

penditures under this subchapter, and prohibited from implementing this section prior to Mar. 31, 1985.

ESTABLISHMENT AND EVALUATION OF TRANSITIONAL ALLOWANCES; REPORT AND RECOMMENDATIONS TO CONGRESS

Section 2101(b) of Pub. L. 97-35 prohibited Secretary of Health and Human Services from establishing under this section transitional allowances with respect to more than 50 hospitals prior to Jan. 1, 1984, and directed Secretary to evaluate effectiveness of program of transitional allowances established under this section and, not later than Jan. 1, 1983, report to Congress on such evaluation and include in such report such recommendations for such legislative changes as deemed appropriate.

§ 1395vv. Withholding payments from certain medicaid providers

(a) Adjustments by Secretary

The Secretary may adjust, in accordance with this section, payments under parts A and B to any institution which has in effect an agreement with the Secretary under section 1395cc of this title, and any person who has accepted payment on the basis of an assignment under section 1395u(b)(3)(B)(ii) of this title, where such institution or person—

(1) has (or previously had) in effect an agreement with a State agency to furnish medical care and services under a State plan approved under subchapter XIX of this chapter, and

(2) from which (or from whom) such State agency (A) has been unable to recover overpayments made under the State plan, or (B) has been unable to collect the information necessary to enable it to determine the amount (if any) of the overpayments made to such institution or person under the State plan.

(b) Implementing regulations; notice, opportunity to be heard, etc.

The Secretary shall by regulation provide procedures for implementation of this section, which procedures shall—

(1) assure that the authority under this section is exercised only on behalf of a State agency which demonstrates to the Secretary's satisfaction that it has provided adequate notice of a determination or of a need for information, and an opportunity to appeal such determination or to provide such information,

(2) determine the amount of the payment to which the institution or person would otherwise be entitled under this subchapter which shall be treated as a setoff against overpayments under subchapter XIX of this chapter, and

(3) assure the restoration to the institution or person of amounts withheld under this section which are ultimately determined to be in excess of overpayments under subchapter XIX of this chapter and to which the institution or person would otherwise be entitled under this subchapter.

(c) Payment to States of amounts recovered

Notwithstanding any other provision of this chapter, from the trust funds established under sections 1395i and 1395t of this title, as appropriate, the Secretary shall pay to the appropriate State agency amounts recovered under

this section to offset the State agency's overpayment under subchapter XIX of this chapter. Such payments shall be accounted for by the State agency as recoveries of overpayments under the State plan.

(Aug. 14, 1935, ch. 531, title XVIII, § 1885, as added Pub. L. 97-35, title XXI, § 2104, Aug. 13, 1981, 95 Stat. 788.)

§ 1395ww. Payments to hospitals for inpatient hospital services

(a) Determination of costs for inpatient hospital services; limitations; exemptions; "operating costs of inpatient hospital services" defined

(1)(A)(i) The Secretary, in determining the amount of the payments that may be made under this subchapter 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 subchapter.

(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) of this section).

(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 subchapter for such hospital for such hospital's last cost reporting period prior to the hospital's first cost reporting period for which this section is in effect.

(D) Subparagraph (A) shall not apply to cost reporting periods beginning on or after October 1, 1983.

(2) The Secretary shall provide for such exemptions from, and exceptions and adjustments to, the limitation established under paragraph (1)(A) as he deems appropriate, including those which he deems necessary to take into account—

(A) the special needs of sole community hospitals, of new hospitals, of risk based health maintenance organizations, and of hospitals which provide atypical services or essential community services, and to take into account extraordinary circumstances beyond the hospital's control, medical and paramedical education costs, significantly fluctuating population in the service area of the hospital, and unusual labor costs,

(B) the special needs of psychiatric hospitals and of public or other hospitals that serve a significantly disproportionate number of patients who have low income or are entitled to benefits under part A of this subchapter, 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 September 3, 1982.

(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 subchapter 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 subchapter 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) Computation of payment; definitions; exemptions; adjustments

(1) Notwithstanding section 1395f(b) of this title but subject to the provisions of section 1395e of this title, if the operating costs of inpatient hospital services (as defined in subsection (a)(4) of this section) of a hospital (other than a subsection (d) hospital, as defined in subsection (d)(1)(B) of this section and other than a rehabilitation facility described in subsection (j)(1) of this section) 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 of this subchapter 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 of this subchapter 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 of this subchapter 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 subchapter (other than on the basis of a DRG prospective payment rate determined under subsection (d) of this section) with respect to operating costs of inpatient hospital services exceed the maximum amount payable with respect to such costs pursuant to subsection (a) of this section.

(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 November 29, 1999, 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) of this section 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) of this section) recognized under this subchapter 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) of this section and subsection (j) of this section 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) of this section), and 1.0 percent for hospitals located in other urban areas,

(IV) for fiscal year 1989, the market basket percentage increase minus 1.5 percent 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 0.55¹ 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

¹So in original. Probably should be followed by “percentage point”.

will provide for the average standardized amount determined under subsection (d)(3)(A) of this section 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;² 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 non-

operating 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 subchapter for the cost reporting period beginning in fiscal year 1990 exceeds the hospital’s target amount (as determined under subparagraph (A)) for such cost reporting period, increased for each fiscal year (beginning with fiscal year 1994) by the sum of any of the hospital’s applicable reductions under subclause (V) for previous fiscal years; and

(II) the “applicable reduction” with respect to a hospital for a fiscal year is the lesser of 1 percentage point or the percentage point difference between 10 percent and the hospital’s update adjustment percentage for the fiscal year.

(vi) For purposes of clause (ii)(VII) for a fiscal year, if a hospital’s allowable operating costs of inpatient hospital services recognized under this subchapter 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 hos-

² So in original. The semicolon probably should be a comma.

pital, 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 $\frac{3}{4}$ of such target amount for the hospital, the applicable update factor specified under this clause is 0 percent.

(vii)(I) For purposes of clause (i)(XIX) for fiscal years 2005 and 2006, in a case of a subsection (d) hospital that does not submit data to the Secretary in accordance with subclause (II) with respect to such a fiscal year, the applicable percentage increase under such clause for such fiscal year shall be reduced by 0.4 percentage points. Such reduction shall apply only with respect to the fiscal year involved, and the Secretary shall not take into account such reduction in computing the applicable percentage increase under clause (i)(XIX) for a subsequent fiscal year.

(II) For fiscal years 2005 and 2006, each subsection (d) hospital shall submit to the Secretary quality data (for a set of 10 indicators established by the Secretary as of November 1, 2003) that relate to the quality of care furnished by the hospital in inpatient settings in a form and manner, and at a time, specified by the Secretary for purposes of this clause, but with respect to fiscal year 2005, the Secretary shall provide for a 30-day grace period for the submission of data by a hospital.

(viii)(I) For purposes of clause (i) for fiscal year 2007 and each subsequent fiscal year, in the case of a subsection (d) hospital that does not submit, to the Secretary in accordance with this clause, data required to be submitted on measures selected under this clause with respect to such a fiscal year, the applicable percentage increase under clause (i) for such fiscal year shall be reduced by 2.0 percentage points (or, beginning with fiscal year 2015, by one-quarter of such applicable percentage increase (determined without regard to clause (ix), (xi), or (xii))). Such reduction shall apply only with respect to the fiscal year involved and the Secretary shall not take into account such reduction in computing the applicable percentage increase under clause (i) for a subsequent fiscal year, and the Secretary and the Medicare Payment Advisory Commission shall carry out the requirements under section 5001(b) of the Deficit Reduction Act of 2005.

(II) Each subsection (d) hospital shall submit data on measures selected under this clause to the Secretary in a form and manner, and at a time, specified by the Secretary for purposes of this clause. The Secretary may require hospitals to submit data on measures that are not used for the determination of value-based incentive payments under subsection (o).

(III) The Secretary shall expand, beyond the measures specified under clause (vii)(II) and consistent with the succeeding subclauses, the set of measures that the Secretary determines to be appropriate for the measurement of the quality of care (including medication errors) furnished by hospitals in inpatient settings.

(IV) Effective for payments beginning with fiscal year 2007, in expanding the number of measures under subclause (III), the Secretary shall begin to adopt the baseline set of performance

measures as set forth in the November 2005 report by the Institute of Medicine of the National Academy of Sciences under section 238(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

(V) Effective for payments for fiscal years 2008 through 2012, the Secretary shall add other measures that reflect consensus among affected parties and, to the extent feasible and practicable, shall include measures set forth by one or more national consensus building entities.

(VI) For purposes of this clause and clause (vii), the Secretary may replace any measures or indicators in appropriate cases, such as where all hospitals are effectively in compliance or the measures or indicators have been subsequently shown not to represent the best clinical practice.

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

(VIII) Effective for payments beginning with fiscal year 2013, with respect to quality measures for outcomes of care, the Secretary shall provide for such risk adjustment as the Secretary determines to be appropriate to maintain incentives for hospitals to treat patients with severe illnesses or conditions.

(IX)(aa) Subject to item (bb), effective for payments beginning with fiscal year 2013, each measure specified by the Secretary under this clause shall be endorsed by the entity with a contract under section 1395aaa(a) of this title.

(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 1395aaa(a) of this title, 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 1395w-4(k) of this title; and

(bb) other providers of services and suppliers under this subchapter.

(XI) The Secretary shall establish a process to validate measures specified under this clause as appropriate. Such process shall include the auditing of a number of randomly selected hospitals sufficient to ensure validity of the reporting program under this clause as a whole and shall provide a hospital with an opportunity to appeal the validation of measures reported by such hospital.

(ix)(I) For purposes of clause (i) for fiscal year 2015 and each subsequent fiscal year, in the case of an eligible hospital (as defined in subsection (n)(6)(A))³ 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, exempt a subsection (d) hospital from the application of subclause (I) with respect to a fiscal year if the Secretary determines, subject to annual renewal, that requiring such hospital to be a meaningful EHR user during such fiscal year would result in a significant hardship, such as in the case of a hospital in a rural area without sufficient Internet access. In no case may a hospital be granted an exemption under this subclause for more than 5 years.

(III) For fiscal year 2015 and each subsequent fiscal year, a State in which hospitals are paid for services under section 1395f(b)(3) of this title 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, fac-

tor, 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) of this section), 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) of this section) recognized under this subchapter 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

³ So in original. Probably should be “(n)(6)(B)”.

(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 discharges occurring on or after October 1, 1997, and before October 1, 2012, in the case of a hospital that is a medicare-dependent, small rural hospital (as defined in subsection (d)(5)(G) of this section), 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) of this section) recognized under this subchapter 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 2012, 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) of this section, 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) of this section) recognized under this subchapter 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) of this section) 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 August 5, 1997.

(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) of this section 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) of this section) recognized under this subchapter 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) of this section during each of the 2 cost reporting periods for which the Secretary has the most recent settled cost reports as of August 5, 1997, for each of which—

(I) the hospital's allowable operating costs of inpatient hospital services recognized under this subchapter 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) of this section) 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) of this section 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) of this section, 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) of this section (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) of this section—

(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) of this section, 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 hos-

pitals 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 1395f(b) of this title.

(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 1986, 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) of this section, 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 of this subchapter 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) of this section 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) Payment in accordance with State hospital reimbursement control system; amount of payment; discontinuance of payments

(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 subchapter, 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 subchapter XIX of this chapter;

(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 hos-

pitals 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 subchapter under such system will not exceed the amount of payments which would otherwise have been made under this subchapter not using such system;

(D) the Secretary determines that the system will not preclude an eligible organization (as defined in section 1395mm(b) of this title) 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 1395cc(a)(1)(G) of this title and the system provides for the exclusion of certain costs in accordance with section 1395y(a)(14) of this title (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 subchapter under such system must be less than the amount of payments which would otherwise have been made under this subchapter 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 of this subchapter) 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 of this subchapter for inpatient hospital services, the Secretary cannot deny the application of a State under this subsection on the ground that the State's rate of increase in such payments for such services must be less than such national average rate of increase.

(2) In determining under paragraph (1)(C) the amount of payment which would otherwise have been made under this subchapter 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 subchapter 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) of this section) under this subchapter for hospitals in the State which is less than the aggregate rate of increase in such costs under this subchapter 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 this subchapter has been approved on or before (and which is in effect as of) April 20, 1983, pursuant to section 1395b-1(a) of this title 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 subchapter, 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 subchapter) 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 subchapter to hospitals under the system in an amount equal to the amount by which the payment under this subchapter under such system for such period exceeded the amount of payments which would otherwise have been made under this subchapter 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) Inpatient hospital service payments on basis of prospective rates; Medicare Geographical Classification Review Board

(1)(A) Notwithstanding section 1395f(b) of this title but subject to the provisions of section 1395e of this title, the amount of the payment with respect to the operating costs of inpatient hospital services (as defined in subsection (a)(4) of this section) 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) of this section, but determined without the application of subsection (a) of this section), 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) of this section, but determined without the application of subsection (a) of this section), 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 large urban or other 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 “sub-section (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 1395x(f) of this title),

(ii) a rehabilitation hospital (as defined by the Secretary),

(iii) a hospital whose inpatients are predominantly individuals under 18 years of age,

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

(II) a hospital that first received payment under this subsection in 1986 which has an average inpatient length of stay (as determined by the Secretary) of greater than 20 days and that has 80 percent or more of its annual medicare inpatient discharges with a principal diagnosis that reflects a finding of neoplastic disease in the 12-month cost reporting period ending in fiscal year 1997, or

(v)(I) a hospital that the Secretary has classified, at any time on or before December 31, 1990,⁴ (or, in the case of a hospital that, as of December 19, 1989, is located in a State operating a demonstration project under section 1395f(b) of this title, 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 1395f(b) of this title, 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 August 5, 1997), that as of August 5, 1997, 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 1395f(b) of this title, 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 December 21, 2000, is licensed for 162 acute care beds, and that demonstrates for the 4-year period ending on June 30, 1999, that at least 50 percent of its total discharges have a principal finding of neoplastic disease, as defined in subparagraph (E);

and, in accordance with regulations of the Secretary, does not include a psychiatric or rehabilitation unit of the hospital which is a distinct part of the hospital (as defined by the Secretary). A hospital that was classified by the Secretary on or before September 30, 1995, as a hospital described in clause (iv) shall continue to be so classified notwithstanding that it is located in the same building as, or on the same campus as, another hospital.

(C) For purposes of this subsection, for cost reporting periods beginning—

(i) on or after October 1, 1983, and before October 1, 1984, the “target percentage” is 75 percent and the “DRG percentage” is 25 percent;

(ii) on or after October 1, 1984, and before October 1, 1985, the “target percentage” is 50 percent and the “DRG percentage” is 50 percent;

(iii) on or after October 1, 1985, and before October 1, 1986, the “target percentage” is 45 percent and the “DRG percentage” is 55 percent; and

(iv) on or after October 1, 1986, and before October 1, 1987, the “target percentage” is 25

⁴So in original. The comma probably should not appear.

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 subchapter. 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) of this section) 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)⁵ 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) of this section 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) of this section 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 Metro-

⁵ See References in Text note below.

politan 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 subchapter) 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) of this section 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 subchapter. 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) of this section. 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) of this section 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) of this section 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) of this section 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) MAINTAINING BUDGET NEUTRALITY FOR FISCAL YEAR 1985.—(i) 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) of this section for that fiscal year.

(ii) 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, tech-

nology (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 subchapter.

(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) of this section, 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 $c \times (((1+r) \text{ to the } n\text{th power}) - 1)$, where “r” is the ratio of the hospital’s full-time equivalent interns and residents to beds and “n” equals .405. Subject to clause (ix), for discharges occurring—

(I) on or after October 1, 1988, and before October 1, 1997, “c” is equal to 1.89;

(II) during fiscal year 1998, “c” is equal to 1.72;

(III) during fiscal year 1999, “c” is equal to 1.6;

(IV) during fiscal year 2000, “c” is equal to 1.47;

(V) during fiscal year 2001, “c” is equal to 1.54;

(VI) during fiscal year 2002, “c” is equal to 1.6;

(VII) on or after October 1, 2002, and before April 1, 2004, “c” is equal to 1.35;

(VIII) on or after April 1, 2004, and before October 1, 2004, “c” is equal to 1.47;

(IX) during fiscal year 2005, “c” is equal to 1.42;

(X) during fiscal year 2006, “c” is equal to 1.37;

(XI) during fiscal year 2007, “c” is equal to 1.32; and

(XII) on or after October 1, 2007, “c” is equal to 1.35.

(iii) In determining such adjustment the Secretary shall not distinguish between those interns and residents who are employees of a hospital and those interns and residents who furnish services to a hospital but are not employees of such hospital.

(iv)(I) Effective for discharges occurring on or after October 1, 1997, and before July 1, 2010, all the time spent by an intern or resident in patient care activities under an approved medical residency training program at an entity in a nonhospital setting shall be counted towards the determination of full-time equivalency if the hospital incurs all, or substantially all, of the costs for the training program in that setting.

(II) Effective for discharges occurring on or after July 1, 2010, all the time spent by an intern or resident in patient care activities in a nonprovider setting shall be counted towards the determination of full-time equivalency if a hospital incurs the costs of the stipends and fringe benefits of the intern or resident during the time the intern or resident spends in that setting. If more than one hospital incurs these costs, either directly or through a third party, such hospitals shall count a proportional share of the time, as determined by written agreement between the hospitals, that a resident spends training in that setting.

(v) In determining the adjustment with respect to a hospital for discharges occurring on or after October 1, 1997, the total number of full-time equivalent interns and residents in the fields of allopathic and osteopathic medicine in either a hospital or nonhospital setting may not exceed the number (or, 130 percent of such number in the case of a hospital located in a rural area) of such full-time equivalent interns and residents in the hospital with re-

spect 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) of this section shall apply for purposes of this clause. The provisions of subsections (h)(4)(H)(vi), (h)(7), and (h)(8) of this section 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) of this section.

(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) of this section 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) of this section, 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)⁶ For discharges occurring on or after July 1, 2011, insofar as an additional payment amount under this subparagraph is attributable to resident positions distributed to a hospital under subsection (h)(8)(B), the indirect teaching adjustment factor shall be computed in the same manner as provided under clause (ii) with respect to such resident positions.

(x)(I)⁶ 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 1395f(b)(3) of this title; or

(dd) is a provider-based hospital outpatient department.

(III) In determining the hospital's number of full-time equivalent residents for purposes of this subparagraph, all the time spent by an intern or resident in an approved medical residency training program in research activities that are not associated with the treatment or diagnosis of a particular patient, as such time and activities are defined by the Secretary, shall not be counted toward the determination of full-time equivalency.

(C)(i) The Secretary shall provide for such exceptions and adjustments to the payment amounts established under this subsection (other than under paragraph (9)) as the Secretary deems appropriate to take into account the special needs of regional and national referral centers (including those hospitals of 275 or more beds located in rural areas). A hospital which is classified as a rural hospital may appeal to the Secretary to be classified as a rural referral center under this clause on the basis of criteria (established by the Secretary) which shall allow the hospital to demonstrate that it should be so reclassified by reason of certain of its operating characteristics being similar to those of a typical urban hospital located in the same census region and which shall not require a rural osteopathic hospital to have more than 3,000 discharges in a year in order to be classified as a rural referral center. Such characteristics may include wages, scope of services, service area, and the mix of medical specialties. The Secretary shall publish the criteria not later than August 17, 1984, for implementation by October 1, 1984. An appeal allowed under this clause must be submitted to the Secretary (in such form and manner as the Secretary may prescribe) during the quarter before the first quarter of the hospital's cost reporting period (or, in the case of a cost reporting period beginning during October 1984, during the first quarter of that period), and the Secretary must make a final determination with respect to such appeal within 60 days after the date the appeal was submitted. Any payment adjustments necessitated by a reclassification based upon the appeal shall be effective at the beginning of such cost reporting period.

(ii) The Secretary shall provide, under clause (i), for the classification of a rural hospital as a regional referral center if the hospital has a case mix index equal to or greater than the median case mix index for hospitals (other than hos-

⁶ So in original. Two cls. (x) have been enacted.

pitals 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) of this section, 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 subchapter, 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 of this subchapter, or

(III) that is located in a rural area and designated by the Secretary as an essential access community hospital under section 1395i-4(i)(1) of this title 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

1395i-4(i)(1) of this title 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 1395i-4(d) of this title) 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) of this section to account for such incurred increases.

(E)(i) The Secretary shall estimate the amount of reimbursement made for services described in section 1395y(a)(14) of this title with respect to which payment was made under part B of this subchapter 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 subchapter or State plans approved under subchapter XIX of this chapter), 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 subchapter and were entitled to supplementary security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, 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 subchapter, 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 subchapter XIX of this chapter, but who were not entitled to benefits under part A of this subchapter, 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 subchapter XIX, the Secretary may, to the extent and for the period the Secretary determines appropriate, include patient days of patients not so eligible but who are regarded as such because they receive benefits under a demonstration project approved under subchapter 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, $(P - 15)(.6) + 2.5$,⁷

(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

⁷ So in original. Probably should be followed by “and”.

“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, 2012, 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) of this section) 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, 2012, 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) of this section) exceeds the amount determined under paragraph (1)(A)(iii).

(iii) In the case of a medicare dependent, small rural hospital that experiences, in a cost reporting period compared to the previous cost reporting period, a decrease of more than 5 percent in its total number of inpatient cases due to circumstances beyond its control, the Secretary shall provide for such adjustment to the payment amounts under this subsection (other than under paragraph (9)) as may be necessary to fully compensate the hospital for the fixed costs it incurs in the period in providing inpatient hospital services, including the reasonable cost of maintaining necessary core staff and services.

(iv) The term “medicare-dependent, small rural hospital” means, with respect to any cost

reporting period to which clause (i) applies, any hospital—

- (I) located in a rural area,
- (II) that has not more than 100 beds,
- (III) that is not classified as a sole community hospital under subparagraph (D), and
- (IV) for which not less than 60 percent of its inpatient days or discharges during the cost reporting period beginning in fiscal year 1987, or two of the three most recently audited cost reporting periods for which the Secretary has a settled cost report, were attributable to inpatients entitled to benefits under part A of this subchapter.

(H) The Secretary may provide for such adjustments to the payment amounts under this subsection as the Secretary deems appropriate to take into account the unique circumstances of hospitals located in Alaska and Hawaii.

(I)(i) The Secretary shall provide by regulation for such other exceptions and adjustments to such payment amounts under this subsection as the Secretary deems appropriate.

(ii) In making adjustments under clause (i) for transfer cases (as defined by the Secretary) in a fiscal year, not taking in account the effect of subparagraph (J), the Secretary may make adjustments to each of the average standardized amounts determined under paragraph (3) to assure that the aggregate payments made under this subsection for such fiscal year are not greater or lesser than those that would have otherwise been made in such fiscal year.

(J)(i) The Secretary shall treat the term “transfer case” (as defined in subparagraph (I)(ii)) as including the case of a qualified discharge (as defined in clause (ii)), which is classified within a diagnosis-related group described in clause (iii), and which occurs on or after October 1, 1998. In the case of a qualified discharge for which a substantial portion of the costs of care are incurred in the early days of the inpatient stay (as defined by the Secretary), in no case may the payment amount otherwise provided under this subsection exceed an amount equal to the sum of—

- (I) 50 percent of the amount of payment under this subsection for transfer cases (as established under subparagraph (I)(i)), and
- (II) 50 percent of the amount of payment which would have been made under this subsection with respect to the qualified discharge if no transfer were involved.

(ii) For purposes of clause (i), subject to clause (iii), the term “qualified discharge” means a discharge classified with a diagnosis-related group (described in clause (iii)) of an individual from a subsection (d) hospital, if upon such discharge the individual—

- (I) is admitted as an inpatient to a hospital or hospital unit that is not a subsection (d) hospital for the provision of inpatient hospital services;
- (II) is admitted to a skilled nursing facility;
- (III) is provided home health services from a home health agency, if such services relate to the condition or diagnosis for which such individual received inpatient hospital services from the subsection (d) hospital, and if such services are provided within an appropriate period (as determined by the Secretary); or

(IV) for discharges occurring on or after October 1, 2000, the individual receives post discharge services described in clause (iv)(I).

(iii) Subject to clause (iv), a diagnosis-related group described in this clause is—

- (I) 1 of 10 diagnosis-related groups selected by the Secretary based upon a high volume of discharges classified within such groups and a disproportionate use of post discharge services described in clause (ii); and
- (II) a diagnosis-related group specified by the Secretary under clause (iv)(II).

(iv) The Secretary shall include in the proposed rule published under subsection (e)(5)(A) of this section for fiscal year 2001, a description of the effect of this subparagraph. The Secretary may include in the proposed rule (and in the final rule published under paragraph (6)) for fiscal year 2001 or a subsequent fiscal year, a description of—

- (I) post-discharge services not described in subclauses (I), (II), and (III) of clause (ii), the receipt of which results in a qualified discharge; and
- (II) diagnosis-related groups described in clause (iii)(I) in addition to the 10 selected under such clause.

(K)(i) Effective for discharges beginning on or after October 1, 2001, the Secretary shall establish a mechanism to recognize the costs of new medical services and technologies under the payment system established under this subsection. Such mechanism shall be established after notice and opportunity for public comment (in the publications required by subsection (e)(5) of this section 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 1395m of this title 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 of this subchapter as follows:

(I) The Secretary shall make public and periodically update a list of all the services and technologies for which an application for additional payment under this subparagraph is pending.

(II) The Secretary shall accept comments, recommendations, and data from the public regarding whether the service or technology represents a substantial improvement.

(III) The Secretary shall provide for a meeting at which organizations representing hospitals, physicians, such individuals, manufacturers, and any other interested party may present comments, recommendations, and

data to the clinical staff of the Centers for Medicare & Medicaid Services before publication of a notice of proposed rulemaking regarding whether service or technology represents a substantial improvement.

(ix) Before establishing any add-on payment under this subparagraph with respect to a new technology, the Secretary shall seek to identify one or more diagnosis-related groups associated with such technology, based on similar clinical or anatomical characteristics and the cost of the technology. Within such groups the Secretary shall assign an eligible new technology into a diagnosis-related group where the average costs of care most closely approximate the costs of care of using the new technology. No add-on payment under this subparagraph shall be made with respect to such new technology and this clause shall not affect the application of paragraph (4)(C)(iii).

(L)(i) In establishing the mechanism under subparagraph (K), the Secretary may establish new-technology groups into which a new medical service or technology will be classified if, based on the estimated average costs incurred with respect to discharges involving such service or technology, the DRG prospective payment rate otherwise applicable to such discharges under this subsection is inadequate.

(ii) Such groups—

(I) shall not be based on the costs associated with a specific new medical service or technology; but

(II) shall, in combination with the applicable standardized amounts and the weighting factors assigned to such groups under paragraph (4)(B), reflect such cost cohorts as the Secretary determines are appropriate for all new medical services and technologies that are likely to be provided as inpatient hospital services in a fiscal year.

(iii) The methodology for classifying specific hospital discharges within a diagnosis-related group under paragraph (4)(A) or a new-technology group shall provide that a specific hospital discharge may not be classified within both a diagnosis-related group and a new-technology group.

(6) The Secretary shall provide for publication in the Federal Register, on or before the August 1 before each fiscal year (beginning with fiscal year 1984), of a description of the methodology and data used in computing the adjusted DRG prospective payment rates under this subsection, including any adjustments required under subsection (e)(1)(B) of this section.

(7) There shall be no administrative or judicial review under section 1395oo of this title or otherwise of—

(A) the determination of the requirement, or the proportional amount, of any adjustment effected pursuant to subsection (e)(1) of this section 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 1395f(b) of this title but subject to the provisions of section 1395e of this title, 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 subchapter. 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) of this section) 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) of this section) 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 subchapter. 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) of this section, and adjusted for subsequent fiscal years in accordance with the final determination of the Secretary under subsection (e)(4) of this section, and adjusted to reflect the most recent case-mix data available.

(II) For discharges occurring in a fiscal year (beginning with fiscal year 2004), the Secretary shall compute an average standardized amount for hospitals located in any area of Puerto Rico that is equal to the average standardized amount computed under subclause (I) for fiscal year 2003 for hospitals in a large urban area (or, beginning with fiscal year 2005, for all hospitals in the previous fiscal year) increased by the applicable percentage increase under subsection (b)(3)(B) of this section 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; and

(iv) on or after October 1, 2004, the applicable Puerto Rico percentage is 25 percent and the applicable Federal percentage is 75 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, 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 December 19, 1989.

(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 557b⁸ of title 5. 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 subchapter 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 405 of this title with respect to subpoenas shall apply to the Board to the same extent as such provisions apply to the Secretary with respect to subchapter II of this chapter.

(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 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

⁸ So in original. Probably should be section "557(b)".

subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, 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 1395mm of this title and who is entitled to benefits under part A of this subchapter or any individual who is enrolled with a Medicare+Choice organization under part C of this subchapter.

(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 this section) 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 1395f(b)(3) of this title 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 2013 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 and 2012, 15 road miles) from another subsection (d) hospital and has less than 800 discharges (or, with respect to fiscal years 2011 and 2012, 1,600 discharges of individuals entitled to, or enrolled for, benefits under part A) during the fiscal year.

(ii) DISCHARGE.—For purposes of subparagraph (B) and clause (i), the term “discharge” means an inpatient acute care discharge of an individual regardless of whether the individual is entitled to benefits under part A of this subchapter.

(D) TEMPORARY APPLICABLE PERCENTAGE INCREASE.—For discharges occurring in fiscal years 2011 and 2012, the Secretary shall determine an applicable percentage increase for purposes of subparagraph (A) using a continuous linear sliding scale ranging from 25 percent for low-volume hospitals with 200 or fewer discharges of individuals entitled to, or enrolled for, benefits under part A in the fiscal year to 0 percent for low-volume hospitals with greater than 1,600 discharges of such individuals in the fiscal year.

(13)(A) In order to recognize commuting patterns among geographic areas, the Secretary shall establish a process through application or otherwise for an increase of the wage index applied under paragraph (3)(E) for subsection (d) hospitals located in a qualifying county described in subparagraph (B) in the amount computed under subparagraph (D) based on out-migration of hospital employees who reside in that county to any higher wage index area.

(B) The Secretary shall establish criteria for a qualifying county under this subparagraph based on the out-migration referred to in subparagraph (A) and differences in the area wage indices. Under such criteria the Secretary shall, utilizing such data as the Secretary determines to be appropriate, establish—

(i) a threshold percentage, established by the Secretary, of the weighted average of the area wage index or indices for the higher wage index areas involved;

(ii) a threshold (of not less than 10 percent) for minimum out-migration to a higher wage index area or areas; and

(iii) a requirement that the average hourly wage of the hospitals in the qualifying county equals or exceeds the average hourly wage of all the hospitals in the area in which the qualifying county is located.

(C) For purposes of this paragraph, the term “higher wage index area” means, with respect to

a county, an area with a wage index that exceeds that of the county.

(D) The increase in the wage index under subparagraph (A) for a qualifying county shall be equal to the percentage of the hospital employees residing in the qualifying county who are employed in any higher wage index area multiplied by the sum of the products, for each higher wage index area of—

(i) the difference between—

(I) the wage index for such higher wage index area, and

(II) the wage index of the qualifying county; and

(ii) the number of hospital employees residing in the qualifying county who are employed in such higher wage index area divided by the total number of hospital employees residing in the qualifying county who are employed in any higher wage index area.

(E) The process under this paragraph may be based upon the process used by the Medicare Geographic Classification Review Board under paragraph (10). As the Secretary determines to be appropriate to carry out such process, the Secretary may require hospitals (including subsection (d) hospitals and other hospitals) and critical access hospitals, as required under section 1395cc(a)(1)(T) of this title, 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) Proportional adjustments in applicable percentage increases

(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) of this section) as may be necessary to assure that—

(i) the aggregate payment amounts otherwise provided under subsection (d)(1)(A)(i)(I) of

this section for that fiscal year for operating costs of inpatient hospital services of hospitals (excluding payments made under section 1395cc(a)(1)(F) of this title),

are not greater or less than—

(ii) the target percentage (as defined in subsection (d)(1)(C) of this section) 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 April 20, 1983 (excluding payments made under section 1395cc(a)(1)(F) of this title);

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) of this section or subsection (d)(3)(A) of this section.

(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) of this section 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) of this section for that fiscal year for operating costs of inpatient hospital services of hospitals (excluding payments made under section 1395cc(a)(1)(F) of this title),

are not greater or less than—

(ii) the DRG percentage (as defined in subsection (d)(1)(C) of this section) 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 April 20, 1983 (excluding payments made under section 1395cc(a)(1)(F) of this title).

(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) of this section 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) of this section 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.

(2) Repealed. Pub. L. 105-33, title IV, § 4022(b)(1)(A)(i), Aug. 5, 1997, 111 Stat. 354.

(3) Repealed. Pub. L. 109-432, div. B, title I, § 106(c)(2), Dec. 20, 2006, 120 Stat. 2983.

(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 fac-

tor 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) of this section, 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 subchapter 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) Reporting of costs of hospitals receiving payments on basis of prospective rates

(1)(A) The Secretary shall maintain a system for the reporting of costs of hospitals receiving payments computed under subsection (d) of this section.

(B)(i) Subject to clause (ii), the Secretary shall place into effect a standardized electronic cost reporting format for hospitals under this subchapter.

(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 subchapter).

(2) If the Secretary determines, based upon information supplied by a utilization and quality control peer review organization under part B of subchapter XI of this chapter, 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 ad-

missions 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 of this subchapter 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 1320a-7 of this title shall apply to determinations made under paragraph (2) in the same manner as they apply to exclusions effected under section 1320a-7(b)(13) of this title.

(g) Prospective payment for capital-related costs; return on equity capital for hospitals

(1)(A) Notwithstanding section 1395x(v) of this title, instead of any amounts that are otherwise payable under this subchapter with respect to the reasonable costs of subsection (d) hospitals and subsection (d) Puerto Rico hospitals for capital-related costs of inpatient hospital services, the Secretary shall, for hospital cost reporting periods beginning on or after October 1, 1991, provide for payments for such costs in accordance with a prospective payment system established by the Secretary. Aggregate payments made under subsection (d) of this section 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 1395x(v) of this title). 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 August 10, 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) of this section 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 subchapter, for a return on equity capital for hospitals shall, for cost reporting periods beginning on or after April 20, 1983, 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 subchapter 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 subchapter 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) of this section) or a critical access hospital (as defined in section 1395x(mm)(1) of this title).

(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 subchapter 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) of this section 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 subchapter by 15 percent.

(h) Payments for direct graduate medical education costs

(1) Substitution of special payment rules

Notwithstanding section 1395x(v) of this title, instead of any amounts that are otherwise payable under this subchapter 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 of this subchapter (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 subchapter 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 hos-

pital if the hospital's reporting period, described in subparagraph (A), began on or after July 1, 1984, and before October 1, 1984.

(C) Amount for first cost reporting period

For the first cost reporting period of the hospital beginning on or after July 1, 1985, the approved FTE resident amount for the hospital is equal to the amount determined under subparagraph (B) increased by 1 percent.

(D) Amount for subsequent cost reporting periods

(i) In general

Except as provided in a subsequent clause, for each subsequent cost reporting period, the approved FTE resident amount for the hospital is equal to the approved FTE resident amount determined under this paragraph for the previous cost reporting period updated, through the midpoint of the period, by projecting the estimated percentage change in the consumer price index during the 12-month period ending at that midpoint, with appropriate adjustments to reflect previous under- or over-estimations under this subparagraph in the projected percentage change in the consumer price index.

(ii) Freeze in update for fiscal years 1994 and 1995

For cost reporting periods beginning during fiscal year 1994 or fiscal year 1995, the approved FTE resident amount for a hospital shall not be updated under clause (i) for a resident who is not a primary care resident (as defined in paragraph (5)(H)) or a resident enrolled in an approved medical residency training program in obstetrics and gynecology.

(iii) Floor for locality adjusted national average per resident amount

The approved FTE resident amount for a hospital for the cost reporting period beginning during fiscal year 2001 shall not be less than 70 percent, and for the cost reporting period beginning during fiscal year 2002 shall not be less than 85 percent, of the locality adjusted national average per resident amount computed under subparagraph (E) for the hospital and period.

(iv) Adjustment in rate of increase for hospitals with FTE approved amount above 140 percent of locality adjusted national average per resident amount

(I) Freeze for fiscal years 2001 and 2002 and 2004 through 2013

For a cost reporting period beginning during fiscal year 2001 or fiscal year 2002 or during the period beginning with fiscal year 2004 and ending with fiscal year 2013, if the approved FTE resident amount for a hospital for the preceding cost reporting period exceeds 140 percent of the locality adjusted national average per resident amount computed under subparagraph (E) for that hospital and

period, subject to subclause (III), the approved FTE resident amount for the period involved shall be the same as the approved FTE resident amount for the hospital for such preceding cost reporting period.

(II) 2 percent decrease in update for fiscal years 2003, 2004, and 2005

For the cost reporting period beginning during fiscal year 2003, if the approved FTE resident amount for a hospital for the preceding cost reporting period exceeds 140 percent of the locality adjusted national average per resident amount computed under subparagraph (E) for that hospital and preceding period, the approved FTE resident amount for the period involved shall be updated in the manner described in subparagraph (D)(i) except that, subject to subclause (III), the consumer price index applied for a 12-month period shall be reduced (but not below zero) by 2 percentage points.

(III) No adjustment below 140 percent

In no case shall subclause (I) or (II) reduce an approved FTE resident amount for a hospital for a cost reporting period below 140 percent of the locality adjusted national average per resident amount computed under subparagraph (E) for such hospital and period.

(E) Determination of locality adjusted national average per resident amount

The Secretary shall determine a locality adjusted national average per resident amount with respect to a cost reporting period of a hospital beginning during a fiscal year as follows:

(i) Determining hospital single per resident amount

The Secretary shall compute for each hospital operating an approved graduate medical education program a single per resident amount equal to the average (weighted by number of full-time equivalent residents, as determined under paragraph (4)) of the primary care per resident amount and the non-primary care per resident amount computed under paragraph (2) for cost reporting periods ending during fiscal year 1997.

(ii) Standardizing per resident amounts

The Secretary shall compute a standardized per resident amount for each such hospital by dividing the single per resident amount computed under clause (i) by an average of the 3 geographic index values (weighted by the national average weight for each of the work, practice expense, and malpractice components) as applied under section 1395w-4(e) of this title 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 subchapter 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 subchapter, 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) of this section 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 of this subchapter.

(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 1395mm of this title and who are entitled to part A of this subchapter or with a Medicare+Choice organization under part C of this subchapter. 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 be-

ginning 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) of this section 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 1395f(b)(3) of this title 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;⁹ 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; and

(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.

Any hospital claiming under this subparagraph for time spent in a nonprovider setting shall maintain and make available to the Secretary records regarding the amount of such time and such amount in comparison with amounts of such time in such base year as the Secretary shall specify.

(F) Limitation on number of residents in allopathic and osteopathic medicine

(i) In general

Such rules shall provide that for purposes of a cost reporting period beginning on or after October 1, 1997, subject to paragraphs (7) and (8), the total number of full-time equivalent residents before application of weighting factors (as determined under this paragraph) with respect to a hospital's approved medical residency training program in the fields of allopathic

⁹ So in original. The semicolon probably should not appear.

medicine and osteopathic medicine may not exceed the number (or, 130 percent of such number in the case of a hospital located in a rural area) of such full-time equivalent residents for the hospital's most recent cost reporting period ending on or before December 31, 1996.

(ii) Counting primary care residents on certain approved leaves of absence in base year FTE count

(I) In general

In determining the number of such full-time equivalent residents for a hospital's most recent cost reporting period ending on or before December 31, 1996, for purposes of clause (i), the Secretary shall count an individual to the extent that the individual would have been counted as a primary care resident for such period but for the fact that the individual, as determined by the Secretary, was on maternity or disability leave or a similar approved leave of absence.

(II) Limitation to 3 FTE residents for any hospital

The total number of individuals counted under subclause (I) for a hospital may not exceed 3 full-time equivalent residents.

(G) Counting interns and residents for FY 1998 and subsequent years

(i) In general

For cost reporting periods beginning during fiscal years beginning on or after October 1, 1997, subject to the limit described in subparagraph (F), the total number of full-time equivalent residents for determining a hospital's graduate medical education payment shall equal the average of the actual full-time equivalent resident counts for the cost reporting period and the preceding two cost reporting periods.

(ii) Adjustment for short periods

If any cost reporting period beginning on or after October 1, 1997, is not equal to twelve months, the Secretary shall make appropriate modifications to ensure that the average full-time equivalent resident counts pursuant to clause (i) are based on the equivalent of full twelve-month cost reporting periods.

(iii) Transition rule for 1998

In the case of a hospital's first cost reporting period beginning on or after October 1, 1997, clause (i) shall be applied by using the average for such period and the preceding cost reporting period.

(H) Special rules for application of subparagraphs (F) and (G)

(i) New facilities

The Secretary shall, consistent with the principles of subparagraphs (F) and (G) and subject to paragraphs (7) and (8), prescribe rules for the application of such subparagraphs in the case of medical residency

training programs established on or after January 1, 1995. In promulgating such rules for purposes of subparagraph (F), the Secretary shall give special consideration to facilities that meet the needs of underserved rural areas.

(ii) Aggregation

The Secretary may prescribe rules which allow institutions which are members of the same affiliated group (as defined by the Secretary) to elect to apply the limitation of subparagraph (F) on an aggregate basis.

(iii) Data collection

The Secretary may require any entity that operates a medical residency training program and to which subparagraphs (F) and (G) apply to submit to the Secretary such additional information as the Secretary considers necessary to carry out such subparagraphs.

(iv) Nonrural hospitals operating training programs in rural areas

In the case of a hospital that is not located in a rural area but establishes separately accredited approved medical residency training programs (or rural tracks) in an¹⁰ 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 1395cc(a) of this title to provide hospital services on the same physical site previously used by Medicare Provider No. 05-0578—

(I) the limitation on the number of total full time equivalent residents under subparagraph (F) and clauses (v) and (vi)(I) of subsection (d)(5)(B) applicable to such provider shall be equal to the limitation applicable under such provisions to Provider No. 05-0578 for its cost reporting period ending on June 30, 2006; and

(II) the provisions of subparagraph (G) and subsection (d)(5)(B)(vi)(II) shall not be applicable to such provider for the first three cost reporting years in which such provider trains residents under any approved medical residency training program.

(vi) Redistribution of residency slots after a hospital closes

(I) In general

Subject to the succeeding provisions of this clause, the Secretary shall, by regulation, establish a process under which, in the case where a hospital (other than a hospital described in clause (v)) with

¹⁰So in original. Probably should be "a".

an approved medical residency program closes on or after a date that is 2 years before March 23, 2010, 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 shall not apply to the implementation of this clause.

(J)¹¹ 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 activi-

ties 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 successor examination recognized by the Secretary for this purpose.

(F) Initial residency period

The term "initial residency period" means the period of board eligibility, except that—

¹¹ So in original. No subpar. (I) has been enacted.

(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 eligi-

bility 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 subchapter or a State plan under subchapter XIX of this chapter) 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 subchapter 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 subchapter.

(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) of this section 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 subchapter 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, 1999,¹²

(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.

¹²So in original. The comma probably should be a semicolon.

(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)(i); 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 in-

creases 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) of this section) 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) of this section).

(II) Second, to hospitals located in urban areas that are not large urban areas (as defined for purposes of subsection (d) of this section).

(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 1395ff, 1395oo of this title, or otherwise, with respect to determinations made under this this¹³ paragraph, paragraph (8), or paragraph (4)(H)(vi).

(8) Distribution of additional residency positions

(A) Reductions in limit based on unused positions

(i) In general

Except as provided in clause (ii), if a hospital's reference resident level (as defined in subparagraph (H)(i)) is less than the otherwise applicable resident limit (as defined in subparagraph (H)(iii)), effective for portions of cost reporting periods occurring on or after July 1, 2011, the otherwise applicable resident limit shall be reduced by 65 percent of the difference between such otherwise applicable resident limit and such reference resident level.

(ii) Exceptions

This subparagraph shall not apply to—

(I) a hospital located in a rural area (as defined in subsection (d)(2)(D)(ii)) with fewer than 250 acute care inpatient beds;

(II) a hospital that was part of a qualifying entity which had a voluntary residency reduction plan approved under paragraph (6)(B) or under the authority of section 402 of Public Law 90-248, if the hospital demonstrates to the Secretary that it has a specified plan in place for filling the unused positions by not later than 2 years after March 23, 2010; 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 March 23, 2010; 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 (i) 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)⁵) as a health professional shortage area (as of the date of enactment of this paragraph); to

¹³ So in original.

(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 March 23, 2010) of the hospital for which a cost report has been settled (or, if not, submitted (subject to audit)), as determined by the Secretary.

(ii) Resident level

The term “resident level” has the meaning given such term in paragraph (7)(C)(i).

(iii) Otherwise applicable resident limit

The term “otherwise applicable resident limit” means, with respect to a hospital, the limit otherwise applicable under subparagraphs (F)(i) and (H) of paragraph (4) on the resident level for the hospital determined without regard to this paragraph but taking into account paragraph (7)(A).

(I) Affiliation

The provisions of this paragraph shall be applied to hospitals which are members of the same affiliated group (as defined by the Secretary under paragraph (4)(H)(ii)) and the reference resident level for each such hospital shall be the reference resident level with respect to the cost reporting period that results in the smallest difference between the reference resident level and the otherwise applicable resident limit.

(i) Avoiding duplicative payments to hospitals participating in rural demonstration programs

The Secretary shall reduce any payment amounts otherwise determined under this section to the extent necessary to avoid duplication of any payment made under section 4005(e) of the Omnibus Budget Reconciliation Act of 1987.

(j) Prospective payment for inpatient rehabilitation services

(1) Payment during transition period

(A) In general

Notwithstanding section 1395f(b) of this title, but subject to the provisions of section 1395e of this title, the amount of the payment with respect to the operating and capital costs of inpatient hospital services of a rehabilitation hospital or a rehabilitation unit (in this subsection referred to as a “rehabilitation facility”), other than a facility making an election under subparagraph (F) in a cost reporting period beginning on or after October 1, 2000, and before October 1, 2002, is equal to the sum of—

(i) the TEFRA percentage (as defined in subparagraph (C)) of the amount that would have been paid under part A of this subchapter 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 1395f(b) of this title, but subject to the provisions of section 1395e of this title, the amount of the payment with respect to the operating and capital costs of inpatient hospital services of a rehabilitation facility for a payment unit in a cost reporting period beginning on or after October 1, 2002, or, in the case of a facility making an election under subparagraph (F), for any cost reporting period described in such subparagraph, is equal to the per unit payment rate established under this subsection for the fiscal year in which the payment unit of service occurs.

(C) TEFRA and prospective payment percentages specified

For purposes of subparagraph (A), for a cost reporting period beginning—

(i) on or after October 1, 2000, and before October 1, 2001, the “TEFRA percentage” is 66⅔ percent and the “prospective payment percentage” is 33⅓ percent; and

(ii) on or after October 1, 2001, and before October 1, 2002, the “TEFRA percentage” is 33⅓ percent and the “prospective payment percentage” is 66⅔ percent.

(D) Payment unit

For purposes of this subsection, the term “payment unit” means a discharge.

(E) Construction relating to transfer authority

Nothing in this subsection shall be construed as preventing the Secretary from providing for an adjustment to payments to take into account the early transfer of a patient from a rehabilitation facility to another site of care.

(F) Election to apply full prospective payment system

A rehabilitation facility may elect, not later than 30 days before its first cost reporting period for which the payment methodology under this subsection applies to the facility, to have payment made to the facility under this subsection under the provisions of subparagraph (B) (rather than subparagraph (A)) for each cost reporting period to which such payment methodology applies.

(2) Patient case mix groups

(A) Establishment

The Secretary shall establish—

(i) classes of patient discharges of rehabilitation facilities by functional-related groups (each in this subsection referred to as a “case mix group”), based on impairment, age, comorbidities, and functional capability of the patient and such other factors as the Secretary deems appropriate to improve the explanatory power of functional independence measure-function related groups; and

(ii) a method of classifying specific patients in rehabilitation facilities within these groups.

(B) Weighting factors

For each case mix group the Secretary shall assign an appropriate weighting which reflects the relative facility resources used with respect to patients classified within that group compared to patients classified within other groups.

(C) Adjustments for case mix

(i) In general

The Secretary shall from time to time adjust the classifications and weighting factors established under this paragraph as appropriate to reflect changes in treatment patterns, technology, case mix, number of payment units for which payment is made under this subchapter, 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 subchapter. 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 subchapter 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) of this section (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 subchapter 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 clause (ii). 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) of this section. 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

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 subsection (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.

(D) Other adjustment

For purposes of subparagraph (C)(ii)(II), the other adjustment described in this subparagraph is—

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

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

(iii) for fiscal year 2014, 0.3 percentage point;

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

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

(4) Outlier and special payments**(A) Outliers****(i) In general**

The Secretary may provide for an additional payment to a rehabilitation facility for patients in a case mix group, based upon the patient being classified as an outlier based on an unusual length of stay, costs, or other factors specified by the Secretary.

(ii) Payment based on marginal cost of care

The amount of such additional payment under clause (i) shall be determined by the Secretary and shall approximate the marginal cost of care beyond the cutoff point applicable under clause (i).

(iii) Total payments

The total amount of the additional payments made under this subparagraph for payment units in a fiscal year may not exceed 5 percent of the total payments projected or estimated to be made based on prospective payment rates for payment units in that year.

(B) Adjustment

The Secretary may provide for such adjustments to the payment amounts under this subsection as the Secretary deems appropriate to take into account the unique circumstances of rehabilitation facilities located in Alaska and Hawaii.

(5) Publication

The Secretary shall provide for publication in the Federal Register, on or before August 1 before each fiscal year (beginning with fiscal year 2001), of the classification and weighting factors for case mix groups under paragraph (2) for such fiscal year and a description of the methodology and data used in computing the prospective payment rates under this subsection for that fiscal year.

(6) Area wage adjustment

The Secretary shall adjust the proportion (as estimated by the Secretary from time to time) of rehabilitation facilities' costs which are attributable to wages and wage-related costs, of the prospective payment rates computed under paragraph (3) for area differences in wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the rehabilitation facility compared to the national average wage level for such facilities. Not later than October 1, 2001 (and at least every 36 months thereafter), the Secretary shall update the factor under the preceding sentence on the basis of information available to the Secretary (and updated as appropriate) of the wages and wage-related costs incurred in furnishing rehabilitation services. Any adjustments or up-

dates 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 subparagraph (C) with respect to such a fiscal year, after determining the increase factor described in paragraph (3)(C), and after application of paragraph (3)(D), 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

For fiscal year 2014 and each subsequent rate 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 1395aaa(a) of this title.

(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 1395aaa(a) of this title, 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) 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.

(8) Limitation on review

There shall be no administrative or judicial review under section 1395ff of this title, 1395oo of this title, 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) of this section. 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 subchapter.

(2) Qualified nonhospital providers

For purposes of this subsection, the term “qualified nonhospital providers” means—

(A) a Federally¹⁴ qualified health center, as defined in section 1395x(aa)(4) of this title;

(B) a rural health clinic, as defined in section 1395x(aa)(2) of this title;

(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 1395x(v)(1) of this title.

¹⁴So in original. Probably should not be capitalized.

(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) of this section to total direct graduate medical education payments estimated for such portions of periods under subsection (h)(3) of this section.

(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 1395x(v) of this title 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 1395x(v) of this title 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 1395mm of this title and who are entitled to benefits under part A of this subchapter or who are enrolled with a Medicare+Choice organization under part C of this subchapter; 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 subchapter 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**

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 subsection (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.

(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 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 (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

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 1395aaa(a) of this title.

(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 1395aaa(a) of this title, 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 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.

(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 1395i of this title, 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 at-

tributable 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 subchapter), 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.

(iii) Reporting on measures using EHR

Subject to subparagraph (B)(ii) and using such certified EHR technology, the eligible hospital submits information for such period, in a form and manner specified by the Secretary, on such clinical quality measures and such other measures as selected by the Secretary under subparagraph (B)(i).

The Secretary shall seek to improve the use of electronic health records and health care quality over time by requiring more stringent measures of meaningful use selected under this paragraph.

(B) Reporting on measures

(i) Selection

The Secretary shall select measures for purposes of subparagraph (A)(iii) but only consistent with the following:

(I) The Secretary shall provide preference to clinical quality measures that have been selected for purposes of applying subsection (b)(3)(B)(viii) or that have been endorsed by the entity with a contract with the Secretary under section 1395aaa(a) of this title.

(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 1395w-115(d)(2)(B) and 1395w-115(f)(2) of this title, the Secretary may use data regarding drug claims submitted for purposes of section 1395w-115 of this title that are necessary for purposes of subparagraph (A).

(4) Application

(A) Limitations on review

There shall be no administrative or judicial review under section 1395ff of this title, section 1395oo of this title, 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)¹⁵ 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 1395f(l) of this title 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 1395w-4(o)(4) this title.

(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 subsection (d) 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.

¹⁵ So in original. Probably should be “(6)(A)”.

(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 1395f(b)(3) of this title, the Secretary may exempt such hospital from the application of this subsection if the State which is paid under such section submits an annual report to the Secretary describing how a similar program in the State for a participating hospital or hospitals achieves or surpasses the measured results in terms of patient health outcomes and cost savings established under this subsection.

(2) Measures**(A) In general**

The Secretary shall select measures, other than measures of readmissions, for purposes of the Program. Such measures shall be selected from the measures specified under subsection (b)(3)(B)(viii).

(B) Requirements**(i) For fiscal year 2013**

For value-based incentive payments made with respect to discharges occurring during fiscal year 2013, the Secretary shall ensure the following:

(I) Conditions or procedures

Measures are selected under subparagraph (A) that cover at least the following 5 specific conditions or procedures:

(aa) Acute myocardial infarction (AMI).

(bb) Heart failure.

(cc) Pneumonia.

(dd) Surgeries, as measured by the Surgical Care Improvement Project (formerly referred to as “Surgical Infection Prevention” for discharges occurring before July 2006).

(ee) Healthcare-associated infections, as measured by the prevention metrics and targets established in the HHS Action Plan to Prevent Healthcare-Associated Infections (or any successor plan) of the Department of Health and Human Services.

(II) HCAHPS

Measures selected under subparagraph (A) shall be related to the Hospital Consumer Assessment of Healthcare Providers and Systems survey (HCAHPS).

