

OPIOID WORKFORCE ACT OF 2019

DECEMBER 24, 2020.—Committed to the Committee on the Whole House on the State of the Union and ordered to be printed

Mr. NEAL, from the Committee on Ways and Means,
 submitted the following

R E P O R T

together with

DISSENTING VIEWS

[To accompany H.R. 3414]

[Including cost estimate of the Congressional Budget Office]

The Committee on Ways and Means, to whom was referred the bill (H.R. 3414) to amend title XVIII of the Social Security Act to provide for the distribution of additional residency positions to help combat the opioid crisis, having considered the same, reports favorably thereon with an amendment and recommends that the bill as amended do pass.

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The amendment is as follows:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the “Opioid Workforce Act of 2019”.

SEC. 2. DISTRIBUTION OF ADDITIONAL RESIDENCY POSITIONS TO HELP COMBAT OPIOID CRISIS.

(a) IN GENERAL.—Section 1886(h) of the Social Security Act (42 U.S.C. 1395ww(h)) is amended—

(1) in paragraph (4)(F)(i), by striking “paragraphs (7) and (8)” and inserting “paragraphs (7), (8), and (9)”;

(2) in paragraph (4)(H)(i), by striking “paragraphs (7) and (8)” and inserting “paragraphs (7), (8), and (9)”;

(3) in paragraph (7)(E), by inserting “paragraph (9),” after “paragraph (8),”; and

(4) by adding at the end the following new paragraph:

“(9) DISTRIBUTION OF ADDITIONAL RESIDENCY POSITIONS TO HELP COMBAT OPIOID CRISIS.—

“(A) ADDITIONAL RESIDENCY POSITIONS.—During the period of fiscal years 2022 through 2026 (and succeeding fiscal years if the Secretary determines that there are additional full-time-equivalent residency positions available to distribute under subparagraph (D)), the Secretary shall distribute additional full-time-equivalent residency positions to increase the otherwise applicable resident limit for each qualifying hospital that submits a timely application under this paragraph by such number as the Secretary may approve, effective beginning July 1 of the fiscal year of the increase. The aggregate number of additional full-time-equivalent residency positions available for distribution under this paragraph shall be equal to 500 in fiscal year 2022 and 500 over the period of fiscal years 2023 through 2026, distributed in accordance with the succeeding subparagraphs of this paragraph.

“(B) DISTRIBUTION FOR FISCAL YEAR 2022.—

“(i) IN GENERAL.—For fiscal year 2022, the positions available for distribution for such fiscal year (as described in subparagraph (A)) may only be distributed to hospitals that have established (as of the date of the enactment of this paragraph) approved programs in addiction medicine, addiction psychiatry, or pain medicine, as determined by the Secretary.

“(ii) CONSIDERATIONS IN DISTRIBUTION.—The Secretary shall distribute additional residency positions under this subparagraph based on the demonstrated likelihood, as determined by the Secretary, of the hospital filling such positions within the first 4 training years (as specified by the Secretary) after the increase would be effective.

“(iii) REQUIREMENTS.—A hospital that receives an increase in the otherwise applicable resident limit under this subparagraph shall ensure, during the 5-year period beginning after the date of such increase, that the hospital uses the positions made available under this subparagraph for a program described in clause (i) or a program that is a prerequisite (as determined by the Secretary) for such a program so described, such as internal medicine. 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.

“(iv) REDISTRIBUTION OF POSITIONS IF HOSPITAL NO LONGER MEETS CERTAIN REQUIREMENTS.—In the case in which the Secretary determines that a hospital described in clause (iii) does not meet the requirements 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 subparagraph; and

“(II) provide for the distribution of positions attributable to such reduction in accordance with the requirements of this paragraph.

“(v) POSITIONS NOT DISTRIBUTED DURING FISCAL YEAR 2022.—If the number of full-time-equivalent residency positions distributed under this subparagraph is less than the aggregate number of positions available for distribution for fiscal year 2022 (as described in subparagraph (A)), the difference between such number distributed and such number available for distribution shall be added to the aggregate number of positions available for distribution under subparagraph (C).

“(C) DISTRIBUTION FOR FISCAL YEARS 2023 THROUGH 2026.—

“(i) IN GENERAL.—For the period of fiscal years 2023 through 2026, the positions available for distribution for such period (as described in subparagraph (A)), and any positions made available pursuant to subparagraph (B)(v), shall be distributed to hospitals which demonstrate to the Secretary that the hospital has established or will establish an approved residency training program in addiction medicine, addiction psychiatry, or pain medicine.

“(ii) CONSIDERATIONS IN DISTRIBUTION.—The Secretary shall distribute additional residency positions under this subparagraph based on the demonstrated likelihood, as determined by the Secretary, of the hospital filling such positions within the first 4 training years (as specified by the Secretary) after the increase would be effective.

“(iii) REQUIREMENTS.—A hospital that receives an increase in the otherwise applicable resident limit under this subparagraph shall ensure, during the 5-year period beginning after the date of such increase, that the hospital uses the positions made available under this subparagraph for a program described in clause (i) or a program that is a prerequisite (as determined by the Secretary) for such a program so described, such as internal medicine. 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.

“(iv) REDISTRIBUTION OF POSITIONS IF HOSPITAL NO LONGER MEETS CERTAIN REQUIREMENTS.—In the case where the Secretary determines that a hospital described in clause (iii) does not meet the requirements 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 subparagraph; and

“(II) provide for the distribution of positions attributable to such reduction in accordance with the requirements of this paragraph.

“(D) DISTRIBUTION OF REMAINING POSITIONS.—If the aggregate number of positions distributed under subparagraphs (B) and (C) during the period of fiscal years 2022 through 2026 is less than 1000, the Secretary shall distribute the remaining residency positions in succeeding fiscal years according to criteria consistent with this paragraph until such time as the aggregate amount of positions distributed under this paragraph is equal to 1000.

“(E) LIMITATION.—An individual hospital may not receive more than 25 full-time-equivalent residency positions under this paragraph.

“(F) NOTIFICATION.—The Secretary shall notify hospitals of the number of positions distributed to the hospital under this paragraph as a result of an increase in the otherwise applicable resident limit by January 1 of the fiscal year of the increase. Such increase shall be effective beginning July 1 of that fiscal year.

