)(A) (relating to outlier payments).

(C)(i) MAINTAINING BUDGET NEUTRALITY FOR FISCAL YEAR 1985.—For discharges occurring in fiscal year 1985, the Secretary shall adjust each of such average standardized amounts as may be required under subsection (e)(1)(B) for that fiscal year.

(ii) REDUCING FOR SAVINGS FROM AMENDMENT TO INDIRECT TEACHING ADJUSTMENT FOR DISCHARGES AFTER SEPTEMBER 30, 1986.—For discharges occurring after September 30, 1986, the Secretary shall further reduce each of the average standardized amounts (in a proportion which takes into account the differing effects of the standardization effected under paragraph (2)(C)(i)) so as to provide for a reduction in the total of the payments (attributable to this paragraph) made for discharges occurring on or after October 1, 1986, of an amount equal to the estimated reduction in the payment amounts under paragraph (5)(B) that would have resulted from the enactment of the amendments made by section 9104 of the Medicare and Medicaid Budget Reconciliation Amendments of 1985 and by section 4003(a)(1) of the Omnibus Budget Reconciliation Act of 1987 if the factor described in clause (ii)(II) of paragraph (5)(B) (determined without regard to amendments made by the Omnibus Budget Reconciliation Act of 1990) were applied for discharges occurring on or after such date instead of the factor described in clause (ii) of that paragraph.

(D) COMPUTING DRG-SPECIFIC RATES FOR HOSPITALS.—For each discharge classified within a diagnosis-related group, the Secretary shall establish for the fiscal year a national DRG prospective payment rate and shall establish, for fiscal years before fiscal year 1997, a regional DRG prospective payment rate for each region which is equal—

(i) for fiscal years before fiscal year 2004, for hospitals located in a large urban area in the United States or that region (respectively), to the product of—

(I) the average standardized amount (computed under subparagraph (A), reduced under subparagraph (B), and adjusted or reduced under subparagraph (C)) for the fiscal year for hospitals located in such a large urban area in the United States or that region, and

(II) the weighting factor (determined under paragraph (4)(B)) for that diagnosis-related group;

(ii) for fiscal years before fiscal year 2004, for hospitals located in other areas in the United States or that region (respectively), to the product of—

(I) the average standardized amount (computed under subparagraph (A), reduced under subparagraph (B), and adjusted or reduced under subparagraph (C)) for the fiscal year for hospitals located in other areas in the United States or that region, and

(II) the weighting factor (determined under paragraph (4)(B)) for that diagnosis-related group; and

(iii) for a fiscal year beginning after fiscal year 2003, for hospitals located in all areas, to the product of—

(I) the applicable standardized amount (computed under subparagraph (A)), reduced under subparagraph (B), and adjusted or reduced under subparagraph (C) for the fiscal year; and

(II) the weighting factor (determined under paragraph (4)(B)) for that diagnosis-related group.

(E) ADJUSTING FOR DIFFERENT AREA WAGE LEVELS.—

(i) IN GENERAL.—Except as provided in clause (ii) or (iii), the Secretary shall adjust the proportion, (as estimated by the Secretary from time to time) of hospitals' costs which are attributable to wages and wage-related costs, of the DRG prospective payment rates computed under subparagraph (D) for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level. Not later than October 1, 1990, and October 1, 1993 (and at least every 12 months thereafter), the Secretary shall update the factor under the preceding sentence on the basis of a survey conducted by the Secretary (and updated as appropriate) of the wages and wage-related costs of subsection (d) hospitals in the United States. Not less often than once every 3 years the Secretary (through such survey or otherwise) shall measure the earnings and paid hours of employment by occupational category and shall exclude data with respect to the wages and wage-related costs incurred in furnishing skilled nursing facility services. Any adjustments or updates made under this subparagraph for a fiscal year (beginning with fiscal year 1991) shall be made in a manner that assures that the aggregate payments under this subsection in the fiscal year are not greater or less than those that would have been made in the year without such adjustment. The Secretary shall apply the previous sentence for any period as if the amendments made by section 403(a)(1) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and the amendments made by section 10324(a)(1) of the Patient Protection and Affordable Care Act had not been enacted.

(ii) ALTERNATIVE PROPORTION TO BE ADJUSTED BEGINNING IN FISCAL YEAR 2005.—For discharges occurring on or after October 1, 2004, the Secretary shall substitute "62 percent" for the proportion described in the first sentence of clause (i), unless the application of this clause would result in lower payments to a hospital than would otherwise be made.

(iii) FLOOR ON AREA WAGE INDEX FOR HOSPITALS IN FRONTIER STATES.—

(I) IN GENERAL.—Subject to subclause (IV), for discharges occurring on or after October 1, 2010, the area wage index applicable under this subparagraph to any

hospital which is located in a frontier State (as defined in subclause (II)) may not be less than 1.00.

(II) FRONTIER STATE DEFINED.—In this clause, the term "frontier State" means a State in which at least 50 percent of the counties in the State are frontier counties.

(III) FRONTIER COUNTY DEFINED.—In this clause, the term "frontier county" means a county in which the population per square mile is less than 6.

(IV) LIMITATION.—This clause shall not apply to any hospital located in a State that receives a non-labor related share adjustment under paragraph (5)(H).

(4)(A) The Secretary shall establish a classification of inpatient hospital discharges by diagnosis-related groups and a methodology for classifying specific hospital discharges within these groups.

(B) For each such diagnosis-related group the Secretary shall assign an appropriate weighting factor which reflects the relative hospital resources used with respect to discharges classified within that group compared to discharges classified within other groups.

(C)(i) The Secretary shall adjust the classifications and weighting factors established under subparagraphs (A) and (B), for discharges in fiscal year 1988 and at least annually thereafter, to reflect changes in treatment patterns, technology (including a new medical service or technology under paragraph (5)(K)), and other factors which may change the relative use of hospital resources.

(ii) For discharges in fiscal year 1990, the Secretary shall reduce the weighting factor for each diagnosis-related group by 1.22 percent.

(iii) Any such adjustment under clause (i) for discharges in a fiscal year (beginning with fiscal year 1991) shall be made in a manner that assures that the aggregate payments under this subsection for discharges in the fiscal year are not greater or less than those that would have been made for discharges in the year without such adjustment.

(D)(i) For discharges occurring on or after October 1, 2008, the diagnosis-related group to be assigned under this paragraph for a discharge described in clause (ii) shall be a diagnosis-related group that does not result in higher payment based on the presence of a secondary diagnosis code described in clause (iv).

(ii) A discharge described in this clause is a discharge which meets the following requirements:

(I) The discharge includes a condition identified by a diagnosis code selected under clause (iv) as a secondary diagnosis.

(II) But for clause (i), the discharge would have been classified to a diagnosis-related group that results in a higher payment based on the presence of a secondary diagnosis code selected under clause (iv).

(III) At the time of admission, no code selected under clause (iv) was present.

(iii) As part of the information required to be reported by a hospital with respect to a discharge of an individual in order for payment to be made under this subsection, for discharges occurring on or after October 1, 2007, the information shall include the secondary diagnosis of the individual at admission.

(iv) By not later than October 1, 2007, the Secretary shall select diagnosis codes associated with at least two conditions, each of which codes meets all of the following requirements (as determined by the Secretary):

(I) Cases described by such code have a high cost or high volume, or both, under this title.

(II) The code results in the assignment of a case to a diagnosis-related group that has a higher payment when the code is present as a secondary diagnosis.

(III) The code describes such conditions that could reasonably have been prevented through the application of evidence-based guidelines.

The Secretary may from time to time revise (through addition or deletion of codes) the diagnosis codes selected under this clause so long as there are diagnosis codes associated with at least two conditions selected for discharges occurring during any fiscal year.

(v) In selecting and revising diagnosis codes under clause (iv), the Secretary shall consult with the Centers for Disease Control and Prevention and other appropriate entities.

(vi) Any change resulting from the application of this subparagraph shall not be taken into account in adjusting the weighting factors under subparagraph (C)(i) or in applying budget neutrality under subparagraph (C)(iii).

(5)(A)(i) For discharges occurring during fiscal years ending on or before September 30, 1997, the Secretary shall provide for an additional payment for a subsection (d) hospital for any discharge in a diagnosis-related group, the length of stay of which exceeds the mean length of stay for discharges within that group by a fixed number of days, or exceeds such mean length of stay by some fixed number of standard deviations, whichever is the fewer number of days.

(ii) For cases which are not included in clause (i), a subsection (d) hospital may request additional payments in any case where charges, adjusted to cost, exceed a fixed multiple of the applicable DRG prospective payment rate, or exceed such other fixed dollar amount, whichever is greater, or for discharges in fiscal years beginning on or after October 1, 1994, exceed the sum of the applicable DRG prospective payment rate plus any amounts payable under subparagraphs (B) and (F) plus a fixed dollar amount determined by the Secretary.

(iii) The amount of such additional payment under clauses (i) and (ii) shall be determined by the Secretary and shall (except as payments under clause (i) are required to be reduced to take into account the requirements of clause (v)) approximate the marginal cost of care beyond the cutoff point applicable under clause (i) or (ii).

(iv) The total amount of the additional payments made under this subparagraph for discharges in a fiscal year may not be less than 5 percent nor more than 6 percent of the total payments projected or estimated to be made based on DRG prospective payment rates for discharges in that year.

(v) The Secretary shall provide that—

(I) the day outlier percentage for fiscal year 1995 shall be 75 percent of the day outlier percentage for fiscal year 1994;

(II) the day outlier percentage for fiscal year 1996 shall be 50 percent of the day outlier percentage for fiscal year 1994; and

(III) the day outlier percentage for fiscal year 1997 shall be 25 percent of the day outlier percentage for fiscal year 1994.

(vi) For purposes of this subparagraph the term "day outlier percentage" means, for a fiscal year, the percentage of the total additional payments made by the Secretary under this subparagraph for discharges in that fiscal year which are additional payments under clause (i).

(B) The Secretary shall provide for an additional payment amount for subsection (d) hospitals with indirect costs of medical education, in an amount computed in the same manner as the adjustment for such costs under regulations (in effect as of January 1, 1983) under subsection (a)(2), except as follows:

(i) The amount of such additional payment shall be determined by multiplying (I) the sum of the amount determined under paragraph (1)(A)(ii)(II) (or, if applicable, the amount determined under paragraph (1)(A)(iii)) and, for cases qualifying for additional payment under subparagraph (A)(i), the amount paid to the hospital under subparagraph (A), by (II) the indirect teaching adjustment factor described in clause (ii).

(ii) For purposes of clause (i)(II), the indirect teaching adjustment factor is equal to c × (((1+r) to the nth power) − 1), where "r" is the ratio of the hospital's full-time equivalent interns and residents to beds and "n" equals .405. Subject to clause (ix), for discharges occurring—

(I) on or after October 1, 1988, and before October 1, 1997, "c" is equal to 1.89;

(II) during fiscal year 1998, "c" is equal to 1.72;

(III) during fiscal year 1999, "c" is equal to 1.6;

(IV) during fiscal year 2000, "c" is equal to 1.47;

(V) during fiscal year 2001, "c" is equal to 1.54;

(VI) during fiscal year 2002, "c" is equal to 1.6;

(VII) on or after October 1, 2002, and before April 1, 2004, "c" is equal to 1.35;

(VIII) on or after April 1, 2004, and before October 1, 2004, "c" is equal to 1.47;

(IX) during fiscal year 2005, "c" is equal to 1.42;

(X) during fiscal year 2006, "c" is equal to 1.37;

(XI) during fiscal year 2007, "c" is equal to 1.32; and

(XII) on or after October 1, 2007, "c" is equal to 1.35.

(iii) In determining such adjustment the Secretary shall not distinguish between those interns and residents who are employees of a hospital and those interns and residents who furnish services to a hospital but are not employees of such hospital.

(iv)(I) Effective for discharges occurring on or after October 1, 1997, and before July 1, 2010, all the time spent by an intern or resident in patient care activities under an approved medical residency training program at an entity in a nonhospital setting shall be counted towards the determination of full-time equivalency if the hospital incurs all, or substantially all, of the costs for the training program in that setting.

(II) Effective for discharges occurring on or after July 1, 2010, all the time spent by an intern or resident in patient care activities in a nonprovider setting shall be counted towards the determination of full-time equivalency if a hospital incurs the costs of the stipends and fringe benefits of the intern or resident during the time the intern or resident spends in that setting. If more than one hospital incurs these costs, either directly or through a third party, such hospitals shall count a proportional share of the time, as determined by written agreement between the hospitals, that a resident spends training in that setting.

(v) In determining the adjustment with respect to a hospital for discharges occurring on or after October 1, 1997, the total number of full-time equivalent interns and residents in the fields of allopathic and osteopathic medicine in either a hospital or nonhospital setting may not exceed the number (or, 130 percent of such number in the case of a hospital located in a rural area) of such full-time equivalent interns and residents in the hospital with respect to the hospital's most recent cost reporting period ending on or before December 31, 1996. Rules similar to the rules of subsection (h)(4)(F)(ii) shall apply for purposes of this clause. The provisions of subsections (h)(4)(H)(vi), (h)(7), and (h)(8) shall apply with respect to the first sentence of this clause in the same manner as they apply with respect to subsection (h)(4)(F)(i).

(vi) For purposes of clause (ii)—

(I) "r" may not exceed the ratio of the number of interns and residents, subject to the limit under clause (v), with respect to the hospital for its most recent cost reporting period to the hospital's available beds (as defined by the Secretary) during that cost reporting period, and

(II) for the hospital's cost reporting periods beginning on or after October 1, 1997, subject to the limits described in clauses (iv) and (v), the total number of full-time equivalent residents for payment purposes shall equal the average of the actual full-time equivalent resident count for the cost reporting period and the preceding two cost reporting periods.

In the case of the first cost reporting period beginning on or after October 1, 1997, subclause (II) shall be applied by using the average for such period and the preceding cost reporting period.

(vii) If any cost reporting period beginning on or after October 1, 1997, is not equal to twelve months, the Secretary shall make appropriate modifications to ensure that the average full-time equivalent residency count pursuant to subclause (II) of clause (vi) is based on the equivalent of full twelve-month cost reporting periods.

(viii) Rules similar to the rules of subsection (h)(4)(H) shall apply for purposes of clauses (v) and (vi).

(ix) For discharges occurring on or after July 1, 2005, insofar as an additional payment amount under this subparagraph is attributable to resident positions redistributed to a hospital under subsection (h)(7)(B), in computing the indirect teaching adjustment factor under clause (ii) the adjustment shall be

computed in a manner as if "c" were equal to 0.66 with respect to such resident positions.

(x) For discharges occurring on or after July 1, 2011, insofar as an additional payment amount under this subparagraph is attributable to resident positions distributed to a hospital under subsection (h)(8)(B), the indirect teaching adjustment factor shall be computed in the same manner as provided under clause (ii) with respect to such resident positions.

(x)(I) The provisions of subparagraph (K) of subsection (h)(4) shall apply under this subparagraph in the same manner as they apply under such subsection.

(II) In determining the hospital's number of full-time equivalent residents for purposes of this subparagraph, all the time spent by an intern or resident in an approved medical residency training program in non-patient care activities, such as didactic conferences and seminars, as such time and activities are defined by the Secretary, that occurs in the hospital shall be counted toward the determination of full-time equivalency if the hospital—

(aa) is recognized as a subsection (d) hospital;

(bb) is recognized as a subsection (d) Puerto Rico hospital;

(cc) is reimbursed under a reimbursement system authorized under section 1814(b)(3); or

(dd) is a provider-based hospital outpatient department.

(III) In determining the hospital's number of full-time equivalent residents for purposes of this subparagraph, all the time spent by an intern or resident in an approved medical residency training program in research activities that are not associated with the treatment or diagnosis of a particular patient, as such time and activities are defined by the Secretary, shall not be counted toward the determination of full-time equivalency.

(C)(i) The Secretary shall provide for such exceptions and adjustments to the payment amounts established under this subsection (other than under paragraph (9)) as the Secretary deems appropriate to take into account the special needs of regional and national referral centers (including those hospitals of 275 or more beds located in rural areas). A hospital which is classified as a rural hospital may appeal to the Secretary to be classified as a rural referral center under this clause on the basis of criteria (established by the Secretary) which shall allow the hospital to demonstrate that it should be so reclassified by reason of certain of its operating characteristics being similar to those of a typical urban hospital located in the same census region and which shall not require a rural osteopathic hospital to have more than 3,000 discharges in a year in order to be classified as a rural referral center. Such characteristics may include wages, scope of services, service area, and the mix of medical specialties. The Secretary shall publish the criteria not later than August 17, 1984, for implementation by October 1, 1984. An appeal allowed under this clause must be submitted to the Secretary (in such form and manner as the Sec-

retary may prescribe) during the quarter before the first quarter of the hospital's cost reporting period (or, in the case of a cost reporting period beginning during October 1984, during the first quarter of that period), and the Secretary must make a final determination with respect to such appeal within 60 days after the date the appeal was submitted. Any payment adjustments necessitated by a reclassification based upon the appeal shall be effective at the beginning of such cost reporting period.

(ii) The Secretary shall provide, under clause (i), for the classification of a rural hospital as a regional referral center if the hospital has a case mix index equal to or greater than the median case mix index for hospitals (other than hospitals with approved teaching programs) located in an urban area in the same region (as defined in paragraph (2)(D)), has at least 5,000 discharges a year or, if less, the median number of discharges in urban hospitals in the region in which the hospital is located (or, in the case of a rural osteopathic hospital, meets the criterion established by the Secretary under clause (i) with respect to the annual number of discharges for such hospitals), and meets any other criteria established by the Secretary under clause (i).

(D)(i) For any cost reporting period beginning on or after April 1, 1990, with respect to a subsection (d) hospital which is a sole community hospital, payment under paragraph (1)(A) shall be—

(I) an amount based on 100 percent of the hospital's target amount for the cost reporting period, as defined in subsection (b)(3)(C), or

(II) the amount determined under paragraph (1)(A)(iii),

whichever results in greater payment to the hospital.

(ii) In the case of a sole community hospital that experiences, in a cost reporting period compared to the previous cost reporting period, a decrease of more than 5 percent in its total number of inpatient cases due to circumstances beyond its control, the Secretary shall provide for such adjustment to the payment amounts under this subsection (other than under paragraph (9)) as may be necessary to fully compensate the hospital for the fixed costs it incurs in the period in providing inpatient hospital services, including the reasonable cost of maintaining necessary core staff and services.

(iii) For purposes of this title, the term "sole community hospital" means any hospital—

(I) that the Secretary determines is located more than 35 road miles from another hospital,

(II) that, by reason of factors such as the time required for an individual to travel to the nearest alternative source of appropriate inpatient care (in accordance with standards promulgated by the Secretary), location, weather conditions, travel conditions, or absence of other like hospitals (as determined by the Secretary), is the sole source of inpatient hospital services reasonably available to individuals in a geographic area who are entitled to benefits under part A, or

(III) that is located in a rural area and designated by the Secretary as an essential access community hospital under section 1820(i)(1) as in effect on September 30, 1997.

(iv) The Secretary shall promulgate a standard for determining whether a hospital meets the criteria for classification as a sole community hospital under clause (iii)(II) because of the time re-

quired for an individual to travel to the nearest alternative source of appropriate inpatient care.

(v) If the Secretary determines that, in the case of a hospital located in a rural area and designated by the Secretary as an essential access community hospital under section 1820(i)(1) as in effect on September 30, 1997, the hospital has incurred increases in reasonable costs during a cost reporting period as a result of becoming a member of a rural health network (as defined in section 1820(d)) in the State in which it is located, and in incurring such increases, the hospital will increase its costs for subsequent cost reporting periods, the Secretary shall increase the hospital's target amount under subsection (b)(3)(C) to account for such incurred increases.

(E)(i) The Secretary shall estimate the amount of reimbursement made for services described in section 1862(a)(14) with respect to which payment was made under part B in the base reporting periods referred to in paragraph (2)(A) and with respect to which payment is no longer being made.

(ii) The Secretary shall provide for an adjustment to the payment for subsection (d) hospitals in each fiscal year so as appropriately to reflect the net amount described in clause (i).

(F)(i) Subject to subsection (r), for discharges occurring on or after May 1, 1986, the Secretary shall provide, in accordance with this subparagraph, for an additional payment amount for each subsection (d) hospital which—

(I) serves a significantly disproportionate number of low-income patients (as defined in clause (v)), or

(II) is located in an urban area, has 100 or more beds, and can demonstrate that its net inpatient care revenues (excluding any of such revenues attributable to this title or State plans approved under title XIX), during the cost reporting period in which the discharges occur, for indigent care from State and local government sources exceed 30 percent of its total of such net inpatient care revenues during the period.

(ii) Subject to clause (ix), the amount of such payment for each discharge shall be determined by multiplying (I) the sum of the amount determined under paragraph (1)(A)(ii)(II) (or, if applicable, the amount determined under paragraph (1)(A)(iii)) and, for cases qualifying for additional payment under subparagraph (A)(i), the amount paid to the hospital under subparagraph (A) for that discharge, by (II) the disproportionate share adjustment percentage established under clause (iii) or (iv) for the cost reporting period in which the discharge occurs.

(iii) The disproportionate share adjustment percentage for a cost reporting period for a hospital described in clause (i)(II) is equal to 35 percent.

(iv) The disproportionate share adjustment percentage for a cost reporting period for a hospital that is not described in clause (i)(II) and that—

(I) is located in an urban area and has 100 or more beds or is described in the second sentence of clause (v), is equal to the percent determined in accordance with the applicable formula described in clause (vii);

(II) is located in an urban area and has less than 100 beds, is equal to 5 percent or, subject to clause (xiv) and for dis-

charges occurring on or after April 1, 2001, is equal to the percent determined in accordance with clause (xiii);

(III) is located in a rural area and is not described in subclause (IV) or (V) or in the second sentence of clause (v), is equal to 4 percent or, subject to clause (xiv) and for discharges occurring on or after April 1, 2001, is equal to the percent determined in accordance with clause (xii);

(IV) is located in a rural area, is classified as a rural referral center under subparagraph (C), and is classified as a sole community hospital under subparagraph (D), is equal to 10 percent or, if greater, the percent determined in accordance with the applicable formula described in clause (viii) or, subject to clause (xiv) and for discharges occurring on or after April 1, 2001, the greater of the percentages determined under clause (x) or (xi);

(V) is located in a rural area, is classified as a rural referral center under subparagraph (C), and is not classified as a sole community hospital under subparagraph (D), is equal to the percent determined in accordance with the applicable formula described in clause (viii) or, subject to clause (xiv) and for discharges occurring on or after April 1, 2001, is equal to the percent determined in accordance with clause (xi); or

(VI) is located in a rural area, is classified as a sole community hospital under subparagraph (D), and is not classified as a rural referral center under subparagraph (C), is 10 percent or, subject to clause (xiv) and for discharges occurring on or after April 1, 2001, is equal to the percent determined in accordance with clause (x).

(v) In this subparagraph, a hospital "serves a significantly disproportionate number of low income patients" for a cost reporting period if the hospital has a disproportionate patient percentage (as defined in clause (vi)) for that period which equals, or exceeds—

(I) 15 percent, if the hospital is located in an urban area and has 100 or more beds,

(II) 30 percent (or 15 percent, for discharges occurring on or after April 1, 2001), if the hospital is located in a rural area and has more than 100 beds, or is located in a rural area and is classified as a sole community hospital under subparagraph (D),

(III) 40 percent (or 15 percent, for discharges occurring on or after April 1, 2001), if the hospital is located in an urban area and has less than 100 beds, or

(IV) 45 percent (or 15 percent, for discharges occurring on or after April 1, 2001), if the hospital is located in a rural area and is not described in subclause (II).

A hospital located in a rural area and with 500 or more beds also "serves a significantly disproportionate number of low income patients" for a cost reporting period if the hospital has a disproportionate patient percentage (as defined in clause (vi)) for that period which equals or exceeds a percentage specified by the Secretary.

(vi) In this subparagraph, the term "disproportionate patient percentage" means, with respect to a cost reporting period of a hospital, the sum of—

(I) the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such

period which were made up of patients who (for such days) were entitled to benefits under part A of this title and were entitled to supplementary security income benefits (excluding any State supplementation) under title XVI of this Act, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were entitled to benefits under part A of this title, and

(II) the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under title XIX, but who were not entitled to benefits under part A of this title, and the denominator of which is the total number of the hospital's patient days for such period.

In determining under subclause (II) the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under title XIX, the Secretary may, to the extent and for the period the Secretary determines appropriate, include patient days of patients not so eligible but who are regarded as such because they receive benefits under a demonstration project approved under title XI.

(vii) The formula used to determine the disproportionate share adjustment percentage for a cost reporting period for a hospital described in clause (iv)(I) is—

(I) in the case of such a hospital with a disproportionate patient percentage (as defined in clause (vi)) greater than 20.2—

(a) for discharges occurring on or after April 1, 1990, and on or before December 31, 1990, (P–20.2)(.65) + 5.62,

(b) for discharges occurring on or after January 1, 1991, and on or before September 30, 1993, (P–20.2)(.7) + 5.62,

(c) for discharges occurring on or after October 1, 1993, and on or before September 30, 1994, (P–20.2)(.8) + 5.88, and

(d) for discharges occurring on or after October 1, 1994, (P–20.2)(.825) + 5.88; or

(II) in the case of any other such hospital—

(a) for discharges occurring on or after April 1, 1990, and on or before December 31, 1990, (P–15)(.6) + 2.5,

(b) for discharges occurring on or after January 1, 1991, and on or before September 30, 1993, (P–15)(.6) + 2.5,

(c) for discharges occurring on or after October 1, 1993, (P–15)(.65) + 2.5,

where "P" is the hospital's disproportionate patient percentage (as defined in clause (vi)).

(viii) Subject to clause (xiv), the formula used to determine the disproportionate share adjustment percentage for a cost reporting period for a hospital described in clause (iv)(IV) or (iv)(V) is the percentage determined in accordance with the following formula:(P–30)(.6) + 4.0, where "P" is the hospital's disproportionate patient percentage (as defined in clause (vi)).

(ix) In the case of discharges occurring—

(I) during fiscal year 1998, the additional payment amount otherwise determined under clause (ii) shall be reduced by 1 percent;

(II) during fiscal year 1999, such additional payment amount shall be reduced by 2 percent;

(III) during fiscal years 2000 and 2001, such additional payment amount shall be reduced by 3 percent and 2 percent, respectively;

(IV) during fiscal year 2002, such additional payment amount shall be reduced by 3 percent; and

(V) during fiscal year 2003 and each subsequent fiscal year, such additional payment amount shall be reduced by 0 percent.