(ii) Inclusion of efficiency measures

For value-based incentive payments made with respect to discharges occurring during fiscal year 2014 or a subsequent fiscal year, the Secretary shall ensure that measures selected under subparagraph (A) include efficiency measures, including measures of “Medicare spending per beneficiary”. Such measures shall be adjusted for factors such as age, sex, race, severity of illness, and other factors that the Secretary determines appropriate.

(C) Limitations**(i) Time requirement for prior reporting and notice**

The Secretary may not select a measure under subparagraph (A) for use under the Program with respect to a performance period for a fiscal year (as established under paragraph (4)) unless such measure has been specified under subsection (b)(3)(B)(viii) and included on the Hospital Compare Internet website for at least 1 year prior to the beginning of such performance period.

(ii) Measure not applicable unless hospital furnishes services appropriate to the measure

A measure selected under subparagraph (A) shall not apply to a hospital if such hospital does not furnish services appropriate to such measure.

(D) Replacing measures

Subclause (VI) of subsection (b)(3)(B)(viii) shall apply to measures selected under subparagraph (A) in the same manner as such subclause applies to measures selected under such subsection.

(3) Performance standards**(A) Establishment**

The Secretary shall establish performance standards with respect to measures selected under paragraph (2) for a performance period for a fiscal year (as established under paragraph (4)).

(B) Achievement and improvement

The performance standards established under subparagraph (A) shall include levels of achievement and improvement.

(C) Timing

The Secretary shall establish and announce the performance standards under subparagraph (A) not later than 60 days prior to the beginning of the performance period for the fiscal year involved.

(D) Considerations in establishing standards

In establishing performance standards with respect to measures under this paragraph, the Secretary shall take into account appropriate factors, such as—

- (i) practical experience with the measures involved, including whether a significant proportion of hospitals failed to meet the performance standard during previous performance periods;
- (ii) historical performance standards;
- (iii) improvement rates; and
- (iv) the opportunity for continued improvement.

(4) Performance period

For purposes of the Program, the Secretary shall establish the performance period for a fiscal year. Such performance period shall begin and end prior to the beginning of such fiscal year.

(5) Hospital performance score**(A) In general**

Subject to subparagraph (B), the Secretary shall develop a methodology for assessing the total performance of each hospital based on performance standards with respect to the measures selected under paragraph (2) for a performance period (as established under paragraph (4)). Using such methodology, the Secretary shall provide for an assessment (in this subsection referred to as the “hospital performance score”) for each hospital for each performance period.

(B) Application**(i) Appropriate distribution**

The Secretary shall ensure that the application of the methodology developed under subparagraph (A) results in an appropriate distribution of value-based incentive payments under paragraph (6) among hospitals achieving different levels of hospital performance scores, with hospitals achieving the highest hospital performance scores receiving the largest value-based incentive payments.

(ii) Higher of achievement or improvement

The methodology developed under subparagraph (A) shall provide that the hospital performance score is determined using the higher of its achievement or improvement score for each measure.

(iii) Weights

The methodology developed under subparagraph (A) shall provide for the assignment of weights for categories of measures as the Secretary determines appropriate.

(iv) No minimum performance standard

The Secretary shall not set a minimum performance standard in determining the

hospital performance score for any hospital.

(v) Reflection of measures applicable to the hospital

The hospital performance score for a hospital shall reflect the measures that apply to the hospital.

(6) Calculation of value-based incentive payments**(A) In general**

In the case of a hospital that the Secretary determines meets (or exceeds) the performance standards under paragraph (3) for the performance period for a fiscal year (as established under paragraph (4)), the Secretary shall increase the base operating DRG payment amount (as defined in paragraph (7)(D)), as determined after application of paragraph (7)(B)(i), for a hospital for each discharge occurring in such fiscal year by the value-based incentive payment amount.

(B) Value-based incentive payment amount

The value-based incentive payment amount for each discharge of a hospital in a fiscal year shall be equal to the product of—

- (i) the base operating DRG payment amount (as defined in paragraph (7)(D)) for the discharge for the hospital for such fiscal year; and
- (ii) the value-based incentive payment percentage specified under subparagraph (C) for the hospital for such fiscal year.

(C) Value-based incentive payment percentage**(i) In general**

The Secretary shall specify a value-based incentive payment percentage for a hospital for a fiscal year.

(ii) Requirements

In specifying the value-based incentive payment percentage for each hospital for a fiscal year under clause (i), the Secretary shall ensure that—

- (I) such percentage is based on the hospital performance score of the hospital under paragraph (5); and
- (II) the total amount of value-based incentive payments under this paragraph to all hospitals in such fiscal year is equal to the total amount available for value-based incentive payments for such fiscal year under paragraph (7)(A), as estimated by the Secretary.

(7) Funding for value-based incentive payments**(A) Amount**

The total amount available for value-based incentive payments under paragraph (6) for all hospitals for a fiscal year shall be equal to the total amount of reduced payments for all hospitals under subparagraph (B) for such fiscal year, as estimated by the Secretary.

(B) Adjustment to payments**(i) In general**

The Secretary shall reduce the base operating DRG payment amount (as defined

in subparagraph (D)) for a hospital for each discharge in a fiscal year (beginning with fiscal year 2013) by an amount equal to the applicable percent (as defined in subparagraph (C)) of the base operating DRG payment amount for the discharge for the hospital for such fiscal year. The Secretary shall make such reductions for all hospitals in the fiscal year involved, regardless of whether or not the hospital has been determined by the Secretary to have earned a value-based incentive payment under paragraph (6) for such fiscal year.

(ii) No effect on other payments

Payments described in items (aa) and (bb) of subparagraph (D)(i)(II) for a hospital shall be determined as if this subsection had not been enacted.

(C) Applicable percent defined

For purposes of subparagraph (B), the term “applicable percent” means—

- (i) with respect to fiscal year 2013, 1.0 percent;
- (ii) with respect to fiscal year 2014, 1.25 percent;
- (iii) with respect to fiscal year 2015, 1.5 percent;
- (iv) with respect to fiscal year 2016, 1.75 percent; and
- (v) with respect to fiscal year 2017 and succeeding fiscal years, 2 percent.

(D) Base operating DRG payment amount defined

(i) In general

Except as provided in clause (ii), in this subsection, the term “base operating DRG payment amount” means, with respect to a hospital for a fiscal year—

- (I) the payment amount that would otherwise be made under subsection (d) (determined without regard to subsection (q)) for a discharge if this subsection did not apply; reduced by
 - (II) any portion of such payment amount that is attributable to—
 - (aa) payments under paragraphs (5)(A), (5)(B), (5)(F), and (12) of subsection (d); and
 - (bb) such other payments under subsection (d) determined appropriate by the Secretary.

(ii) Special rules for certain hospitals

(I) Sole community hospitals and medicare-dependent, small rural hospitals

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

(II) Hospitals paid under section 1395f

In the case of a hospital that is paid under section 1395f(b)(3) of this title, 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 1395ff of this title, section 1395oo of this title, 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 subchapter, 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 1395f(b)(3) of this title, 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 1395f(b)(3) of this title (determined after the application of subsections (o) and (q) and section 1395f(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 1395f(b)(3) of this title, 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 1395ff of this title, section 1395oo of this title, 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 1395f(b)(3) of this title, 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 1395f of this title

In the case of a hospital that is paid under section 1395f(b)(3) of this title, the

Secretary may exempt such hospitals provided that States paid under such section submit an annual report to the Secretary describing how a similar program in the State for a participating hospital or hospitals achieves or surpasses the measured results in terms of patient health outcomes and cost savings established herein with respect to this section.

(3) Adjustment factor**(A) In general**

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

- (i) the ratio described in subparagraph (B) for the hospital for the applicable period (as defined in paragraph (5)(D)) for such fiscal year; or
- (ii) the floor adjustment factor specified in subparagraph (C).

(B) Ratio

The ratio described in this subparagraph for a hospital for an applicable period is equal to 1 minus the ratio of—

- (i) the aggregate payments for excess readmissions (as defined in paragraph (4)(A)) with respect to an applicable hospital for the applicable period; and
- (ii) the aggregate payments for all discharges (as defined in paragraph (4)(B)) with respect to such applicable hospital for such applicable period.

(C) Floor adjustment factor

For purposes of subparagraph (A), the floor adjustment factor specified in this subparagraph for—

- (i) fiscal year 2013 is 0.99;
- (ii) fiscal year 2014 is 0.98; or
- (iii) fiscal year 2015 and subsequent fiscal years is 0.97.

(4) Aggregate payments, excess readmission ratio defined

For purposes of this subsection:

(A) Aggregate payments for excess readmissions

The term “aggregate payments for excess readmissions” means, for a hospital for an applicable period, the sum, for applicable conditions (as defined in paragraph (5)(A)), of the product, for each applicable condition, of—

- (i) the base operating DRG payment amount for such hospital for such applicable period for such condition;
- (ii) the number of admissions for such condition for such hospital for such applicable period; and
- (iii) the excess readmissions ratio (as defined in subparagraph (C)) for such hospital for such applicable period minus 1.

(B) Aggregate payments for all discharges

The term “aggregate payments for all discharges” means, for a hospital for an applicable period, the sum of the base operating DRG payment amounts for all discharges for all conditions from such hospital for such applicable period.

(C) Excess readmission ratio**(i) In general**

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

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

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

(ii) Exclusion of certain readmissions

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

(5) Definitions

For purposes of this subsection:

(A) Applicable condition

The term “applicable condition” means, subject to subparagraph (B), a condition or procedure selected by the Secretary among conditions and procedures for which—

(i) readmissions (as defined in subparagraph (E)) that represent conditions or procedures that are high volume or high expenditures under this subchapter (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 1395aaa(a) of this title; 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 March 23, 2010, 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 Sec-

retary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1395aaa(a) of this title 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 1395f(b)(3) of this title, 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 1395ff of this title, section 1395oo of this title, 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 subchapter and posted on the CMS Hospital Compare website.

(B) Posting of hospital specific all patient readmission rates

The Secretary shall make information on all patient readmission rates calculated under subparagraph (A) available on the CMS Hospital Compare website in a form and manner determined appropriate by the Secretary. The Secretary may also make other information determined appropriate by the Secretary available on such website.

(C) Hospital submission of all patient data

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

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

(D) Definitions

For purposes of this paragraph:

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

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

(r) Adjustments to medicare DSH payments**(1) Empirically justified DSH payments**

For fiscal year 2014 and each subsequent fiscal year, instead of the amount of disproportionate share hospital payment that would otherwise be made under subsection (d)(5)(F) to a subsection (d) hospital for the fiscal year, the Secretary shall pay to the subsection (d) hospital 25 percent of such amount (which represents the empirically justified amount for such payment, as determined by the Medicare Payment Advisory Commission in its March 2007 Report to the Congress).

(2) Additional payment

In addition to the payment made to a subsection (d) hospital under paragraph (1), for fiscal year 2014 and each subsequent fiscal year, the Secretary shall pay to such subsection (d) hospitals an additional amount equal to the product of the following factors:

(A) Factor one

A factor equal to the difference between—

(i) the aggregate amount of payments that would be made to subsection (d) hospitals under subsection (d)(5)(F) if this subsection did not apply for such fiscal year (as estimated by the Secretary); and

(ii) the aggregate amount of payments that are made to subsection (d) hospitals under paragraph (1) for such fiscal year (as so estimated).

(B) Factor two**(i) Fiscal years 2014, 2015, 2016, and 2017**

For each of fiscal years 2014, 2015, 2016, and 2017, a factor equal to 1 minus the percent change in the percent of individuals under the age of 65 who are uninsured, as determined by comparing the percent of such individuals—

(I) who are uninsured in 2013, the last year before coverage expansion under the Patient Protection and Affordable Care Act (as calculated by the Secretary based on the most recent estimates available from the Director of the Congressional Budget Office before a vote in either House on the Health Care and Education Reconciliation Act of 2010 that, if determined in the affirmative, would clear such Act for enrollment); and

(II) who are uninsured in the most recent period for which data is available (as so calculated),

minus 0.1 percentage points for fiscal year 2014 and minus 0.2 percentage points for each of fiscal years 2015, 2016, and 2017.

(ii) 2018 and subsequent years

For fiscal year 2018 and each subsequent fiscal year, a factor equal to 1 minus the percent change in the percent of individuals who are uninsured, as determined by comparing the percent of individuals—

(I) who are uninsured in 2013 (as estimated by the Secretary, based on data from the Census Bureau or other sources the Secretary determines appropriate, and certified by the Chief Actuary of the Centers for Medicare & Medicaid Services); and

(II) who are uninsured in the most recent period for which data is available (as so estimated and certified),

minus 0.2 percentage points for each of fiscal years 2018 and 2019.

(C) Factor three

A factor equal to the percent, for each subsection (d) hospital, that represents the quotient of—

(i) the amount of uncompensated care for such hospital for a period selected by

the Secretary (as estimated by the Secretary, based on appropriate data (including, in the case where the Secretary determines that alternative data is available which is a better proxy for the costs of subsection (d) hospitals for treating the uninsured, the use of such alternative data)); and

(ii) the aggregate amount of uncompensated care for all subsection (d) hospitals that receive a payment under this subsection for such period (as so estimated, based on such data).

(3) Limitations on review

There shall be no administrative or judicial review under section 1395ff of this title, section 1395oo of this title, 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 subchapter 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 subsection (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 1395aaa(a) of this title.

(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 1395aaa(a) of this title, 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.

(Aug. 14, 1935, ch. 531, title XVIII, § 1886, as added and amended Pub. L. 97-248, title I, §§101(a)(1), 110, Sept. 3, 1982, 96 Stat. 331, 339; Pub. L. 97-448, title III, §309(b)(13)-(15), Jan. 12, 1983, 96 Stat. 2409; Pub. L. 98-21, title VI, §601(a)(1), (2), (b), (c), (d)(2), (e), Apr. 20, 1983, 97 Stat. 149, 150, 152; Pub. L. 98-369, div. B, title III, §§2307(b)(1), 2310(a), 2311(a)-(c), 2312(a), (b), 2313(a), (b), (d), 2315(a)-(c), 2354(b)(42)-(44), July 18, 1984, 98 Stat. 1073, 1075-1080, 1102; Pub. L. 98-617, §3(b)(9), Nov. 8, 1984, 98 Stat. 3296; Pub. L. 99-272, title IX, §§9101(b), (c), 9102(a)-(c), 9104(a), (b), 9105(a)-(c), 9106(a), 9107(a), 9109(a), 9111(a), 9127(a), 9202(a), Apr. 7, 1986, 100 Stat. 153-155, 157-162, 170, 171; Pub. L. 99-349, title II, §206, July 2, 1986, 100 Stat. 749; Pub. L. 99-509, title IX, §§9302(a)(1), (2), (b)(1), (c), (d)(1)(A), (e), 9303, 9304(a)-(c), 9306(a)-(c), 9307(c)(1), 9314(a), 9320(g), 9321(e)(2), Oct. 21, 1986, 100 Stat. 1982-1985, 1988, 1995, 2005, 2015, 2018; Pub. L. 99-514, §2, title XVIII, §1895(b)(1)(A)-(C), (2)(A)-(C), (3), (9), Oct. 22, 1986, 100 Stat. 2095, 2931-2933; Pub. L. 100-93, §8(c)(4), Aug. 18, 1987, 101 Stat. 693; Pub. L. 100-203, title IV, §§4002(a)-(f)(1), 4003(a)-(c), 4004(a), 4005(a)(1), (c)(1), (d)(1)(A), 4006(a)-(b)(2), 4007(b)(1), 4009(d)(1), (j)(1)-(6)(B), 4083(b)(1), Dec. 22, 1987, 101 Stat. 1330-42 to 1330-44, 1330-46, 1330-47, 1330-49, 1330-52, 1330-53, 1330-57 to 1330-59, 1330-129, as amended Pub. L. 100-360, title IV, §411(b)(1)(E), (3), (4)(C)(i), (5)(B), (6)(B), (8)(B), July 1, 1988, 102 Stat. 769, 770, 772; Pub. L. 100-360, title IV, §411(b)(1)(A)-(D), (F)-(H)(i), (4)(A), (B), (5)(A), July 1, 1988, 102 Stat. 768-770; Pub. L. 100-485, title VI, §608(d)(18)(A), (B), Oct. 13, 1988, 102 Stat. 2418; Pub. L. 100-647, title I, §1018(r)(1), title VIII, §§8401, 8403(a), Nov. 10, 1988, 102 Stat. 3586, 3798; Pub. L. 101-234, title III, §301(b)(3), (c)(3), Dec. 13, 1989, 103 Stat. 1985, 1986; Pub. L. 101-239, title VI, §§6002, 6003(a)(1), (b)-(c)(3), (e)(1), (2)(B)-(E), (f), (g)(2), (4)-(h)(4), (6), 6004(a)(1), (2), (b)(1), 6011(a), 6015(a), 6022, Dec. 19, 1989, 103 Stat. 2140-2144, 2151, 2154-2157, 2159-2161, 2164, 2167; Pub. L. 101-403, title I, §115(b)(1), Oct. 1, 1990, 104 Stat. 870; Pub. L. 101-508, title IV, §§4001, 4002(a)(1), (b)(1)-(4), (c)(1), (2), (e)(1), (g)(1), (2), (h)(1)(A), (2)(B), 4003(a), 4005(a)(1), (c)(1)(B), (2), 4008(f)(1), (m)(2)(A), Nov. 5, 1990, 104 Stat. 1388-31 to 1388-38, 1388-40, 1388-42, 1388-45, 1388-53; Pub. L. 103-66, title XIII, §§13501(a), (b)(1), (c), (e)(1), (f), 13502, 13506, 13563(a), (b)(1), (c)(1), Aug. 10, 1993, 107 Stat. 572, 574, 575, 577, 579, 605; Pub. L. 103-432, title I, §§101(a)(1), (b), (c), 102(b)(1)(B), 105, 108-110(a), (c), 153(a), Oct. 31, 1994, 108 Stat. 4400-4402, 4405, 4407, 4408, 4437; Pub. L. 105-33,

title IV, §§4022(b)(1)(A), 4201(c)(1), (4), 4202(a), 4204(a)(1), (2), 4401(a), 4402, 4403(a), 4405(a)-(c), 4406, 4407, 4411-4415(c), 4416, 4417(a)(1), (b)(1), 4418(a), 4419(a)(1), 4421(a), (b), 4621-4626(a), 4627(a), 4644(a)(1), (b)(1), (c)(1), Aug. 5, 1997, 111 Stat. 354, 373-375, 397, 398, 400, 401, 403-410, 413, 475-480, 483, 488; Pub. L. 106-113, div. B, §1000(a)(6) [title I, §§111(a), (c), 112(a), 121(a), 122, 125(a), title III, §§311, 312(a), 321(b), (e), (f), (h), (k)(15)-(17), title IV, §§401(a), 402(a), 404(a), (b)(1), 405-407(a)(2), (b)(1), (2), (c)(1), title V, §541], Nov. 29, 1999, 113 Stat. 1536, 1501A-329 to 1501A-332, 1501A-362 to 150A-366, 1501A-368, 1501A-369, 1501A-372 to 1501A-374, 1501A-391; Pub. L. 106-554, §1(a)(4) [div. B, title I, §152(a), (b)], §1(a)(6) [title II, §§211, 212(a), 213(a), title III, §§301(a), (e)(1), 302(a), (c), (d), 303(a), (c), (d)(1), 304(a), (c)(2), 305(a), (b), 307(a)(1), title V, §§511, 512(a), 533(b)(1), (3)], Dec. 21, 2000, 114 Stat. 2763, 2763A-251, 2763A-252, 2763A-483, 2763A-485, 2763A-491 to 2763A-496, 2763A-533, 2763A-548, 2763A-550; Pub. L. 108-173, title IV, §§401(a)-(c), 402, 403, 406, 407(a), 422(a), (b)(1), title V, §§501(a), (b), 502(a), (b), 503(a)-(d)(1), 504, 505(a), title VII, §§711, 736(a)(9), (15), (c)(6), Dec. 8, 2003, 117 Stat. 2262-2265, 2269, 2270, 2284, 2286, 2289-2293, 2340, 2355, 2356; Pub. L. 109-171, title V, §§5001(a), (c), 5002(a), 5003(a)(1), (2)(A), (b)-(d), Feb. 8, 2006, 120 Stat. 28, 30-32; Pub. L. 109-432, div. B, title I, §§106(c), 109(a)(2), title II, §205(b)(1), Dec. 20, 2006, 120 Stat. 2983, 2985, 2989; Pub. L. 110-161, div. G, title II, §225(a), (b)(1), Dec. 26, 2007, 121 Stat. 2189; Pub. L. 110-173, title I, §§114(e)(1), 115(a)(1), Dec. 29, 2007, 121 Stat. 2504, 2506; Pub. L. 110-275, title I, §122, July 15, 2008, 122 Stat. 2514; Pub. L. 111-5, div. B, title IV, §4102(a)(1), (b)(1), Feb. 17, 2009, 123 Stat. 477, 482; Pub. L. 111-148, title III, §§3001(a)(1)-(3), 3004(a), (b), 3008(a), 3025(a), 3124(a), (b)(1), 3125, 3133, 3401(a), (c), (d), (f), title V, §§5503(a), (b), 5504(a), (b), 5505(a), (b), 5506(a), (b), (e), title X, §§10309, 10314, 10316, 10319(a)-(c), (e), 10322(a), 10324(a), 10335, Mar. 23, 2010, 124 Stat. 353-360, 368, 369, 376, 408, 424, 425, 432, 480-483, 655, 658-663, 942, 944, 946, 948, 949, 952, 959, 974; Pub. L. 111-152, title I, §§1104-1105(d), Mar. 30, 2010, 124 Stat. 1047, 1048; Pub. L. 111-192, title I, §102(a), June 25, 2010, 124 Stat. 1281; Pub. L. 111-309, title II, §203, Dec. 15, 2010, 124 Stat. 3289.)

REFERENCES IN TEXT

Parts A, B, C, and D of this subchapter, referred to in text, are classified to sections 1395c et seq., 1395j et seq., 1395w-21 et seq., and 1395w-101 et seq., respectively, of this title.

Section 5001(b) of the Deficit Reduction Act of 2005, referred to in subsec. (b)(3)(B)(viii)(I), is section 5001(b) of Pub. L. 109-171, which is set out below.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, referred to in subsecs. (b)(3)(B)(viii)(IV) and (d)(2)(C)(i), is Pub. L. 108-173, Dec. 8, 2003, 117 Stat. 2066. Section 238(b) of the Act is set out as a note under section 1395ll of this title. Section 402(a) of the Act, which amended this section, does not contain a par. (1). Section 403(a)(1) of the Act amended this section. For complete classification of this Act to the Code, see Short Title of 2003 Amendment note set out under section 1305 of this title and Tables.

The Internal Revenue Code of 1986, referred to in subsec. (b)(6), is classified generally to Title 26, Internal Revenue Code.

Section 222(a) of the Social Security Amendments of 1972, referred to in subsec. (c)(4)(B), is section 222(a) of Pub. L. 92-603, Oct. 30, 1972, 86 Stat. 1329, which is set out as a note under section 1395b-1 of this title.

Section 9104(a) of the Medicare and Medicaid Budget Reconciliation Amendments of 1985, referred to in subsec. (d)(2)(C)(i), is section 9104(a) of Pub. L. 99-272, which amended subsec. (d)(5)(B) of this section.

Section 4621(a)(1) of the Balanced Budget Act of 1997, referred to in subsec. (d)(2)(C)(i), is section 4621(a)(1) of Pub. L. 105-33, which amended subsec. (d)(5)(B)(ii) of this section.

Section 111 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, referred to in subsec. (d)(2)(C)(i), is section 1000(a)(6) [title I, §111] of Pub. L. 106-113, which amended this section and enacted provisions set out as a note under this section.

Section 302 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, referred to in subsec. (d)(2)(C)(i), is section 1(a)(6) [title III, §302] of Pub. L. 106-554, which amended this section and enacted provisions set out as a note under this section.

Section 6003(c) of the Omnibus Budget Reconciliation Act of 1989, referred to in subsec. (d)(2)(C)(iv), is section 6003(c) of Pub. L. 101-239, which amended this section and enacted provisions set out below.

Section 4002(b) of the Omnibus Budget Reconciliation Act of 1990, referred to in subsec. (d)(2)(C)(iv), is section 4002(b) of Pub. L. 101-508, which amended this section and enacted provisions set out below.

Section 303 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, referred to in subsec. (d)(2)(C)(iv), is section 1(a)(6) [title III, §303] of Pub. L. 106-554, which amended this section and enacted provisions set out as notes under this section.

Section 9104 of the Medicare and Medicaid Budget Reconciliation Amendments of 1985, referred to in subsec. (d)(3)(C)(ii), is section 9104 of Pub. L. 99-272, which amended subsec. (d)(2)(C)(i), (3)(C), (D)(i)(I), (ii)(I), and (5)(B) of this section.

Section 4003(a)(1) of the Omnibus Budget Reconciliation Act of 1987, referred to in subsec. (d)(3)(C)(ii), is section 4003(a)(1) of Pub. L. 100-203, which amended subsec. (d)(5)(B)(ii) of this section.

The Omnibus Budget Reconciliation Act of 1990, referred to in subsec. (d)(3)(C)(ii), is Pub. L. 101-508, Nov. 5, 1990, 104 Stat. 1388. For complete classification of this Act to the Code, see Tables.

The Patient Protection and Affordable Care Act, referred to in subssecs. (d)(3)(E)(i) and (r)(2)(B)(i)(I), is Pub. L. 111-148, Mar. 23, 2010, 124 Stat. 119. Section 10324(a)(1) of the Act amended this section. For complete classification of this Act to the Code, see Short Title note set out under section 18001 of this title and Tables.

Section 9304 of the Omnibus Budget Reconciliation Act of 1986, referred to in subsec. (e)(1)(C)(ii), is section 9304 of Pub. L. 99-509, which enacted subssecs. (d)(9) and (e)(1)(C) of this section and amended subsec. (d)(5)(C)(i)(I), (ii) of this section.

Part B of subchapter XI of this chapter, referred to in subsec. (f)(2), is classified to section 1320c et seq. of this title.

Section 4628 of the Balanced Budget Act of 1997, referred to in subsec. (h)(6)(C)(iii), is section 4628 of Pub. L. 105-33, which is set out as a note below.

Section 402 of Public Law 90-248, referred to in subsec. (h)(7)(B)(vi), (8)(A)(ii)(II), is section 402 of Pub. L. 90-248, title IV, Jan. 2, 1968, 81 Stat. 930, which enacted section 1395b-1 of this title and amended section 1395l of this title.

Such section 332(a)(1)(A), referred to in subsec. (h)(8)(D)(ii)(I), probably means section 332(a)(1)(A) of the Public Health Service Act, which is classified to section 254e(a)(1)(A) of this title.

Section 4005(e) of the Omnibus Budget Reconciliation Act of 1987, referred to in subsec. (i), is section 4005(e) of Pub. L. 100-203, which is set out below.

Section 123 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, referred to in subsec. (m)(1), is section 1000(a)(6) [title I, §123] of Pub. L. 106-113, which enacted provisions set out as a note under this section.

Section 307(b) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, referred to in subsec. (m)(1), is section 1(a)(6) [title III, §307(b)] of Pub. L. 106-554, which enacted provisions set out as a note under this section.

The Health Care and Education Reconciliation Act of 2010, referred to in subsec. (r)(2)(B)(i)(I), is Pub. L. 111-152, Mar. 30, 2010, 124 Stat. 1029. For complete classification of this Act to the Code, see Short Title of 2010 Amendment note set out under section 1305 of this title and Tables.

Section 124 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, referred to in subsec. (s)(1), is section 1000(a)(6) [title I, §124] of Pub. L. 106-113, which enacted provisions set out as a note under this section.

AMENDMENTS

2010—Subsec. (a)(4). Pub. L. 111-192, §102(a)(1), inserted “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 subchapter that are provided by a hospital (or an entity wholly owned or operated by the hospital) to a patient—” after “hemophilia.” and added subpars. (A) and (B).

Subsec. (b)(3)(B)(i)(XX). Pub. L. 111-148, §3401(a)(1), substituted “clauses (viii), (ix), (xi), and (xii)” for “clause (viii)”.

Subsec. (b)(3)(B)(viii)(I). Pub. L. 111-148, §3401(a)(2), inserted “of such applicable percentage increase (determined without regard to clause (ix), (xi), or (xii))” after “one-quarter”.

Subsec. (b)(3)(B)(viii)(II). Pub. L. 111-148, §3001(a)(2)(A), inserted at end “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).”

Subsec. (b)(3)(B)(viii)(V). Pub. L. 111-148, §3001(a)(2)(B), substituted “for fiscal years 2008 through 2012” for “beginning with fiscal year 2008”.

Subsec. (b)(3)(B)(viii)(VII). Pub. L. 111-148, §3001(a)(2)(C), substituted “information regarding measures submitted” for “data submitted”.

Subsec. (b)(3)(B)(viii)(VIII) to (XI). Pub. L. 111-148, §3001(a)(2)(D), added subcls. (VIII) to (XI).

Subsec. (b)(3)(B)(ix)(I). Pub. L. 111-148, §3401(a)(3), inserted “(determined without regard to clause (viii), (xi), or (xii))” after “otherwise applicable under clause (i)”.

Subsec. (b)(3)(B)(x). Pub. L. 111-148, §3001(a)(3), added cl. (x).

Subsec. (b)(3)(B)(xi), (xii). Pub. L. 111-148, §3401(a)(4), added cls. (xi) and (xii).

Subsec. (b)(3)(B)(xii)(I). Pub. L. 111-148, §10319(a)(1), struck out “and” at end.

Subsec. (b)(3)(B)(xii)(II). Pub. L. 111-152, §1105(a)(1)(A), placed subcl. (II), which was directed to be added by Pub. L. 111-148, §10319(a)(3), after subcl. (I) and struck out “and” at end. See Amendment note below.

Pub. L. 111-148, §10319(a)(3), which directed addition of subcl. (II) “after subclause (II)”, could not be executed. See Amendment note above. Former subcl. (II) redesignated (III).

Subsec. (b)(3)(B)(xii)(III). Pub. L. 111-152, §1105(a)(1)(B), added subcl. (III) and struck out former subcl. (III) which read “subject to clause (xiii), for each of fiscal years 2014 through 2019, by 0.2 percentage point.”

Pub. L. 111-148, §10319(a)(2), (4), redesignated subcl. (II) as (III) and substituted “2014” for “2012”.

Subsec. (b)(3)(B)(xii)(IV), (V). Pub. L. 111-152, §1105(a)(1)(B), added subcls. (IV) and (V).

Subsec. (b)(3)(B)(xiii). Pub. L. 111-152, §1105(a)(2), struck out cl. (xiii) which read as follows: “Clause (xii) shall be applied with respect to any of fiscal years 2014 through 2019 by substituting ‘0.0 percentage points’ for ‘0.2 percentage point’, if for such fiscal year—

“(I) the excess (if any) of—

“(aa) the total percentage of the non-elderly insured population for the preceding fiscal year (based on the most recent estimates available from the Director of the Congressional Budget Office before a vote in either House on the Patient Protection and Affordable Care Act that, if determined in the affirmative, would clear such Act for enrollment); over

“(bb) the total percentage of the non-elderly insured population for such preceding fiscal year (as estimated by the Secretary); exceeds

“(II) 5 percentage points.”

Pub. L. 111-148, §3401(a)(4), added cl. (xiii).

Subsec. (b)(3)(D). Pub. L. 111-148, §3124(b)(1)(A), substituted “October 1, 2012” for “October 1, 2011” in introductory provisions.

Subsec. (b)(3)(D)(iv). Pub. L. 111-148, §3124(b)(1)(B), substituted “through fiscal year 2012” for “through fiscal year 2011”.

Subsec. (d)(3)(E)(i). Pub. L. 111-148, §10324(a)(2), which directed the amendment of the third sentence of subsec. (d)(3)(E) by inserting “and the amendments made by section 10324(a)(1) of the Patient Protection and Affordable Care Act” after “2003”, was executed by making the insertion in the fifth sentence of cl. (i) to reflect the probable intent of Congress.

Pub. L. 111-148, §10324(a)(1)(A), substituted “clause (ii) or (iii)” for “clause (ii)”.

Subsec. (d)(3)(E)(iii). Pub. L. 111-148, §10324(a)(1)(B), added cl. (iii).

Subsec. (d)(5)(B)(iv). Pub. L. 111-148, §5504(b), designated existing provisions as subcl. (I), inserted “, and before July 1, 2010” after “1997”, and added subcl. (II).

Subsec. (d)(5)(B)(v). Pub. L. 111-148, §5506(b), which directed substitution of “subsections (h)(4)(H)(vi), (h)(7), and (h)(8)” for “subsections (h)(7) and (h)(8)” in second sentence, was executed by making the substitution in the third sentence to reflect the probable intent of Congress.

Pub. L. 111-148, §5503(b)(1), which directed the substitution, in second sentence, of “subsections (h)(7) and (h)(8)” for “subsection (h)(7)” and “they apply” for “it applies”, was executed by making the substitution in the third sentence to reflect the probable intent of Congress.

Subsec. (d)(5)(B)(x). Pub. L. 111-148, §5505(b), added cl. (x) relating to determining the hospital’s number of full-time equivalent residents.

Pub. L. 111-148, §5503(b)(2), added cl. (x) relating to indirect teaching adjustment factor for additional payment amount attributable to resident positions.

Subsec. (d)(5)(F)(i). Pub. L. 111-148, §3133(1), substituted “Subject to subsection (r), for” for “For” in introductory provisions.

Subsec. (d)(5)(G)(i). Pub. L. 111-148, §3124(a)(1), substituted “October 1, 2012” for “October 1, 2011”.

Subsec. (d)(5)(G)(ii)(II). Pub. L. 111-148, §3124(a)(2), substituted “October 1, 2012” for “October 1, 2011”.

Subsec. (d)(7)(C). Pub. L. 111-192, §102(a)(2), added subpar. (C).

Subsec. (d)(12)(A). Pub. L. 111-148, §3125(1), inserted “or (D)” after “subparagraph (B)”.

Subsec. (d)(12)(B). Pub. L. 111-148, §3125(2), substituted “For discharges occurring in fiscal years 2005 through 2010 and for discharges occurring in fiscal year 2013 and subsequent fiscal years, the Secretary” for “The Secretary” in introductory provisions.

Subsec. (d)(12)(C)(i). Pub. L. 111-148, §10314(1), substituted “1,600 discharges” for “1,500 discharges”.

Pub. L. 111-148, §3125(3), inserted “(or, with respect to fiscal years 2011 and 2012, 15 road miles)” after “25 road miles” and “(or, with respect to fiscal years 2011 and 2012, 1,500 discharges of individuals entitled to, or enrolled for, benefits under part A)” after “800 discharges”.

Subsec. (d)(12)(D). Pub. L. 111-148, §10314(2), substituted “1,600 discharges” for “1,500 discharges”.

Pub. L. 111-148, §3125(4), added subpar. (D).

Subsec. (h)(4)(E). Pub. L. 111-148, §5505(a)(1)(A), substituted “Subject to subparagraphs (J) and (K), such rules” for “Such rules” in introductory provisions.

Pub. L. 111-148, §5504(a), substituted “shall be counted and that—” for “shall be counted and that all the time”, inserted cl. (i) designation and “effective for cost reporting periods beginning before July 1, 2010, all the time;” before “so spent”, substituted “; and” for period at end, added cl. (ii), and inserted concluding provisions.

Subsec. (h)(4)(F)(i). Pub. L. 111-148, §5503(a)(1), substituted “paragraphs (7) and (8)” for “paragraph (7)”.

Subsec. (h)(4)(H)(i). Pub. L. 111-148, §5503(a)(2), substituted “paragraphs (7) and (8)” for “paragraph (7)”.

Subsec. (h)(4)(H)(vi). Pub. L. 111-148, §5506(a), added cl. (vi).

Subsec. (h)(4)(J), (K). Pub. L. 111-148, §5505(a)(1)(B), added subpars. (J) and (K).

Subsec. (h)(5)(K). Pub. L. 111-148, §5505(a)(2), added subpar. (K).

Subsec. (h)(7)(E). Pub. L. 111-148, §5506(e), substituted “this paragraph, paragraph (8), or paragraph (4)(H)(vi)” for “paragraph or paragraph (8)”.

Pub. L. 111-148, §5503(a)(3), inserted “or paragraph (8)” before period at end.

Subsec. (h)(8). Pub. L. 111-148, §5503(a)(4), added par. (8).

Subsec. (h)(8)(I). Pub. L. 111-309 added subpar. (I).

Subsec. (j)(3)(C). Pub. L. 111-148, §3401(d)(1), designated existing provisions as cl. (i), inserted heading and “subject to clause (ii)” after “establish an increase factor” in text, and added cl. (ii).

Subsec. (j)(3)(D). Pub. L. 111-152, §1105(c)(3), struck out cl. (i) designation and heading, redesignated subcls. (I) to (V) of former cl. (i) as cls. (i) to (v), respectively, and realigned margins.

Pub. L. 111-148, §3401(d)(2), added subpar. (D).

Subsec. (j)(3)(D)(i)(I). Pub. L. 111-148, §10319(c)(1), struck out “and” at end.

Subsec. (j)(3)(D)(i)(II). Pub. L. 111-152, §1105(c)(1)(A), placed subcl. (II), which was directed to be added by Pub. L. 111-148, §10319(c)(3), after subcl. (I) and struck out “and” at end. See Amendment note below.

Pub. L. 111-148, §10319(c)(3), which directed addition of subcl. (II) “after subclause (II)”, could not be executed. See Amendment note above. Former subcl. (II) redesignated (III).

Subsec. (j)(3)(D)(i)(III). Pub. L. 111-152, §1105(c)(1)(B), added subcl. (III) and struck out former subcl. (III) which read as follows: “subject to clause (ii), for each of fiscal years 2014 through 2019, 0.2 percentage point.”

Pub. L. 111-148, §10319(c)(2), (4), redesignated subcl. (II) as (III) and substituted “2014” for “2012”.

Subsec. (j)(3)(D)(i)(IV), (V). Pub. L. 111-152, §1105(c)(1)(B), added subcls. (IV) and (V).

Subsec. (j)(3)(D)(ii). Pub. L. 111-152, §1105(c)(2), struck out cl. (ii). Text read as follows: “Clause (i)(II) shall be applied with respect to any of fiscal years 2014 through 2019 by substituting ‘0.0 percentage points’ for ‘0.2 percentage point’, if for such fiscal year—

“(I) the excess (if any) of—

“(aa) the total percentage of the non-elderly insured population for the preceding fiscal year (based on the most recent estimates available from the Director of the Congressional Budget Office before a vote in either House on the Patient Protection and Affordable Care Act that, if determined in the affirmative, would clear such Act for enrollment); over

“(bb) the total percentage of the non-elderly insured population for such preceding fiscal year (as estimated by the Secretary); exceeds

“(II) 5 percentage points.”

Subsec. (j)(7), (8). Pub. L. 111-148, §3004(b), added par. (7) and redesignated former par. (7) as (8).

Subsec. (m)(3), (4). Pub. L. 111-148, §3401(c), added pars. (3) and (4).

Subsec. (m)(4)(A). Pub. L. 111-152, §1105(b)(3), struck out subpar. (A) designation and heading before “For purposes”, redesignated cl. (i) as subpar. (A), and realigned margin.

Subsec. (m)(4)(A)(i). Pub. L. 111-148, §10319(b)(1)(A), substituted “rate year 2010” for “each of rate years 2010 and 2011” and struck out “and” at end.

Subsec. (m)(4)(A)(ii), (iii). Pub. L. 111–152, §1105(b)(3), redesignated cls. (ii) and (iii) as subpars. (B) and (C), respectively, and realigned margins.

Pub. L. 111–148, §10319(b)(1), (C), added cls. (ii) and (iii). Former cl. (ii) redesignated (iv).

Subsec. (m)(4)(A)(iv). Pub. L. 111–152, §1105(b)(3), redesignated cl. (iv) as subpar. (D) and realigned margin.

Pub. L. 111–152, §1105(b)(1), added cl. (iv) and struck out former cl. (iv), which read as follows: “subject to subparagraph (B), for each of rate years 2014 through 2019, 0.2 percentage point.”

Pub. L. 111–148, §10319(b)(1)(B), (D), redesignated cl. (ii) as (iv) and substituted “2014” for “2012”.

Subsec. (m)(4)(A)(v), (vi). Pub. L. 111–152, §1105(b)(3), redesignated cls. (v) and (vi) as subpars. (E) and (F), respectively, and realigned margins.

Pub. L. 111–152, §1105(b)(1)(B), added cls. (v) and (vi).

Subsec. (m)(4)(B). Pub. L. 111–152, §1105(b)(3), redesignated cl. (ii) of former subpar. (A) as subpar. (B) and realigned margin.

Pub. L. 111–152, §1105(b)(2), struck out subpar. (B). Prior to amendment, text read as follows: “Subparagraph (A)(iv) shall be applied with respect to any of rate years 2014 through 2019 by substituting ‘0.0 percentage points’ for ‘0.2 percentage point’, if for such rate year—

“(i) the excess (if any) of—

“(I) the total percentage of the non-elderly insured population for the preceding rate year (based on the most recent estimates available from the Director of the Congressional Budget Office before a vote in either House on the Patient Protection and Affordable Care Act that, if determined in the affirmative, would clear such Act for enrollment); over

“(II) the total percentage of the non-elderly insured population for such preceding rate year (as estimated by the Secretary); exceeds

“(ii) 5 percentage points.”

Pub. L. 111–148, §10319(b)(2), substituted “(A)(iv)” for “(A)(ii)” in introductory provisions.

Subsec. (m)(4)(C) to (F). Pub. L. 111–152, §1105(b)(3), redesignated cls. (iii) to (vi) of former subpar. (A) as subpars. (C) to (F), respectively, and realigned margins.

Subsec. (m)(5). Pub. L. 111–148, §3004(a), added par. (5).

Subsec. (o). Pub. L. 111–148, §3001(a)(1), added subsec. (o).

Subsec. (o)(2)(A). Pub. L. 111–148, §10335, inserted “, other than measures of readmissions,” after “shall select measures”.

Subsec. (p). Pub. L. 111–148, §3008(a), added subsec. (p).

Subsec. (q). Pub. L. 111–148, §3025(a), added subsec. (q).

Subsec. (q)(1). Pub. L. 111–148, §10309, in introductory provisions, substituted “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 1395f(b)(3) of this title, as the case may be) in an amount equal to the product of” for “the Secretary shall reduce the payments that would otherwise be made to such hospital under subsection (d) (or section 1395f(b)(3) of this title, as the case may be) for such a discharge by an amount equal to the product of”.

Subsec. (r). Pub. L. 111–148, §3133(2), added subsec. (r).

Subsec. (r)(1). Pub. L. 111–152, §1104(1), substituted “2014” for “2015”.

Subsec. (r)(2). Pub. L. 111–152, §1104(2)(A), substituted “2014” for “2015” in introductory provisions.

Subsec. (r)(2)(B)(i). Pub. L. 111–152, §1104(2)(B)(i), (ii), (iv), inserted “2014,” after “years” in heading and “2014,” after “each of fiscal years” in introductory provisions and substituted “minus 0.1 percentage points for fiscal year 2014 and minus 0.2 percentage points for each of fiscal years 2015, 2016, and 2017” for “minus 1.5 percentage points” in concluding provisions.

Pub. L. 111–148, §10316(1)(A), (D), struck out “(divided by 100)” after “change” in introductory provisions and inserted concluding provisions.

Subsec. (r)(2)(B)(i)(I). Pub. L. 111–152, §1104(2)(B)(iii), substituted “on the Health Care and Education Reconciliation Act of 2010” for “on such Act”.

Pub. L. 111–148, §10316(1)(B), substituted “2013” for “2012”.

Subsec. (r)(2)(B)(i)(II). Pub. L. 111–148, §10316(1)(C), substituted comma for period at end.

Subsec. (r)(2)(B)(ii). Pub. L. 111–152, §1104(2)(C), substituted “minus 0.2 percentage points for each of fiscal years 2018 and 2019” for “and, for each of 2018 and 2019, minus 1.5 percentage points” in concluding provisions.

Pub. L. 111–148, §10316(2), struck out “(divided by 100)” after “change” in introductory provisions, substituted “2013” for “2012” in subcl. (I), substituted comma for period at end of subcl. (II), and inserted concluding provisions.

Subsec. (s). Pub. L. 111–148, §3401(f), added subsec. (s).

Subsec. (s)(3). Pub. L. 111–152, §1105(d)(3), struck out subpar. (A) designation and heading, redesignated cls. (i) to (v) of former subpar. (A) as subpars. (A) to (E), respectively, and realigned margins.

Subsec. (s)(3)(A)(i). Pub. L. 111–148, §10319(e)(1), struck out “and” at end.

Subsec. (s)(3)(A)(ii). Pub. L. 111–152, §1105(d)(1)(A), placed cl. (ii), which was directed to be added by Pub. L. 111–148, §10319(e)(3), after cl. (i) and struck out “and” at end. See Amendment note below.

Pub. L. 111–148, §10319(e)(3), which directed addition of cl. (ii) “after clause (ii)”, could not be executed. See Amendment note above. Former cl. (ii) redesignated (iii).

Subsec. (s)(3)(A)(iii). Pub. L. 111–152, §1105(d)(1)(B), added cl. (iii) and struck out former cl. (iii) which read as follows: “subject to subparagraph (B), for each of the rate years beginning in 2014 through 2019, 0.2 percentage point.”

Pub. L. 111–148, §10319(e)(2), (4), redesignated cl. (ii) as (iii) and substituted “2014” for “2012”.

Subsec. (s)(3)(A)(iv), (v). Pub. L. 111–152, §1105(d)(1)(B), added cls. (iv) and (v).

Subsec. (s)(3)(B). Pub. L. 111–152, §1105(d)(2), struck out subpar. (B). Prior to amendment, text read as follows: “Subparagraph (A)(ii) shall be applied with respect to any of rate years 2014 through 2019 by substituting ‘0.0 percentage points’ for ‘0.2 percentage point’, if for such rate year—

“(i) the excess (if any) of—

“(I) the total percentage of the non-elderly insured population for the preceding rate year (based on the most recent estimates available from the Director of the Congressional Budget Office before a vote in either House on the Patient Protection and Affordable Care Act that, if determined in the affirmative, would clear such Act for enrollment); over

“(II) the total percentage of the non-elderly insured population for such preceding rate year (as estimated by the Secretary); exceeds

“(ii) 5 percentage points.”

Subsec. (s)(4). Pub. L. 111–148, §10322(a), added par. (4). 2009—Subsec. (b)(3)(B)(viii)(I). Pub. L. 111–5, §4102(b)(1)(A), inserted “(or, beginning with fiscal year 2015, by one-quarter)” after “2.0 percentage points”.

Subsec. (b)(3)(B)(ix). Pub. L. 111–5, §4102(b)(1)(B), added cl. (ix).

Subsec. (n). Pub. L. 111–5, §4102(a)(1), added subsec. (n).

2008—Subsec. (b)(3)(C). Pub. L. 110–275, §122(b)(1), substituted “subparagraphs (I) and (L)” for “subparagraph (I)” in introductory provisions.

Subsec. (b)(3)(D)(i). Pub. L. 110–275, §122(b)(2), substituted “Subject to subparagraph (L), for” for “For” in introductory provisions.

Subsec. (b)(3)(L). Pub. L. 110–275, §122(a), added subpar. (L).

2007—Subsec. (h)(4)(H)(v). Pub. L. 110–161, §225(a), added cl. (v).

Subsec. (h)(7)(D), (E). Pub. L. 110–161, §225(b)(1), added subpar. (D) and redesignated former subpar. (D) as (E).

Subsec. (j)(3)(C). Pub. L. 110–173, §115(a)(1), inserted at end “The increase factor to be applied under this subparagraph for each of fiscal years 2008 and 2009 shall be 0 percent.”

Subsec. (m). Pub. L. 110-173, § 114(e)(1), added subsec. (m).

2006—Subsec. (b)(3)(B)(i)(XIX). Pub. L. 109-171, § 5001(a)(1)(A), substituted “2006” for “2007”.

Subsec. (b)(3)(B)(i)(XX). Pub. L. 109-171, § 5001(a)(1)(B), substituted “for each subsequent fiscal year, subject to clause (viii),” for “for fiscal year 2008 and each subsequent fiscal year.”

Subsec. (b)(3)(B)(vii)(I). Pub. L. 109-171, § 5001(a)(2)(A), substituted “for fiscal years 2005 and 2006” for “for each of fiscal years 2005 through 2007”.

Subsec. (b)(3)(B)(vii)(II). Pub. L. 109-171, § 5001(a)(2)(B), substituted “For fiscal years 2005 and 2006, each” for “Each”.

Subsec. (b)(3)(B)(viii). Pub. L. 109-432, § 205(b)(1), realigned margins.

Pub. L. 109-171, § 5001(a)(3), added cl. (viii).

Subsec. (b)(3)(B)(viii)(III). Pub. L. 109-432, § 109(a)(2), inserted “(including medication errors)” after “quality of care”.

Subsec. (b)(3)(D). Pub. L. 109-171, § 5003(b)(1), inserted “subject to subparagraph (K),” after “(d)(5)(G) of this section,” in introductory provisions.

Pub. L. 109-171, § 5003(a)(2)(A)(i), substituted “occurring” for “beginning” and “October 1, 2011” for “October 1, 2006” in introductory provisions.

Subsec. (b)(3)(D)(iv). Pub. L. 109-171, § 5003(a)(2)(A)(ii), substituted “through fiscal year 2011” for “through fiscal year 2005”.

Subsec. (b)(3)(K). Pub. L. 109-171, § 5003(b)(2), added subpar. (K).

Subsec. (d)(4)(C)(iv). Pub. L. 109-432, § 106(c)(1), struck out cl. (iv) which read as follows: “The Secretary shall include recommendations with respect to adjustments to weighting factors under clause (i) in the annual report to Congress required under subsection (e)(3)(B) of this section.”

Subsec. (d)(4)(D). Pub. L. 109-171, § 5001(c)(1), added subpar. (D).

Subsec. (d)(5)(F)(vi). Pub. L. 109-171, § 5002(a), inserted concluding provisions.

Subsec. (d)(5)(F)(xiv)(II). Pub. L. 109-171, § 5003(d), inserted “or, in the case of discharges occurring on or after October 1, 2006, as a medicare-dependent, small rural hospital under subparagraph (G)(iv)” before period at end.

Subsec. (d)(5)(G)(i). Pub. L. 109-171, § 5003(a)(1)(A), substituted “October 1, 2011” for “October 1, 2006”.

Subsec. (d)(5)(G)(ii)(II). Pub. L. 109-171, § 5003(c), inserted “(or 75 percent in the case of discharges occurring on or after October 1, 2006)” after “50 percent”.

Pub. L. 109-171, § 5003(a)(1)(B), substituted “October 1, 2011” for “October 1, 2006” and inserted “or for discharges in the fiscal year” after “for the cost reporting period”.

Subsec. (d)(7)(B). Pub. L. 109-171, § 5001(c)(2), inserted “, including the selection and revision of codes under paragraph (4)(D)” before period at end.

Subsec. (e)(3). Pub. L. 109-432, § 106(c)(2), struck out par. (3) which read as follows: “The Secretary, not later than April 1, 1987, for fiscal year 1988 and not later than March 1 before the beginning of each fiscal year (beginning with fiscal year 1989), shall report to the Congress the Secretary’s initial estimate of the percentage change that the Secretary will recommend under paragraph (4) with respect to that fiscal year.”

2003—Subsec. (b)(3)(B)(i)(XIX), (XX). Pub. L. 108-173, § 501(a), added subcls. (XIX) and (XX) and struck out former subcl. (XIX) which read as follows: “for fiscal year 2004 and each subsequent fiscal year, the market basket percentage increase for hospitals in all areas.”

Subsec. (b)(3)(B)(vii). Pub. L. 108-173, § 501(b), added cl. (vii).

Subsec. (b)(3)(I)(i)(I). Pub. L. 108-173, § 736(a)(9), substituted “the amount” for “the the amount”.

Subsec. (b)(3)(I)(iii). Pub. L. 108-173, § 407(a), added cl. (iii).

Subsec. (d)(2)(C)(i). Pub. L. 108-173, § 502(b), substituted “1999,” for “1999 or” and inserted “, or the Medicare Prescription Drug, Improvement, and Modernization Act of 2003” before comma at end.

Subsec. (d)(2)(C)(iv). Pub. L. 108-173, § 402(b)(2), struck out “or” before “the enactment of section 303” and inserted “, or the enactment of section 402(a)(1) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003” before period at end.

Subsec. (d)(3). Pub. L. 108-173, § 401(b)(2)(A), inserted “, for fiscal years before fiscal year 1997,” before “a regional adjusted DRG prospective payment rate” in introductory provisions.

Subsec. (d)(3)(A)(iii). Pub. L. 108-173, § 401(b)(3), substituted “in an urban area” for “in an other urban area”.

Subsec. (d)(3)(A)(iv). Pub. L. 108-173, § 401(a), designated existing provisions as subcl. (I), substituted “Subject to subclause (II), for discharges” for “For discharges”, and added subcl. (II).

Subsec. (d)(3)(D). Pub. L. 108-173, § 401(b)(1)(A), (B), (2)(B), in heading, struck out “in different areas” after “hospitals” and, in introductory provisions, inserted “, for fiscal years before fiscal year 1997,” before “a regional DRG prospective payment rate” and struck out “, each of” before “which is equal—”.

Subsec. (d)(3)(D)(i). Pub. L. 108-173, § 401(b)(1)(C)(i), inserted “for fiscal years before fiscal year 2004,” before “for hospitals” in introductory provisions.

Subsec. (d)(3)(D)(i)(II). Pub. L. 108-173, § 401(b)(1)(C)(ii), struck out “and” at end.

Subsec. (d)(3)(D)(ii). Pub. L. 108-173, § 401(b)(1)(D)(i), inserted “for fiscal years before fiscal year 2004,” before “for hospitals” in introductory provisions.

Subsec. (d)(3)(D)(ii)(II). Pub. L. 108-173, § 401(b)(1)(D)(ii), substituted “; and” for period at end.