“(G) APPLICATION OF PER RESIDENT AMOUNTS FOR PRIMARY CARE AND NON-PRIMARY 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) PERMITTING FACILITIES TO APPLY AGGREGATION RULES.—The Secretary shall permit hospitals receiving additional residency positions attributable to the increase provided under this paragraph to, beginning in the fifth year after the effective date of such increase, apply such positions to the limitation amount under paragraph (4)(F) that may be aggregated pursuant to paragraph (4)(H) among members of the same affiliated group.

“(I) CLARIFICATION.—Chapter 35 of title 44, United States Code, shall not apply to the implementation of this paragraph.

“(J) DEFINITIONS.—In this paragraph:

“(i) OTHERWISE APPLICABLE RESIDENT LIMIT.—The term ‘otherwise applicable resident limit’ means, with respect to a hospital, the limit otherwise applicable under paragraph (4)(F)(i) on the resident level for the hospital determined without regard to this paragraph but taking into account paragraphs (7)(A), (7)(B), (8)(A), and (8)(B).

“(ii) RESIDENT LEVEL.—The term ‘resident level’ has the meaning given such term in paragraph (7)(C)(i).”.

(b) IME.—

(1) IN GENERAL.—Section 1886(d)(5)(B)(v) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)(v)), in the third sentence, is amended by striking “and (h)(8)” and inserting “(h)(8), and (h)(9)”.

(2) CONFORMING PROVISION.—Section 1886(d)(5)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)) is amended—

(A) by redesignating clause (x), as added by section 5505(b) of the Patient Protection and Affordable Care Act (Public Law 111–148), as clause (xi) and moving such clause 4 ems to the left; and

(B) by adding after clause (xi), as redesignated by subparagraph (A), the following new clause:

“(xii) For discharges occurring on or after July 1, 2022, insofar as an additional payment amount under this subparagraph is attributable to residency positions distributed to a hospital under subsection (h)(9), the indirect teaching adjustment factor shall be computed in the same manner as provided under clause (ii) with respect to such residency positions.”.

I. SUMMARY AND BACKGROUND

A. PURPOSE AND SUMMARY

The bill, H.R. 3414, the “Opioid Workforce Act of 2019,” as amended and ordered reported by the Committee on Ways and Means on June 26, 2019, increases the number of residency positions available to help address the physician shortage as it relates to the opioid crisis as well as other substance use and mental health disorders. The bill will open a total of 1,000 positions from fiscal year (FY) 2021 through FY 2025 to be filled with residents training in addiction medicine, addiction psychiatry, or pain management. Hospitals with existing training programs in any of the target specialties will have priority access to the expanded residency slots, up to 25 slots over the five years of the program.

This bill was introduced by Representatives Brad Schneider (D–IL), Susan Brooks (R–IN), Ann Kuster (D–NH), and Elise Stefanik (R–NY).

B. BACKGROUND AND NEED FOR LEGISLATION

The opioid crisis has increased demand for providers and specialists trained in handling addiction medicine and pain management. The demand for these specialists has far outpaced the availability, and as a result many of the individuals in crisis are being managed by emergency services or primary care physicians—neither of which is trained in how to work with patients to overcome addiction. In 2015, at the height of the opioid crisis, Pew Trusts estimated that more than 330,000 addiction service positions would need to be filled before 2020, just to keep pace with demand.¹

Similarly, more than 75 percent of all U.S. counties are considered mental health shortage areas, and half of all U.S. counties

¹Christine Vestal, *How Severe is the Shortage of Substance Abuse Specialists?* PEW (Apr. 1, 2015), <https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2015/4/01/how-severe-is-the-shortage-of-substance-abuse-specialists>.

have no mental health professional.² According to the National Alliance on Mental Illness, one in five American adults experiences a mental illness in a given year, and one in 25 experiences a serious mental illness that interferes with their daily activities.³ In the Medicare population, this rate is higher, with more than a quarter of beneficiaries experiencing some kind of mental disorder.⁴

Graduate Medical Education (GME) is the education in the form of a residency or fellowship that takes place after a provider completes medical school. GME funding is primarily provided through Medicare through direct and indirect GME and covers costs such as resident salaries and benefits, teaching hospital compensation, and funding for underserved populations. The passage of the Balanced Budget Act of 1997 capped the number of residency slots that would be paid for under Direct GME thus limiting the number of future providers to meet demand.⁵

GME programs are heavily audited and are required to submit detailed financial data. Teaching hospitals comply with these federally mandated transparency measures by annually submitting detailed Medicare cost reports to CMS. Such information includes audited financial data, total Medicare payments, total Medicare GME payments, number of resident FTEs trained, number of resident FTEs over the cap, number of resident FTEs trained outside the hospital, and total GME costs, among other metrics. During Committee consideration of H.R. 3414 Representative Adrian Smith (R-NE) offered an amendment that would have duplicated these existing reporting requirements and placed increased burdens on GMEs. The Committee accordingly rejected the amendment.

H.R. 3414 begins to address the extreme provider shortage by creating additional training slots for residents training in addiction medicine, addiction psychiatry, or pain management.

This legislation has the support of a broad cross section of medical organizations, including the Association of American Medical Colleges, American Hospital Association, America's Essential Hospitals, Federation of American Hospitals, Greater New York Hospital Association, Healthcare Leadership Council, the American Society of Addiction Medicine, National Council for Behavioral Health, American Academy of Addiction Psychiatry, American Osteopathic Academy of Addiction Medicine, American Psychiatric Association, American Association of Colleges of Osteopathic Medicine, Healthcare Association of New York State, California Hospital Association, and the Hospital and Health System Association of Pennsylvania. In a letter expressing support for H.R. 3414, 56 organizations, including those above, stated that the "Opioid Workforce Act of 2019 is a targeted and important step the Congress must take to help ensure a robust physician workforce that can de-

² *Rural Behavioral Health: Telehealth Challenges and Opportunities*, 9:2 SUBSTANCE ABUSE & MENTAL HEALTH SRVS. ADMIN. at 4 (2016), <https://store.samhsa.gov/sites/default/files/d7/priv/sma16-4989.pdf>.

³ *Mental Health By the Numbers*, NAT'L ALLIANCE ON MENTAL ILLNESS (Sept. 2019), <https://www.nami.org/mhstats>.