(x) Subject to clause (xiv), for purposes of clause (iv)(VI) (relating to sole community hospitals), in the case of a hospital for a cost reporting period with a disproportionate patient percentage (as defined in clause (vi)) that—

(I) is less than 19.3, the disproportionate share adjustment percentage is determined in accordance with the following formula: (P–15)(.65) + 2.5;

(II) is equal to or exceeds 19.3, but is less than 30.0, such adjustment percentage is equal to 5.25 percent; or

(III) is equal to or exceeds 30, such adjustment percentage is equal to 10 percent,

where "P" is the hospital's disproportionate patient percentage (as defined in clause (vi)).

(xi) Subject to clause (xiv), for purposes of clause (iv)(V) (relating to rural referral centers), in the case of a hospital for a cost reporting period with a disproportionate patient percentage (as defined in clause (vi)) that—

(I) is less than 19.3, the disproportionate share adjustment percentage is determined in accordance with the following formula: (P–15)(.65) + 2.5;

(II) is equal to or exceeds 19.3, but is less than 30.0, such adjustment percentage is equal to 5.25 percent; or

(III) is equal to or exceeds 30, such adjustment percentage is determined in accordance with the following formula: (P–30)(.6) + 5.25,

where "P" is the hospital's disproportionate patient percentage (as defined in clause (vi)).

(xii) Subject to clause (xiv), for purposes of clause (iv)(III) (relating to small rural hospitals generally), in the case of a hospital for a cost reporting period with a disproportionate patient percentage (as defined in clause (vi)) that—

(I) is less than 19.3, the disproportionate share adjustment percentage is determined in accordance with the following formula: (P–15)(.65) + 2.5; or

(II) is equal to or exceeds 19.3, such adjustment percentage is equal to 5.25 percent,

where "P" is the hospital's disproportionate patient percentage (as defined in clause (vi)).

(xiii) Subject to clause (xiv), for purposes of clause (iv)(II) (relating to urban hospitals with less than 100 beds), in the case of a hospital for a cost reporting period with a disproportionate patient percentage (as defined in clause (vi)) that—

(I) is less than 19.3, the disproportionate share adjustment percentage is determined in accordance with the following formula: (P–15)(.65) + 2.5; or

(II) is equal to or exceeds 19.3, such adjustment percentage is equal to 5.25 percent,

where "P" is the hospital's disproportionate patient percentage (as defined in clause (vi)).

(xiv)(I) In the case of discharges occurring on or after April 1, 2004, subject to subclause (II), there shall be substituted for the disproportionate share adjustment percentage otherwise determined under clause (iv) (other than subclause (I)) or under clause (viii), (x), (xi), (xii), or (xiii), the disproportionate share adjustment percentage determined under clause (vii) (relating to large, urban hospitals).

(II) Under subclause (I), the disproportionate share adjustment percentage shall not exceed 12 percent for a hospital that is not classified as a rural referral center under subparagraph (C) or, in the case of discharges occurring on or after October 1, 2006, as a medicare-dependent, small rural hospital under subparagraph (G)(iv).

(G)(i) For any cost reporting period beginning on or after April 1, 1990, and before October 1, 1994, or discharges occurring on or after October 1, 1997, and before October 1, 2017, in the case of a subsection (d) hospital which is a medicare-dependent, small rural hospital, payment under paragraph (1)(A) shall be equal to the sum of the amount determined under clause (ii) and the amount determined under paragraph (1)(A)(iii).

(ii) The amount determined under this clause is—

(I) for discharges occurring during the 36-month period beginning with the first day of the cost reporting period that begins on or after April 1, 1990, the amount by which the hospital's target amount for the cost reporting period (as defined in subsection (b)(3)(D)) exceeds the amount determined under paragraph (1)(A)(iii); and

(II) for discharges occurring during any subsequent cost reporting period (or portion thereof) and before October 1, 1994, or discharges occurring on or after October 1, 1997, and before October 1, 2017, 50 percent (or 75 percent in the case of discharges occurring on or after October 1, 2006) of the amount by which the hospital's target amount for the cost reporting period or for discharges in the fiscal year (as defined in subsection (b)(3)(D)) exceeds the amount determined under paragraph (1)(A)(iii).

(iii) In the case of a medicare dependent, small rural hospital that experiences, in a cost reporting period compared to the previous cost reporting period, a decrease of more than 5 percent in its total number of inpatient cases due to circumstances beyond its control, the Secretary shall provide for such adjustment to the payment amounts under this subsection (other than under paragraph (9)) as may be necessary to fully compensate the hospital for the fixed costs it incurs in the period in providing inpatient hospital services, including the reasonable cost of maintaining necessary core staff and services.

(iv) The term "medicare-dependent, small rural hospital" means, with respect to any cost reporting period to which clause (i) applies, any hospital—

(I) located in a rural area,

(II) that has not more than 100 beds,

(III) that is not classified as a sole community hospital under subparagraph (D), and

(IV) for which not less than 60 percent of its inpatient days or discharges during the cost reporting period beginning in fiscal year 1987, or two of the three most recently audited cost reporting periods for which the Secretary has a settled cost report, were attributable to inpatients entitled to benefits under part A.

(H) The Secretary may provide for such adjustments to the payment amounts under this subsection as the Secretary deems appropriate to take into account the unique circumstances of hospitals located in Alaska and Hawaii.

(I)(i) The Secretary shall provide by regulation for such other exceptions and adjustments to such payment amounts under this subsection as the Secretary deems appropriate.

(ii) In making adjustments under clause (i) for transfer cases (as defined by the Secretary) in a fiscal year, not taking in account the effect of subparagraph (J), the Secretary may make adjustments to each of the average standardized amounts determined under paragraph (3) to assure that the aggregate payments made under this subsection for such fiscal year are not greater or lesser than those that would have otherwise been made in such fiscal year.

(J)(i) The Secretary shall treat the term "transfer case" (as defined in subparagraph (I)(ii)) as including the case of a qualified discharge (as defined in clause (ii)), which is classified within a diagnosis-related group described in clause (iii), and which occurs on or after October 1, 1998. In the case of a qualified discharge for which a substantial portion of the costs of care are incurred in the early days of the inpatient stay (as defined by the Secretary), in no case may the payment amount otherwise provided under this subsection exceed an amount equal to the sum of—

(I) 50 percent of the amount of payment under this subsection for transfer cases (as established under subparagraph (I)(i)), and

(II) 50 percent of the amount of payment which would have been made under this subsection with respect to the qualified discharge if no transfer were involved.

(ii) For purposes of clause (i), subject to clause (iii), the term "qualified discharge" means a discharge classified with a diagnosis-related group (described in clause (iii)) of an individual from a subsection (d) hospital, if upon such discharge the individual—

(I) is admitted as an inpatient to a hospital or hospital unit that is not a subsection (d) hospital for the provision of inpatient hospital services;

(II) is admitted to a skilled nursing facility;

(III) is provided home health services from a home health agency, if such services relate to the condition or diagnosis for which such individual received inpatient hospital services from the subsection (d) hospital, and if such services are provided

within an appropriate period (as determined by the Secretary); or

(IV) for discharges occurring on or after October 1, 2000, the individual receives post discharge services described in clause (iv)(I).

(iii) Subject to clause (iv), a diagnosis-related group described in this clause is—

(I) 1 of 10 diagnosis-related groups selected by the Secretary based upon a high volume of discharges classified within such groups and a disproportionate use of post discharge services described in clause (ii); and

(II) a diagnosis-related group specified by the Secretary under clause (iv)(II).

(iv) The Secretary shall include in the proposed rule published under subsection (e)(5)(A) for fiscal year 2001, a description of the effect of this subparagraph. The Secretary may include in the proposed rule (and in the final rule published under paragraph (6)) for fiscal year 2001 or a subsequent fiscal year, a description of—

(I) post-discharge services not described in subclauses (I), (II), and (III) of clause (ii), the receipt of which results in a qualified discharge; and

(II) diagnosis-related groups described in clause (iii)(I) in addition to the 10 selected under such clause.

(K)(i) Effective for discharges beginning on or after October 1, 2001, the Secretary shall establish a mechanism to recognize the costs of new medical services and technologies under the payment system established under this subsection. Such mechanism shall be established after notice and opportunity for public comment (in the publications required by subsection (e)(5) for a fiscal year or otherwise). Such mechanism shall be modified to meet the requirements of clause (viii).

(ii) The mechanism established pursuant to clause (i) shall—

(I) apply to a new medical service or technology if, based on the estimated costs incurred with respect to discharges involving such service or technology, the DRG prospective payment rate otherwise applicable to such discharges under this subsection is inadequate (applying a threshold specified by the Secretary that is the lesser of 75 percent of the standardized amount (increased to reflect the difference between cost and charges) or 75 percent of one standard deviation for the diagnosis-related group involved);

(II) provide for the collection of data with respect to the costs of a new medical service or technology described in subclause (I) for a period of not less than two years and not more than three years beginning on the date on which an inpatient hospital code is issued with respect to the service or technology;

(III) provide for additional payment to be made under this subsection with respect to discharges involving a new medical service or technology described in subclause (I) that occur during the period described in subclause (II) in an amount that adequately reflects the estimated average cost of such service or technology; and

(IV) provide that discharges involving such a service or technology that occur after the close of the period described in subclause (II) will be classified within a new or existing diagnosis-

related group with a weighting factor under paragraph (4)(B) that is derived from cost data collected with respect to discharges occurring during such period.

(iii) For purposes of clause (ii)(II), the term "inpatient hospital code" means any code that is used with respect to inpatient hospital services for which payment may be made under this subsection and includes an alphanumeric code issued under the International Classification of Diseases, 9th Revision, Clinical Modification ("ICD–9–CM") and its subsequent revisions.

(iv) For purposes of clause (ii)(III), the term "additional payment" means, with respect to a discharge for a new medical service or technology described in clause (ii)(I), an amount that exceeds the prospective payment rate otherwise applicable under this subsection to discharges involving such service or technology that would be made but for this subparagraph.

(v) The requirement under clause (ii)(III) for an additional payment may be satisfied by means of a new-technology group (described in subparagraph (L)), an add-on payment, a payment adjustment, or any other similar mechanism for increasing the amount otherwise payable with respect to a discharge under this subsection. The Secretary may not establish a separate fee schedule for such additional payment for such services and technologies, by utilizing a methodology established under subsection (a) or (h) of section 1834 to determine the amount of such additional payment, or by other similar mechanisms or methodologies.

(vi) For purposes of this subparagraph and subparagraph (L), a medical service or technology will be considered a "new medical service or technology" if the service or technology meets criteria established by the Secretary after notice and an opportunity for public comment.

(vii) Under the mechanism under this subparagraph, the Secretary shall provide for the addition of new diagnosis and procedure codes in April 1 of each year, but the addition of such codes shall not require the Secretary to adjust the payment (or diagnosis-related group classification) under this subsection until the fiscal year that begins after such date.

(viii) The mechanism established pursuant to clause (i) shall be adjusted to provide, before publication of a proposed rule, for public input regarding whether a new service or technology represents an advance in medical technology that substantially improves the diagnosis or treatment of individuals entitled to benefits under part A as follows:

(I) The Secretary shall make public and periodically update a list of all the services and technologies for which an application for additional payment under this subparagraph is pending.

(II) The Secretary shall accept comments, recommendations, and data from the public regarding whether the service or technology represents a substantial improvement.

(III) The Secretary shall provide for a meeting at which organizations representing hospitals, physicians, such individuals, manufacturers, and any other interested party may present comments, recommendations, and data to the clinical staff of the Centers for Medicare & Medicaid Services before publica-

tion of a notice of proposed rulemaking regarding whether service or technology represents a substantial improvement.

(ix) Before establishing any add-on payment under this subparagraph with respect to a new technology, the Secretary shall seek to identify one or more diagnosis-related groups associated with such technology, based on similar clinical or anatomical characteristics and the cost of the technology. Within such groups the Secretary shall assign an eligible new technology into a diagnosis-related group where the average costs of care most closely approximate the costs of care of using the new technology. No add-on payment under this subparagraph shall be made with respect to such new technology and this clause shall not affect the application of paragraph (4)(C)(iii).

(L)(i) In establishing the mechanism under subparagraph (K), the Secretary may establish new-technology groups into which a new medical service or technology will be classified if, based on the estimated average costs incurred with respect to discharges involving such service or technology, the DRG prospective payment rate otherwise applicable to such discharges under this subsection is inadequate.

(ii) Such groups—

(I) shall not be based on the costs associated with a specific new medical service or technology; but

(II) shall, in combination with the applicable standardized amounts and the weighting factors assigned to such groups under paragraph (4)(B), reflect such cost cohorts as the Secretary determines are appropriate for all new medical services and technologies that are likely to be provided as inpatient hospital services in a fiscal year.

(iii) The methodology for classifying specific hospital discharges within a diagnosis-related group under paragraph (4)(A) or a new-technology group shall provide that a specific hospital discharge may not be classified within both a diagnosis-related group and a new-technology group.

(6) The Secretary shall provide for publication in the Federal Register, on or before the August 1 before each fiscal year (beginning with fiscal year 1984), of a description of the methodology and data used in computing the adjusted DRG prospective payment rates under this subsection, including any adjustments required under subsection (e)(1)(B).

(7) There shall be no administrative or judicial review under section 1878 or otherwise of—

(A) the determination of the requirement, or the proportional amount, of any adjustment effected pursuant to subsection (e)(1) or the determination of the applicable percentage increase under paragraph (12)(A)(ii),

(B) the establishment of diagnosis-related groups, of the methodology for the classification of discharges within such groups, and of the appropriate weighting factors thereof under paragraph (4), including the selection and revision of codes under paragraph (4)(D), and

(C) the determination of whether services provided prior to a patient's inpatient admission are related to the admission (as described in subsection (a)(4)).

(8)(A) In the case of any hospital which is located in an area which is, at any time after April 20, 1983, reclassified from an urban to a rural area, payments to such hospital for the first two cost reporting periods for which such reclassification is effective shall be made as follows:

(i) For the first such cost reporting period, payment shall be equal to the amount payable to such hospital for such reporting period on the basis of the rural classification, plus an amount equal to two-thirds of the amount (if any) by which—

(I) the amount which would have been payable to such hospital for such reporting period on the basis of an urban classification, exceeds

(II) the amount payable to such hospital for such reporting period on the basis of the rural classification.

(ii) For the second such cost reporting period, payment shall be equal to the amount payable to such hospital for such reporting period on the basis of the rural classification, plus an amount equal to one-third of the amount (if any) by which—

(I) the amount which would have been payable to such hospital for such reporting period on the basis of an urban classification, exceeds

(II) the amount payable to such hospital for such reporting period on the basis of the rural classification.

(B)(i) For purposes of this subsection, the Secretary shall treat a hospital located in a rural county adjacent to one or more urban areas as being located in the urban metropolitan statistical area to which the greatest number of workers in the county commute, if the rural county would otherwise be considered part of an urban area, under the standards for designating Metropolitan Statistical Areas (and for designating New England County Metropolitan Areas) described in clause (ii), if the commuting rates used in determining outlying counties (or, for New England, similar recognized areas) were determined on the basis of the aggregate number of resident workers who commute to (and, if applicable under the standards, from) the central county or counties of all contiguous Metropolitan Statistical Areas (or New England County Metropolitan Areas).

(ii) The standards described in this clause for cost reporting periods beginning in a fiscal year—

(I) before fiscal year 2003, are the standards published in the Federal Register on January 3, 1980, or, at the election of the hospital with respect to fiscal years 2001 and 2002, standards so published on March 30, 1990; and

(II) after fiscal year 2002, are the standards published in the Federal Register by the Director of the Office of Management and Budget based on the most recent available decennial population data.

Subparagraphs (C) and (D) shall not apply with respect to the application of subclause (I).

(C)(i) If the application of subparagraph (B) or a decision of the Medicare Geographic Classification Review Board or the Secretary under paragraph (10), by treating hospitals located in a rural county or counties as being located in an urban area, or by treating hospitals located in one urban area as being located in another urban area—

(I) reduces the wage index for that urban area (as applied under this subsection) by 1 percentage point or less, the Secretary, in calculating such wage index under this subsection, shall exclude those hospitals so treated, or

(II) reduces the wage index for that urban area by more than 1 percentage point (as applied under this subsection), the Secretary shall calculate and apply such wage index under this subsection separately to hospitals located in such urban area (excluding all the hospitals so treated) and to the hospitals so treated (as if such hospitals were located in such urban area).

(ii) If the application of subparagraph (B) or a decision of the Medicare Geographic Classification Review Board or the Secretary under paragraph (10), by treating hospitals located in a rural county or counties as not being located in the rural area in a State, reduces the wage index for that rural area (as applied under this subsection), the Secretary shall calculate and apply such wage index under this subsection as if the hospitals so treated had not been excluded from calculation of the wage index for that rural area.

(iii) The application of subparagraph (B) or a decision of the Medicare Geographic Classification Review Board or the Secretary under paragraph (10) may not result in the reduction of any county's wage index to a level below the wage index for rural areas in the State in which the county is located.

(iv) The application of subparagraph (B) or a decision of the Medicare Geographic Classification Review Board or of the Secretary under paragraph (10) may not result in a reduction in an urban area's wage index if—

(I) the urban area has a wage index below the wage index for rural areas in the State in which it is located; or

(II) the urban area is located in a State that is composed of a single urban area.

(v) This subparagraph shall apply with respect to discharges occurring in a fiscal year only if the Secretary uses a method for making adjustments to the DRG prospective payment rate for area differences in hospital wage levels under paragraph (3)(E) for the fiscal year that is based on the use of Metropolitan Statistical Area classifications.

(D) The Secretary shall make a proportional adjustment in the standardized amounts determined under paragraph (3) to assure that the provisions of subparagraphs (B) and (C) or a decision of the Medicare Geographic Classification Review Board or the Secretary under paragraph (10) do not result in aggregate payments under this section that are greater or less than those that would otherwise be made.

(E)(i) For purposes of this subsection, not later than 60 days after the receipt of an application (in a form and manner determined by the Secretary) from a subsection (d) hospital described in clause (ii), the Secretary shall treat the hospital as being located in the rural area (as defined in paragraph (2)(D)) of the State in which the hospital is located.

(ii) For purposes of clause (i), a subsection (d) hospital described in this clause is a subsection (d) hospital that is located in an urban area (as defined in paragraph (2)(D)) and satisfies any of the following criteria:

(I) The hospital is located in a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725)).

(II) The hospital is located in an area designated by any law or regulation of such State as a rural area (or is designated by such State as a rural hospital).

(III) The hospital would qualify as a rural, regional, or national referral center under paragraph (5)(C) or as a sole community hospital under paragraph (5)(D) if the hospital were located in a rural area.

(IV) The hospital meets such other criteria as the Secretary may specify.

(9)(A) Notwithstanding section 1814(b) but subject to the provisions of section 1813, the amount of the payment with respect to the operating costs of inpatient hospital services of a subsection (d) Puerto Rico hospital for inpatient hospital discharges is equal to the sum of—

(i) the applicable Puerto Rico percentage (specified in subparagraph (E)) of the Puerto Rico adjusted DRG prospective payment rate (determined under subparagraph (B) or (C)) for such discharges,

(ii) the applicable Federal percentage (specified in subparagraph (E)) of—

(I) for discharges beginning in a fiscal year beginning on or after October 1, 1997, and before October 1, 2003, the discharge-weighted average of—

(aa) the national adjusted DRG prospective payment rate (determined under paragraph (3)(D)) for hospitals located in a large urban area,

(bb) such rate for hospitals located in other urban areas, and

(cc) such rate for hospitals located in a rural area, for such discharges, adjusted in the manner provided in paragraph (3)(E) for different area wage levels; and

(II) for discharges in a fiscal year beginning on or after October 1, 2003, the national DRG prospective payment rate determined under paragraph (3)(D)(iii) for hospitals located in any area for such discharges, adjusted in the manner provided in paragraph (3)(E) for different area wage levels.

As used in this section, the term "subsection (d) Puerto Rico hospital" means a hospital that is located in Puerto Rico and that would be a subsection (d) hospital (as defined in paragraph (1)(B)) if it were located in one of the 50 States.

(B) The Secretary shall determine a Puerto Rico adjusted DRG prospective payment rate, for each inpatient hospital discharge in fiscal year 1988 involving inpatient hospital services of a subsection (d) Puerto Rico hospital for which payment may be made under part A of this title. Such rate shall be determined for such hospitals located in urban or rural areas within Puerto Rico, as follows:

(i) The Secretary shall determine the target amount (as defined in subsection (b)(3)(A)) for the hospital for the cost re-

porting period beginning in fiscal year 1987 and increase such amount by prorating the applicable percentage increase (as defined in subsection (b)(3)(B)) to update the amount to the midpoint in fiscal year 1988.

(ii) The Secretary shall standardize the amount determined under clause (i) for each hospital by—

(I) excluding an estimate of indirect medical education costs,

(II) adjusting for variations among hospitals by area in the average hospital wage level,

(III) adjusting for variations in case mix among hospitals, and

(IV) excluding an estimate of the additional payments to certain subsection (d) Puerto Rico hospitals to be made under subparagraph (D)(iii) (relating to disproportionate share payments).

(iii) The Secretary shall compute a discharge weighted average of the standardized amounts determined under clause (ii) for all hospitals located in an urban area and for all hospitals located in a rural area (as such terms are defined in paragraph (2)(D)).

(iv) The Secretary shall reduce the average standardized amount by a proportion equal to the proportion (estimated by the Secretary) of the amount of payments under this paragraph which are additional payments described in subparagraph (D)(i) (relating to outlier payments).

(v) For each discharge classified within a diagnosis-related group for hospitals located in an urban or rural area, respectively, the Secretary shall establish a Puerto Rico DRG prospective payment rate equal to the product of—

(I) the average standardized amount (computed under clause (iii) and reduced under clause (iv)) for hospitals located in an urban or rural area, respectively, and

(II) the weighting factor (determined under paragraph (4)(B)) for that diagnosis-related group.

(vi) The Secretary shall adjust the proportion (as estimated by the Secretary from time to time) of hospitals' costs which are attributable to wages and wage-related costs, of the Puerto Rico DRG prospective payment rate computed under clause (v) for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the Puerto Rican average hospital wage level.

(C) The Secretary shall determine a Puerto Rico adjusted DRG prospective payment rate, for each inpatient hospital discharge after fiscal year 1988 involving inpatient hospital services of a subsection (d) Puerto Rico hospital for which payment may be made under part A of this title. Such rate shall be determined for hospitals located in urban or rural areas within Puerto Rico as follows:

(i)(I) For discharges in a fiscal year after fiscal year 1988 and before fiscal year 2004, the Secretary shall compute an average standardized amount for hospitals located in an urban area and for hospitals located in a rural area equal to the respective average standardized amount computed for the previous fiscal year under subparagraph (B)(iii) or under this clause, in-

creased for fiscal year 1989 by the applicable percentage increase under subsection (b)(3)(B), and adjusted for subsequent fiscal years in accordance with the final determination of the Secretary under subsection (e)(4), and adjusted to reflect the most recent case-mix data available.

(II) For discharges occurring in a fiscal year (beginning with fiscal year 2004), the Secretary shall compute an average standardized amount for hospitals located in any area of Puerto Rico that is equal to the average standardized amount computed under subclause (I) for fiscal year 2003 for hospitals in a large urban area (or, beginning with fiscal year 2005, for all hospitals in the previous fiscal year) increased by the applicable percentage increase under subsection (b)(3)(B) for the fiscal year involved.

(ii) The Secretary shall reduce each of the average standardized amounts (or for fiscal year 2004 and thereafter, the average standardized amount) by a proportion equal to the proportion (estimated by the Secretary) of the amount of payments under this paragraph which are additional payments described in subparagraph (D)(i) (relating to outlier payments).

(iii) For each discharge classified within a diagnosis-related group for hospitals located in an urban or rural area, respectively, the Secretary shall establish a Puerto Rico DRG prospective payment rate equal to the product of—

(I) the average standardized amount (computed under clause (i) and reduced under clause (ii)), and

(II) the weighting factor (determined under paragraph (4)(B)) for that diagnosis-related group.

(iv)(I) The Secretary shall adjust the proportion (as estimated by the Secretary from time to time) of hospitals' costs which are attributable to wages and wage-related costs, of the Puerto Rico DRG prospective payment rate computed under clause (iii) for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the Puerto Rico average hospital wage level. The second and third sentences of paragraph (3)(E)(i) shall apply to subsection (d) Puerto Rico hospitals under this clause in the same manner as they apply to subsection (d) hospitals under such paragraph and, for purposes of this clause, any reference in such paragraph to a subsection (d) hospital is deemed a reference to a subsection (d) Puerto Rico hospital.

(II) For discharges occurring on or after October 1, 2004, the Secretary shall substitute "62 percent" for the proportion described in the first sentence of clause (i), unless the application of this subclause would result in lower payments to a hospital than would otherwise be made.

(D) The following provisions of paragraph (5) shall apply to subsection (d) Puerto Rico hospitals receiving payment under this paragraph in the same manner and to the extent as they apply to subsection (d) hospitals receiving payment under this subsection:

(i) Subparagraph (A) (relating to outlier payments).

(ii) Subparagraph (B) (relating to payments for indirect medical education costs), except that for this purpose the sum of the amount determined under subparagraph (A) of this para-

graph and the amount paid to the hospital under clause (i) of this subparagraph shall be substituted for the sum referred to in paragraph (5)(B)(i)(I).

(iii) Subparagraph (F) (relating to disproportionate share payments), except that for this purpose the sum described in clause (ii) of this subparagraph shall be substituted for the sum referred to in paragraph (5)(F)(ii)(I).

(iv) Subparagraph (H) (relating to exceptions and adjustments).

(E) For purposes of subparagraph (A), for discharges occurring—

(i) on or after October 1, 1987, and before October 1, 1997, the applicable Puerto Rico percentage is 75 percent and the applicable Federal percentage is 25 percent;

(ii) on or after October 1, 1997, and before April 1, 2004, the applicable Puerto Rico percentage is 50 percent and the applicable Federal percentage is 50 percent;

(iii) on or after April 1, 2004, and before October 1, 2004, the applicable Puerto Rico percentage is 37.5 percent and the applicable Federal percentage is 62.5 percent;

(iv) on or after October 1, 2004, and before January 1, 2016, the applicable Puerto Rico percentage is 25 percent and the applicable Federal percentage is 75 percent; and

(v) on or after January 1, 2016, the applicable Puerto Rico percentage is 0 percent and the applicable Federal percentage is 100 percent.

(10)(A) There is hereby established the Medicare Geographic Classification Review Board (hereinafter in this paragraph referred to as the "Board").