Subsec. (d)(3)(D)(iii). Pub. L. 108-173, § 401(b)(1)(E), added cl. (iii).

Subsec. (d)(3)(E). Pub. L. 108-173, § 403(a), designated existing provisions as cl. (i), inserted cl. heading, substituted “Except as provided in clause (ii), the Secretary” for “The Secretary”, inserted at end “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 had not been enacted.”, and added cl. (ii).

Subsec. (d)(5)(B)(ii). Pub. L. 108-173, § 422(b)(1)(A), substituted “Subject to clause (ix), for discharges” for “For discharges” in introductory provisions.

Subsec. (d)(5)(B)(ii)(VI). Pub. L. 108-173, § 502(a)(1), struck out “and” at end.

Subsec. (d)(5)(B)(ii)(VII). Pub. L. 108-173, § 502(a)(2), inserted “and before April 1, 2004,” after “on or after October 1, 2002,” and substituted semicolon for period at end.

Subsec. (d)(5)(B)(ii)(VIII) to (XII). Pub. L. 108-173, § 502(a)(3), added subcls. (VIII) to (XII).

Subsec. (d)(5)(B)(v). Pub. L. 108-173, § 422(b)(1)(B), inserted at end “The provisions of subsection (h)(7) of this section shall apply with respect to the first sentence of this clause in the same manner as it applies with respect to subsection (h)(4)(F)(i) of this section.”

Subsec. (d)(5)(B)(ix). Pub. L. 108-173, § 422(b)(1)(C), added cl. (ix).

Subsec. (d)(5)(F)(iv)(II) to (VI). Pub. L. 108-173, § 402(b)(1)(A), inserted “subject to clause (xiv) and” before “for discharges occurring”.

Subsec. (d)(5)(F)(viii). Pub. L. 108-173, § 402(b)(1)(B), substituted “Subject to clause (xiv), the formula” for “The formula”.

Subsec. (d)(5)(F)(x) to (xiii). Pub. L. 108-173, § 402(b)(1)(C), substituted “Subject to clause (xiv), for purposes” for “For purposes” in introductory provisions.

Subsec. (d)(5)(F)(xiv). Pub. L. 108-173, § 402(a), added cl. (xiv).

Subsec. (d)(5)(K)(i). Pub. L. 108-173, § 503(b)(2)(A), inserted at end “Such mechanism shall be modified to meet the requirements of clause (viii).”

Subsec. (d)(5)(K)(ii)(I). Pub. L. 108-173, § 503(b)(1), inserted “(applying a threshold specified by the Secretary that is the lesser of 75 percent of the standardized amount (increased to reflect the difference be-

tween cost and charges) or 75 percent of one standard deviation for the diagnosis-related group involved)” after “is inadequate”.

Subsec. (d)(5)(K)(ii)(III). Pub. L. 108–173, § 503(d)(1), struck out “subject to paragraph (4)(C)(iii),” before “provide for additional payment”.

Subsec. (d)(5)(K)(vii). Pub. L. 108–173, § 503(a), added cl. (vii).

Subsec. (d)(5)(K)(viii). Pub. L. 108–173, § 503(b)(2)(B), added cl. (viii).

Subsec. (d)(5)(K)(ix). Pub. L. 108–173, § 503(c), added cl. (ix).

Subsec. (d)(7)(A). Pub. L. 108–173, § 406(b), inserted “or the determination of the applicable percentage increase under paragraph (12)(A)(ii)” after “to subsection (e)(1) of this section”.

Subsec. (d)(9)(A). Pub. L. 108–173, § 401(c)(1)(B), added cl. (i) and concluding provisions and struck out former cl. (ii) which read as follows: “for discharges beginning in a fiscal year beginning on or after October 1, 1997, 50 percent (and for discharges between October 1, 1987, and September 30, 1997, 25 percent) of the discharge-weighted average of—

“(I) the national adjusted DRG prospective payment rate (determined under paragraph (3)(D)) for hospitals located in a large urban area,

“(II) such rate for hospitals located in other urban areas, and

“(III) 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. 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 fifty States.”

Subsec. (d)(9)(A)(i). Pub. L. 108–173, §§ 401(c)(1)(A), 504(1)(A), substituted “the applicable Puerto Rico percentage (specified in subparagraph (E))” for “for discharges beginning on or after October 1, 1997, 50 percent (and for discharges between October 1, 1987, and September 30, 1997, 75 percent)” and struck out “and” at end.

Subsec. (d)(9)(A)(ii). Pub. L. 108–173, § 504(1)(B), which directed the substitution of “the applicable Federal percentage (specified in subparagraph (E))” for “for discharges beginning in a fiscal year beginning on or after October 1, 1997, 50 percent (and for discharges between October 1, 1987, and September 30, 1997, 25 percent)”, could not be executed because of the amendment by Pub. L. 108–173, § 401(c)(1)(B). See above.

Subsec. (d)(9)(C)(i). Pub. L. 108–173, § 401(c)(2)(A), designated existing provisions as subcl. (I), substituted “For discharges in a fiscal year after fiscal year 1988 and before fiscal year 2004, the Secretary” for “The Secretary”, and added subcl. (II).

Subsec. (d)(9)(C)(ii). Pub. L. 108–173, § 401(c)(2)(B), inserted “(or for fiscal year 2004 and thereafter, the average standardized amount)” after “each of the average standardized amounts”.

Subsec. (d)(9)(C)(iii)(I). Pub. L. 108–173, § 401(c)(2)(C), struck out “for hospitals located in an urban or rural area, respectively” after “reduced under clause (ii)”.

Subsec. (d)(9)(C)(iv). Pub. L. 108–173, § 403(b), designated existing provisions as subcl. (I), substituted “paragraph (3)(E)(i)” for “paragraph (3)(E)”, and added subcl. (II).

Subsec. (d)(9)(E). Pub. L. 108–173, § 504(2), added subpar. (E).

Subsec. (d)(12). Pub. L. 108–173, § 406(a), added par. (12).

Subsec. (d)(13). Pub. L. 108–173, § 505(a), added par. (13).

Subsec. (g)(3)(B). Pub. L. 108–173, § 736(a)(15), inserted closing parenthesis after “(as defined in subsection (d)(5)(D)(iii) of this section”.

Subsec. (h)(2)(D)(iv)(I). Pub. L. 108–173, § 711(1), in heading, inserted “and 2004 through 2013” after “and 2002” and, in text, inserted “or during the period beginning with fiscal year 2004 and ending with fiscal year 2013” after “during fiscal year 2001 or fiscal year 2002”.

Subsec. (h)(2)(D)(iv)(II). Pub. L. 108–173, § 711(2), substituted “For the” for “For a” and struck out “fiscal

year 2004, or fiscal year 2005,” after “during fiscal year 2003.”.

Subsec. (h)(3)(D)(ii)(III). Pub. L. 108–173, § 736(c)(6), struck out “and” at end.

Subsec. (h)(4)(F)(i). Pub. L. 108–173, § 422(a)(1), inserted “subject to paragraph (7),” after “October 1, 1997.”.

Subsec. (h)(4)(H)(i). Pub. L. 108–173, § 422(a)(2), inserted “and subject to paragraph (7)” after “subparagraphs (F) and (G)”.

Subsec. (h)(7). Pub. L. 108–173, § 422(a)(3), added par. (7).

2000—Subsec. (b)(3)(B)(i)(XVI). Pub. L. 106–554, § 1(a)(6) [title III, § 301(a)(1)], substituted “for hospitals in all areas,” for “minus 1.1 percentage points for hospitals (other than sole community hospitals) in all areas, and the market basket percentage increase for sole community hospitals.”.

Subsec. (b)(3)(B)(i)(XVII). Pub. L. 106–554, § 1(a)(6) [title III, § 301(a)(2)(B)], struck out “and” at end.

Pub. L. 106–554, § 1(a)(6) [title III, § 301(a)(2)(A)], which directed amendment of subcl. (XVII) by “striking ‘minus 1.1 percentage points’ and inserting ‘minus 0.55 percentage points; and’”, was executed as if an end quotation mark for the inserted material followed “points”, to reflect the probable intent of Congress.

Subsec. (b)(3)(B)(i)(XVIII). Pub. L. 106–554, § 1(a)(6) [title III, § 301(a)(5)], added subcl. (XVIII). Former subcl. (XVIII) redesignated (XIX).

Subsec. (b)(3)(B)(i)(XIX). Pub. L. 106–554, § 1(a)(6) [title III, § 301(a)(3), (4)], redesignated subcl. (XVIII) as (XIX) and substituted “fiscal year 2004” for “fiscal year 2003”.

Subsec. (b)(3)(H)(ii)(III). Pub. L. 106–554, § 1(a)(6) [title III, § 307(a)(1)(A)], inserted “subject to subparagraph (J),” after “2002.”.

Subsec. (b)(3)(I)(i). Pub. L. 106–554, § 1(a)(6) [title II, § 213(a)(1)], in introductory provisions, substituted “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” for “that for its cost reporting period beginning during 1999 is paid on the basis of the target amount applicable to the hospital under subparagraph (C) and that elects (in a form and manner determined by the Secretary) this subparagraph to apply to the hospital, there shall be substituted for such target amount”.

Subsec. (b)(3)(I)(i)(I). Pub. L. 106–554, § 1(a)(6) [title II, § 213(a)(2)], substituted “the amount otherwise applicable to the hospital under subsection (d)(5)(D)(i) of this section (referred to in this clause as the ‘subsection (d)(5)(D)(i) amount’)” for “target amount otherwise applicable to the hospital under subparagraph (C) (referred to in this clause as the ‘subparagraph (C) target amount’)”.

Subsec. (b)(3)(I)(i)(II), (III). Pub. L. 106–554, § 1(a)(6) [title II, § 213(a)(3)], substituted “subsection (d)(5)(D)(i) amount” for “subparagraph (C) target amount”.

Subsec. (b)(3)(J). Pub. L. 106–554, § 1(a)(6) [title III, § 307(a)(1)(B)], added subpar. (J).

Subsec. (d)(1)(B)(v)(III). Pub. L. 106–554, § 1(a)(4) [div. B, title I, § 152(a)], added subcl. (III).

Subsec. (d)(1)(E). Pub. L. 106–554, § 1(a)(4) [div. B, title I, § 152(b)], substituted “For purposes of subclauses (II) and (III) of subparagraph (B)(v)” for “For purposes of subparagraph (B)(v)(II)”.

Subsec. (d)(2)(C)(i). Pub. L. 106–554, § 1(a)(6) [title III, § 302(c)], inserted “or of section 302 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000” after “Balanced Budget Refinement Act of 1999”.

Subsec. (d)(2)(C)(iv). Pub. L. 106–554, § 1(a)(6) [title III, § 303(c)], substituted “1989,” for “1989 or” and inserted “, or the enactment of section 303 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000” after “Omnibus Budget Reconciliation Act of 1990”.

Subsec. (d)(3)(A)(vi). Pub. L. 106–554, § 1(a)(6) [title III, § 301(e)(1)], added cl. (vi).

Subsec. (d)(3)(E). Pub. L. 106–554, § 1(a)(6) [title III, § 304(c)(2)], in third sentence, substituted “Not less

often than once every 3 years the Secretary (through such survey or otherwise) shall measure” for “To the extent determined feasible by the Secretary, such survey shall measure”.

Subsec. (d)(4)(C)(i). Pub. L. 106-554, §1(a)(6) [title V, §533(b)(3)], substituted “technology (including a new medical service or technology under paragraph (5)(K)),” for “technology.”

Subsec. (d)(5)(B). Pub. L. 106-554, §1(a)(6) [title III, §302(d)], realigned margins.

Subsec. (d)(5)(B)(ii)(V). Pub. L. 106-554, §1(a)(6) [title III, §302(a)(1)], struck out “and” at end.

Subsec. (d)(5)(B)(ii)(VI). Pub. L. 106-554, §1(a)(6) [title III, §302(a)(4)], added subcl. (VI). Former subcl. (VI) redesignated (VII).

Subsec. (d)(5)(B)(ii)(VII). Pub. L. 106-554, §1(a)(6) [title III, §302(a)(2), (3)], redesignated subcl. (VI) as (VII) and substituted “2002” for “2001”.

Subsec. (d)(5)(F)(i). Pub. L. 106-554, §1(a)(6) [title III, §303(d)(1)], struck out “and before October 1, 1997,” before “the Secretary shall provide” in introductory provisions.

Subsec. (d)(5)(F)(iv)(II). Pub. L. 106-554, §1(a)(6) [title II, §211(b)(5)(A)], inserted “or, for discharges occurring on or after April 1, 2001, is equal to the percent determined in accordance with clause (xiii)” after “5 percent”.

Subsec. (d)(5)(F)(iv)(III). Pub. L. 106-554, §1(a)(6) [title II, §211(b)(3)(A)], inserted “or, for discharges occurring on or after April 1, 2001, is equal to the percent determined in accordance with clause (xii)” after “4 percent”.

Subsec. (d)(5)(F)(iv)(IV). Pub. L. 106-554, §1(a)(6) [title II, §211(b)(4)], inserted “or, for discharges occurring on or after April 1, 2001, the greater of the percentages determined under clause (x) or (xi)” after “clause (viii)”.

Subsec. (d)(5)(F)(iv)(V). Pub. L. 106-554, §1(a)(6) [title II, §211(b)(2)(A)], inserted “or, for discharges occurring on or after April 1, 2001, is equal to the percent determined in accordance with clause (xi)” after “clause (viii)”.

Subsec. (d)(5)(F)(iv)(VI). Pub. L. 106-554, §1(a)(6) [title II, §211(b)(1)(A)], inserted “or, for discharges occurring on or after April 1, 2001, is equal to the percent determined in accordance with clause (x)” after “10 percent”.

Subsec. (d)(5)(F)(v)(II). Pub. L. 106-554, §1(a)(6) [title II, §211(a)(1)], inserted “(or 15 percent, for discharges occurring on or after April 1, 2001)” after “30 percent”.

Subsec. (d)(5)(F)(v)(III). Pub. L. 106-554, §1(a)(6) [title II, §211(a)(2)], inserted “(or 15 percent, for discharges occurring on or after April 1, 2001)” after “40 percent”.

Subsec. (d)(5)(F)(v)(IV). Pub. L. 106-554, §1(a)(6) [title II, §211(a)(3)], inserted “(or 15 percent, for discharges occurring on or after April 1, 2001)” after “45 percent”.

Subsec. (d)(5)(F)(ix)(III). Pub. L. 106-554, §1(a)(6) [title III, §303(a)(1)], struck out “each of” after “during” and inserted “and 2 percent, respectively” after “3 percent”.

Subsec. (d)(5)(F)(ix)(IV). Pub. L. 106-554, §1(a)(6) [title III, §303(a)(2)], substituted “3 percent” for “4 percent”.

Subsec. (d)(5)(F)(x). Pub. L. 106-554, §1(a)(6) [title II, §211(b)(1)(B)], added cl. (x).

Subsec. (d)(5)(F)(xi). Pub. L. 106-554, §1(a)(6) [title II, §211(b)(2)(B)], added cl. (xi).

Subsec. (d)(5)(F)(xii). Pub. L. 106-554, §1(a)(6) [title II, §211(b)(3)(B)], added cl. (xii).

Subsec. (d)(5)(F)(xiii). Pub. L. 106-554, §1(a)(6) [title II, §211(b)(5)(B)], added cl. (xiii).

Subsec. (d)(5)(G)(iv)(IV). Pub. L. 106-554, §1(a)(6) [title II, §212(a)], inserted “, or two of the three most recently audited cost reporting periods for which the Secretary has a settled cost report,” after “1987”.

Subsec. (d)(5)(K), (L). Pub. L. 106-554, §1(a)(6) [title V, §533(b)(1)], added subpars. (K) and (L).

Subsec. (d)(10)(D)(v), (vi). Pub. L. 106-554, §1(a)(6) [title III, §304(a)], added cls. (v) and (vi).

Subsec. (h)(2)(D)(iii). Pub. L. 106-554, §1(a)(6) [title V, §511], in heading substituted “for” for “in fiscal year 2001 at 70 percent of” and in text inserted “, and for the

cost reporting period beginning during fiscal year 2002 shall not be less than 85 percent,” after “70 percent”.

Subsec. (j)(1)(A). Pub. L. 106-554, §1(a)(6) [title III, §305(b)(1)(A)], inserted “other than a facility making an election under subparagraph (F)” before “in a cost reporting period” in introductory provisions.

Subsec. (j)(1)(B). Pub. L. 106-554, §1(a)(6) [title III, §305(b)(1)(B)], inserted “or, in the case of a facility making an election under subparagraph (F), for any cost reporting period described in such subparagraph,” after “2002.”

Subsec. (j)(1)(F). Pub. L. 106-554, §1(a)(6) [title III, §305(b)(1)(C)], added subpar. (F).

Subsec. (j)(3)(B). Pub. L. 106-554, §1(a)(6) [title III, §305(b)(2)], inserted “but not taking into account any payment adjustment resulting from an election permitted under paragraph (1)(F)” after “paragraphs (4) and (6)”.

Pub. L. 106-554, §1(a)(6) [title III, §305(a)], substituted “98 percent for fiscal year 2001 and 100 percent for fiscal year 2002” for “98 percent”.

Subsec. (j)(2)(C). Pub. L. 106-554, §1(a)(6) [title V, §512(a)], substituted “the ratio of—” and cls. (i) and (ii) for “the Secretary’s estimate of the ratio of the amount of payments made under section 1395x(v) of this title 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 total of such amounts for all hospitals for such cost reporting periods.”

1999—Subsec. (b)(1). Pub. L. 106-113, §1000(a)(6) [title III, §321(k)(15)(A)], inserted a comma after “paragraph (2)” in concluding provisions.

Subsec. (b)(2)(A). Pub. L. 106-113, §1000(a)(6) [title I, §122(1)], substituted “Except as provided in subparagraph (E), in addition to” for “In addition to”.

Subsec. (b)(2)(E). Pub. L. 106-113, §1000(a)(6) [title I, §122(2)], added subpar. (E).

Subsec. (b)(3)(B)(i)(XVI) to (XVIII). Pub. L. 106-113, §1000(a)(6) [title IV, §406], added subcls. (XVI) and (XVII), redesignated former subcl. (XVII) as (XVIII), and struck out former subcl. (XVI) which read as follows: “for each of fiscal years 2001 and 2002, the market basket percentage increase minus 1.1 percentage point for hospitals in all areas, and”.

Subsec. (b)(3)(B)(ii)(VI). Pub. L. 106-113, §1000(a)(6) [title III, §321(k)(15)(B)(i)], substituted comma for semicolon at end.

Subsec. (b)(3)(B)(ii)(VII). Pub. L. 106-113, §1000(a)(6) [title III, §321(k)(15)(B)(ii)], substituted “year,” for “year;”.

Subsec. (b)(3)(C). Pub. L. 106-113, §1000(a)(6) [title IV, §405(1)], inserted “subject to subparagraph (I),” before “the term ‘target amount’ means” in introductory provisions.

Subsec. (b)(3)(D). Pub. L. 106-113, §1000(a)(6) [title IV, §404(b)(1)(A)], substituted “and before October 1, 2006,” for “and before October 1, 2001,” in introductory provisions.

Pub. L. 106-113, §1000(a)(6) [title III, §321(b)(2)], substituted “and for discharges beginning on or after October 1, 1997, and before October 1, 2001,” for “and for cost reporting periods beginning on or after October 1, 1997, and before October 1, 2001,” in introductory provisions.

Subsec. (b)(3)(D)(iv). Pub. L. 106-113, §1000(a)(6) [title IV, §404(b)(1)(B)], substituted “fiscal year 2005” for “fiscal year 2000”.

Subsec. (b)(3)(H)(i) to (iii). Pub. L. 106-113, §1000(a)(6) [title I, §121(a)], added cl. (i), redesignated former cl. (i) as subcl. (I) of cl. (ii) and inserted “, as adjusted under clause (iii)” after “fiscal year 1996”, redesignated former cl. (ii) as subcl. (II) of cl. (ii) and substituted “subclause (I)” for “clause (i)” and “such subclause” for “such clause”, added cl. (iii), and redesignated former cl. (iii) as subcl. (III) of cl. (ii).

Subsec. (b)(3)(I). Pub. L. 106-113, §1000(a)(6) [title IV, §405(2)], added subpar. (I).

Subsec. (b)(4)(A)(i). Pub. L. 106-113, §1000(a)(6) [title III, §321(f)], struck out “or unit” after “(and in the case of a hospital”.

Subsec. (b)(7)(A)(i)(II). Pub. L. 106–113, § 1000(a)(6) [title III, § 321(h)], inserted “(as estimated by the Secretary)” after “median”.

Subsec. (d)(2)(C)(i). Pub. L. 106–113, § 1000(a)(6) [title I, § 111(c)], inserted “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” after “Balanced Budget Act of 1997”.

Subsec. (d)(5)(B)(ii)(V), (VI). Pub. L. 106–113, § 1000(a)(6) [title I, § 111(a)], added subcl. (V), redesignated former subcl. (V) as (VI), and substituted “2001” for “2000” in subcl. (VI).

Subsec. (d)(5)(B)(v). Pub. L. 106–113, § 1000(a)(6) [title IV, § 407(b)(2)], inserted “(or, 130 percent of such number in the case of a hospital located in a rural area)” after “may not exceed the number”.

Pub. L. 106–113, § 1000(a)(6) [title IV, § 407(a)(2)], inserted at end “Rules similar to the rules of subsection (h)(4)(F)(ii) of this section shall apply for purposes of this clause.”

Subsec. (d)(5)(F)(i). Pub. L. 106–113, § 1000(a)(6) [title III, § 321(k)(16)], inserted a comma after “1986” in introductory provisions.

Subsec. (d)(5)(F)(ix)(III). Pub. L. 106–113, § 1000(a)(6) [title I, § 112(a)(1)], substituted “during each of fiscal years 2000 and 2001” for “during fiscal year 2000”.

Subsec. (d)(5)(F)(ix)(IV). Pub. L. 106–113, § 1000(a)(6) [title I, § 112(a)(2)–(4)], redesignated subcl. (V) as (IV), substituted “reduced by 4 percent” for “reduced by 5 percent”, and struck out former subcl. (IV) which read as follows: “during fiscal year 2001, such additional payment amount shall be reduced by 4 percent;”.

Subsec. (d)(5)(F)(ix)(V), (VI). Pub. L. 106–113, § 1000(a)(6) [title I, § 112(a)(3)], redesignated subcl. (VI) as (V). Former subcl. (V) redesignated (IV).

Subsec. (d)(5)(G)(i). Pub. L. 106–113, § 1000(a)(6) [title IV, § 404(a)(1)], substituted “October 1, 2006,” for “October 1, 2001,”.

Pub. L. 106–113, § 1000(a)(6) [title III, § 321(b)(1)(A)], substituted “or discharges occurring on or after October 1, 1997, and before October 1, 2001,” for “or beginning on or after October 1, 1997, and before October 1, 2001,”.

Subsec. (d)(5)(G)(ii)(II). Pub. L. 106–113, § 1000(a)(6) [title IV, § 404(a)(2)], substituted “October 1, 2006,” for “October 1, 2001,”.

Pub. L. 106–113, § 1000(a)(6) [title III, § 321(b)(1)(B)], substituted “or discharges occurring on or after October 1, 1997, and before October 1, 2001,” for “or beginning on or after October 1, 1997, and before October 1, 2001,”.

Subsec. (d)(8)(B). Pub. L. 106–113, § 1000(a)(6) [title IV, § 402(a)], designated existing provisions as cl. (i), substituted “described in clause (ii)” for “published in the Federal Register on January 3, 1980”, and added cl. (ii).

Subsec. (d)(8)(E). Pub. L. 106–113, § 1000(a)(6) [title IV, § 401(a)], added subpar. (E).

Subsec. (d)(9)(A)(ii). Pub. L. 106–113, § 1000(a)(6) [title III, § 321(k)(17)], inserted a comma after “1987” in introductory provisions.

Subsec. (g)(1)(A). Pub. L. 106–113, § 1000(a)(6) [title III, § 321(e)], substituted “October 1, 2002,” for “September 30, 2002,” in last sentence.

Subsec. (h)(2)(D)(i). Pub. L. 106–113, § 1000(a)(6) [title III, § 311(a)(1), (b)(1)], inserted heading and substituted “a subsequent clause” for “clause (ii)” and “the approved FTE resident amount determined” for “the amount determined”.

Subsec. (h)(2)(D)(ii). Pub. L. 106–113, § 1000(a)(6) [title III, § 311(b)(2)], inserted heading and realigned margins.

Subsec. (h)(2)(D)(iii), (iv). Pub. L. 106–113, § 1000(a)(6) [title III, § 311(a)(2)], added cls. (iii) and (iv).

Subsec. (h)(2)(E), (F). Pub. L. 106–113, § 1000(a)(6) [title III, § 311(a)(3), (4)], added subpar. (E) and redesignated former subpar. (E) as (F).

Subsec. (h)(3)(D)(i). Pub. L. 106–113, § 1000(a)(6) [title V, § 541(b)(1)], inserted “, subject to clause (iii),” after “shall equal” in introductory provisions.

Subsec. (h)(3)(D)(iii), (iv). Pub. L. 106–113, § 1000(a)(6) [title V, § 541(b)(2), (3)], added cl. (iii) and redesignated former cl. (iii) as (iv).

Subsec. (h)(4)(F). Pub. L. 106–113, § 1000(a)(6) [title IV, § 407(a)(1)], designated existing provisions as cl. (i), inserted heading, realigned margins, and added cl. (ii).

Subsec. (h)(4)(F)(i). Pub. L. 106–113, § 1000(a)(6) [title IV, § 407(b)(1)], inserted “(or, 130 percent of such number in the case of a hospital located in a rural area)” after “may not exceed the number”.

Subsec. (h)(4)(H)(iv). Pub. L. 106–113, § 1000(a)(6) [title IV, § 407(c)(1)], added cl. (iv).

Subsec. (h)(5)(F). Pub. L. 106–113, § 1000(a)(6) [title III, § 312(a)(1)], substituted “Subject to subparagraph (G)(v), the initial residency period” for “The initial residency period” in concluding provisions.

Subsec. (h)(5)(G)(i). Pub. L. 106–113, § 1000(a)(6) [title III, § 312(a)(2)(A)], substituted “(iv), and (v)” for “and (iv)”.

Subsec. (h)(5)(G)(v). Pub. L. 106–113, § 1000(a)(6) [title III, § 312(a)(2)(B)], added cl. (v).

Subsec. (j)(1)(D). Pub. L. 106–113, § 1000(a)(6) [title I, § 125(a)(1)], struck out “, day of inpatient hospital services, or other unit of payment defined by the Secretary” before period at end.

Subsec. (j)(1)(E). Pub. L. 106–113, § 1000(a)(6) [title I, § 125(a)(3)], added subpar. (E).

Subsec. (j)(2)(A)(i). Pub. L. 106–113, § 1000(a)(6) [title I, § 125(a)(2)], amended cl. (i) generally. Prior to amendment, cl. (i) read as follows: “classes of patients of rehabilitation facilities (each in this subsection referred to as a ‘case mix group’), based on such factors as the Secretary deems appropriate, which may include impairment, age, related prior hospitalization, comorbidities, and functional capability of the patient; and”.

Subsec. (l). Pub. L. 106–113, § 1000(a)(6) [title V, § 541(a)], added subsec. (l).

1997—Subsec. (b)(1). Pub. L. 105–33, § 4421(b)(1), inserted “and other than a rehabilitation facility described in subsection (j)(1) of this section” after “subsection (d)(1)(B) of this section” in introductory provisions.

Pub. L. 105–33, § 4415(b)(1), inserted “plus the amount, if any, provided under paragraph (2)” before “except that in no case” in concluding provisions.

Subsec. (b)(1)(A). Pub. L. 105–33, § 4415(a), added cls. (i) and (ii) and concluding provisions and struck out former cls. (i) and (ii) and former concluding provisions which read as follows:

“(i) 50 percent of the amount by which the target amount exceeds the amount of the operating costs, or
“(ii) 5 percent of the target amount,
whichever is less; or”.

Subsec. (b)(1)(B). Pub. L. 105–33, § 4415(c)(3), added subpar. (B). Former subpar. (B) redesignated (C).

Subsec. (b)(1)(C). Pub. L. 105–33, § 4415(c)(1), (2), redesignated subpar. (B) as (C) and substituted “greater than 110 percent of the target amount” for “greater than the target amount” and “exceed 110 percent of the target amount” for “exceed the target amount”.

Subsec. (b)(2). Pub. L. 105–33, § 4415(b)(2), added par. (2).

Subsec. (b)(3)(A). Pub. L. 105–33, §§ 4413(a)(1), 4416(2), in introductory provisions, substituted “subparagraph (C) and succeeding subparagraph,” for “subparagraphs (C), (D), and (E),” and inserted “and in paragraph (7)(A)(ii),” before “for purposes of this subsection”.

Subsec. (b)(3)(B)(i). Pub. L. 105–33, § 4421(b)(2), inserted “and subsection (j) of this section” after “For purposes of subsection (d) of this section” in introductory provisions.

Subsec. (b)(3)(B)(i)(XIII) to (XVII). Pub. L. 105–33, § 4401(a), added subcls. (XIII) to (XVII) and struck out former subcl. (XIII) which read as follows: “for fiscal year 1998 and each subsequent fiscal year, the market basket percentage increase for hospitals in all areas.”

Subsec. (b)(3)(B)(ii)(VI) to (VIII). Pub. L. 105–33, § 4411(a)(1), added subcls. (VI) and (VII) and redesignated former subcl. (VI) as (VIII).

Subsec. (b)(3)(B)(vi). Pub. L. 105–33, § 4411(a)(2), added cl. (vi).

Subsec. (b)(3)(D). Pub. L. 105–33, § 4204(a)(2)(A), substituted “September 30, 1994, and for cost reporting pe-

riods beginning on or after October 1, 1997, and before October 1, 2001,” for “September 30, 1994,” in introductory provisions.

Subsec. (b)(3)(D)(iv). Pub. L. 105–33, § 4204(a)(2)(B)–(D), added cl. (iv).

Subsec. (b)(3)(F), (G). Pub. L. 105–33, § 4413(a)(2), (b), added subpars. (F) and (G).

Subsec. (b)(3)(H). Pub. L. 105–33, § 4414, added subpar. (H).

Subsec. (b)(4)(A)(i). Pub. L. 105–33, § 4419(a)(1), in first sentence, substituted “The Secretary shall provide for an exception and adjustment to (and in the case of a hospital or unit described in subsection (d)(1)(B)(iii) of this section, may provide an exemption from)” for “The Secretary shall provide for an exemption from, or an exception and adjustment to.”

Subsec. (b)(4)(A)(ii). Pub. L. 105–33, § 4411(b), inserted at end “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.”

Subsec. (b)(7). Pub. L. 105–33, § 4416(1), added par. (7).

Subsec. (d)(1)(B). Pub. L. 105–33, § 4417(a)(1), inserted at end “A hospital that was classified by the Secretary on or before September 30, 1995, as a hospital described in clause (iv) shall continue to be so classified notwithstanding that it is located in the same building as, or on the same campus as, another hospital.”

Subsec. (d)(1)(B)(iv). Pub. L. 105–33, § 4417(b)(1), designated existing provisions as subcl. (I) and added subcl. (II).

Subsec. (d)(1)(B)(v). Pub. L. 105–33, § 4418(a)(1), designated existing provisions as subcl. (I), substituted “, or” for semicolon at end, and added subcl. (II).

Subsec. (d)(1)(E). Pub. L. 105–33, § 4418(a)(2), added subpar. (E).

Subsec. (d)(2)(C)(i). Pub. L. 105–33, § 4621(a)(2), inserted at end “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.”

Subsec. (d)(5)(A)(ii). Pub. L. 105–33, § 4405(c), substituted “exceed the sum of the applicable DRG prospective payment rate plus any amounts payable under subparagraphs (B) and (F)” for “exceed the applicable DRG prospective payment rate”.

Subsec. (d)(5)(B)(i)(I). Pub. L. 105–33, § 4405(a), inserted “, for cases qualifying for additional payment under subparagraph (A)(i),” before “the amount paid to the hospital”.

Subsec. (d)(5)(B)(ii). Pub. L. 105–33, § 4621(a)(1), amended cl. (ii) generally. Prior to amendment, cl. (ii) read as follows: “For purposes of clause (i)(II), the indirect teaching adjustment factor for discharges occurring on or after October 1, 1988, is equal to $1.89 \times ((1 + r) \text{ to the } n\text{th power}) - 1$, where ‘r’ is the ratio of the hospital’s full-time equivalent interns and residents to beds and ‘n’ equals 405.”

Subsec. (d)(5)(B)(iv). Pub. L. 105–33, § 4621(b)(2), amended cl. (iv) generally. Prior to amendment, cl. (iv) read as follows: “In determining such adjustment, the Secretary shall continue to count interns and residents assigned to outpatient services of the hospital or providing services at any entity receiving a grant under section 254c of this title that is under the ownership or control of the hospital (if the hospital incurs all, or substantially all, of the costs of the services furnished by such interns and residents) as part of the calculation of the full-time-equivalent number of interns and residents.”

Subsec. (d)(5)(B)(v) to (viii). Pub. L. 105–33, § 4621(b)(1), added cls. (v) to (viii).

Subsec. (d)(5)(D)(iii)(III). Pub. L. 105–33, § 4201(c)(4)(A), inserted “as in effect on September 30, 1997” before period at end.

Subsec. (d)(5)(D)(v). Pub. L. 105–33, § 4201(c)(4)(B), inserted “as in effect on September 30, 1997” after “section 1395i–4(i)(1) of this title” and substituted “(as defined in section 1395i–4(d) of this title)” for “(as defined in section 1395i–4(g) of this title)”.

Subsec. (d)(5)(F)(i). Pub. L. 105–33, § 4403(a)(1), inserted “and before October 1, 1997” after “May 1, 1986” in introductory provisions.

Subsec. (d)(5)(F)(ii). Pub. L. 105–33, § 4403(a)(2), substituted “Subject to clause (ix), the amount” for “The amount”.

Subsec. (d)(5)(F)(ii)(I). Pub. L. 105–33, § 4405(b), inserted “, for cases qualifying for additional payment under subparagraph (A)(i),” before “the amount paid to the hospital”.

Subsec. (d)(5)(F)(ix). Pub. L. 105–33, § 4403(a)(3), added cl. (ix).

Subsec. (d)(5)(G)(i), (ii)(II). Pub. L. 105–33, § 4204(a)(1), substituted “October 1, 1994, or beginning on or after October 1, 1997, and before October 1, 2001,” for “October 1, 1994,”.

Subsec. (d)(5)(I)(ii). Pub. L. 105–33, § 4407(1), inserted “not taking into account the effect of subparagraph (J),” after “in a fiscal year;”.

Subsec. (d)(5)(J). Pub. L. 105–33, § 4407(2), added subpar. (J).

Subsec. (d)(6). Pub. L. 105–33, § 4644(a)(1), substituted “August 1” for “September 1”.

Subsec. (d)(9)(A). Pub. L. 105–33, § 4406(1), struck out “in a fiscal year beginning on or after October 1, 1987,” after “inpatient hospital discharges” in introductory provisions.

Subsec. (d)(9)(A)(i). Pub. L. 105–33, § 4406(2), substituted “for discharges beginning on or after October 1, 1997, 50 percent (and for discharges between October 1, 1987, and September 30, 1997, 75 percent)” for “75 percent”.

Subsec. (d)(9)(A)(ii). Pub. L. 105–33, § 4406(3), substituted “for discharges beginning in a fiscal year beginning on or after October 1, 1997, 50 percent (and for discharges between October 1, 1987 and September 30, 1997, 25 percent)” for “25 percent”.

Subsec. (d)(10)(C)(ii). Pub. L. 105–33, § 4644(c)(1), substituted “the first day of the 13-month period ending on September 30 of the preceding fiscal year.” for “the first day of the preceding fiscal year.”

Subsec. (d)(10)(D)(iii), (iv). Pub. L. 105–33, § 4202(a), added cl. (iii) and redesignated former cl. (iii) as (iv).

Subsec. (d)(11). Pub. L. 105–33, § 4622, added par. (11).

Subsec. (e)(2). Pub. L. 105–33, § 4022(b)(1)(A)(i), struck out par. (2) which related to appointment, composition, and responsibilities of the Prospective Payment Assessment Commission.

Subsec. (e)(3). Pub. L. 105–33, § 4022(b)(1)(A)(ii), redesignated subpar. (B) as par. (3) and struck out subpar. (A) which read as follows: “The Commission, not later than the March 1 before the beginning of each fiscal year (beginning with fiscal year 1986), shall report its recommendations to Congress on an appropriate change factor which should be used for inpatient hospital services for discharges in that fiscal year, together with its general recommendations under paragraph (2)(B) regarding the effectiveness and quality of health care delivery systems in the United States.”

Subsec. (e)(5)(A). Pub. L. 105–33, § 4644(b)(1)(A), substituted “April 1” for “May 1”.

Subsec. (e)(5)(B). Pub. L. 105–33, § 4644(b)(1)(B), substituted “August 1” for “September 1”.

Subsec. (e)(6). Pub. L. 105–33, § 4022(b)(1)(A)(i), struck out par. (6) which related to appointments, membership, responsibilities, compensation, access to records and information, audits, and appropriations concerning the Prospective Payment Assessment Commission.

Subsec. (g)(1)(A). Pub. L. 105–33, § 4402, inserted at end “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 ef-

fect on September 30, 1997), and, for discharges occurring on or after October 1, 1997, and before September 30, 2002, reduce the rates described in clauses (i) and (ii) by 2.1 percent.”

Subsec. (g)(3)(B). Pub. L. 105–33, § 4201(c)(1), substituted “critical access” for “rural primary care”.

Subsec. (g)(4). Pub. L. 105–33, § 4412, added par. (4).

Subsec. (h)(3)(B). Pub. L. 105–33, § 4625(b), inserted concluding provisions.

Subsec. (h)(3)(D). Pub. L. 105–33, § 4624, added subpar. (D).

Subsec. (h)(4)(F) to (H). Pub. L. 105–33, § 4623, added subpars. (F) to (H).

Subsec. (h)(5)(G). Pub. L. 105–33, § 4627(a), substituted “Subject to clauses (ii), (iii), and (iv)” for “Subject to clauses (ii) and (iii)” in cl. (i) and added cl. (iv).

Subsec. (h)(6). Pub. L. 105–33, § 4626(a), added par. (6).

Subsec. (j). Pub. L. 105–33, § 4421(a), added subsec. (j).

Subsec. (k). Pub. L. 105–33, § 4625(a), added subsec. (k). 1994—Subsec. (a)(4). Pub. L. 103–432, § 110(a), inserted “(or, in the case of a hospital that is not a subsection (d) hospital, during the 1 day)” after “3 days”.

Subsec. (b)(3)(B)(iv)(II). Pub. L. 103–432, § 105(b), substituted “(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))” for “(taking into account any portion of the 12-month cost reporting period beginning during fiscal year 1993 that occurred during fiscal year 1994)”.

Subsec. (b)(3)(D). Pub. L. 103–432, § 105(a)(2), substituted “September 30, 1994” for “March 31, 1993” in introductory provisions.

Subsec. (d)(3)(A)(iii). Pub. L. 103–432, § 101(c), inserted at end “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.”

Subsec. (d)(5)(B)(ii). Pub. L. 103–432, § 110(c), substituted “October 1, 1988” for “May 1, 1986”.

Subsec. (d)(5)(D)(iii)(III). Pub. L. 103–432, § 102(b)(1)(B)(i), substituted “that is located in a rural area and designated” for “that is designated”.

Subsec. (d)(5)(D)(v). Pub. L. 103–432, § 102(b)(1)(B)(ii), substituted “in the case of a hospital located in a rural area and designated” for “in the case of a hospital designated”.

Subsec. (d)(5)(G)(ii)(I). Pub. L. 103–432, § 105(a)(1), substituted “the 36-month period beginning with the first day of the cost reporting period that begins” for “the first 3 12-month cost reporting periods that begin”.

Subsec. (d)(5)(I). Pub. L. 103–432, § 109, designated existing provisions as cl. (i) and added cl. (ii).

Subsec. (d)(8)(C)(iv). Pub. L. 103–432, § 101(b)(1)(A), substituted “paragraph (10)” for “paragraph (1)”.

Subsec. (d)(8)(C)(v). Pub. L. 103–432, § 101(b)(1)(B), added cl. (v).

Subsec. (d)(10)(C)(i)(II). Pub. L. 103–432, § 101(b)(2)(A), substituted “the factor used to adjust the DRG prospective payment rate for area differences in hospital wage levels that applies” for “the area wage index applicable”.

Subsec. (d)(10)(D)(i)(I). Pub. L. 103–432, § 101(a)(1), inserted “(to the extent the Secretary determines appropriate)” after “taking into account”.

Subsec. (d)(10)(D)(ii), (iii). Pub. L. 103–432, § 101(b)(2)(B), added cl. (ii) and redesignated former cl. (ii) as (iii).

Subsec. (e)(6)(B). Pub. L. 103–432, § 108, substituted “health facility management, reimbursement of health facilities or other providers of services which reflect the scope of the Commission’s responsibilities” for “hospital reimbursement, hospital financial management”.

Subsec. (h)(5)(E). Pub. L. 103–432, § 153(a), inserted “or any successor examination” after “Medical Sciences”. 1993—Subsec. (b)(3)(B)(i)(IX). Pub. L. 103–66, § 13501(a)(1)(A), substituted “percentage increase minus 2.5 percentage points for hospitals” for “percentage in-

crease for hospitals” and “percentage increase minus 1.0 percentage point” for “percentage increase plus 1.5 percentage points”.

Subsec. (b)(3)(B)(i)(X). Pub. L. 103–66, § 13501(a)(1)(B), substituted “percentage increase minus 2.5 percentage points for hospitals” for “percentage increase for hospitals” and struck out “and” at end.

Subsec. (b)(3)(B)(i)(XI). Pub. L. 103–66, § 13501(a)(1)(C), struck out “and each subsequent fiscal year” after “1996”, inserted “minus 2.0 percentage points” after “percentage increase”, and substituted a comma for period at end.

Subsec. (b)(3)(B)(i)(XII), (XIII). Pub. L. 103–66, § 13501(a)(1)(D), added subcls. (XII) and (XIII).

Subsec. (b)(3)(B)(ii). Pub. L. 103–66, § 13501(a)(2)(B)(i), struck out “, (C), (D),” after “subparagraphs (A)”.

Subsec. (b)(3)(B)(ii)(III) to (VI). Pub. L. 103–66, § 13502(a)(1), struck out “and” at end of subcl. (III), in subcl. (IV), substituted “a subsequent fiscal year ending on or before September 30, 1993,” for “subsequent fiscal years” and a comma for the period at end, and added subcls. (V) and (VI).

Subsec. (b)(3)(B)(iv). Pub. L. 103–66, § 13501(a)(2)(A), added cl. (iv).

Subsec. (b)(3)(B)(v). Pub. L. 103–66, § 13502(a)(2), added cl. (v).

Subsec. (b)(3)(C)(i)(II). Pub. L. 103–66, § 13501(a)(2)(B)(ii), struck out “or” at end.

Subsec. (b)(3)(C)(ii). Pub. L. 103–66, § 13501(a)(2)(B)(iii), substituted “period beginning before fiscal year 1994, the target” for “period, the target”, “subparagraph (B)(iv)” for “subparagraph (B)(ii)”, and a comma for period at end.

Subsec. (b)(3)(C)(iii), (iv). Pub. L. 103–66, § 13501(a)(2)(B)(iv), added cls. (iii) and (iv).

Subsec. (b)(3)(D)(ii). Pub. L. 103–66, § 13501(a)(2)(B)(v), substituted “period beginning before fiscal year 1994, the target” for “period, the target”, “subparagraph (B)(iv)” for “subparagraph (B)(ii)”, and “, and” for period at end.

Subsec. (b)(3)(D)(iii). Pub. L. 103–66, § 13501(a)(2)(B)(vi), added cl. (iii).

Subsec. (b)(4)(A). Pub. L. 103–66, § 13502(b), designated existing provisions as cl. (i) and added cl. (ii).

Subsec. (d)(1)(A)(iii). Pub. L. 103–66, § 13501(f), amended cl. (iii) generally. Prior to amendment, cl. (iii) read as follows: “beginning on or after April 1, 1988, and ending on September 30, 1993., the sum of (I) 85 percent of the national adjusted DRG prospective payment rate determined under paragraph (3) for such discharges, and (II) 15 percent of the regional adjusted DRG prospective payment rate determined under such paragraph.”

Subsec. (d)(5)(A)(i). Pub. L. 103–66, § 13501(c)(1), substituted “For discharges occurring during fiscal years ending on or before September 30, 1997, the Secretary” for “The Secretary”.

Subsec. (d)(5)(A)(ii). Pub. L. 103–66, § 13501(c)(2), substituted “, or, for discharges in fiscal years beginning on or after October 1, 1994, exceed the applicable DRG prospective payment rate plus a fixed dollar amount determined by the Secretary.” for period at end.

Subsec. (d)(5)(A)(iii). Pub. L. 103–66, § 13501(c)(3), substituted “shall (except as payments under clause (i) are required to be reduced to take into account the requirements of clause (v)) approximate” for “shall approximate”.

Subsec. (d)(5)(A)(v), (vi). Pub. L. 103–66, § 13501(c)(4), added cls. (v) and (vi).

Subsec. (d)(5)(B)(iv). Pub. L. 103–66, § 13506, inserted “or providing services at any entity receiving a grant under section 254c of this title that is under the ownership or control of the hospital (if the hospital incurs all, or substantially all, of the costs of the services furnished by such interns and residents)” after “the hospital”.

Subsec. (d)(5)(G)(i). Pub. L. 103–66, § 13501(e)(1)(A), which directed amendment of subsec. (d)(5)(G) in clause (i) in the matter preceding subclause (I), by striking “ending on or before March 31, 1993,” and all that fol-

lows and inserting “before October 1, 1994, 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 (i) and the amount determined under paragraph (1)(A)(iii).”, was executed by substituting the new language for “ending on or before March 31, 1993, with respect to a subsection (d) hospital which is a medicare-dependent, small rural 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)(D) of this section, or

“(II) the amount determined under paragraph (1)(A)(iii), whichever results in the greater payment to the hospital.” to reflect the probable intent of Congress.

Subsec. (d)(5)(G)(ii) to (iv). Pub. L. 103-66, § 13501(e)(1)(B), (C), added cl. (i) and redesignated former cls. (ii) and (iii) as (iii) and (iv), respectively.

Subsec. (d)(8)(C)(iv). Pub. L. 103-66, § 13501(b)(1), added cl. (iv).

Subsec. (g)(1)(A). Pub. L. 103-66, § 13501(a)(3), inserted at end “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 August 10, 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.”

Subsec. (h)(2)(D). Pub. L. 103-66, § 13563(a)(1), designated existing provisions as cl. (i), substituted “Except as provided in clause (ii), for each” for “For each”, and added cl. (ii).

Subsec. (h)(5)(F). Pub. L. 103-66, § 13563(b)(1)(A), struck out “plus one year” after “board eligibility” in introductory provisions.

Subsec. (h)(5)(F)(ii). Pub. L. 103-66, § 13563(b)(1)(B), inserted “or a preventive medicine residency or fellowship program” after “fellowship program”.

Subsec. (h)(5)(H), (I). Pub. L. 103-66, § 13563(a)(2), added subpar. (H) and redesignated former subpar. (H) as (I).

Subsec. (h)(5)(J). Pub. L. 103-66, § 13563(c)(1), added subpar. (J).

1990—Subsec. (a)(4). Pub. L. 101-508, § 4003(a), struck out period at end of first sentence and inserted “, and includes the costs of all services for which payment may be made under this subchapter that are provided by the hospital (or by an entity wholly owned or operated by the hospital) to the patient during the 3 days 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).”

Subsec. (b)(1)(B)(ii). Pub. L. 101-508, § 4005(a)(1), added cl. (ii) and struck out former cl. (ii) which read as follows: “in the case of cost reporting periods beginning on or after October 1, 1982, and before October 1, 1984, 25 percent of the amount by which the amount of the operating costs exceeds the target amount;”

Subsec. (b)(3)(B)(i)(V). Pub. L. 101-508, § 4002(a)(1)(A), struck out “and” after semicolon at end.

Subsec. (b)(3)(B)(i)(VI). Pub. L. 101-508, § 4002(c)(1)(A), substituted “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” for “in all areas”.

Pub. L. 101-508, § 4002(a)(1)(C), added subcl. (VI). Former subcl. (VI) redesignated (IX).

Pub. L. 101-508, § 4002(a)(1)(B)(i), substituted “1994” for “1991”.

Subsec. (b)(3)(B)(i)(VII). Pub. L. 101-508, § 4002(c)(1)(B), substituted “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” for “in all areas”.

Pub. L. 101-508, § 4002(a)(1)(C), added subcl. (VII).

Subsec. (b)(3)(B)(i)(VIII). Pub. L. 101-508, § 4002(c)(1)(C), substituted “in a large urban or other

urban area, and the market basket percentage increase minus 0.55 for hospitals located in a rural area,” for “in all areas, and”.

Pub. L. 101-508, § 4002(a)(1)(C), added subcl. (VIII).

Subsec. (b)(3)(B)(i)(IX). Pub. L. 101-508, § 4002(c)(1)(E), added subcl. (IX). Former subcl. (IX) redesignated (XI).

Pub. L. 101-508, § 4002(c)(1)(D)(i), substituted “1996” for “1994”.

Pub. L. 101-508, § 4002(a)(1)(B)(ii), redesignated subcl. (VI) as (IX).

Subsec. (b)(3)(B)(i)(X). Pub. L. 101-508, § 4002(c)(1)(E), added subcl. (X).

Subsec. (b)(3)(B)(i)(XI). Pub. L. 101-508, § 4002(c)(1)(D)(ii), redesignated subcl. (IX) as (XI).

Subsec. (b)(3)(B)(ii). Pub. L. 101-508, § 4002(c)(2)(A)(i), substituted “(A), (C), (D), and (E),” for “(A) and (E),” in introductory provisions.

Subsec. (b)(3)(C)(ii), (D)(ii). Pub. L. 101-508, § 4002(c)(2)(A)(ii), substituted “subparagraph (B)(ii)” for “subparagraph (B)(i)”.

Subsec. (b)(4)(A). Pub. L. 101-508, § 4005(c)(1)(B), inserted at end “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.”

Subsec. (b)(4)(B), (C). Pub. L. 101-508, § 4005(c)(2), added subpar. (B) and redesignated former subpar. (B) as (C).

Subsec. (c)(4). Pub. L. 101-508, § 4008(f)(1), substituted “payments under the State system as compared to aggregate payments which would have been made under the national system since” for “rate of increase from” in last sentence.

Subsec. (d)(1)(A)(iii). Pub. L. 101-508, § 4002(e)(1), substituted “beginning on or after April 1, 1988, and ending on September 30, 1993,” for “beginning on or after October 1, 1987, is equal to the national adjusted DRG prospective payment rate determined under paragraph (3) for such discharges, or, 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 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 the period beginning on April 1, 1988, and ending on October 20, 1990”.

Pub. L. 101-508, § 4002(c)(2)(B)(i), substituted “large urban or other area” for “rural, large urban, or other urban area” in text of cl. (iii)(II) as amended by Pub. L. 103-66, § 13501(f). See 1993 Amendment note above.

Pub. L. 101-403 substituted “October 20, 1990” for “September 30, 1990”.

Subsec. (d)(2)(C)(iv). Pub. L. 101-508, § 4002(b)(4)(B), substituted “1989 or the enactment of section 4002(b) of the Omnibus Budget Reconciliation Act of 1990.” for “1989.”

Pub. L. 101-508, § 4002(b)(4)(A), struck out period at end and inserted “, 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.”

Pub. L. 101-508, § 4002(b)(3)(A), struck out “and before October 1, 1995,” after “October 1, 1986.”

Subsec. (d)(3)(A)(ii). Pub. L. 101-508, § 4002(c)(2)(B)(ii)(I), substituted “and ending on or before September 30, 1994, the Secretary” for “the Secretary”.

Subsec. (d)(3)(A)(iii) to (v). Pub. L. 101-508, § 4002(c)(2)(B)(ii)(II), (III), added cls. (iii) and (iv) and redesignated former cl. (iii) as (v).

Subsec. (d)(3)(B). Pub. L. 101-508, § 4002(c)(2)(B)(iii), substituted “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)." for "for hospitals located in an urban area and for hospitals located in a rural area by a proportion equal to the proportion (estimated by the Secretary) of the amount of payments under this subsection based on DRG prospective payment amounts which are additional payments described in paragraph (5)(A) (relating to outlier payments) for hospitals located in such respective area."

Subsec. (d)(3)(C)(ii). Pub. L. 101-508, § 4002(b)(3)(B)(B), substituted "occurring on or after October 1, 1986," through the end of cl. (ii) for "occurring—" and subcls. (I) and (II) which read as follows:

"(I) on or after October 1, 1986, and before October 1, 1995, 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) were applied for discharges occurring during such period instead of the factor described in clause (ii)(I) of that paragraph, and

"(II) on or after October 1, 1995, of an amount equal to the estimated reduction in the payment amounts under paragraph (5)(B) for those discharges that has 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."

Subsec. (d)(3)(D)(i). Pub. L. 101-508, § 4002(c)(2)(B)(iv)(I), which directed amendment of cl. (i) by substituting "a large urban area" for "an urban area (or," and all that follows through "area)," was executed by making the substitution for "an urban area (or, for discharges occurring on or after April 1, 1988, in a large urban area or other urban area)" to reflect the probable intent of Congress.

Subsec. (d)(3)(D)(i)(I). Pub. L. 101-508, § 4002(c)(2)(B)(iv)(II), substituted "a large urban area" for "an urban area".

Subsec. (d)(3)(D)(ii). Pub. L. 101-508, § 4002(c)(2)(B)(v), substituted "other areas" for "a rural area" in introductory provisions and in subcl. (I).

Subsec. (d)(4)(D). Pub. L. 101-508, § 4002(g)(2)(A), struck out subpar. (D) which read as follows: "The Commission (established under subsection (e)(2) of this section) shall consult with and make recommendations to the Secretary with respect to the need for adjustments under subparagraph (C), based upon its evaluation of scientific evidence with respect to new practices, including the use of new technologies and treatment modalities. The Commission shall report to the Congress with respect to its evaluation of any adjustments made by the Secretary under subparagraph (C)."