⁴ Beth McGinty, *Medicare's Mental Health Coverage: How COVID-19 Highlights Gaps and Opportunities for Improvement*, THE COMMONWEALTH FUND (July 9, 2020), <https://www.commonwealthfund.org/publications/issue-briefs/2020/jul/medicare-mental-health-coverage-covid-19-gaps-opportunities>.

⁵ *Consolidate and Reduce Federal Payments for Graduate Medical Education at Teaching Hospitals*, CONGRESSIONAL BUDGET OFFICE (Dec. 13, 2018), <https://www.cbo.gov/budget-options/54738>.

liver high-quality care to those suffering from substance use disorders.”⁶

C. LEGISLATIVE HISTORY

Background

H.R. 3414 was introduced on June 21, 2019 and was referred to the Committee on Ways and Means and additionally the Committee on Energy and Commerce.

Committee hearings

On June 4, 2019, the Committee on Ways and Means held a full committee Member Day hearing to discuss the range of issues, concerns, and proposals among on-committee and off-committee members. During that hearing, Representatives Brad Schneider (D–IL), Jackie Walorski (R–IN), Xochitl Torres Small (D–NM) and Anthony Brindisi (D–NY) discussed the opioid epidemic and the national physician shortage—particularly for mental health services—as well as the importance of increasing Graduate Medical Education (GME) slots.

Committee action

The Committee on Ways and Means marked up H.R. 3414, the “Opioid Workforce Act of 2019,” on June 26, 2019, and ordered the bill, as amended, favorably reported (with a quorum being present) by a roll-call vote of 25 to 12.

II. EXPLANATION OF THE BILL

A. OPIOID WORKFORCE ACT OF 2019

CURRENT LAW⁷

The Social Security Act (SSA; 42 U.S.C. 13951) Sections 1886(h) and 1886(d)(5)(B) require the Secretary of Health and Human Services (HHS Secretary) to make Medicare GME payments to hospitals for the Medicare share of direct and indirect costs, respectively, of an approved medical residency training program in allopathic or osteopathic medicine, dentistry, and podiatry.⁸ Direct costs include resident stipends, supervisory physician salaries, and administrative costs. Indirect costs associated with residency programs relate to the higher patient care costs in teaching hospitals relative to non-teaching hospitals. Medicare uses different formulae for determining payments for direct costs (referred to as Direct Graduate Medical Education or DGME) and indirect costs (referred to as Indirect Medical Education or IME). DGME is a lump sum (or pass-through) payment and IME is an adjustment to a hospital’s per-discharge Medicare payment.

Medicare GME payments for training residents in allopathic and osteopathic medicine are subject to a hospital-specific limit or “cap”

⁶Letter from 56 Health Care Organizations to the Honorable Richard Neal and the Honorable Kevin Brady in Support of H.R. 3414, AM. OSTEOPATHIC ACADEMY OF ADDICTION MEDICINE (June 26, 2019), https://aoaam.org/resources/Documents/Newsletter%20Articles/Opioid%20Workforce%20Act%20Sign-On%20Letter%202019%20FINAL_6-26.pdf.

⁷All discussions of Current Law in this report refer to current law as of the date of the markup (i.e., June 26, 2019) and do not reflect subsequent law changes.

⁸Social Security Act, 42 U.S.C. 13951 §§ 1886(h), 1886(d)(5)(B).

on the number of full-time equivalents (FTEs). The FTE cap is based on the number of FTE residents that a hospital was training in the base year, which is the hospital's most recent cost reporting period ending on or before December 31, 1996. The FTE cap applies to both DGME and IME payments.

There are some options that permit a hospital to increase its Medicare GME FTE cap. For example, a hospital may increase its FTE cap if it establishes a new GME program that meets Medicare requirements for a new program. The Centers for Medicare & Medicaid Services (CMS), however, maintains stringent requirements for new programs because it interprets the intent of the FTE cap statute to be a limit on the growth of Medicare-funded FTEs, particularly in hospitals with existing medical residency programs. Other options for a hospital to increase its FTE cap include establishing a new rural training track or a hospital may receive a temporary FTE cap increase for training residents that were in-training at another hospital that has closed.

REASONS FOR CHANGE

The opioid crisis has increased demand for providers and specialists trained in handling addiction medicine and pain management. The demand for these specialists has far outpaced the availability. As a result, many of the individuals in crisis are being managed by emergency services or primary care—neither of which is trained in how to work with patients to overcome addiction. Effective July 1, 2022, this bill will support the training of 1,000 new residencies for physicians trained to treat patients with substance use disorders to significantly increase access to patients in need and begin addressing the physician shortage.

EXPLANATION OF PROVISIONS

Section 1. Short title. The short title for this bill is the Opioid Workforce Act of 2019.

Section 2. Distribution of additional residency positions to help combat opioid crisis. This section increases the number of GME residency slots available to train addiction specialists to help combat the opioid crisis and other substance use and mental health disorders.

Effective Fiscal Year (FY) 2022, the Secretary of the Department of Health and Human Services is directed to increase the applicable resident limit for qualifying hospitals that apply under this provision to add 1,000 aggregate FTE resident positions distributed nationwide. Five-hundred positions will be distributed to hospitals with established programs in addiction medicine, addiction psychiatry, or pain medicine.

Effective FY 2023, the remaining 500 positions will be distributed to hospitals who have or will establish an approved residency training program in addiction medicine, addiction psychiatry, or pain medicine. The additional positions must be used to increase residency training in the identified areas of medicine, or the additional positions will be redistributed. No individual hospital may receive more than 25 full-time residency positions under this provision.

EFFECTIVE DATE

Section 2: Effective beginning on FY 2022.

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. 3414, the Opioid Workforce Act of 2019, on June 26, 2019.

The Chairman's amendment in the nature of a substitute was adopted by voice vote (with a quorum being present).