(B)(i) The Board shall be composed of 5 members appointed by the Secretary without regard to the provisions of title 5, United States Code, governing appointments in the competitive service. Two of such members shall be representative of subsection (d) hospitals located in a rural area under paragraph (2)(D). At least 1 member shall be knowledgeable in the field of analyzing costs with respect to the provision of inpatient hospital services.

(ii) The Secretary shall make initial appointments to the Board as provided in this paragraph within 180 days after the date of the enactment of this paragraph.

(C)(i) The Board shall consider the application of any subsection (d) hospital requesting that the Secretary change the hospital's geographic classification for purposes of determining for a fiscal year—

(I) the hospital's average standardized amount under paragraph (2)(D), or

(II) the factor used to adjust the DRG prospective payment rate for area differences in hospital wage levels that applies to such hospital under paragraph (3)(E).

(ii) A hospital requesting a change in geographic classification under clause (i) for a fiscal year shall submit its application to the Board not later than the first day of the 13-month period ending on September 30 of the preceding fiscal year.

(iii)(I) The Board shall render a decision on an application submitted under clause (i) not later than 180 days after the deadline referred to in clause (ii).

(II) Appeal of decisions of the Board shall be subject to the provisions of section 557b of title 5, United States Code. The Secretary

shall issue a decision on such an appeal not later than 90 days after the date on which the appeal is filed. The decision of the Secretary shall be final and shall not be subject to judicial review.

(D)(i) The Secretary shall publish guidelines to be utilized by the Board in rendering decisions on applications submitted under this paragraph, and shall include in such guidelines the following:

(I) Guidelines for comparing wages, taking into account (to the extent the Secretary determines appropriate) occupational mix, in the area in which the hospital is classified and the area in which the hospital is applying to be classified.

(II) Guidelines for determining whether the county in which the hospital is located should be treated as being a part of a particular Metropolitan Statistical Area.

(III) Guidelines for considering information provided by an applicant with respect to the effects of the hospital's geographic classification on access to inpatient hospital services by medicare beneficiaries.

(IV) Guidelines for considering the appropriateness of the criteria used to define New England County Metropolitan Areas.

(ii) Notwithstanding clause (i), if the Secretary uses a method for making adjustments to the DRG prospective payment rate for area differences in hospital wage levels under paragraph (3)(E) that is not based on the use of Metropolitan Statistical Area classifications, the Secretary may revise the guidelines published under clause (i) to the extent such guidelines are used to determine the appropriateness of the geographic area in which the hospital is determined to be located for purposes of making such adjustments.

(iii) Under the guidelines published by the Secretary under clause (i), in the case of a hospital which has ever been classified by the Secretary as a rural referral center under paragraph (5)(C), the Board may not reject the application of the hospital under this paragraph on the basis of any comparison between the average hourly wage of the hospital and the average hourly wage of hospitals in the area in which it is located.

(iv) The Secretary shall publish the guidelines described in clause (i) by July 1, 1990.

(v) Any decision of the Board to reclassify a subsection (d) hospital for purposes of the adjustment factor described in subparagraph (C)(i)(II) for fiscal year 2001 or any fiscal year thereafter shall be effective for a period of 3 fiscal years, except that the Secretary shall establish procedures under which a subsection (d) hospital may elect to terminate such reclassification before the end of such period.

(vi) Such guidelines shall provide that, in making decisions on applications for reclassification for the purposes described in clause (v) for fiscal year 2003 and any succeeding fiscal year, the Board shall base any comparison of the average hourly wage for the hospital with the average hourly wage for hospitals in an area on—

(I) an average of the average hourly wage amount for the hospital from the most recently published hospital wage survey data of the Secretary (as of the date on which the hospital applies for reclassification) and such amount from each of the two immediately preceding surveys; and

(II) an average of the average hourly wage amount for hospitals in such area from the most recently published hospital wage survey data of the Secretary (as of the date on which the hospital applies for reclassification) and such amount from each of the two immediately preceding surveys.

(E)(i) The Board shall have full power and authority to make rules and establish procedures, not inconsistent with the provisions of this title or regulations of the Secretary, which are necessary or appropriate to carry out the provisions of this paragraph. In the course of any hearing the Board may administer oaths and affirmations. The provisions of subsections (d) and (e) of section 205 with respect to subpenas shall apply to the Board to the same extent as such provisions apply to the Secretary with respect to title II.

(ii) The Board is authorized to engage such technical assistance and to receive such information as may be required to carry out its functions, and the Secretary shall, in addition, make available to the Board such secretarial, clerical, and other assistance as the Board may require to carry out its functions.

(F)(i) Each member of the Board who is not an officer or employee of the Federal Government shall be compensated at a rate equal to the daily equivalent of the annual rate of basic pay prescribed for grade GS–18 of the General Schedule under section 5332 of title 5, United States Code, for each day (including travel time) during which such member is engaged in the performance of the duties of the Board. Each member of the Board who is an officer or employee of the United States shall serve without compensation in addition to that received for service as an officer or employee of the United States.

(ii) Members of the Board shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Board.

(11) ADDITIONAL PAYMENTS FOR MANAGED CARE ENROLLEES.—

(A) IN GENERAL.—For portions of cost reporting periods occurring on or after January 1, 1998, the Secretary shall provide for an additional payment amount for each applicable discharge of any subsection (d) hospital that has an approved medical residency training program.

(B) APPLICABLE DISCHARGE.—For purposes of this paragraph, the term "applicable discharge" means the discharge of any individual who is enrolled under a risk-sharing contract with an eligible organization under section 1876 and who is entitled to benefits under part A or any individual who is enrolled with a Medicare+Choice organization under part C.

(C) DETERMINATION OF AMOUNT.—The amount of the payment under this paragraph with respect to any applicable discharge shall be equal to the applicable percentage (as defined in subsection (h)(3)(D)(ii)) of the estimated average per discharge amount that would otherwise have been paid under paragraph (5)(B) if the individuals had not been enrolled as described in subparagraph (B).

(D) SPECIAL RULE FOR HOSPITALS UNDER REIMBURSEMENT SYSTEM.—The Secretary shall establish rules for the application of this paragraph to a hospital reimbursed under a reimbursement system authorized under section 1814(b)(3) in the same manner as it would apply to the hospital if it were not reimbursed under such section.

(12) PAYMENT ADJUSTMENT FOR LOW-VOLUME HOSPITALS.—

(A) IN GENERAL.—In addition to any payments calculated under this section for a subsection (d) hospital, for discharges occurring during a fiscal year (beginning with fiscal year 2005), the Secretary shall provide for an additional payment amount to each low-volume hospital (as defined in subparagraph (C)(i)) for discharges occurring during that fiscal year that is equal to the applicable percentage increase (determined under subparagraph (B) or (D) for the hospital involved) in the amount paid to such hospital under this section for such discharges (determined without regard to this paragraph).

(B) APPLICABLE PERCENTAGE INCREASE.—For discharges occurring in fiscal years 2005 through 2010 and for discharges occurring in fiscal year 2018 and subsequent fiscal years, the Secretary shall determine an applicable percentage increase for purposes of subparagraph (A) as follows:

(i) The Secretary shall determine the empirical relationship for subsection (d) hospitals between the standardized cost-per-case for such hospitals and the total number of discharges of such hospitals and the amount of the additional incremental costs (if any) that are associated with such number of discharges.

(ii) The applicable percentage increase shall be determined based upon such relationship in a manner that reflects, based upon the number of such discharges for a subsection (d) hospital, such additional incremental costs.

(iii) In no case shall the applicable percentage increase exceed 25 percent.

(C) DEFINITIONS.—

(i) LOW-VOLUME HOSPITAL.—For purposes of this paragraph, the term "low-volume hospital" means, for a fiscal year, a subsection (d) hospital (as defined in paragraph (1)(B)) that the Secretary determines is located more than 25 road miles (or, with respect to fiscal years 2011 through 2017, 15 road miles) from another subsection (d) hospital and has less than 800 discharges (or, with respect to fiscal years 2011 through 2017, 1,600 discharges of individuals entitled to, or enrolled for, benefits under part A) during the fiscal year or portion of fiscal year.

(ii) DISCHARGE.—For purposes of subparagraph (B) and clause (i), the term "discharge" means an inpatient acute care discharge of an individual regardless of whether the individual is entitled to benefits under part A.

(D) TEMPORARY APPLICABLE PERCENTAGE INCREASE.—For discharges occurring in fiscal years 2011 through 2017, the

Secretary shall determine an applicable percentage increase for purposes of subparagraph (A) using a continuous linear sliding scale ranging from 25 percent for low-volume hospitals with 200 or fewer discharges of individuals entitled to, or enrolled for, benefits under part A in the fiscal year or the portion of fiscal year to 0 percent for low-volume hospitals with greater than 1,600 discharges of such individuals in the fiscal year.

(13)(A) In order to recognize commuting patterns among geographic areas, the Secretary shall establish a process through application or otherwise for an increase of the wage index applied under paragraph (3)(E) for subsection (d) hospitals located in a qualifying county described in subparagraph (B) in the amount computed under subparagraph (D) based on out-migration of hospital employees who reside in that county to any higher wage index area.

(B) The Secretary shall establish criteria for a qualifying county under this subparagraph based on the out-migration referred to in subparagraph (A) and differences in the area wage indices. Under such criteria the Secretary shall, utilizing such data as the Secretary determines to be appropriate, establish—

(i) a threshold percentage, established by the Secretary, of the weighted average of the area wage index or indices for the higher wage index areas involved;

(ii) a threshold (of not less than 10 percent) for minimum out-migration to a higher wage index area or areas; and

(iii) a requirement that the average hourly wage of the hospitals in the qualifying county equals or exceeds the average hourly wage of all the hospitals in the area in which the qualifying county is located.

(C) For purposes of this paragraph, the term "higher wage index area" means, with respect to a county, an area with a wage index that exceeds that of the county.

(D) The increase in the wage index under subparagraph (A) for a qualifying county shall be equal to the percentage of the hospital employees residing in the qualifying county who are employed in any higher wage index area multiplied by the sum of the products, for each higher wage index area of—

(i) the difference between—

(I) the wage index for such higher wage index area, and

(II) the wage index of the qualifying county; and

(ii) the number of hospital employees residing in the qualifying county who are employed in such higher wage index area divided by the total number of hospital employees residing in the qualifying county who are employed in any higher wage index area.

(E) The process under this paragraph may be based upon the process used by the Medicare Geographic Classification Review Board under paragraph (10). As the Secretary determines to be appropriate to carry out such process, the Secretary may require hospitals (including subsection (d) hospitals and other hospitals) and critical access hospitals, as required under section 1866(a)(1)(T), to submit data regarding the location of residence, or the Secretary may use data from other sources.

(F) A wage index increase under this paragraph shall be effective for a period of 3 fiscal years, except that the Secretary shall establish procedures under which a subsection (d) hospital may elect to waive the application of such wage index increase.

(G) A hospital in a county that has a wage index increase under this paragraph for a period and that has not waived the application of such an increase under subparagraph (F) is not eligible for reclassification under paragraph (8) or (10) during that period.

(H) Any increase in a wage index under this paragraph for a county shall not be taken into account for purposes of—

(i) computing the wage index for portions of the wage index area (not including the county) in which the county is located; or

(ii) applying any budget neutrality adjustment with respect to such index under paragraph (8)(D).

(I) The thresholds described in subparagraph (B), data on hospital employees used under this paragraph, and any determination of the Secretary under the process described in subparagraph (E) shall be final and shall not be subject to judicial review.

(e)(1)(A) For cost reporting periods of hospitals beginning in fiscal year 1984 or fiscal year 1985, the Secretary shall provide for such proportional adjustment in the applicable percentage increase (otherwise applicable to the periods under subsection (b)(3)(B)) as may be necessary to assure that—

(i) the aggregate payment amounts otherwise provided under subsection (d)(1)(A)(i)(I) for that fiscal year for operating costs of inpatient hospital services of hospitals (excluding payments made under section 1866(a)(1)(F)),

are not greater or less than—

(ii) the target percentage (as defined in subsection (d)(1)(C)) of the payment amounts which would have been payable for such services for those same hospitals for that fiscal year under this section under the law as in effect before the date of the enactment of the Social Security Amendments of 1983 (excluding payments made under section 1866(a)(1)(F));

except that the adjustment made under this subparagraph shall apply only to subsection (d) hospitals and shall not apply for purposes of making computations under subsection (d)(2)(B)(ii) or subsection (d)(3)(A).

(B) For discharges occurring in fiscal year 1984 or fiscal year 1985, the Secretary shall provide under subsections (d)(2)(F) and (d)(3)(C) for such equal proportional adjustment in each of the average standardized amounts otherwise computed for that fiscal year as may be necessary to assure that—

(i) the aggregate payment amounts otherwise provided under subsection (d)(1)(A)(i)(II) and (d)(5) for that fiscal year for operating costs of inpatient hospital services of hospitals (excluding payments made under section 1866(a)(1)(F)),

are not greater or less than—

(ii) the DRG percentage (as defined in subsection (d)(1)(C)) of the payment amounts which would have been payable for such services for those same hospitals for that fiscal year under this section under the law as in effect before the date of the enactment of the Social Security Amendments of 1983 (excluding payments made under section 1866(a)(1)(F)).

(C) For discharges occurring in fiscal year 1988, the Secretary shall provide for such equal proportional adjustment in each of the average standardized amounts otherwise computed under subsection (d)(3) for that fiscal year as may be necessary to assure that—

(i) the aggregate payment amounts otherwise provided under subsections (d)(1)(A)(iii), (d)(5), and (d)(9) for that fiscal year for operating costs of inpatient hospital services of subsection (d) hospitals and subsection (d) Puerto Rico hospitals,

are not greater or less than—

(ii) the payment amounts that would have been payable for such services for those same hospitals for that fiscal year but for the enactment of the amendments made by section 9304 of the Omnibus Budget Reconciliation Act of 1986.

(4)(A) Taking into consideration the recommendations of the Commission, the Secretary shall recommend for each fiscal year (beginning with fiscal year 1988) an appropriate change factor for inpatient hospital services for discharges in that fiscal year which will take into account amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality. The appropriate change factor may be different for all large urban subsection (d) hospitals, other urban subsection (d) hospitals, urban subsection (d) Puerto Rico hospitals, rural subsection (d) hospitals, and rural subsection (d) Puerto Rico hospitals, and all other hospitals and units not paid under subsection (d), and may vary among such other hospitals and units.

(B) In addition to the recommendation made under subparagraph (A), the Secretary shall, taking into consideration the recommendations of the Commission under paragraph (2)(B), recommend for each fiscal year (beginning with fiscal year 1992) other appropriate changes in each existing reimbursement policy under this title under which payments to an institution are based upon prospectively determined rates.

(5) The Secretary shall cause to have published in the Federal Register, not later than—

(A) the April 1 before each fiscal year (beginning with fiscal year 1986), the Secretary's proposed recommendations under paragraph (4) for that fiscal year for public comment, and

(B) the August 1 before such fiscal year after such consideration of public comment on the proposal as is feasible in the time available, the Secretary's final recommendations under such paragraph for that year.

The Secretary shall include in the publication referred to in subparagraph (A) for a fiscal year the report of the Commission's recommendations submitted under paragraph (3) for that fiscal year. To the extent that the Secretary's recommendations under paragraph (4) differ from the Commission's recommendations for that fiscal year, the Secretary shall include in the publication referred to in subparagraph (A) an explanation of the Secretary's grounds for not following the Commission's recommendations.

(f)(1)(A) The Secretary shall maintain a system for the reporting of costs of hospitals receiving payments computed under subsection (d).

(B)(i) Subject to clause (ii), the Secretary shall place into effect a standardized electronic cost reporting format for hospitals under this title.

(ii) The Secretary may delay or waive the implementation of such format in particular instances where such implementation would result in financial hardship (in particular with respect to hospitals with a small percentage of inpatients entitled to benefits under this title).

(2) If the Secretary determines, based upon information supplied by a quality improvement organization under part B of title XI, that a hospital, in order to circumvent the payment method established under subsection (b) or (d) of this section, has taken an action that results in the admission of individuals entitled to benefits under part A unnecessarily, unnecessary multiple admissions of the same such individuals, or other inappropriate medical or other practices with respect to such individuals, the Secretary may—

(A) deny payment (in whole or in part) under part A with respect to inpatient hospital services provided with respect to such an unnecessary admission (or subsequent admission of the same individual), or

(B) require the hospital to take other corrective action necessary to prevent or correct the inappropriate practice.

(3) The provisions of subsections (c) through (g) of section 1128 shall apply to determinations made under paragraph (2) in the same manner as they apply to exclusions effected under section 1128(b)(13).

(g)(1)(A) Notwithstanding section 1861(v), instead of any amounts that are otherwise payable under this title with respect to the reasonable costs of subsection (d) hospitals and subsection (d) Puerto Rico hospitals for capital-related costs of inpatient hospital services, the Secretary shall, for hospital cost reporting periods beginning on or after October 1, 1991, provide for payments for such costs in accordance with a prospective payment system established by the Secretary. Aggregate payments made under subsection (d) and this subsection during fiscal years 1992 through 1995 shall be reduced in a manner that results in a reduction (as estimated by the Secretary) in the amount of such payments equal to a 10 percent reduction in the amount of payments attributable to capital-related costs that would otherwise have been made during such fiscal year had the amount of such payments been based on reasonable costs (as defined in section 1861(v)). For discharges occurring after September 30, 1993, the Secretary shall reduce by 7.4 percent the unadjusted standard Federal capital payment rate (as described in 42 CFR 412.308(c), as in effect on the date of the enactment of the Omnibus Budget Reconciliation Act of 1993) and shall (for hospital cost reporting periods beginning on or after October 1, 1993) redetermine which payment methodology is applied to the hospital under such system to take into account such reduction. In addition to the reduction described in the preceding sentence, for discharges occurring on or after October 1, 1997, the Secretary shall apply the budget neutrality adjustment factor used to determine the Federal capital payment rate in effect on September 30, 1995 (as described in section 412.352 of title 42 of the Code of Federal Regulations), to (i) the unadjusted standard Federal capital payment rate (as described in section 412.308(c) of that title, as in

effect on September 30, 1997), and (ii) the unadjusted hospital-specific rate (as described in section 412.328(e)(1) of that title, as in effect on September 30, 1997), and, for discharges occurring on or after October 1, 1997, and before October 1, 2002, reduce the rates described in clauses (i) and (ii) by 2.1 percent.

(B) Such system—

(i) shall provide for (I) a payment on a per discharge basis, and (II) an appropriate weighting of such payment amount as relates to the classification of the discharge;

(ii) may provide for an adjustment to take into account variations in the relative costs of capital and construction for the different types of facilities or areas in which they are located;

(iii) may provide for such exceptions (including appropriate exceptions to reflect capital obligations) as the Secretary determines to be appropriate, and

(iv) may provide for suitable adjustment to reflect hospital occupancy rate.

(C) In this paragraph, the term "capital-related costs" has the meaning given such term by the Secretary under subsection (a)(4) as of September 30, 1987, and does not include a return on equity capital.

(2)(A) The Secretary shall provide that the amount which is allowable, with respect to reasonable costs of inpatient hospital services for which payment may be made under this title, for a return on equity capital for hospitals shall, for cost reporting periods beginning on or after the date of the enactment of this subsection, be equal to amounts otherwise allowable under regulations in effect on March 1, 1983, except that the rate of return to be recognized shall be equal to the applicable percentage (described in subparagraph (B)) of the average of the rates of interest, for each of the months any part of which is included in the reporting period, on obligations issued for purchase by the Federal Hospital Insurance Trust Fund.

(B) In this paragraph, the "applicable percentage" is—

(i) 75 percent, for cost reporting periods beginning during fiscal year 1987,

(ii) 50 percent, for cost reporting periods beginning during fiscal year 1988,

(iii) 25 percent, for cost reporting periods beginning during fiscal year 1989, and

(iv) 0 percent, for cost reporting periods beginning on or after October 1, 1989.

(3)(A) Except as provided in subparagraph (B), in determining the amount of the payments that may be made under this title with respect to all the capital-related costs of inpatient hospital services of a subsection (d) hospital and a subsection (d) Puerto Rico hospital, the Secretary shall reduce the amounts of such payments otherwise established under this title by—

(i) 3.5 percent for payments attributable to portions of cost reporting periods occurring during fiscal year 1987,

(ii) 7 percent for payments attributable to portions of cost reporting periods or discharges (as the case may be) occurring during fiscal year 1988 on or after October 1, 1987, and before January 1, 1988,

(iii) 12 percent for payments attributable to portions of cost reporting periods or discharges (as the case may be) in fiscal year 1988, occurring on or after January 1, 1988,

(iv) 15 percent for payments attributable to portions of cost reporting periods or discharges (as the case may be) occurring during fiscal year 1989, and

(v) 15 percent for payments attributable to portions of cost reporting periods or discharges (as the case may be) occurring during the period beginning January 1, 1990, and ending September 30, 1991.

(B) Subparagraph (A) shall not apply to payments with respect to the capital-related costs of any hospital that is a sole community hospital (as defined in subsection (d)(5)(D)(iii)) or a critical access hospital (as defined in section 1861(mm)(1)).

(4) In determining the amount of the payments that are attributable to portions of cost reporting periods occurring during fiscal years 1998 through 2002 and that may be made under this title with respect to capital-related costs of inpatient hospital services of a hospital which is described in clause (i), (ii), or (iv) of subsection (d)(1)(B) or a unit described in the matter after clause (v) of such subsection, the Secretary shall reduce the amounts of such payments otherwise determined under this title by 15 percent.

(h) PAYMENTS FOR DIRECT GRADUATE MEDICAL EDUCATION COSTS.—

(1) SUBSTITUTION OF SPECIAL PAYMENT RULES.—Notwithstanding section 1861(v), instead of any amounts that are otherwise payable under this title with respect to the reasonable costs of hospitals for direct graduate medical education costs, the Secretary shall provide for payments for such costs in accordance with paragraph (3) of this subsection. In providing for such payments, the Secretary shall provide for an allocation of such payments between part A and part B (and the trust funds established under the respective parts) as reasonably reflects the proportion of direct graduate medical education costs of hospitals associated with the provision of services under each respective part.

(2) DETERMINATION OF HOSPITAL-SPECIFIC APPROVED FTE RESIDENT AMOUNTS.—The Secretary shall determine, for each hospital with an approved medical residency training program, an approved FTE resident amount for each cost reporting period beginning on or after July 1, 1985, as follows:

(A) DETERMINING ALLOWABLE AVERAGE COST PER FTE RESIDENT IN A HOSPITAL'S BASE PERIOD.—The Secretary shall determine, for the hospital's cost reporting period that began during fiscal year 1984, the average amount recognized as reasonable under this title for direct graduate medical education costs of the hospital for each full-time-equivalent resident.

(B) UPDATING TO THE FIRST COST REPORTING PERIOD.—

(i) IN GENERAL.—The Secretary shall update each average amount determined under subparagraph (A) by the percentage increase in the consumer price index during the 12-month cost reporting period described in such subparagraph.

(ii) EXCEPTION.—The Secretary shall not perform an update under clause (i) in the case of a hospital if the hospital's reporting period, described in subparagraph (A), began on or after July 1, 1984, and before October 1, 1984.

(C) AMOUNT FOR FIRST COST REPORTING PERIOD.—For the first cost reporting period of the hospital beginning on or after July 1, 1985, the approved FTE resident amount for the hospital is equal to the amount determined under subparagraph (B) increased by 1 percent.

(D) AMOUNT FOR SUBSEQUENT COST REPORTING PERIODS.—

(i) IN GENERAL.—Except as provided in a subsequent clause, for each subsequent cost reporting period, the approved FTE resident amount for the hospital is equal to the approved FTE resident amount determined under this paragraph for the previous cost reporting period updated, through the midpoint of the period, by projecting the estimated percentage change in the consumer price index during the 12-month period ending at that midpoint, with appropriate adjustments to reflect previous under-or over-estimations under this subparagraph in the projected percentage change in the consumer price index.

(ii) FREEZE IN UPDATE FOR FISCAL YEARS 1994 AND 1995.—For cost reporting periods beginning during fiscal year 1994 or fiscal year 1995, the approved FTE resident amount for a hospital shall not be updated under clause (i) for a resident who is not a primary care resident (as defined in paragraph (5)(H)) or a resident enrolled in an approved medical residency training program in obstetrics and gynecology.

(iii) FLOOR FOR LOCALITY ADJUSTED NATIONAL AVERAGE PER RESIDENT AMOUNT.—The approved FTE resident amount for a hospital for the cost reporting period beginning during fiscal year 2001 shall not be less than 70 percent, and for the cost reporting period beginning during fiscal year 2002 shall not be less than 85 percent, of the locality adjusted national average per resident amount computed under subparagraph (E) for the hospital and period.

(iv) ADJUSTMENT IN RATE OF INCREASE FOR HOSPITALS WITH FTE APPROVED AMOUNT ABOVE 140 PERCENT OF LOCALITY ADJUSTED NATIONAL AVERAGE PER RESIDENT AMOUNT.—

(I) FREEZE FOR FISCAL YEARS 2001 AND 2002 AND 2004 THROUGH 2013.—For a cost reporting period beginning during fiscal year 2001 or fiscal year 2002 or during the period beginning with fiscal year 2004 and ending with fiscal year 2013, if the approved FTE resident amount for a hospital for the preceding cost reporting period exceeds 140 percent of the locality adjusted national average per resident amount computed under subparagraph (E) for that hospital and period, subject to

subclause (III), the approved FTE resident amount for the period involved shall be the same as the approved FTE resident amount for the hospital for such preceding cost reporting period.

(II) 2 PERCENT DECREASE IN UPDATE FOR FISCAL YEARS 2003, 2004, AND 2005.—For the cost reporting period beginning during fiscal year 2003, if the approved FTE resident amount for a hospital for the preceding cost reporting period exceeds 140 percent of the locality adjusted national average per resident amount computed under subparagraph (E) for that hospital and preceding period, the approved FTE resident amount for the period involved shall be updated in the manner described in subparagraph (D)(i) except that, subject to subclause (III), the consumer price index applied for a 12-month period shall be reduced (but not below zero) by 2 percentage points.

(III) NO ADJUSTMENT BELOW 140 PERCENT.—In no case shall subclause (I) or (II) reduce an approved FTE resident amount for a hospital for a cost reporting period below 140 percent of the locality adjusted national average per resident amount computed under subparagraph (E) for such hospital and period.