Subsec. (d)(5)(B)(ii). Pub. L. 101-508, § 4002(b)(3)(B)(A), amended cl. (ii) generally. Prior to amendment, cl. (ii) read as follows: "For purposes of clause (i)(II), the indirect teaching adjustment factor for discharges occurring—

"(I) on or after May 1, 1986, and before October 1, 1995, is equal to $1.89 \times ((1+r)^{405} - 1)$, or

"(II) on or after October 1, 1995, is equal to $1.43 \times ((1+r)^{5795} - 1)$, where "r" is the ratio of the hospital's full-time equivalent interns and residents to beds."

Subsec. (d)(5)(D)(iii). Pub. L. 101-508, § 4008(m)(2)(A), substituted "For purposes of this subchapter, the term" for "The term" at beginning.

Subsec. (d)(5)(F)(i). Pub. L. 101-508, § 4002(b)(3)(A), struck out "and before October 1, 1995," after "May 1, 1986,".

Subsec. (d)(5)(F)(iii). Pub. L. 101-508, § 4002(b)(2), substituted "35 percent" for "30 percent".

Subsec. (d)(5)(F)(vii)(I). Pub. L. 101-508, § 4002(b)(1)(A), substituted "greater than 20.2—" and subdvs. (a) to (d) for "greater than 20.2, $(P - 20.2) \cdot (.65) + 5.62$, or".

Subsec. (d)(5)(F)(vii)(II). Pub. L. 101-508, § 4002(b)(1)(B), substituted "hospital—" and subdvs. (a) to (c) for "hospital, $(P - 15) \cdot (.6) + 2.5$,".

Subsec. (d)(8)(C)(i). Pub. L. 101-508, § 4002(h)(1)(A)(i), substituted "area, or by treating hospitals located in one urban area as being located in another urban area—" for "area—".

Subsec. (d)(8)(C)(i)(II). Pub. L. 101-508, § 4002(h)(1)(A)(ii), amended subcl. (II) generally. Prior to amendment, subcl. (II) read as follows: "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 each affected rural county were a separate urban area)."

Subsec. (d)(8)(C)(ii) to (iv). Pub. L. 101-508, § 4002(h)(1)(A)(iii), (iv), redesignated cls. (iii) and (iv) as (ii) and (iii), respectively, and struck out former cl. (ii) which read as follows: "If the application of subparagraph (B) or a decision of the Medicare Geographic Classification Review Board or the Secretary under paragraph (10), by reclassifying a county from a rural to an urban area or by reclassifying an urban county from one urban area to another urban area—

"(I) reduces the wage index for the urban area within which the county or counties is reclassified by 1 percentage point or less (as applied under this subsection), the Secretary, in calculating such wage index under this subsection, shall exclude those counties so reclassified, or

"(II) reduces the wage index for the urban area within which the county or counties is reclassified 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 reclassified) and to hospitals located in the counties so reclassified (as if each affected county were a separate area)."

Subsec. (d)(8)(D). Pub. L. 101-508, § 4002(c)(2)(B)(vi), struck out "for hospitals located in an urban area" after "determined under paragraph (3)" and struck out at end "The Secretary shall make such adjustment in payments under this section to hospitals located in rural areas as are necessary to assure that the aggregate of payments to rural hospitals not affected by subparagraphs (B) and (C) or a decision of the Medicare Geographic Classification Review Board or the Secretary under paragraph (10) are not changed as a result of the application of subparagraphs (B) and (C) or a decision of the Medicare Geographic Classification Review Board or the Secretary under paragraph (10)."

Subsec. (d)(10)(A). Pub. L. 101-508, § 4002(h)(2)(B)(i), substituted "Geographic" for "Geographical".

Subsec. (d)(10)(B)(i). Pub. L. 101-508, § 4002(h)(2)(B)(ii), substituted "representative" for "representatives" and struck out "1 member shall be a member of the Prospective Payment Assessment Commission, and at least" after "At least".

Subsec. (d)(10)(B)(ii). Pub. L. 101-508, § 4002(h)(2)(B)(iii), substituted "initial" for "all".

Subsec. (d)(10)(C)(iii)(II). Pub. L. 101-508, § 4002(h)(2)(B)(iv), substituted "Appeal of decisions of the Board shall be subject to the provisions of section 557b of title 5" for "A decision of the Board shall be final unless the unsuccessful applicant appeals such decision to the Secretary by not later than 15 days after the Board renders its decision. The Secretary in considering the appeal of an applicant shall receive no new evidence but shall consider the record as a whole as such record appeared before the Board" and substituted "after the date on which" for "after".

Subsec. (e)(2). Pub. L. 101-508, § 4002(g)(1), designated existing provisions as subpar. (A) and added subpars. (B) and (C).

Subsec. (e)(2)(A). Pub. L. 101-508, § 4002(g)(2)(B), substituted "The Commission" for "In addition to carrying out its functions under subsection (d)(4)(D) of this section, the Commission".

Subsec. (e)(3)(A). Pub. L. 101-508, § 4002(g)(2)(C), substituted "Congress" for "the Secretary" and inserted

before period at end “, together with its general recommendations under paragraph (2)(B) regarding the effectiveness and quality of health care delivery systems in the United States”.

Subsec. (e)(4). Pub. L. 101-508, § 4002(g)(2)(D), designated existing provisions as subpar. (A) and added subpar. (B).

Subsec. (e)(5). Pub. L. 101-508, § 4002(g)(2)(E), substituted “recommendations” for “recommendation” in subpars. (A) and (B) and inserted at end “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.”

Subsec. (e)(6)(G). Pub. L. 101-508, § 4002(g)(2)(F), redesignated cls. (ii) and (iii) as (i) and (ii), respectively, and struck out former cl. (i) which read as follows: “The Office shall report annually to the Congress on the functioning and progress of the Commission and on the status of the assessment of medical procedures and services by the Commission.”

Subsec. (g)(1)(A). Pub. L. 101-508, § 4001(b), inserted at end “Aggregate payments made under subsection (d) of this section 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 1395x(v) of this title).”

Subsec. (g)(3)(A)(v). Pub. L. 101-508, § 4001(a), substituted “September 30, 1991” for “September 30, 1990”.

Subsec. (g)(3)(B). Pub. L. 101-508, § 4001(c), substituted “subsection (d)(5)(D)(iii) of this section or a rural primary care hospital (as defined in section 1395x(mm)(1) of this title)” for “subsection (d)(5)(D)(iii) of this section”.

1989—Subsec. (a)(4). Pub. L. 101-239, § 6011(a), struck out “or,” after “equity capital,” and substituted “October 1, 1987,” or costs with respect to administering blood clotting factors to individuals with hemophilia” for “October 1, 1987”.

Subsec. (b)(3)(A). Pub. L. 101-239, § 6004(b)(1)(A), substituted “(C), (D), and (E)” for “(C) and (D)” in introductory provisions.

Pub. L. 101-239, § 6003(f)(2)(i), substituted “subparagraphs (C) and (D)” for “subparagraph (C)” in introductory provisions.

Pub. L. 101-239, § 6003(e)(1)(B)(i), substituted “(A) Except as provided in subparagraph (C), for purposes of this subsection” for “(A) For purposes of this subsection” in introductory provisions.

Subsec. (b)(3)(B)(i)(V), (VI). Pub. L. 101-239, § 6003(a)(1), added subcl. (V), redesignated former subcl. (V) as (VI), and substituted “fiscal year 1991” for “fiscal year 1990” in subcl. (VI).

Subsec. (b)(3)(B)(ii). Pub. L. 101-239, § 6004(b)(1)(B), substituted “For purposes of subparagraphs (A) and (E)” for “For purposes of subparagraph (A)” in introductory provisions.

Subsec. (b)(3)(C). Pub. L. 101-239, § 6003(e)(1)(B)(ii), added subpar. (C).

Subsec. (b)(3)(D). Pub. L. 101-239, § 6003(f)(2)(ii), added subpar. (D).

Subsec. (b)(3)(E). Pub. L. 101-239, § 6004(b)(1)(C), added subpar. (E).

Subsec. (b)(4)(A). Pub. L. 101-239, § 6015(a), substituted “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” for “deems appropriate.”

Subsec. (c)(4). Pub. L. 101-239, § 6022, substituted “the aggregate rate of increase from October 1, 1984, to the most recent date for which annual data are available” for “the aggregate payment or payments per inpatient

admission or discharge during the three cost reporting periods beginning on or after October 1, 1983, after which such test, at the option of the Secretary, shall no longer apply, and such State systems shall be treated in the same manner as under other waivers” in second sentence.

Subsec. (d)(1)(B)(v). Pub. L. 101-239, § 6004(a)(1), added cl. (v).

Subsec. (d)(3)(E). Pub. L. 101-239, § 6003(h)(6), substituted “October 1, 1990, and October 1, 1993 (and at least every 12 months thereafter)” for “October 1, 1990 (and at least every 36 months thereafter)” and inserted at end “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.”

Subsec. (d)(4)(C). Pub. L. 101-239, § 6003(b), designated existing provisions as cl. (i) and added cls. (ii) to (iv).

Subsec. (d)(5)(C). Pub. L. 101-239, § 6003(e)(1)(A)(i), (ii), (iv), (2)(B), redesignated former cl. (i)(I) as cl. (i), redesignated former cl. (i)(II) as cl. (ii) and substituted “clause (i)” for “subclause (I)” in three places, and redesignated former cls. (ii), (iii), and (iv) as subpars. (D), (I), and (H), respectively.

Subsec. (d)(5)(D). Pub. L. 101-239, § 6003(e)(1)(A)(iv), amended former subpar. (C)(ii) generally, redesignating it as subpar. (D) and substituting cls. (i) to (iv) relating to payments to sole community hospitals for cost reporting periods beginning on or after Apr. 1, 1990, for former single paragraph relating to payments to such hospitals for cost reporting periods beginning on or after Oct. 1, 1984.

Subsec. (d)(5)(D)(iii)(III). Pub. L. 101-239, § 6003(g)(2)(A), added subcl. (III).

Subsec. (d)(5)(D)(v). Pub. L. 101-239, § 6003(g)(2)(B), added cl. (v).

Subsec. (d)(5)(E). Pub. L. 101-239, § 6003(e)(1)(A)(iii), redesignated subpar. (D) as (E).

Subsec. (d)(5)(F)(iii). Pub. L. 101-239, § 6003(c)(3), substituted “30 percent” for “25 percent”.

Subsec. (d)(5)(F)(iv)(I). Pub. L. 101-239, § 6003(c)(1)(A), substituted “the applicable formula described in clause (vii)” for “the following formula: $(P - 15) \cdot .5 + 2.5$, where ‘P’ is the hospital’s disproportionate patient percentage (as defined in clause (vi))”.

Subsec. (d)(5)(F)(iv)(III). Pub. L. 101-239, § 6003(c)(2)(A)(ii), inserted “in subclause (IV) or (V) or” after “described”.

Subsec. (d)(5)(F)(iv)(IV) to (VI). Pub. L. 101-239, § 6003(c)(2)(A)(i), (iii), (iv), added subcls. (IV) to (VI).

Subsec. (d)(5)(F)(v)(II) to (IV). Pub. L. 101-239, § 6003(c)(2)(B), added subcl. (II), redesignated former subcls. (II) and (III) as (III) and (IV), respectively, and substituted “area and is not described in subclause (II)” for “area” in subcl. (IV).

Subsec. (d)(5)(F)(vii). Pub. L. 101-239, § 6003(c)(1)(B), added cl. (vii).

Subsec. (d)(5)(F)(viii). Pub. L. 101-239, § 6003(c)(2)(C), added cl. (viii).

Subsec. (d)(5)(G). Pub. L. 101-239, § 6003(f)(1), added subpar. (G).

Subsec. (d)(5)(H). Pub. L. 101-239, § 6003(e)(1)(A)(i), redesignated subpar. (C)(iv) as subpar. (H).

Subsec. (d)(5)(I). Pub. L. 101-239, § 6004(a)(2), struck out “(including exceptions and adjustments that may be appropriate with respect to hospitals involved extensively in treatment for and research on cancer)” after “deems appropriate”.

Pub. L. 101-239, § 6003(e)(1)(A)(ii), redesignated subpar. (C)(iii) as subpar. (I).

Subsec. (d)(8)(C). Pub. L. 101-239, § 6003(h)(3), amended subpar. (C) generally. Prior to amendment, subpar. (C) read as follows:

“(i) If the application of subparagraph (B) or a decision of the Medicare Geographic Classification Review Board or the Secretary under paragraph (10), [sic] by treating hospitals located in a rural county or counties

as being located in an urban area, reduces the wage index for that urban area (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 each affected rural county were a separate urban area). If the application of subparagraph (B) or a decision of the Medicare Geographic Classification Review Board or the Secretary under paragraph (10), [sic] by treating the 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.

“(ii) Clause (i) shall only apply to discharges occurring on or after October 1, 1989, and before October 1, 1991.”

Subsec. (d)(8)(C)(i). Pub. L. 101-239, § 6003(h)(2), substituted “subparagraph (B) or a decision of the Medicare Geographic Classification Review Board or the Secretary under paragraph (10),” for “subparagraph (B)” in two places.

Subsec. (d)(8)(C)(iv). Pub. L. 101-239, § 6003(h)(4), added cl. (iv).

Subsec. (d)(8)(D). Pub. L. 101-239, § 6003(h)(2)(B), substituted “(B) and (C) or a decision of the Medicare Geographic Classification Review Board or the Secretary under paragraph (10)” for “(B) and (C)” in three places.

Subsec. (d)(9)(B)(ii)(IV). Pub. L. 101-239, § 6003(e)(2)(C), substituted “subparagraph (D)(iii)” for “subparagraph (D)(v)”.

Subsec. (d)(9)(D)(iii). Pub. L. 101-239, § 6003(e)(2)(D)(ii), redesignated cl. (v) as (iii). Former cl. (iii) redesignated (iv).

Subsec. (d)(9)(D)(iv). Pub. L. 101-239, § 6003(e)(2)(D)(i), (ii), redesignated former cl. (iii) as (iv), substituted “Subparagraph (H)” for “Subparagraph (C)(iii)”, and struck out former cl. (iv) which read as follows: “Subparagraph (E) (relating to payments for costs of certified registered nurse anesthetists).”

Subsec. (d)(9)(D)(v). Pub. L. 101-239, § 6003(e)(2)(D)(iii), redesignated cl. (v) as (iii).

Subsec. (d)(10). Pub. L. 101-239, § 6003(h)(1), added par. (10).

Subsec. (g)(3)(A)(iv). Pub. L. 101-234, § 301(b)(3), (c)(3), amended cl. (iv) identically, substituting “(as the case may be)” for “(as the case may be)”.

Subsec. (g)(3)(A)(v). Pub. L. 101-239, § 6002, added cl. (v).

Subsec. (g)(3)(B). Pub. L. 101-239, § 6003(e)(2)(E), substituted “subsection (d)(5)(D)(iii)” for “subsection (d)(5)(C)(ii)”.

Subsec. (i). Pub. L. 101-239, § 6003(g)(4), added subsec. (i).

1988—Subsec. (b)(3)(B)(i)(III). Pub. L. 100-485, § 608(d)(18)(A), substituted “for hospitals” for “for for hospitals” before “located in other urban areas”.

Pub. L. 100-360, § 411(b)(1)(A), substituted “for hospitals located in other urban areas” for “other hospitals”.

Subsec. (b)(3)(B)(i)(IV). Pub. L. 100-485, § 608(d)(18)(A), substituted “for hospitals” for “for for hospitals” before “located in other urban areas”.

Pub. L. 100-360, § 411(b)(1)(A), (B), substituted “percentage points” for “percent” in three places and “for hospitals located in other urban areas” for “other hospitals”.

Subsec. (b)(3)(B)(i)(V). Pub. L. 100-360, § 411(b)(1)(C), inserted “increase” after “market basket percentage”.

Subsec. (d)(1)(A)(iii). Pub. L. 100-360, § 411(b)(1)(G), substituted “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 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 “if greater”.

Subsec. (d)(2)(C)(i). Pub. L. 100-647, § 1018(r)(1), struck out Pub. L. 99-514, § 1895(b)(1), (2). Previously, Pub. L. 99-509, § 9307(c)(1)(A), struck out Pub. L. 99-514, § 1895(b)(1)(A). See 1986 Amendment note below.

Subsec. (d)(2)(C)(iv). Pub. L. 100-647, § 8401, substituted “1995” for “1990”.

Pub. L. 100-647, § 1018(r)(1), struck out Pub. L. 99-514, § 1895(b)(1), (2). Previously, Pub. L. 99-509, § 9307(c)(1)(B)(i), as amended by Pub. L. 100-203, § 4009(j)(6)(A), struck out Pub. L. 99-514, § 1895(b)(2)(A). See 1986 Amendment note below.

Subsec. (d)(2)(D). Pub. L. 100-360, § 411(b)(1)(D), substituted “the publications described in subsection (e)(5) of this section” for “the publication described in subsection (e)(5)(B) of this section” in second sentence.

Pub. L. 100-360, § 411(b)(1)(H)(i), struck out at end “For purposes of payment under this subsection, a hospital is considered to be located in an urban area or large urban area, respectively, if the hospital is paid under this subsection at the rate for hospitals located in such an area.”

Subsec. (d)(3)(A). Pub. L. 100-647, § 1018(r)(1), struck out Pub. L. 99-514, § 1895(b)(1), (2). Previously, Pub. L. 99-509, § 9307(c)(1)(A), struck out Pub. L. 99-514, § 1895(b)(1)(B). See 1986 Amendment note below.

Subsec. (d)(3)(A)(i). Pub. L. 100-360, § 411(b)(1)(E)(i), as added by Pub. L. 100-485, § 608(d)(18)(B), substituted “occurring” for “occur” in first sentence.

Pub. L. 100-360, § 411(b)(1)(E)(ii), formerly § 411(b)(1)(E), as redesignated by Pub. L. 100-485, § 608(d)(18)(B), made technical correction to Pub. L. 100-203, § 4002(c)(1)(B)(iii), see 1987 Amendment note below.

Subsec. (d)(3)(A)(ii). Pub. L. 100-360, § 411(b)(1)(F), substituted “in other urban areas” for “in urban areas”.

Subsec. (d)(3)(C)(ii). Pub. L. 100-647, § 1018(r)(1), struck out Pub. L. 99-514, § 1895(b)(1), (2). Previously, Pub. L. 99-509, § 9307(c)(1)(A), struck out Pub. L. 99-514, § 1895(b)(1)(C). See 1986 Amendment note below.

Subsec. (d)(3)(C)(ii)(I), (II). Pub. L. 100-647, § 8401, substituted “1995” for “1990”.

Subsec. (d)(3)(C)(iii). Pub. L. 100-647, § 1018(r)(1), struck out Pub. L. 99-514, § 1895(b)(1), (2). Previously, Pub. L. 99-509, § 9307(c)(1)(B)(i), as amended by Pub. L. 100-203, § 4009(j)(6)(A), struck out Pub. L. 99-514, § 1895(b)(2)(B). See 1986 Amendment note below.

Subsec. (d)(5)(B)(ii)(I), (II). Pub. L. 100-647, § 8401, substituted “1995” for “1990”.

Subsec. (d)(5)(F)(i). Pub. L. 100-647, § 8401, substituted “1995” for “1990”.

Subsec. (d)(5)(F)(vi)(I). Pub. L. 100-647, § 1018(r)(1), struck out Pub. L. 99-514, § 1895(b)(1), (2). See 1986 Amendment note below.

Subsec. (d)(8). Pub. L. 100-360, § 411(b)(4)(C)(i), made technical correction to directory language of Pub. L. 100-203, § 4005(a)(1)(D), see 1987 Amendment note below.

Subsec. (d)(8)(B). Pub. L. 100-360, § 411(b)(4)(A)(i), substituted “For purposes of this subsection, the Secretary” for “The Secretary”.

Pub. L. 100-360, § 411(b)(4)(A)(ii), substituted “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) published in the Federal Register on January 3, 1980, 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).” for “—

“(i) the rural county would otherwise be considered part of an urban area but for the fact that the rural county does not meet the standard relating to the rate of commutation between the rural county and the central county or counties of any adjacent urban area; and

“(ii) either (I) the number of residents of the rural county who commute for employment to the central

county or counties of any adjacent urban area is equal to at least 15 percent of the number of residents of the rural county who are employed, or (II) the sum of the number of residents of the rural county who commute for employment to the central county or counties of any adjacent urban area and the number of residents of any adjacent urban area who commute for employment to the rural county is at least equal to 20 percent of the number of residents of the rural county who are employed.”

Subsec. (d)(8)(C). Pub. L. 100-647, § 8403(a)(2), added subpar. (C). Former subpar. (C) redesignated (D).

Pub. L. 100-360, § 411(b)(4)(B), substituted “standardized amounts” for “standardized amount”.

Subsec. (d)(8)(D). Pub. L. 100-647, § 8403(a)(1), redesignated former subpar. (C) as (D) and substituted “subparagraphs (B) and (C)” for “subparagraph (B)” wherever appearing.

Subsec. (d)(9)(C)(iv). Pub. L. 100-360, § 411(b)(3), added Pub. L. 100-203, § 4004(a)(2), see 1987 Amendment note below.

Subsec. (e)(6)(B). Pub. L. 100-360, § 411(b)(8)(B), amended Pub. L. 100-203, § 4009(d)(1), see 1987 Amendment note below.

Subsec. (f)(1)(A). Pub. L. 100-360, § 411(b)(6)(B), added Pub. L. 100-203, § 4007(b)(1)(A), (B), see 1987 Amendment note below.

Subsec. (f)(1)(B). Pub. L. 100-360, § 411(b)(6)(B), added Pub. L. 100-203, § 4007(b)(1)(C), see 1987 Amendment note below.

Subsec. (g)(3)(A)(ii) to (iv). Pub. L. 100-360, § 411(b)(5)(B), made technical amendment to Pub. L. 100-203, § 4006(a), see 1987 Amendment note below.

Subsec. (g)(3)(A)(iv). Pub. L. 100-360, § 411(b)(5)(A), inserted “for payments attributable” after “15 percent”. 1987—Subsec. (a)(4). Pub. L. 100-203, § 4009(j)(1), inserted a comma after “educational activities”.

Pub. L. 100-203, § 4006(b)(2)(A), substituted “other capital-related costs (as defined by the Secretary for periods before October 1, 1987)” for “with respect to costs incurred in cost reporting periods beginning prior to October 1 of 1987 (or of such later year as the Secretary may, in his discretion, select), other capital-related costs, as defined by the Secretary”.

Subsec. (b)(3)(B)(i). Pub. L. 100-203, § 4002(e)(1), struck out “subparagraph (A) for 12-month cost reporting periods beginning during a fiscal year and for purposes of” after “For purposes of”.

Subsec. (b)(3)(B)(i)(II). Pub. L. 100-203, § 4002(a), struck out “and for fiscal year 1988, the market basket percentage increase (as defined in clause (ii)) minus 2.0 percentage points, and” after “1.15 percent,”.

Subsec. (b)(3)(B)(i)(III) to (V). Pub. L. 100-203, § 4002(a), added subcls. (III) to (V) and struck out former subcl. (III) which read “for fiscal year 1989 and subsequent fiscal years, the percentage determined by the Secretary pursuant to subsection (e)(4) of this section.”

Subsec. (b)(3)(B)(ii), (iii). Pub. L. 100-203, § 4002(e)(2), (3), added cl. (ii), redesignated former cl. (ii) as (iii), and substituted “For purposes of this subparagraph” for “For purposes of clause (i)”.

Subsec. (d)(1)(A)(iii). Pub. L. 100-203, § 4002(d), inserted before period at end “, or, if greater for discharges occurring during the period beginning on April 1, 1988, and ending on September 30, 1990, the sum of (I) 85 percent of the national adjusted DRG prospective payment rate determined under paragraph (3) for such discharges, and (II) 15 percent of the regional adjusted DRG prospective payment rate determined under such paragraph”.

Subsec. (d)(2)(C)(iv). Pub. L. 100-203, § 4009(j)(6)(A), made technical amendment to Pub. L. 99-509, § 9307(c)(1)(B). See 1986 Amendment note below.

Pub. L. 100-203, § 4003(c), substituted “1990” for “1989”.

Subsec. (d)(2)(D). Pub. L. 100-203, § 4002(f)(1)(A), inserted sentence at end providing that hospital is considered located in urban area or large urban area, respectively, if it is paid under this subsection at rate for hospitals located in such area.

Pub. L. 100-203, § 4002(b), in second sentence inserted definition of “large urban area”.

Subsec. (d)(3). Pub. L. 100-203, § 4002(c)(1)(A), substituted “large urban, other urban, or rural areas” for “urban or rural areas” in second sentence.

Subsec. (d)(3)(A)(i). Pub. L. 100-203, § 4002(c)(1)(B), (C), as amended by Pub. L. 100-360, § 411(b)(1)(E)(ii), designated existing provisions as cl. (i), substituted “For discharges occurring [sic] in a fiscal year beginning before October 1, 1987, the Secretary” for “The Secretary” and “the fiscal year involved” for “each of fiscal years 1985, 1986, 1987, and 1988”, struck out “, and adjusted for subsequent fiscal years in accordance with the final determination of the Secretary under subsection (e)(4) of this section, and adjusted to reflect the most recent case-mix data available”, and added cls. (ii) and (iii).

Subsec. (d)(3)(C)(ii). Pub. L. 100-203, § 4003(c), substituted “1990” for “1989” in subcls. (I) and (II).

Pub. L. 100-203, § 4003(a)(2), inserted “and by section 4003(a)(1) of the Omnibus Budget Reconciliation Act of 1987” after “Amendments of 1985” in subcls. (I) and (II).

Subsec. (d)(3)(C)(iii). Pub. L. 100-203, § 4009(j)(6)(A), made technical amendment to Pub. L. 99-509, § 9307(c)(1)(B). See 1986 Amendment note below.

Subsec. (d)(3)(D). Pub. L. 100-203, § 4002(c)(1)(D)(i), substituted “hospitals in different areas” for “urban and rural hospitals” in heading.

Subsec. (d)(3)(D)(i). Pub. L. 100-203, § 4002(c)(1)(D)(ii), (iii), inserted “(or, for discharges occurring on or after April 1, 1988, in a large urban area or other urban area)” after first reference to “urban area”, and in subcl. (I) inserted “such” before “an urban area”.

Subsec. (d)(3)(E). Pub. L. 100-203, § 4004(a)(1), formerly § 4004(a), as redesignated by Pub. L. 100-360, § 411(b)(3), inserted at end “Not later than October 1, 1990 (and at least every 36 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. To the extent determined feasible by the Secretary, such survey 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.”

Subsec. (d)(5)(B)(ii). Pub. L. 100-203, § 4003(c), substituted “1990” for “1989” in subcls. (I) and (II).

Pub. L. 100-203, § 4003(a)(1), substituted “1.89” for “2” in subcl. (I) and “1.43” for “1.5” in subcl. (II).

Subsec. (d)(5)(C)(i)(I). Pub. L. 100-203, § 4005(d)(1)(A), substituted “275” for “500”.

Subsec. (d)(5)(C)(i)(II). Pub. L. 100-203, § 4009(j)(2), inserted “index” after “case mix” in two places.

Subsec. (d)(5)(C)(ii). Pub. L. 100-203, § 4005(c)(1), substituted “1990” for “1988” in second sentence and inserted after second sentence “A subsection (d) hospital that meets the criteria for classification as a sole community hospital and otherwise qualifies for the adjustment authorized by the preceding sentence may qualify for such an adjustment without regard to the formula by which payments are determined for the hospital under paragraph (1)(A).”

Subsec. (d)(5)(F)(i). Pub. L. 100-203, § 4003(c), substituted “1990” for “1989”.

Subsec. (d)(5)(F)(i)(II). Pub. L. 100-203, § 4009(j)(3)(A), substituted “such net inpatient care revenues” for second reference to “such revenues”.

Subsec. (d)(5)(F)(iii). Pub. L. 100-203, § 4003(b)(1), substituted “25 percent” for “15 percent”.

Subsec. (d)(5)(F)(iv)(I). Pub. L. 100-203, § 4009(j)(3)(B), substituted “clause (v)” for “subclause (III)”.

Pub. L. 100-203, § 4003(b)(2), struck out “the lesser of 15 percent, or” after “is equal to”.

Subsec. (d)(5)(F)(vi)(I). Pub. L. 100-203, § 4009(j)(6)(A), made technical amendment to Pub. L. 99-509, § 9307(c)(1)(B)(ii). See 1986 Amendment note below.

Subsec. (d)(8). Pub. L. 100-203, § 4005(a)(1), as amended by Pub. L. 100-360, § 411(b)(4)(C)(i), designated existing provisions as subpar. (A), redesignated former subpar. (A) and cls. (i) and (ii) as cl. (i) and subcls. (I) and (II),

respectively, redesignated former subpar. (B) and cls. (i) and (ii) as cl. (ii) and subcl. (I) and (II), respectively, and added subpars. (B) and (C).

Subsec. (d)(9)(A)(ii). Pub. L. 100-203, § 4002(c)(2), substituted “a large urban area,” for “an urban area, and” in subcl. (I), added subcl. (II), and redesignated former subcl. (II) as (III).

Subsec. (d)(9)(B). Pub. L. 100-203, § 4009(j)(4), realigned margin of introductory provisions.

Subsec. (d)(9)(C)(iv). Pub. L. 100-203, § 4004(a)(2), as added by Pub. L. 100-360, § 411(b)(3), inserted at end “The second and third sentences of paragraph (3)(E) 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.”

Subsec. (e)(3)(B). Pub. L. 100-203, § 4002(f)(1)(B), struck out “or determine” after “recommend”.

Subsec. (e)(4). Pub. L. 100-203, § 4002(f)(1)(C), substituted “for each fiscal year (beginning with fiscal year 1988)” for “for fiscal year 1988”, struck out “and shall determine for each subsequent fiscal year the percentage change which will apply for purposes of this section as the applicable percentage increase (otherwise described in subsection (b)(3)(B) of this section) for discharges in that fiscal year, and” after “in that fiscal year”, and amended last sentence generally. Prior to amendment, last sentence read as follows: “The percentage change shall be the same for all subsection (d) hospitals and subsection (d) Puerto Rico hospitals, but may be different from that for other hospitals (and units not included as such hospitals) and may vary among such other hospitals and units.”

Subsec. (e)(5). Pub. L. 100-203, § 4009(j)(6)(B), amended Pub. L. 99-509, § 9302(a)(2)(C). See 1986 Amendment note below.

Pub. L. 100-203, § 4002(f)(1)(D), struck out “or determination” after “recommendation” in subpars. (A) and (B).

Subsec. (e)(6)(B). Pub. L. 100-203, § 4009(d)(1), as amended by Pub. L. 100-360, § 411(b)(8)(B), substituted “include individuals with national recognition for their expertise in health economics, hospital reimbursement, hospital financial management, and other related fields, who provide a mix of different professionals, broad geographic representation, and a balance between urban and rural representatives” for “provide expertise and experience in the provision and financing of health care”, and struck out last sentence which required Director to seek nominations from wide range of groups, including specified types of national organizations.

Subsec. (e)(6)(D). Pub. L. 100-203, § 4083(b)(1), inserted at end “For purposes of pay (other than pay of members of the Commission) and employment benefits, rights, and privileges, all personnel of the Commission shall be treated as if they were employees of the United States Senate.”

Subsec. (f)(1)(A). Pub. L. 100-203, § 4007(b)(1)(A), (B), as added by Pub. L. 100-360, § 411(b)(6)(B), inserted subpar. (A) designation and struck out “, for a period ending not earlier than September 30, 1988,” after “shall maintain”.

Subsec. (f)(1)(B). Pub. L. 100-203, § 4007(b)(1)(C), as added by Pub. L. 100-360, § 411(b)(6)(B), added subpar. (B).

Subsec. (f)(3). Pub. L. 100-93 amended par. (3) generally. Prior to amendment, par. (3) read as follows: “The provisions of paragraphs (2), (3), and (4) of section 1395y(d) of this title shall apply to determinations under paragraph (2) of this subsection in the same manner as they apply to determinations made under section 1395y(d)(1) of this title.”

Subsec. (g)(1). Pub. L. 100-203, § 4006(b)(1), amended par. (1) generally. Prior to amendment, par. (1) read as follows: “If the Congress does not enact legislation, after April 20, 1983, and before October 1, 1987, respecting the payment under this subchapter for capital-related

costs for inpatient hospital services, no payment may be made under this subchapter for capital-related costs of capital expenditures (as defined in section 1320a-1(g) of this title and except as provided in section 1320a-1(j) of this title) for inpatient hospital services in a State, which expenditures are obligated after September 30, 1987, unless the State has an agreement with the Secretary under section 1320a-1(b) of this title and under the agreement the State has recommended approval of the capital expenditures.”

Subsec. (g)(3)(A)(i) to (iv). Pub. L. 100-203, § 4006(a), as amended by Pub. L. 100-360, § 411(b)(5)(B), substituted “on or after October 1, 1987, and before January 1, 1988,” for “, and”, at end of cl. (ii), added cls. (iii) and (iv), and struck out former cl. (iii) which read as follows: “10 percent for payments attributable to portions of cost reporting periods or discharges (as the case may be) occurring during fiscal year 1989.”

Subsec. (g)(3)(C). Pub. L. 100-203, § 4006(b)(2)(B), struck out subpar. (C) which read as follows: “If the Secretary provides, under subsection (a)(4) of this section, for the inclusion of other capital-related costs in operating costs of inpatient hospital services, the Secretary shall provide—

“(i) notwithstanding any other provision of this subchapter, for the continuation of payment under the reasonable cost methodology described in section 1395x(v)(1) of this title with respect to capital-related costs of any hospital that is such a sole community hospital for cost reporting periods beginning before October 1, 1990, and

“(ii) in the design of such payment system that the aggregate payment amounts under this subchapter for such other capital-related costs for payments attributable to portions of cost reporting periods occurring during fiscal year 1988 and fiscal year 1989 shall approximate the aggregate payment amount under this subchapter that would have been made (taking into account the provisions of subparagraphs (A) and (B) during that fiscal year but for the inclusion of such costs by the Secretary.”

Subsec. (h)(4)(C). Pub. L. 100-203, § 4009(j)(5), substituted “subparagraph (D)” for “subparagraph (E)”.

1986—Subsec. (a)(4). Pub. L. 99-509, § 9320(g)(1), struck out “, costs of anesthesia services provided by a certified registered nurse anesthetist,” after “approved educational activities”.

Pub. L. 99-509, § 9303(c), substituted “October 1 of 1987 (or of such later year as the Secretary may, in his discretion, select)” for “October 1, 1987”.

Pub. L. 99-349 substituted “1987” for “1986”.

Pub. L. 99-272, § 9107(a)(2), inserted “a return on equity capital,” after “anesthetist,” and “other” before “capital-related costs”.

Subsec. (b)(3)(B). Pub. L. 99-272, § 9101(b), amended subpar. (B) generally. Prior to amendment, subpar. (B) read as follows: “For purposes of subparagraph (A) and subsection (d) of this section and except as provided in subsection (e) of this section, the ‘applicable percentage increase’ for any 12-month cost reporting period or fiscal year shall be equal to one-quarter of 1 percentage point plus the percentage, estimated by the Secretary before the beginning of the period or year, by which the cost of the mix of goods and services (including personnel costs but excluding non-operating 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 such cost reporting 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. In determining a percentage change under subsection (e)(4) of this section with respect to discharges occurring in any cost reporting period or fiscal year beginning on or after October 1, 1985, and before October 1, 1986, the Secretary may not establish a percentage increase which exceeds the applicable percentage increase otherwise determined for that period or fiscal year under the preceding sentence.”

Subsec. (b)(3)(B)(i)(II). Pub. L. 99-509, §9302(a)(1), amended subcl. (II) generally. Prior to amendment, subcl. (II) read as follows: “for fiscal years 1987 and 1988, a percentage determined by the Secretary pursuant to subsection (e)(4) of this section, but not to exceed the market basket percentage increase (as defined in clause (ii)), and”.

Subsec. (b)(6). Pub. L. 99-514, §2, substituted “Internal Revenue Code of 1986” for “Internal Revenue Code of 1954”.

Subsec. (c)(7). Pub. L. 99-272, §9109(a), added par. (7).
Subsec. (d)(1)(A). Pub. L. 99-272, §9102(a), substituted “1987” for “1986” in cls. (ii) and (iii).

Subsec. (d)(1)(C). Pub. L. 99-272, §9102(b), struck out “, or discharges occurring” after “periods beginning” in introductory provision, and “and” after “percent;” in cl. (ii), added cl. (iii), redesignated former cl. (iii) as (iv), and in cl. (iv) substituted “on or after October 1, 1986, and before October 1, 1987” for “on or after October 1, 1985, and before October 1, 1986”.

Subsec. (d)(1)(D). Pub. L. 99-272, §9102(c), struck out “cost reporting periods beginning, or” before “discharges occurring” in introductory provision, in cl. (i) substituted “1986” for “1985”, and in cl. (ii) substituted “1986” and “1987” for “1985” and “1986”, respectively.

Subsec. (d)(2)(C)(i). Pub. L. 99-509, §9307(c)(1)(A), struck out Pub. L. 99-514, §1895(b)(1)(A), which had directed the striking out of “(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)” after “medical education costs”.

Pub. L. 99-272, §9104(b)(1), inserted “(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)” after “medical education costs”.

Subsec. (d)(2)(C)(iv). Pub. L. 99-509, §9306(c), substituted “1989” for “1988”.

Pub. L. 99-509, §9307(c)(1)(B)(i), as amended by Pub. L. 100-203, §4009(j)(6)(A), struck out Pub. L. 99-514, §1895(b)(2)(A), which had directed that cl. (iv) was to be struck out.

Pub. L. 99-272, §9105(b), added cl. (iv).

Subsec. (d)(3)(A). Pub. L. 99-509, §9302(a)(2)(A), (c), substituted “1986, 1987, and 1988” for “and 1986” and inserted provisions relating to the computation of urban and rural averages with respect to discharges occurring on or after October 1, 1987.

Pub. L. 99-509, §9307(c)(1)(A), struck out Pub. L. 99-514, §1895(b)(1)(B), which had directed insertion of “If the formula under paragraph (5)(B) for determining payments for the indirect costs of medical education is changed for any fiscal year, the Secretary shall readjust the standardized amounts previously determined for each hospital to take into account the changes in that formula.”

Pub. L. 99-272, §9101(c)(1), substituted “for each of fiscal years 1985 and 1986” for “for fiscal year 1985”.

Subsec. (d)(3)(B). Pub. L. 99-509, §9302(b)(1), inserted “for hospitals located in an urban area and for hospitals located in a rural area” after “subparagraph (A)”, and inserted before the period “for hospitals located in such respective area”.

Subsec. (d)(3)(C). Pub. L. 99-272, §9104(b)(2), inserted “for fiscal year 1985” after “neutrality” in heading, designated existing provision as cl. (i), substituted “For discharges occurring in fiscal year 1985, the Secretary” for “The Secretary”, and added cl. (ii).

Subsec. (d)(3)(C)(ii). Pub. L. 99-509, §9306(c), substituted “1989” for “1988” in subcls. (I) and (II).

Pub. L. 99-509, §9307(c)(1)(A), struck out Pub. L. 99-514, §1895(b)(1)(C), which had directed a general amendment of cl. (ii) to read as follows: “The Secretary shall further reduce each of the average standardized amounts by a proportion equal to the proportion (estimated by the Secretary) of the amount of payments under this subsection based on DRG prospective payment amounts which is the difference between—

“(I) the sum of the additional payment amounts under paragraph (5)(B) (relating to indirect costs of

medical education) if the indirect teaching adjustment factor were equal to 1.159r (as ‘r’ is defined in paragraph (5)(B)(ii)), and

“(II) that sum using the factor specified in paragraph (5)(B)(ii)(II).”

Subsec. (d)(3)(C)(iii). Pub. L. 99-509, §9307(c)(1)(B)(i), as amended by Pub. L. 100-203, §4009(j)(6)(A), struck out Pub. L. 99-514, §1895(b)(2)(B), which had added cl. (iii) reading as follows: “The Secretary shall further reduce each of the average standardized amounts by reducing the standardized amount for each hospital (as previously determined without regard to this clause) by a proportion equal to the proportion (established by the Secretary) of the amount of payments under this subsection based on DRG prospective payment amounts which are additional payments described in paragraph (5)(F) (relating to disproportionate share payments) for subsection (d) hospitals.”

Subsec. (d)(3)(D)(i)(I), (ii)(I). Pub. L. 99-272, §9104(b)(3), inserted “or reduced” after “(B), and adjusted”.

Subsec. (d)(4)(C). Pub. L. 99-509, §9302(e)(1), substituted “in fiscal year 1988 and at least annually” for “in fiscal year 1986 and at least every four fiscal years”.

Subsec. (d)(5)(B). Pub. L. 99-272, §9104(a), amended subpar. (B) generally. Prior to amendment, subpar. (B) read as follows: “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) of this section, except that in the computation under this subparagraph the Secretary shall use an educational adjustment factor equal to twice the factor provided under such regulations. 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.”

Subsec. (d)(5)(B)(ii). Pub. L. 99-509, §9306(c), substituted “1989” for “1988” in subcls. (I) and (II).

Subsec. (d)(5)(C)(i). Pub. L. 99-509, §9302(d)(1)(A), designated existing provisions as subcl. (I) and added subcl. (II).

Pub. L. 99-272, §9106(a), inserted “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” before the period in second sentence.

Pub. L. 99-272, §9105(c), struck out “, and of public or other hospitals that serve a significantly disproportionate number of patients who have low income or are entitled to benefits under part A of this subchapter” after “in rural areas”.

Subsec. (d)(5)(C)(i)(I). Pub. L. 99-509, §9304(b)(1), inserted “(other than under paragraph (9))” after “established under this subsection” in first sentence.

Subsec. (d)(5)(C)(ii). Pub. L. 99-509, §9304(b)(2), inserted “(other than under paragraph (9))” after “this subsection” in second and third sentences.

Pub. L. 99-509, §9302(e)(4), substituted “1988” for “1986”.

Pub. L. 99-272, §9111(a), inserted provision authorizing the Secretary to adjust amount of payments to sole community hospitals that realize a significant increase in operating costs in a cost reporting period attributable to addition of new inpatient facilities or services.

Subsec. (d)(5)(E). Pub. L. 99-509, §9320(g)(2), struck out subpar. (E) which read as follows: “The Secretary shall provide for an additional payment amount for any subsection (d) hospital equal to the reasonable costs incurred by such hospital for anesthesia services provided by a certified registered nurse anesthetist. Payment under this subparagraph shall be the only payment made to such hospital with respect to such services.”

Subsec. (d)(5)(F). Pub. L. 99-272, §9105(a), added subpar. (F).

Subsec. (d)(5)(F)(i). Pub. L. 99-509, §9306(c), substituted "1989" for "1988".

Subsec. (d)(5)(F)(iv)(I). Pub. L. 99-509, §9306(b)(1), inserted "or is described in the second sentence of subclause (III)" after "100 or more beds".

Subsec. (d)(5)(F)(iv)(III). Pub. L. 99-509, §9306(b)(2), inserted "and is not described in the second sentence of clause (v)" after "rural area".

Subsec. (d)(5)(F)(v). Pub. L. 99-509, §9306(a), inserted at end "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."

Subsec. (d)(5)(F)(vi)(I). Pub. L. 99-514, §1895(b)(2)(A), formerly §1895(b)(2)(C), as amended by Pub. L. 99-509, §9307(c)(1)(B)(ii), as amended by Pub. L. 100-203, §4009(j)(6)(A), which directed the substitution of "supplemental" for "supplementary" and "period" for "fiscal year", was repealed by Pub. L. 100-647, §1018(r)(1).

Subsec. (d)(9). Pub. L. 99-509, §9304(a), added par. (9).

Subsec. (e)(1)(C). Pub. L. 99-509, §9304(c), added subpar. (C).

Subsec. (e)(3). Pub. L. 99-509, §9302(e)(3), designated existing provisions as subpar. (A) and added subpar. (B).

Pub. L. 99-272, §9101(c)(2), struck out "(instead of the applicable percentage increase described in subsection (b)(3)(B) of this section)" after "should be used".

Subsec. (e)(3)(A). Pub. L. 99-509, §9321(e)(2)(A), substituted "March" for "April".

Subsec. (e)(4). Pub. L. 99-509, §9302(a)(2)(B), (e)(2), substituted "recommend for fiscal year 1988 an appropriate change factor for inpatient hospital services for discharges in that fiscal year and shall determine for each subsequent fiscal year" for "determine for each fiscal year (beginning with fiscal year 1987) and inserted at end "The percentage change shall be the same for all subsection (d) hospitals and subsection (d) Puerto Rico hospitals, but may be different from that for other hospitals (and units not included as such hospitals) and may vary among such other hospitals and units."

Pub. L. 99-272, §9101(c)(3), substituted "fiscal year 1987" for "fiscal year 1986".

Subsec. (e)(5). Pub. L. 99-509, §9302(a)(2)(C), as amended by Pub. L. 100-203, §4009(j)(6)(B), inserted "recommendation or" before "determination" in subpars. (A) and (B).

Subsec. (e)(5)(A). Pub. L. 99-509, §9321(e)(2)(B), substituted "May" for "June".

Subsec. (e)(6)(A). Pub. L. 99-272, §9127(a), substituted "17 individuals" for "15 individuals".

Subsec. (g)(1). Pub. L. 99-349 substituted "1987" for "1986" in two places.

Subsec. (g)(2). Pub. L. 99-272, §9107(a)(1), designated existing provision as subpar. (A), inserted "the applicable percentage (described in subparagraph (B)) of", and added subpar. (B).

Subsec. (g)(2)(B). Pub. L. 99-514, §1895(b)(3), realigned margins of subpar. (B).

Subsec. (g)(3). Pub. L. 99-509, §9303(a), added par. (3).

Subsec. (g)(3)(A). Pub. L. 99-509, §9303(b), inserted "and a subsection (d) Puerto Rico hospital" after "subsection (d) hospital".

Subsec. (h). Pub. L. 99-272, §9202(a), added subsec. (h).

Subsec. (h)(2)(C). Pub. L. 99-514, §1895(b)(9)(A), substituted "subparagraph (B)" for "paragraph (B)".

Subsec. (h)(4)(D). Pub. L. 99-514, §1895(b)(9)(B), (C), redesignated subpar. (E) as (D) and in cl. (ii) inserted "but before July 1, 1987."

Subsec. (h)(4)(E). Pub. L. 99-509, §9314(a), added subpar. (E).

Pub. L. 99-514, §1895(b)(9)(C), redesignated former subpar. (E) as (D).

Subsec. (h)(5)(B). Pub. L. 99-514, §1895(b)(9)(D), substituted "The" for "As used in this paragraph, the".

1984—Subsec. (a)(2)(B). Pub. L. 98-369, §2354(b)(42), substituted "disproportionate" for "disportionate".

Subsec. (a)(4). Pub. L. 98-369, §2312(b), temporarily inserted "costs of anesthesia services provided by a cer-

tified registered nurse anesthetist" after "approved educational activities". See Effective and Termination Dates of 1984 Amendments note below.

Subsec. (b)(3)(A)(ii). Pub. L. 98-369, §2354(b)(43), inserted "of" after "in the case".

Subsec. (b)(3)(B). Pub. L. 98-369, §2310(a), substituted "one-quarter of 1 percentage point" for "1 percentage point" and inserted provision that in determining the percentage change under subsec. (e) of this section with respect to discharges occurring in any cost reporting period or fiscal year beginning on or after Oct. 1, 1985, and before Oct. 1, 1986, the Secretary may not establish a percentage increase which exceeds the applicable percentage increase otherwise determined for that period or fiscal year under the preceding sentence.

Subsec. (c)(4)(A). Pub. L. 98-369, §2315(a), substituted "(D), and (E)" for "and (D)".

Subsec. (d)(2)(D). Pub. L. 98-369, §2315(b), struck out "Standard" before "Metropolitan" in provision following cl. (ii).

Pub. L. 98-369, §2311(b), inserted provision for determining the region a hospital located in a Metropolitan Statistical Area would be deemed to be located.

Subsec. (d)(3)(D)(i)(I). Pub. L. 98-369, §2354(b)(44), substituted "(C)" for "(C),".

Subsec. (d)(5)(B). Pub. L. 98-369, §2307(b)(1), inserted provision that in determining such adjustment the Secretary not distinguish between those interns and residents who are employees of a hospital and those who furnish services to a hospital but are not employees of such hospital.

Subsec. (d)(5)(C)(i). Pub. L. 98-617 substituted "August 17, 1984" for "30 days after July 18, 1984" before "for implementation by".

Pub. L. 98-369, §2311(a), inserted provisions permitting a hospital classified as a rural hospital to appeal to the Secretary for reclassification as a rural referral center on the basis of criteria established and published by the Secretary and requiring the Secretary to make a final determination with respect to such appeal within 60 days after the date the appeal was submitted.

Subsec. (d)(5)(E). Pub. L. 98-369, §2312(a), temporarily added subpar. (E). See Effective and Termination Dates of 1984 Amendments note below.

Subsec. (d)(8). Pub. L. 98-369, §2311(c), added par. (8).

Subsec. (e)(2). Pub. L. 98-369, §2313(a), inserted "(without regard to the provisions of title 5 governing appointments in the competitive service)" after "appointed by the Director".

Subsec. (e)(5). Pub. L. 98-369, §2315(c)(1), struck out "for public comment" after "have published" in provisions preceding subpar. (A).

Subsec. (e)(5)(A). Pub. L. 98-369, §2315(c)(2), inserted "for public comment" after "that fiscal year".

Subsec. (e)(6)(C). Pub. L. 98-369, §2313(b)(3), inserted provision that section 10(a)(1) of the Federal Advisory Committee Act not apply to any portion of a Commission meeting if the Commission, by majority vote, determines such portion of such meeting should be closed.

Subsec. (e)(6)(C)(i). Pub. L. 98-369, §2313(b)(1), amended cl. (i) generally, substituting provision authorizing the Commission to employ and fix the compensation of an Executive Director, subject to the approval of the Director of the Office, and such other personnel, not to exceed 25, as necessary, without regard to the provisions of title 5 governing appointment in the competitive service, for provision authorizing the Commission to employ and fix the compensation of such personnel, not to exceed 25, as may be necessary to carry out its duties.

Subsec. (e)(6)(C)(iii). Pub. L. 98-369, §2313(b)(2), inserted "(without regard to section 5 of title 41)" after "Commission".

Subsec. (e)(6)(D). Pub. L. 98-369, §2313(b)(4), inserted provision relating to payment of physician comparability allowance in the same manner as provided under section 5948 of title 5 and providing that for such purpose subsec. (i) of such section apply to the Commission in the same manner as it applies to the Tennessee Valley Authority.

Subsec. (e)(6)(J). Pub. L. 98-369, §2313(d), added subpar. (J).

1983—Subsec. (a)(1)(D). Pub. L. 98-21, §601(a)(1), added subpar. (D).

Subsec. (a)(4). Pub. L. 98-21, §601(a)(2), inserted provision that term “operating costs of inpatient hospital services” does not include costs of approved educational activities, or, with respect to costs incurred in cost reporting periods beginning prior to Oct. 1, 1986, capital-related costs, as defined by the Secretary.

Pub. L. 97-448, §309(b)(13), substituted “as such costs are determined” for “and such costs are determined”.

Subsec. (b)(1). Pub. L. 98-21, §601(b)(1), (2), in provisions preceding subpar. (A), substituted “Notwithstanding section 1395f(b) of this title but subject to the provisions of section 1395e of this title” for “Notwithstanding sections 1395f(b) of this title, but subject to the provisions of sections 1395e of this title” and inserted “(other than a subsection (d) hospital, as defined in subsection (d)(1)(B) of this section)”.

Pub. L. 98-21, §601(b)(3), inserted “(other than on the basis of a DRG prospective payment rate determined under subsection (d) of this section)” in provisions following subpar. (B).

Pub. L. 97-448, §309(b)(14), substituted “section 1395f(b)” for “sections 1395f(b)” in provisions preceding subpar. (A).

Subsec. (b)(2). Pub. L. 98-21, §601(b)(4), struck out par. (2) which provided that par. (1) would not apply to cost reporting periods of hospitals beginning on or after Oct. 1, 1985.

Subsec. (b)(3)(B). Pub. L. 98-21, §601(b)(5)–(8), inserted “and subsection (d) of this section and except as provided in subsection (e) of this section” after “subparagraph (A)”, inserted “or fiscal year” after “cost reporting period” each place it appears, inserted “before the beginning of the period or year” after “estimated by the Secretary”, and substituted “will exceed” for “exceeds”.

Subsec. (b)(6). Pub. L. 98-21, §601(b)(9), added par. (6) and repealed a prior par. (6) which directed the Secretary to provide for an adjustment under this paragraph in the amount of payment otherwise provided a hospital under this subsection in the case of a hospital which, as of Aug. 15, 1982, was subject to FICA taxes and which was not subject to such taxes for part or all of a cost reporting period beginning on or after Oct. 1, 1982, that in making such adjustment for a cost reporting period the Secretary was to estimate the amount of the operating costs of inpatient hospital services that would have resulted if the hospital was subject to the FICA taxes during that period, that in making such estimate the Secretary was to reduce the amount of such FICA taxes that would have been paid (but not below zero) by the amount of costs which the hospital demonstrated to the satisfaction of the Secretary were incurred in the period for pensions, health, and other fringe benefits for employees (and former employees and family members) comparable to, and in lieu of, the benefits provided under subchapter II of this chapter and this subchapter, that if a hospital’s operating costs of inpatient hospital services estimated under subparagraph (B) was greater than the hospital’s operating costs of inpatient hospital services determined without regard to this paragraph for a cost reporting period, then the Secretary was to reduce the amount otherwise paid the hospital (respecting operating costs of inpatient hospital services) under this title (taking into account any limitation under subsection (a) of this section) for the period by the amount by which (i) the amount that would have been paid the hospital if (I) the amount of the operating costs of inpatient hospital services estimated under subparagraph (B) were treated as the amount of the operating costs of inpatient hospital services and (II) subsection (a) of this section did not apply to the determination, exceeded (ii) the amount that would otherwise have been paid the hospital if subsection (a) of this section (and this paragraph) did not apply, except that, in making such determination for cost reporting periods beginning on or

after Oct. 1, 1984, clause (ii) of paragraph (1)(B) was to continue to apply.