The bill, H.R. 3414, was ordered favorably reported as amended by a 25 12 roll-call vote (with a quorum being present). The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Neal	X	.....	.....	Mr. Brady .....	.....	X	.....
Mr. Lewis	X	.....	.....	Mr. Nunes .....	.....	.....	.....
Mr. Doggett	X	.....	.....	Mr. Buchanan	X	.....	.....
Mr. Thompson	X	.....	.....	Mr. Smith (NE) .....	.....	X	.....
Mr. Larson	X	.....	.....	Mr. Marchant .....	.....	X	.....
Mr. Blumenauer .....	.....	.....	.....	Mr. Reed .....	.....	X	.....
Mr. Kind	X	.....	.....	Mr. Kelly	X	.....	.....
Mr. Pascrell	X	.....	.....	Mr. Holding .....	.....	.....	.....
Mr. Davis	X	.....	.....	Mr. Smith (MO) .....	.....	X	.....
Ms. Sanchez	X	.....	.....	Mr. Rice .....	.....	X	.....
Mr. Higgins	X	.....	.....	Mr. Schweikert .....	.....	X	.....
Ms. Sewell	X	.....	.....	Ms. Walorski .....	.....	.....	.....
Ms. DelBene	X	.....	.....	Mr. LaHood .....	.....	X	.....
Ms. Chu	X	.....	.....	Mr. Wenstrup .....	.....	X	.....
Ms. Moore	X	.....	.....	Mr. Arrington .....	.....	X	.....
Mr. Kildee	X	.....	.....	Mr. Ferguson .....	.....	X	.....
Mr. Boyle	X	.....	.....	Mr. Estes .....	.....	X	.....
Mr. Beyer	X	.....	.....		
Mr. Evans	X	.....	.....		
Mr. Schneider	X	.....	.....		
Mr. Suozzi	X	.....	.....		
Mr. Panetta	X	.....	.....		
Ms. Murphy	X	.....	.....		
Mr. Gomez	X	.....	.....		
Mr. Horsford .....	.....	.....	.....	

VOTES ON AMENDMENTS

A roll call vote was conducted on the following amendments to the Chairman's Amendment in the Nature of a Substitute.

An amendment to the amendment in the nature of a substitute which would improve transparency and reporting on the new Medicare GME slots created under the amendment in the nature of a substitute was offered by Representatives Estes and Wenstrup.

The amendment was defeated by a roll call vote of 16 yeas to 24 nays. The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Neal	X	.....	Mr. Brady	X	.....	.....
Mr. Lewis	X	.....	Mr. Nunes	X	.....	.....
Mr. Doggett	X	.....	Mr. Buchanan	X	.....	.....
Mr. Thompson	X	.....	Mr. Smith	X	.....	.....
Mr. Larson	X	.....	Mr. Marchant	X	.....	.....
Mr. Blumenauer	X	.....	Mr. Reed	X	.....	.....

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Kind		X		Mr. Kelly	X		
Mr. Pascrell		X		Mr. Holding	X		
Mr. Davis		X		Mr. Smith	X		
Ms. Sanchez		X		Mr. Rice	X		
Mr. Higgins		X		Mr. Schweikert	X		
Ms. Sewell		X		Ms. Walorski			
Ms. DelBene		X		Mr. LaHood (IL)	X		
Ms. Chu (CA)		X		Mr. Wenstrup	X		
Ms. Moore		X		Mr. Arrington	X		
Mr. Kildee		X		Mr. Ferguson	X		
Mr. Boyle		X		Mr. Estes	X		
Mr. Beyer		X					
Mr. Evans		X					
Mr. Schneider		X					
Mr. Suozzi		X					
Mr. Panetta		X					
Ms. Murphy		X					
Mr. Gomez		X					
Mr. Horsford							

An amendment to the amendment in the nature of a substitute which would prioritize new slots created by the Amendment in the nature of a substitute was offered by Representatives Jason Smith, Arrington, Reed, Holding, Kelly, and Ferguson.

The amendment was defeated by a roll call vote of 15 yeas to 22 nays. The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Neal		X		Mr. Brady	X		
Mr. Lewis		X		Mr. Nunes			
Mr. Doggett		X		Mr. Buchanan	X		
Mr. Thompson		X		Mr. Smith	X		
Mr. Larson		X		Mr. Marchant	X		
Mr. Blumenauer		X		Mr. Reed	X		
Mr. Kind	X			Mr. Kelly	X		
Mr. Pascrell		X		Mr. Holding	X		
Mr. Davis		X		Mr. Smith	X		
Ms. Sanchez		X		Mr. Rice	X		
Mr. Higgins		X		Mr. Schweikert	X		
Ms. Sewell		X		Ms. Walorski			
Ms. DelBene		X		Mr. LaHood (IL)	X		
Ms. Chu (CA)		X		Mr. Wenstrup	X		
Ms. Moore		X		Mr. Arrington	X		
Mr. Kildee		X		Mr. Ferguson	X		
Mr. Boyle		X		Mr. Estes	X		
Mr. Beyer		X					
Mr. Evans		X					
Mr. Schneider		X					
Mr. Suozzi		X					
Mr. Panetta		X					
Ms. Murphy		X					
Mr. Gomez		X					
Mr. Horsford							

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. 3414, 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, September 16, 2019.

Hon. RICHARD NEAL,
*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. 3414, the Opioid Workforce Act of 2019.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contacts are Jamease Kowalczyk and Sarah Sajewski.

Sincerely,

PHILLIP L. SWAGEL,
Director.

Enclosure.

At a Glance			
H.R. 3414, Opioid Workforce Act of 2019			
As ordered reported by the House Committee on Ways and Means on June 26, 2019			
By Fiscal Year, Millions of Dollars	2019	2019-2024	2019-2029
Direct Spending (Outlays)	0	220	1,070
Revenues	0	0	0
Deficit Effect	0	220	1,070
Spending Subject to Appropriation (Outlays)	0	0	0
Statutory pay-as-you-go procedures apply?	Yes	Mandate Effects	
Increases on-budget deficits in any of the four consecutive 10-year periods beginning in 2030?	> \$5 billion	Contains intergovernmental mandate?	No
		Contains private-sector mandate?	No

The bill would

- Increase the limit on residency positions in hospitals that are eligible for Medicare payments

Estimated budgetary effects would primarily stem from

- Increased Medicare payments for graduate medical education

Areas of significant uncertainty include

- The number of specialty positions versus sub-specialty positions
- The time needed to fill 1,000 new full-time equivalent residency positions

Bill summary: H.R. 3414 would increase by up to 1,000 the number of full-time equivalent (FTE) residency positions eligible for Medicare payments. Those 1,000 additional positions would be for programs in addiction medicine, addiction psychiatry, and pain medicine, or for associated pre-requisite programs. The first 500 of those positions would become available in fiscal year 2022. The next 500 positions would become available during fiscal years 2023 through 2026.