(E) DETERMINATION OF LOCALITY ADJUSTED NATIONAL AVERAGE PER RESIDENT AMOUNT.—The Secretary shall determine a locality adjusted national average per resident amount with respect to a cost reporting period of a hospital beginning during a fiscal year as follows:

(i) DETERMINING HOSPITAL SINGLE PER RESIDENT AMOUNT.—The Secretary shall compute for each hospital operating an approved graduate medical education program a single per resident amount equal to the average (weighted by number of full-time equivalent residents, as determined under paragraph (4)) of the primary care per resident amount and the non-primary care per resident amount computed under paragraph (2) for cost reporting periods ending during fiscal year 1997.

(ii) STANDARDIZING PER RESIDENT AMOUNTS.—The Secretary shall compute a standardized per resident amount for each such hospital by dividing the single per resident amount computed under clause (i) by an average of the 3 geographic index values (weighted by the national average weight for each of the work, practice expense, and malpractice components) as applied under section 1848(e) for 1999 for the fee schedule area in which the hospital is located.

(iii) COMPUTING OF WEIGHTED AVERAGE.—The Secretary shall compute the average of the standardized per resident amounts computed under clause (ii) for such hospitals, with the amount for each hospital weighted by the average number of full-time equiva-

lent residents at such hospital (as determined under paragraph (4)).

(iv) COMPUTING NATIONAL AVERAGE PER RESIDENT AMOUNT.—The Secretary shall compute the national average per resident amount, for a hospital's cost reporting period that begins during fiscal year 2001, equal to the weighted average computed under clause (iii) increased by the estimated percentage increase in the consumer price index for all urban consumers during the period beginning with the month that represents the midpoint of the cost reporting periods described in clause (i) and ending with the midpoint of the hospital's cost reporting period that begins during fiscal year 2001.

(v) ADJUSTING FOR LOCALITY.—The Secretary shall compute the product of—

(I) the national average per resident amount computed under clause (iv) for the hospital, and

(II) the geographic index value average (described and applied under clause (ii)) for the fee schedule area in which the hospital is located.

(vi) COMPUTING LOCALITY ADJUSTED AMOUNT.—The locality adjusted national per resident amount for a hospital for—

(I) the cost reporting period beginning during fiscal year 2001 is the product computed under clause (v); or

(II) each subsequent cost reporting period is equal to the locality adjusted national per resident amount for the hospital for the previous cost reporting period (as determined under this clause) updated, through the midpoint of the period, by projecting the estimated percentage change in the consumer price index for all urban consumers during the 12-month period ending at that midpoint.

(F) TREATMENT OF CERTAIN HOSPITALS.—In the case of a hospital that did not have an approved medical residency training program or was not participating in the program under this title for a cost reporting period beginning during fiscal year 1984, the Secretary shall, for the first such period for which it has such a residency training program and is participating under this title, provide for such approved FTE resident amount as the Secretary determines to be appropriate, based on approved FTE resident amounts for comparable programs.

(3) HOSPITAL PAYMENT AMOUNT PER RESIDENT.—

(A) IN GENERAL.—The payment amount, for a hospital cost reporting period beginning on or after July 1, 1985, is equal to the product of—

(i) the aggregate approved amount (as defined in subparagraph (B)) for that period, and

(ii) the hospital's medicare patient load (as defined in subparagraph (C)) for that period.

(B) AGGREGATE APPROVED AMOUNT.—As used in subparagraph (A), the term "aggregate approved amount"

means, for a hospital cost reporting period, the product of—

(i) the hospital's approved FTE resident amount (determined under paragraph (2)) for that period, and

(ii) the weighted average number of full-time-equivalent residents (as determined under paragraph (4)) in the hospital's approved medical residency training programs in that period.

The Secretary shall reduce the aggregate approved amount to the extent payment is made under subsection (k) for residents included in the hospital's count of full-time equivalent residents.

(C) MEDICARE PATIENT LOAD.—As used in subparagraph (A), the term "medicare patient load" means, with respect to a hospital's cost reporting period, the fraction of the total number of inpatient-bed-days (as established by the Secretary) during the period which are attributable to patients with respect to whom payment may be made under part A.

(D) PAYMENT FOR MANAGED CARE ENROLLEES.—

(i) IN GENERAL.—For portions of cost reporting periods occurring on or after January 1, 1998, the Secretary shall provide for an additional payment amount under this subsection for services furnished to individuals who are enrolled under a risk-sharing contract with an eligible organization under section 1876 and who are entitled to part A or with a Medicare+Choice organization under part C. The amount of such a payment shall equal, subject to clause (iii), the applicable percentage of the product of—

(I) the aggregate approved amount (as defined in subparagraph (B)) for that period; and

(II) the fraction of the total number of inpatient-bed days (as established by the Secretary) during the period which are attributable to such enrolled individuals.

(ii) APPLICABLE PERCENTAGE.—For purposes of clause (i), the applicable percentage is—

(I) 20 percent in 1998,

(II) 40 percent in 1999,

(III) 60 percent in 2000,

(IV) 80 percent in 2001, and

(V) 100 percent in 2002 and subsequent years.

(iii) PROPORTIONAL REDUCTION FOR NURSING AND ALLIED HEALTH EDUCATION.—The Secretary shall estimate a proportional adjustment in payments to all hospitals determined under clauses (i) and (ii) for portions of cost reporting periods beginning in a year (beginning with 2000) such that the proportional adjustment reduces payments in an amount for such year equal to the total additional payment amounts for nursing and allied health education determined under subsection (l) for portions of cost reporting periods occurring in that year.

(iv) SPECIAL RULE FOR HOSPITALS UNDER REIMBURSEMENT SYSTEM.—The Secretary shall establish rules for the application of this subparagraph to a hospital reimbursed under a reimbursement system authorized under section 1814(b)(3) in the same manner as it would apply to the hospital if it were not reimbursed under such section.

(4) DETERMINATION OF FULL-TIME-EQUIVALENT RESIDENTS.—

(A) RULES.—The Secretary shall establish rules consistent with this paragraph for the computation of the number of full-time- equivalent residents in an approved medical residency training program.

(B) ADJUSTMENT FOR PART-YEAR OR PART-TIME RESIDENTS.—Such rules shall take into account individuals who serve as residents for only a portion of a period with a hospital or simultaneously with more than one hospital.

(C) WEIGHTING FACTORS FOR CERTAIN RESIDENTS.—Subject to subparagraph (D), such rules shall provide, in calculating the number of full-time-equivalent residents in an approved residency program—

(i) before July 1, 1986, for each resident the weighting factor is 1.00,

(ii) on or after July 1, 1986, for a resident who is in the resident's initial residency period (as defined in paragraph (5)(F)), the weighting factor is 1.00,

(iii) on or after July 1, 1986, and before July 1, 1987, for a resident who is not in the resident's initial residency period (as defined in paragraph (5)(F)), the weighting factor is .75, and

(iv) on or after July 1, 1987, for a resident who is not in the resident's initial residency period (as defined in paragraph (5)(F)), the weighting factor is .50.

(D) FOREIGN MEDICAL GRADUATES REQUIRED TO PASS FMGEMS EXAMINATION.—

(i) IN GENERAL.—Except as provided in clause (ii), such rules shall provide that, in the case of an individual who is a foreign medical graduate (as defined in paragraph (5)(D)), the individual shall not be counted as a resident on or after July 1, 1986, unless—

(I) the individual has passed the FMGEMS examination (as defined in paragraph (5)(E)), or

(II) the individual has previously received certification from, or has previously passed the examination of, the Educational Commission for Foreign Medical Graduates.

(ii) TRANSITION FOR CURRENT FMGS.—On or after July 1, 1986, but before July 1, 1987, in the case of a foreign medical graduate who—

(I) has served as a resident before July 1, 1986, and is serving as a resident after that date, but

(II) has not passed the FMGEMS examination or a previous examination of the Educational Commission for Foreign Medical Graduates before July 1, 1986,

the individual shall be counted as a resident at a rate equal to one-half of the rate at which the individual would otherwise be counted.

(E) COUNTING TIME SPENT IN OUTPATIENT SETTINGS.—Subject to subparagraphs (J) and (K), such rules shall provide that only time spent in activities relating to patient care shall be counted and that—

(i) effective for cost reporting periods beginning before July 1, 2010, all the time;

(ii) effective for cost reporting periods beginning on or after July 1, 2010, all the time so spent by a resident shall be counted towards the determination of full-time equivalency, without regard to the setting in which the activities are performed, if a hospital incurs the costs of the stipends and fringe benefits of the resident during the time the resident spends in that setting. If more than one hospital incurs these costs, either directly or through a third party, such hospitals shall count a proportional share of the time, as determined by written agreement between the hospitals, that a resident spends training in that setting.

so spent by a resident under an approved medical residency training program shall be counted towards the determination of full-time equivalency, without regard to the setting in which the activities are performed, if the hospital incurs all, or substantially all, of the costs for the training program in that setting.

Any hospital claiming under this subparagraph for time spent in a nonprovider setting shall maintain and make available to the Secretary records regarding the amount of such time and such amount in comparison with amounts of such time in such base year as the Secretary shall specify.

(F) LIMITATION ON NUMBER OF RESIDENTS IN ALLOPATHIC AND OSTEOPATHIC MEDICINE.—

(i) IN GENERAL.—Such rules shall provide that for purposes of a cost reporting period beginning on or after October 1, 1997, subject to paragraphs (7) and (8), the total number of full-time equivalent residents before application of weighting factors (as determined under this paragraph) with respect to a hospital's approved medical residency training program in the fields of allopathic medicine and osteopathic medicine may not exceed the number (or, 130 percent of such number in the case of a hospital located in a rural area) of such full-time equivalent residents for the hospital's most recent cost reporting period ending on or before December 31, 1996.

(ii) COUNTING PRIMARY CARE RESIDENTS ON CERTAIN APPROVED LEAVES OF ABSENCE IN BASE YEAR FTE COUNT.—

(I) IN GENERAL.—In determining the number of such full-time equivalent residents for a hospital's most recent cost reporting period ending on or before December 31, 1996, for purposes of clause (i),

the Secretary shall count an individual to the extent that the individual would have been counted as a primary care resident for such period but for the fact that the individual, as determined by the Secretary, was on maternity or disability leave or a similar approved leave of absence.

(II) LIMITATION TO 3 FTE RESIDENTS FOR ANY HOSPITAL.—The total number of individuals counted under subclause (I) for a hospital may not exceed 3 full-time equivalent residents.

(G) COUNTING INTERNS AND RESIDENTS FOR FY 1998 AND SUBSEQUENT YEARS.—

(i) IN GENERAL.—For cost reporting periods beginning during fiscal years beginning on or after October 1, 1997, subject to the limit described in subparagraph (F), the total number of full-time equivalent residents for determining a hospital's graduate medical education payment shall equal the average of the actual full-time equivalent resident counts for the cost reporting period and the preceding two cost reporting periods.

(ii) ADJUSTMENT FOR SHORT PERIODS.—If any cost reporting period beginning on or after October 1, 1997, is not equal to twelve months, the Secretary shall make appropriate modifications to ensure that the average full-time equivalent resident counts pursuant to clause (i) are based on the equivalent of full twelve-month cost reporting periods.

(iii) TRANSITION RULE FOR 1998.—In the case of a hospital's first cost reporting period beginning on or after October 1, 1997, clause (i) shall be applied by using the average for such period and the preceding cost reporting period.

(H) SPECIAL RULES FOR APPLICATION OF SUBPARAGRAPHS (F) AND (G).—

(i) NEW FACILITIES.—The Secretary shall, consistent with the principles of subparagraphs (F) and (G) and subject to paragraphs (7) and (8), prescribe rules for the application of such subparagraphs in the case of medical residency training programs established on or after January 1, 1995. In promulgating such rules for purposes of subparagraph (F), the Secretary shall give special consideration to facilities that meet the needs of underserved rural areas.

(ii) AGGREGATION.—The Secretary may prescribe rules which allow institutions which are members of the same affiliated group (as defined by the Secretary) to elect to apply the limitation of subparagraph (F) on an aggregate basis.

(iii) DATA COLLECTION.—The Secretary may require any entity that operates a medical residency training program and to which subparagraphs (F) and (G) apply to submit to the Secretary such additional information as the Secretary considers necessary to carry out such subparagraphs.

(iv) NONRURAL HOSPITALS OPERATING TRAINING PROGRAMS IN RURAL AREAS.—In the case of a hospital that is not located in a rural area but establishes separately accredited approved medical residency training programs (or rural tracks) in an rural area or has an accredited training program with an integrated rural track, the Secretary shall adjust the limitation under subparagraph (F) in an appropriate manner insofar as it applies to such programs in such rural areas in order to encourage the training of physicians in rural areas.

(v) SPECIAL PROVIDER AGREEMENT.—If an entity enters into a provider agreement pursuant to section 1866(a) to provide hospital services on the same physical site previously used by Medicare Provider No. 05–0578—

(I) the limitation on the number of total full time equivalent residents under subparagraph (F) and clauses (v) and (vi)(I) of subsection (d)(5)(B) applicable to such provider shall be equal to the limitation applicable under such provisions to Provider No. 05–0578 for its cost reporting period ending on June 30, 2006; and

(II) the provisions of subparagraph (G) and subsection (d)(5)(B)(vi)(II) shall not be applicable to such provider for the first three cost reporting years in which such provider trains residents under any approved medical residency training program.

(vi) REDISTRIBUTION OF RESIDENCY SLOTS AFTER A HOSPITAL CLOSES.—

(I) IN GENERAL.—Subject to the succeeding provisions of this clause, the Secretary shall, by regulation, establish a process under which, in the case where a hospital (other than a hospital described in clause (v)) with an approved medical residency program closes on or after a date that is 2 years before the date of enactment of this clause, the Secretary shall increase the otherwise applicable resident limit under this paragraph for other hospitals in accordance with this clause.

(II) PRIORITY FOR HOSPITALS IN CERTAIN AREAS.—Subject to the succeeding provisions of this clause, in determining for which hospitals the increase in the otherwise applicable resident limit is provided under such process, the Secretary shall distribute the increase to hospitals in the following priority order (with preference given within each category to hospitals that are members of the same affiliated group (as defined by the Secretary under clause (ii)) as the closed hospital):

(aa) First, to hospitals located in the same core-based statistical area as, or a core-based statistical area contiguous to, the hospital that closed.

(bb) Second, to hospitals located in the same State as the hospital that closed.

(cc) Third, to hospitals located in the same region of the country as the hospital that closed.

(dd) Fourth, only if the Secretary is not able to distribute the increase to hospitals described in item (cc), to qualifying hospitals in accordance with the provisions of paragraph (8).

(III) REQUIREMENT HOSPITAL LIKELY TO FILL POSITION WITHIN CERTAIN TIME PERIOD.—The Secretary may only increase the otherwise applicable resident limit of a hospital under such process if the Secretary determines the hospital has demonstrated a likelihood of filling the positions made available under this clause within 3 years.

(IV) LIMITATION.—The aggregate number of increases in the otherwise applicable resident limits for hospitals under this clause shall be equal to the number of resident positions in the approved medical residency programs that closed on or after the date described in subclause (I).

(V) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to the implementation of this clause.

(J) TREATMENT OF CERTAIN NONPROVIDER AND DIDACTIC ACTIVITIES.—Such rules shall provide that all time spent by an intern or resident in an approved medical residency training program in a nonprovider setting that is primarily engaged in furnishing patient care (as defined in paragraph (5)(K)) in non-patient care activities, such as didactic conferences and seminars, but not including research not associated with the treatment or diagnosis of a particular patient, as such time and activities are defined by the Secretary, shall be counted toward the determination of full-time equivalency.

(K) TREATMENT OF CERTAIN OTHER ACTIVITIES.—In determining the hospital's number of full-time equivalent residents for purposes of this subsection, all the time that is spent by an intern or resident in an approved medical residency training program on vacation, sick leave, or other approved leave, as such time is defined by the Secretary, and that does not prolong the total time the resident is participating in the approved program beyond the normal duration of the program shall be counted toward the determination of full-time equivalency.

(5) DEFINITIONS AND SPECIAL RULES.—As used in this subsection:

(A) APPROVED MEDICAL RESIDENCY TRAINING PROGRAM.—The term "approved medical residency training program" means a residency or other postgraduate medical training program participation in which may be counted toward certification in a specialty or subspecialty and includes for-

mal postgraduate training programs in geriatric medicine approved by the Secretary.

(B) CONSUMER PRICE INDEX.—The term "consumer price index" refers to the Consumer Price Index for All Urban Consumers (United States city average), as published by the Secretary of Commerce.

(C) DIRECT GRADUATE MEDICAL EDUCATION COSTS.—The term "direct graduate medical education costs" means direct costs of approved educational activities for approved medical residency training programs.

(D) FOREIGN MEDICAL GRADUATE.—The term "foreign medical graduate" means a resident who is not a graduate of—

(i) a school of medicine accredited by the Liaison Committee on Medical Education of the American Medical Association and the Association of American Medical Colleges (or approved by such Committee as meeting the standards necessary for such accreditation),

(ii) a school of osteopathy accredited by the American Osteopathic Association, or approved by such Association as meeting the standards necessary for such accreditation, or

(iii) a school of dentistry or podiatry which is accredited (or meets the standards for accreditation) by an organization recognized by the Secretary for such purpose.

(E) FMGEMS EXAMINATION.—The term "FMGEMS examination" means parts I and II of the Foreign Medical Graduate Examination in the Medical Sciences or any successor examination recognized by the Secretary for this purpose.

(F) INITIAL RESIDENCY PERIOD.—The term "initial residency period" means the period of board eligibility, except that—

(i) except as provided in clause (ii), in no case shall the initial period of residency exceed an aggregate period of formal training of more than five years for any individual, and

(ii) a period, of not more than two years, during which an individual is in a geriatric residency or fellowship program or a preventive medicine residency or fellowship program which meets such criteria as the Secretary may establish, shall be treated as part of the initial residency period, but shall not be counted against any limitation on the initial residency period.

Subject to subparagraph (G)(v), the initial residency period shall be determined, with respect to a resident, as of the time the resident enters the residency training program.

(G) PERIOD OF BOARD ELIGIBILITY.—

(i) GENERAL RULE.—Subject to clauses (ii), (iii), (iv), and (v), the term "period of board eligibility" means, for a resident, the minimum number of years of formal training necessary to satisfy the requirements for ini-

tial board eligibility in the particular specialty for which the resident is training.

(ii) APPLICATION OF 1985–1986 DIRECTORY.—Except as provided in clause (iii), the period of board eligibility shall be such period specified in the 1985–1986 Directory of Residency Training Programs published by the Accreditation Council on Graduate Medical Education.

(iii) CHANGES IN PERIOD OF BOARD ELIGIBILITY.—On or after July 1, 1989, if the Accreditation Council on Graduate Medical Education, in its Directory of Residency Training Programs—

(I) increases the minimum number of years of formal training necessary to satisfy the requirements for a specialty, above the period specified in its 1985–1986 Directory, the Secretary may increase the period of board eligibility for that specialty, but not to exceed the period of board eligibility specified in that later Directory, or

(II) decreases the minimum number of years of formal training necessary to satisfy the requirements for a specialty, below the period specified in its 1985–1986 Directory, the Secretary may decrease the period of board eligibility for that specialty, but not below the period of board eligibility specified in that later Directory.

(iv) SPECIAL RULE FOR CERTAIN PRIMARY CARE COMBINED RESIDENCY PROGRAMS.—(I) In the case of a resident enrolled in a combined medical residency training program in which all of the individual programs (that are combined) are for training a primary care resident (as defined in subparagraph (H)), the period of board eligibility shall be the minimum number of years of formal training required to satisfy the requirements for initial board eligibility in the longest of the individual programs plus one additional year.

(II) A resident enrolled in a combined medical residency training program that includes an obstetrics and gynecology program shall qualify for the period of board eligibility under subclause (I) if the other programs such resident combines with such obstetrics and gynecology program are for training a primary care resident.

(v) CHILD NEUROLOGY TRAINING PROGRAMS.—In the case of a resident enrolled in a child neurology residency training program, the period of board eligibility and the initial residency period shall be the period of board eligibility for pediatrics plus 2 years.

(H) PRIMARY CARE RESIDENT.—The term "primary care resident" means a resident enrolled in an approved medical residency training program in family medicine, general internal medicine, general pediatrics, preventive medicine, geriatric medicine, or osteopathic general practice.

(I) RESIDENT.—The term "resident" includes an intern or other participant in an approved medical residency training program.

(J) ADJUSTMENTS FOR CERTAIN FAMILY PRACTICE RESIDENCY PROGRAMS.—

(i) IN GENERAL.—In the case of an approved medical residency training program (meeting the requirements of clause (ii)) of a hospital which received funds from the United States, a State, or a political subdivision of a State or an instrumentality of such a State or political subdivision (other than payments under this title or a State plan under title XIX) for the program during the cost reporting period that began during fiscal year 1984, the Secretary shall—

(I) provide for an average amount under paragraph (2)(A) that takes into account the Secretary's estimate of the amount that would have been recognized as reasonable under this title if the hospital had not received such funds, and

(II) reduce the payment amount otherwise provided under this subsection in an amount equal to the proportion of such program funds received during the cost reporting period involved that is allocable to this title.

(ii) ADDITIONAL REQUIREMENTS.—A hospital's approved medical residency program meets the requirements of this clause if—

(I) the program is limited to training for family and community medicine;

(II) the program is the only approved medical residency program of the hospital; and

(III) the average amount determined under paragraph (2)(A) for the hospital (as determined without regard to the increase in such amount described in clause (i)(I)) does not exceed $10,000.

(K) NONPROVIDER SETTING THAT IS PRIMARILY ENGAGED IN FURNISHING PATIENT CARE.—The term "nonprovider setting that is primarily engaged in furnishing patient care" means a nonprovider setting in which the primary activity is the care and treatment of patients, as defined by the Secretary.

(6) INCENTIVE PAYMENT UNDER PLANS FOR VOLUNTARY REDUCTION IN NUMBER OF RESIDENTS.—

(A) IN GENERAL.—In the case of a voluntary residency reduction plan for which an application is approved under subparagraph (B), subject to subparagraph (F), each hospital which is part of the qualifying entity submitting the plan shall be paid an applicable hold harmless percentage (as specified in subparagraph (E)) of the sum of—

(i) the amount (if any) by which—

(I) the amount of payment which would have been made under this subsection if there had been a 5-percent reduction in the number of full-time equivalent residents in the approved medical education training programs of the hospital as of June 30, 1997, exceeds

(II) the amount of payment which is made under this subsection, taking into account the re-

duction in such number effected under the reduction plan; and

(ii) the amount of the reduction in payment under subsection (d)(5)(B) for the hospital that is attributable to the reduction in number of residents effected under the plan below 95 percent of the number of full-time equivalent residents in such programs of the hospital as of June 30, 1997.

The determination of the amounts under clauses (i) and (ii) for any year shall be made on the basis of the provisions of this title in effect on the application deadline date for the first calendar year to which the reduction plan applies.

(B) APPROVAL OF PLAN APPLICATIONS.—The Secretary may not approve the application of an qualifying entity unless—

(i) the application is submitted in a form and manner specified by the Secretary and by not later than November 1, 1999,

(ii) the application provides for the operation of a plan for the reduction in the number of full-time equivalent residents in the approved medical residency training programs of the entity consistent with the requirements of subparagraph (D);

(iii) the entity elects in the application the period of residency training years (not greater than 5) over which the reduction will occur;

(iv) the entity will not reduce the proportion of its residents in primary care (to the total number of residents) below such proportion as in effect as of the applicable time described in subparagraph (D)(v); and

(v) the Secretary determines that the application and the entity and such plan meet such other requirements as the Secretary specifies in regulations.

(C) QUALIFYING ENTITY.—For purposes of this paragraph, any of the following may be a qualifying entity:

(i) Individual hospitals operating one or more approved medical residency training programs.

(ii) Two or more hospitals that operate such programs and apply for treatment under this paragraph as a single qualifying entity.

(iii) A qualifying consortium (as described in section 4628 of the Balanced Budget Act of 1997).

(D) RESIDENCY REDUCTION REQUIREMENTS.—

(i) INDIVIDUAL HOSPITAL APPLICANTS.—In the case of a qualifying entity described in subparagraph (C)(i), the number of full-time equivalent residents in all the approved medical residency training programs operated by or through the entity shall be reduced as follows:

(I) If the base number of residents exceeds 750 residents, by a number equal to at least 20 percent of such base number.

(II) Subject to subclause (IV), if the base number of residents exceeds 600 but is less than 750 residents, by 150 residents.

(III) Subject to subclause (IV), if the base number of residents does not exceed 600 residents, by a number equal to at least 25 percent of such base number.

(IV) In the case of a qualifying entity which is described in clause (v) and which elects treatment under this subclause, by a number equal to at least 20 percent of the base number.

(ii) JOINT APPLICANTS.—In the case of a qualifying entity described in subparagraph (C)(ii), the number of full-time equivalent residents in the aggregate for all the approved medical residency training programs operated by or through the entity shall be reduced as follows:

(I) Subject to subclause (II), by a number equal to at least 25 percent of the base number.

(II) In the case of such a qualifying entity which is described in clause (v) and which elects treatment under this subclause, by a number equal to at least 20 percent of the base number.

(iii) CONSORTIA.—In the case of a qualifying entity described in subparagraph (C)(iii), the number of full-time equivalent residents in the aggregate for all the approved medical residency training programs operated by or through the entity shall be reduced by a number equal to at least 20 percent of the base number.

(iv) MANNER OF REDUCTION.—The reductions specified under the preceding provisions of this subparagraph for a qualifying entity shall be below the base number of residents for that entity and shall be fully effective not later than the 5th residency training year in which the application under subparagraph (B) is effective.

(v) ENTITIES PROVIDING ASSURANCE OF INCREASE IN PRIMARY CARE RESIDENTS.—An entity is described in this clause if—

(I) the base number of residents for the entity is less than 750 or the entity is described in subparagraph (C)(ii); and

(II) the entity represents in its application under subparagraph (B) that it will increase the number of full-time equivalent residents in primary care by at least 20 percent (from such number included in the base number of residents) by not later than the 5th residency training year in which the application under subparagraph (B) is effective.

If a qualifying entity fails to comply with the representation described in subclause (II) by the end of such 5th residency training year, the entity shall be subject to repayment of all amounts paid under this paragraph, in accordance with procedures established to carry out subparagraph (F).

(vi) BASE NUMBER OF RESIDENTS DEFINED.—For purposes of this paragraph, the term "base number of residents" means, with respect to a qualifying entity (or its participating hospitals) operating approved medical residency training programs, the number of full-time equivalent residents in such programs (before application of weighting factors) of the entity as of the most recent residency training year ending before June 30, 1997, or, if less, for any subsequent residency training year that ends before the date the entity makes application under this paragraph.