Subsec. (b)(6)(C). Pub. L. 97-448, §309(b)(15), substituted “under this subchapter (taking into account any limitation under subsection (a) of this section)” for “under this subsection” in provisions preceding cl. (i).

Subsec. (c)(1). Pub. L. 98-21, §601(c)(1), added subpars. (D) and (E) and provisions following subpar. (E).

Subsec. (c)(3)(A). Pub. L. 98-21, §601(c)(2)(A), substituted “meets the requirements of subparagraphs (A), (D), and (E) of paragraph (1) and, if applicable, the requirements of paragraph (5),” for “meets the requirement of paragraph (1)(A)”.

Subsec. (c)(3)(B). Pub. L. 98-21, §601(c)(2)(B), inserted “(or, if applicable, in paragraph (5))”.

Subsec. (c)(4) to (6). Pub. L. 98-21, §601(c)(3), added pars. (4) to (6).

Subsec. (d). Pub. L. 98-21, §601(d)(2), (e), added subsec. (d) and redesignated former subsec. (d), relating to the elimination of lesser-of-cost-or-charges provisions, as subsec. (j) of section 1814 of act Aug. 14, 1935, which is classified to subsec. (j) of section 1395f of this title.

Subsecs. (e) to (g). Pub. L. 98-21, §601(e), added subsecs. (e) to (g).

1982—Subsec. (d). Pub. L. 97-248, §110, added subsec. (d).

CHANGE OF NAME

References to Medicare+Choice deemed to refer to Medicare Advantage or MA, subject to an appropriate transition provided by the Secretary of Health and Human Services in the use of those terms, see section 201 of Pub. L. 108-173, set out as a note under section 1395w-21 of this title.

EFFECTIVE DATE OF 2010 AMENDMENT

Pub. L. 111-309, title II, §203, Dec. 15, 2010, 124 Stat. 3289, provided that the amendment made by section 203 is effective as if included in the enactment of section 5503(a) of Pub. L. 111-148.

Pub. L. 111-192, title I, §102(b), June 25, 2010, 124 Stat. 1281, provided that: “The amendments made by subsection (a) [amending this section] shall apply to services furnished on or after the date of the enactment of this Act [June 25, 2010].”

Pub. L. 111-148, title III, §3401(p), Mar. 23, 2010, 124 Stat. 488, provided that: “Notwithstanding the preceding provisions of this section [amending this section and sections 1395f, 1395l, 1395m, 1395u, 1395rr, 1395yy, and 1395fff of this title], the amendments made by subsections (a), (c), and (d) [amending this section] shall not apply to discharges occurring before April 1, 2010.”

Pub. L. 111-148, title V, §5505(c), Mar. 23, 2010, 124 Stat. 661, provided that:

“(1) IN GENERAL.—Except as otherwise provided, the Secretary of Health and Human Services shall implement the amendments made by this section [amending this section] in a manner so as to apply to cost reporting periods beginning on or after January 1, 1983.

“(2) GME.—Section 1886(h)(4)(J) of the Social Security Act [42 U.S.C. 1395ww(h)(4)(J)], as added by subsection (a)(1)(B), shall apply to cost reporting periods beginning on or after July 1, 2009.

“(3) IME.—Section 1886(d)(5)(B)(x)(III) of the Social Security Act [42 U.S.C. 1395ww(d)(5)(B)(x)(III)], as added by subsection (b), shall apply to cost reporting periods beginning on or after October 1, 2001. Such section, as so added, shall not give rise to any inference as to how the law in effect prior to such date should be interpreted.”

EFFECTIVE DATE OF 2007 AMENDMENT

Pub. L. 110-173, title I, §114(e)(2), Dec. 29, 2007, 121 Stat. 2505, provided that: “Subsection (m)(2) of section 1886 of the Social Security Act [subsec. (m)(2) of this section], as added by paragraph (1), shall not apply to discharges occurring on or after July 1, 2007, and before April 1, 2008.”

Pub. L. 110-173, title I, §115(a)(2), Dec. 29, 2007, 121 Stat. 2506, provided that: “The amendment made by

paragraph (1) [amending this section] shall not apply to payment units occurring before April 1, 2008.”

Pub. L. 110-161, div. G, title II, § 225(b)(2), Dec. 26, 2007, 121 Stat. 2189, provided that: “Subject to paragraph (3) [section 225(b) of title II of div. G of Pub. L. 110-161 does not contain a par. (3)], the amendments made by paragraph (1) [amending this section] shall take effect as if included in the enactment of section 422 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173).”

EFFECTIVE DATE OF 2006 AMENDMENT

Amendment by section 109(a)(2) of Pub. L. 109-432 applicable to payment for services furnished on or after Jan. 1, 2009, see section 109(c) of Pub. L. 109-432, set out as a note under section 1395f of this title.

Amendment by section 205(b)(1) of Pub. L. 109-432 effective as if included in the enactment of Pub. L. 109-171, see section 205(c) of Pub. L. 109-432, set out as a note under section 1395u of this title.

EFFECTIVE DATE OF 2003 AMENDMENT

Pub. L. 108-173, title IV, § 407(b), Dec. 8, 2003, 117 Stat. 2270, provided that: “The amendment made by subsection (a) [amending this section] shall apply to cost reporting periods beginning on or after January 1, 2004.”

Pub. L. 108-173, title V, § 502(c), Dec. 8, 2003, 117 Stat. 2291, provided that: “The amendments made by this section [amending this section] shall apply to discharges occurring on or after April 1, 2004.”

Pub. L. 108-173, title V, § 503(e), Dec. 8, 2003, 117 Stat. 2292, provided that:

“(1) IN GENERAL.—The Secretary [of Health and Human Services] shall implement the amendments made by this section [amending this section] so that they apply to classification for fiscal years beginning with fiscal year 2005.

“(2) RECONSIDERATIONS OF APPLICATIONS FOR FISCAL YEAR 2004 THAT ARE DENIED.—In the case of an application for a classification of a medical service or technology as a new medical service or technology under section 1886(d)(5)(K) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(K)) that was filed for fiscal year 2004 and that is denied—

“(A) the Secretary shall automatically reconsider the application as an application for fiscal year 2005 under the amendments made by this section; and

“(B) the maximum time period otherwise permitted for such classification of the service or technology shall be extended by 12 months.”

Pub. L. 108-173, title V, § 505(c), Dec. 8, 2003, 117 Stat. 2294, provided that: “The amendments made by this section [amending this section and section 1395cc of this title] shall first apply to the wage index for discharges occurring on or after October 1, 2004. In initially implementing such amendments, the Secretary [of Health and Human Services] may modify the deadlines otherwise applicable under clauses (ii) and (iii)(I) of section 1886(d)(10)(C) of the Social Security Act (42 U.S.C. 1395ww(d)(10)(C)), for submission of, and actions on, applications relating to changes in hospital geographic reclassification.”

EFFECTIVE DATE OF 2000 AMENDMENT

Pub. L. 106-554, § 1(a)(6) [title II, § 212(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A-485, provided that: “The amendment made by this section [amending this section] shall apply with respect to cost reporting periods beginning on or after April 1, 2001.”

Pub. L. 106-554, § 1(a)(6) [title II, § 213(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A-486, provided that: “The amendments made by this section [amending this section] shall take effect as if included in the enactment of section 405 of BBA [Pub. L. 106-113, § 1000(a)(6) [title IV, § 405]] (113 Stat. 1501A-372).”

Pub. L. 106-554, § 1(a)(6) [title III, § 301(e)(2)], Dec. 21, 2000, 114 Stat. 2763, 2763A-492, provided that: “The amendment made by paragraph (1) [amending this sec-

tion] shall apply to discharges occurring on or after October 1, 2001.”

Pub. L. 106-554, § 1(a)(6) [title III, § 303(d)(2)], Dec. 21, 2000, 114 Stat. 2763, 2763A-494, provided that: “The amendment made by paragraph (1) [amending this section] is effective as if included in the enactment of BBA [Pub. L. 105-33].”

Pub. L. 106-554, § 1(a)(6) [title III, § 305(c)], Dec. 21, 2000, 114 Stat. 2763, 2763A-496, provided that: “The amendments made by this section [amending this section] take effect as if included in the enactment of BBA [Pub. L. 105-33].”

Pub. L. 106-554, § 1(a)(6) [title V, § 512(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A-534, provided that: “The amendment made by subsection (a) [amending this section] shall apply to portions of cost reporting periods occurring on or after January 1, 2001.”

EFFECTIVE DATE OF 1999 AMENDMENT

Pub. L. 106-113, div. B, § 1000(a)(6) [title I, § 121(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A-330, provided that: “The amendments made by subsection (a) [amending this section] apply to cost reporting periods beginning on or after October 1, 1999.”

Pub. L. 106-113, div. B, § 1000(a)(6) [title I, § 125(c)], Nov. 29, 1999, 113 Stat. 1536, 1501A-333, provided that: “The amendments made by subsection (a) [amending this section] are effective as if included in the enactment of section 4421(a) of BBA [the Balanced Budget Act of 1997, Pub. L. 105-33].”

Pub. L. 106-113, div. B, § 1000(a)(6) [title III, § 312(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A-365, provided that: “The amendments made by subsection (a) [amending this section] apply on and after July 1, 2000, to residency programs that began before, on, or after the date of the enactment of this Act [Nov. 29, 1999].”

Amendment by section 1000(a)(6) [title III, § 321(b), (e), (f), (h), (k)(15)-(17)] of Pub. L. 106-113 effective as if included in the enactment of the Balanced Budget Act of 1997, Pub. L. 105-33, except as otherwise provided, see section 1000(a)(6) [title III, § 321(m)] of Pub. L. 106-113, set out as a note under section 1395d of this title.

Amendment by section 1000(a)(6) [title IV, § 401(a)] of Pub. L. 106-113 effective Jan. 1, 2000, see section 1000(a)(6) [title IV, § 401(c)] of Pub. L. 106-113, set out as a note under section 1395i-4 of this title.

Pub. L. 106-113, div. B, § 1000(a)(6) [title IV, § 402(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A-370, provided that: “The amendments made by subsection (a) [amending this section] apply with respect to discharges occurring during cost reporting periods beginning on or after October 1, 1999.”

Pub. L. 106-113, div. B, § 1000(a)(6) [title IV, § 407(a)(3)], Nov. 29, 1999, 113 Stat. 1536, 1501A-373, provided that:

“(A) DGME.—The amendments made by paragraph (1) [amending this section] apply to cost reporting periods that begin on or after the date of the enactment of this Act [Nov. 29, 1999].

“(B) IME.—The amendment made by paragraph (2) [amending this section] applies to discharges occurring in cost reporting periods that begin on or after such date of enactment.”

Pub. L. 106-113, div. B, § 1000(a)(6) [title IV, § 407(b)(3)], Nov. 29, 1999, 113 Stat. 1536, 1501A-374, provided that:

“(A) DGME.—The amendment made by paragraph (1) [amending this section] applies to cost reporting periods beginning on or after April 1, 2000.

“(B) IME.—The amendment made by paragraph (2) [amending this section] applies to discharges occurring on or after April 1, 2000.”

Pub. L. 106-113, div. B, § 1000(a)(6) [title IV, § 407(c)(2)], Nov. 29, 1999, 113 Stat. 1536, 1501A-374, provided that: “The amendment made by paragraph (1) [amending this section] applies with respect to—

“(A) payments to hospitals under section 1886(h) of the Social Security Act (42 U.S.C. 1395ww(h)) for cost reporting periods beginning on or after April 1, 2000; and

“(B) payments to hospitals under section 1886(d)(5)(B)(v) of such Act (42 U.S.C.

1395ww(d)(5)(B)(v)) for discharges occurring on or after April 1, 2000.”

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by section 4022(b) of Pub. L. 105-33 effective Nov. 1, 1997, the date of termination of the Prospective Payment Assessment Commission and the Physician Payment Review Commission, see section 4022(c)(2) of Pub. L. 105-33, set out as an Effective Date; Transition; Transfer of Functions note under section 1395b-6 of this title.

Amendment by section 4201(c)(1), (4) of Pub. L. 105-33 applicable to services furnished on or after Oct. 1, 1997, see section 4201(d) of Pub. L. 105-33, set out as a note under section 1395f of this title.

Section 4204(b) of Pub. L. 105-33 provided that: “The amendments made by subsection (a) [amending this section and provisions set out as a note below] shall apply with respect to discharges occurring on or after October 1, 1997.”

Section 4405(d) of Pub. L. 105-33 provided that: “The amendments made by this section [amending this section] apply to discharges occurring after September 30, 1997.”

Section 4415(e) of Pub. L. 105-33 provided that: “The amendments made by subsections (a) and (c) [amending this section] shall apply with respect to cost reporting periods beginning on or after October 1, 1997.”

Section 4417(a)(2) of Pub. L. 105-33 provided that: “The amendment made by paragraph (1) [amending this section] shall apply to discharges occurring on or after October 1, 1995.”

Section 4417(b)(2) of Pub. L. 105-33 provided that: “The amendment made by paragraph (1) [amending this section] shall apply to cost reporting periods beginning on or after the date of the enactment of this Act [Aug. 5, 1997].”

Section 4419(a)(2) of Pub. L. 105-33 provided that: “The amendment made by paragraph (1) [amending this section] shall apply to hospitals or units that first qualify as a hospital or unit described in section 1886(d)(1)(B) (42 U.S.C. 1395ww(d)(1)(B)) for cost reporting periods beginning on or after October 1, 1997.”

Section 4421(c) of Pub. L. 105-33 provided that: “The amendments made by this section [amending this section] shall apply to cost reporting periods beginning on or after October 1, 2000, except that the Secretary of Health and Human Services may require the submission of data under section 1886(j)(2)(D) of the Social Security Act [subsec. (j)(2)(D) of this section] (as added by subsection (a)) on and after the date of the enactment of this section [Aug. 5, 1997].”

Section 4627(b) of Pub. L. 105-33 provided that: “The amendments made by subsection (a) [amending this section] apply to combined medical residency training programs in effect for residency years beginning on or after July 1, 1997.”

EFFECTIVE DATE OF 1994 AMENDMENT

Section 101(a)(2) of Pub. L. 103-432 provided that: “The amendment made by paragraph (1) [amending this section] shall take effect as if included in the enactment of OBRA-1989 [Pub. L. 101-239].”

Section 153(b) of Pub. L. 103-432 provided that: “The amendment made by subsection (a) [amending this section] shall apply as if included in the enactment of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272).”

EFFECTIVE DATE OF 1993 AMENDMENT

Section 13501(b)(3) of Pub. L. 103-66 provided that: “The amendment made by paragraph (1) [amending this section] shall apply to discharges occurring on or after October 1, 1991.”

Section 13563(b)(2) of Pub. L. 103-66 provided that: “The amendments made by paragraphs (1)(A) and (1)(B) [amending this section] shall take effect on July 1, 1995, and the date of the enactment of this Act [Aug. 10, 1993], respectively.”

Section 13563(c)(2) of Pub. L. 103-66 provided that: “The amendment made by paragraph (1) [amending this section] shall apply to payments under section 1886(h) of the Social Security Act [subsec. (h) of this section] for cost reporting periods beginning on or after October 1, 1992.”

EFFECTIVE DATE OF 1990 AMENDMENT

Section 4002(a)(2) of Pub. L. 101-508 provided that: “The amendments made by paragraph (1) [amending this section] shall apply to payments for discharges occurring on or after January 1, 1991.”

Section 4002(b)(5) of Pub. L. 101-508 provided that: “The amendments made by paragraphs (1), (3), and (4)(B) [amending this section] shall apply to discharges occurring on or after January 1, 1991, the amendment made by paragraph (2) [amending this section] shall apply to discharges occurring on or after October 1, 1991, and the amendment made by paragraph (4)(A) [amending this section] shall take effect as if included in the enactment of the Omnibus Budget Reconciliation Act of 1989 [Pub. L. 101-239].”

Section 4002(c)(3) of Pub. L. 101-508 provided that: “The amendments made by paragraph (1) and paragraph (2)(A) [amending this section] shall apply to payments for discharges occurring on or after January 1, 1991, and the amendments made by paragraph (2)(B) [amending this section] shall take effect October 1, 1994.”

Section 4002(e)(4)(3) of Pub. L. 101-508 provided that: “The amendment made by paragraph (1) [amending this section] shall apply to discharges occurring on or after October 1, 1990.”

Section 4002(g)(5) of Pub. L. 101-508 provided that: “The amendments made by this subsection [amending this section and section 1395w-1 of this title] shall take effect on the date of the enactment of this Act [Nov. 5, 1990].”

Section 4002(h)(1)(B) of Pub. L. 101-508 provided that: “The amendments made by subparagraph (A) [amending this section] shall apply to discharges occurring on or after January 1, 1991.”

Section 4003(b) of Pub. L. 101-508 provided that: “The amendment made by subsection (a) [amending this section] shall apply—

“(1) in the case of any services provided during the day immediately preceding the date of a patient’s admission (without regard to whether the services are related to the admission), to services furnished on or after the date of the enactment of this Act [Nov. 5, 1990] and before October 1, 1991;

“(2) in the case of diagnostic services (including clinical diagnostic laboratory tests), to services furnished on or after January 1, 1991; and

“(3) in the case of any other services, to services furnished on or after October 1, 1991.”

Section 4005(a)(2) of Pub. L. 101-508 provided that: “The amendment made by paragraph (1) [amending this section] shall apply to cost reporting periods beginning on or after October 1, 1991.”

Section 4005(c)(4) of Pub. L. 101-508 provided that: “The amendments made by paragraph (1) [amending this section and section 1395h of this title] shall take effect on the date of the enactment of this Act [Nov. 5, 1990], and the amendments made by paragraph (2) [amending this section] shall take effect as if included in the enactment of the Omnibus Budget Reconciliation Act of 1989 [Pub. L. 101-239].”

Section 4008(f)(2) of Pub. L. 101-508 provided that: “The amendment made by paragraph (1) [amending this section] shall take effect as if included in the enactment of the Omnibus Budget Reconciliation Act of 1989 [Pub. L. 101-239].”

EFFECTIVE DATE OF 1989 AMENDMENT

Section 6003(a)(2) of Pub. L. 101-239 provided that: “The amendments made by paragraph (1) [amending this section] shall apply to payments for discharges occurring on or after January 1, 1990.”

Section 6003(c)(4) of Pub. L. 101-239 provided that: "The amendments made by this subsection [amending this section] shall apply with respect to discharges occurring on or after April 1, 1990."

Section 6003(h)(7) of Pub. L. 101-239 provided that: "The amendments made by paragraphs (3) and (4) [amending this section] shall apply to discharges occurring on or after April 1, 1990."

Section 6004(a)(3) of Pub. L. 101-239 provided that: "The amendments made by this subsection [amending this section] shall apply with respect to cost reporting periods beginning on or after October 1, 1989, except that—

"(A) in the case of a hospital classified by the Secretary of Health and Human Services as a hospital involved extensively in treatment for or research on cancer under section 1886(d)(5)(I) of the Social Security Act [subsec. (d)(5)(I) of this section] (as redesignated by section 6003(e)(1)(A)) after the date of the enactment of this Act [Dec. 19, 1989], such amendments shall apply with respect to cost reporting periods beginning on or after the date of such classification.

"(B) in the case of a hospital that is not described in subparagraph (A), such amendments shall apply with respect to portions of cost reporting periods or discharges occurring during and after fiscal year 1987 for purposes of section 1886(g) of the Social Security Act [subsec. (g) of this section], and

"(C) such amendments shall take effect 30 days after the date of the enactment of this Act for purposes of determining the eligibility of a hospital to receive periodic interim payments under section 1815(e)(2) of the Social Security Act [section 1395g(e)(2) of this title]."

Section 6004(b)(2) of Pub. L. 101-239 provided that: "The amendments made by paragraph (1) [amending this section] shall apply with respect to cost reporting periods beginning on or after April 1, 1989."

Section 6011(d) of Pub. L. 101-239, as amended by Pub. L. 103-66, title XIII, § 13505, Aug. 10, 1993, 107 Stat. 579; Pub. L. 105-33, title IV, § 4452, Aug. 5, 1997, 111 Stat. 425, provided that: "The amendments made by subsection (a) [amending this section] shall apply with respect to items furnished 6 months after the date of enactment of this Act [Dec. 19, 1989] and on or before September 30, 1994, and on or after October 1, 1997."

[Section 13505 of Pub. L. 103-66 provided in part that the amendment made by that section to section 6011(d) of Pub. L. 101-239, set out above, is effective as if included in the enactment of Pub. L. 101-239.]

Section 6015(c) of Pub. L. 101-239 provided that: "The amendment made by subsection (a) [amending this section] shall become effective with respect to cost reporting periods beginning on or after April 1, 1990."

EFFECTIVE DATE OF 1988 AMENDMENTS

Amendment by section 1018(r)(1) of Pub. L. 100-647 effective, except as otherwise provided, as if included in the provision of the Tax Reform Act of 1986, Pub. L. 99-514, to which such amendment relates, see section 1019(a) of Pub. L. 100-647, set out as a note under section 1 of Title 26, Internal Revenue Code.

Amendment by Pub. L. 100-485 effective as if included in the enactment of the Medicare Catastrophic Coverage Act of 1988, Pub. L. 100-360, see section 608(g)(1) of Pub. L. 100-485, set out as a note under section 704 of this title.

Except as specifically provided in section 411 of Pub. L. 100-360, amendment by Pub. L. 100-360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100-203, effective as if included in the enactment of that provision in Pub. L. 100-203, see section 411(a) of Pub. L. 100-360, set out as a Reference to OBRA; Effective Date note under section 106 of Title 1, General Provisions.

EFFECTIVE DATE OF 1987 AMENDMENTS

Section 4002(g) of Pub. L. 100-203, as amended by Pub. L. 100-360, title IV, § 411(b)(1)(I), July 1, 1988, 102 Stat. 769, provided that:

"(1) PPS HOSPITALS, DRG PORTION OF PAYMENT.—In the case of a subsection (d) hospital (as defined in paragraph (6))—

"(A) the amendments made by subsections (a) and (c) [amending this section] shall apply to payments made under section 1886(d)(1)(A)(iii) of the Social Security Act [subsec. (d)(1)(A)(iii) of this section] on the basis of discharges occurring on or after April 1, 1988, and

"(B) for discharges occurring on or after October 1, 1988, the applicable percentage increase (described in section 1886(b)(3)(B) of such Act [subsec. (b)(3)(B) of this section]) for discharges occurring during fiscal year 1987 is deemed to have been such percentage increase as amended by subsection (a).

"(2) PPS SOLE COMMUNITY HOSPITALS, HOSPITAL SPECIFIC PORTION OF PAYMENT.—In the case of a subsection (d) hospital which receives payments made under section 1886(d)(1)(A) of the Social Security Act [subsec. (d)(1)(A) of this section] because it is a sole community hospital—

"(A) the amendment made by subsections (a) and (c) [amending this section] shall apply to payments under section 1886(d)(1)(A)(ii)(I) of the Social Security Act made on the basis of discharges occurring during a cost reporting period of a hospital, for the hospital's cost reporting period beginning on or after October 1, 1987;

"(B) notwithstanding subparagraph (A), for cost reporting period beginning during fiscal year 1988, the applicable percentage increase (as defined in section 1886(b)(3)(B) of such Act [subsec. (b)(3)(B) of this section]) for the—

"(i) first 51 days of the cost reporting period shall be 0 percent,

"(ii) next 132 days of such period shall be 2.7 percent, and

"(iii) remainder of such period of the cost reporting period shall be the applicable percentage increase (as so defined, as amended by subsection (a)); and

"(C) for cost reporting periods beginning on or after October 1, 1988, the applicable percentage increase (as so defined) with respect to the previous cost reporting period shall be deemed to have been the applicable percentage increase (as so defined, as amended by subsection (a)).

"(3) PPS-EXEMPT HOSPITALS.—In the case of a hospital that is not a subsection (d) hospital—

"(A) the amendments made by subsection (e) [amending this section] shall apply to cost reporting periods beginning on or after October 1, 1987;

"(B) notwithstanding subparagraph (A), for the hospital's cost reporting period beginning during fiscal year 1988, payment under title XVIII of the Social Security Act [this subchapter] shall be made as though the applicable percentage increase described in section 1886(b)(3)(B) of such Act [subsec. (b)(3)(B) of this section] were equal to the product of 2.7 percent and the ratio of 315 to 366; and

"(C) for cost reporting periods beginning on or after October 1, 1988, the applicable percentage increase (as so defined) with respect to the cost reporting period beginning during fiscal year 1988 shall be deemed to have been 2.7 percent.

"(4) DEFINITION, REGIONAL FLOOR, AND TECHNICAL AND CONFORMING AMENDMENTS.—The amendments made by subsections (b) and (d) and paragraphs (1) and (2) of subsection (f) [amending this section and provisions set out as a note below] shall take effect on the date of the enactment of this Act [Dec. 22, 1987].

"(5) TRANSITION FOR LARGE URBAN AREA RATES.—In computing the average standardized amount for hospitals located in a large urban area or other urban area under section 1886(d)(3)(A)(ii) of the Social Security Act [subsec. (d)(3)(A)(ii) of this section] (as amended by subsection (c)) for fiscal year 1988, the reference to 'the respective average standardized amount computed for the previous fiscal year under this subparagraph' is deemed a reference to the average standardized amount com-

puted for hospitals located in an urban area for the 51-day period beginning on October 1, 1987.

“(6) DEFINITION.—In this subsection, the term ‘subsection (d) hospital’ has the meaning given such term in section 1886(d)(1)(B) of the Social Security Act [subsec. (d)(1)(B) of this section].”

Section 4003(e) of Pub. L. 100-203 provided that: “The amendments made by this section [amending this section] shall apply to payments for discharges occurring on or after October 1, 1988.”

Section 4005(a)(3) of Pub. L. 100-203, as amended by Pub. L. 100-360, title IV, § 411(b)(4)(C)(ii), July 1, 1988, 102 Stat. 770, provided that: “This subsection [amending this section] shall apply to discharges occurring on or after October 1, 1988.”

Section 4005(c)(2)(A) of Pub. L. 100-203 provided that: “The amendments made by paragraph (1) [amending this section] shall apply to cost reporting periods beginning on or after October 1, 1987[.]”

Section 4005(d)(1)(B) of Pub. L. 100-203 provided that: “The amendment made by subparagraph (A) [amending this section] shall apply to discharges occurring on or after April 1, 1988.”

Section 4006(b)(3) of Pub. L. 100-203 provided that: “The amendment made by paragraph (1) [amending this section] shall take effect on October 1, 1987. The amendments made by paragraph (2) [amending this section] shall apply to cost reporting periods beginning on or after October 1, 1987.”

Section 4007(b)(2) of Pub. L. 100-203, as amended by Pub. L. 100-360, title IV, § 411(b)(6)(B), July 1, 1988, 102 Stat. 770, provided that: “The amendment made by paragraph (1)(C) [amending this section] shall apply to hospital cost reporting periods beginning on or after October 1, 1989.”

Section 4009(d)(2) of Pub. L. 100-203 provided that: “The amendments made by paragraph (1) [amending this section] shall apply to appointments made after the date of the enactment of this Act [Dec. 22, 1987].”

Section 4009(j)(6) of Pub. L. 100-203 provided that the amendment made by that section is effective as if included in the enactment of Pub. L. 99-509.

Section 4083(b)(2) of Pub. L. 100-203 provided that: “The amendments made by paragraph (1) [amending this section] shall take effect on the date of the enactment of this Act [Dec. 22, 1987].”

Amendment by Pub. L. 100-93 effective at end of fourteen-day period beginning Aug. 18, 1987, and inapplicable to administrative proceedings commenced before end of such period, see section 15(a) of Pub. L. 100-93, set out as a note under section 1320a-7 of this title.

EFFECTIVE DATE OF 1986 AMENDMENTS

Section 1895(b)(1)(D) of Pub. L. 99-514, which provided for applicability of amendments to this section by section 1895(b)(1) of Pub. L. 99-514 to discharges occurring on or after Oct. 1, 1986, with certain exceptions, was repealed by Pub. L. 99-509, title IX, § 9307(c)(1)(A), Oct. 21, 1986, 100 Stat. 1995, and by Pub. L. 100-647, title I, § 1018(r)(1), Nov. 10, 1988, 102 Stat. 3586.

Section 1895(b)(2)(B), formerly § 1895(b)(2)(D), of Pub. L. 99-514, as amended by Pub. L. 99-509, title IX, § 9307(c)(1)(B)(iii), as amended by Pub. L. 100-203, title IV, § 4009(j)(6)(A), Dec. 22, 1987, 101 Stat. 1330-59, which provided for applicability of amendments to this section by section 1895(b)(2)(A) of Pub. L. 99-514 to discharges occurring on or after May 1, 1986, was repealed by Pub. L. 100-647, title I, § 1018(r)(1), Nov. 10, 1988, 102 Stat. 3586.

Amendment by section 1895(b)(3), (9) of Pub. L. 99-514 effective, except as otherwise provided, as if included in enactment of the Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. 99-272, see section 1895(e) of Pub. L. 99-514, set out as a note under section 162 of Title 26, Internal Revenue Code.

Section 9302(a)(3) of Pub. L. 99-509 provided that: “The amendment made by paragraph (1) [amending this section] shall apply to cost reporting periods beginning on or after October 1, 1986 and, for purposes of section 1886(d) of the Social Security Act [subsec. (d) of this

section], for cost reporting periods beginning and discharges occurring on or after October 1, 1986.”

Section 9302(b)(2) of Pub. L. 99-509 provided that: “The amendments made by paragraph (1) [amending this section] shall apply to discharges occurring on or after October 1, 1986.”

Section 9302(d)(1)(B) of Pub. L. 99-509 provided that:

“(i) Subject to clause (ii), the amendments made by subparagraph (A) [amending this section] shall apply to payments for discharges occurring on or after October 1, 1986.

“(ii) An appeal for classification of a rural hospital as a regional referral center, pursuant to the amendments made by subparagraph (A), which is filed before January 1, 1987, and which is approved shall be effective with respect to discharges occurring on or after October 1, 1986.”

Section 9303(b) of Pub. L. 99-509 provided that the amendment made by such section 9303(b) is effective for cost reporting periods beginning and discharges occurring (as the case may be) on or after Oct. 1, 1987.

Section 9304(d) of Pub. L. 99-509 provided that: “The amendments made by this section [amending this section] shall apply to discharges occurring on or after October 1, 1987.”

Section 9306(d) of Pub. L. 99-509 provided that: “The amendments made by subsections (a) and (b) [amending this section] shall apply to discharges occurring on or after October 1, 1986.”

Section 9307(c)(1) of Pub. L. 99-509 provided that the amendment made by such section 9307(c)(1) is effective as if included in the enactment of the Tax Reform Act of 1986 (Pub. L. 99-514), if H.Con.Res. 395, 99th Congress, 2d Session, is not adopted. H.Con.Res. 395 was not adopted.

Section 9314(b) of Pub. L. 99-509 provided that: “The amendments made by subsection (a) [amending this section] shall apply to payments for approved residency training programs as of July 1, 1987.”

Amendment by section 9320(g) of Pub. L. 99-509 applicable to services furnished on or after Jan. 1, 1989, with exceptions for hospitals located in rural areas which meet certain requirements related to certified registered nurse anesthetists, see section 9320(i), (k) of Pub. L. 99-509, as amended, set out as notes under section 1395k of this title.

Section 9321(e)(3)(B) of Pub. L. 99-509 provided that: “The amendments made by paragraph (2) [amending this section] shall take effect beginning with fiscal year 1989.”

Section 9101(d) of Pub. L. 99-272 provided that: “The amendment made by subsection (a) [amending section 5(c) of Pub. L. 99-107, set out below] shall take effect on March 15, 1986, and the amendments made by subsection (c) [amending this section] shall take effect on the date of the enactment of this Act [Apr. 7, 1986].”

Section 9101(e) of Pub. L. 99-272 provided that: “(1) PPS HOSPITALS, DRG PORTION OF PAYMENT.—In the case of a subsection (d) hospital (as defined in paragraph (4))—

“(A) the amendment made by subsection (b) [amending this section] shall apply to payments made under section 1886(d)(1)(A) of such Act [subsec. (d)(1)(A) of this section] made on the basis of discharges occurring on or after May 1, 1986; and

“(B) for discharges occurring on or after October 1, 1986, the applicable percentage increase (described in section 1886(b)(3)(B) [subsec. (b)(3)(B) of this section]) for discharges occurring during fiscal year 1986 shall be deemed to have been ½ percent.

“(2) PPS HOSPITALS, HOSPITAL SPECIFIC PORTION OF PAYMENT.—In the case of a subsection (d) hospital—

“(A) the amendment made by subsection (b) [amending this section] shall apply to payments under section 1886(d)(1)(A) of the Social Security Act [subsec. (d)(1)(A) of this section] made on the basis of discharges occurring during a cost reporting period of a hospital, for the hospital’s cost reporting periods beginning on or after October 1, 1985;

“(B) notwithstanding subparagraph (A), for the cost reporting period beginning during fiscal year 1986, the

applicable percentage increase (as defined in section 1886(b)(3)(B) of such Act [subsec. (b)(3)(B) of this section]) for the—

“(i) first 7 months of the cost reporting period shall be 0 percent, and

“(ii) for the remaining 5 months of the cost reporting period shall be ½ percent; and

“(C) for cost reporting periods beginning on or after October 1, 1986, the applicable percentage increase (as so defined) with respect to the previous cost reporting period shall be deemed to have been ½ percent.

“(3) PPS-EXEMPT HOSPITALS.—In the case of a hospital that is not a subsection (d) hospital—

“(A) the amendment made by subsection (b) [amending this section] shall apply to cost reporting periods beginning on or after October 1, 1985;

“(B) notwithstanding subparagraph (A), for the hospital's cost reporting period beginning during fiscal year 1986, payment under title XVIII of the Social Security Act [this subchapter] shall be made as though the applicable percentage increase described in section 1886(b)(3)(B) [subsec. (b)(3)(B) of this section] were equal to ¾ of 1 percent; and

“(C) for cost reporting periods beginning on or after October 1, 1986, the applicable percentage increase (as so defined) with respect to the cost reporting period beginning during fiscal year 1986 shall be deemed to have been ½ percent.

“(4) DEFINITION.—In this subsection, the term ‘subsection (d) hospital’ has the meaning given such term in section 1886(d)(1)(B) of the Social Security Act [subsec. (d)(1)(B) of this section].”

Section 9102(d) of Pub. L. 99-272 provided that:

“(1) DELAY IN FINAL TRANSITION.—The amendment made by subsection (a) [amending this section] shall take effect on the date of the enactment of this Act [Apr. 7, 1986].”

“(2) CHANGE IN HOSPITAL SPECIFIC PERCENTAGE.—The amendments made by subsection (b) [amending this section] shall apply—

“(A) to cost reporting periods beginning on or after October 1, 1985, but

“(B) notwithstanding subparagraph (A), for a hospital's cost reporting period beginning during fiscal year 1986, for purposes of section 1886(d)(1)(A) of the Social Security Act [subsec. (d)(1)(A) of this section]—

“(i) during the first 7 months of the period the ‘target percentage’ is 50 percent and the ‘DRG percentage’ is 50 percent, and

“(ii) during the remaining 5 months of the period the ‘target percentage’ is 45 percent and the ‘DRG percentage’ is 55 percent.

“(3) CHANGE IN BLENDED RATE.—The amendments made by subsection (c) [amending this section] shall apply to discharges occurring on or after May 1, 1986.

“(4) EXCEPTION.—

“(A) Notwithstanding any other provision of this subsection, the amendments made by this section [amending this section] shall not apply to payments with respect to the operating costs of inpatient hospital services (as defined in section 1886(a)(4) of the Social Security Act [subsec. (a)(4) of this section]) of a subsection (d) hospital (as defined in section 1886(d)(1)(B) of such Act [subsec. (d)(1)(B) of this section]) located in the State of Oregon.

“(B) Notwithstanding any other provision of law, for a cost reporting period beginning during fiscal year 1986 of a subsection (d) hospital to which the amendments made by this section [amending this section] do not apply, for purposes of section 1886(d)(1)(A) of of [sic] Social Security Act [subsec. (d)(1)(A) of this section]—

“(i) during the first 7 months of the period the ‘target percentage’ is 50 percent and the ‘DRG percentage’ is 50 percent, and

“(ii) during the remaining 5 months of the period the ‘target percentage’ is 25 percent and the ‘DRG percentage’ is 75 percent.

“(C) Notwithstanding any other provision of law, for purposes of section 1886(d)(1)(D) of such Act [sub-

sec. (d)(1)(D) of this section], the applicable combined adjusted DRG prospective payment rate for a subsection (d) hospital to which the amendments made by this section [amending this section] do not apply is, for discharges occurring on or after October 1, 1985, and before May 1, 1986, 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 for such discharges.”

Section 9104(c) of Pub. L. 99-272 provided that:

“(1) Except as provided in paragraph (2), the amendments made by this section [amending this section] shall apply to discharges occurring on or after May 1, 1986.

“(2) The amendments made by this section shall not first be applied to discharges occurring as of a date unless, for discharges occurring on that date, the amendments made by section 9105 [amending this section] are also being applied.”

Section 9105(e) of Pub. L. 99-272 provided that: “The amendments made by this section [amending this section] shall apply to discharges occurring on or after May 1, 1986.”

Section 9106(b) of Pub. L. 99-272 provided that: “The amendment made by subsection (a) [amending this section] shall apply to cost reporting periods beginning on or after January 1, 1986.”

Section 9107(c)(1) of Pub. L. 99-272 provided that: “The amendments made by subsection (a) [amending this section] shall apply to hospital cost reporting periods beginning on or after October 1, 1986.”

Section 9109(b) of Pub. L. 99-272 provided that: “The amendment made by subsection (a) [amending this section] shall take effect on the date of the enactment of this Act [Apr. 7, 1986].”

Section 9111(b) of Pub. L. 99-272 provided that: “The amendment made by this section [amending this section] shall apply to payments for cost reporting periods beginning on or after October 1, 1983, and before October 1, 1989.”

Section 9202(b) of Pub. L. 99-272 provided that: “The amendment made by subsection (a) [amending this section] shall apply to hospital cost reporting periods beginning on or after July 1, 1985.”

EFFECTIVE AND TERMINATION DATES OF 1984 AMENDMENTS

Amendment by Pub. L. 98-617 effective as if originally included in the Deficit Reduction Act of 1984, Pub. L. 98-369, see section 3(c) of Pub. L. 98-617, set out as a note under section 1395f of this title.

Section 2307(b)(2) of Pub. L. 98-369 provided that: “The amendment made by paragraph (1) [amending this section] shall apply to cost reporting periods beginning on or after October 1, 1984.”

Section 2310(b) of Pub. L. 98-369 provided that: “The amendments made by this section [amending this section] shall apply to cost reporting periods beginning in, and discharges occurring in, fiscal year 1985 and thereafter.”

Section 2311(d) of Pub. L. 98-369 provided that:

“(1) Except as provided in paragraph (2), the amendments made by subsections (b) and (c) [amending this section] shall be effective with respect to cost reporting periods beginning on or after October 1, 1983, and the amendment made by subsection (a) [amending this section] shall be effective with respect to cost reporting periods beginning on or after October 1, 1984.

“(2) The amendment made by subsection (b) [amending this section] shall not apply so as to reduce any payment under section 1886(d) of the Social Security Act [subsec. (d) of this section] to a hospital the region of which is deemed to be changed pursuant to such amendment for discharges occurring in any cost reporting period beginning before October 1, 1984.”

Section 2312(c) of Pub. L. 98-369, as amended by Pub. L. 99-509, title IX, §9320(a), Oct. 21, 1986, 100 Stat. 2013; Pub. L. 100-360, title IV, §411(p), July 1, 1988, as added by Pub. L. 100-485, title VI, §608(d)(29), Oct. 13, 1988, 102

Stat. 2424, provided that: “The amendments made by subsections (a) and (b) [amending this section] shall apply to cost reporting periods beginning on or after October 1, 1984, and before January 1, 1989. In the case of a cost reporting period that begins before January 1, 1989, but ends after such date, additional payments under the amendment made by subsection (a) shall be proportionately reduced to reflect the portion of the period occurring after such date.”

Amendment by section 2313(a), (b), (d) of Pub. L. 98-369 effective July 18, 1984, see section 2313(e) of Pub. L. 98-369, set out as an Effective Date of 1984 Amendment note under section 1395y of this title.

Section 2315(g) of Pub. L. 98-369 provided that: “The amendments made by this section [amending this section and sections 1395i-2 and 1395cc of this title and enacting and amending provisions set out as notes under this section] shall be effective as though they had been included in the enactment of the Social Security Amendments of 1983 (Public Law 98-21).”

Amendment by section 2354(b)(42)-(44) of Pub. L. 98-369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2354(e)(1) of Pub. L. 98-369, set out as an Effective Date of 1984 Amendment note under section 1320a-1 of this title.

EFFECTIVE DATE OF 1983 AMENDMENTS

Section 601(b)(9) of Pub. L. 98-21 provided that the repeal of subsec. (b)(6) of this section is effective with respect to cost reporting periods beginning on or after October 1, 1982, and that the enactment of a new subsec. (b)(6) of this section is effective with respect to cost reporting periods beginning on or after October 1, 1983.

Section 604 of title VI of Pub. L. 98-21, as amended by Pub. L. 98-369, div. B, title III, § 2315(f)(1), July 18, 1984, 98 Stat. 1080, provided that:

“(a)(1) Except as provided in section 602(l) [amending section 1395cc of this title] and in paragraph (2), the amendments made by the preceding provisions of this title [amending this section and sections 1320c-2, 1395f, 1395n, 1395x, 1395y, 1395cc, 1395mm, 1395oo, 1395rr, and 1395xx of this title] apply to items and services furnished by or under arrangements with a hospital beginning with its first cost reporting period that begins on or after October 1, 1983. A change in a hospital’s cost reporting period that has been made after November 1982 shall be recognized for purposes of this section only if the Secretary finds good cause for that change.

“(2) Section 1866(a)(1)(F) of the Social Security Act [section 1395cc(a)(1)(F) of this title] (as added by section 602(f)(1)(C) of this title), section 1862(a)(14) [section 1395y(a)(14) of this title] (as added by section 602(e)(3) of this title) and sections 1866(a)(1)(G) and (H) of such Act [probably should be section 1866(a)(1)(G) and (H) which is classified to section 1395cc(a)(1)(G) and (H) of this title] (as added by section 602(f)(1)(C) of this title) take effect on October 1, 1983.

“(b) The Secretary shall make an appropriate reduction in the payment amount under section 1886(d) of the Social Security Act [subsec. (d) of this section] (as amended by this title) for any discharge, if the admission has occurred before a hospital’s first cost reporting period that begins after September 1983, to take into account amounts payable under title XVIII of that Act [this subchapter] (as in effect before the date of the enactment of this Act [Apr. 20, 1983]) for items and services furnished before that period.

“(c)(1) The Secretary shall cause to be published in the Federal Register a notice of the interim final DRG prospective payment rates established under subsection (d) of section 1886 of the Social Security Act [subsec. (d) of this section] (as amended by this title) no later than September 1, 1983, and allow for a period of public comment thereon. Payment on the basis of prospective rates shall become effective on October 1, 1983, without the necessity for consideration of comments received, but the Secretary shall, by notice published in the Federal Register, affirm or modify the amounts by December 31, 1983, after considering those comments.

“(2) A modification under paragraph (1) that reduces a prospective payment rate shall apply only to discharges occurring after 30 days after the date the notice of the modification is published in the Federal Register.

“(3) Rules to implement the amendments made by this title [amending this section and sections 1320a-1, 1320c-2, 1395f, 1395i-2, 1395n, 1395r, 1395v, 1395w, 1395x, 1395y, 1395cc, 1395mm, 1395oo, 1395rr, and 1395xx of this title, enacting provisions set out as notes under sections 1395r and 1395x of this title, and amending provisions set out as a note under section 1395x of this title] shall be established in accordance with the procedure described in this subsection.”

Amendment by Pub. L. 97-448 effective as if originally included as a part of this section as this section was added by the Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. 97-248, see section 309(c)(2) of Pub. L. 97-448, set out as a note under section 426-1 of this title.

EFFECTIVE DATE

Section 101(b)(1) of Pub. L. 97-248 provided that: “The amendments made by subsection (a) [enacting this section and amending section 1395x of this title] shall apply to cost reporting periods beginning on or after October 1, 1982.”

REGULATIONS

Section 4003(c) of Pub. L. 101-508 provided that: “The Secretary of Health and Human Services shall issue such regulations (on an interim or other basis) as may be necessary to implement this section [amending this section and enacting provisions set out as a note above].”

Section 2315(f)(2) of Pub. L. 98-369 provided that: “Notwithstanding section 604(c) of the Social Security Amendments of 1983 [section 604(c) of Pub. L. 98-21, set out above], the Secretary of Health and Human Services shall cause to be published in the Federal Register proposed regulations to carry out subsection (c) of section 1886 of the Social Security Act [subsec. (c) of this section] not later than July 1, 1984, and allow for a period of 45 days for public comment thereon. After consideration of the comments received, the Secretary shall cause to be published in the Federal Register final regulations to carry out such subsection not later than October 1, 1984.”

Section 101(b)(2)(A) of Pub. L. 97-248 provided that: “The Secretary of Health and Human Services shall first issue such final regulations (whether on an interim or other basis) before October 1, 1982, as may be necessary to implement such amendments [amendments by section 101(a) of Pub. L. 97-248, enacting this section and amending section 1395x of this title] on a timely basis. If such regulations are promulgated on an interim final basis, the Secretary shall take such steps as may be necessary to provide opportunity for public comment, and appropriate revision based thereon, so as to provide that such regulations are not on an interim basis later than March 31, 1983.”

CONSTRUCTION OF 2010 AMENDMENT

Pub. L. 111-192, title I, § 102(e), June 25, 2010, 124 Stat. 1282, provided that: “Nothing in the amendments made by this section [amending this section] shall be construed as changing the policy described in section 1886(a)(4) of the Social Security Act (42 U.S.C. 1395ww(a)(4)), as applied by the Secretary of Health and Human Services before the date of the enactment of this Act [June 25, 2010], with respect to diagnostic services.”

Pub. L. 111-148, title V, § 5504(c), Mar. 23, 2010, 124 Stat. 660, provided that: “The amendments made by this section [amending this section] shall not be applied in a manner that requires reopening of any settled hospital cost reports as to which there is not a jurisdictionally proper appeal pending as of the date of the enactment of this Act [Mar. 23, 2010] on the issue of payment for indirect costs of medical education under

section 1886(d)(5)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)) or for direct graduate medical education costs under section 1886(h) of such Act (42 U.S.C. 1395ww(h)).”

Pub. L. 111-148, title V, §5505(d), title X, §10501(j), Mar. 23, 2010, 124 Stat. 999, provided that: “The amendments made by this section [amending this section] shall not be applied in a manner that requires reopening of any settled cost reports as to which there is not a jurisdictionally proper appeal pending as of the date of the enactment of this Act [Mar. 23, 2010] on the issue of payment for indirect costs of medical education under section 1886(d)(5)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)) or for direct graduate medical education costs under section 1886(h) of such Act (42 U.S.C. 1395ww(h)).”

Pub. L. 111-148, title V, §5506(c), Mar. 23, 2010, 124 Stat. 662, provided that: “The amendments made by this section [amending this section] shall not be applied in a manner that requires reopening of any settled hospital cost reports as to which there is not a jurisdictionally proper appeal pending as of the date of the enactment of this Act [Mar. 23, 2010] on the issue of payment for indirect costs of medical education under section 1886(d)(5)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)) or for direct graduate medical education costs under section 1886(h) of such Act (42 U.S.C. Section [sic] 1395ww(h)).”

TRANSFER OF FUNCTIONS

Prospective Payment Assessment Commission (ProPAC) was terminated and its assets and staff transferred to the Medicare Payment Advisory Commission (MedPAC) by section 4022(c)(2), (3) of Pub. L. 105-33, set out as a note under section 1395b-6 of this title. Section 4022(c)(2), (3) further provided that MedPAC was to be responsible for preparation and submission of reports required by law to be submitted by ProPAC, and that, for that purpose, any reference in law to ProPAC was to be deemed, after the appointment of MedPAC, to refer to MedPAC.

SPECIAL RULE FOR FISCAL YEAR 2011 AND ADJUSTMENT FOR CERTAIN HOSPITALS IN FISCAL YEAR 2011

Pub. L. 111-309, title I, §102(a)(2), (3), Dec. 15, 2010, 124 Stat. 3286, provided that:

“(2) SPECIAL RULE FOR FISCAL YEAR 2011.—

“(A) IN GENERAL.—Subject to subparagraph (B), for purposes of implementation of the amendment made by paragraph (1) [amending section 106(a) of div. B of Pub. L. 109-432, set out as a note under this section], including (notwithstanding paragraph (3) of section 117(a) of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110-173) [set out as a note under this section], as amended by section 124(b) of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110-275)] for purposes of the implementation of paragraph (2) of such section 117(a), during fiscal year 2011, the Secretary of Health and Human Services shall use the hospital wage index that was promulgated by the Secretary of Health and Human Services in the Federal Register on August 16, 2010 (75 Fed. Reg. 50042), and any subsequent corrections.

“(B) EXCEPTION.—Beginning on April 1, 2011, in determining the wage index applicable to hospitals that qualify for wage index reclassification, the Secretary shall include the average hourly wage data of hospitals whose reclassification was extended pursuant to the amendment made by paragraph (1) only if including such data results in a higher applicable reclassified wage index. Any revision to hospital wage indexes made as a result of this subparagraph shall not be effected in a budget neutral manner.

“(3) ADJUSTMENT FOR CERTAIN HOSPITALS IN FISCAL YEAR 2011.—

“(A) IN GENERAL.—In the case of a subsection (d) hospital (as defined in subsection (d)(1)(B) of section 1886 of the Social Security Act (42 U.S.C. 1395ww)) with respect to which—

“(i) a reclassification of its wage index for purposes of such section was extended pursuant to the amendment made by paragraph (1); and

“(ii) the wage index applicable for such hospital for the period beginning on October 1, 2010, and ending on March 31, 2011, was lower than for the period beginning on April 1, 2011, and ending on September 30, 2011, by reason of the application of paragraph (2)(B);

“the Secretary shall pay such hospital an additional payment that reflects the difference between the wage index for such periods.

“(B) TIMEFRAME FOR PAYMENTS.—The Secretary shall make payments required under subparagraph (A) by not later than December 31, 2011.”

Similar provisions were contained in Pub. L. 111-148, title III, §3137(a)(2), (3), title X, §10317, Mar. 23, 2010, 124 Stat. 438, 947.

NO REOPENING OF PREVIOUSLY BUNDLED CLAIMS

Pub. L. 111-192, title I, §102(c), June 25, 2010, 124 Stat. 1281, provided that:

“(1) IN GENERAL.—The Secretary of Health and Human Services may not reopen a claim, adjust a claim, or make a payment pursuant to any request for payment under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.], submitted by an entity (including a hospital or an entity wholly owned or operated by the hospital) for services described in paragraph (2) for purposes of treating, as unrelated to a patient’s inpatient admission, services provided 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 inpatient admission.

“(2) SERVICES DESCRIBED.—For purposes of paragraph (1), the services described in this paragraph are other services related to the admission (as described in section 1886(a)(4) of the Social Security Act (42 U.S.C. 1395ww(a)(4)), as amended by subsection (a)) which were previously included on a claim or request for payment submitted under part A of title XVIII of such Act [42 U.S.C. 1395c et seq.] for which a reopening, adjustment, or request for payment under part B of such title [42 U.S.C. 1395j et seq.], was not submitted prior to the date of the enactment of this Act [June 25, 2010].”

IMPLEMENTATION OF AMENDMENT BY PUB. L. 111-192

Pub. L. 111-192, title I, §102(d), June 25, 2010, 124 Stat. 1281, provided that: “Notwithstanding any other provision of law, the Secretary of Health and Human Services may implement the provisions of this section [amending this section and enacting provisions set out as notes under this section] (and amendments made by this section) by program instruction or otherwise.”

PAYMENT FOR QUALIFYING HOSPITALS

Pub. L. 111-152, title I, §1109, Mar. 30, 2010, 124 Stat. 1051, provided that:

“(a) IN GENERAL.—From the amount available under subsection (b), the Secretary of Health and Human Services shall provide for a payment to qualifying hospitals (as defined in subsection (d)) for fiscal years 2011 and 2012 of the amount determined under subsection (c).

“(b) AMOUNTS AVAILABLE.—There shall be available from the Federal Hospital Insurance Trust Fund \$400,000,000 for payments under this section for fiscal years 2011 and 2012.

“(c) PAYMENT AMOUNT.—The amount of payment under this section for a qualifying hospital shall be determined, in a manner consistent with the amount available under subsection (b), in proportion to the portion of the amount of the aggregate payments under section 1886(d) of the Social Security Act [42 U.S.C. 1395ww(d)] to the hospital for fiscal year 2009 bears to the sum of all such payments to all qualifying hospitals for such fiscal year.

“(d) QUALIFYING HOSPITAL DEFINED.—In this section, the term ‘qualifying hospital’ means a subsection (d)

hospital (as defined for purposes of section 1886(d) of the Social Security Act) that is located in a county that ranks, based upon its ranking in age, sex, and race adjusted spending for benefits under parts A and B under title XVIII of such Act [42 U.S.C. 1395c et seq.; 42 U.S.C. 1395j et seq.] per enrollee, within the lowest quartile of such counties in the United States.”

VALUE-BASED PURCHASING DEMONSTRATION PROGRAMS

Pub. L. 111-148, title III, §3001(b), Mar. 23, 2010, 124 Stat. 362, provided that:

“(1) VALUE-BASED PURCHASING DEMONSTRATION PROGRAM FOR INPATIENT CRITICAL ACCESS HOSPITALS.—

“(A) ESTABLISHMENT.—

“(i) IN GENERAL.—Not later than 2 years after the date of enactment of this Act [Mar. 23, 2010], the Secretary of Health and Human Services (in this subsection referred to as the ‘Secretary’) shall establish a demonstration program under which the Secretary establishes a value-based purchasing program under the Medicare program under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] for critical access hospitals (as defined in paragraph (1) of section 1861(mm) of such Act (42 U.S.C. 1395x(mm))) with respect to inpatient critical access hospital services (as defined in paragraph (2) of such section) in order to test innovative methods of measuring and rewarding quality and efficient health care furnished by such hospitals.