Estimated federal cost: The estimated budgetary effect of H.R. 3414 is shown in Table 1. The costs of the legislation fall within budget function 570 (Medicare).

TABLE 1.—ESTIMATED BUDGETARY EFFECTS OF H.R. 3414

	By fiscal year, millions of dollars—													2019–2024	2019–2029
	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029				
Net Increases in the Deficit From Changes in Direct Spending															
Estimated Budget Authority	0	0	0	15	80	125	150	160	170	180	190	220	1,070		
Estimated Outlays	0	0	0	15	80	125	150	160	170	180	190	220	1,070		

Basis of estimate: For this estimate, CBO assumes H.R. 3414 will be enacted near the end of 2019.

CBO estimates that enacting H.R. 3414 would increase Medicare spending by increasing the number of FTE residency positions for which Medicare will pay. Currently, Medicare pays certain hospitals for some of the costs associated with medical education through two types of payments: direct graduate medical education (DGME) and indirect medical education (IME) payments. DGME is the amount Medicare pays for costs directly associated with internships and residency training (like salaries). The amount of DGME payment varies based on whether the position involves training for a specialty or a sub-specialty. Sub-specialty positions are paid at half the rate of specialty positions. IME payments cover additional costs for patient care related to internship and residency training and do not vary by specialty or sub-specialty. DGME and IME payments are calculated separately for each hospital. For fiscal year 2022, CBO estimates the average DGME payment to be about \$40,000 per FTE and the average IME payment to be about \$100,000 per FTE.

Developing and expanding a graduate medical education (GME) program can take time and be expensive; therefore, CBO expects that the number of residency positions would increase gradually between fiscal years 2022 and 2026. CBO estimates that all 1,000 residency positions would be filled in fiscal year 2026, with 500 po-

sitions in sub-specialty programs in addiction medicine, addiction psychiatry, and pain medicine, and 500 positions in pre-requisite residency programs (such as internal medicine). Based on projected DGME and IME payments per resident, CBO estimates that enacting H.R. 3414 would increase direct spending by \$1.1 billion over the 2020–2029 period.

Two key factors of this estimate are subject to uncertainty: the number of specialty versus sub-specialty positions that would be created and the length of the ramp-up period for creating them. Because the size of DGME payments varies by type of position, a change in the percentage allocated to each type could result in higher or lower spending than estimated here. Furthermore, if GME programs respond to this legislation by increasing the number of available positions at a faster or slower rate than CBO estimates, spending could also vary.

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 Table 1.

Increase in long-term deficits: CBO estimates that enacting H.R. 3414 would increase on-budget deficits by more than \$5 billion beginning in the second or third of the four consecutive 10-year periods beginning in 2030.

Mandates: None.

Estimate prepared by: Federal Costs: Jamease Kowalczyk, Sarah Sajewski; Mandates: Andrew Laughlin.

Estimate reviewed by: Tom Bradley, Chief, Health Systems and Medicare Cost Estimates Unit; Leo Lex, Deputy Assistant Director for Budget Analysis; Theresa Gullo, Assistant Director for Budget Analysis.

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

A. COMMITTEE OVERSIGHT FINDINGS AND RECOMMENDATIONS

With respect to clause 3(c)(1) of rule XIII and clause 2(b)(1) of rule X of the Rules of the House of Representatives, the Committee made findings and recommendations that are reflected in 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 deter-

mined 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 clause 3(c)(5) of rule XIII of the Rules of the House of Representatives, 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 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 section 6104 of title 31, United States Code.

F. HEARINGS

In compliance with Sec. 103(i) of H. Res. 6 (116th Congress) the following hearing was used to develop or consider H.R. 3414: Committee on Ways and Means “Member Day Hearing,” held on June 4, 2019.

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

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made 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, and existing law in which no change is proposed is shown in roman):

SOCIAL SECURITY ACT

* * * * *

TITLE XVIII—HEALTH INSURANCE FOR THE AGED AND DISABLED

* * * * *

PART E—MISCELLANEOUS PROVISIONS

* * * * *

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, other capital-related costs (as defined by the Secretary for periods before October 1, 1987), or costs with respect to administering blood clotting factors to individuals with hemophilia. 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 sub-

paragraph (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 $\frac{2}{3}$ 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 $\frac{2}{3}$ 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 re-

gard 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 (vi)(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 (vi), 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.

(XII)(aa) With respect to a Hospital Consumer Assessment of Healthcare Providers and Systems survey (or a successor survey) conducted on or after January 1, 2020, such survey may not include questions about communication by hospital staff with an individual about such individual's pain unless such questions take into account, as applicable, whether an individual experiencing pain was informed about risks associated with the use of opioids and about non-opioid alternatives for the treatment of pain.

(bb) The Secretary shall not include on the Hospital Compare internet website any measures based on the questions appearing on the Hospital Consumer Assessment of Healthcare Providers and Systems survey in 2018 or 2019 about communication by hospital staff with an individual about such individual's pain.

(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 $33\frac{1}{3}$ percent for fiscal year 2015, $66\frac{2}{3}$ 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. The Secretary shall exempt an eligible hospital from the application of the payment adjustment under subclause (I) with respect to a fiscal year, subject to annual renewal, if the Secretary determines that compliance with the requirement for being a meaningful EHR user is not possible because the certified EHR technology used by such hospital is decertified under a program kept or recognized pursuant to section 3001(c)(5) of the Public Health Service Act. 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, 2022, 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 2022, 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 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 pay-

ments 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) a hospital which has an average inpatient length of stay (as determined by the Secretary) of greater than 25 days,

(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), or

(vi) 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;

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) (as in effect as of such date) shall continue to be so classified (or, in the case of a hospital described in clause (iv)(II), as so in effect, shall be classified under clause (vi) on and after the effective date of such clause (vi) and for cost reporting periods beginning on or after January 1, 2015, shall not be subject to subsection (m) as of the date of such classification) 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 $c \times (((1+r)^n - 1) / r)$, 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)]** *(h)(8)*, and *(h)(9)* 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)] (xi)(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 resi-

gency 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.

(xii) For discharges occurring on or after July 1, 2022, insofar as an additional payment amount under this subparagraph is attributable to residency positions distributed to a hospital under subsection (h)(9), the indirect teaching adjustment factor shall be computed in the same manner as provided under clause (ii) with respect to such residency positions.