(E) APPLICABLE HOLD HARMLESS PERCENTAGE.—For purposes of subparagraph (A), the "applicable hold harmless percentage" for the—

(i) first and second residency training years in which the reduction plan is in effect, 100 percent,

(ii) third such year, 75 percent,

(iii) fourth such year, 50 percent, and

(iv) fifth such year, 25 percent.

(F) PENALTY FOR NONCOMPLIANCE.—

(i) IN GENERAL.—No payment may be made under this paragraph to a hospital for a residency training year if the hospital has failed to reduce the number of full-time equivalent residents (in the manner required under subparagraph (D)) to the number agreed to by the Secretary and the qualifying entity in approving the application under this paragraph with respect to such year.

(ii) INCREASE IN NUMBER OF RESIDENTS IN SUBSEQUENT YEARS.—If payments are made under this paragraph to a hospital, and if the hospital increases the number of full-time equivalent residents above the number of such residents permitted under the reduction plan as of the completion of the plan, then, as specified by the Secretary, the entity is liable for repayment to the Secretary of the total amounts paid under this paragraph to the entity.

(G) TREATMENT OF ROTATING RESIDENTS.—In applying this paragraph, the Secretary shall establish rules regarding the counting of residents who are assigned to institutions the medical residency training programs in which are not covered under approved applications under this paragraph.

(7) REDISTRIBUTION OF UNUSED RESIDENT POSITIONS.—

(A) REDUCTION IN LIMIT BASED ON UNUSED POSITIONS.—

(i) PROGRAMS SUBJECT TO REDUCTION.—

(I) IN GENERAL.—Except as provided in subclause (II), if a hospital's reference resident level (specified in clause (ii)) is less than the otherwise applicable resident limit (as defined in subparagraph (C)(ii)), effective for portions of cost reporting periods occurring on or after July 1, 2005, the otherwise applicable resident limit shall be reduced by 75 percent of the difference between

such otherwise applicable resident limit and such reference resident level.

(II) EXCEPTION FOR SMALL RURAL HOSPITALS.—This subparagraph shall not apply to a hospital located in a rural area (as defined in subsection (d)(2)(D)(ii)) with fewer than 250 acute care inpatient beds.

(ii) REFERENCE RESIDENT LEVEL.—

(I) IN GENERAL.—Except as otherwise provided in subclauses (II) and (III), the reference resident level specified in this clause for a hospital is the resident level for the most recent cost reporting period of the hospital ending on or before September 30, 2002, for which a cost report has been settled (or, if not, submitted (subject to audit)), as determined by the Secretary.

(II) USE OF MOST RECENT ACCOUNTING PERIOD TO RECOGNIZE EXPANSION OF EXISTING PROGRAMS.—If a hospital submits a timely request to increase its resident level due to an expansion of an existing residency training program that is not reflected on the most recent settled cost report, after audit and subject to the discretion of the Secretary, the reference resident level for such hospital is the resident level for the cost reporting period that includes July 1, 2003, as determined by the Secretary.

(III) EXPANSIONS UNDER NEWLY APPROVED PROGRAMS.—Upon the timely request of a hospital, the Secretary shall adjust the reference resident level specified under subclause (I) or (II) to include the number of medical residents that were approved in an application for a medical residency training program that was approved by an appropriate accrediting organization (as determined by the Secretary) before January 1, 2002, but which was not in operation during the cost reporting period used under subclause (I) or (II), as the case may be, as determined by the Secretary.

(iii) AFFILIATION.—The provisions of clause (i) shall be applied to hospitals which are members of the same affiliated group (as defined by the Secretary under paragraph (4)(H)(ii)) as of July 1, 2003.

(B) REDISTRIBUTION.—

(i) IN GENERAL.—The Secretary is authorized to increase the otherwise applicable resident limit for each qualifying hospital that submits a timely application under this subparagraph by such number as the Secretary may approve for portions of cost reporting periods occurring on or after July 1, 2005. The aggregate number of increases in the otherwise applicable resident limits under this subparagraph may not exceed the Secretary's estimate of the aggregate reduction in such limits attributable to subparagraph (A).

(ii) CONSIDERATIONS IN REDISTRIBUTION.—In determining for which hospitals the increase in the otherwise applicable resident limit is provided under clause (i), the Secretary shall take into account the demonstrated likelihood of the hospital filling the positions within the first 3 cost reporting periods beginning on or after July 1, 2005, made available under this subparagraph, as determined by the Secretary.

(iii) PRIORITY FOR RURAL AND SMALL URBAN AREAS.—In determining for which hospitals and residency training programs an increase in the otherwise applicable resident limit is provided under clause (i), the Secretary shall distribute the increase to programs of hospitals located in the following priority order:

(I) First, to hospitals located in rural areas (as defined in subsection (d)(2)(D)(ii)).

(II) Second, to hospitals located in urban areas that are not large urban areas (as defined for purposes of subsection (d)).

(III) Third, to other hospitals in a State if the residency training program involved is in a specialty for which there are not other residency training programs in the State.

Increases of residency limits within the same priority category under this clause shall be determined by the Secretary.

(iv) LIMITATION.—In no case shall more than 25 full-time equivalent additional residency positions be made available under this subparagraph with respect to any hospital.

(v) APPLICATION OF LOCALITY ADJUSTED NATIONAL AVERAGE PER RESIDENT AMOUNT.—With respect to additional residency positions in a hospital attributable to the increase provided under this subparagraph, notwithstanding any other provision of this subsection, the approved FTE resident amount is deemed to be equal to the locality adjusted national average per resident amount computed under paragraph (4)(E) for that hospital.

(vi) CONSTRUCTION.—Nothing in this subparagraph shall be construed as permitting the redistribution of reductions in residency positions attributable to voluntary reduction programs under paragraph (6), under a demonstration project approved as of October 31, 2003, under the authority of section 402 of Public Law 90–248, or as affecting the ability of a hospital to establish new medical residency training programs under paragraph (4)(H).

(C) RESIDENT LEVEL AND LIMIT DEFINED.—In this paragraph:

(i) RESIDENT LEVEL.—The term "resident level" means, with respect to a hospital, the total number of full-time equivalent residents, before the application of weighting factors (as determined under paragraph (4)),

in the fields of allopathic and osteopathic medicine for the hospital.

(ii) OTHERWISE APPLICABLE RESIDENT LIMIT.—The term "otherwise applicable resident limit" means, with respect to a hospital, the limit otherwise applicable under subparagraphs (F)(i) and (H) of paragraph (4) on the resident level for the hospital determined without regard to this paragraph.

(D) ADJUSTMENT BASED ON SETTLED COST REPORT.—In the case of a hospital with a dual accredited osteopathic and allopathic family practice program for which—

(i) the otherwise applicable resident limit was reduced under subparagraph (A)(i)(I); and

(ii) such reduction was based on a reference resident level that was determined using a cost report and where a revised or corrected notice of program reimbursement was issued for such cost report between September 1, 2006 and September 15, 2006, whether as a result of an appeal or otherwise, and the reference resident level under such settled cost report is higher than the level used for the reduction under subparagraph (A)(i)(I);

the Secretary shall apply subparagraph (A)(i)(I) using the higher resident reference level and make any necessary adjustments to such reduction. Any such necessary adjustments shall be effective for portions of cost reporting periods occurring on or after July 1, 2005.

(E) JUDICIAL REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise, with respect to determinations made under this this paragraph, paragraph (8), or paragraph (4)(H)(vi).

(8) DISTRIBUTION OF ADDITIONAL RESIDENCY POSITIONS.—

(A) REDUCTIONS IN LIMIT BASED ON UNUSED POSITIONS.—

(i) IN GENERAL.—Except as provided in clause (ii), if a hospital's reference resident level (as defined in subparagraph (H)(i)) is less than the otherwise applicable resident limit (as defined in subparagraph (H)(iii)), effective for portions of cost reporting periods occurring on or after July 1, 2011, the otherwise applicable resident limit shall be reduced by 65 percent of the difference between such otherwise applicable resident limit and such reference resident level.

(ii) EXCEPTIONS.—This subparagraph shall not apply to—

(I) a hospital located in a rural area (as defined in subsection (d)(2)(D)(ii)) with fewer than 250 acute care inpatient beds;

(II) a hospital that was part of a qualifying entity which had a voluntary residency reduction plan approved under paragraph (6)(B) or under the authority of section 402 of Public Law 90–248, if the hospital demonstrates to the Secretary that it has a specified plan in place for filling the unused positions by not later than 2 years after the date of enactment of this paragraph; or

(III) a hospital described in paragraph (4)(H)(v).

(B) DISTRIBUTION.—

(i) IN GENERAL.—The Secretary shall increase the otherwise applicable resident limit for each qualifying hospital that submits an application under this subparagraph by such number as the Secretary may approve for portions of cost reporting periods occurring on or after July 1, 2011. The aggregate number of increases in the otherwise applicable resident limit under this subparagraph shall be equal to the aggregate reduction in such limits attributable to subparagraph (A) (as estimated by the Secretary).

(ii) REQUIREMENTS.—Subject to clause (iii), a hospital that receives an increase in the otherwise applicable resident limit under this subparagraph shall ensure, during the 5-year period beginning on the date of such increase, that—

(I) the number of full-time equivalent primary care residents, as defined in paragraph (5)(H) (as determined by the Secretary), excluding any additional positions under subclause (II), is not less than the average number of full-time equivalent primary care residents (as so determined) during the 3 most recent cost reporting periods ending prior to the date of enactment of this paragraph; and

(II) not less than 75 percent of the positions attributable to such increase are in a primary care or general surgery residency (as determined by the Secretary).

The Secretary may determine whether a hospital has met the requirements under this clause during such 5-year period in such manner and at such time as the Secretary determines appropriate, including at the end of such 5-year period.

(iii) REDISTRIBUTION OF POSITIONS IF HOSPITAL NO LONGER MEETS CERTAIN REQUIREMENTS.—In the case where the Secretary determines that a hospital described in clause (ii) does not meet either of the requirements under subclause (I) or (II) of such clause, the Secretary shall—

(I) reduce the otherwise applicable resident limit of the hospital by the amount by which such limit was increased under this paragraph; and

(II) provide for the distribution of positions attributable to such reduction in accordance with the requirements of this paragraph.

(C) CONSIDERATIONS IN REDISTRIBUTION.—In determining for which hospitals the increase in the otherwise applicable resident limit is provided under subparagraph (B), the Secretary shall take into account—

(i) the demonstration likelihood of the hospital filling the positions made available under this paragraph within the first 3 cost reporting periods beginning on

or after July 1, 2011, as determined by the Secretary; and

(ii) whether the hospital has an accredited rural training track (as described in paragraph (4)(H)(iv)).

(D) PRIORITY FOR CERTAIN AREAS.—In determining for which hospitals the increase in the otherwise applicable resident limit is provided under subparagraph (B), subject to subparagraph (E), the Secretary shall distribute the increase to hospitals based on the following factors:

(i) Whether the hospital is located in a State with a resident-to-population ratio in the lowest quartile (as determined by the Secretary).

(ii) Whether the hospital is located in a State, a territory of the United States, or the District of Columbia that is among the top 10 States, territories, or Districts in terms of the ratio of—

(I) the total population of the State, territory, or District living in an area designated (under such section 332(a)(1)(A)) as a health professional shortage area (as of the date of enactment of this paragraph); to

(II) the total population of the State, territory, or District (as determined by the Secretary based on the most recent available population data published by the Bureau of the Census).

(iii) Whether the hospital is located in a rural area (as defined in subsection (d)(2)(D)(ii)).

(E) RESERVATION OF POSITIONS FOR CERTAIN HOSPITALS.—

(i) IN GENERAL.—Subject to clause (ii), the Secretary shall reserve the positions available for distribution under this paragraph as follows:

(I) 70 percent of such positions for distribution to hospitals described in clause (i) of subparagraph (D).

(II) 30 percent of such positions for distribution to hospitals described in clause (ii) and (iii) of such subparagraph.

(ii) EXCEPTION IF POSITIONS NOT REDISTRIBUTED BY JULY 1, 2011.—In the case where the Secretary does not distribute positions to hospitals in accordance with clause (i) by July 1, 2011, the Secretary shall distribute such positions to other hospitals in accordance with the considerations described in subparagraph (C) and the priority described in subparagraph (D).

(F) LIMITATION.—A hospital may not receive more than 75 full-time equivalent additional residency positions under this paragraph.

(G) APPLICATION OF PER RESIDENT AMOUNTS FOR PRIMARY CARE AND NONPRIMARY CARE.—With respect to additional residency positions in a hospital attributable to the increase provided under this paragraph, the approved FTE per resident amounts are deemed to be equal to the hospital per resident amounts for primary care and nonpri-

mary care computed under paragraph (2)(D) for that hospital.

(H) DEFINITIONS.—In this paragraph:

(i) REFERENCE RESIDENT LEVEL.—The term "reference resident level" means, with respect to a hospital, the highest resident level for any of the 3 most recent cost reporting periods (ending before the date of the enactment of this paragraph) of the hospital for which a cost report has been settled (or, if not, submitted (subject to audit)), as determined by the Secretary.

(ii) RESIDENT LEVEL.—The term "resident level" has the meaning given such term in paragraph (7)(C)(i).

(iii) OTHERWISE APPLICABLE RESIDENT LIMIT.—The term "otherwise applicable resident limit" means, with respect to a hospital, the limit otherwise applicable under subparagraphs (F)(i) and (H) of paragraph (4) on the resident level for the hospital determined without regard to this paragraph but taking into account paragraph (7)(A).

(I) AFFILIATION.—The provisions of this paragraph shall be applied to hospitals which are members of the same affiliated group (as defined by the Secretary under paragraph (4)(H)(ii)) and the reference resident level for each such hospital shall be the reference resident level with respect to the cost reporting period that results in the smallest difference between the reference resident level and the otherwise applicable resident limit.

(i) AVOIDING DUPLICATIVE PAYMENTS TO HOSPITALS PARTICIPATING IN RURAL DEMONSTRATION PROGRAMS.—The Secretary shall reduce any payment amounts otherwise determined under this section to the extent necessary to avoid duplication of any payment made under section 4005(e) of the Omnibus Budget Reconciliation Act of 1987.

(j) PROSPECTIVE PAYMENT FOR INPATIENT REHABILITATION SERVICES.—

(1) PAYMENT DURING TRANSITION PERIOD.—

(A) IN GENERAL.—Notwithstanding section 1814(b), but subject to the provisions of section 1813, the amount of the payment with respect to the operating and capital costs of inpatient hospital services of a rehabilitation hospital or a rehabilitation unit (in this subsection referred to as a "rehabilitation facility"), other than a facility making an election under subparagraph (F) in a cost reporting period beginning on or after October 1, 2000, and before October 1, 2002, is equal to the sum of—

(i) the TEFRA percentage (as defined in subparagraph (C)) of the amount that would have been paid under part A with respect to such costs if this subsection did not apply, and

(ii) the prospective payment percentage (as defined in subparagraph (C)) of the product of (I) the per unit payment rate established under this subsection for the fiscal year in which the payment unit of service oc-

curs, and (II) the number of such payment units occurring in the cost reporting period.

(B) FULLY IMPLEMENTED SYSTEM.—Notwithstanding section 1814(b), but subject to the provisions of section 1813, the amount of the payment with respect to the operating and capital costs of inpatient hospital services of a rehabilitation facility for a payment unit in a cost reporting period beginning on or after October 1, 2002, or, in the case of a facility making an election under subparagraph (F), for any cost reporting period described in such subparagraph, is equal to the per unit payment rate established under this subsection for the fiscal year in which the payment unit of service occurs.

(C) TEFRA AND PROSPECTIVE PAYMENT PERCENTAGES SPECIFIED.—For purposes of subparagraph (A), for a cost reporting period beginning—

(i) on or after October 1, 2000, and before October 1, 2001, the "TEFRA percentage" is 66⅔ percent and the "prospective payment percentage" is 33⅓ percent; and

(ii) on or after October 1, 2001, and before October 1, 2002, the "TEFRA percentage" is 33⅓ percent and the "prospective payment percentage" is 66⅔ percent.

(D) PAYMENT UNIT.—For purposes of this subsection, the term "payment unit" means a discharge.

(E) CONSTRUCTION RELATING TO TRANSFER AUTHORITY.—Nothing in this subsection shall be construed as preventing the Secretary from providing for an adjustment to payments to take into account the early transfer of a patient from a rehabilitation facility to another site of care.

(F) ELECTION TO APPLY FULL PROSPECTIVE PAYMENT SYSTEM.—A rehabilitation facility may elect, not later than 30 days before its first cost reporting period for which the payment methodology under this subsection applies to the facility, to have payment made to the facility under this subsection under the provisions of subparagraph (B) (rather than subparagraph (A)) for each cost reporting period to which such payment methodology applies.

(2) PATIENT CASE MIX GROUPS.—

(A) ESTABLISHMENT.—The Secretary shall establish—

(i) classes of patient discharges of rehabilitation facilities by functional-related groups (each in this subsection referred to as a "case mix group"), based on impairment, age, comorbidities, and functional capability of the patient and such other factors as the Secretary deems appropriate to improve the explanatory power of functional independence measure-function related groups; and

(ii) a method of classifying specific patients in rehabilitation facilities within these groups.

(B) WEIGHTING FACTORS.—For each case mix group the Secretary shall assign an appropriate weighting which reflects the relative facility resources used with respect to patients classified within that group compared to patients classified within other groups.

(C) ADJUSTMENTS FOR CASE MIX.—

(i) IN GENERAL.—The Secretary shall from time to time adjust the classifications and weighting factors established under this paragraph as appropriate to reflect changes in treatment patterns, technology, case mix, number of payment units for which payment is made under this title, and other factors which may affect the relative use of resources. Such adjustments shall be made in a manner so that changes in aggregate payments under the classification system are a result of real changes and are not a result of changes in coding that are unrelated to real changes in case mix.

(ii) ADJUSTMENT.—Insofar as the Secretary determines that such adjustments for a previous fiscal year (or estimates that such adjustments for a future fiscal year) did (or are likely to) result in a change in aggregate payments under the classification system during the fiscal year that are a result of changes in the coding or classification of patients that do not reflect real changes in case mix, the Secretary shall adjust the per payment unit payment rate for subsequent years so as to eliminate the effect of such coding or classification changes.

(D) DATA COLLECTION.—The Secretary is authorized to require rehabilitation facilities that provide inpatient hospital services to submit such data as the Secretary deems necessary to establish and administer the prospective payment system under this subsection.

(3) PAYMENT RATE.—

(A) IN GENERAL.—The Secretary shall determine a prospective payment rate for each payment unit for which such rehabilitation facility is entitled to receive payment under this title. Subject to subparagraph (B), such rate for payment units occurring during a fiscal year shall be based on the average payment per payment unit under this title for inpatient operating and capital costs of rehabilitation facilities using the most recent data available (as estimated by the Secretary as of the date of establishment of the system) adjusted—

(i) by updating such per-payment-unit amount to the fiscal year involved by the weighted average of the applicable percentage increases provided under subsection (b)(3)(B)(ii) (for cost reporting periods beginning during the fiscal year) covering the period from the midpoint of the period for such data through the midpoint of fiscal year 2000 and by an increase factor (described in subparagraph (C)) specified by the Secretary for subsequent fiscal years up to the fiscal year involved;

(ii) by reducing such rates by a factor equal to the proportion of payments under this subsection (as estimated by the Secretary) based on prospective payment amounts which are additional payments described in

paragraph (4) (relating to outlier and related payments);

(iii) for variations among rehabilitation facilities by area under paragraph (6);

(iv) by the weighting factors established under paragraph (2)(B); and

(v) by such other factors as the Secretary determines are necessary to properly reflect variations in necessary costs of treatment among rehabilitation facilities.

(B) BUDGET NEUTRAL RATES.—The Secretary shall establish the prospective payment amounts under this subsection for payment units during fiscal years 2001 and 2002 at levels such that, in the Secretary's estimation, the amount of total payments under this subsection for such fiscal years (including any payment adjustments pursuant to paragraphs (4) and (6) but not taking into account any payment adjustment resulting from an election permitted under paragraph (1)(F)) shall be equal to 98 percent for fiscal year 2001 and 100 percent for fiscal year 2002 of the amount of payments that would have been made under this title during the fiscal years for operating and capital costs of rehabilitation facilities had this subsection not been enacted. In establishing such payment amounts, the Secretary shall consider the effects of the prospective payment system established under this subsection on the total number of payment units from rehabilitation facilities and other factors described in subparagraph (A).

(C) INCREASE FACTOR.—

(i) IN GENERAL.—For purposes of this subsection for payment units in each fiscal year (beginning with fiscal year 2001), the Secretary shall establish an increase factor subject to clauses (ii) and (iii). Such factor shall be based on an appropriate percentage increase in a market basket of goods and services comprising services for which payment is made under this subsection, which may be the market basket percentage increase described in subsection (b)(3)(B)(iii). The increase factor to be applied under this subparagraph for each of fiscal years 2008 and 2009 shall be 0 percent.

(ii) PRODUCTIVITY AND OTHER ADJUSTMENT.—Subject to clause (iii), after establishing the increase factor described in clause (i) for a fiscal year, the Secretary shall reduce such increase factor—

(I) for fiscal year 2012 and each subsequent fiscal year, by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II); and

(II) for each of fiscal years 2010 through 2019, by the other adjustment described in subparagraph (D).

The application of this clause may result in the increase factor under this subparagraph being less than 0.0 for a fiscal year, and may result in payment rates

under this subsection for a fiscal year being less than such payment rates for the preceding fiscal year.

(iii) SPECIAL RULE FOR FISCAL YEAR 2018.—The increase factor to be applied under this subparagraph for fiscal year 2018, after the application of clause (ii), shall be 1 percent.

(D) OTHER ADJUSTMENT.—For purposes of subparagraph (C)(ii)(II), the other adjustment described in this subparagraph is—

(i) for each of fiscal years 2010 and 2011, 0.25 percentage point;

(ii) for each of fiscal years 2012 and 2013, 0.1 percentage point;

(iii) for fiscal year 2014, 0.3 percentage point;

(iv) for each of fiscal years 2015 and 2016, 0.2 percentage point; and

(v) for each of fiscal years 2017, 2018, and 2019, 0.75 percentage point.

(4) OUTLIER AND SPECIAL PAYMENTS.—

(A) OUTLIERS.—

(i) IN GENERAL.—The Secretary may provide for an additional payment to a rehabilitation facility for patients in a case mix group, based upon the patient being classified as an outlier based on an unusual length of stay, costs, or other factors specified by the Secretary.

(ii) PAYMENT BASED ON MARGINAL COST OF CARE.—The amount of such additional payment under clause (i) shall be determined by the Secretary and shall approximate the marginal cost of care beyond the cutoff point applicable under clause (i).

(iii) TOTAL PAYMENTS.—The total amount of the additional payments made under this subparagraph for payment units in a fiscal year may not exceed 5 percent of the total payments projected or estimated to be made based on prospective payment rates for payment units in that year.

(B) ADJUSTMENT.—The Secretary may provide for such adjustments to the payment amounts under this subsection as the Secretary deems appropriate to take into account the unique circumstances of rehabilitation facilities located in Alaska and Hawaii.

(5) PUBLICATION.—The Secretary shall provide for publication in the Federal Register, on or before August 1 before each fiscal year (beginning with fiscal year 2001), of the classification and weighting factors for case mix groups under paragraph (2) for such fiscal year and a description of the methodology and data used in computing the prospective payment rates under this subsection for that fiscal year.

(6) AREA WAGE ADJUSTMENT.—The Secretary shall adjust the proportion (as estimated by the Secretary from time to time) of rehabilitation facilities' costs which are attributable to wages and wage-related costs, of the prospective payment rates computed under paragraph (3) for area differences in wage levels by a factor (established by the Secretary) reflecting the rel-

ative hospital wage level in the geographic area of the rehabilitation facility compared to the national average wage level for such facilities. Not later than October 1, 2001 (and at least every 36 months thereafter), the Secretary shall update the factor under the preceding sentence on the basis of information available to the Secretary (and updated as appropriate) of the wages and wage-related costs incurred in furnishing rehabilitation services. Any adjustments or updates made under this paragraph for a fiscal year shall be made in a manner that assures that the aggregated payments under this subsection in the fiscal year are not greater or less than those that would have been made in the year without such adjustment.

(7) QUALITY REPORTING.—

(A) REDUCTION IN UPDATE FOR FAILURE TO REPORT.—

(i) IN GENERAL.—For purposes of fiscal year 2014 and each subsequent fiscal year, in the case of a rehabilitation facility that does not submit data to the Secretary in accordance with subparagraphs (C) and (F) with respect to such a fiscal year, after determining the increase factor described in paragraph (3)(C), and after application of subparagraphs (C)(iii) and (D) of paragraph (3), the Secretary shall reduce such increase factor for payments for discharges occurring during such fiscal year by 2 percentage points.

(ii) SPECIAL RULE.—The application of this subparagraph may result in the increase factor described in paragraph (3)(C) being less than 0.0 for a fiscal year, and may result in payment rates under this subsection for a fiscal year being less than such payment rates for the preceding fiscal year.

(B) NONCUMULATIVE APPLICATION.—Any reduction under subparagraph (A) shall apply only with respect to the fiscal year involved and the Secretary shall not take into account such reduction in computing the payment amount under this subsection for a subsequent fiscal year.

(C) SUBMISSION OF QUALITY DATA.—Subject to subparagraph (G), for fiscal year 2014 and each subsequent fiscal year, each rehabilitation facility shall submit to the Secretary data on quality measures specified under subparagraph (D). Such data shall be submitted in a form and manner, and at a time, specified by the Secretary for purposes of this subparagraph.

(D) QUALITY MEASURES.—

(i) IN GENERAL.—Subject to clause (ii), any measure specified by the Secretary under this subparagraph must have been endorsed by the entity with a contract under section 1890(a).

(ii) EXCEPTION.—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), the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted

by a consensus organization identified by the Secretary.

(iii) TIME FRAME.—Not later than October 1, 2012, the Secretary shall publish the measures selected under this subparagraph that will be applicable with respect to fiscal year 2014.

(E) PUBLIC AVAILABILITY OF DATA SUBMITTED.—The Secretary shall establish procedures for making data submitted under subparagraph (C) and subparagraph (F)(i) available to the public. Such procedures shall ensure that a rehabilitation facility has the opportunity to review the data that is to be made public with respect to the facility prior to such data being made public. The Secretary shall report quality measures that relate to services furnished in inpatient settings in rehabilitation facilities on the Internet website of the Centers for Medicare & Medicaid Services.