“(ii) DURATION.—The demonstration program under this paragraph shall be conducted for a 3-year period.

“(iii) SITES.—The Secretary shall conduct the demonstration program under this paragraph at an appropriate number (as determined by the Secretary) of critical access hospitals. The Secretary shall ensure that such hospitals are representative of the spectrum of such hospitals that participate in the Medicare program.

“(B) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act [42 U.S.C. 1301 et seq., 1395 et seq.] as may be necessary to carry out the demonstration program under this paragraph.

“(C) BUDGET NEUTRALITY REQUIREMENT.—In conducting the demonstration program under this section [amending this section and enacting this note], the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration program under this section was not implemented.

“(D) REPORT.—Not later than 18 months after the completion of the demonstration program under this paragraph, the Secretary shall submit to Congress a report on the demonstration program together with—

“(i) recommendations on the establishment of a permanent value-based purchasing program under the Medicare program for critical access hospitals with respect to inpatient critical access hospital services; and

“(ii) recommendations for such other legislation and administrative action as the Secretary determines appropriate.

“(2) VALUE-BASED PURCHASING DEMONSTRATION PROGRAM FOR HOSPITALS EXCLUDED FROM HOSPITAL VALUE-BASED PURCHASING PROGRAM AS A RESULT OF INSUFFICIENT NUMBERS OF MEASURES AND CASES.—

“(A) ESTABLISHMENT.—

“(i) IN GENERAL.—Not later than 2 years after the date of enactment of this Act [Mar. 23, 2010], the Secretary shall establish a demonstration program under which the Secretary establishes a value-based purchasing program under the Medicare program under title XVIII of the Social Security Act for applicable hospitals (as defined in clause (ii)) with respect to inpatient hospital services (as defined in section 1861(b) of the Social Security Act (42 U.S.C. 1395x(b))) in order to test innovative methods of measuring and rewarding quality and efficient health care furnished by such hospitals.

“(ii) APPLICABLE HOSPITAL DEFINED.—For purposes of this paragraph, the term ‘applicable hospital’ means a hospital described in subclause (III) or (IV) of section 1886(o)(1)(C)(ii) of the Social Security Act [42 U.S.C. 1395ww(o)(1)(C)(ii)], as added by subsection (a)(1).

“(iii) DURATION.—The demonstration program under this paragraph shall be conducted for a 3-year period.

“(iv) SITES.—The Secretary shall conduct the demonstration program under this paragraph at an appropriate number (as determined by the Secretary) of applicable hospitals. The Secretary shall ensure that such hospitals are representative of the spectrum of such hospitals that participate in the Medicare program.

“(B) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act [42 U.S.C. 1301 et seq., 1395 et seq.] as may be necessary to carry out the demonstration program under this paragraph.

“(C) BUDGET NEUTRALITY REQUIREMENT.—In conducting the demonstration program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration program under this section was not implemented.

“(D) REPORT.—Not later than 18 months after the completion of the demonstration program under this paragraph, the Secretary shall submit to Congress a report on the demonstration program together with—

“(i) recommendations on the establishment of a permanent value-based purchasing program under the Medicare program for applicable hospitals with respect to inpatient hospital services; and

“(ii) recommendations for such other legislation and administrative action as the Secretary determines appropriate.”

REFORMING THE MEDICARE HOSPITAL WAGE INDEX SYSTEM

Pub. L. 111-148, title III, §3137(b), (c), Mar. 23, 2010, 124 Stat. 438, 439, provided that:

“(b) PLAN FOR REFORMING THE MEDICARE HOSPITAL WAGE INDEX SYSTEM

“(1) IN GENERAL.—Not later than December 31, 2011, the Secretary of Health and Human Services (in this section referred to as the ‘Secretary’) shall submit to Congress a report that includes a plan to reform the hospital wage index system under section 1886 of the Social Security Act [42 U.S.C. 1395ww].

“(2) DETAILS.—In developing the plan under paragraph (1), the Secretary shall take into account the goals for reforming such system set forth in the Medicare Payment Advisory Commission June 2007 report entitled ‘Report to Congress: Promoting Greater Efficiency in Medicare’, including establishing a new hospital compensation index system that—

“(A) uses Bureau of Labor Statistics data, or other data or methodologies, to calculate relative wages for each geographic area involved;

“(B) minimizes wage index adjustments between and within metropolitan statistical areas and statewide rural areas;

“(C) includes methods to minimize the volatility of wage index adjustments that result from implementation of policy, while maintaining budget neutrality in applying such adjustments;

“(D) takes into account the effect that implementation of the system would have on health care providers and on each region of the country;

“(E) addresses issues related to occupational mix, such as staffing practices and ratios, and any evidence on the effect on quality of care or patient safety as a result of the implementation of the system; and

“(F) provides for a transition.

“(3) CONSULTATION.—In developing the plan under paragraph (1), the Secretary shall consult with relevant affected parties.

“(c) USE OF PARTICULAR CRITERIA FOR DETERMINING RECLASSIFICATIONS.—Notwithstanding any other provision of law, in making decisions on applications for reclassification of a subsection (d) hospital (as defined in paragraph (1)(B) of section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d))[]) for the purposes described in paragraph (10)(D)(v) of such section for fiscal year 2011 and each subsequent fiscal year (until the first fiscal year beginning on or after the date that is 1 year after the Secretary of Health and Human Services submits the report to Congress under subsection (b)), the Geographic Classification Review Board established under paragraph (10) of such section shall use the average hourly wage comparison criteria used in making such decisions as of September 30, 2008. The preceding sentence shall be effected in a budget neutral manner.”

APPLICATION OF BUDGET NEUTRALITY ON A NATIONAL BASIS IN THE CALCULATION OF THE MEDICARE HOSPITAL WAGE INDEX FLOOR

Pub. L. 111–148, title III, §3141, Mar. 23, 2010, 124 Stat. 441, provided that: “In the case of discharges occurring on or after October 1, 2010, for purposes of applying section 4410 of the Balanced Budget Act of 1997 [section 4410 of Pub. L. 105–33, set out as a note under this section] (42 U.S.C. 1395ww note) and paragraph (h)(4) of section 412.64 of title 42, Code of Federal Regulations, the Secretary of Health and Human Services shall administer subsection (b) of such section 4410 and paragraph (e) of such section 412.64 in the same manner as the Secretary administered such subsection (b) and paragraph (e) for discharges occurring during fiscal year 2008 (through a uniform, national adjustment to the area wage index).”

EFFECT ON TEMPORARY FTE CAP ADJUSTMENTS

Pub. L. 111–148, title V, §5506(d), Mar. 23, 2010, 124 Stat. 662, provided that: “The Secretary of Health and Human Services shall give consideration to the effect of the amendments made by this section [amending this section] on any temporary adjustment to a hospital’s FTE cap under section 413.79(h) of title 42, Code of Federal Regulations (as in effect on the date of enactment of this Act [Mar. 23, 2010]) in order to ensure that there is no duplication of FTE slots. Such amendments shall not affect the application of section 1886(h)(4)(H)(v) of the Social Security Act (42 U.S.C. 1395ww(h)(4)(H)(v)).”

GRADUATE NURSE EDUCATION DEMONSTRATION

Pub. L. 111–148, title V, §5509, Mar. 23, 2010, 124 Stat. 674, provided that:

“(a) IN GENERAL.—

“(1) ESTABLISHMENT.—

“(A) IN GENERAL.—The Secretary shall establish a graduate nurse education demonstration under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) under which an eligible hospital may receive payment for the hospital’s reasonable costs (described in paragraph (2)) for the provision of qualified clinical training to advance practice nurses.

“(B) NUMBER.—The demonstration shall include up to 5 eligible hospitals.

“(C) WRITTEN AGREEMENTS.—Eligible hospitals selected to participate in the demonstration shall enter into written agreements pursuant to subsection (b) in order to reimburse the eligible partners of the hospital the share of the costs attributable to each partner.

“(2) COSTS DESCRIBED.—

“(A) IN GENERAL.—Subject to subparagraph (B) and subsection (d), the costs described in this paragraph are the reasonable costs (as described in section 1861(v) of the Social Security Act (42 U.S.C. 1395x(v))) of each eligible hospital for the clinical training costs (as determined by the Secretary) that are attributable to providing advanced practice registered nurses with qualified training.

“(B) LIMITATION.—With respect to a year, the amount reimbursed under subparagraph (A) may not exceed the amount of costs described in subparagraph (A) that are attributable to an increase in the number of advanced practice registered nurses enrolled in a program that provides qualified training during the year and for which the hospital is being reimbursed under the demonstration, as compared to the average number of advanced practice registered nurses who graduated in each year during the period beginning on January 1, 2006, and ending on December 31, 2010 (as determined by the Secretary) from the graduate nursing education program operated by the applicable school of nursing that is an eligible partner of the hospital for purposes of the demonstration.

“(3) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act [42 U.S.C. 1301 et seq., 1395 et seq.] as may be necessary to carry out the demonstration.

“(4) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to the implementation of this section.

“(b) WRITTEN AGREEMENTS WITH ELIGIBLE PARTNERS.—No payment shall be made under this section to an eligible hospital unless such hospital has in effect a written agreement with the eligible partners of the hospital. Such written agreement shall describe, at a minimum—

“(1) the obligations of the eligible partners with respect to the provision of qualified training; and

“(2) the obligation of the eligible hospital to reimburse such eligible partners applicable (in a timely manner) for the costs of such qualified training attributable to partner.

“(c) EVALUATION.—Not later than October 17, 2017, the Secretary shall submit to Congress a report on the demonstration. Such report shall include an analysis of the following:

“(1) The growth in the number of advanced practice registered nurses with respect to a specific base year as a result of the demonstration.

“(2) The growth for each of the specialties described in subparagraphs (A) through (D) of subsection (e)(1).

“(3) The costs to the Medicare program under title XVIII of the Social Security Act as a result of the demonstration.

“(4) Other items the Secretary determines appropriate and relevant.

“(d) FUNDING.—

“(1) IN GENERAL.—There is hereby appropriated to the Secretary, out of any funds in the Treasury not otherwise appropriated, \$50,000,000 for each of fiscal years 2012 through 2015 to carry out this section, including the design, implementation, monitoring, and evaluation of the demonstration.

“(2) PRORATION.—If the aggregate payments to eligible hospitals under the demonstration exceed \$50,000,000 for a fiscal year described in paragraph (1), the Secretary shall prorate the payment amounts to each eligible hospital in order to ensure that the aggregate payments do not exceed such amount.

“(3) WITHOUT FISCAL YEAR LIMITATION.—Amounts appropriated under this subsection shall remain available without fiscal year limitation.

“(e) DEFINITIONS.—In this section:

“(1) ADVANCED PRACTICE REGISTERED NURSE.—The term ‘advanced practice registered nurse’ includes the following:

“(A) A clinical nurse specialist (as defined in subsection (aa)(5) of section 1861 of the Social Security Act (42 U.S.C. 1395x)).

“(B) A nurse practitioner (as defined in such subsection).

“(C) A certified registered nurse anesthetist (as defined in subsection (bb)(2) of such section).

“(D) A certified nurse-midwife (as defined in subsection (gg)(2) of such section).

“(2) APPLICABLE NON-HOSPITAL COMMUNITY-BASED CARE SETTING.—The term ‘applicable non-hospital

community-based care setting' means a non-hospital community-based care setting which has entered into a written agreement (as described in subsection (b)) with the eligible hospital participating in the demonstration. Such settings include Federally qualified health centers, rural health clinics, and other non-hospital settings as determined appropriate by the Secretary.

“(3) APPLICABLE SCHOOL OF NURSING.—The term ‘applicable school of nursing’ means an accredited school of nursing (as defined in section 801 of the Public Health Service Act [42 U.S.C. 296]) which has entered into a written agreement (as described in subsection (b)) with the eligible hospital participating in the demonstration.

“(4) DEMONSTRATION.—The term ‘demonstration’ means the graduate nurse education demonstration established under subsection (a).

“(5) ELIGIBLE HOSPITAL.—The term ‘eligible hospital’ means a hospital (as defined in subsection (e) of section 1861 of the Social Security Act (42 U.S.C. 1395x) or a critical access hospital (as defined in subsection (mm)(1) of such section) that has a written agreement in place with—

“(A) 1 or more applicable schools of nursing; and

“(B) 2 or more applicable non-hospital community-based care settings.

“(6) ELIGIBLE PARTNERS.—The term ‘eligible partners’ includes the following:

“(A) An applicable non-hospital community-based care setting.

“(B) An applicable school of nursing.

“(7) QUALIFIED TRAINING.—

“(A) IN GENERAL.—The term ‘qualified training’ means training—

“(i) that provides an advanced practice registered nurse with the clinical skills necessary to provide primary care, preventive care, transitional care, chronic care management, and other services appropriate for individuals entitled to, or enrolled for, benefits under part A of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq.], or enrolled under part B of such title [42 U.S.C. 1395j et seq.]; and

“(ii) subject to subparagraph (B), at least half of which is provided in a non-hospital community-based care setting.

“(B) WAIVER OF REQUIREMENT HALF OF TRAINING BE PROVIDED IN NON-HOSPITAL COMMUNITY-BASED CARE SETTING IN CERTAIN AREAS.—The Secretary may waive the requirement under subparagraph (A)(ii) with respect to eligible hospitals located in rural or medically underserved areas.

“(8) SECRETARY.—The term ‘Secretary’ means the Secretary of Health and Human Services.”

PAYMENT FOR LONG-TERM CARE HOSPITAL SERVICES

Pub. L. 110-173, title I, §114(c), Dec. 29, 2007, 121 Stat. 2502, as amended by Pub. L. 111-5, div. B, title IV, §4302(a), Feb. 17, 2009, 123 Stat. 495; Pub. L. 111-148, title III, §3106(a), title X, §10312(a), Mar. 23, 2010, 124 Stat. 418, 943, provided that:

“(1) DELAY IN APPLICATION OF 25 PERCENT PATIENT THRESHOLD PAYMENT ADJUSTMENT.—The Secretary [of Health and Human Services] shall not apply, for cost reporting periods beginning on or after July 1, 2007, for a 5-year period—

“(A) section 412.536 of title 42, Code of Federal Regulations, or any similar provision, to freestanding long-term care hospitals or to a long-term care hospital, or satellite facility, that as of December 29, 2007, was co-located with an entity that is a provider-based, off-campus location of a subsection (d) hospital which did not provide services payable under section 1886(d) of the Social Security Act [42 U.S.C. 1395ww(d)] at the off-campus location; and

“(B) such section or section 412.534 of title 42, Code of Federal Regulations, or any similar provisions, to a long-term care hospital identified by the amendment made by section 4417(a) of the Balanced Budget

Act of 1997 (Public Law 105-33) [amending this section and enacting provisions set out as a note under this section].

“(2) PAYMENT FOR HOSPITALS-WITHIN-HOSPITALS.—

“(A) IN GENERAL.—Payment to an applicable long-term care hospital or satellite facility which is located in a rural area or which is co-located with an urban single or MSA dominant hospital under paragraphs (d)(1), (e)(1), and (e)(4) of section 412.534 of title 42, Code of Federal Regulations, shall not be subject to any payment adjustment under such section if no more than 75 percent of the hospital’s Medicare discharges (other than discharges described in paragraph (d)(2) or (e)(3) of such section) are admitted from a co-located hospital.

“(B) CO-LOCATED LONG-TERM CARE HOSPITALS AND SATELLITE FACILITIES.—

“(i) IN GENERAL.—Payment to an applicable long-term care hospital or satellite facility which is co-located with another hospital shall not be subject to any payment adjustment under section 412.534 of title 42, Code of Federal Regulations, if no more than 50 percent of the hospital’s Medicare discharges (other than discharges described in paragraph (c)(3) of such section) are admitted from a co-located hospital.

“(ii) APPLICABLE LONG-TERM CARE HOSPITAL OR SATELLITE FACILITY DEFINED.—In this paragraph, the term ‘applicable long-term care hospital or satellite facility’ means a hospital or satellite facility that is subject to the transition rules under section 412.534(g) of title 42, Code of Federal Regulations or that is described in section 412.22(h)(3)(i) of such title.

“(C) EFFECTIVE DATE.—Subparagraphs (A) and (B) shall apply to cost reporting periods beginning on or after October 1, 2007 (or July 1, 2007, in the case of a satellite facility described in section 412.22(h)(3)(i) of title 42, Code of Federal Regulations) for a 5-year period.

“(3) NO APPLICATION OF VERY SHORT-STAY OUTLIER POLICY.—The Secretary shall not apply, for the 5-year period beginning on the date of the enactment of this Act, the amendments finalized on May 11, 2007 (72 Federal Register 26904, 26992) made to the short-stay outlier payment provision for long-term care hospitals contained in section 412.529(c)(3)(i) of title 42, Code of Federal Regulations, or any similar provision.

“(4) NO APPLICATION OF ONE-TIME ADJUSTMENT TO STANDARD AMOUNT.—The Secretary shall not, for the 5-year period beginning on the date of the enactment of this Act, make the one-time prospective adjustment to long-term care hospital prospective payment rates provided for in section 412.523(d)(3) of title 42, Code of Federal Regulations, or any similar provision.”

[Pub. L. 111-5, div. B, title IV, §4302(c), Feb. 17, 2009, 123 Stat. 496, provided that: “The amendments made by this section [amending Pub. L. 110-173, §114(c), set out above, and Pub. L. 110-173, §114(d), set out below] shall be effective and apply as if included in the enactment of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110-173).”]

MORATORIUM ON THE ESTABLISHMENT OF LONG-TERM CARE HOSPITALS, LONG-TERM CARE SATELLITE FACILITIES AND ON THE INCREASE OF LONG-TERM CARE HOSPITAL BEDS IN EXISTING LONG-TERM CARE HOSPITALS OR SATELLITE FACILITIES

Pub. L. 110-173, title I, §114(d), Dec. 29, 2007, 121 Stat. 2503, as amended by Pub. L. 111-5, div. B, title IV, §4302(b), Feb. 17, 2009, 123 Stat. 496; Pub. L. 111-148, title III, §3106(b), title X, §10312(b), Mar. 23, 2010, 124 Stat. 418, 943, provided that:

“(1) IN GENERAL.—During the 5-year period beginning on the date of the enactment of this Act [Dec. 29, 2007], the Secretary [of Health and Human Services] shall impose a moratorium for purposes of the Medicare program under title XVIII of the Social Security Act [this subchapter]—

“(A) subject to paragraph (2), on the establishment and classification of a long-term care hospital or sat-

elite facility, other than an existing long-term care hospital or facility; and

“(B) subject to paragraph (3), on an increase of long-term care hospital beds in existing long-term care hospitals or satellite facilities.

“(2) EXCEPTION FOR CERTAIN LONG-TERM CARE HOSPITALS.—The moratorium under paragraph (1)(A) shall not apply to a long-term care hospital that as of the date of the enactment of this Act—

“(A) began its qualifying period for payment as a long-term care hospital under section 412.23(e) of title 42, Code of Federal Regulations, on or before the date of the enactment of this Act;

“(B) has a binding written agreement with an outside, unrelated party for the actual construction, renovation, lease, or demolition for a long-term care hospital, and has expended, before the date of the enactment of this Act, at least 10 percent of the estimated cost of the project (or, if less, \$2,500,000); or

“(C) has obtained an approved certificate of need in a State where one is required on or before the date of the enactment of this Act.

“(3) EXCEPTION FOR BED INCREASES DURING MORATORIUM.—

“(A) IN GENERAL.—Subject to subparagraph (B), the moratorium under paragraph (1)(B) shall not apply to an increase in beds in an existing hospital or satellite facility if the hospital or facility obtained a certificate of need for an increase in beds that is in a State for which such certificate of need is required and that was issued on or after April 1, 2005, and before December 29, 2007, or if the hospital or facility—

“(i) is located in a State where there is only one other long-term care hospital; and

“(ii) requests an increase in beds following the closure or the decrease in the number of beds of another long-term care hospital in the State.

“(B) NO EFFECT ON CERTAIN LIMITATION.—The exception under subparagraph (A) shall not effect the limitation on increasing beds under sections 412.22(h)(3) and 412.22(f) of title 42, Code of Federal Regulations.

“(4) EXISTING HOSPITAL OR SATELLITE FACILITY DEFINED.—For purposes of this subsection, the term ‘existing’ means, with respect to a hospital or satellite facility, a hospital or satellite facility that received payment under the provisions of subpart O of part 412 of title 42, Code of Federal Regulations, as of the date of the enactment of this Act.

“(5) JUDICIAL REVIEW.—There shall be no administrative or judicial review under section 1869 of the Social Security Act (42 U.S.C. 1395ff), section 1878 of such Act (42 U.S.C. 1395oo), or otherwise, of the application of this subsection by the Secretary.”

[For effective date of amendment by Pub. L. 111–5, see section 4302(c) of Pub. L. 111–5, set out as a note following section 114(c) of Pub. L. 110–173, set out above.]

EXPANDED REVIEW OF MEDICAL NECESSITY

Pub. L. 110–173, title I, § 114(f), Dec. 29, 2007, 121 Stat. 2505, provided that:

“(1) IN GENERAL.—The Secretary of Health and Human Services shall provide, under contracts with one or more appropriate fiscal intermediaries or medicare administrative contractors under section 1874A(a)(4)(G) of the Social Security Act (42 U.S.C. 1395kk–1(a)(4)(G)), for reviews of the medical necessity of admissions to long-term care hospitals (described in section 1886(d)(1)(B)(iv) of such Act [subsec. (d)(1)(B)(iv) of this section]) and continued stay at such hospitals, of individuals entitled to, or enrolled for, benefits under part A of title XVIII of such Act [part A of this subchapter] consistent with this subsection. Such reviews shall be made for discharges occurring on or after October 1, 2007.

“(2) REVIEW METHODOLOGY.—The medical necessity reviews under paragraph (1) shall be conducted on an annual basis in accordance with rules specified by the Secretary. Such reviews shall—

“(A) provide for a statistically valid and representative sample of admissions of such individuals suffi-

cient to provide results at a 95 percent confidence interval; and

“(B) guarantee that at least 75 percent of overpayments received by long-term care hospitals for medically unnecessary admissions and continued stays of individuals in long-term care hospitals will be identified and recovered and that related days of care will not be counted toward the length of stay requirement contained in section 1886(d)(1)(B)(iv) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)(iv)).

“(3) CONTINUATION OF REVIEWS.—Under contracts under this subsection, the Secretary shall establish an error rate with respect to such reviews that could require further review of the medical necessity of admissions and continued stay in the hospital involved and other actions as determined by the Secretary.

“(4) TERMINATION OF REQUIRED REVIEWS.—

“(A) IN GENERAL.—Subject to subparagraph (B), the previous provisions of this subsection shall cease to apply for discharges occurring on or after October 1, 2010.

“(B) CONTINUATION.—As of the date specified in subparagraph (A), the Secretary shall determine whether to continue to guarantee, through continued medical review and sampling under this paragraph, recovery of at least 75 percent of overpayments received by long-term care hospitals due to medically unnecessary admissions and continued stays.

“(5) FUNDING.—The costs to fiscal intermediaries or medicare administrative contractors conducting the medical necessity reviews under paragraph (1) shall be funded from the aggregate overpayments recouped by the Secretary of Health and Human Services from long-term care hospitals due to medically unnecessary admissions and continued stays. The Secretary may use an amount not in excess of 40 percent of the overpayments recouped under this paragraph to compensate the fiscal intermediaries or Medicare administrative contractors for the costs of services performed.”

EXTENDING CERTAIN MEDICARE HOSPITAL WAGE INDEX RECLASSIFICATIONS

Pub. L. 110–173, title I, § 117(a)(2), (3), Dec. 29, 2007, 121 Stat. 2507, as amended by Pub. L. 110–275, title I, § 124(b), July 15, 2008, 122 Stat. 2518; Pub. L. 111–309, title I, § 102(b), Dec. 15, 2010, 124 Stat. 3287, provided that:

“(2) SPECIAL EXCEPTION RECLASSIFICATIONS.—The Secretary of Health and Human Services shall extend for discharges occurring through the last date of the extension of reclassifications under section 106(a) of the Medicare Improvement[s] and Extension Act of 2006 (division B of Public Law 109–432) [set out below], the special exception reclassifications made under the authority of section 1886(d)(5)(I)(i) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(I)(i)) and contained in the final rule promulgated by the Secretary in the Federal Register on August 11, 2004 (69 Fed. Reg. 49105, 49107).

“(3) USE OF PARTICULAR WAGE INDEX.—For purposes of implementation of this subsection [par. (1) of this subsection amended section 106(a) of Pub. L. 109–432, set out below] in fiscal years 2008 and 2009, the Secretary shall use the hospital wage index that was promulgated by the Secretary in the Federal Register on October 10, 2007 (72 Fed. Reg. 57634), and any subsequent corrections.”

CORRECTION OF APPLICATION OF WAGE INDEX DURING TAX RELIEF AND HEALTH CARE ACT EXTENSION

Pub. L. 110–173, title I, § 117(c), Dec. 29, 2007, 121 Stat. 2508, provided that: “In the case of a subsection (d) hospital (as defined for purposes of section 1886 of the Social Security Act (42 U.S.C. 1395ww)) with respect to which—

“(1) a reclassification of its wage index for purposes of such section was extended for the period beginning on April 1, 2007, and ending on September 30, 2007, pursuant to subsection (a) of section 106 of division B of the Tax Relief and Health Care Act of 2006 [Pub. L. 109–432] (42 U.S.C. 1395[ww] note); and

“(2) the wage index applicable for such hospital during such period was lower than the wage index applicable for such hospital during the period beginning on October 1, 2006, and ending on March 31, 2007, the Secretary [of Health and Human Services] shall apply the higher wage index that was applicable for such hospital during the period beginning on October 1, 2006, and ending on March 31, 2007, for the entire fiscal year 2007. If the Secretary determines that the application of the preceding sentence to a hospital will result in a hospital being owed additional reimbursement, the Secretary shall make such payments within 90 days after the settlement of the applicable cost report.”

CORRECTION OF MID-YEAR RECLASSIFICATION EXPIRATION

Pub. L. 109-432, div. B, title I, §106(a), Dec. 20, 2006, 120 Stat. 2982, as amended by Pub. L. 110-173, title I, §117(a)(1), Dec. 29, 2007, 121 Stat. 2507; Pub. L. 110-275, title I, §124(a), July 15, 2008, 122 Stat. 2518; Pub. L. 111-148, title III, §3137(a)(1), title X, §10317, Mar. 23, 2010, 124 Stat. 438, 947; Pub. L. 111-309, title I, §102(a)(1), Dec. 15, 2010, 124 Stat. 3286, provided that: “Notwithstanding any other provision of law, in the case of a subsection (d) hospital (as defined for purposes of section 1886 of the Social Security Act (42 U.S.C. 1395ww)) with respect to which a reclassification of its wage index for purposes of such section would (but for this subsection) expire on March 31, 2007, such reclassification of such hospital shall be extended through September 30, 2011. The previous sentence shall not be effected in a budget-neutral manner.”

PLAN FOR HOSPITAL VALUE BASED PURCHASING PROGRAM

Pub. L. 109-171, title V, §5001(b), Feb. 8, 2006, 120 Stat. 29, provided that:

“(1) IN GENERAL.—The Secretary of Health and Human Services shall develop a plan to implement a value based purchasing program for payments under the Medicare program for subsection (d) hospitals beginning with fiscal year 2009.

“(2) DETAILS.—Such a plan shall include consideration of the following issues:

“(A) The on-going development, selection, and modification process for measures of quality and efficiency in hospital inpatient settings.

“(B) The reporting, collection, and validation of quality data.

“(C) The structure of value based payment adjustments, including the determination of thresholds or improvements in quality that would substantiate a payment adjustment, the size of such payments, and the sources of funding for the value based payments.

“(D) The disclosure of information on hospital performance.

In developing such a plan, the Secretary shall consult with relevant affected parties and shall consider experience with such demonstrations that are relevant to the value based purchasing program under this subsection.”

EXTENDED PHASE-IN OF THE INPATIENT REHABILITATION FACILITY CLASSIFICATION CRITERIA

Pub. L. 109-171, title V, §5005, Feb. 8, 2006, 120 Stat. 33, as amended by Pub. L. 110-173, title I, §115(b)(1), Dec. 29, 2007, 121 Stat. 2506, provided that:

“(a) IN GENERAL.—Notwithstanding section 412.23(b)(2) of title 42, Code of Federal Regulations, the Secretary of Health and Human Services shall require a compliance rate that is no greater than the 60 percent compliance rate that became effective for cost reporting periods beginning on or after July 1, 2006, in the classification criterion used under the IRF regulation (as defined in subsection (c)) to determine whether a hospital or unit of a hospital is an inpatient rehabilitation facility under the Medicare program under title XVIII of the Social Security Act [this subchapter].

“(b) CONTINUED USE OF COMORBIDITIES.—For cost reporting periods beginning on or after July 1, 2007, the

Secretary shall include patients with comorbidities as described in section 412.23(b)(2)(i) of title 42, Code of Federal Regulations (as in effect as of January 1, 2007), in the inpatient population that counts toward the percent specified in subsection (a).

“(c) IRF REGULATION.—For purposes of subsection (a), the term ‘IRF regulation’ means the rule published in the Federal Register on May 7, 2004, entitled ‘Medicare Program; Final Rule; Changes to the Criteria for Being Classified as an Inpatient Rehabilitation Facility’ (69 Fed. Reg. 25752).”

[Pub. L. 110-173, title I, §115(b)(2), Dec. 29, 2007, 121 Stat. 2506, provided that: “The amendment made by paragraph (1)(A) [amending section 5005(a) of Pub. L. 109-171, set out above] shall apply for cost reporting periods beginning on or after July 1, 2007.”]

MEDICARE DEMONSTRATION PROJECTS TO PERMIT GAINSHARING ARRANGEMENTS

Pub. L. 109-171, title V, §5007, Feb. 8, 2006, 120 Stat. 34, as amended by Pub. L. 111-148, title III, §3027, Mar. 23, 2010, 124 Stat. 415, provided that:

“(a) ESTABLISHMENT.—The Secretary shall establish under this section a qualified gainsharing demonstration program under which the Secretary shall approve demonstration projects by not later than November 1, 2006, to test and evaluate methodologies and arrangements between hospitals and physicians designed to govern the utilization of inpatient hospital resources and physician work to improve the quality and efficiency of care provided to Medicare beneficiaries and to develop improved operational and financial hospital performance with sharing of remuneration as specified in the project. Such projects shall be operational by not later than January 1, 2007.

“(b) REQUIREMENTS DESCRIBED.—A demonstration project under this section shall meet the following requirements for purposes of maintaining or improving quality while achieving cost savings:

“(1) ARRANGEMENT FOR REMUNERATION AS SHARE OF SAVINGS.—The demonstration project shall involve an arrangement between a hospital and a physician under which the hospital provides remuneration to the physician that represents solely a share of the savings incurred directly as a result of collaborative efforts between the hospital and the physician.

“(2) WRITTEN PLAN AGREEMENT.—The demonstration project shall be conducted pursuant to a written agreement that—

“(A) is submitted to the Secretary prior to implementation of the project; and

“(B) includes a plan outlining how the project will achieve improvements in quality and efficiency.

“(3) PATIENT NOTIFICATION.—The demonstration project shall include a notification process to inform patients who are treated in a hospital participating in the project of the participation of the hospital in such project.

“(4) MONITORING QUALITY AND EFFICIENCY OF CARE.—The demonstration project shall provide measures to ensure that the quality and efficiency of care provided to patients who are treated in a hospital participating in the demonstration project is continuously monitored to ensure that such quality and efficiency is maintained or improved.

“(5) INDEPENDENT REVIEW.—The demonstration project shall certify, prior to implementation, that the elements of the demonstration project are reviewed by an organization that is not affiliated with the hospital or the physician participating in the project.

“(6) REFERRAL LIMITATIONS.—The demonstration project shall not be structured in such a manner as to reward any physician participating in the project on the basis of the volume or value of referrals to the hospital by the physician.

“(c) WAIVER OF CERTAIN RESTRICTIONS.—

“(1) IN GENERAL.—An incentive payment made by a hospital to a physician under and in accordance with a demonstration project shall not constitute—

“(A) remuneration for purposes of section 1128B of the Social Security Act (42 U.S.C. 1320a-7b);

“(B) a payment intended to induce a physician to reduce or limit services to a patient entitled to benefits under Medicare or a State plan approved under title XIX of such Act [subchapter XIX of this chapter] in violation of section 1128A of such Act (42 U.S.C. 1320a-7a); or

“(C) a financial relationship for purposes of section 1877 of such Act (42 U.S.C. 1395nn).

“(2) PROTECTION FOR EXISTING ARRANGEMENTS.—In no case shall the failure to comply with the requirements described in paragraph (1) affect a finding made by the Inspector General of the Department of Health and Human Services prior to the date of the enactment of this Act [Feb. 8, 2006] that an arrangement between a hospital and a physician does not violate paragraph (1) or (2) of section 1128A(a) of the Social Security Act (42 U.S.C. 1320a-7(a) [42 U.S.C. 1320a-7a(a)]).

“(d) PROGRAM ADMINISTRATION.—

“(1) SOLICITATION OF APPLICATIONS.—By not later than 90 days after the date of the enactment of this Act [Feb. 8, 2006], the Secretary shall solicit applications for approval of a demonstration project, in such form and manner, and at such time specified by the Secretary.

“(2) NUMBER OF PROJECTS APPROVED.—The Secretary shall approve not more than 6 demonstration projects, at least 2 of which shall be located in a rural area.

“(3) DURATION.—The qualified gainsharing demonstration program under this section shall be conducted for the period beginning on January 1, 2007, and ending on December 31, 2009 (or September 30, 2011, in the case of a demonstration project in operation as of October 1, 2008).

“(e) REPORTS.—

“(1) INITIAL REPORT.—By not later than December 1, 2006, the Secretary shall submit to Congress a report on the number of demonstration projects that will be conducted under this section.

“(2) PROJECT UPDATE.—By not later than December 1, 2007, the Secretary shall submit to Congress a report on the details of such projects (including the project improvements towards quality and efficiency described in subsection (b)(2)(B)).

“(3) QUALITY IMPROVEMENT AND SAVINGS.—By not later than March 31, 2011, the Secretary shall submit to Congress a report on quality improvement and savings achieved as a result of the qualified gainsharing demonstration program established under subsection (a).

“(4) FINAL REPORT.—By not later than March 31, 2013, the Secretary shall submit to Congress a final report on the information described in paragraph (3).

“(f) FUNDING.—

“(1) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary for fiscal year 2006 \$6,000,000, and for fiscal year 2010, \$1,600,000, to carry out this section.

“(2) AVAILABILITY.—Funds appropriated under paragraph (1) shall remain available for expenditure through fiscal year 2014 or until expended.

“(g) DEFINITIONS.—For purposes of this section:

“(1) DEMONSTRATION PROJECT.—The term ‘demonstration project’ means a project implemented under the qualified gainsharing demonstration program established under subsection (a).

“(2) HOSPITAL.—The term ‘hospital’ means a hospital that receives payment under section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)), and does not include a critical access hospital (as defined in section 1861(mm) of such Act (42 U.S.C. 1395x(mm))).

“(3) MEDICARE.—The term ‘Medicare’ means the programs under title XVIII of the Social Security Act [this subchapter].

“(4) PHYSICIAN.—The term ‘physician’ means, with respect to a demonstration project, a physician de-

scribed in paragraph (1) or (3) of section 1861(r) of the Social Security Act (42 U.S.C. 1395x(r)) who is licensed as such a physician in the area in which the project is located and meets requirements to provide services for which benefits are provided under Medicare. Such term shall be deemed to include a practitioner described in section 1842(e)(18)(C) of such Act (42 U.S.C. 1395u(e)(18)(C)).

“(5) SECRETARY.—The term ‘Secretary’ means the Secretary of Health and Human Services.”

MORE FREQUENT UPDATE IN WEIGHTS USED IN HOSPITAL MARKET BASKET

Pub. L. 108-173, title IV, §404, Dec. 8, 2003, 117 Stat. 2266, provided that:

“(a) MORE FREQUENT UPDATES IN WEIGHTS.—After revising the weights used in the hospital market basket under section 1886(b)(3)(B)(iii) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)(iii)) to reflect the most current data available, the Secretary [of Health and Human Services] shall establish a frequency for revising such weights, including the labor share, in such market basket to reflect the most current data available more frequently than once every 5 years.

“(b) INCORPORATION OF EXPLANATION IN RULE-MAKING.—The Secretary shall include in the publication of the final rule for payment for inpatient hospital services under section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)) for fiscal year 2006, an explanation of the reasons for, and options considered, in determining frequency established under subsection (a).”

RURAL COMMUNITY HOSPITAL DEMONSTRATION PROGRAM

Pub. L. 108-173, title IV, §410A, Dec. 8, 2003, 117 Stat. 2272, as amended by Pub. L. 111-148, title III, §3123, title X, §10313, Mar. 23, 2010, 124 Stat. 423, 943, provided that:

“(a) ESTABLISHMENT OF RURAL COMMUNITY HOSPITAL (RCH) DEMONSTRATION PROGRAM.—

“(1) IN GENERAL.—The Secretary [of Health and Human Services] shall establish a demonstration program to test the feasibility and advisability of the establishment of rural community hospitals (as defined in subsection (f)(1)) to furnish covered inpatient hospital services (as defined in subsection (f)(2)) to medicare beneficiaries.

“(2) DEMONSTRATION AREAS.—The program shall be conducted in rural areas selected by the Secretary in States with low population densities, as determined by the Secretary.

“(3) APPLICATION.—Each rural community hospital that is located in a demonstration area selected under paragraph (2) that desires to participate in the demonstration program under this section shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

“(4) SELECTION OF HOSPITALS.—The Secretary shall select from among rural community hospitals submitting applications under paragraph (3) not more than 15 of such hospitals to participate in the demonstration program under this section.

“(5) DURATION.—The Secretary shall conduct the demonstration program under this section for a 5-year period (in this section referred to as the ‘initial 5-year period’) and, as provided in subsection (g), for the 5-year extension period.

“(6) IMPLEMENTATION.—The Secretary shall implement the demonstration program not later than January 1, 2005, but may not implement the program before October 1, 2004.

“(b) PAYMENT.—

“(1) IN GENERAL.—The amount of payment under the demonstration program for covered inpatient hospital services furnished in a rural community hospital, other than such services furnished in a psychiatric or rehabilitation unit of the hospital which is a distinct part, is—

“(A) for discharges occurring in the first cost reporting period beginning on or after the implemen-

tation of the demonstration program, the reasonable costs of providing such services; and

“(B) for discharges occurring in a subsequent cost reporting period under the demonstration program, the lesser of—

“(i) the reasonable costs of providing such services in the cost reporting period involved; or

“(ii) the target amount (as defined in paragraph (2)), applicable to the cost reporting period involved.

“(2) TARGET AMOUNT.—For purposes of paragraph (1)(B)(ii), the term ‘target amount’ means, with respect to a rural community hospital for a particular 12-month cost reporting period—

“(A) in the case of the second such cost reporting period for which this subsection is in effect, the reasonable costs of providing such covered inpatient hospital services as determined under paragraph (1)(A), and

“(B) in the case of a later cost reporting period, the target amount for the preceding 12-month cost reporting period,

increased by the applicable percentage increase (under clause (i) of section 1886(b)(3)(B) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B))) in the market basket percentage increase (as defined in clause (iii) of such section) for that particular cost reporting period.

“(c) FUNDING.—

“(1) IN GENERAL.—The Secretary shall provide for the transfer from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) of such funds as are necessary for the costs of carrying out the demonstration program under this section.

“(2) BUDGET NEUTRALITY.—In conducting the demonstration program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration program under this section was not implemented.

“(d) WAIVER AUTHORITY.—The Secretary may waive such requirements of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) as may be necessary for the purpose of carrying out the demonstration program under this section.

“(e) REPORT.—Not later than 6 months after the completion of the demonstration program under this section, the Secretary shall submit to Congress a report on such program, together with recommendations for such legislation and administrative action as the Secretary determines to be appropriate.

“(f) DEFINITIONS.—In this section:

“(1) RURAL COMMUNITY HOSPITAL DEFINED.—

“(A) IN GENERAL.—The term ‘rural community hospital’ means a hospital (as defined in section 1861(e) of the Social Security Act (42 U.S.C. 1395x(e))) that—

“(i) is located in a rural area (as defined in section 1886(d)(2)(D) of such Act (42 U.S.C. 1395ww(d)(2)(D))) or treated as being so located pursuant to section 1886(d)(8)(E) of such Act (42 U.S.C. 1395ww(d)(8)(E));

“(ii) subject to subparagraph (B), has fewer than 51 acute care inpatient beds, as reported in its most recent cost report;

“(iii) makes available 24-hour emergency care services; and

“(iv) is not eligible for designation, or has not been designated, as a critical access hospital under section 1820 [probably means section 1820 of the Social Security Act which is classified to section 1395i-4 of this title].

“(B) TREATMENT OF PSYCHIATRIC AND REHABILITATION UNITS.—For purposes of subparagraph (A)(ii), beds in a psychiatric or rehabilitation unit of the hospital which is a distinct part of the hospital shall not be counted.

“(2) COVERED INPATIENT HOSPITAL SERVICES.—The term ‘covered inpatient hospital services’ means in-

patient hospital services, and includes extended care services furnished under an agreement under section 1883 of the Social Security Act (42 U.S.C. 1395tt).”

“(g) FIVE-YEAR EXTENSION OF DEMONSTRATION PROGRAM.—

“(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, the Secretary shall conduct the demonstration program under this section for an additional 5-year period (in this section referred to as the ‘5-year extension period’) that begins on the date immediately following the last day of the initial 5-year period under subsection (a)(5).

“(2) EXPANSION OF DEMONSTRATION STATES.—Notwithstanding subsection (a)(2), during the 5-year extension period, the Secretary shall expand the number of States with low population densities determined by the Secretary under such subsection to 20. In determining which States to include in such expansion, the Secretary shall use the same criteria and data that the Secretary used to determine the States under such subsection for purposes of the initial 5-year period.

“(3) INCREASE IN MAXIMUM NUMBER OF HOSPITALS PARTICIPATING IN THE DEMONSTRATION PROGRAM.—Notwithstanding subsection (a)(4), during the 5-year extension period, not more than 30 rural community hospitals may participate in the demonstration program under this section.

“(4) HOSPITALS IN DEMONSTRATION PROGRAM ON DATE OF ENACTMENT [Mar. 23, 2010].—In the case of a rural community hospital that is participating in the demonstration program under this section as of the last day of the initial 5-year period, the Secretary—

“(A) shall provide for the continued participation of such rural community hospital in the demonstration program during the 5-year extension period unless the rural community hospital makes an election, in such form and manner as the Secretary may specify, to discontinue such participation; and

“(B) in calculating the amount of payment under subsection (b) to the rural community hospital for covered inpatient hospital services furnished by the hospital during such 5-year extension period, shall substitute, under paragraph (1)(A) of such subsection—

“(i) the reasonable costs of providing such services for discharges occurring in the first cost reporting period beginning on or after the first day of the 5-year extension period, for

“(ii) the reasonable costs of providing such services for discharges occurring in the first cost reporting period beginning on or after the implementation of the demonstration program.”

APPLICABILITY OF CHAPTER 35 OF TITLE 44

Pub. L. 108-173, title IV, §422(b)(2), Dec. 8, 2003, 117 Stat. 2286, as amended by Pub. L. 111-148, title V, §5503(c), Mar. 23, 2010, 124 Stat. 659, provided that: “Chapter 35 of title 44, United States Code, shall not apply with respect to applications under paragraphs (7) and (8) of subsection (h) of section 1886 of the Social Security Act [42 U.S.C. 1395ww(h)(7), (8)].”

REPORT ON EXTENSION OF APPLICATIONS UNDER REDISTRIBUTION PROGRAM

Pub. L. 108-173, title IV, §422(c), Dec. 8, 2003, 117 Stat. 2286, provided that: “Not later than July 1, 2005, the Secretary [of Health and Human Services] shall submit to Congress a report containing recommendations regarding whether to extend the deadline for applications for an increase in resident limits under section 1886(h)(4)(I)(ii)(II) of the Social Security Act [section 1886(h)(4) (subsec. (h)(4) of this section) does not contain a subpar. (I)] (as added by subsection (a)).”

MEDPAC STUDY ON RURAL HOSPITAL PAYMENT ADJUSTMENTS

Pub. L. 108-173, title IV, §433, Dec. 8, 2003, 117 Stat. 2288, provided that:

“(a) IN GENERAL.—The Medicare Payment Advisory Commission shall conduct a study of the impact of sections 401 through 406, 411, 416, and 505 [amending this section and sections 1395f, 1395g, 1395i-4, 1395l, 1395m, 1395cc, and 1395tt of this title and enacting provisions set out as notes under this section and sections 1395f, 1395g, 1395i-4, 1395l, and 1395m of this title]. The Commission shall analyze the effect on total payments, growth in costs, capital spending, and such other payment effects under those sections.

“(b) REPORTS.—

“(1) INTERIM REPORT.—Not later than 18 months after the date of the enactment of this Act [Dec. 8, 2003], the Commission shall submit to Congress an interim report on the matters studied under subsection (a) with respect only to changes to the critical access hospital provisions under section 405 [amending sections 1395f, 1395g, 1395i-4, 1395m, and 1395tt of this title and enacting provisions set out as notes under sections 1395f, 1395g, 1395i-4, and 1395m of this title].

“(2) FINAL REPORT.—Not later than 3 years after the date of the enactment of this Act [Dec. 8, 2003], the Commission shall submit to Congress a final report on all matters studied under subsection (a).”

GAO STUDY AND REPORT ON APPROPRIATENESS OF PAYMENTS UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR INPATIENT HOSPITAL SERVICES

Pub. L. 108-173, title V, § 501(c), Dec. 8, 2003, 117 Stat. 2290, provided that:

“(1) STUDY.—The Comptroller General of the United States, using the most current data available, shall conduct a study to determine—

“(A) the appropriate level and distribution of payments in relation to costs under the prospective payment system under section 1886 of the Social Security Act (42 U.S.C. 1395ww) for inpatient hospital services furnished by subsection (d) hospitals (as defined in subsection (d)(1)(B) of such section); and

“(B) whether there is a need to adjust such payments under such system to reflect legitimate differences in costs across different geographic areas, kinds of hospitals, and types of cases.

“(2) REPORT.—Not later than 24 months after the date of the enactment of this Act [Dec. 8, 2003], the Comptroller General of the United States shall submit to Congress a report on the study conducted under paragraph (1) together with such recommendations for legislative and administrative action as the Comptroller General determines appropriate.”

NOT BUDGET NEUTRAL

Pub. L. 108-173, title V, § 503(d)(2), Dec. 8, 2003, 117 Stat. 2292, provided that: “There shall be no reduction or other adjustment in payments under section 1886 of the Social Security Act [this section] because an additional payment is provided under subsection (d)(5)(K)(ii)(III) of such section.”

ONE-TIME APPEALS PROCESS FOR HOSPITAL WAGE INDEX CLASSIFICATION

Pub. L. 108-173, title V, § 508, Dec. 8, 2003, 117 Stat. 2297, as amended by Pub. L. 110-173, title I, § 117(b), Dec. 29, 2007, 121 Stat. 2507; Pub. L. 110-275, title I, § 124(c), July 15, 2008, 122 Stat. 2518, provided that:

“(a) ESTABLISHMENT OF PROCESS.—

“(1) IN GENERAL.—The Secretary [of Health and Human Services] shall establish not later than January 1, 2004, by instruction or otherwise a process under which a hospital may appeal the wage index classification otherwise applicable to the hospital and select another area within the State (or, at the discretion of the Secretary, within a contiguous State) to which to be reclassified.

“(2) PROCESS REQUIREMENTS.—The process established under paragraph (1) shall be consistent with the following:

“(A) Such an appeal may be filed as soon as possible after the date of the enactment of this Act

[Dec. 8, 2003] but shall be filed by not later than February 15, 2004.

“(B) Such an appeal shall be heard by the Medicare Geographic Reclassification Review Board.

“(C) There shall be no further administrative or judicial review of a decision of such Board.

“(3) RECLASSIFICATION UPON SUCCESSFUL APPEAL.—If the Medicare Geographic Reclassification Review Board determines that the hospital is a qualifying hospital (as defined in subsection (c)), the hospital shall be reclassified to the area selected under paragraph (1). Such reclassification shall apply with respect to discharges occurring during the 3-year period beginning with April 1, 2004.

“(4) INAPPLICABILITY OF CERTAIN PROVISIONS.—Except as the Secretary may provide, the provisions of paragraphs (8) and (10) of section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)) shall not apply to an appeal under this section.

“(b) APPLICATION OF RECLASSIFICATION.—In the case of an appeal decided in favor of a qualifying hospital under subsection (a), the wage index reclassification shall not affect the wage index computation for any area or for any other hospital and shall not be effected in a budget neutral manner. The provisions of this section shall not affect payment for discharges occurring after the end of the 3-year-period referred to in subsection (a).

“(c) QUALIFYING HOSPITAL DEFINED.—For purposes of this section, the term ‘qualifying hospital’ means a subsection (d) hospital (as defined in section 1886(d)(1)(B) of the Social Security Act, 42 U.S.C. 1395ww(d)(1)(B)) that—

“(1) does not qualify for a change in wage index classification under paragraph (8) or (10) of section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)) on the basis of requirements relating to distance or commuting; and

“(2) meets such other criteria, such as quality, as the Secretary may specify by instruction or otherwise.

The Secretary may modify the wage comparison guidelines promulgated under section 1886(d)(10)(D) of such Act (42 U.S.C. 1395ww(d)(10)(D)) in carrying out this section.

“(d) WAGE INDEX CLASSIFICATION.—For purposes of this section, the term ‘wage index classification’ means the geographic area in which it is classified for purposes of determining for a fiscal year the factor used to adjust the DRG prospective payment rate under section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)) for area differences in hospital wage levels that applies to such hospital under paragraph (3)(E) of such section.

“(e) LIMITATION ON EXPENDITURES.—The aggregate amount of additional expenditures resulting from the application of this section shall not exceed \$900,000,000.

“(f) TRANSITIONAL EXTENSION.—Any reclassification of a county or other area made by Act of Congress for purposes of making payments under section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)) that expired on September 30, 2003, shall be deemed to be in effect during the period beginning on January 1, 2004, and ending on September 30, 2004.

“(g) DISREGARDING HOSPITAL RECLASSIFICATIONS FOR PURPOSES OF GROUP RECLASSIFICATIONS.—For purposes of the reclassification of a group of hospitals in a geographic area under section 1886(d) of the Social Security Act [subsec. (d) of this section] for purposes of discharges occurring beginning on October 1, 2007, and ending on the last date of the extension of reclassifications under section 106(a) of the Medicare Improvement[s] and Extension Act of 2006 (division B of Public Law 109-432) [set out above], a hospital reclassified under this section (including any such reclassification which is extended under section 106(a) of the Medicare Improvements and Extension Act of 2006) [div. B of Pub. L. 109-432, set out as a note under this section] shall not be taken into account and shall not prevent the other hospitals in such area from continuing such a group for such purpose.”

EXCEPTION TO INITIAL RESIDENCY PERIOD FOR
GERIATRIC RESIDENCY OR FELLOWSHIP PROGRAMS

Pub. L. 108-173, title VII, §712, Dec. 8, 2003, 117 Stat. 2340, provided that:

“(a) CLARIFICATION OF CONGRESSIONAL INTENT.—Congress intended section 1886(h)(5)(F)(ii) of the Social Security Act (42 U.S.C. 1395ww(h)(5)(F)(ii)), as added by section 9202 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272), to provide an exception to the initial residency period for geriatric residency or fellowship programs such that, where a particular approved geriatric training program requires a resident to complete 2 years of training to initially become board eligible in the geriatric specialty, the 2 years spent in the geriatric training program are treated as part of the resident’s initial residency period, but are not counted against any limitation on the initial residency period.

“(b) INTERIM FINAL REGULATORY AUTHORITY AND EFFECTIVE DATE.—The Secretary [of Health and Human Services] shall promulgate interim final regulations consistent with the congressional intent expressed in this section after notice and pending opportunity for public comment to be effective for cost reporting periods beginning on or after October 1, 2003.”

TREATMENT OF VOLUNTEER SUPERVISION

Pub. L. 108-173, title VII, §713, Dec. 8, 2003, 117 Stat. 2340, provided that:

“(a) MORATORIUM ON CHANGES IN TREATMENT.—During the 1-year period beginning on January 1, 2004, for purposes of applying subsections (d)(5)(B) and (h) of section 1886 of the Social Security Act (42 U.S.C. 1395ww), the Secretary [of Health and Human Services] shall allow all hospitals to count residents in osteopathic and allopathic family practice programs in existence as of January 1, 2002, who are training at non-hospital sites, without regard to the financial arrangement between the hospital and the teaching physician practicing in the non-hospital site to which the resident has been assigned.

“(b) STUDY AND REPORT.—

“(1) STUDY.—The Inspector General of the Department of Health and Human Services shall conduct a study of the appropriateness of alternative payment methodologies under such sections for the costs of training residents in non-hospital settings.

“(2) REPORT.—Not later than 1 year after the date of the enactment of this Act [Dec. 8, 2003], the Inspector General shall submit to Congress a report on the study conducted under paragraph (1), together with such recommendations as the Inspector General determines appropriate.”

FURNISHING HOSPITALS WITH INFORMATION TO
COMPUTE DSH FORMULA

Pub. L. 108-173, title IX, §951, Dec. 8, 2003, 117 Stat. 2427, provided that: “Beginning not later than 1 year after the date of the enactment of this Act [Dec. 8, 2003], the Secretary [of Health and Human Services] shall arrange to furnish to subsection (d) hospitals (as defined in section 1886(d)(1)(B) of the Social Security Act, 42 U.S.C. 1395ww(d)(1)(B)) the data necessary for such hospitals to compute the number of patient days used in computing the disproportionate patient percentage under such section for that hospital for the current cost reporting year. Such data shall also be furnished to other hospitals which would qualify for additional payments under part A of title XVIII of the Social Security Act [part A of this subchapter] on the basis of such data.”