(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 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 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 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 be-

cause 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, 2022, 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, 2022, 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) that is located in—

(aa) a rural area; or

(bb) a State with no rural area (as defined in paragraph (2)(D)) and satisfies any of the criteria in subclause (I), (II), or (III) of paragraph (8)(E)(ii),

(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.

Subclause (I)(bb) shall apply for purposes of payment under clause (ii) only for discharges of a hospital occurring on or after the effective date of a determination of medicare-dependent small rural hospital status made by the Secretary with respect to the hospital after the date of the enactment of this sentence. For purposes of applying subclause (II) of paragraph (8)(E)(ii) under subclause (I)(bb), such subclause (II) shall be applied by inserting "as of January 1, 2018," after "such State" each place it appears.

(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);

(IV) for discharges occurring on or after October 1, 2018, is provided hospice care by a hospice program; or

(V) 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 shall include in the proposed rule published for fiscal year 2019, a description of the effect of clause (ii)(IV). 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), (III), and, in the case of proposed and final rules for fiscal year 2019 and subsequent fiscal years, (IV) 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 pay-

ment 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 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 Puer-

to 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 subpoenas 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 2023 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 2022, 15 road miles) from another subsection (d) hospital and has—

(I) with respect to each of fiscal years 2005 through 2010, less than 800 discharges during the fiscal year;

(II) with respect to each of fiscal years 2011 through 2018, less than 1,600 discharges of individuals entitled to, or enrolled for, benefits under part A during the fiscal year or portion of fiscal year;

(III) with respect to each of fiscal years 2019 through 2022, less than 3,800 discharges during the fiscal year; and

(IV) with respect to fiscal year 2023 and each subsequent fiscal year, less than 800 discharges during the fiscal year.

(ii) DISCHARGE.—For purposes of subparagraphs (B) and (D) and clause (i), the term “discharge” means an inpatient acute care discharge of an individual regardless (except as provided in clause (i)(II) and subpara-

graph (D)(i)) of whether the individual is entitled to benefits under part A.

(iii) TREATMENT OF INDIAN HEALTH SERVICE AND NON-INDIAN HEALTH SERVICE FACILITIES.—For purposes of determining whether—

(I) a subsection (d) hospital of the Indian Health Service (whether operated by such Service or by an Indian tribe or tribal organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act)), or

(II) a subsection (d) hospital other than a hospital of the Indian Health Service meets the mileage criterion under clause (i) with respect to fiscal year 2011 or a succeeding fiscal year, the Secretary shall apply the policy described in the regulation at part 412.101(e) of title 42, Code of Federal Regulations (as in effect on the date of enactment of this clause).

(D) TEMPORARY APPLICABLE PERCENTAGE INCREASE.—For discharges occurring in fiscal years 2011 through 2022, 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—

(i) with respect to each of fiscal years 2011 through 2018, 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 or portion of fiscal year; and

(ii) with respect to each of fiscal years 2019 through 2022, with 500 or fewer discharges in the fiscal year to 0 percent for low-volume hospitals with greater than 3,800 discharges 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 peri-

ods 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 hos-

pital 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)] *paragraphs (7), (8), and (9)*, 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)] *paragraphs (7), (8), and (9)*, 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 a 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 CLOSURES.—

(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 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 suc-

cessor 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 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 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 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 paragraph, paragraph (8), *paragraph (9)*, 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.

(9) DISTRIBUTION OF ADDITIONAL RESIDENCY POSITIONS TO HELP COMBAT OPIOID CRISIS.—

(A) ADDITIONAL RESIDENCY POSITIONS.—*During the period of fiscal years 2022 through 2026 (and succeeding fiscal years if the Secretary determines that there are addi-*

tional full-time-equivalent residency positions available to distribute under subparagraph (D)), the Secretary shall distribute additional full-time-equivalent residency positions to increase the otherwise applicable resident limit for each qualifying hospital that submits a timely application under this paragraph by such number as the Secretary may approve, effective beginning July 1 of the fiscal year of the increase. The aggregate number of additional full-time-equivalent residency positions available for distribution under this paragraph shall be equal to 500 in fiscal year 2022 and 500 over the period of fiscal years 2023 through 2026, distributed in accordance with the succeeding subparagraphs of this paragraph.

(B) DISTRIBUTION FOR FISCAL YEAR 2022.—

(i) **IN GENERAL.**—For fiscal year 2022, the positions available for distribution for such fiscal year (as described in subparagraph (A)) may only be distributed to hospitals that have established (as of the date of the enactment of this paragraph) approved programs in addiction medicine, addiction psychiatry, or pain medicine, as determined by the Secretary.

(ii) **CONSIDERATIONS IN DISTRIBUTION.**—The Secretary shall distribute additional residency positions under this subparagraph based on the demonstrated likelihood, as determined by the Secretary, of the hospital filling such positions within the first 4 training years (as specified by the Secretary) after the increase would be effective.

(iii) **REQUIREMENTS.**—A hospital that receives an increase in the otherwise applicable resident limit under this subparagraph shall ensure, during the 5-year period beginning after the date of such increase, that the hospital uses the positions made available under this subparagraph for a program described in clause (i) or a program that is a prerequisite (as determined by the Secretary) for such a program so described, such as internal medicine. 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.

(iv) **REDISTRIBUTION OF POSITIONS IF HOSPITAL NO LONGER MEETS CERTAIN REQUIREMENTS.**—In the case in which the Secretary determines that a hospital described in clause (iii) does not meet the requirements 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 subparagraph; and

(II) provide for the distribution of positions attributable to such reduction in accordance with the requirements of this paragraph.

(v) **POSITIONS NOT DISTRIBUTED DURING FISCAL YEAR 2022.**—If the number of full-time-equivalent residency positions distributed under this subparagraph is less

than the aggregate number of positions available for distribution for fiscal year 2022 (as described in subparagraph (A)), the difference between such number distributed and such number available for distribution shall be added to the aggregate number of positions available for distribution under subparagraph (C).

(C) DISTRIBUTION FOR FISCAL YEARS 2023 THROUGH 2026.—

(i) IN GENERAL.—For the period of fiscal years 2023 through 2026, the positions available for distribution for such period (as described in subparagraph (A)), and any positions made available pursuant to subparagraph (B)(v), shall be distributed to hospitals which demonstrate to the Secretary that the hospital has established or will establish an approved residency training program in addiction medicine, addiction psychiatry, or pain medicine.