(F) SUBMISSION OF ADDITIONAL DATA.—

(i) IN GENERAL.—For the fiscal year beginning on the specified application date (as defined in subsection (a)(2)(E) of section 1899B), as applicable with respect to inpatient rehabilitation facilities and quality measures under subsection (c)(1) of such section and measures under subsection (d)(1) of such section, and each subsequent fiscal year, in addition to such data on the quality measures described in subparagraph (C), each rehabilitation facility shall submit to the Secretary data on the quality measures under such subsection (c)(1) and any necessary data specified by the Secretary under such subsection (d)(1).

(ii) STANDARDIZED PATIENT ASSESSMENT DATA.—For fiscal year 2019 and each subsequent fiscal year, in addition to such data described in clause (i), each rehabilitation facility shall submit to the Secretary standardized patient assessment data required under subsection (b)(1) of section 1899B.

(iii) SUBMISSION.—Such data shall be submitted in the form and manner, and at the time, specified by the Secretary for purposes of this subparagraph.

(G) NON-DUPLICATION.—To the extent data submitted under subparagraph (F) duplicates other data required to be submitted under subparagraph (C), the submission of such data under subparagraph (F) shall be in lieu of the submission of such data under subparagraph (C). The previous sentence shall not apply insofar as the Secretary determines it is necessary to avoid a delay in the implementation of section 1899B, taking into account the different specified application dates under subsection (a)(2)(E) of such section.

(8) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise of the establishment of—

(A) case mix groups, of the methodology for the classification of patients within such groups, and of the appropriate weighting factors thereof under paragraph (2),

(B) the prospective payment rates under paragraph (3),

(C) outlier and special payments under paragraph (4), and

(D) area wage adjustments under paragraph (6).

(k) PAYMENT TO NONHOSPITAL PROVIDERS.—

(1) IN GENERAL.—For cost reporting periods beginning on or after October 1, 1997, the Secretary may establish rules for payment to qualified nonhospital providers for their direct costs of medical education, if those costs are incurred in the operation of an approved medical residency training program described in subsection (h). Such rules shall specify the amounts, form, and manner in which such payments will be made and the portion of such payments that will be made from each of the trust funds under this title.

(2) QUALIFIED NONHOSPITAL PROVIDERS.—For purposes of this subsection, the term "qualified nonhospital providers" means—

(A) a Federally qualified health center, as defined in section 1861(aa)(4);

(B) a rural health clinic, as defined in section 1861(aa)(2);

(C) Medicare+Choice organizations; and

(D) such other providers (other than hospitals) as the Secretary determines to be appropriate.

(l) PAYMENT FOR NURSING AND ALLIED HEALTH EDUCATION FOR MANAGED CARE ENROLLEES.—

(1) IN GENERAL.—For portions of cost reporting periods occurring in a year (beginning with 2000), the Secretary shall provide for an additional payment amount for any hospital that receives payments for the costs of approved educational activities for nurse and allied health professional training under section 1861(v)(1).

(2) PAYMENT AMOUNT.—The additional payment amount under this subsection for each hospital for portions of cost reporting periods occurring in a year shall be an amount specified by the Secretary in a manner consistent with the following:

(A) DETERMINATION OF MANAGED CARE ENROLLEE PAYMENT RATIO FOR GRADUATE MEDICAL EDUCATION PAYMENTS.—The Secretary shall estimate the ratio of payments for all hospitals for portions of cost reporting periods occurring in the year under subsection (h)(3)(D) to total direct graduate medical education payments estimated for such portions of periods under subsection (h)(3).

(B) APPLICATION TO FEE-FOR-SERVICE NURSING AND ALLIED HEALTH EDUCATION PAYMENTS.—Such ratio shall be applied to the Secretary's estimate of total payments for nursing and allied health education determined under section 1861(v) for portions of cost reporting periods occurring in the year to determine a total amount of additional payments for nursing and allied health education to be distributed to hospitals under this subsection for portions of cost reporting periods occurring in the year; except that in no case shall such total amount exceed $60,000,000 in any year.

(C) APPLICATION TO HOSPITAL.—The amount of payment under this subsection to a hospital for portions of cost reporting periods occurring in a year is equal to the total amount of payments determined under subparagraph (B) for the year multiplied by the ratio of—

(i) the product of (I) the Secretary's estimate of the ratio of the amount of payments made under section 1861(v) to the hospital for nursing and allied health education activities for the hospital's cost reporting period ending in the second preceding fiscal year, to the hospital's total inpatient days for such period, and (II) the total number of inpatient days (as established by the Secretary) for such period which are attributable to services furnished to individuals who are enrolled under a risk sharing contract with an eligible organization under section 1876 and who are entitled to benefits under part A or who are enrolled with a Medicare+Choice organization under part C; to

(ii) the sum of the products determined under clause (i) for such cost reporting periods.

(m) PROSPECTIVE PAYMENT FOR LONG-TERM CARE HOSPITALS.—

(1) REFERENCE TO ESTABLISHMENT AND IMPLEMENTATION OF SYSTEM.—For provisions related to the establishment and implementation of a prospective payment system for payments under this title for inpatient hospital services furnished by a long-term care hospital described in subsection (d)(1)(B)(iv), see section 123 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 and section 307(b) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000.

(2) UPDATE FOR RATE YEAR 2008.—In implementing the system described in paragraph (1) for discharges occurring during the rate year ending in 2008 for a hospital, the base rate for such discharges for the hospital shall be the same as the base rate for discharges for the hospital occurring during the rate year ending in 2007.

(3) IMPLEMENTATION FOR RATE YEAR 2010 AND SUBSEQUENT YEARS.—

(A) IN GENERAL.—Subject to subparagraph (C), in implementing the system described in paragraph (1) for rate year 2010 and each subsequent rate year, any annual update to a standard Federal rate for discharges for the hospital during the rate year, shall be reduced—

(i) for rate year 2012 and each subsequent rate year, by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II); and

(ii) for each of rate years 2010 through 2019, by the other adjustment described in paragraph (4).

(B) SPECIAL RULE.—The application of this paragraph may result in such annual update being less than 0.0 for a rate year, and may result in payment rates under the system described in paragraph (1) for a rate year being less than such payment rates for the preceding rate year.

(C) ADDITIONAL SPECIAL RULE.—For fiscal year 2018, the annual update under subparagraph (A) for the fiscal year,

after application of clauses (i) and (ii) of subparagraph (A), shall be 1 percent.

(4) OTHER ADJUSTMENT.—For purposes of paragraph (3)(A)(ii), the other adjustment described in this paragraph is—

(A) for rate year 2010, 0.25 percentage point;

(B) for rate year 2011, 0.50 percentage point;

(C) for each of the rate years beginning in 2012 and 2013, 0.1 percentage point;

(D) for rate year 2014, 0.3 percentage point;

(E) for each of rate years 2015 and 2016, 0.2 percentage point; and

(F) for each of rate years 2017, 2018, and 2019, 0.75 percentage point.

(5) QUALITY REPORTING.—

(A) REDUCTION IN UPDATE FOR FAILURE TO REPORT.—

(i) IN GENERAL.—Under the system described in paragraph (1), for rate year 2014 and each subsequent rate year, in the case of a long-term care hospital that does not submit data to the Secretary in accordance with subparagraphs (C) and (F) with respect to such a rate year, any annual update to a standard Federal rate for discharges for the hospital during the rate year, and after application of paragraph (3), shall be reduced by 2 percentage points.

(ii) SPECIAL RULE.—The application of this subparagraph may result in such annual update being less than 0.0 for a rate year, and may result in payment rates under the system described in paragraph (1) for a rate year being less than such payment rates for the preceding rate year.

(B) NONCUMULATIVE APPLICATION.—Any reduction under subparagraph (A) shall apply only with respect to the rate year involved and the Secretary shall not take into account such reduction in computing the payment amount under the system described in paragraph (1) for a subsequent rate year.

(C) SUBMISSION OF QUALITY DATA.—Subject to subparagraph (G), for rate year 2014 and each subsequent rate year, each long-term care hospital shall submit to the Secretary data on quality measures specified under subparagraph (D). Such data shall be submitted in a form and manner, and at a time, specified by the Secretary for purposes of this subparagraph.

(D) QUALITY MEASURES.—

(i) IN GENERAL.—Subject to clause (ii), any measure specified by the Secretary under this subparagraph must have been endorsed by the entity with a contract under section 1890(a).

(ii) EXCEPTION.—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), the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted

by a consensus organization identified by the Secretary.

(iii) TIME FRAME.—Not later than October 1, 2012, the Secretary shall publish the measures selected under this subparagraph that will be applicable with respect to rate year 2014.

(iv) ADDITIONAL QUALITY MEASURES.—Not later than October 1, 2015, the Secretary shall establish a functional status quality measure for change in mobility among inpatients requiring ventilator support.

(E) PUBLIC AVAILABILITY OF DATA SUBMITTED.—The Secretary shall establish procedures for making data submitted under subparagraph (C) and subparagraph (F)(i) available to the public. Such procedures shall ensure that a long-term care hospital has the opportunity to review the data that is to be made public with respect to the hospital prior to such data being made public. The Secretary shall report quality measures that relate to services furnished in inpatient settings in long-term care hospitals on the Internet website of the Centers for Medicare & Medicaid Services.

(F) SUBMISSION OF ADDITIONAL DATA.—

(i) IN GENERAL.—For the rate year beginning on the specified application date (as defined in subsection (a)(2)(E) of section 1899B), as applicable with respect to long-term care hospitals and quality measures under subsection (c)(1) of such section and measures under subsection (d)(1) of such section, and each subsequent rate year, in addition to the data on the quality measures described in subparagraph (C), each long-term care hospital (other than a hospital classified under subsection (d)(1)(B)(iv)(II)) shall submit to the Secretary data on the quality measures under such subsection (c)(1) and any necessary data specified by the Secretary under such subsection (d)(1).

(ii) STANDARDIZED PATIENT ASSESSMENT DATA.—For rate year 2019 and each subsequent rate year, in addition to such data described in clause (i), each long-term care hospital (other than a hospital classified under subsection (d)(1)(B)(iv)(II)) shall submit to the Secretary standardized patient assessment data required under subsection (b)(1) of section 1899B.

(iii) SUBMISSION.—Such data shall be submitted in the form and manner, and at the time, specified by the Secretary for purposes of this subparagraph.

(G) NON-DUPLICATION.—To the extent data submitted under subparagraph (F) duplicates other data required to be submitted under subparagraph (C), the submission of such data under subparagraph (F) shall be in lieu of the submission of such data under subparagraph (C). The previous sentence shall not apply insofar as the Secretary determines it is necessary to avoid a delay in the implementation of section 1899B, taking into account the different specified application dates under subsection (a)(2)(E) of such section.

(6) APPLICATION OF SITE NEUTRAL IPPS PAYMENT RATE IN CERTAIN CASES.—

(A) GENERAL APPLICATION OF SITE NEUTRAL IPPS PAYMENT AMOUNT FOR DISCHARGES FAILING TO MEET APPLICABLE CRITERIA.—

(i) IN GENERAL.—For a discharge in cost reporting periods beginning on or after October 1, 2015, except as provided in clause (ii) and subparagraphs (C) and (E), payment under this title to a long-term care hospital for inpatient hospital services shall be made at the applicable site neutral payment rate (as defined in subparagraph (B)).

(ii) EXCEPTION FOR CERTAIN DISCHARGES MEETING CRITERIA.—Clause (i) shall not apply (and payment shall be made to a long-term care hospital without regard to this paragraph) for a discharge if—

(I) the discharge meets the ICU criterion under clause (iii) or the ventilator criterion under clause (iv); and

(II) the discharge does not have a principal diagnosis relating to a psychiatric diagnosis or to rehabilitation.

(iii) INTENSIVE CARE UNIT (ICU) CRITERION.—

(I) IN GENERAL.—The criterion specified in this clause (in this paragraph referred to as the "ICU criterion"), for a discharge from a long-term care hospital, is that the stay in the long-term care hospital ending with such discharge was immediately preceded by a discharge from a stay in a subsection (d) hospital that included at least 3 days in an intensive care unit (ICU), as determined by the Secretary.

(II) DETERMINING ICU DAYS.—In determining intensive care unit days under subclause (I), the Secretary shall use data from revenue center codes 020x or 021x (or such successor codes as the Secretary may establish).

(iv) VENTILATOR CRITERION.—The criterion specified in this clause (in this paragraph referred to as the "ventilator criterion"), for a discharge from a long-term care hospital, is that—

(I) the stay in the long-term care hospital ending with such discharge was immediately preceded by a discharge from a stay in a subsection (d) hospital; and

(II) the individual discharged was assigned to a Medicare-Severity-Long-Term-Care-Diagnosis-Related-Group (MS–LTC–DRG) based on the receipt of ventilator services of at least 96 hours.

(B) APPLICABLE SITE NEUTRAL PAYMENT RATE DEFINED.—

(i) IN GENERAL.—In this paragraph, the term "applicable site neutral payment rate" means—

(I) for discharges in cost reporting periods beginning during fiscal year 2016 or fiscal year

2017, the blended payment rate specified in clause (iii); and

(II) for discharges in cost reporting periods beginning during fiscal year 2018 or a subsequent fiscal year, the site neutral payment rate (as defined in clause (ii)).

(ii) SITE NEUTRAL PAYMENT RATE DEFINED.—In this paragraph, the term "site neutral payment rate" means the lower of—

(I) the IPPS comparable per diem amount determined under paragraph (d)(4) of section 412.529 of title 42, Code of Federal Regulations, including any applicable outlier payments under section 412.525 of such title; or

(II) 100 percent of the estimated cost for the services involved.

(iii) BLENDED PAYMENT RATE.—The blended payment rate specified in this clause, for a long-term care hospital for inpatient hospital services for a discharge, is comprised of—

(I) half of the site neutral payment rate (as defined in clause (ii)) for the discharge; and

(II) half of the payment rate that would otherwise be applicable to such discharge without regard to this paragraph, as determined by the Secretary.

(C) LIMITING PAYMENT FOR ALL HOSPITAL DISCHARGES TO SITE NEUTRAL PAYMENT RATE FOR HOSPITALS FAILING TO MEET APPLICABLE LTCH DISCHARGE THRESHOLDS.—

(i) NOTICE OF LTCH DISCHARGE PAYMENT PERCENTAGE.—For cost reporting periods beginning during or after fiscal year 2016, the Secretary shall inform each long-term care hospital of its LTCH discharge payment percentage (as defined in clause (iv)) for such period.

(ii) LIMITATION.—For cost reporting periods beginning during or after fiscal year 2020, if the Secretary determines for a long-term care hospital that its LTCH discharge payment percentage for the period is not at least 50 percent—

(I) the Secretary shall inform the hospital of such fact; and

(II) subject to clause (iii), for all discharges in the hospital in each succeeding cost reporting period, the payment amount under this subsection shall be the payment amount that would apply under subsection (d) for the discharge if the hospital were a subsection (d) hospital.

(iii) PROCESS FOR REINSTATEMENT.—The Secretary shall establish a process whereby a long-term care hospital may seek to and have the provisions of subclause (II) of clause (ii) discontinued with respect to that hospital.

(iv) LTCH DISCHARGE PAYMENT PERCENTAGE.—In this subparagraph, the term "LTCH discharge pay-

ment percentage" means, with respect to a long-term care hospital for a cost reporting period beginning during or after fiscal year 2020, the ratio (expressed as a percentage) of—

(I) the number of Medicare fee-for-service discharges for such hospital and period for which payment is not made at the site neutral payment rate, to

(II) the total number of Medicare fee-for-service discharges for such hospital and period.

(D) INCLUSION OF SUBSECTION (d) PUERTO RICO HOSPITALS.—In this paragraph, any reference in this paragraph to a subsection (d) hospital shall be deemed to include a reference to a subsection (d) Puerto Rico hospital.

(E) TEMPORARY EXCEPTION FOR CERTAIN SEVERE WOUND DISCHARGES FROM CERTAIN LONG-TERM CARE HOSPITALS.—

(i) IN GENERAL.—In the case of a discharge occurring prior to January 1, 2017, subparagraph (A)(i) shall not apply (and payment shall be made to a long-term care hospital without regard to this paragraph) if such discharge—

(I) is from a long-term care hospital that is—

(aa) identified by the amendment made by section 4417(a) of the Balanced Budget Act of 1997 (42 U.S.C. 1395ww note, Public Law 105–33); and

(bb) located in a rural area (as defined in subsection (d)(2)(D)) or treated as being so located pursuant to subsection (d)(8)(E); and

(II) the individual discharged has a severe wound.

(ii) SEVERE WOUND DEFINED.—In this subparagraph, the term "severe wound" means a stage 3 wound, stage 4 wound, unstageable wound, non-healing surgical wound, infected wound, fistula, osteomyelitis, or wound with morbid obesity, as identified in the claim from the long-term care hospital.

(7) TREATMENT OF HIGH COST OUTLIER PAYMENTS.—

(A) ADJUSTMENT TO THE STANDARD FEDERAL PAYMENT RATE FOR ESTIMATED HIGH COST OUTLIER PAYMENTS.—Under the system described in paragraph (1), for fiscal years beginning on or after October 1, 2017, the Secretary shall reduce the standard Federal payment rate as if the estimated aggregate amount of high cost outlier payments for standard Federal payment rate discharges for each such fiscal year would be equal to 8 percent of estimated aggregate payments for standard Federal payment rate discharges for each such fiscal year.

(B) LIMITATION ON HIGH COST OUTLIER PAYMENT AMOUNTS.—Notwithstanding subparagraph (A), the Secretary shall set the fixed loss amount for high cost outlier payments such that the estimated aggregate amount of high cost outlier payments made for standard Federal payment rate discharges for fiscal years beginning on or after October 1, 2017, shall be equal to 99.6875 percent of 8 percent

of estimated aggregate payments for standard Federal payment rate discharges for each such fiscal year.

(C) WAIVER OF BUDGET NEUTRALITY.—Any reduction in payments resulting from the application of subparagraph (B) shall not be taken into account in applying any budget neutrality provision under such system.

(D) NO EFFECT ON SITE NEUTRAL HIGH COST OUTLIER PAYMENT RATE.—This paragraph shall not apply with respect to the computation of the applicable site neutral payment rate under paragraph (6).

(n) INCENTIVES FOR ADOPTION AND MEANINGFUL USE OF CERTIFIED EHR TECHNOLOGY.—

(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, with respect to inpatient hospital services furnished by an eligible hospital during a payment year (as defined in paragraph (2)(G)), if the eligible hospital is a meaningful EHR user (as determined under paragraph (3)) for the EHR reporting period with respect to such year, in addition to the amount otherwise paid under this section, there also shall be paid to the eligible hospital, from the Federal Hospital Insurance Trust Fund established under section 1817, an amount equal to the applicable amount specified in paragraph (2)(A) for the hospital for such payment year.

(2) PAYMENT AMOUNT.—

(A) IN GENERAL.—Subject to the succeeding subparagraphs of this paragraph, the applicable amount specified in this subparagraph for an eligible hospital for a payment year is equal to the product of the following:

(i) INITIAL AMOUNT.—The sum of—

(I) the base amount specified in subparagraph (B); plus

(II) the discharge related amount specified in subparagraph (C) for a 12-month period selected by the Secretary with respect to such payment year.

(ii) MEDICARE SHARE.—The Medicare share as specified in subparagraph (D) for the eligible hospital for a period selected by the Secretary with respect to such payment year.

(iii) TRANSITION FACTOR.—The transition factor specified in subparagraph (E) for the eligible hospital for the payment year.

(B) BASE AMOUNT.—The base amount specified in this subparagraph is $2,000,000.

(C) DISCHARGE RELATED AMOUNT.—The discharge related amount specified in this subparagraph for a 12-month period selected by the Secretary shall be determined as the sum of the amount, estimated based upon total discharges for the eligible hospital (regardless of any source of payment) for the period, for each discharge up to the 23,000th discharge as follows:

(i) For the first through 1,149th discharge, $0.

(ii) For the 1,150th through the 23,000th discharge, $200.

(iii) For any discharge greater than the 23,000th, $0.

(D) MEDICARE SHARE.—The Medicare share specified under this subparagraph for an eligible hospital for a period selected by the Secretary for a payment year is equal to the fraction—

(i) the numerator of which is the sum (for such period and with respect to the eligible hospital) of—

(I) the estimated number of inpatient-bed-days (as established by the Secretary) which are attributable to individuals with respect to whom payment may be made under part A; and

(II) the estimated number of inpatient-bed-days (as so established) which are attributable to individuals who are enrolled with a Medicare Advantage organization under part C; and

(ii) the denominator of which is the product of—

(I) the estimated total number of inpatient-bed-days with respect to the eligible hospital during such period; and

(II) the estimated total amount of the eligible hospital's charges during such period, not including any charges that are attributable to charity care (as such term is used for purposes of hospital cost reporting under this title), divided by the estimated total amount of the hospital's charges during such period.

Insofar as the Secretary determines that data are not available on charity care necessary to calculate the portion of the formula specified in clause (ii)(II), the Secretary shall use data on uncompensated care and may adjust such data so as to be an appropriate proxy for charity care including a downward adjustment to eliminate bad debt data from uncompensated care data. In the absence of the data necessary, with respect to a hospital, for the Secretary to compute the amount described in clause (ii)(II), the amount under such clause shall be deemed to be 1. In the absence of data, with respect to a hospital, necessary to compute the amount described in clause (i)(II), the amount under such clause shall be deemed to be 0.

(E) TRANSITION FACTOR SPECIFIED.—

(i) IN GENERAL.—Subject to clause (ii), the transition factor specified in this subparagraph for an eligible hospital for a payment year is as follows:

(I) For the first payment year for such hospital, 1.

(II) For the second payment year for such hospital, ¾.

(III) For the third payment year for such hospital, ½.

(IV) For the fourth payment year for such hospital, ¼.

(V) For any succeeding payment year for such hospital, 0.

(ii) PHASE DOWN FOR ELIGIBLE HOSPITALS FIRST ADOPTING EHR AFTER 2013.—If the first payment year for an eligible hospital is after 2013, then the transi-

tion factor specified in this subparagraph for a payment year for such hospital is the same as the amount specified in clause (i) for such payment year for an eligible hospital for which the first payment year is 2013. If the first payment year for an eligible hospital is after 2015 then the transition factor specified in this subparagraph for such hospital and for such year and any subsequent year shall be 0.

(F) FORM OF PAYMENT.—The payment under this subsection for a payment year may be in the form of a single consolidated payment or in the form of such periodic installments as the Secretary may specify.

(G) PAYMENT YEAR DEFINED.—

(i) IN GENERAL.—For purposes of this subsection, the term "payment year" means a fiscal year beginning with fiscal year 2011.

(ii) FIRST, SECOND, ETC. PAYMENT YEAR.—The term "first payment year" means, with respect to inpatient hospital services furnished by an eligible hospital, the first fiscal year for which an incentive payment is made for such services under this subsection. The terms "second payment year", "third payment year", and "fourth payment year" mean, with respect to an eligible hospital, each successive year immediately following the first payment year for that hospital.

(3) MEANINGFUL EHR USER.—

(A) IN GENERAL.—For purposes of paragraph (1), an eligible hospital shall be treated as a meaningful EHR user for an EHR reporting period for a payment year (or, for purposes of subsection (b)(3)(B)(ix), for an EHR reporting period under such subsection for a fiscal year) if each of the following requirements are met:

(i) MEANINGFUL USE OF CERTIFIED EHR TECHNOLOGY.—The eligible hospital demonstrates to the satisfaction of the Secretary, in accordance with subparagraph (C)(i), that during such period the hospital is using certified EHR technology in a meaningful manner.

(ii) INFORMATION EXCHANGE.—The eligible hospital demonstrates to the satisfaction of the Secretary, in accordance with subparagraph (C)(i), that during such period such certified EHR technology is connected in a manner that provides, in accordance with law and standards applicable to the exchange of information, for the electronic exchange of health information to improve the quality of health care, such as promoting care coordination, and the hospital demonstrates (through a process specified by the Secretary, such as the use of an attestation) that the hospital has not knowingly and willfully taken action (such as to disable functionality) to limit or restrict the compatibility or interoperability of the certified EHR technology.

(iii) REPORTING ON MEASURES USING EHR.—Subject to subparagraph (B)(ii) and using such certified EHR technology, the eligible hospital submits information

for such period, in a form and manner specified by the Secretary, on such clinical quality measures and such other measures as selected by the Secretary under subparagraph (B)(i).

The Secretary shall seek to improve the use of electronic health records and health care quality over time by requiring more stringent measures of meaningful use selected under this paragraph.

(B) REPORTING ON MEASURES.—

(i) SELECTION.—The Secretary shall select measures for purposes of subparagraph (A)(iii) but only consistent with the following:

(I) The Secretary shall provide preference to clinical quality measures that have been selected for purposes of applying subsection (b)(3)(B)(viii) or that have been endorsed by the entity with a contract with the Secretary under section 1890(a).

(II) Prior to any measure (other than a clinical quality measure that has been selected for purposes of applying subsection (b)(3)(B)(viii)) being selected under this subparagraph, the Secretary shall publish in the Federal Register such measure and provide for a period of public comment on such measure.

(ii) LIMITATIONS.—The Secretary may not require the electronic reporting of information on clinical quality measures under subparagraph (A)(iii) unless the Secretary has the capacity to accept the information electronically, which may be on a pilot basis.

(iii) COORDINATION OF REPORTING OF INFORMATION.—In selecting such measures, and in establishing the form and manner for reporting measures under subparagraph (A)(iii), the Secretary shall seek to avoid redundant or duplicative reporting with reporting otherwise required, including reporting under subsection (b)(3)(B)(viii).

(C) DEMONSTRATION OF MEANINGFUL USE OF CERTIFIED EHR TECHNOLOGY AND INFORMATION EXCHANGE.—

(i) IN GENERAL.—An eligible hospital may satisfy the demonstration requirement of clauses (i) and (ii) of subparagraph (A) through means specified by the Secretary, which may include—

(I) an attestation;

(II) the submission of claims with appropriate coding (such as a code indicating that inpatient care was documented using certified EHR technology);

(III) a survey response;

(IV) reporting under subparagraph (A)(iii); and

(V) other means specified by the Secretary.

(ii) USE OF PART D DATA.—Notwithstanding sections 1860D–15(d)(2)(B) and 1860D–15(f)(2), the Secretary may use data regarding drug claims submitted for purposes of section 1860D–15 that are necessary for purposes of subparagraph (A).