SPECIAL RULES FOR PAYMENT FOR FISCAL YEAR 2001

Pub. L. 106-554, §1(a)(6) [title III, §301(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A-491, provided that: “Notwithstanding the amendment made by subsection (a) [amending this section], for purposes of making payments for fiscal year 2001 for inpatient hospital services furnished by subsection (d) hospitals (as defined in sec-

tion 1886(d)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B))[]), the ‘applicable percentage increase’ referred to in section 1886(b)(3)(B)(i) of such Act (42 U.S.C. 1395ww(b)(3)(B)(i))—

“(1) for discharges occurring on or after October 1, 2000, and before April 1, 2001, shall be determined in accordance with subclause (XVI) of such section as in effect on the day before the date of the enactment of this Act [Dec. 21, 2000]; and

“(2) for discharges occurring on or after April 1, 2001, and before October 1, 2001, shall be equal to—

“(A) the market basket percentage increase plus 1.1 percentage points for hospitals (other than sole community hospitals) in all areas; and

“(B) the market basket percentage increase for sole community hospitals.”

Pub. L. 106-554, §1(a)(6) [title III, §302(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A-493, provided that: “Notwithstanding paragraph (5)(B)(ii)(V) of section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)(ii)(V)), for purposes of making payments for subsection (d) hospitals (as defined in paragraph (1)(B) of such section) with indirect costs of medical education, the indirect teaching adjustment factor referred to in paragraph (5)(B)(ii) of such section shall be determined, for discharges occurring on or after April 1, 2001, and before October 1, 2001, as if ‘c’ in paragraph (5)(B)(ii)(V) of such section equalled 1.66 rather than 1.54.”

Pub. L. 106-554, §1(a)(6) [title III, §303(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A-493, provided that: “Notwithstanding the amendment made by subsection (a)(1) [amending this section], for purposes of making disproportionate share payments for subsection (d) hospitals (as defined in section 1886(d)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B))[]) for fiscal year 2001, the additional payment amount otherwise determined under clause (ii) of section 1886(d)(5)(F) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(F))—

“(1) for discharges occurring on or after October 1, 2000, and before April 1, 2001, shall be adjusted as provided by clause (ix)(III) of such section as in effect on the day before the date of the enactment of this Act [Dec. 21, 2000]; and

“(2) for discharges occurring on or after April 1, 2001, and before October 1, 2001, shall, instead of being reduced by 3 percent as provided by clause (ix)(III) of such section as in effect after the date of the enactment of this Act, be reduced by 1 percent.”

Pub. L. 106-554, §1(a)(6) [title V, §547(a)], Dec. 21, 2000, 114 Stat. 2763, 2763A-553, provided that:

“(a) INPATIENT HOSPITAL SERVICES.—The payment increase provided under the following sections shall not apply to discharges occurring after fiscal year 2001 and shall not be taken into account in calculating the payment amounts applicable for discharges occurring after such fiscal year:

“(1) Section 301(b)(2)(A) [set out as a note above] (relating to acute care hospital payment update).

“(2) Section 302(b) [set out as a note above] (relating to IME percentage adjustment).

“(3) Section 303(b)(2) [set out as a note above] (relating to DSH payments).”

CONSIDERATION OF PRICE OF BLOOD AND BLOOD
PRODUCTS IN MARKET BASKET INDEX

Pub. L. 106-554, §1(a)(6) [title III, §301(c)], Dec. 21, 2000, 114 Stat. 2763, 2763A-491, provided that: “The Secretary of Health and Human Services shall, when next (after the date of the enactment of this Act [Dec. 21, 2000]) rebasing and revising the hospital market basket index (as defined in section 1886(b)(3)(B)(iii) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)(iii))), consider the prices of blood and blood products purchased by hospitals and determine whether those prices are adequately reflected in such index.”

MEDPAC STUDY AND REPORT REGARDING CERTAIN
HOSPITAL COSTS

Pub. L. 106-554, §1(a)(6) [title III, §301(d)], Dec. 21, 2000, 114 Stat. 2763, 2763A-491, provided that:

“(1) STUDY.—The Medicare Payment Advisory Commission shall conduct a study on—

“(A) any increased costs incurred by subsection (d) hospitals (as defined in paragraph (1)(B) of section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d))) in providing inpatient hospital services to medicare beneficiaries under title XVIII of such Act [this subchapter] during the period beginning on October 1, 1983, and ending on September 30, 1999, that were attributable to—

“(i) complying with new blood safety measure requirements; and

“(ii) providing such services using new technologies;

“(B) the extent to which the prospective payment system for such services under such section provides adequate and timely recognition of such increased costs;

“(C) the prospects for (and to the extent practicable, the magnitude of) cost increases that hospitals will incur in providing such services that are attributable to complying with new blood safety measure requirements and providing such services using new technologies during the 10 years after the date of the enactment of this Act [Dec. 21, 2000]; and

“(D) the feasibility and advisability of establishing mechanisms under such payment system to provide for more timely and accurate recognition of such cost increases in the future.

“(2) CONSULTATION.—In conducting the study under this subsection, the Commission shall consult with representatives of the blood community, including—

“(A) hospitals;

“(B) organizations involved in the collection, processing, and delivery of blood; and

“(C) organizations involved in the development of new blood safety technologies.

“(3) REPORT.—Not later than 1 year after the date of the enactment of this Act [Dec. 21, 2000], the Commission shall submit to Congress a report on the study conducted under paragraph (1) together with such recommendations for legislation and administrative action as the Commission determines appropriate.”

PROCESS TO PERMIT STATEWIDE WAGE INDEX CALCULATION AND APPLICATION

Pub. L. 106-554, §1(a)(6) [title III, §304(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A-494, provided that:

“(1) IN GENERAL.—The Secretary of Health and Human Services shall establish a process (based on the voluntary process utilized by the Secretary of Health and Human Services under section 1848 of the Social Security Act (42 U.S.C. 1395w-4) for purposes of computing and applying a statewide geographic adjustment factor) under which an appropriate statewide entity may apply to have all the geographic areas in a State treated as a single geographic area for purposes of computing and applying the area wage index under section 1886(d)(3)(E) of such Act (42 U.S.C. 1395ww(d)(3)(E)). Such process shall be established by October 1, 2001, for reclassifications beginning in fiscal year 2003.

“(2) PROHIBITION ON INDIVIDUAL HOSPITAL RECLASSIFICATION.—Notwithstanding any other provision of law, if the Secretary applies a statewide geographic wage index under paragraph (1) with respect to a State, any application submitted by a hospital in that State under section 1886(d)(10) of the Social Security Act (42 U.S.C. 1395ww(d)(10)) for geographic reclassification shall not be considered.”

COLLECTION OF INFORMATION ON OCCUPATIONAL MIX

Pub. L. 106-554, §1(a)(6) [title III, §304(c)(1)], Dec. 21, 2000, 114 Stat. 2763, 2763A-495, provided that: “The Secretary of Health and Human Services shall provide for the collection of data every 3 years on occupational mix for employees of each subsection (d) hospital (as defined in section 1886(d)(1)(D) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(D))) in the provision of inpatient hospital services, in order to construct an occupa-

tional mix adjustment in the hospital area wage index applied under section 1886(d)(3)(E) of such Act (42 U.S.C. 1395ww(d)(3)(E)).”

Pub. L. 106-554, §1(a)(6) [title III, §304(c)(3)], Dec. 21, 2000, 114 Stat. 2763, 2763A-495, provided that: “By not later than September 30, 2003, for application beginning October 1, 2004, the Secretary shall first complete—

“(A) the collection of data under paragraph (1) [set out above]; and

“(B) the measurement under the third sentence of section 1886(d)(3)(E) [subsection (d)(3)(E) of this section], as amended by paragraph (2).”

PAYMENT FOR INPATIENT SERVICES OF PSYCHIATRIC HOSPITALS

Pub. L. 106-554, §1(a)(6) [title III, §306], Dec. 21, 2000, 114 Stat. 2763, 2763A-496, provided that: “With respect to hospitals described in clause (i) of section 1886(d)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)) and psychiatric units described in the matter following clause (v) of such section, in making incentive payments to such hospitals under section 1886(b)(1)(A) of such Act (42 U.S.C. 1395ww(b)(1)(A)) for cost reporting periods beginning on or after October 1, 2000, and before October 1, 2001, the Secretary of Health and Human Services, in clause (ii) of such section, shall substitute ‘3 percent’ for ‘2 percent’.”

EXPEDITING RECOGNITION OF NEW TECHNOLOGIES INTO INPATIENT PPS CODING SYSTEM

Pub. L. 106-554, §1(a)(6) [title V, §533(a)], Dec. 21, 2000, 114 Stat. 2763, 2763A-548, provided that:

“(1) REPORT.—Not later than April 1, 2001, the Secretary of Health and Human Services shall submit to Congress a report on methods of expeditiously incorporating new medical services and technologies into the clinical coding system used with respect to payment for inpatient hospital services furnished under the medicare program under title XVIII of the Social Security Act [this subchapter], together with a detailed description of the Secretary’s preferred methods to achieve this purpose.

“(2) IMPLEMENTATION.—Not later than October 1, 2001, the Secretary shall implement the preferred methods described in the report transmitted pursuant to paragraph (1).”

CONSULTATION PRIOR TO RULEMAKING

Pub. L. 106-554, §1(a)(6) [title V, §533(b)(2)], Dec. 21, 2000, 114 Stat. 2763, 2763A-549, provided that: “The Secretary of Health and Human Services shall consult with groups representing hospitals, physicians, and manufacturers of new medical technologies before publishing the notice of proposed rulemaking required by section 1886(d)(5)(K)(i) of the Social Security Act [subsection (d)(5)(K)(i) of this section] (as added by paragraph (1)).”

SPECIAL PAYMENTS TO MAINTAIN 6.5 PERCENT IME PAYMENT FOR FISCAL YEAR 2000

Pub. L. 106-113, div. B, §1000(a)(6) [title I, §111(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A-329, provided that:

“(1) ADDITIONAL PAYMENT.—In addition to payments made to each subsection (d) hospital (as defined in section 1886(d)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)) under section 1886(d)(5)(B) of such Act (42 U.S.C. 1395ww(d)(5)(B))) which receives payment for the direct costs of medical education for discharges occurring in fiscal year 2000, the Secretary of Health and Human Services shall make one or more payments to each such hospital in an amount which, as estimated by the Secretary, is equal in the aggregate to the difference between the amount of payments to the hospital under such section for such discharges and the amount of payments that would have been paid under such section for such discharges if ‘c’ in clause (ii)(IV) of such section equalled 1.6 rather than 1.47. Additional payments made under this subsection shall be made applying the same structure as applies to payments made under section 1886(d)(5)(B) of such Act.

“(2) NO EFFECT ON OTHER PAYMENTS OR DETERMINATIONS.—In making such additional payments, the Secretary shall not change payments, determinations, or budget neutrality adjustments made for such period under section 1886(d) of such Act (42 U.S.C. 1395ww(d)).”

DATA COLLECTION

Pub. L. 106-113, div. B, §1000(a)(6) [title I, §112(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A-330, provided that:

“(1) IN GENERAL.—The Secretary of Health and Human Services shall require any subsection (d) hospital (as defined in section 1886(d)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B))) to submit to the Secretary, in the cost reports submitted to the Secretary by such hospital for discharges occurring during a fiscal year, data on the costs incurred by the hospital for providing inpatient and outpatient hospital services for which the hospital is not compensated, including non-medicare bad debt, charity care, and charges for medicaid and indigent care.

“(2) EFFECTIVE DATE.—The Secretary shall require the submission of the data described in paragraph (1) in cost reports for cost reporting periods beginning on or after October 1, 2001.”

PER DISCHARGE PROSPECTIVE PAYMENT SYSTEM FOR LONG-TERM CARE HOSPITALS

Pub. L. 106-554, §1(a)(6) [title III, §307(a)(2)], Dec. 21, 2000, 114 Stat. 2763, 2763A-496, provided that: “The amendments made by subsection (a) [amending this section] and by section 122 of BBRA [Pub. L. 106-113, §1000(a)(6) [title I, §122], amending this section] (113 Stat. 1501A-331) shall not be taken into account in the development and implementation of the prospective payment system under section 123 of BBRA [Pub. L. 106-113, §1000(a)(6) [title I, §123], set out as a note below] (113 Stat. 1501A-331).”

Pub. L. 106-554, §1(a)(6) [title III, §307(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A-496, provided that:

“(1) MODIFICATION OF REQUIREMENT.—In developing the prospective payment system for payment for inpatient hospital services provided in long-term care hospitals described in section 1886(d)(1)(B)(iv) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)(iv)) under the medicare program under title XVIII of such Act [this subchapter] required under section 123 of BBRA [Pub. L. 106-113, §1000(a)(6) [title I, §123], set out as a note below], the Secretary of Health and Human Services shall examine the feasibility and the impact of basing payment under such a system on the use of existing (or refined) hospital diagnosis-related groups (DRGs) that have been modified to account for different resource use of long-term care hospital patients as well as the use of the most recently available hospital discharge data. The Secretary shall examine and may provide for appropriate adjustments to the long-term hospital payment system, including adjustments to DRG weights, area wage adjustments, geographic reclassification, outliers, updates, and a disproportionate share adjustment consistent with section 1886(d)(5)(F) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(F)).

“(2) DEFAULT IMPLEMENTATION OF SYSTEM BASED ON EXISTING DRG METHODOLOGY.—If the Secretary is unable to implement the prospective payment system under section 123 of the BBRA by October 1, 2002, the Secretary shall implement a prospective payment system for such hospitals that bases payment under such a system using existing hospital diagnosis-related groups (DRGs), modified where feasible to account for resource use of long-term care hospital patients using the most recently available hospital discharge data for such services furnished on or after that date.”

Pub. L. 106-113, div. B, §1000(a)(6) [title I, §123], Nov. 29, 1999, 113 Stat. 1536, 1501A-331, provided that:

“(a) DEVELOPMENT OF SYSTEM.—

“(1) IN GENERAL.—The Secretary of Health and Human Services shall develop a per discharge prospective payment system for payment for inpatient hospital services of long-term care hospitals de-

scribed in section 1886(d)(1)(B)(iv) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)(iv)) under the medicare program. Such system shall include an adequate patient classification system that is based on diagnosis-related groups (DRGs) and that reflects the differences in patient resource use and costs, and shall maintain budget neutrality.

“(2) COLLECTION OF DATA AND EVALUATION.—In developing the system described in paragraph (1), the Secretary may require such long-term care hospitals to submit such information to the Secretary as the Secretary may require to develop the system.

“(b) REPORT.—Not later than October 1, 2001, the Secretary shall submit to the appropriate committees of Congress a report that includes a description of the system developed under subsection (a)(1).

“(c) IMPLEMENTATION OF PROSPECTIVE PAYMENT SYSTEM.—Notwithstanding section 1886(b)(3) of the Social Security Act (42 U.S.C. 1395ww(b)(3)), the Secretary shall provide, for cost reporting periods beginning on or after October 1, 2002, for payments for inpatient hospital services furnished by long-term care hospitals under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) in accordance with the system described in subsection (a).”

PER DIEM PROSPECTIVE PAYMENT SYSTEM FOR PSYCHIATRIC HOSPITALS

Pub. L. 106-113, div. B, §1000(a)(6) [title I, §124], Nov. 29, 1999, 113 Stat. 1536, 1501A-332, provided that:

“(a) DEVELOPMENT OF SYSTEM.—

“(1) IN GENERAL.—The Secretary of Health and Human Services shall develop a per diem prospective payment system for payment for inpatient hospital services of psychiatric hospitals and units (as defined in paragraph (3)) under the medicare program. Such system shall include an adequate patient classification system that reflects the differences in patient resource use and costs among such hospitals and shall maintain budget neutrality.

“(2) COLLECTION OF DATA AND EVALUATION.—In developing the system described in paragraph (1), the Secretary may require such psychiatric hospitals and units to submit such information to the Secretary as the Secretary may require to develop the system.

“(3) DEFINITION.—In this section, the term ‘psychiatric hospitals and units’ means a psychiatric hospital described in clause (i) of section 1886(d)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)) and psychiatric units described in the matter following clause (v) of such section.

“(b) REPORT.—Not later than October 1, 2001, the Secretary shall submit to the appropriate committees of Congress a report that includes a description of the system developed under subsection (a)(1).

“(c) IMPLEMENTATION OF PROSPECTIVE PAYMENT SYSTEM.—Notwithstanding section 1886(b)(3) of the Social Security Act (42 U.S.C. 1395ww(b)(3)), the Secretary shall provide, for cost reporting periods beginning on or after October 1, 2002, for payments for inpatient hospital services furnished by psychiatric hospitals and units under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) in accordance with the prospective payment system established by the Secretary under this section in a budget neutral manner.”

STUDY ON IMPACT OF IMPLEMENTATION OF PROSPECTIVE PAYMENT SYSTEM

Pub. L. 106-113, div. B, §1000(a)(6) [title I, §125(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A-333, provided that:

“(1) STUDY.—The Secretary of Health and Human Services shall conduct a study of the impact on utilization and beneficiary access to services of the implementation of the medicare prospective payment system for inpatient hospital services or rehabilitation facilities under section 1886(j) of the Social Security Act (42 U.S.C. 1395ww(j)).

“(2) REPORT.—Not later than 3 years after the date such system is first implemented, the Secretary shall submit to Congress a report on such study.”

MEDPAC STUDY ON MEDICARE PAYMENT FOR NON-PHYSICIAN HEALTH PROFESSIONAL CLINICAL TRAINING IN HOSPITALS

Pub. L. 106-113, div. B, §1000(a)(6) [title I, §141], Nov. 29, 1999, 113 Stat. 1536, 1501A-334, provided that:

“(a) IN GENERAL.—The Medicare Payment Advisory Commission shall conduct a study of medicare payment policy with respect to professional clinical training of different classes of nonphysician health care professionals (such as nurses, nurse practitioners, allied health professionals, physician assistants, and psychologists) and the basis for any differences in treatment among such classes.

“(b) REPORT.—Not later than 18 months after the date of the enactment of this Act [Nov. 29, 1999], the Commission shall submit a report to Congress on the study conducted under subsection (a).”

NOT COUNTING AGAINST NUMERICAL LIMITATION CERTAIN INTERNS AND RESIDENTS TRANSFERRED FROM A VA RESIDENCY PROGRAM THAT LOSES ACCREDITATION

Pub. L. 106-113, div. B, §1000(a)(6) [title IV, §407(d)], Nov. 29, 1999, 113 Stat. 1536, 1501A-374, provided that:

“(1) IN GENERAL.—Any applicable resident described in paragraph (2) shall not be taken into account in applying any limitation regarding the number of residents or interns for which payment may be made under section 1886 of the Social Security Act (42 U.S.C. 1395ww).

“(2) APPLICABLE RESIDENT DESCRIBED.—An applicable resident described in this paragraph is a resident or intern who—

“(A) participated in graduate medical education at a facility of the Department of Veterans Affairs;

“(B) was subsequently transferred on or after January 1, 1997, and before July 31, 1998, to a hospital that was not a Department of Veterans Affairs facility; and

“(C) was transferred because the approved medical residency program in which the resident or intern participated would lose accreditation by the Accreditation Council on Graduate Medical Education if such program continued to train residents at the Department of Veterans Affairs facility.

“(3) EFFECTIVE DATE.—

“(A) IN GENERAL.—Paragraph (1) applies as if included in the enactment of BBA [the Balanced Budget Act of 1997, Pub. L. 105-33].

“(B) RETROACTIVE PAYMENTS.—If the Secretary of Health and Human Services determines that a hospital operating an approved medical residency program is owed payments as a result of enactment of this subsection, the Secretary shall make such payments not later than 60 days after the date of the enactment of this Act [Nov. 29, 1999].”

GAO STUDY ON GEOGRAPHIC RECLASSIFICATION

Pub. L. 106-113, div. B, §1000(a)(6) [title IV, §410], Nov. 29, 1999, 113 Stat. 1536, 1501A-376, provided that:

“(a) IN GENERAL.—The Comptroller General of the United States shall conduct a study of the current laws and regulations for geographic reclassification of hospitals to determine whether such reclassification is appropriate for purposes of applying wage indices under the medicare program and whether such reclassification results in more accurate payments for all hospitals. Such study shall examine data on the number of hospitals that are reclassified and their reclassified status in determining payments under the medicare program. The study shall evaluate—

“(1) the magnitude of the effect of geographic reclassification on rural hospitals that are not reclassified;

“(2) whether the current thresholds used in geographic reclassification reclassify hospitals to the appropriate labor markets;

“(3) the effect of eliminating geographic reclassification through use of the occupational mix data;

“(4) the group reclassification policy;

“(5) changes in the number of reclassifications and the compositions of the groups;

“(6) the effect of State-specific budget neutrality compared to national budget neutrality; and

“(7) whether there are sufficient controls over the intermediary evaluation of the wage data reported by hospitals.

“(b) REPORT.—Not later than 18 months after the date of the enactment of this Act [Nov. 29, 1999], the Comptroller General of the United States shall submit to Congress a report on the study conducted under subsection (a).”

CONTINUING TREATMENT OF PREVIOUSLY DESIGNATED CENTERS

Section 4202(b) of Pub. L. 105-33 provided that:

“(1) IN GENERAL.—Any hospital classified as a rural referral center by the Secretary of Health and Human Services under section 1886(d)(5)(C) of the Social Security Act [subsec. (d)(5)(C) of this section] for fiscal year 1991 shall be classified as such a rural referral center for fiscal year 1998 and each subsequent fiscal year.

“(2) BUDGET NEUTRALITY.—The provisions of section 1886(d)(8)(D) of the Social Security Act [subsec. (d)(8)(D) of this section] shall apply to reclassifications made pursuant to paragraph (1) in the same manner as such provisions apply to a reclassification under section 1886(d)(10) of such Act [subsec. (d)(10) of this section].”

HOSPITAL GEOGRAPHIC RECLASSIFICATION PERMITTED FOR PURPOSES OF DISPROPORTIONATE SHARE PAYMENT ADJUSTMENTS

Section 4203 of Pub. L. 105-33 provided that:

“(a) IN GENERAL.—For the period described in subsection (c), the Medicare Geographic Classification Review Board shall consider the application under section 1886(d)(10)(C)(i) of the Social Security Act (42 U.S.C. 1395ww(d)(10)(C)(i)) of a hospital described in 1886(d)(1)(B) of such Act (42 U.S.C. 1395ww(d)(1)(B)) to change the hospital's geographic classification for purposes of determining for a fiscal year eligibility for and amount of additional payment amounts under section 1886(d)(5)(F) of such Act (42 U.S.C. 1395ww(d)(5)(F)).

“(b) APPLICABLE GUIDELINES.—The Medicare Geographic Classification Review Board shall apply the guidelines established for reclassification under subclause (I) of section 1886(d)(10)(C)(i) of such Act to reclassification by reason of subsection (a) until the Secretary of Health and Human Services promulgates separate guidelines for such reclassification.

“(c) PERIOD DESCRIBED.—The period described in this subsection is the period beginning on the date of the enactment of this Act [Aug. 5, 1997] and ending 30 months after such date.”

TEMPORARY RELIEF FOR CERTAIN NON-TEACHING, NON-DSH HOSPITALS

Pub. L. 105-33, title IV, §4401(b), Aug. 5, 1997, 111 Stat. 397, as amended by Pub. L. 106-113, div. B, §1000(a)(6) [title III, §321(d)], Nov. 29, 1999, 113 Stat. 1536, 1501A-366, provided that:

“(1) IN GENERAL.—In the case of a hospital described in paragraph (2) for its cost reporting period—

“(A) beginning in fiscal year 1998 the amount of payment made to the hospital under section 1886(d) of the Social Security Act [subsec. (d) of this section] for discharges occurring during such fiscal year only shall be increased as though the applicable percentage increase (otherwise applicable to discharges occurring during fiscal year 1998 under section 1886(b)(3)(B)(i)(XIII) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)(i)(XIII))) had been increased by 0.5 percentage points; and

“(B) beginning in fiscal year 1999 the amount of payment made to the hospital under section 1886(d) of

the Social Security Act for discharges occurring during such fiscal year only shall be increased as though the applicable percentage increase (otherwise applicable to discharges occurring during fiscal year 1999 under section 1886(b)(3)(B)(i)(XIV) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)(i)(XIV))) had been increased by 0.3 percentage points.

Subparagraph (A) shall not apply in computing the increase under subparagraph (B) and neither subparagraph shall affect payment for discharges for any hospital occurring during a fiscal year after fiscal year 1999. Payment increases under this subsection for discharges occurring during a fiscal year are subject to settlement after the close of the fiscal year.

“(2) HOSPITALS COVERED.—A hospital described in this paragraph for a cost reporting period is a hospital—

“(A) that is described in paragraph (3) for such period;

“(B) that is located in a State in which the amount of the aggregate payments under section 1886(d) of such Act [subsec. (d) of this section] for hospitals located in the State and described in paragraph (3) for their cost reporting periods beginning during fiscal year 1995 is less than the aggregate allowable operating costs of inpatient hospital services (as defined in section 1886(a)(4) of such Act) for all such hospitals in such State with respect to such cost reporting periods; and

“(C) with respect to which the payments under section 1886(d) of such Act (42 U.S.C. 1395ww(d)) for discharges occurring in the cost reporting period involved, as estimated by the Secretary, is less than the allowable operating costs of inpatient hospital services (as defined in section 1886(a)(4) of such Act (42 U.S.C. 1395ww(a)(4)))] for such hospital for such period, as estimated by the Secretary.

“(3) NON-TEACHING, NON-DSH HOSPITALS DESCRIBED.—A hospital described in this paragraph for a cost reporting period is a subsection (d) hospital (as defined in section 1886(d)(1)(B) of such Act (42 U.S.C. 1395ww(d)(1)(B))) that—

“(A) is not receiving any additional payment amount described in section 1886(d)(5)(F) of such Act (42 U.S.C. 1395ww(d)(5)(F)) for discharges occurring during the period;

“(B) is not receiving any additional payment under section 1886(d)(5)(B) of such Act (42 U.S.C. 1395ww(d)(5)(B)) or a payment under section 1886(h) of such Act (42 U.S.C. 1395ww(h)) for discharges occurring during the period; and

“(C) does not qualify for payment under section 1886(d)(5)(G) of such Act (42 U.S.C. 1395ww(d)(5)(G)) for the period.”

FORMULA FOR ADDITIONAL PAYMENT AMOUNTS; REPORT

Section 4403(b), (c) of Pub. L. 105-33 provided that:

“(b) REPORT ON NEW PAYMENT FORMULA.—

“(1) REPORT.—Not later than 1 year after the date of the enactment of this Act [Aug. 5, 1997], the Secretary of Health and Human Services shall submit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate a report that contains a formula for determining additional payment amounts to hospitals under section 1886(d)(5)(F) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(F)).

“(2) FACTORS IN DETERMINATION OF FORMULA.—In determining such formula the Secretary shall—

“(A) establish a single threshold for costs incurred by hospitals in serving low-income patients, and

“(B) consider the costs described in paragraph (3).

“(3) The costs described in this paragraph are as follows:

“(A) The costs incurred by the hospital during a period (as determined by the Secretary) of furnishing hospital services to individuals who are entitled to benefits under part A of title XVIII of the Social Security Act [part A of this subchapter] and who receive supplemental security income benefits

under title XVI of such Act [subchapter XVI of this chapter] (excluding any supplementation of those benefits by a State under section 1616 of such Act (42 U.S.C. 1382e)).

“(B) The costs incurred by the hospital during a period (as so determined) of furnishing hospital services to individuals who receive medical assistance under the State plan under title XIX of such Act [subchapter XIX of this chapter] and are not entitled to benefits under part A of title XVIII of such Act [part A of this subchapter] (including individuals enrolled in a managed care organization (as defined in section 1903(m)(1)(A) of such Act (42 U.S.C. 1396b(m)(1)(A))) or any other managed care plan under such title and individuals who receive medical assistance under such title pursuant to a waiver approved by the Secretary under section 1115 of such Act (42 U.S.C. 1315)).

“(c) DATA COLLECTION.—In developing the formula described in subsection (b), the Secretary of Health and Human Services may require any subsection (d) hospital (as defined in section 1886(d)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B))) receiving additional payments by reason of section 1886(d)(5)(F) of such Act (42 U.S.C. 1395ww(d)(5)(F)) to submit to the Secretary any information that the Secretary determines is necessary to develop such formula.”

GEOGRAPHIC RECLASSIFICATION FOR CERTAIN DISPROPORTIONATELY LARGE HOSPITALS

Section 4409 of Pub. L. 105-33 provided that:

“(a) NEW GUIDELINES FOR RECLASSIFICATION.—Notwithstanding the guidelines published under section 1886(d)(10)(D)(i)(I) of the Social Security Act (42 U.S.C. 1395ww(d)(10)(D)(i)(I)), the Secretary of Health and Human Services shall publish and use alternative guidelines under which a hospital described in subsection (b) qualifies for geographic reclassification under such section for a fiscal year beginning with fiscal year 1998.

“(b) HOSPITALS COVERED.—A hospital described in this subsection is a hospital that demonstrates that—

“(1) the average hourly wage paid by the hospital is not less than 108 percent of the average hourly wage paid by all other hospitals located in the Metropolitan Statistical Area (or the New England County Metropolitan Area) in which the hospital is located;

“(2) not less than 40 percent of the adjusted uninflated wages paid by all hospitals located in such Area is attributable to wages paid by the hospital; and

“(3) the hospital submitted an application requesting reclassification for purposes of wage index under section 1886(d)(10)(C) of such Act (42 U.S.C. 1395ww(d)(10)(C)) in each of fiscal years 1992 through 1997 and that such request was approved for each of such fiscal years.”

FLOOR ON AREA WAGE INDEX

Section 4410 of Pub. L. 105-33 provided that:

“(a) IN GENERAL.—For purposes of section 1886(d)(3)(E) of the Social Security Act (42 U.S.C. 1395ww(d)(3)(E)) for discharges occurring on or after October 1, 1997, the area wage index applicable under such section to any hospital which is not located in a rural area (as defined in section 1886(d)(2)(D) of such Act (42 U.S.C. 1395ww(d)(2)(D))) may not be less than the area wage index applicable under such section to hospitals located in rural areas in the State in which the hospital is located.

“(b) IMPLEMENTATION.—The Secretary of Health and Human Services shall adjust the area wage index referred to in subsection (a) for hospitals not described in such subsection in a manner which assures that the aggregate payments made under section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)) in a fiscal year for the operating costs of inpatient hospital services are not greater or less than those which would have been made in the year if this section did not apply.

“(c) EXCLUSION OF CERTAIN WAGES.—In the case of a hospital that is owned by a municipality and that was reclassified as an urban hospital under section 1886(d)(10) of the Social Security Act [subsec. (d)(10) of this section] for fiscal year 1996, in calculating the hospital’s average hourly wage for purposes of geographic reclassification under such section for fiscal year 1998, the Secretary of Health and Human Services shall exclude the general service wages and hours of personnel associated with a skilled nursing facility that is owned by the hospital of the same municipality and that is physically separated from the hospital to the extent that such wages and hours of such personnel are not shared with the hospital and are separately documented. A hospital that applied for and was denied reclassification as an urban hospital for fiscal year 1998, but that would have received reclassification had the exclusion required by this section been applied to it, shall be reclassified as an urban hospital for fiscal year 1998.”

REPORT ON EFFECT OF AMENDMENTS BY PUB. L. 105-33,
§ 4415, ON PSYCHIATRIC HOSPITALS

Section 4415(d) of Pub. L. 105-33 provided that: “Not later than October 1, 1999, the Secretary of Health and Human Services shall submit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate a report that describes the effect of the amendments to section 1886(b)(1) of the Social Security Act (42 U.S.C. 1395ww(b)(1)), made under this section, on psychiatric hospitals (as defined in section 1886(d)(1)(B)(i) of such Act (42 U.S.C. 1395ww(d)(1)(B)(i)) that have approved medical residency training programs under title XVIII of such Act (42 U.S.C. 1395 et seq.).”

TREATMENT OF CERTAIN CANCER HOSPITALS; PAYMENT

Pub. L. 106-554, §1(a)(4) [div. B, title I, §152(c)], Dec. 21, 2000, 114 Stat. 2763, 2763A-252, provided that:

“(1) APPLICATION TO COST REPORTING PERIODS.—Any classification by reason of section 1886(d)(1)(B)(v)(III) of the Social Security Act [subsec. (d)(1)(B)(v)(III) of this section] (as added by subsection (a)) shall apply to 12-month cost reporting periods beginning on or after July 1, 1999.

“(2) BASE YEAR.—Notwithstanding the provisions of section 1886(b)(3)(E) of such Act (42 U.S.C. 1395ww(b)(3)(E)) or other provisions to the contrary, the base cost reporting period for purposes of determining the target amount for any hospital classified by reason of section 1886(d)(1)(B)(v)(III) of such Act [subsec. (d)(1)(B)(v)(III) of this section] (as added by subsection (a)) shall be the 12-month cost reporting period beginning on July 1, 1995.

“(3) DEADLINE FOR PAYMENTS.—Any payments owed to a hospital by reason of this subsection shall be made expeditiously, but in no event later than 1 year after the date of the enactment of this Act [Dec. 21, 2000].”

Section 4418(b) of Pub. L. 105-33 provided that:

“(1) APPLICATION TO COST REPORTING PERIODS.—Any classification by reason of section 1886(d)(1)(B)(v)(II) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)(v)(II)) (as added by subsection (a)) shall apply to all cost reporting periods beginning on or after January 1, 1991.

“(2) BASE YEAR.—Notwithstanding the provisions of section 1886(b)(3)(E) of such Act (42 U.S.C. 1395ww(b)(3)(E)) or other provisions to the contrary, the base cost reporting period for purposes of determining the target amount for any hospital classified by reason of section 1886(d)(1)(B)(v)(II) of such Act shall be either—

“(A) the hospital’s cost reporting period beginning during fiscal year 1990, or

“(B) pursuant to an election under 1886(b)(3)(G) of such Act (42 U.S.C. 1395ww(b)(3)(G)), as added in section 4413(b), the period provided for under such section.

“(3) DEADLINE FOR PAYMENTS.—Any payments owed to a hospital by reason of this subsection shall be made

expeditiously, but in no event later than 1 year after the date of the enactment of this Act [Aug. 5, 1997].”

REPORT ON EXCEPTIONS

Section 4419(b) of Pub. L. 105-33 provided that: “The Secretary of Health and Human Services shall publish annually in the Federal Register a report describing the total amount of payments made to hospitals by reason of section 1886(b)(4) of the Social Security Act (42 U.S.C. 1395ww(b)(4)), as amended by subsection (a), ending during the previous fiscal year.”

DEVELOPMENT OF PROPOSAL ON PAYMENTS FOR LONG-TERM CARE HOSPITALS

Section 4422 of Pub. L. 105-33 provided that:

“(a) IN GENERAL.—

“(1) LEGISLATIVE PROPOSAL.—The Secretary of Health and Human Services shall develop a legislative proposal for establishing a case-mix adjusted prospective payment system for payment of long-term care hospitals described in section 1886(d)(1)(B)(iv) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)(iv)) under the medicare program. Such system shall include an adequate patient classification system that reflects the differences in patient resource use and costs among such hospitals.

“(2) COLLECTION OF DATA AND EVALUATION.—In developing the legislative proposal described in paragraph (1), the Secretary—

“(A) may require such long-term care hospitals to submit such information to the Secretary as the Secretary may require to develop the proposal; and

“(B) shall consider several payment methodologies, including the feasibility of expanding the current diagnosis-related groups and prospective payment system established under section 1886(d) of the Social Security Act [subsec. (d) of this section] to apply to payments under the medicare program to long-term care hospitals.

“(b) REPORT.—Not later than October 1, 1999, the Secretary shall submit to the appropriate committees of Congress a report that includes the legislative proposal developed under subsection (a)(1).”

DISSEMINATION OF INFORMATION ON HIGH PER DISCHARGE RELATIVE VALUES FOR IN-HOSPITAL PHYSICIANS’ SERVICES

Section 4506 of title IV of Pub. L. 105-33 provided that:

“(a) DETERMINATION AND NOTICE CONCERNING HOSPITAL-SPECIFIC PER DISCHARGE RELATIVE VALUES.—

“(1) IN GENERAL.—For 1999 and 2001 the Secretary of Health and Human Services shall determine for each hospital—

“(A) the hospital-specific per discharge relative value under subsection (b); and

“(B) whether the hospital-specific relative value is projected to be excessive (as determined based on such value represented as a percentage of the median of hospital-specific per discharge relative values determined under subsection (b)).

“(2) NOTICE TO SUBSET OF MEDICAL STAFFS; EVALUATION OF RESPONSES.—The Secretary shall notify the medical executive committee of a subset of the hospitals identified under paragraph (1)(B) as having an excessive hospital-specific relative value, of the determinations made with respect to the medical staff under paragraph (1). The Secretary shall evaluate the responses of the hospitals so notified with the responses of other hospitals so identified that were not so notified.

“(b) DETERMINATION OF HOSPITAL-SPECIFIC PER DISCHARGE RELATIVE VALUES.—

“(1) IN GENERAL.—For purposes of this section, the hospital-specific per discharge relative value for the medical staff of a hospital (other than a teaching hospital) for a year shall be equal to the average per discharge relative value (as determined under section 1848(c)(2) of the Social Security Act (42 U.S.C.

1395w-4(c)(2)(I)] for physicians' services furnished to inpatients of the hospital by the hospital's medical staff (excluding interns and residents) during the second year preceding that calendar year, adjusted for variations in case-mix among hospitals and disproportionate share status and teaching status among hospitals (as determined by the Secretary under paragraph (3)).

“(2) SPECIAL RULE FOR TEACHING HOSPITALS.—The hospital-specific relative value projected for a teaching hospital in a year shall be equal to the sum of—

“(A) the average per discharge relative value (as determined under section 1848(c)(2) of such Act [section 1395w-4(c)(2) of this title] for physicians' services furnished to inpatients of the hospital by the hospital's medical staff (excluding interns and residents) during the second year preceding that calendar year, and

“(B) the equivalent per discharge relative value (as determined under such section) for physicians' services furnished to inpatients of the hospital by interns and residents of the hospital during the second year preceding that calendar year, adjusted for variations in case-mix among hospitals, and in disproportionate share status and teaching status among hospitals (as determined by the Secretary under paragraph (3)).

The Secretary shall determine the equivalent relative value unit per discharge for interns and residents based on the best available data and may make such adjustment in the aggregate.

“(3) ADJUSTMENT FOR TEACHING AND DISPROPORTIONATE SHARE HOSPITALS.—The Secretary shall adjust the allowable per discharge relative values otherwise determined under this subsection to take into account the needs of teaching hospitals and hospitals receiving additional payments under subparagraphs (F) and (G) of section 1886(d)(5) of the Social Security Act (42 U.S.C. 1395ww(d)(5)). The adjustment for teaching status or disproportionate share shall not be less than zero.

“(c) DEFINITIONS.—For purposes of this section:

“(1) HOSPITAL.—The term ‘hospital’ means a subsection (d) hospital as defined in section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)).

“(2) MEDICAL STAFF.—An individual furnishing a physician's service is considered to be on the medical staff of a hospital—

“(A) if (in accordance with requirements for hospitals established by the Joint Commission on Accreditation of Health Organizations)—

“(i) the individual is subject to bylaws, rules, and regulations established by the hospital to provide a framework for the self-governance of medical staff activities,

“(ii) subject to the bylaws, rules, and regulations, the individual has clinical privileges granted by the hospital's governing body, and

“(iii) under the clinical privileges, the individual may provide physicians' services independently within the scope of the individual's clinical privileges, or

“(B) if the physician provides at least one service to an individual entitled to benefits under this title in that hospital.

“(3) PHYSICIANS' SERVICES.—The term ‘physicians' services’ means the services described in section 1848(j)(3) of the Social Security Act (42 U.S.C. 1395w-4(j)(3)).

“(4) RURAL AREA; URBAN AREA.—The terms ‘rural area’ and ‘urban area’ have the meaning given those terms under section 1886(d)(2)(D) of such Act (42 U.S.C. 1395ww(d)(2)(D)).

“(5) SECRETARY.—The term ‘Secretary’ means the Secretary of Health and Human Services.

“(6) TEACHING HOSPITAL.—The term ‘teaching hospital’ means a hospital which has a teaching program

approved as specified in section 1861(b)(6) of the Social Security Act (42 U.S.C. 1395x(b)(6)).”

INCENTIVE PAYMENTS UNDER PLANS FOR VOLUNTARY REDUCTION IN NUMBER OF RESIDENTS; RELATION TO DEMONSTRATION PROJECTS AND AUTHORITY; REGULATIONS

Section 4626(b), (c) of Pub. L. 105-33 provided that:

“(b) RELATION TO DEMONSTRATION PROJECTS AND AUTHORITY.—

“(1) Section 1886(h)(6) of the Social Security Act [subsec. (h)(6) of this section], added by subsection (a), other than subparagraph (F)(ii) thereof, shall not apply to any residency training program with respect to which a demonstration project described in paragraph (3) has been approved by the Health Care Financing Administration as of May 27, 1997.

“(2) Effective May 27, 1997, the Secretary of Health and Human Services is not authorized to approve any demonstration project described in paragraph (3) for any residency training year beginning before July 1, 2006.

“(3) A demonstration project described in this paragraph is a project that primarily provides for additional payments under title XVIII of the Social Security Act [this subchapter] in connection with a reduction in the number of residents in a medical residency training program.

“(c) INTERIM, FINAL REGULATIONS.—In order to carry out the amendment made by subsection (a) in a timely manner, the Secretary of Health and Human Services may first promulgate regulations, that take effect on an interim basis, after notice and pending opportunity for public comment, by not later than 6 months after the date of the enactment of this Act [Aug. 5, 1997].”

DEMONSTRATION PROJECT ON USE OF CONSORTIA

Section 4628 of Pub. L. 105-33 provided that:

“(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ‘Secretary’) shall establish a demonstration project under which, instead of making payments to teaching hospitals pursuant to section 1886(h) of the Social Security Act [subsec. (h) of this section], the Secretary shall make payments under this section to each consortium that meets the requirements of subsection (b) and that applies to be included under the project.

“(b) QUALIFYING CONSORTIA.—For purposes of subsection (a), a consortium meets the requirements of this subsection if the consortium is in compliance with the following:

“(1) The consortium consists of a teaching hospital with one or more approved medical residency training programs and one or more of the following entities:

“(A) A school of allopathic medicine or osteopathic medicine.

“(B) Another teaching hospital, which may be a children's hospital.

“(C) A Federally qualified health center.

“(D) A medical group practice.

“(E) A managed care entity.

“(F) An entity furnishing outpatient services.

“(G) Such other entity as the Secretary determines to be appropriate.

“(2) The members of the consortium have agreed to participate in the programs of graduate medical education that are operated by the entities in the consortium.

“(3) With respect to the receipt by the consortium of payments made pursuant to this section, the members of the consortium have agreed on a method for allocating the payments among the members.

“(4) The consortium meets such additional requirements as the Secretary may establish.

“(c) AMOUNT AND SOURCE OF PAYMENT.—The total of payments to a qualifying consortium for a fiscal year pursuant to subsection (a) shall not exceed the amount that would have been paid under section 1886(h) or (k)

of the Social Security Act [subsecs. (h), (k) of this section] for the teaching hospital (or hospitals) in the consortium. Such payments shall be made in such proportion from each of the trust funds established under title XVIII of such Act [this subchapter] as the Secretary specifies.”

RECOMMENDATIONS ON LONG-TERM POLICIES REGARDING TEACHING HOSPITALS AND GRADUATE MEDICAL EDUCATION

Section 4629 of Pub. L. 105-33 provided that:

“(a) IN GENERAL.—The Medicare Payment Advisory Commission (established under section 1805 of the Social Security Act [section 1395b-6 of this title] and in this section referred to as the ‘Commission’) shall examine and develop recommendations on whether and to what extent medicare payment policies and other Federal policies regarding teaching hospitals and graduate medical education should be changed. Such recommendations shall include recommendations regarding each of the following:

“(1) Possible methodologies for making payments for graduate medical education and the selection of entities to receive such payments. Matters considered under this paragraph shall include—

“(A) issues regarding children’s hospitals and approved medical residency training programs in pediatrics, and

“(B) whether and to what extent payments are being made (or should be made) for training in the nursing and other allied health professions.

“(2) Federal policies regarding international medical graduates.

“(3) The dependence of schools of medicine on service-generated income.

“(4) Whether and to what extent the needs of the United States regarding the supply of physicians, in the aggregate and in different specialties, will change during the 10-year period beginning on October 1, 1997, and whether and to what extent any such changes will have significant financial effects on teaching hospitals.

“(5) Methods for promoting an appropriate number, mix, and geographical distribution of health professionals.

“(b) CONSULTATION.—In conducting the study under subsection (a), the Commission shall consult with the Council on Graduate Medical Education and individuals with expertise in the area of graduate medical education, including—

“(1) deans from allopathic and osteopathic schools of medicine;

“(2) chief executive officers (or equivalent administrative heads) from academic health centers, integrated health care systems, approved medical residency training programs, and teaching hospitals that sponsor approved medical residency training programs;

“(3) chairs of departments or divisions from allopathic and osteopathic schools of medicine, schools of dentistry, and approved medical residency training programs in oral surgery;

“(4) individuals with leadership experience from representative fields of non-physician health professionals;

“(5) individuals with substantial experience in the study of issues regarding the composition of the health care workforce of the United States; and

“(6) individuals with expertise in health care payment policies.

“(c) REPORT.—Not later than 2 years after the date of the enactment of this Act [Aug. 5, 1997], the Commission shall submit to the Congress a report providing its recommendations under this section and the reasons and justifications for such recommendations.”

STUDY OF HOSPITAL OVERHEAD AND SUPERVISORY PHYSICIAN COMPONENTS OF DIRECT MEDICAL EDUCATION COSTS

Section 4630 of Pub. L. 105-33 provided that:

“(a) IN GENERAL.—The Secretary of Health and Human Services shall conduct a study with respect to—

“(1) variations among hospitals in the hospital overhead and supervisory physician components of their direct medical education costs taken into account under section 1886(h) of the Social Security Act [subsec. (h) of this section], and

“(2) the reasons for such variations.

“(b) REPORT.—Not later than 1 year after the date of the enactment of this Act [Aug. 5, 1997], the Secretary shall report the results of the study conducted under subsection (a) to the appropriate committees of Congress, including recommendations for legislation reducing variations described in subsection (a) that the Secretary finds inappropriate.”

DRG PROSPECTIVE PAYMENT RATE METHODOLOGY; TRANSITION RULE FOR FISCAL YEAR 1998

Section 4644(a)(2) of Pub. L. 105-33 provided that: “With respect to the publication in the Federal Register of the DRG prospective payment rate methodology under such section for fiscal year 1998, the term ‘60 days’ in section 801(a)(3)(A) and section 802(a) of title 5, United States Code, is deemed to be a reference to ‘30 days’.”

HOSPITAL PAYMENT UPDATES; TRANSITION RULE FOR FISCAL YEAR 1998

Section 4644(b)(2) of Pub. L. 105-33 provided that: “With respect to the publication in the Federal Register of the appropriate change factor for inpatient hospital services for discharges in fiscal year 1998 under section 1886(e)(5)(B) (42 U.S.C. 1395ww(e)(5)(B)), the term ‘60 days’ in section 801(a)(3)(A) and section 802(a) of title 5, United States Code, is deemed to be a reference to ‘30 days’.”

GEOGRAPHICAL RECLASSIFICATION; SPECIAL RULE FOR APPLICATIONS RECEIVED IN FISCAL YEAR 1997

Section 4644(c)(2) of Pub. L. 105-33 provided that: “In the case of an application for a change in geographic classification under such section [subsec. (d)(10)(C)(ii) of this section] for fiscal year 1999, the Secretary of Health and Human Services shall shorten the deadlines under such section so as to permit completion of a final decision by the Secretary by June 15, 1998.”

NO STANDARDIZED AMOUNT ADJUSTMENTS FOR FISCAL YEARS 1992 OR 1993

Section 13501(b)(2) of Pub. L. 103-66 provided that: “The Secretary of Health and Human Services shall not revise the fiscal year 1992 or fiscal year 1993 standardized amounts pursuant to subsections (d)(3)(B) and (d)(8)(D) of section 1886 of the Social Security Act [subsec. (d)(3)(B) and (d)(8)(D) of this section] to account for the amendment made by paragraph (1) [amending this section].”

EXTENSION OF REGIONAL REFERRAL CENTER CLASSIFICATIONS THROUGH FISCAL YEAR 1994; RECLASSIFICATION

Section 13501(d) of Pub. L. 103-66 provided that:

“(1) EXTENSION OF CLASSIFICATION THROUGH FISCAL YEAR 1994.—Any hospital that is classified as a regional referral center under section 1886(d)(5)(C) of the Social Security Act [subsec. (d)(5)(C) of this section] as of September 30, 1992, shall continue to be so classified for cost reporting periods beginning during fiscal year 1993 or fiscal year 1994, unless the area in which the hospital is located is redesignated as a Metropolitan Statistical Area by the Office of Management and Budget for such a fiscal year.

“(2) PERMITTING HOSPITALS TO DECLINE RECLASSIFICATION.—If any hospital fails to qualify as a rural referral center under section 1886(d)(5)(C) of the Social Security Act as a result of a decision by the Medicare Geographic Classification Review Board under section 1886(d)(10) of such Act to reclassify the hospital as being located in an urban area for fiscal year 1993 or fis-

cal year 1994, the Secretary of Health and Human Services shall—

“(A) notify such hospital of such failure to qualify,

“(B) provide an opportunity for such hospital to decline such reclassification, and

“(C) if the hospital—

“(i) declines such reclassification, administer the Social Security Act [this chapter] (other than section 1886(d)(8)(D)) for such fiscal year as if the decision by the Review Board had not occurred, or

“(ii) fails to decline such reclassification, administer the Social Security Act without regard to paragraph (1).

“(3) REQUIRING LUMP-SUM RETROACTIVE PAYMENT FOR HOSPITALS LOSING CLASSIFICATION.—

“(A) IN GENERAL.—In the case of a hospital described in paragraph (1), the Secretary of Health and Human Services shall make a lump-sum payment to the hospital equal to the difference between the aggregate payment made to the hospital under section 1886 of such Act (excluding outlier payments under subsection (d)(5)(A) of such section) during the period of applicability described in subparagraph (B) and the aggregate payment that would have been made to the hospital under such section if, during the period of applicability, the hospital was classified a regional referral center under section 1886(d)(5)(C) of such Act.

“(B) PERIOD OF APPLICABILITY.—In subparagraph (A), the ‘period of applicability’ is the period that begins on October 1, 1992, and ends on the date of the enactment of this Act [Aug. 10, 1993].”

HOSPITALS DECLINING URBAN AREA RECLASSIFICATIONS; RETROACTIVE PAYMENTS

Pub. L. 103–66, title XIII, §13501(e)(2), (3), Aug. 10, 1993, 107 Stat. 576, as amended by Pub. L. 105–33, title IV, §4204(a)(3), Aug. 5, 1997, 111 Stat. 376; Pub. L. 106–113, div. B, §1000(a)(6) [title IV, §404(b)(2)], Nov. 29, 1999, 113 Stat. 1536, 1501A–372; Pub. L. 109–171, title V, §5003(a)(2)(B), Feb. 8, 2006, 120 Stat. 32; Pub. L. 111–148, title III, §3124(b)(2), Mar. 23, 2010, 124 Stat. 425, provided that:

“(2) PERMITTING HOSPITALS TO DECLINE RECLASSIFICATION.—If any hospital fails to qualify as a medicare-dependent, small rural hospital under section 1886(d)(5)(G)(i) of the Social Security Act [subsec. (d)(5)(G)(i) of this section] as a result of a decision by the Medicare Geographic Classification Review Board under section 1886(d)(10) of such Act to reclassify the hospital as being located in an urban area for fiscal year 1993, fiscal year 1994, fiscal year 1998, fiscal year 1999, or fiscal year 2000 through fiscal year 2012, the Secretary of Health and Human Services shall—

“(A) notify such hospital of such failure to qualify,

“(B) provide an opportunity for such hospital to decline such reclassification, and

“(C) if the hospital declines such reclassification, administer the Social Security Act [this chapter] (other than section 1886(d)(8)(D)) for such fiscal year as if the decision by the Review Board had not occurred.

“(3) REQUIRING LUMP-SUM RETROACTIVE PAYMENT.—

“(A) IN GENERAL.—In the case of a hospital treated as a medicare-dependent, small rural hospital under section 1886(d)(5)(G) of the Social Security Act, the Secretary of Health and Human Services shall make a lump-sum payment to the hospital equal to the difference between the aggregate payment made to the hospital under section 1886 of such Act (excluding outlier payments under subsection (d)(5)(A) of such section) during the period of applicability described in subparagraph (B) and the aggregate payment that would have been made to the hospital under such section if, during the period of applicability, section 1886(d)(5)(G) of such Act had been applied as if the amendments made by paragraph (1) [amending this section] had been in effect.

“(B) PERIOD OF APPLICABILITY.—In subparagraph (A), the ‘period of applicability’ is, with respect to a hospital, the period that begins on the first day of the

hospital’s first 12-month cost reporting period that begins after April 1, 1992, and ends on the date of the enactment of this Act [Aug. 10, 1993].”

ADJUSTMENT IN GME BASE-YEAR COSTS OF FEDERAL INSURANCE CONTRIBUTIONS ACT

Section 13563(d) of Pub. L. 103–66 provided that:

“(1) IN GENERAL.—In determining the amount of payment to be made under section 1886(h) of the Social Security Act [subsec. (h) of this section] in the case of a hospital described in paragraph (2) for cost reporting periods beginning on or after October 1, 1992, the Secretary of Health and Human Services shall redetermine the approved FTE resident amount to reflect the amount that would have been paid the hospital if, during the hospital’s base cost reporting period, the hospital had been liable for FICA taxes or for contributions to the retirement system of a State, a political subdivision of a State, or an instrumentality of such a State or political subdivision with respect to interns and residents in its medical residency training program.