(ii) CONSIDERATIONS IN DISTRIBUTION.—The Secretary shall distribute additional residency positions under this subparagraph based on the demonstrated likelihood, as determined by the Secretary, of the hospital filling such positions within the first 4 training years (as specified by the Secretary) after the increase would be effective.

(iii) REQUIREMENTS.—A hospital that receives an increase in the otherwise applicable resident limit under this subparagraph shall ensure, during the 5-year period beginning after the date of such increase, that the hospital uses the positions made available under this subparagraph for a program described in clause (i) or a program that is a prerequisite (as determined by the Secretary) for such a program so described, such as internal medicine. 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.

(iv) REDISTRIBUTION OF POSITIONS IF HOSPITAL NO LONGER MEETS CERTAIN REQUIREMENTS.—In the case where the Secretary determines that a hospital described in clause (iii) does not meet the requirements 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 subparagraph; and

(II) provide for the distribution of positions attributable to such reduction in accordance with the requirements of this paragraph.

(D) DISTRIBUTION OF REMAINING POSITIONS.—If the aggregate number of positions distributed under subparagraphs (B) and (C) during the period of fiscal years 2022 through 2026 is less than 1000, the Secretary shall distribute the remaining residency positions in succeeding fiscal years according to criteria consistent with this para-

graph until such time as the aggregate amount of positions distributed under this paragraph is equal to 1000.

(E) *LIMITATION.*—An individual hospital may not receive more than 25 full-time-equivalent residency positions under this paragraph.

(F) *NOTIFICATION.*—The Secretary shall notify hospitals of the number of positions distributed to the hospital under this paragraph as a result of an increase in the otherwise applicable resident limit by January 1 of the fiscal year of the increase. Such increase shall be effective beginning July 1 of that fiscal year.

(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) *PERMITTING FACILITIES TO APPLY AGGREGATION RULES.*—The Secretary shall permit hospitals receiving additional residency positions attributable to the increase provided under this paragraph to, beginning in the fifth year after the effective date of such increase, apply such positions to the limitation amount under paragraph (4)(F) that may be aggregated pursuant to paragraph (4)(H) among members of the same affiliated group.

(I) *CLARIFICATION.*—Chapter 35 of title 44, United States Code, shall not apply to the implementation of this paragraph.

(J) *DEFINITIONS.*—In this paragraph:

(i) *OTHERWISE APPLICABLE RESIDENT LIMIT.*—The term “otherwise applicable resident limit” means, with respect to a hospital, the limit otherwise applicable under paragraph (4)(F)(i) on the resident level for the hospital determined without regard to this paragraph but taking into account paragraphs (7)(A), (7)(B), (8)(A), and (8)(B).

(ii) *RESIDENT LEVEL.*—The term “resident level” has the meaning given such term in paragraph (7)(C)(i).

(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 be-

ginning 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 66 $\frac{2}{3}$ percent and the “prospective payment percentage” is 33 $\frac{1}{3}$ percent; and

(ii) on or after October 1, 2001, and before October 1, 2002, the “TEFRA percentage” is 33 $\frac{1}{3}$ percent and the “prospective payment percentage” is 66 $\frac{2}{3}$ 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 Sec-

retary 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 para-

graph (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 implemen-

tation 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)(vi)) 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)(vi)) 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), (E), (F), and (G), 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 years 2016 through 2019, the blended payment rate specified in clause (iii); and

(II) for discharges in cost reporting periods beginning during fiscal year 2020 or a subsequent fiscal year, the site neutral payment rate (as defined in clause (ii)).

(ii) SITE NEUTRAL PAYMENT RATE DEFINED.—Subject to clause (iv), 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.

(iv) ADJUSTMENT.—For each of fiscal years 2018 through 2026, the amount that would otherwise apply under clause (ii)(I) for the year (determined without regard to this clause) shall be reduced by 4.6 percent.

(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 last sentence of subsection (d)(1)(B); 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.

(F) TEMPORARY EXCEPTION FOR CERTAIN SPINAL CORD SPECIALTY HOSPITALS.—For discharges in cost reporting periods beginning during fiscal years 2018 and 2019, 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 is from a long-term care hospital that meets each of the following requirements:

(i) NOT-FOR-PROFIT.—The long-term care hospital was a not-for-profit long-term care hospital on June 1, 2014, as determined by cost report data.

(ii) PRIMARILY PROVIDING TREATMENT FOR CATASTROPHIC SPINAL CORD OR ACQUIRED BRAIN INJURIES OR OTHER PARALYZING NEUROMUSCULAR CONDITIONS.—Of the discharges in calendar year 2013 from the long-term care hospital for which payment was made under this section, at least 50 percent were classified under MS–LTCH–DRGs 28, 29, 52, 57, 551, 573, and 963.

(iii) SIGNIFICANT OUT-OF-STATE ADMISSIONS.—

(I) IN GENERAL.—The long-term care hospital discharged inpatients (including both individuals entitled to, or enrolled for, benefits under this title and individuals not so entitled or enrolled) during fiscal year 2014 who had been admitted from at least 20 of the 50 States, determined by the States of residency of such inpatients and based on such data submitted by the hospital to the Secretary as the Secretary may require.

(II) IMPLEMENTATION.—Notwithstanding any other provision of law, the Secretary may implement subclause (I) by program instruction or otherwise.

(III) NON-APPLICATION OF PAPERWORK REDUCTION ACT.—Chapter 35 of title 44, United States Code, shall not apply to data collected under this clause.

(G) ADDITIONAL TEMPORARY EXCEPTION FOR CERTAIN SEVERE WOUND DISCHARGES FROM CERTAIN LONG-TERM CARE HOSPITALS.—

(i) IN GENERAL.—For a discharge occurring in a cost reporting period beginning during fiscal year 2018, 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 identified by the last sentence of subsection (d)(1)(B);

(II) is classified under MS–LTCH–DRG 602, 603, 539, or 540; and

(III) is with respect to an individual treated by a long-term care hospital for a severe wound.

(ii) SEVERE WOUND DEFINED.—In this subparagraph, the term “severe wound” means a wound which is a stage 3 wound, stage 4 wound, unstageable wound, non-healing surgical wound, or fistula as identified in the claim from the long-term care hospital.