(4) APPLICATION.—

(A) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, of—

(i) the methodology and standards for determining payment amounts under this subsection and payment adjustments under subsection (b)(3)(B)(ix), including selection of periods under paragraph (2) for determining, and making estimates or using proxies of, discharges under paragraph (2)(C) and inpatient-bed-days, hospital charges, charity charges, and Medicare share under paragraph (2)(D);

(ii) the methodology and standards for determining a meaningful EHR user under paragraph (3), including selection of measures under paragraph (3)(B), specification of the means of demonstrating meaningful EHR use under paragraph (3)(C), and the hardship exception under subsection (b)(3)(B)(ix)(II); and

(iii) the specification of EHR reporting periods under paragraph (6)(B) and the selection of the form of payment under paragraph (2)(F).

(B) POSTING ON WEBSITE.—The Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services, in an easily understandable format, a list of the names of the eligible hospitals that are meaningful EHR users under this subsection or subsection (b)(3)(B)(ix) (and a list of the names of critical access hospitals to which paragraph (3) or (4) of section 1814(l) applies), and other relevant data as determined appropriate by the Secretary. The Secretary shall ensure that an eligible hospital (or critical access hospital) has the opportunity to review the other relevant data that are to be made public with respect to the hospital (or critical access hospital) prior to such data being made public.

(5) CERTIFIED EHR TECHNOLOGY DEFINED.—The term "certified EHR technology" has the meaning given such term in section 1848(o)(4).

(6) DEFINITIONS.—For purposes of this subsection:

(A) EHR REPORTING PERIOD.—The term "EHR reporting period" means, with respect to a payment year, any period (or periods) as specified by the Secretary.

(B) ELIGIBLE HOSPITAL.—The term "eligible hospital" means a hospital that is a subsection (d) hospital or a subsection (d) Puerto Rico hospital.

(o) HOSPITAL VALUE-BASED PURCHASING PROGRAM.—

(1) ESTABLISHMENT.—

(A) IN GENERAL.—Subject to the succeeding provisions of this subsection, the Secretary shall establish a hospital value-based purchasing program (in this subsection referred to as the "Program") under which value-based incentive payments are made in a fiscal year to hospitals that meet the performance standards under paragraph (3) for the performance period for such fiscal year (as established under paragraph (4)).

(B) PROGRAM TO BEGIN IN FISCAL YEAR 2013.—The Program shall apply to payments for discharges occurring on or after October 1, 2012.

(C) APPLICABILITY OF PROGRAM TO HOSPITALS.—

(i) IN GENERAL.—For purposes of this subsection, subject to clause (ii), the term "hospital" means a subsection (d) hospital (as defined in subsection (d)(1)(B)).

(ii) EXCLUSIONS.—The term "hospital" shall not include, with respect to a fiscal year, a hospital—

(I) that is subject to the payment reduction under subsection (b)(3)(B)(viii)(I) for such fiscal year;

(II) for which, during the performance period for such fiscal year, the Secretary has cited deficiencies that pose immediate jeopardy to the health or safety of patients;

(III) for which there are not a minimum number (as determined by the Secretary) of measures that apply to the hospital for the performance period for such fiscal year; or

(IV) for which there are not a minimum number (as determined by the Secretary) of cases for the measures that apply to the hospital for the performance period for such fiscal year.

(iii) INDEPENDENT ANALYSIS.—For purposes of determining the minimum numbers under subclauses (III) and (IV) of clause (ii), the Secretary shall have conducted an independent analysis of what numbers are appropriate.

(iv) EXEMPTION.—In the case of a hospital that is paid under section 1814(b)(3), the Secretary may exempt such hospital from the application of this subsection if the State which is paid under such section submits 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 under this subsection.

(2) MEASURES.—

(A) IN GENERAL.—The Secretary shall select measures, other than measures of readmissions, for purposes of the Program. Such measures shall be selected from the measures specified under subsection (b)(3)(B)(viii).

(B) REQUIREMENTS.—

(i) FOR FISCAL YEAR 2013.—For value-based incentive payments made with respect to discharges occurring during fiscal year 2013, the Secretary shall ensure the following:

(I) CONDITIONS OR PROCEDURES.—Measures are selected under subparagraph (A) that cover at least the following 5 specific conditions or procedures:

(aa) Acute myocardial infarction (AMI).

(bb) Heart failure.

(cc) Pneumonia.

(dd) Surgeries, as measured by the Surgical Care Improvement Project (formerly referred to as "Surgical Infection Prevention" for discharges occurring before July 2006).

(ee) Healthcare-associated infections, as measured by the prevention metrics and targets established in the HHS Action Plan to Prevent Healthcare-Associated Infections (or any successor plan) of the Department of Health and Human Services.

(II) HCAHPS.—Measures selected under subparagraph (A) shall be related to the Hospital Consumer Assessment of Healthcare Providers and Systems survey (HCAHPS).

(ii) INCLUSION OF EFFICIENCY MEASURES.—For value-based incentive payments made with respect to discharges occurring during fiscal year 2014 or a subsequent fiscal year, the Secretary shall ensure that measures selected under subparagraph (A) include efficiency measures, including measures of "Medicare spending per beneficiary". Such measures shall be adjusted for factors such as age, sex, race, severity of illness, and other factors that the Secretary determines appropriate.

(C) LIMITATIONS.—

(i) TIME REQUIREMENT FOR PRIOR REPORTING AND NOTICE.—The Secretary may not select a measure under subparagraph (A) for use under the Program with respect to a performance period for a fiscal year (as established under paragraph (4)) unless such measure has been specified under subsection (b)(3)(B)(viii) and included on the Hospital Compare Internet website for at least 1 year prior to the beginning of such performance period.

(ii) MEASURE NOT APPLICABLE UNLESS HOSPITAL FURNISHES SERVICES APPROPRIATE TO THE MEASURE.—A measure selected under subparagraph (A) shall not apply to a hospital if such hospital does not furnish services appropriate to such measure.

(D) REPLACING MEASURES.—Subclause (VI) of subsection (b)(3)(B)(viii) shall apply to measures selected under subparagraph (A) in the same manner as such subclause applies to measures selected under such subsection.

(3) PERFORMANCE STANDARDS.—

(A) ESTABLISHMENT.—The Secretary shall establish performance standards with respect to measures selected under paragraph (2) for a performance period for a fiscal year (as established under paragraph (4)).

(B) ACHIEVEMENT AND IMPROVEMENT.—The performance standards established under subparagraph (A) shall include levels of achievement and improvement.

(C) TIMING.—The Secretary shall establish and announce the performance standards under subparagraph (A) not later than 60 days prior to the beginning of the performance period for the fiscal year involved.

(D) CONSIDERATIONS IN ESTABLISHING STANDARDS.—In establishing performance standards with respect to measures under this paragraph, the Secretary shall take into account appropriate factors, such as—

(i) practical experience with the measures involved, including whether a significant proportion of hospitals failed to meet the performance standard during previous performance periods;

(ii) historical performance standards;

(iii) improvement rates; and

(iv) the opportunity for continued improvement.

(4) PERFORMANCE PERIOD.—For purposes of the Program, the Secretary shall establish the performance period for a fiscal year. Such performance period shall begin and end prior to the beginning of such fiscal year.

(5) HOSPITAL PERFORMANCE SCORE.—

(A) IN GENERAL.—Subject to subparagraph (B), the Secretary shall develop a methodology for assessing the total performance of each hospital based on performance standards with respect to the measures selected under paragraph (2) for a performance period (as established under paragraph (4)). Using such methodology, the Secretary shall provide for an assessment (in this subsection referred to as the "hospital performance score") for each hospital for each performance period.

(B) APPLICATION.—

(i) APPROPRIATE DISTRIBUTION.—The Secretary shall ensure that the application of the methodology developed under subparagraph (A) results in an appropriate distribution of value-based incentive payments under paragraph (6) among hospitals achieving different levels of hospital performance scores, with hospitals achieving the highest hospital performance scores receiving the largest value-based incentive payments.

(ii) HIGHER OF ACHIEVEMENT OR IMPROVEMENT.—The methodology developed under subparagraph (A) shall provide that the hospital performance score is determined using the higher of its achievement or improvement score for each measure.

(iii) WEIGHTS.—The methodology developed under subparagraph (A) shall provide for the assignment of weights for categories of measures as the Secretary determines appropriate.

(iv) NO MINIMUM PERFORMANCE STANDARD.—The Secretary shall not set a minimum performance standard in determining the hospital performance score for any hospital.

(v) REFLECTION OF MEASURES APPLICABLE TO THE HOSPITAL.—The hospital performance score for a hospital shall reflect the measures that apply to the hospital.

(6) CALCULATION OF VALUE-BASED INCENTIVE PAYMENTS.—

(A) IN GENERAL.—In the case of a hospital that the Secretary determines meets (or exceeds) the performance standards under paragraph (3) for the performance period

for a fiscal year (as established under paragraph (4)), the Secretary shall increase the base operating DRG payment amount (as defined in paragraph (7)(D)), as determined after application of paragraph (7)(B)(i), for a hospital for each discharge occurring in such fiscal year by the value-based incentive payment amount.

(B) VALUE-BASED INCENTIVE PAYMENT AMOUNT.—The value-based incentive payment amount for each discharge of a hospital in a fiscal year shall be equal to the product of—

(i) the base operating DRG payment amount (as defined in paragraph (7)(D)) for the discharge for the hospital for such fiscal year; and

(ii) the value-based incentive payment percentage specified under subparagraph (C) for the hospital for such fiscal year.

(C) VALUE-BASED INCENTIVE PAYMENT PERCENTAGE.—

(i) IN GENERAL.—The Secretary shall specify a value-based incentive payment percentage for a hospital for a fiscal year.

(ii) REQUIREMENTS.—In specifying the value-based incentive payment percentage for each hospital for a fiscal year under clause (i), the Secretary shall ensure that—

(I) such percentage is based on the hospital performance score of the hospital under paragraph (5); and

(II) the total amount of value-based incentive payments under this paragraph to all hospitals in such fiscal year is equal to the total amount available for value-based incentive payments for such fiscal year under paragraph (7)(A), as estimated by the Secretary.

(7) FUNDING FOR VALUE-BASED INCENTIVE PAYMENTS.—

(A) AMOUNT.—The total amount available for value-based incentive payments under paragraph (6) for all hospitals for a fiscal year shall be equal to the total amount of reduced payments for all hospitals under subparagraph (B) for such fiscal year, as estimated by the Secretary.

(B) ADJUSTMENT TO PAYMENTS.—

(i) IN GENERAL.—The Secretary shall reduce the base operating DRG payment amount (as defined in subparagraph (D)) for a hospital for each discharge in a fiscal year (beginning with fiscal year 2013) by an amount equal to the applicable percent (as defined in subparagraph (C)) of the base operating DRG payment amount for the discharge for the hospital for such fiscal year. The Secretary shall make such reductions for all hospitals in the fiscal year involved, regardless of whether or not the hospital has been determined by the Secretary to have earned a value-based incentive payment under paragraph (6) for such fiscal year.

(ii) NO EFFECT ON OTHER PAYMENTS.—Payments described in items (aa) and (bb) of subparagraph

(D)(i)(II) for a hospital shall be determined as if this subsection had not been enacted.

(C) APPLICABLE PERCENT DEFINED.—For purposes of subparagraph (B), the term "applicable percent" means—

(i) with respect to fiscal year 2013, 1.0 percent;

(ii) with respect to fiscal year 2014, 1.25 percent;

(iii) with respect to fiscal year 2015, 1.5 percent;

(iv) with respect to fiscal year 2016, 1.75 percent; and

(v) with respect to fiscal year 2017 and succeeding fiscal years, 2 percent.

(D) BASE OPERATING DRG PAYMENT AMOUNT DEFINED.—

(i) IN GENERAL.—Except as provided in clause (ii), 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 (q)) for a discharge if this subsection did not apply; reduced by

(II) any portion of such payment amount that is attributable to—

(aa) payments under paragraphs (5)(A), (5)(B), (5)(F), and (12) of subsection (d); and

(bb) such other payments under subsection (d) determined appropriate by the Secretary.

(ii) 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 year 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 term "base operating DRG payment amount" means the payment amount under such section.

(8) ANNOUNCEMENT OF NET RESULT OF ADJUSTMENTS.—Under the Program, the Secretary shall, not later than 60 days prior to the fiscal year involved, inform each hospital of the adjustments to payments to the hospital for discharges occurring in such fiscal year under paragraphs (6) and (7)(B)(i).

(9) NO EFFECT IN SUBSEQUENT FISCAL YEARS.—The value-based incentive payment under paragraph (6) and the payment reduction under paragraph (7)(B)(i) shall each apply only with respect to the fiscal year involved, and the Secretary shall not take into account such value-based incentive payment or payment reduction in making payments to a hospital under this section in a subsequent fiscal year.

(10) PUBLIC REPORTING.—

(A) HOSPITAL SPECIFIC INFORMATION.—

(i) IN GENERAL.—The Secretary shall make information available to the public regarding the performance of individual hospitals under the Program, including—

(I) the performance of the hospital with respect to each measure that applies to the hospital;

(II) the performance of the hospital with respect to each condition or procedure; and

(III) the hospital performance score assessing the total performance of the hospital.

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

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

(B) AGGREGATE INFORMATION.—The Secretary shall periodically post on the Hospital Compare Internet website aggregate information on the Program, including—

(i) the number of hospitals receiving value-based incentive payments under paragraph (6) and the range and total amount of such value-based incentive payments; and

(ii) the number of hospitals receiving less than the maximum value-based incentive payment available to the hospital for the fiscal year involved and the range and amount of such payments.

(11) IMPLEMENTATION.—

(A) APPEALS.—The Secretary shall establish a process by which hospitals may appeal the calculation of a hospital's performance assessment with respect to the performance standards established under paragraph (3)(A) and the hospital performance score under paragraph (5). The Secretary shall ensure that such process provides for resolution of such appeals in a timely manner.

(B) LIMITATION ON REVIEW.—Except as provided in subparagraph (A), there shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the following:

(i) The methodology used to determine the amount of the value-based incentive payment under paragraph (6) and the determination of such amount.

(ii) The determination of the amount of funding available for such value-based incentive payments under paragraph (7)(A) and the payment reduction under paragraph (7)(B)(i).

(iii) The establishment of the performance standards under paragraph (3) and the performance period under paragraph (4).

(iv) The measures specified under subsection (b)(3)(B)(viii) and the measures selected under paragraph (2).

(v) The methodology developed under paragraph (5) that is used to calculate hospital performance scores and the calculation of such scores.

(vi) The validation methodology specified in subsection (b)(3)(B)(viii)(XI).

(C) CONSULTATION WITH SMALL HOSPITALS.—The Secretary shall consult with small rural and urban hospitals on the application of the Program to such hospitals.

(12) PROMULGATION OF REGULATIONS.—The Secretary shall promulgate regulations to carry out the Program, including the selection of measures under paragraph (2), the methodology developed under paragraph (5) that is used to calculate hospital performance scores, and the methodology used to determine the amount of value-based incentive payments under paragraph (6).

(p) ADJUSTMENT TO HOSPITAL PAYMENTS FOR HOSPITAL ACQUIRED CONDITIONS.—

(1) IN GENERAL.—In order to provide an incentive for applicable hospitals to reduce hospital acquired conditions under this title, with respect to discharges from an applicable hospital occurring during fiscal year 2015 or a subsequent fiscal year, the amount of payment under this section or section 1814(b)(3), as applicable, for such discharges during the fiscal year shall be equal to 99 percent of the amount of payment that would otherwise apply to such discharges under this section or section 1814(b)(3) (determined after the application of subsections (o) and (q) and section 1814(l)(4) but without regard to this subsection).

(2) APPLICABLE HOSPITALS.—

(A) IN GENERAL.—For purposes of this subsection, the term "applicable hospital" means a subsection (d) hospital that meets the criteria described in subparagraph (B).

(B) CRITERIA DESCRIBED.—

(i) IN GENERAL.—The criteria described in this subparagraph, with respect to a subsection (d) hospital, is that the subsection (d) hospital is in the top quartile of all subsection (d) hospitals, relative to the national average, of hospital acquired conditions during the applicable period, as determined by the Secretary.

(ii) RISK ADJUSTMENT.—In carrying out clause (i), the Secretary shall establish and apply an appropriate risk adjustment methodology.

(C) EXEMPTION.—In the case of a hospital that is paid under section 1814(b)(3), the Secretary may exempt such hospital from the application of this subsection if the State which is paid under such section submits 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 under this subsection.

(3) HOSPITAL ACQUIRED CONDITIONS.—For purposes of this subsection, the term "hospital acquired condition" means a condition identified for purposes of subsection (d)(4)(D)(iv) and any other condition determined appropriate by the Secretary that

an individual acquires during a stay in an applicable hospital, as determined by the Secretary.

(4) APPLICABLE PERIOD.—In this subsection, the term "applicable period" means, with respect to a fiscal year, a period specified by the Secretary.

(5) REPORTING TO HOSPITALS.—Prior to fiscal year 2015 and each subsequent fiscal year, the Secretary shall provide confidential reports to applicable hospitals with respect to hospital acquired conditions of the applicable hospital during the applicable period.

(6) REPORTING HOSPITAL SPECIFIC INFORMATION.—

(A) IN GENERAL.—The Secretary shall make information available to the public regarding hospital acquired conditions of each applicable hospital.

(B) OPPORTUNITY TO REVIEW AND SUBMIT CORRECTIONS.—The Secretary shall ensure that an applicable 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 criteria described in paragraph (2)(A).

(B) The specification of hospital acquired conditions under paragraph (3).

(C) The specification of the applicable period under paragraph (4).

(D) The provision of reports to applicable hospitals under paragraph (5) and the information made available to the public under paragraph (6).

(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—

(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), *subject to subparagraph (D),* 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.

(D) TRANSITIONAL ADJUSTMENT FOR DUAL ELIGIBLES.—

(i) IN GENERAL.—In determining a hospital's adjustment factor under this paragraph for purposes of making payments for discharges occurring during and after

fiscal year 2019, and before the application of clause (i) of subparagraph (E), the Secretary shall assign hospitals to groups (as defined by the Secretary under clause (ii)) and apply the applicable provisions of this subsection using a methodology in a manner that allows for separate comparison of hospitals within each such group, as determined by the Secretary.

(ii) DEFINING GROUPS.—For purposes of this subparagraph, the Secretary shall define groups of hospitals based on their overall proportion, of the inpatients who are entitled to, or enrolled for, benefits under part A, who are full-benefit dual eligible individuals (as defined in section 1935(c)(6)). In defining groups, the Secretary shall consult the Medicare Payment Advisory Commission and may consider the analysis done by such Commission in preparing the portion of its report submitted to Congress in June 2013 relating to readmissions.

(iii) MINIMIZING REPORTING BURDEN ON HOSPITALS.—In carrying out this subparagraph, the Secretary shall not impose any additional reporting requirements on hospitals.

(iv) BUDGET NEUTRAL DESIGN METHODOLOGY.—The Secretary shall design the methodology to implement this subparagraph so that the estimated total amount of reductions in payments under this subsection equals the estimated total amount of reductions in payments that would otherwise occur under this subsection if this subparagraph did not apply.

(E) CHANGES IN RISK ADJUSTMENT.—

(i) CONSIDERATION OF RECOMMENDATIONS IN IMPACT REPORTS.—The Secretary may take into account the studies conducted and the recommendations made by the Secretary under section 2(d)(1) of the IMPACT Act of 2014 (Public Law 113–185; 42 U.S.C. 1395lll note) with respect to the application under this subsection of risk adjustment methodologies. Nothing in this clause shall be construed as precluding consideration of the use of groupings of hospitals.

(ii) CONSIDERATION OF EXCLUSION OF PATIENT CASES BASED ON V OR OTHER APPROPRIATE CODES.—In promulgating regulations to carry out this subsection with respect to discharges occurring after fiscal year 2018, the Secretary may consider the use of V or other ICD-related codes for removal of a readmission. The Secretary may consider modifying measures under this subsection to incorporate V or other ICD-related codes at the same time as other changes are being made under this subparagraph.

(iii) REMOVAL OF CERTAIN READMISSIONS.—In promulgating regulations to carry out this subsection, with respect to discharges occurring after fiscal year 2018, the Secretary may consider removal as a readmission of an admission that is classified within one or more of the following: transplants, end-stage renal dis-

ease, burns, trauma, psychosis, or substance abuse. The Secretary may consider modifying measures under this subsection to remove readmissions at the same time as other changes are being made under this subparagraph.

(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.

(r) ADJUSTMENTS TO MEDICARE DSH PAYMENTS.—

(1) EMPIRICALLY JUSTIFIED DSH PAYMENTS.—For fiscal year 2014 and each subsequent fiscal year, instead of the amount of disproportionate share hospital payment that would otherwise be made under subsection (d)(5)(F) to a subsection (d) hospital for the fiscal year, the Secretary shall pay to the subsection (d) hospital 25 percent of such amount (which represents the empirically justified amount for such payment, as determined by the Medicare Payment Advisory Commission in its March 2007 Report to the Congress).

(2) ADDITIONAL PAYMENT.—In addition to the payment made to a subsection (d) hospital under paragraph (1), for fiscal year 2014 and each subsequent fiscal year, the Secretary shall pay to such subsection (d) hospitals an additional amount equal to the product of the following factors:

(A) FACTOR ONE.—A factor equal to the difference between—

(i) the aggregate amount of payments that would be made to subsection (d) hospitals under subsection (d)(5)(F) if this subsection did not apply for such fiscal year (as estimated by the Secretary); and

(ii) the aggregate amount of payments that are made to subsection (d) hospitals under paragraph (1) for such fiscal year (as so estimated).

(B) FACTOR TWO.—

(i) FISCAL YEARS 2014, 2015, 2016, AND 2017.—For each of fiscal years 2014, 2015, 2016, and 2017, a factor equal to 1 minus the percent change in the percent of individuals under the age of 65 who are uninsured, as determined by comparing the percent of such individuals—

(I) who are uninsured in 2013, the last year before coverage expansion under the Patient Protection and Affordable Care Act (as calculated by the Secretary based on the most recent estimates available from the Director of the Congressional Budget Office before a vote in either House on the Health Care and Education Reconciliation Act of 2010 that, if determined in the affirmative, would clear such Act for enrollment); and

(II) who are uninsured in the most recent period for which data is available (as so calculated),

minus 0.1 percentage points for fiscal year 2014 and minus 0.2 percentage points for each of fiscal years 2015, 2016, and 2017.

(ii) 2018 AND SUBSEQUENT YEARS.—For fiscal year 2018 and each subsequent fiscal year, a factor equal to 1 minus the percent change in the percent of individuals who are uninsured, as determined by comparing the percent of individuals—

(I) who are uninsured in 2013 (as estimated by the Secretary, based on data from the Census Bureau or other sources the Secretary determines appropriate, and certified by the Chief Actuary of the Centers for Medicare & Medicaid Services); and

(II) who are uninsured in the most recent period for which data is available (as so estimated and certified),

minus 0.2 percentage points for each of fiscal years 2018 and 2019.

(C) FACTOR THREE.—A factor equal to the percent, for each subsection (d) hospital, that represents the quotient of—

(i) the amount of uncompensated care for such hospital for a period selected by the Secretary (as estimated by the Secretary, based on appropriate data (including, in the case where the Secretary determines that alternative data is available which is a better proxy for the costs of subsection (d) hospitals for treating the uninsured, the use of such alternative data)); and

(ii) the aggregate amount of uncompensated care for all subsection (d) hospitals that receive a payment under this subsection for such period (as so estimated, based on such data).

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

(A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).

(B) Any period selected by the Secretary for such purposes.

(s) PROSPECTIVE PAYMENT FOR PSYCHIATRIC HOSPITALS.—

(1) REFERENCE TO ESTABLISHMENT AND IMPLEMENTATION OF SYSTEM.—For provisions related to the establishment and implementation of a prospective payment system for payments under this title for inpatient hospital services furnished by psychiatric hospitals (as described in clause (i) of subsection (d)(1)(B)) and psychiatric units (as described in the matter following clause (v) of such subsection), see section 124 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999.

(2) IMPLEMENTATION FOR RATE YEAR BEGINNING IN 2010 AND SUBSEQUENT RATE YEARS.—

(A) IN GENERAL.—In implementing the system described in paragraph (1) for the rate year beginning in 2010 and any subsequent rate year, any update to a base rate for days during the rate year for a psychiatric hospital or unit, respectively, shall be reduced—

(i) for the rate year beginning in 2012 and each subsequent rate year, by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II); and

(ii) for each of the rate years beginning in 2010 through 2019, by the other adjustment described in paragraph (3).

(B) SPECIAL RULE.—The application of this paragraph may result in such update being less than 0.0 for a rate year, and may result in payment rates under the system described in paragraph (1) for a rate year being less than such payment rates for the preceding rate year.

(3) OTHER ADJUSTMENT.—For purposes of paragraph (2)(A)(ii), the other adjustment described in this paragraph is—

(A) for each of the rate years beginning in 2010 and 2011, 0.25 percentage point;

(B) for each of the rate years beginning in 2012 and 2013, 0.1 percentage point;

(C) for the rate year beginning in 2014, 0.3 percentage point;

(D) for each of the rate years beginning in 2015 and 2016, 0.2 percentage point; and

(E) for each of the rate years beginning in 2017, 2018, and 2019, 0.75 percentage point.

(4) QUALITY REPORTING.—

(A) REDUCTION IN UPDATE FOR FAILURE TO REPORT.—

(i) IN GENERAL.—Under the system described in paragraph (1), for rate year 2014 and each subsequent rate year, in the case of a psychiatric hospital or psychiatric unit that does not submit data to the Secretary in accordance with subparagraph (C) with respect to such a rate year, any annual update to a standard Federal rate for discharges for the hospital during the rate year, and after application of paragraph (2), shall be reduced by 2 percentage points.

(ii) SPECIAL RULE.—The application of this subparagraph may result in such annual update being less than 0.0 for a rate year, and may result in payment rates under the system described in paragraph (1) for a rate year being less than such payment rates for the preceding rate year.

(B) NONCUMULATIVE APPLICATION.—Any reduction under subparagraph (A) shall apply only with respect to the rate year involved and the Secretary shall not take into account such reduction in computing the payment amount under the system described in paragraph (1) for a subsequent rate year.

(C) SUBMISSION OF QUALITY DATA.—For rate year 2014 and each subsequent rate year, each psychiatric hospital and psychiatric unit shall submit to the Secretary data on quality measures specified under subparagraph (D). Such data shall be submitted in a form and manner, and at a time, specified by the Secretary for purposes of this subparagraph.

(D) QUALITY MEASURES.—

(i) IN GENERAL.—Subject to clause (ii), any measure specified by the Secretary under this subparagraph must have been endorsed by the entity with a contract under section 1890(a).

(ii) EXCEPTION.—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), the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

(iii) TIME FRAME.—Not later than October 1, 2012, the Secretary shall publish the measures selected under this subparagraph that will be applicable with respect to rate year 2014.

(E) PUBLIC AVAILABILITY OF DATA SUBMITTED.—The Secretary shall establish procedures for making data submitted under subparagraph (C) available to the public. Such procedures shall ensure that a psychiatric hospital and a psychiatric unit has the opportunity to review the data that is to be made public with respect to the hospital or unit prior to such data being made public. The Secretary shall report quality measures that relate to services furnished in inpatient settings in psychiatric hospitals and psychiatric units on the Internet website of the Centers for Medicare & Medicaid Services.

(t) RELATING SIMILAR INPATIENT AND OUTPATIENT HOSPITAL SERVICES.—

(1) DEVELOPMENT OF HCPCS VERSION OF MS–DRG CODES.—

(A) IN GENERAL.—Not later than January 1, 2018, the Secretary shall develop HCPCS versions for MS–DRGs that is similar to the ICD–10–PCS for such MS–DRGs such that, to the extent possible, the MS–DRG assignment shall be similar for a claim coded with the HCPCS version as an identical claim coded with a ICD–10–PCS code.

(B) COVERAGE OF SURGICAL MS–DRGS.—In carrying out subparagraph (A), the Secretary shall develop HCPCS versions of MS–DRG codes for not fewer than 10 surgical MS–DRGs.

(C) PUBLICATION AND DISSEMINATION OF THE HCPCS VERSIONS OF MS–DRGS.—

(i) IN GENERAL.—The Secretary shall develop a HCPCS MS–DRG definitions manual and software that is similar to the definitions manual and software for ICD–10–PCS codes for such MS–DRGs. The Secretary shall post the HCPCS MS–DRG definitions manual and software on the Internet website of the Centers for Medicare & Medicaid Services. The HCPCS MS–DRG definitions manual and software shall be in the public domain and available for use and redistribution without charge.

(ii) USE OF PREVIOUS ANALYSIS DONE BY MEDPAC.—In developing the HCPCS MS–DRG definitions manual and software under clause (i), the Secretary shall consult with the Medicare Payment Advisory Commission and shall consider the analysis done by such Commission in translating outpatient surgical claims into

inpatient surgical MS–DRGs in preparing chapter 7 (relating to hospital short-stay policy issues) of its "Medicare and the Health Care Delivery System" report submitted to Congress in June 2015.

(D) DEFINITION AND REFERENCE.—In this paragraph:

(i) HCPCS.—The term "HCPCS" means, with respect to hospital items and services, the code under the Healthcare Common Procedure Coding System (HCPCS) (or a successor code) for such items and services.

(ii) ICD–10–PCS.—The term "ICD–10–PCS" means the International Classification of Diseases, 10th Revision, Procedure Coding System, and includes a subsequent revision of such International Classification of Diseases, Procedure Coding System.

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MEDICARE PRESCRIPTION DRUG, IMPROVEMENT, AND MODERNIZATION ACT OF 2003

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TITLE IV—RURAL PROVISIONS

Subtitle A—Provisions Relating to Part A Only

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SEC. 410A. RURAL COMMUNITY HOSPITAL DEMONSTRATION PROGRAM.

(a) ESTABLISHMENT OF RURAL COMMUNITY HOSPITAL (RCH) DEMONSTRATION PROGRAM.—

(1) IN GENERAL.—The Secretary shall establish a demonstration program to test the feasibility and advisability of the establishment of rural community hospitals (as defined in subsection (f)(1)) to furnish covered inpatient hospital services (as defined in subsection (f)(2)) to medicare beneficiaries.

(2) DEMONSTRATION AREAS.—The program shall be conducted in rural areas selected by the Secretary in States with low population densities, as determined by the Secretary.

(3) APPLICATION.—Each rural community hospital that is located in a demonstration area selected under paragraph (2) that desires to participate in the demonstration program under this section shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

(4) SELECTION OF HOSPITALS.—The Secretary shall select from among rural community hospitals submitting applications under paragraph (3) not more than 15 of such hospitals to participate in the demonstration program under this section.

(5) DURATION.—The Secretary shall conduct the demonstration program under this section for a 5-year period (in this section referred to as the "initial 5-year period") and, as provided

in subsection (g), for the [5-year extension period] *10-year extension period*.

(6) IMPLEMENTATION.—The Secretary shall implement the demonstration program not later than January 1, 2005, but may not implement the program before October 1, 2004.

(b) PAYMENT.—

(1) IN GENERAL.—The amount of payment under the demonstration program for covered inpatient hospital services furnished in a rural community hospital, other than such services furnished in a psychiatric or rehabilitation unit of the hospital which is a distinct part, is—

(A) for discharges occurring in the first cost reporting period beginning on or after the implementation of the demonstration program, the reasonable costs of providing such services; and

(B) for discharges occurring in a subsequent cost reporting period under the demonstration program, the lesser of—

(i) the reasonable costs of providing such services in the cost reporting period involved; or

(ii) the target amount (as defined in paragraph (2)), applicable to the cost reporting period involved.

(2) TARGET AMOUNT.—For purposes of paragraph (1)(B)(ii), the term "target amount" means, with respect to a rural community hospital for a particular 12-month cost reporting period—

(A) in the case of the second such cost reporting period for which this subsection is in effect, the reasonable costs of providing such covered inpatient hospital services as determined under paragraph (1)(A), and

(B) in the case of a later cost reporting period, the target amount for the preceding 12-month cost reporting period, increased by the applicable percentage increase (under clause (i) of section 1886(b)(3)(B) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B))) in the market basket percentage increase (as defined in clause (iii) of such section) for that particular cost reporting period.

(c) FUNDING.—

(1) IN GENERAL.—The Secretary shall provide for the transfer from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) of such funds as are necessary for the costs of carrying out the demonstration program under this section.

(2) BUDGET NEUTRALITY.—In conducting the demonstration program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration program under this section was not implemented.

(d) WAIVER AUTHORITY.—The Secretary may waive such requirements of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) as may be necessary for the purpose of carrying out the demonstration program under this section.

(e) REPORT.—[Not later than 6 months after the completion of the demonstration program under this section] *Not later than August 1, 2018*, the Secretary shall submit to Congress a report on

[such program] *the demonstration program under this section*, together with recommendations for such legislation and administrative action as the Secretary determines to be appropriate.

(f) DEFINITIONS.—In this section:

(1) RURAL COMMUNITY HOSPITAL DEFINED.—

(A) IN GENERAL.—The term "rural community hospital" means a hospital (as defined in section 1861(e) of the Social Security Act (42 U.S.C. 1395x(e))) that—

(i) is located in a rural area (as defined in section 1886(d)(2)(D) of such Act (42 U.S.C. 1395ww(d)(2)(D))) or treated as being so located pursuant to section 1886(d)(8)(E) of such Act (42 U.S.C. 1395ww(d)(8)(E));

(ii) subject to subparagraph (B), has fewer than 51 acute care inpatient beds, as reported in its most recent cost report;

(iii) makes available 24-hour emergency care services; and

(iv) is not eligible for designation, or has not been designated, as a critical access hospital under section 1820.

(B) TREATMENT OF PSYCHIATRIC AND REHABILITATION UNITS.—For purposes of subparagraph (A)(ii), beds in a psychiatric or rehabilitation unit of the hospital which is a distinct part of the hospital shall not be counted.

(2) COVERED INPATIENT HOSPITAL SERVICES.—The term "covered inpatient hospital services" means inpatient hospital services, and includes extended care services furnished under an agreement under section 1883 of the Social Security Act (42 U.S.C. 1395tt).

(g) [FIVE-YEAR] *TEN-YEAR* EXTENSION OF DEMONSTRATION PROGRAM.—

(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, the Secretary shall conduct the demonstration program under this section for an [additional 5-year] *additional 10-year* period (in this section referred to as the "[5-year extension period] *10-year extension period*") that begins on the date immediately following the last day of the initial 5-year period under subsection (a)(5).

(2) EXPANSION OF DEMONSTRATION STATES.—Notwithstanding subsection (a)(2), during the [5-year extension period] *10-year extension period*, the Secretary shall expand the number of States with low population densities determined by the Secretary under such subsection to 20. In determining which States to include in such expansion, the Secretary shall use the same criteria and data that the Secretary used to determine the States under such subsection for purposes of the initial 5-year period.

(3) INCREASE IN MAXIMUM NUMBER OF HOSPITALS PARTICIPATING IN THE DEMONSTRATION PROGRAM.—Notwithstanding subsection (a)(4), during the [5-year extension period] *10-year extension period*, not more than 30 rural community hospitals may participate in the demonstration program under this section.

(4) HOSPITALS IN DEMONSTRATION PROGRAM ON DATE OF ENACTMENT.—In the case of a rural community hospital that is

participating in the demonstration program under this section as of the last day of the initial 5-year period, the Secretary—

(A) shall provide for the continued participation of such rural community hospital in the demonstration program during the [5-year extension period] *10-year extension period* unless the rural community hospital makes an election, in such form and manner as the Secretary may specify, to discontinue such participation; and

(B) in calculating the amount of payment under subsection (b) to the rural community hospital for covered inpatient hospital services furnished by the hospital during *each 5-year period in* such [5-year extension period] *10-year extension period*, shall substitute, under paragraph (1)(A) of such subsection—

(i) the reasonable costs of providing such services for discharges occurring in the first cost reporting period beginning on or after the first day of *each applicable 5-year period in* the [5-year extension period] *10-year extension period*, for

(ii) the reasonable costs of providing such services for discharges occurring in the first cost reporting period beginning on or after the implementation of the demonstration program.

(5) OTHER HOSPITALS IN DEMONSTRATION PROGRAM.—During the second 5 years of the 10-year extension period, the Secretary shall apply the provisions of paragraph (4) to rural community hospitals that are not described in paragraph (4) but are participating in the demonstration program under this section as of December 30, 2014, in a similar manner as such provisions apply to rural community hospitals described in paragraph (4).

(6) EXPANSION OF DEMONSTRATION PROGRAM TO RURAL AREAS IN ANY STATE.—

(A) IN GENERAL.—The Secretary shall, notwithstanding subsection (a)(2) or paragraph (2) of this subsection, not later than 120 days after the date of the enactment of this paragraph, issue a solicitation for applications to select up to the maximum number of additional rural community hospitals located in any State to participate in the demonstration program under this section for the second 5 years of the 10-year extension period without exceeding the limitation under paragraph (3) of this subsection.

(B) PRIORITY.—In determining which rural community hospitals that submitted an application pursuant to the solicitation under subparagraph (A) to select for participation in the demonstration program, the Secretary—

(i) shall give priority to rural community hospitals located in one of the 20 States with the lowest population densities (as determined by the Secretary using the 2015 Statistical Abstract of the United States); and

(ii) may consider—

(I) closures of hospitals located in rural areas in the State in which the rural community hospital is located during the 5-year period immediately preceding the date of the enactment of this paragraph; and

(II) the population density of the State in which the rural community hospital is located.

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MEDICARE, MEDICAID, AND SCHIP EXTENSION ACT OF 2007

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TITLE I—MEDICARE

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SEC. 114. LONG-TERM CARE HOSPITALS.

(a) [Omitted—Amends other Act]

(b) STUDY AND REPORT ON LONG-TERM CARE HOSPITAL FACILITY AND PATIENT CRITERIA.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the "Secretary") shall conduct a study on the establishment of national long-term care hospital facility and patient criteria for purposes of determining medical necessity, appropriateness of admission, and continued stay at, and discharge from, long-term care hospitals.

(2) REPORT.—Not later than 18 months after the date of the enactment of this Act, the Secretary shall submit to Congress a report on the study conducted under paragraph (1), together with recommendations for such legislation and administrative actions, including timelines for implementation of patient criteria or other actions, as the Secretary determines appropriate.

(3) CONSIDERATIONS.—In conducting the study and preparing the report under this subsection, the Secretary shall consider—

(A) recommendations contained in a report to Congress by the Medicare Payment Advisory Commission in June 2004 for long-term care hospital-specific facility and patient criteria to ensure that patients admitted to long-term care hospitals are medically complex and appropriate to receive long-term care hospital services; and

(B) ongoing work by the Secretary to evaluate and determine the feasibility of such recommendations.

(c) PAYMENT FOR LONG-TERM CARE HOSPITAL SERVICES.—

(1) DELAY IN APPLICATION OF 25 PERCENT PATIENT THRESHOLD PAYMENT ADJUSTMENT.—The Secretary shall not apply, for cost reporting periods beginning on or after July 1, 2007,—

(A) for a 9-year period, section 412.536 of title 42, Code of Federal Regulations, or any similar provision, to free-standing long-term care hospitals or to a long-termcare hospital, or satellite facility, that as of December29, 2007, was co-located with an entity that is a provider-based, off-campus location of a subsection (d) hospital whichdid not provide services payable under section 1886(d) ofthe Social Security Act at the off-campus location; and

(B) such section or section 412.534 of title 42, Code of Federal Regulations, or any similar provisions, to a long-

term care hospital identified by the amendment made by section 4417(a) of the Balanced Budget Act of 1997 (Public Law 105–33).

(2) PAYMENT FOR HOSPITALS-WITHIN-HOSPITALS.—

(A) IN GENERAL.—Payment to an applicable long-term care hospital or satellite facility which is located in a rural area or which is co-located with an urban single or MSA dominant hospital under paragraphs (d)(1), (e)(1), and (e)(4) of section 412.534 of title 42, Code of Federal Regulations, shall not be subject to any payment adjustment under such section if no more than 75 percent of the hospital's Medicare discharges (other than discharges described in paragraph (d)(2) or (e)(3) of such section) are admitted from a co-located hospital.

(B) CO-LOCATED LONG-TERM CARE HOSPITALS AND SATELLITE FACILITIES.—

(i) IN GENERAL.—Payment to an applicable long-term care hospital or satellite facility which is co-located with another hospital shall not be subject to any payment adjustment under section 412.534 of title 42, Code of Federal Regulations, if no more than 50 percent of the hospital's Medicare discharges (other than discharges described in paragraph (c)(3) of such section) are admitted from a co-located hospital.

(ii) APPLICABLE LONG-TERM CARE HOSPITAL OR SATELLITE FACILITY DEFINED.—In this paragraph, the term "applicable long-term care hospital or satellite facility" means a hospital or satellite facility that is subject to the transition rules under section 412.534(g) of title 42, Code of Federal Regulations or that isdescribed in section 412.22(h)(3)(i) of such title.

(C) EFFECTIVE DATE.—Subparagraphs (A) and (B) shall apply to cost reporting periods beginning on or after October 1, 2007 (or July 1, 2007, in the case of a satellite facility described in section 412.22(h)(3)(i) of title 42, Code of Federal Regulations) for a 9-year period.

(3) NO APPLICATION OF VERY SHORT-STAY OUTLIER POLICY.—The Secretary shall not apply, for the 5-year period beginning on the date of the enactment of this Act, the amendments finalized on May 11, 2007 (72 Federal Register 26904, 26992) made to the short-stay outlier payment provision for long-term care hospitals contained in section 412.529(c)(3)(i) of title 42, Code of Federal Regulations, or any similar provision.

(4) NO APPLICATION OF ONE-TIME ADJUSTMENT TO STANDARD AMOUNT.—The Secretary shall not, for the 5-year period beginning on the date of the enactment of this Act, make the one-time prospective adjustment to long-term care hospital prospective payment rates provided for in section 412.523(d)(3) of title 42, Code of Federal Regulations, or any similar provision.

(d) MORATORIUM ON THE ESTABLISHMENT OF LONG-TERM CARE HOSPITALS, LONG-TERM CARE SATELLITE FACILITIES AND ON THE INCREASE OF LONG-TERM CARE HOSPITAL BEDS IN EXISTING LONG-TERM CARE HOSPITALS OR SATELLITE FACILITIES.—

(1) IN GENERAL.—During the 5-year period (and for the period beginning on the date of the enactment of paragraph (7)

of this subsection and ending September 30, 2017) beginning on the date of the enactment of this Act, the Secretary shall impose a moratorium for purposes of the Medicare program under title XVIII of the Social Security Act—

(A) subject to paragraph (2), on the establishment and classification of a long-term care hospital or satellite facility, other than an existing long-term care hospital or facility; and

(B) subject to paragraph (3), on an increase of long-term care hospital beds in existing long-term care hospitals or satellite facilities.

(2) EXCEPTION FOR CERTAIN LONG-TERM CARE HOSPITALS.—The moratorium under paragraph (1)(A) shall not apply to a long-term care hospital that as of the date of the enactment of this Act—

(A) began its qualifying period for payment as a long-term care hospital under section 412.23(e) of title 42, Code of Federal Regulations, on or before the date of the enactment of this Act;

(B) has a binding written agreement with an outside, unrelated party for the actual construction, renovation, lease, or demolition for a long-term care hospital, and has expended, before the date of the enactment of this Act, at least 10 percent of the estimated cost of the project (or, if less, $2,500,000); or

(C) has obtained an approved certificate of need in a State where one is required on or before the date of the enactment of this Act.

(3) EXCEPTION FOR BED INCREASES DURING MORATORIUM.—

(A) IN GENERAL.—Subject to subparagraph (B), the moratorium under paragraph (1)(B) shall not apply to an increase in beds in an existing hospital or satellite facility if the hospital or facility obtained a certificate of need for an increase in beds that is in a State for which such certificate of need is required and that was issued on or after April 1, 2005, and before December 29, 2007, or if the hospital or facility—

(i) is located in a State where there is only one other long-term care hospital; and

(ii) requests an increase in beds following the closure or the decrease in the number of beds of another long-term care hospital in the State.

(B) NO EFFECT ON CERTAIN LIMITATION.—The exception under subparagraph (A) shall not effect the limitation on increasing beds under sections 412.22(h)(3) and 412.22(f) of title 42, Code of Federal Regulations.

(4) EXISTING HOSPITAL OR SATELLITE FACILITY DEFINED.—For purposes of this subsection, the term "existing" means, with respect to a hospital or satellite facility, a hospital or satellite facility that received payment under the provisions of subpart O of part 412 of title 42, Code of Federal Regulations, as of the date of the enactment of this Act.

(5) JUDICIAL REVIEW.—There shall be no administrative or judicial review under section 1869 of the Social Security Act (42 U.S.C. 1395ff), section 1878 of such Act (42 U.S.C. 1395oo),

or otherwise, of the application of this subsection by the Secretary.

(6) LIMITATION ON APPLICATION OF EXCEPTIONS.—Paragraphs (2) and (3) shall not apply during the period beginning on the date of the enactment of paragraph (7) of this subsection and ending September 30, 2017.

(7) ADDITIONAL EXCEPTION FOR CERTAIN LONG-TERM CARE HOSPITALS.—**[**The moratorium under paragraph (1)(A)**]** *Any moratorium under paragraph (1)* shall not apply to a long-term care hospital that—

(A) began its qualifying period for payment as a long-term care hospital under section 412.23(e) of title 42, Code of Federal Regulations, on or before the date of enactment of this paragraph;

(B) has a binding written agreement as of the date of the enactment of this paragraph with an outside, unrelated party for the actual construction, renovation, lease, or demolition for a long-term care hospital, and has expended, before such date of enactment, at least 10 percent of the estimated cost of the project (or, if less, $2,500,000); or

(C) has obtained an approved certificate of need in a State where one is required on or before such date of enactment.

(e) LONG-TERM CARE HOSPITAL PAYMENT UPDATE.—

(1) [Omitted—amends other Act]

(2) DELAYED EFFECTIVE DATE.—Subsection (m)(2) of section 1886 of the Social Security Act, as added by paragraph (1), shall not apply to discharges occurring on or after July 1, 2007, and before April 1, 2008.

(f) EXPANDED REVIEW OF MEDICAL NECESSITY.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall provide, under contracts with one or more appropriate fiscal intermediaries or medicare administrative contractors under section 1874A(a)(4)(G) of the Social Security Act (42 U.S.C. 1395kk–1(a)(4)(G)), for reviews of the medical necessity of admissions to long-term care hospitals (described in section 1886(d)(1)(B)(iv) of such Act) and continued stay at such hospitals, of individuals entitled to, or enrolled for, benefits under part A of title XVIII of such Act consistent with this subsection. Such reviews shall be made for discharges occurring on or after October 1, 2007.

(2) REVIEW METHODOLOGY.—The medical necessity reviews under paragraph (1) shall be conducted on an annual basis in accordance with rules specified by the Secretary. Such reviews shall—

(A) provide for a statistically valid and representative sample of admissions of such individuals sufficient to provide results at a 95 percent confidence interval; and

(B) guarantee that at least 75 percent of overpayments received by long-term care hospitals for medically unnecessary admissions and continued stays of individuals in long-term care hospitals will be identified and recovered and that related days of care will not be counted toward the length of stay requirement contained in section

1886(d)(1)(B)(iv) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)(iv)).

(3) CONTINUATION OF REVIEWS.—Under contracts under this subsection, the Secretary shall establish an error rate with respect to such reviews that could require further review of the medical necessity of admissions and continued stay in the hospital involved and other actions as determined by the Secretary.

(4) TERMINATION OF REQUIRED REVIEWS.—

(A) IN GENERAL.—Subject to subparagraph (B), the previous provisions of this subsection shall cease to apply for discharges occurring on or after October 1, 2010.

(B) CONTINUATION.—As of the date specified in subparagraph (A), the Secretary shall determine whether to continue to guarantee, through continued medical review and sampling under this paragraph, recovery of at least 75 percent of overpayments received by long-term care hospitals due to medically unnecessary admissions and continued stays.

(5) FUNDING.—The costs to fiscal intermediaries or medicare administrative contractors conducting the medical necessity reviews under paragraph (1) shall be funded from the aggregate overpayments recouped by the Secretary of Health and Human Services from long-term care hospitals due to medically unnecessary admissions and continued stays. The Secretary may use an amount not in excess of 40 percent of the overpayments recouped under this paragraph to compensate the fiscal intermediaries or Medicare administrative contractors for the costs of services performed.

(g) IMPLEMENTATION.—For purposes of carrying out the provisions of, and amendments made by, this title, in addition to any amounts otherwise provided in this title, there are appropriated to the Centers for Medicare & Medicaid Services Program Management Account, out of any money in the Treasury not otherwise appropriated, $35,000,000 for the period of fiscal years 2008 and 2009.

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TMA, ABSTINENCE EDUCATION, AND QI PROGRAMS EXTENSION ACT OF 2007

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SEC. 7. DOCUMENTATION AND CODING ADJUSTMENTS IN RESPONSE TO THE IMPLEMENTATION OF THE MEDICARE SEVERITY DIAGNOSIS RELATED GROUP (MS-DRG) SYSTEM UNDER THE MEDICARE PROSPECTIVE PAYMENT SYSTEM FOR INPATIENT HOSPITAL SERVICES.

(a) IN GENERAL.—In implementing the final rule published on August 22, 2007, on pages 47130 through 48175 of volume 72 of the Federal Register, the Secretary of Health and Human Services (in this section referred to as the "Secretary") shall apply prospective documentation and coding adjustments (made in response to the implementation of a Medicare Severity Diagnosis Related Group (MS-DRG) system under the hospital inpatient prospective

payment system under section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)) of—

(1) for discharges occurring during fiscal year 2008, 0.6 percent rather than the 1.2 percent specified in such final rule; and

(2) for discharges occurring during fiscal year 2009, 0.9 percent rather than the 1.8 percent specified in such final rule.

(b) SUBSEQUENT ADJUSTMENTS.—

(1) IN GENERAL.—Notwithstanding any other provision of law, if the Secretary determines that implementation of such Medicare Severity Diagnosis Related Group (MS-DRG) system resulted in changes in coding and classification that did not reflect real changes in case mix under section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)) for discharges occurring during fiscal year 2008 or 2009 that are different than the prospective documentation and coding adjustments applied under subsection (a) or otherwise applied for such year, the Secretary shall—

(A) make an appropriate adjustment under paragraph (3)(A)(vi) of such section 1886(d); and

(B)(i) make an additional adjustment to the standardized amounts under such section 1886(d) for discharges occurring only during fiscal years 2010, 2011, and 2012 to offset the estimated amount of the increase in aggregate payments (including interest as determined by the Secretary) determined, based upon a retrospective evaluation of claims data submitted under such Medicare Severity Diagnosis Related Group (MS-DRG) system, by the Secretary with respect to discharges occurring during fiscal years 2008 and 2009;

(ii) make an additional adjustment to the standardized amounts under such section 1886(d) based upon the Secretary's estimates for discharges occurring only during fiscal years 2014, 2015, 2016, and 2017 to fully offset $11,000,000,000 (which represents the amount of the increase in aggregate payments from fiscal years 2008 through 2013 for which an adjustment was not previously applied); and

(iii) make an additional adjustment to the standardized amounts under such section 1886(d) of ❚an increase of 0.5 percentage points for discharges occurring during each of fiscal years 2018 through 2023❚ *an increase of 0.4590 percentage points for discharges occurring during fiscal year 2018 and 0.5 percentage points for discharges occurring during each of fiscal years 2019 through 2023* and not make the adjustment (estimated to be an increase of 3.2 percent) that would otherwise apply for discharges occurring during fiscal year 2018 by reason of the completion of the adjustments required under clause (ii).

(2) REQUIREMENT.—Any adjustment under paragraph (1)(B) shall reflect the difference between the amount the Secretary estimates that implementation of such Medicare Severity Diagnosis Related Group (MS-DRG) system resulted in changes in coding and classification that did not reflect real changes in case mix and the prospective documentation and coding adjust-

ments applied under subsection (a). An adjustment made under paragraph (1)(B) for discharges occurring in a year shall not be included in the determination of standardized amounts for discharges occurring in a subsequent year.

(3) PROHIBITION.—The Secretary shall not make an additional prospective adjustment (estimated to be a decrease of 0.55 percent) to the standardized amounts under such section 1886(d) to offset the amount of the increase in aggregate payments related to documentation and coding changes for discharges occurring during fiscal year 2010.

(4) RULE OF CONSTRUCTION.—Nothing in this section shall be construed as providing authority to apply the adjustment under paragraph (1)(B) other than for discharges occurring during fiscal years 2010, 2011, 2012, 2014, 2015, 2016, and 2017 and each succeeding fiscal year through fiscal year 2023.

(5) JUDICIAL REVIEW.—There shall be no administrative or judicial review under section 1878 of the Social Security Act (42 U.S.C. 1395oo) or otherwise of any determination or adjustments made under this subsection.

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