(iii) WOUND DEFINED.—In this subparagraph, the term “wound” means an injury involving division of tissue or rupture of the integument or mucous membrane with exposure to the external environment.

(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, $\frac{3}{4}$.

(III) For the third payment year for such hospital, $\frac{1}{2}$.

(IV) For the fourth payment year for such hospital, $\frac{1}{4}$.

(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.

(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.

(iii) HCAHPS PAIN QUESTIONS.—The Secretary may not include under subparagraph (A) a measure that is based on the questions appearing on the Hospital Consumer Assessment of Healthcare Providers and Systems survey in 2018 or 2019 about communication by hospital staff with an individual about the individual’s pain.

(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, and 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 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.

(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.

(F) 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.—Not later than January 1, 2018, the Secretary shall develop HCPCS versions for MS-DRGs that are 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.

(2) COVERAGE OF SURGICAL MS-DRGS.—In carrying out paragraph (1), the Secretary shall develop HCPCS versions of MS-DRG codes for not fewer than 10 surgical MS-DRGs.

(3) PUBLICATION AND DISSEMINATION OF THE HCPCS VERSIONS OF MS-DRGS.—

(A) 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.

(B) USE OF PREVIOUS ANALYSIS DONE BY MEDPAC.—In developing the HCPCS MS-DRG definitions manual and software under subparagraph (A), 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.

(4) DEFINITION AND REFERENCE.—In this subsection:

(A) 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.

(B) ICD-10-PCS.—The term “ICD-10-PCS” means the International Classification of Diseases, 10th Revision, Procedure Coding System, and includes any subsequent revision of such International Classification of Diseases, Procedure Coding System.

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DISSENTING VIEWS

H.R. 3414, introduced by Representative Schneider (D-IL), adds 1,000 full-time equivalent (FTE) graduate medical education (GME) resident positions (or “slots”) from fiscal years 2022–2026 to hospitals that have either established or will establish programs in addiction management, addiction psychiatry or pain medicine, as determined by the Secretary. The slots would have to be used for such programs or for programs that are a prerequisite for such programs (such as internal medicine).

Let there be no doubt that this Congress is dedicated to eradicating the opioid epidemic. Each year, Congress has continued to provide funds in each appropriations funding bill towards addiction treatment. Last Congress passed, on a bipartisan basis, H.R. 6, the SUPPORT Act. That bill represented the single largest congressional effort against a public health crisis.

Republicans want to continue working with our Democratic colleagues on that effort, but H.R. 3414 seeks to expand the massive GME program without attention to the geographic areas that are most in need of addiction medicine services. H.R. 3414 also lacks necessary reforms to GME funding.

Two immediate reforms are needed: improving transparency and targeting communities with the greatest need.

The manner in which taxpayer dollars are used to pay for GME is disjointed, inefficient and opaque. The Government Accountability Office (GAO) reported in March 2018, “[The Department of Health and Human Services (HHS)] lacks comprehensive information on the total number and specialty type of residents supported by all of the federal programs that fund GME training. . . . [U]nless HHS collects more complete and consistent information, it will be limited in its ability to conduct comprehensive, ongoing evaluations of the federal government’s \$14.5 billion annual investment in GME training” (see GAO–18–240).

As the President’s Fiscal Year 2020 Budget noted, “Current funding for Graduate Medical Education comes from multiple fragmented funding streams, and HHS’s GME financing system ineffectively targets training to certain types of physicians that are necessary for the Nation.” Similarly, the American Medical Association’s (AMA) House of Delegates modified AMA policy this year

to encourage [HHS] to coordinate with federal agencies that fund GME training to identify and collect information needed to effectively evaluate how hospitals, health systems and health centers with residency programs are utilizing these financial resources to meet the nation’s health care workforce needs . . . [including] information on payment amounts by the type of training programs supported, resident training costs and revenue generation, output or outcomes related to health workforce planning (i.e., per-

centage of primary care residents that went on to practice in rural or medically underserved areas), and measures related to resident competency and educational quality offered by GME training programs.

According to GAO, CMS does not currently monitor program performance for Medicare GME payments, whereas the Veterans Affairs Department (VA) and the Health Resources and Services Administration (HRSA) are required to do so for VA physician GME programs, children's hospital GME payment programs, and teaching health center GME programs. Finally, the Medicare Payment Advisory Commission recommended Congress should authorize the Secretary to establish a GME performance-based incentive program with payments to institutions contingent on reaching desired educational outcomes and standards (see MedPAC June 2010 Report to Congress: chapter 4).

Moreover, rural communities are most likely to face physician shortages. The bulk of GME federal spending and residents is found in the northeast. A GAO study in March 2018 found that the northeast was the only region for which the percentage of the GME spending was higher than the percentage of GME residents in the region (see GAO-18-240). Another GAO report found that in 2015, the largest percentage of residents (about 30 percent) trained in the Northeast, which also had the smallest percentage of the U.S. population (see GAO-17-411). The same GAO report explained that 50 percent of residents are in counties with just 18 percent of the population. Given the fact that most residents establish their medical practice near where they trained, it is unsurprising there is a shortage of rural health care providers.

According to Becker's Hospital Review, 102 rural hospitals closed between January 2010 and March 2019. According to CMS, 40% of rural hospitals are operating in the red.

If Congress assigns new GME slots, they should be better targeted to these rural areas and areas that have been hit hardest by the opioid epidemic in order to provide relief and help care for those communities most in need.

Republicans offered two amendments to improve H.R. 3414. The first, offered by Representative Ron Estes (R-KS), improves transparency by creating additional reporting requirements for hospitals receiving new GME slots under the underlying bill. The second, offered by Representative Jason Smith (R-MO), prioritizes the new GME slots to hospitals (1) located in areas with the highest rates of mortality and addiction attributable to opioid-use disorder; (2) located in rural areas; (3) that train residents in rural areas; or (4) located in 1 of the 25 States with the lowest number of full-time equivalent residency positions, with preference given to hospitals located in a health professional shortage area.

Both commonsense amendments were rejected by Democrats and not adopted. The first amendment, offered by Representative Ron Estes (R-KS), failed by a roll call vote of 16 yeas to 24 nays. The second amendment, offered Representative Jason Smith (R-MO), failed by a roll call vote of 15 yeas to 22 nays.

KEVIN BRADY,

Republican Leader, Committee on Ways and Means.