“(2) HOSPITALS AFFECTED.—A hospital described in this paragraph is a hospital that did not pay FICA taxes with respect to interns and residents in its medical residency training program during the hospital’s base cost reporting period, but is required to pay FICA taxes or make contributions to a retirement system described in paragraph (1) with respect to such interns and residents because of the amendments made by section 11332(b) of OBRA–1990 [Pub. L. 101–508, amending section 3121 of Title 26, Internal Revenue Code].

“(3) DEFINITIONS.—In this subsection:

“(A) The ‘base cost reporting period’ for a hospital is the hospital’s cost reporting period that began during fiscal year 1984.

“(B) The term ‘FICA taxes’ means, with respect to a hospital, the taxes under section 3111 of the Internal Revenue Code of 1986 [26 U.S.C. 3111].”

DETERMINATION OF AREA WAGE INDEX FOR DISCHARGES OCCURRING JANUARY 1, 1991 TO OCTOBER 1, 1993

Section 4002(d)(1) of Pub. L. 101–508 provided that:

“(A) For purposes of section 1886(d)(3)(E) of the Social Security Act [subsec. (d)(3)(E) of this section] for discharges occurring on or after January 1, 1991, and before October 1, 1993, the Secretary of Health and Human Services shall apply an area wage index determined using the survey of the 1988 wages and wage-related costs of hospitals in the United States conducted under such section.

“(B) The Secretary shall apply the wage index described in subparagraph (A) without regard to a previous survey of wages and wage-related costs.”

STUDY AND REPORT ON RELATIONSHIP BETWEEN NON-WAGE-RELATED INPUT PRICES AND ADJUSTED AVERAGE STANDARDIZED AMOUNTS

Section 4002(e)(2) of Pub. L. 101–508 directed Secretary of Health and Human Services to collect sufficient data on the input prices associated with the non-wage-related portion of the adjusted average standardized amounts established under subsec. (d)(3) of this section to identify extent to which variations in such amounts among hospitals located in different geographic areas are attributable to differences in such prices, and, not later than June 1, 1993, submit a report to Congress analyzing such data, with such report to include recommendations regarding a methodology for adjusting such average standardized amounts to reflect such variations.

DEADLINE FOR SUBMISSION OF APPLICATIONS TO GEOGRAPHIC CLASSIFICATION REVIEW BOARD

Section 4002(h)(2)(A) of Pub. L. 101–508 provided that: “For purposes of determining whether a hospital requesting a change in geographic classification for fiscal year 1992 under section 1886(d)(10) of the Social Security Act [subsec. (d)(10) of this section] has met the

deadline described in subparagraph (C)(ii) of such section, an application submitted under such subparagraph shall be considered to have been submitted by the first day of the preceding fiscal year if it is submitted within 60 days of the date of publication of the guidelines described in subparagraph (D)(i) of such section."

PAYMENTS FOR MEDICAL EDUCATION COSTS

Section 4004 of Pub. L. 101-508 provided that:

"(a) HOSPITAL GRADUATE MEDICAL EDUCATION RECOUPMENT.—

"(1) IN GENERAL.—The Secretary of Health and Human Services may not, before October 1, 1991, recoup payments from a hospital because of alleged overpayments to such hospital under part A of title XVIII of the Social Security Act [part A of this subchapter] due to a determination that the amount of payments made for graduate medical education programs exceeds the amount allowable under section 1886(h) [subsec. (h) of this section].

"(2) CAP ON ANNUAL AMOUNT OF RECOUPMENT.—With respect to overpayments to a hospital described in paragraph (1), the Secretary may not recoup more than 25 percent of the amount of such overpayments from the hospital during a fiscal year.

"(3) EFFECTIVE DATE.—Paragraphs (1) and (2) shall take effect October 1, 1990.

"(b) UNIVERSITY HOSPITAL NURSING EDUCATION.—

"(1) IN GENERAL.—The reasonable costs incurred by a hospital (or by an educational institution related to the hospital by common ownership or control) during a cost reporting period for clinical training (as defined by the Secretary) conducted on the premises of the hospital under approved nursing and allied health education programs that are not operated by the hospital shall be allowable as reasonable costs under part A of title XVIII of the Social Security Act and reimbursed under such part on a pass-through basis.

"(2) CONDITIONS FOR REIMBURSEMENT.—The reasonable costs incurred by a hospital during a cost reporting period shall be reimbursable pursuant to paragraph (1) only if—

"(A) the hospital claimed and was reimbursed for such costs during the most recent cost reporting period that ended on or before October 1, 1989;

"(B) the proportion of the hospital's total allowable costs that is attributable to the clinical training costs of the approved program, and allowable under (b)(1) during the cost reporting period does not exceed the proportion of total allowable costs that were attributable to the clinical training costs during the cost reporting period described in subparagraph (A);

"(C) the hospital receives a benefit for the support it furnishes to such program through the provision of clinical services by nursing or allied health students participating in such program; and

"(D) the costs incurred by the hospital for such program do not exceed the costs that would be incurred by the hospital if it operated the program itself.

"(3) PROHIBITION AGAINST RECOUPMENT OF COSTS BY SECRETARY.—

"(A) IN GENERAL.—The Secretary of Health and Human Services may not recoup payments from (or otherwise reduce or adjust payments under part A of title XVIII of the Social Security Act to) a hospital because of alleged overpayments to such hospital under such title due to a determination that costs which were reported by the hospital on its medicare cost reports for cost reporting periods beginning on or after October 1, 1983, and before October 1, 1990, relating to approved nursing and allied health education programs did not meet the requirements for allowable nursing and allied health education costs (as developed by the Secretary pursuant to section 1861(v) of such Act [section 1395x(v) of this title]).

"(B) REFUND OF AMOUNTS RECOUPED.—If, prior to the date of the enactment of this Act [Nov. 5, 1990],

the Secretary has recouped payments from (or otherwise reduced or adjusted payments under part A of title XVIII of the Social Security Act to) a hospital because of overpayments described in subparagraph (A), the Secretary shall refund the amount recouped, reduced, or adjusted from the hospital.

"(4) SPECIAL AUDIT TO DETERMINE COSTS.—In determining the amount of costs incurred by, claimed by, and reimbursed to, a hospital for purposes of this subsection, the Secretary shall conduct a special audit (or use such other appropriate mechanism) to ensure the accuracy of such past claims and payments.

"(5) EFFECTIVE DATE.—Except as provided in paragraph (3), the provisions of this subsection shall apply to cost reporting periods beginning on or after October 1, 1990."

Section 4159 of Pub. L. 101-508 provided that:

"(a) HOSPITAL GRADUATE MEDICAL EDUCATION RECOUPMENT.—

"(1) IN GENERAL.—The Secretary of Health and Human Services may not, before October 1, 1991, recoup payments from a hospital because of alleged overpayments to such hospital under part B of title XVIII of the Social Security Act [part B of this subchapter] due to a determination that the amount of payments made for graduate medical education programs exceeds the amount allowable under section 1886(h) [subsec. (h) of this section].

"(2) CAP ON ANNUAL AMOUNT OF RECOUPMENT.—With respect to overpayments to a hospital described in paragraph (1), the Secretary may not recoup more than 25 percent of the amount of such overpayments from the hospital during a fiscal year.

"(3) EFFECTIVE DATE.—Paragraphs (1) and (2) shall take effect October 1, 1990.

"(b) UNIVERSITY HOSPITAL NURSING EDUCATION.—

"(1) IN GENERAL.—The reasonable costs incurred by a hospital (or by an educational institution related to the hospital by common ownership or control) during a cost reporting period for clinical training (as defined by the Secretary) conducted on the premises of the hospital under approved nursing and allied health education programs that are not operated by the hospital shall be allowable as reasonable costs under part B of title XVIII of the Social Security Act and reimbursed under such part on a pass-through basis.

"(2) CONDITIONS FOR REIMBURSEMENT.—The reasonable costs incurred by a hospital during a cost reporting period shall be reimbursable pursuant to paragraph (1) only if—

"(A) the hospital claimed and was reimbursed for such costs during the most recent cost reporting period that ended on or before October 1, 1989;

"(B) the proportion of the hospital's total allowable costs that is attributable to the clinical training costs of the approved program, and allowable under (b)(1) during the cost reporting period does not exceed the proportion of total allowable costs that were attributable to clinical training costs during the cost reporting period described in subparagraph (A);

"(C) the hospital receives a benefit for the support it furnishes to such program through the provision of clinical services by nursing or allied health students participating in such program; and

"(D) the costs incurred by the hospital for such program do not exceed the costs that would be incurred by the hospital if it operated the program itself.

"(3) PROHIBITION AGAINST RECOUPMENT OF COSTS BY SECRETARY.—

"(A) IN GENERAL.—The Secretary of Health and Human Services may not recoup payments from (or otherwise reduce or adjust payments under part B of title XVIII of the Social Security Act to) a hospital because of alleged overpayments to such hospital under such title due to a determination that costs which were reported by the hospital on its medicare cost reports for cost reporting periods be-

ginning on or after October 1, 1983, and before October 1, 1990, relating to approved nursing and allied health education programs did not meet the requirements for allowable nursing and allied health education costs (as developed by the Secretary pursuant to section 1861(v) of such Act [section 1395x(v) of this title]).

“(B) REFUND OF AMOUNTS RECOUPED.—If, prior to the date of the enactment of this Act [Nov. 5, 1990], the Secretary has recouped payments from (or otherwise reduced or adjusted payments under part B of title XVIII of the Social Security Act to) a hospital because of overpayments described in subparagraph (A), the Secretary shall refund the amount recouped, reduced, or adjusted from the hospital.

“(4) SPECIAL AUDIT TO DETERMINE COSTS.—In determining the amount of costs incurred by, claimed by, and reimbursed to, a hospital for purposes of this subsection, the Secretary shall conduct a special audit (or use such other appropriate mechanism) to ensure the accuracy of such past claims and payments.

“(5) EFFECTIVE DATE.—Except as provided in paragraph (3), the provisions of this subsection shall apply to cost reporting periods beginning on or after October 1, 1990.”

DEVELOPMENT OF NATIONAL PROSPECTIVE PAYMENT RATES FOR CURRENT NON-PPS HOSPITALS

Section 4005(b) of Pub. L. 101-508 provided that:

“(1) DEVELOPMENT OF PROPOSAL.—The Secretary of Health and Human Services shall develop a proposal to modify the current system under which hospitals that are not subsection (d) hospitals (as defined in section 1886(d)(1)(B) of the Social Security Act [subsec. (d)(1)(B) of this section]) receive payment for the operating and capital-related costs of inpatient hospital services under part A [part A of this subchapter] of the medicare program or a proposal to replace such system with a system under which such payments would be made on the basis of nationally-determined average standardized amounts. In developing any proposal under this paragraph to replace the current system with a prospective payment system, the Secretary shall—

“(A) take into consideration the need to provide for appropriate limits on increases in expenditures under the medicare program;

“(B) provide for adjustments to prospectively determined rates to account for changes in a hospital's case mix, severity of illness of patients, volume of cases, and the development of new technologies and standards of medical practice;

“(C) take into consideration the need to increase the payment otherwise made under such system in the case of services provided to patients whose length of stay or costs of treatment greatly exceed the length of stay or cost of treatment provided for under the applicable prospectively determined payment rate;

“(D) take into consideration the need to adjust payments under the system to take into account factors such as a disproportionate share of low-income patients, costs related to graduate medical education programs, differences in wages and wage-related costs among hospitals located in various geographic areas, and other factors the Secretary considers appropriate; and

“(E) provide for the appropriate allocation of operating and capital-related costs of hospitals not subject to the new prospective payment system and distinct units of such hospitals that would be paid under such system.

“(2) REPORTS.—(A) By not later than April 1, 1992, the Secretary shall submit the proposal developed under paragraph (1) to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives.

“(B) By not later than June 1, 1992, the Prospective Payment Assessment Commission shall submit an analysis of and comments on the proposal developed

under paragraph (1) to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives.”

GUIDANCE TO INTERMEDIARIES AND HOSPITALS

Section 4005(c)(3) of Pub. L. 101-508 provided that: “The Administrator of the Health Care Financing Administration shall provide guidance to agencies and organizations performing functions pursuant to section 1816 of the Social Security Act [section 1395h of this title] and to hospitals that are not subsection (d) hospitals (as defined in section 1886(d)(1)(B) of such Act [subsec. (d)(1)(B) of this section]) to assist such agencies, organizations, and hospitals in filing complete applications with the Administrator for exemptions, exceptions, and adjustments under section 1886(b)(4)(A) of such Act.”

FREEZE IN PAYMENTS UNDER PART A OF THIS SUBCHAPTER THROUGH DECEMBER 31, 1990

Section 4007 of Pub. L. 101-508 provided that:

“(a) IN GENERAL.—Notwithstanding any other provision of law, for purposes of determining the amount of payment for items or services under part A of title XVIII of the Social Security Act [part A of this subchapter] (including payments under section 1886 of such Act [this section]) attributable to or allocated under such part) during the period described in subsection (b):

“(1) The market basket percentage increase (described in section 1886(b)(3)(B)(iii) of the Social Security Act) shall be deemed to be 0 for discharges occurring during such period.

“(2) The percentage increase or decrease in the medical care expenditure category of the consumer price index applicable under section 1814(i)(2)(B) of such Act [section 1395f(i)(2)(B) of this title] shall be deemed to be 0.

“(3) The area wage index applicable to a subsection (d) hospital under section 1886(d)(3)(E) of such Act shall be deemed to be the area wage index applicable to such hospital as of September 30, 1990.

“(4) The percentage change in the consumer price index applicable under section 1886(h)(2)(D) of such Act shall be deemed to be 0.

“(b) DESCRIPTION OF PERIOD.—The period referred to in subsection (a) is the period beginning on October 21, 1990, and ending on December 31, 1990.”

REVIEW OF HOSPITAL REGULATIONS WITH RESPECT TO RURAL HOSPITALS

Section 4008(l) of Pub. L. 101-508 provided that:

“(1) IN GENERAL.—The Secretary of Health and Human Services shall review the requirements applicable under title XVIII of the Social Security Act [this subchapter] to determine which requirements could be made less administratively and economically burdensome (without diminishing the quality of care) for hospitals defined in section 1886(d)(1)(B) of such Act [subsec. (d)(1)(B) of this section] that are located in a rural area (as defined in section 1886(d)(2)(D) of such Act). Such review shall specifically include standards related to staffing requirements.

“(2) REPORT.—The Secretary of Health and Human Services shall report to Congress by April 1, 1992, on the results of the review conducted under subsection (a), and include conclusions on which regulations, if any, should be modified with respect to hospitals described in subsection (a).”

PROHIBITION ON COST SAVINGS POLICIES BEFORE BEGINNING OF FISCAL YEAR

Section 4207(b)(1), formerly 4027(b)(1), of Pub. L. 101-508, as renumbered and amended by Pub. L. 103-432, title I, § 160(d)(4), (5)(C), Oct. 31, 1994, 108 Stat. 4444, provided that: “Notwithstanding any other provision of law, the Secretary of Health and Human Services may not issue any proposed or final regulation, instruction, or other policy which is estimated by the Secretary to result in a net reduction in expenditures under title

XVIII of the Social Security Act [this subchapter] in a fiscal year (beginning with fiscal year 1991 and ending with fiscal year 1993, or, if later, the last fiscal year for which there is a maximum deficit amount specified under section 601(a)(1) of the Congressional Budget and Impoundment Control Act of 1974 [2 U.S.C. 665(a)(1)]) of more than \$50,000,000, except as follows:

“(A) The Secretary may issue such a proposed regulation, instruction, or other policy with respect to the fiscal year before the May 15 preceding the beginning of the fiscal year.

“(B) The Secretary may issue such a final regulation, instruction, or other policy with respect to the fiscal year on or after October 15 of the fiscal year.

“(C) The Secretary may, at any time, issue such a proposed or final regulation, instruction, or other policy with respect to the fiscal year if required to implement specific provisions under statute.”

PROHIBITION OF PAYMENT CYCLE CHANGES

Section 4207(b)(2), formerly 4027(b)(2), of Pub. L. 101-508, as renumbered by Pub. L. 103-432, title I, §160(d)(4), Oct. 31, 1994, 108 Stat. 4444, provided that: “Notwithstanding any other provision of law, the Secretary of Health and Human Services is not authorized to issue, after the date of the enactment of this Act [Nov. 5, 1990], any final regulation, instruction, or other policy change which is primarily intended to have the effect of slowing down or speeding up claims processing, or delaying payment of claims, under title XVIII of the Social Security Act [this subchapter].”

EXTENSION OF AREA WAGE INDEX

Section 115(a) of Pub. L. 101-403 provided that: “For purposes of determining the amount of payment made to a hospital under part A of title XVIII of the Social Security Act [part A of this subchapter] for the operating costs of inpatient hospital services for discharges occurring on or after October 1, 1990, and on or before October 20, 1990, the Secretary of Health and Human Services, in adjusting such amount under section 1886(d)(3)(E) of such Act [subsec. (d)(3)(E) of this section] to reflect the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage index, shall apply the area wage index applicable to such hospital as of September 30, 1990.”

ADJUSTMENTS RESULTING FROM EXTENSIONS OF REGIONAL FLOOR ON STANDARDIZED AMOUNTS

Section 115(b)(2) of Pub. L. 101-403 provided that: “The Secretary of Health and Human Services shall make any adjustments resulting from the amendment made by paragraph (1) [amending this section] in the amount of the payments made to hospitals under section 1886(d) of the Social Security Act [subsec. (d) of this section] in a fiscal year for the operating costs of inpatient hospital services in a manner that ensures that the aggregate payments under such section are not greater or less than those that would have been made in the year without such adjustments.”

INDEXING OF FUTURE APPLICABLE PERCENTAGE INCREASES

Section 6003(a)(3) of Pub. L. 101-239 provided that: “For discharges occurring on or after October 1, 1990, the applicable percentage increase (described in section 1886(b)(3)(B) of the Social Security Act [subsec. (b)(3)(B) of this section]) for discharges occurring during fiscal year 1990 is deemed to have been such percentage increase as amended by paragraph (1).”

CONTINUATION OF SOLE COMMUNITY HOSPITAL DESIGNATION FOR CURRENT SOLE COMMUNITY HOSPITALS

Section 6003(e)(3) of Pub. L. 101-239 provided that: “Any hospital classified as a sole community hospital under section 1886(d)(5)(C)(ii) of the Social Security Act [subsec. (d)(5)(C)(ii) of this section] on the date of the enactment of this Act [Dec. 19, 1989] that will no longer

be classified as a sole community hospital after such date as a result of the amendments made by paragraph (1) [amending this section] shall continue to be classified as a sole community hospital for purposes of section 1886(d)(5)(D) of such Act [subsec. (d)(5)(D) of this section].”

ADDITIONAL PAYMENT RESULTING FROM CORRECTIONS OF ERRONEOUSLY DETERMINED WAGE INDEX

Section 6003(h)(5) of Pub. L. 101-239 provided that:

“(A) IN GENERAL.—If the Secretary of Health and Human Services (hereinafter referred to as the ‘Secretary’) discovers an error with respect to the determination, adjustment, or computation of the area wage index described in section 1886(d)(3)(E) of the Social Security Act [subsec. (d)(3)(E) of this section] and subsequently corrects such error, the Secretary shall make an additional payment under title XVIII of such Act [this subchapter] to a hospital affected by such error for inpatient hospital discharges occurring during the period when the erroneously determined, adjusted, or computed wage index was in effect.

“(B) CONDITIONS FOR ADDITIONAL PAYMENT.—A hospital is eligible for an additional payment under subparagraph (A) only if—

“(i) the error resulted from the submission of erroneous data, except that a hospital is not eligible for such additional payment if it submitted such erroneous data;

“(ii) the error was made with respect to the survey of the 1984 wages and wage-related costs of hospitals in the United States conducted under section 1886(d)(3)(E) of the Social Security Act; and

“(iii) the correction of the error resulted in an adjustment to the area wage index of not less than 3 percentage points.

“(C) PERIOD OF APPLICABILITY.—A hospital may not receive an additional payment under subparagraph (A) for discharges occurring after October 1, 1990.”

LEGISLATIVE PROPOSAL ELIMINATING SEPARATE AVERAGE STANDARDIZED AMOUNTS

Pub. L. 101-239, title VI, §6003(i), Dec. 19, 1989, 103 Stat. 2158, directed Secretary of Health and Human Services to design a legislative proposal eliminating the system of determining separate average standardized amounts for subsection (d) hospitals classified as being located in large urban, other urban, or rural areas, prior to repeal by Pub. L. 105-362, title VI, §601(b)(4), Nov. 10, 1998, 112 Stat. 3286.

DETERMINATION AND RECOMMENDATIONS OF PAYMENTS FOR COSTS OF ADMINISTERING BLOOD CLOTTING FACTORS TO INDIVIDUALS WITH HEMOPHILIA

Section 6011(b), (c) of Pub. L. 101-239 provided that:

“(b) DETERMINING PAYMENT AMOUNT.—The Secretary of Health and Human Services shall determine the amount of payment made to hospitals under part A of title XVIII of the Social Security Act [part A of this subchapter] for the costs of administering blood clotting factors to individuals with hemophilia by multiplying a predetermined price per unit of blood clotting factor (determined in consultation with the Prospective Payment Assessment Commission) by the number of units provided to the individual.

“(c) RECOMMENDATIONS ON PAYMENTS.—The Prospective Payment Assessment Commission and the Health Care Financing Administration shall develop recommendations with respect to payments to hospitals under part A of title XVIII of the Social Security Act for the costs of administering blood clotting factors to individuals with hemophilia, and shall submit such recommendations to Congress not later than 18 months after the date of enactment of this Act [Dec. 19, 1989].”

PUBLICATION OF INSTRUCTIONS RELATING TO EXCEPTIONS AND ADJUSTMENTS IN TARGET AMOUNTS

Section 6015(b) of Pub. L. 101-239 provided that: “By not later than 180 days after the date of enactment of

this Act [Dec. 19, 1989], the Secretary of Health and Human Services shall publish instructions specifying the application process to be used in providing exceptions and adjustments under section 1886(b)(4)(A) of the Social Security Act [subsec. (b)(4)(A) of this section].”

DELAY IN RECOUPMENT OF CERTAIN NURSING AND ALLIED EDUCATION COSTS

Section 6205(b) of Pub. L. 101-239 provided that:

“(1) The Secretary of Health and Human Services (in this subsection referred to as the ‘Secretary’) shall not, before October 1, 1990, recoup from, or otherwise reduce or adjust payments under title XVIII of the Social Security Act [this subchapter] to, hospitals because of alleged overpayments to such hospitals under such title due to a determination that costs which were reported by a hospital on its medicare cost reports relating to approved nursing and allied health education programs were allowable costs and are included in the definition of ‘operating costs of inpatient hospital services’ pursuant to section 1886(a)(4) of such Act [subsec. (a)(4) of this section], so that no pass-through of such costs was permitted under that section.

“(2)(A) Before July 1, 1990, the Secretary shall issue regulations respecting payment of costs described in paragraph (1).

“(B) In issuing such regulations—

“(i) the Secretary shall allow a comment period of not less than 60 days,

“(ii) the Secretary shall consult with the Prospective Payment Assessment Commission, and

“(iii) any final rule shall not be effective prior to October 1, 1990, or 30 days after publication of the final rule in the Federal Register, whichever is later.

“(C) Such regulations shall specify—

“(i) the relationship required between an approved nursing or allied health education program and a hospital for the program’s costs to be attributed to the hospital;

“(ii) the types of costs related to nursing or allied health education programs that are allowable by medicare;

“(iii) the distinction between costs of approved educational activities as recognized under section 1886(a)(3) of the Social Security Act [subsec. (a)(3) of this section] and educational costs treated as operating costs of inpatient hospital services; and

“(iv) the treatment of other funding sources for the program.”

INNER-CITY HOSPITAL TRIAGE DEMONSTRATION PROJECT

Section 6217 of Pub. L. 101-239, as amended by Pub. L. 101-508, title IV, § 4207(k)(5), formerly § 4027(k)(5), Nov. 5, 1990, 104 Stat. 1388-125, renumbered Pub. L. 103-432, title I, § 160(d)(4), Oct. 31, 1994, 108 Stat. 4444, provided that:

“(a) ESTABLISHMENT.—The Secretary of Health and Human Services shall establish a demonstration project in a public hospital that is located in a large urban area and that has established a triage system, under which the Secretary shall make payments out of the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund (in such proportions as the Secretary determines to be appropriate in a year) for 3 years to reimburse the hospital for the reasonable costs of operating the system, including costs—

“(1) to train hospital personnel to operate and participate in the system; and

“(2) to provide services to patients who might otherwise be denied appropriate and prompt care.

“(b) LIMITATIONS ON PAYMENT.—(1) The Secretary may not make payment under the demonstration project established under subsection (a) for costs that the Secretary determines are not reasonable.

“(2) The amount of payment made under the demonstration project during a single year may not exceed \$500,000.”

TRANSITION ADJUSTMENTS TO TARGET AMOUNTS FOR INPATIENT HOSPITAL SERVICES

Section 101(c)(2)(B) of title I of Pub. L. 101-234 provided that: “The Secretary of Health and Human Serv-

ices shall make an appropriate adjustment to the target amount established under section 1886(b)(3)(A) of the Social Security Act [subsec. (b)(3)(A) of this section] in the case of inpatient hospital services provided to an inpatient whose stay began before January 1, 1990, in order to take into account the target amount that would have applied but for the amendments made by this title [see Tables for classification].”

ELECTION OF PERSONNEL POLICY FOR PROPAC EMPLOYEES

Section 8405 of Pub. L. 100-647 provided that: “With respect to employees of the Prospective Payment Assessment Commission hired before December 22, 1987, such employees shall have the option to elect within 60 days of the date of enactment of this Act [Nov. 10, 1988] to be covered under either the personnel policy in effect with respect to such employees before December 22, 1987, or under the employees coverage provided under the last sentence of section 1886(e)(6)(D) of the Social Security Act [subsec. (e)(6)(D) of this section].”

ADJUSTMENTS IN PAYMENTS FOR INPATIENT HOSPITAL SERVICES

Section 104(c) of Pub. L. 100-360, as amended by Pub. L. 100-485, title VI, § 608(d)(3)(C)-(E), Oct. 13, 1988, 102 Stat. 2413; Pub. L. 101-234, title I, § 101(c)(1), (2)(A), Dec. 13, 1989, 103 Stat. 1980, provided that:

“(1) PPS HOSPITALS.—In adjusting DRG prospective payment rates under section 1886(d) of the Social Security Act [subsec. (d) of this section], outlier cutoff points under section 1886(d)(5)(A) of such Act, and weighting factors under section 1886(d)(4) of such Act for discharges occurring on or after October 1, 1988, and before January 1, 1990, the Secretary of Health and Human Services shall, to the extent appropriate, take into consideration the reductions in payments to hospitals by (or on behalf of) medicare beneficiaries resulting from the elimination of a day limitation on medicare inpatient hospital services (under the amendments made by section 101 [amending section 1395d of this title]).

“(2) PPS-EXEMPT HOSPITALS.—In adjusting target amounts under section 1886(b)(3) of the Social Security Act [subsec. (b)(3) of this section] for portions of cost reporting periods occurring on or after January 1, 1989, and before January 1, 1990, the Secretary shall, on a hospital-specific basis, take into consideration the reductions in payments to hospitals by (or on behalf of) medicare beneficiaries resulting from the elimination of a day limitation on medicare inpatient hospital services (under the amendments made by section 101 [amending section 1395d of this title]), without regard to whether such a hospital is paid on the basis described in subparagraph (A) or (B) of section 1886(b)(1) of such Act, without regard to whether any of such beneficiaries exhausted medicare inpatient hospital insurance benefits before January 1, 1989.”

[Amendment of section 104(c) of Pub. L. 100-360, set out above, by section 101(c)(1), (2)(A) of Pub. L. 101-234 effective as if included in enactment of Pub. L. 100-360, see section 101(d) of Pub. L. 101-234, set out as a note under section 1395c of this title.]

PROPAC STUDY

Section 203(c)(2) of Pub. L. 100-360 directed Prospective Payment Assessment Commission to conduct a study, and make recommendations to Congress and Secretary of Health and Human Services by not later than Mar. 1, 1991, concerning appropriate adjustment to payment amounts provided under subsec. (d) of this section for inpatient hospital services to account for reduced costs to hospitals resulting from amendments made by section 203 of Pub. L. 100-360, amending sections 1320c-3, 1395h, 1395k to 1395n, 1395w-2, 1395x, 1395z, and 1395aa of this title, prior to repeal by Pub. L. 101-234, title II, § 201(a), Dec. 13, 1989, 103 Stat. 1981.

CLINIC HOSPITAL WAGE INDICES

Section 4004(b) of Pub. L. 100-203 provided that: “In calculating the wage index under section 1886(d) of the

Social Security Act [subsec. (d) of this section] for purposes of making payment adjustments after September 30, 1988, as required under paragraphs (2)(H) and (3)(E) of such section, in the case of any institution which received the waiver specified in section 602(k) of the Social Security Amendments of 1983 [section 602(k) of Pub. L. 98-21, set out as a note under section 1395y of this title], the Secretary of Health and Human Services shall include wage costs paid to related organization employees directly involved in the delivery and administration of care provided by the related organization to hospital inpatients. For purposes of the preceding sentence, the term 'wage costs' does not include costs of overhead or home office administrative salaries or any costs that are not incurred in the hospital's Metropolitan Statistical Area."

LIMITATION ON AMOUNTS PAID IN FISCAL YEARS 1988
AND 1989

Section 4005(c)(2)(B) of Pub. L. 100-203 provided that: "The Secretary of Health and Human Services shall take appropriate steps to ensure that the total amount paid in a fiscal year under title XVIII of the Social Security Act [this subchapter] by reason of the amendment made by paragraph (1)(B) [amending this section] does not exceed \$5,000,000 in the case of fiscal year 1988 and \$10,000,000 for fiscal year 1989."

STUDY OF CRITERIA FOR CLASSIFICATION OF HOSPITALS
AS RURAL REFERRAL CENTERS; REPORT

Section 4005(d)(2) of Pub. L. 100-203 directed Secretary of Health and Human Services to provide for a study of the criteria used for the classification of hospitals as rural referral centers, and report to Congress, by not later than Mar. 1, 1989, on the study and on recommendations for the criteria that should be applied for the classification of hospitals as rural referral centers for cost reporting periods beginning on or after Oct. 1, 1989.

GRANT PROGRAM FOR RURAL HEALTH CARE TRANSITION

Section 4005(e) of Pub. L. 100-203, as amended by Pub. L. 101-239, title VI, § 6003(g)(1)(B)(i), Dec. 19, 1989, 103 Stat. 2150; Pub. L. 103-432, title I, § 103(a)(1), (b), (c), Oct. 31, 1994, 108 Stat. 4404, 4405, provided that:

"(1) The Administrator of the Health Care Financing Administration, in consultation with the Assistant Secretary for Health (or a designee), shall establish a program of grants to assist eligible small rural hospitals and their communities in the planning and implementation of projects to modify the type and extent of services such hospitals provide in order to adjust for one or more of the following factors:

"(A) Changes in clinical practice patterns.

"(B) Changes in service populations.

"(C) Declining demand for acute-care inpatient hospital capacity.

"(D) Declining ability to provide appropriate staffing for inpatient hospitals.

"(E) Increasing demand for ambulatory and emergency services.

"(F) Increasing demand for appropriate integration of community health services.

"(G) The need for adequate access (including appropriate transportation) to emergency care and inpatient care in areas in which a significant number of underutilized hospital beds are being eliminated.

"(H) The Administrator shall submit a final report on the program to the Congress not later than 180 days after all projects receiving a grant under the program are completed.

Each demonstration project under this subsection shall demonstrate methods of strengthening the financial and managerial capability of the hospital involved to provide necessary services. Such methods may include programs of cooperation with other health care providers, of diversification in services furnished (including the provision of home health services), of physician recruitment, and of improved management systems.

Grants under this paragraph may be used to provide instruction and consultation (and such other services as the Administrator determines appropriate) via telecommunications to physicians in such rural areas (within the meaning of section 1886(d)(2)(D) of the Social Security Act [subsec. (d)(2)(D) of this section]) as are designated either class 1 or class 2 health manpower shortage areas under section 332(a)(1)(A) of the Public Health Service Act [section 254e(a)(1)(A) of this title].

"(2) For purposes of this subsection, the term 'eligible small rural hospital' means any rural primary care hospital designated by the Secretary under section 1820(i)(2) of the Social Security Act [section 1395i-4(i)(2) of this title], or any non-Federal, short-term general acute care hospital that—

"(A) is located in a rural area (as determined in accordance with subsection (d)),

"(B) has less than 100 beds, and

"(C) is not for profit.

"(3)(A) Any eligible small rural hospital that desires to modify the type or extent of health care services that it provides in order to adjust for one or more of the factors specified in paragraph (1) may submit an application to the Administrator and a copy of such application to the Governor of the State in which it is located. The application shall specify the nature of the project proposed by the hospital, the data and information on which the project is based, and a timetable (of not more than 24 months) for completion of the project. The application shall be submitted on or before a date specified by the Administrator and shall be in such form as the Administrator may require.

"(B) The Governor shall transmit to the Administrator, within a reasonable time after receiving a copy of an application pursuant to subparagraph (A), any comments with respect to the application that the Governor deems appropriate.

"(C) The Governor of a State may designate an appropriate State agency to receive and comment on applications submitted under subparagraph (A).

"(4) A hospital shall be considered to be located in a rural area for purposes of this subsection if it is treated as being located in a rural area for purposes of section 1886(d)(3)(D) of the Social Security Act [subsec. (d)(3)(D) of this section].

"(5) In determining which hospitals making application under paragraph (3) will receive grants under this subsection, the Administrator shall take into account—

"(A) any comments received under paragraph (3)(B) with respect to a proposed project;

"(B) the effect that the project will have on—

"(i) reducing expenditures from the Federal Hospital Insurance Trust Fund,

"(ii) improving the access of medicare beneficiaries to health care of a reasonable quality;

"(C) the extent to which the proposal of the hospital, using appropriate data, demonstrates an understanding of—

"(i) the primary market or service area of the hospital, and

"(ii) the health care needs of the elderly and disabled that are not currently being met by providers in such market or area, and

"(D) the degree of coordination that may be expected between the proposed project and—

"(i) other local or regional health care providers, and

"(ii) community and government leaders,

as evidenced by the availability of support for the project (in cash or in kind) and other relevant factors.

"(6) A grant to a hospital under this subsection may not exceed \$50,000 a year and may not exceed a term of 3 years.

"(7)(A) Except as provided in subparagraphs (B) and (C), a hospital receiving a grant under this subsection may use the grant for any of expenses incurred in planning and implementing the project with respect to which the grant is made.

"(B) A hospital receiving a grant under this subsection for a project may not use the grant to retire

debt incurred with respect to any capital expenditure made prior to the date on which the project is initiated.

“(C) Not more than one-third of any grant made under this subsection may be expended for capital-related costs (as defined by the Secretary for purposes of section 1886(a)(4) of the Social Security Act [subsec. (a)(4) of this section]) of the project, except that this limitation shall not apply with respect to a grant used for the purposes described in subparagraph (D).

“(D) A hospital may use a grant received under this subsection to develop a plan for converting itself to a rural primary care hospital (as described in section 1820 of the Social Security Act [section 1395i-4 of this title]) or to develop a rural health network (as defined in section 1820(g) of such Act) in the State in which it is located if the State is receiving a grant under section 1820(a)(1).

“(8)(A) A hospital receiving a grant under this section [amending this section and section 1395tt of this title and enacting provisions set out as notes under this section and section 1395tt of this title] shall furnish the Administrator with such information as the Administrator may require to evaluate the project with respect to which the grant is made and to ensure that the grant is expended for the purposes for which it was made.

“(B) The Administrator shall report to the Congress at least once every 12 months on the program of grants established under this subsection. The report shall assess the functioning and status of the program, shall evaluate the progress made toward achieving the purposes of the program, and shall include any recommendations the Secretary may deem appropriate with respect to the program. In preparing the report, the Secretary shall solicit and include the comments and recommendations of private and public entities with an interest in rural health care.

“(C) The Administrator shall submit a final report on the program to the Congress not later than 180 days after all projects receiving a grant under the program are completed.

“(9) For purposes of carrying out the program of grants under this subsection, there are authorized to be appropriated from the Federal Hospital Insurance Trust Fund \$15,000,000 for fiscal year 1989, \$25,000,000 for each of the fiscal years 1990, 1991, and 1992 and \$30,000,000 for each of fiscal years 1993 through 1997.”

[For termination, effective May 15, 2000, of provisions of law requiring submittal to Congress of any annual, semiannual, or other regular periodic report listed in House Document No. 103-7 (in which item 6 on page 100 identifies a reporting provision which, as subsequently amended, is contained in section 4005(e)(8)(B) of Pub. L. 100-203, set out above), see section 3003 of Pub. L. 104-66, as amended, set out as a note under section 1113 of Title 31, Money and Finance.]

[Section 103(a)(2) of Pub. L. 103-432 provided that: “The amendment made by paragraph (1) [amending section 4005(e)(2) of Pub. L. 100-203, set out above] shall apply to grants made on or after October 1, 1994.”]

[Pub. L. 103-432, §103(c), which directed amendment of section 4008(e)(8)(B) of Pub. L. 100-203, was executed by amending section 4005(e)(8)(B) of Pub. L. 100-203, set out above, to reflect the probable intent of Congress.]

[Section 6003(g)(1)(B)(ii) of Pub. L. 101-239 provided that: “The amendments made by clause (i) [amending section 4005(e) of Pub. L. 100-203, set out above] shall apply with respect to applications for grants under the Rural Health Care Transition Grant Program described in section 4005(e) of the Omnibus Budget Reconciliation Act of 1987 [Pub. L. 100-203] submitted on or after October 1, 1989, except that the amendments made by subclauses (V) and (VII) of such clause shall take effect on the date of the enactment of this Act [Dec. 19, 1989].”]

REPORTING HOSPITAL INFORMATION

Section 4007 of Pub. L. 100-203, as amended by Pub. L. 100-360, title IV, § 411(b)(6), July 1, 1988, 102 Stat. 770; Pub. L. 100-485, title VI, § 608(d)(18)(D), Oct. 13, 1988, 102 Stat. 2419, provided that:

“(a) DEVELOPMENT OF DATA BASE.—The Secretary of Health and Human Services (in this section referred to as the ‘Secretary’) shall develop and place into effect not later than June 1, 1989, a data base of the operating costs of inpatient hospital services with respect to all hospitals under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.], which data base shall be updated at least once every quarter (and maintained for the 12-month period preceding any such update). The data base under this subsection may include data from preliminary cost reports (but the Secretary shall make available an updated analysis of the differences between preliminary and settled cost reports).

“(b) [Amended subsec. (f) of this section and enacted provisions set out as an Effective Date of 1987 Amendment note above.]

“(c) DEMONSTRATION PROJECT.—

“(1) The Secretary of Health and Human Services shall provide for a demonstration project to develop, and determine the costs and benefits of establishing a uniform system for the reporting by medicare participating hospitals of balance sheet and information described in paragraph (2). In conducting the project, the Secretary shall require hospitals in at least 2 States, one of which maintains a uniform hospital reporting system, to report such information based on standard information established by the Secretary.

“(2) The information described in this paragraph is as follows:

“(A) Hospital discharges (classified by class of primary payer).

“(B) Patient days (classified by class of primary payer).

“(C) Licensed beds, staffed beds, and occupancy.

“(D) Inpatient charges and revenues (classified by class of primary payer).

“(E) Outpatient charges and revenues (classified by class of primary payer).

“(F) Inpatient and outpatient hospital expenses (by cost-center classified for operating and capital).

“(G) Reasonable costs.

“(H) Other income.

“(I) Bad debt and charity care.

“(J) Capital acquisitions.

“(K) Capital assets.

The Secretary shall develop a definition of ‘outpatient visit’ for purposes of reporting hospital information.

“(3) The Secretary shall develop the system under subsection (c) in a manner so as—

“(A) to facilitate the submittal of the information in the report in an electronic form, and

“(B) to be compatible with the needs of the medicare prospective payment system.

“(4) The Secretary shall prepare and submit, to the Prospective Payment Assessment Commission, the Comptroller General, the Committee on Ways and Means of the House of Representatives, and the Committee on Finance of the Senate, by not later than 45 days after the end of each calendar quarter, data collected under the system.

“(5) In paragraph (2):

“(A) The term ‘bad debt and charity care’ has such meaning as the Secretary establishes.

“(B) The term ‘class’ means, with respect to payers at least, the programs under this title XVIII of the Social Security Act [this subchapter], a State plan approved under title XIX of such Act [subchapter XIX of this chapter], other third party-payers, and other persons (including self-paying individuals).

“(6) The Secretary shall set aside at least a total of \$3,000,000 for fiscal years 1988, 1989, and 1990 from existing research funds or from operations funds to develop the format, according to paragraph (1) and for data collection and analysis, but total funds shall not exceed \$15,000,000.

“(7) The Comptroller General shall analyze the adequacy of the existing system for reporting of hospital information and the costs and benefits of data report-

ing under the demonstration system and will recommend improvements in hospital data collection and in analysis and display of data in support of policy making.

“(d) CONSULTATION.—The Secretary shall consult representatives of the hospital industry in carrying out the provisions of this section.”

HOSPITAL OUTLIER PAYMENTS AND POLICY

Section 4008(d) of Pub. L. 100-203, as amended by Pub. L. 100-360, title IV, § 411(b)(7), July 1, 1988, 102 Stat. 771, provided that:

“(1) INCREASE IN OUTLIER PAYMENTS FOR BURN CENTER DRGS.—

“(A) IN GENERAL.—For discharges classified in diagnosis-related groups relating to burn cases and occurring on or after April 1, 1988, and before October 1, 1989, the marginal cost of care permitted by the Secretary of Health and Human Services under section 1886(d)(5)(A)(iii) of the Social Security Act [subsec. (d)(5)(A)(iii) of this section] shall be 90 percent of the appropriate per diem cost of care or 90 percent of the cost for cost outliers.

“(B) BUDGET NEUTRALITY.—Subparagraph (A) shall be implemented in a manner that ensures that total payments under section 1886(d) of the Social Security Act are not increased or decreased by reason of the adjustments required by such subparagraph.

“(2) LIMITATION ON CHANGES IN OUTLIER REGULATIONS.—

“(A) IN GENERAL.—Notwithstanding any other provision of law, except as required to implement specific provisions required under statute, the Secretary of Health and Human Services is not authorized to issue in final form, after the date of the enactment of this Act [Dec. 22, 1987] and before September 1, 1988, any final regulation which changes the method of payment for outlier cases under section 1886(d)(5)(A) of the Social Security Act [subsec. (d)(5)(A) of this section].

“(B) PROPAC REPORT.—The chairman of the Prospective Payment Assessment Commission shall report to the Congress and the Secretary of Health and Human Services, by not later than June 1, 1988, on the method of payment for outlier cases under such section and providing more adequate and appropriate payments with respect to burn outlier cases.

“(3) REPORT ON OUTLIER PAYMENTS.—The Secretary of Health and Human Services shall include in the annual report submitted to the Congress pursuant to section 1875(b) of the Social Security Act [section 1395ll(b) of this title] a comparison with respect to hospitals located in an urban area and hospitals located in a rural area in the amount of reductions under section 1886(d)(3)(B) of the Social Security Act [subsec. (d)(3)(B) of this section] and additional payments under section 1886(d)(5)(A) of such Act.”

PROPAC STUDIES AND REPORTS

Section 4009(h) of Pub. L. 100-203 provided that:

“(1) PROPAC REPORTS ON STUDY OF DRG RATES FOR HOSPITALS IN RURAL AND URBAN AREAS.—The Prospective Payment Assessment Commission shall evaluate the study conducted by the Secretary of Health and Human Services pursuant to section 603(a)(2)(C)(i) of the Social Security Amendments of 1983 [section 603(a)(2)(C)(i) of Pub. L. 98-21, set out below] (relating to the feasibility, impact, and desirability of eliminating or phasing out separate urban and rural DRG prospective payment rates) and report its conclusions and recommendations to the Congress not later than March 1, 1988.

“(2) PROPAC REPORT ON SEPARATE URBAN PAYMENT RATES.—The Prospective Payment Assessment Commission shall evaluate the desirability of maintaining separate DRG prospective payment rates for hospitals located in large urban areas (as defined in section 1886(d)(2)(D)) of the Social Security Act [subsec. (d)(2)(D) of this section] and in other urban areas, and shall report to Congress on such evaluation not later than January 1, 1989.

“(3) REPORT ON ADJUSTMENT FOR NON-LABOR COSTS.—The Prospective Payment Assessment Commission shall perform an analysis to determine the feasibility and appropriateness of adjusting the non-wage-related portion of the adjusted average standardized amounts under section 1886(d)(3) of the Social Security Act [subsec. (d)(3) of this section] based on area differences in hospitals' costs (other than wage-related costs) and input prices. The Commission shall report to the Congress on such analysis by not later than October 1, 1989.”

SPECIAL RULE FOR URBAN AREAS IN NEW ENGLAND

Section 4009(i) of Pub. L. 100-203, as amended by Pub. L. 100-360, title IV, § 411(b)(8)(C), July 1, 1988, 102 Stat. 772, provided that: “In the case of urban areas in New England, the Secretary of Health and Human Services shall apply the second sentence of section 1886(d)(2)(D) of the Social Security Act [subsec. (d)(2)(D) of this section], as amended by section 4002(b) of this subtitle, as though 970,000 were substituted for 1,000,000.”

RURAL HEALTH MEDICAL EDUCATION DEMONSTRATION PROJECT

Section 4038 of Pub. L. 100-203, as amended by Pub. L. 101-239, title VI, § 6216, Dec. 19, 1989, 103 Stat. 2253, provided that:

“(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ‘Secretary’) shall enter into agreements with 10 sponsoring hospitals submitting applications under this subsection to conduct demonstration projects to assist resident physicians in developing field clinical experience in rural areas.

“(b) NATURE OF PROJECT.—Under a demonstration project conducted under subsection (a), a sponsoring hospital entering into an agreement with the Secretary under such subsection shall enter into arrangements with a small rural hospital to provide to such rural hospital, for a period of one to three months of training, physicians (in such number as the agreement under subsection (a) may provide) who have completed one year of residency training.

“(c) SELECTION.—(1) In selecting from among applications submitted under subsection (a), the Secretary shall ensure that four small rural hospitals located in different counties participate in the demonstration project and that—

“(A) two of such hospitals are located in rural counties of more than 2,700 square miles (one of which is east of the Mississippi River and one of which is west of such river); and

“(B) two of such hospitals are located in rural counties with (as determined by the Secretary) a severe shortage of physicians (one of which is east of the Mississippi River and one of which is west of such river).

“(2) The provisions of paragraph (1) shall not apply with respect to applications submitted as a result of amendments made by section 6216 of the Omnibus Budget Reconciliation Act of 1989 [Pub. L. 101-239, amending this note].

“(d) CLARIFICATION OF PAYMENT.—For purposes of section 1886 of the Social Security Act [this section]—

“(1) with respect to subsection (d)(5)(B) of such section, any resident physician participating in the project under subsection (a) for any part of a year shall be treated as if he or she were working at the appropriate sponsoring hospital with an agreement under subsection (a) on September 1 of such year (and shall not be treated as if working at the small rural hospital); and

“(2) with respect to subsection (h) of such section, the payment amount permitted under such subsection for a sponsoring hospital with an agreement under subsection (a) shall be increased (for the duration of the project only) by an amount equal to the amount of any direct graduate medical education costs (as defined in paragraph (5) of such subsection

(h) incurred by such hospital in supervising the education and training activities under a project under subsection (a).

“(e) DURATION OF PROJECT.—Each demonstration project under subsection (a) shall be commenced not later than six months after the date of enactment of this Act [Dec. 22, 1987] (or the date of the enactment of the Omnibus Budget Reconciliation Act of 1989 [Dec. 19, 1989], in the case of a project conducted as a result of the amendments made by section 6216 of such Act [Pub. L. 101-239, amending this note]) and shall be conducted for a period of three years.

“(f) DEFINITION.—In this section, the term ‘sponsoring hospital’ means a hospital that receives payments under sections 1886(d)(5)(B) and 1886(h) of the Social Security Act [subsecs. (d)(5)(B) and (h) of this section].”

PROHIBITION ON POLICY BY SECRETARY OF HEALTH AND HUMAN SERVICES TO REDUCE EXPENDITURES IN FISCAL YEARS 1989, 1990, AND 1991

Section 4039(d) of Pub. L. 100-203, as amended by Pub. L. 100-360, title IV, § 426(e), July 1, 1988, 102 Stat. 814; Pub. L. 101-239, title VI, § 6207(b), Dec. 19, 1989, 103 Stat. 2245, provided that: “Notwithstanding any other provision of law, except as required to implement specific provisions required under statute, the Secretary of Health and Human Services is not authorized to issue in final form, after the date of the enactment of this Act [Dec. 22, 1987] and before October 15, 1990, any regulation, instruction, or other policy which is estimated by the Secretary to result in a net reduction in expenditures under title XVIII of the Social Security Act [this subchapter] in fiscal year 1989 or in fiscal year 1990 or in fiscal year 1991 of more than \$50,000,000.”

TEMPORARY EXTENSION OF PAYMENT POLICIES FOR INPATIENT HOSPITAL SERVICES

Pub. L. 100-119, title I, § 107(a)(1), Sept. 29, 1987, 101 Stat. 782, as amended by Pub. L. 100-203, title IV, § 4002(f)(2), Dec. 22, 1987, 101 Stat. 1330-45, provided that: “Notwithstanding any other provision of law, with respect to payment for inpatient hospital services under section 1886 of the Social Security Act [this section]:

“(A) TEMPORARY FREEZE IN PPS HOSPITAL RATES.—For purposes of subsection (d) of such section for discharges occurring during the period beginning on October 1, 1987, and ending on November 20, 1987 (in this paragraph referred to as the ‘extension period’), the applicable percentage increase under subsection (b)(3)(B) of such section with respect to fiscal year 1988 is deemed to be 0 percent.

“(B) TEMPORARY FREEZE IN PAYMENT BASIS.—

“(i) EXTENSION OF BLENDED DRG RATE.—For purposes of subsection (d)(1) of such section, the ‘applicable combined adjusted DRG prospective payment rate’ for discharges occurring—

“(I) during the extension period is the rate specified in subsection (d)(1)(D)(ii) of such section, or

“(II) after such period is the national adjusted prospective payment rate determined under subsection (d)(3) of such section.

“(ii) EXTENSION OF HOSPITAL-SPECIFIC PAYMENT.—For the first 51 days of a hospital cost reporting period beginning during fiscal year 1988, payment shall be made under clause (ii) (rather than clause (iii)) of subsection (d)(1)(A) of such section (subject to clause (i) of this subparagraph), the target percentage and DRG percentage shall be those specified in subsection (d)(1)(C)(iv) of such section, and the applicable percentage increase in a hospital’s target amount shall be deemed to be 0 percent.

“(C) TEMPORARY FREEZE IN AMOUNTS OF PAYMENT FOR CAPITAL.—For payments attributable to portions of cost reporting periods occurring during the extension period, the percent specified in subsection (g)(3)(A)(ii) of such section is deemed to be 3.5 percent.

“(D) TEMPORARY FREEZE IN RETURN ON EQUITY REDUCTIONS.—For the first 51 days of a cost reporting

period beginning during fiscal year 1988, subsection (g)(2) of such section shall be applied as though the applicable percentage were 75 percent.

“(E) TEMPORARY FREEZE IN PAYMENTS RATES FOR PPS-EXEMPT HOSPITALS.—For purposes of payment under subsection (b) of such section for cost reporting periods beginning during fiscal year 1988, with respect to the first 51 days of such a period the applicable percentage increase under paragraph (3)(B) of such subsection is deemed to be 0 percent.”

[Section 4002(f)(2) of Pub. L. 100-203 provided that the amendment of section 107(a)(1) of Pub. L. 100-119, set out above, by section 4002(f)(2) of Pub. L. 100-203 is effective as of Sept. 29, 1987.]

FREEZING CERTAIN CHANGES IN MEDICARE PAYMENT REGULATIONS AND POLICIES

Pub. L. 100-119, title I, § 107(b), Sept. 29, 1987, 101 Stat. 783, provided that:

“(1) IN GENERAL.—Notwithstanding any other provision of law, the Secretary of Health and Human Services is not authorized to issue after September 18, 1987, and before November 21, 1987—

“(A) any final regulation that changes the policy with respect to payment under title XVIII of the Social Security Act [this subchapter] to providers of service for reasonable costs relating to unrecovered costs associated with unpaid deductible and coinsurance amounts incurred under such title;

“(B) any final regulation, instruction, or other policy change which is primarily intended to have the effect of slowing down claims processing, or delaying payment of claims, under such title; or

“(C) any final regulation that changes the policy under such title with respect to payment for a return on equity capital for outpatient hospital services. The final regulation of the Health Care Financing Administration published on September 1, 1987 (52 Federal Register 32920) and relating to changes to the return on equity capital provisions for outpatient hospital services is void and of no effect.

“(2) OTHER COST SAVINGS POLICIES.—Notwithstanding any other provision of law, except as required to implement specific provisions required under statute, the Secretary of Health and Human Services is not authorized to issue in final form, after September 18, 1987, and before November 21, 1987, any regulation, instruction, or other policy which is estimated by the Secretary to result in a net reduction in expenditures under title XVIII of the Social Security Act in fiscal year 1988 of more than \$50,000,000. Any regulation, instruction, or policy which is issued in violation of this paragraph is void and of no effect.

“(3) EXCEPTION.—Paragraphs (1) and (2) shall not be construed to apply to any regulation, instruction, or policy required to implement the amendment made by section 9311(a) of the Omnibus Budget Reconciliation Act of 1986 [section 9311(a) of Pub. L. 99-509, which amended section 1395g of this title] (relating to periodic interim payments).”

MAINTAINING CURRENT OUTLIER POLICY IN FISCAL YEAR 1987

Section 9302(b)(3) of Pub. L. 99-509 provided that: “For payments made under section 1886(d) of the Social Security Act [subsec. (d) of this section] for discharges occurring in fiscal year 1987—

“(A) the proportions under paragraph (3)(B) for hospitals located in urban and rural areas shall be established at such levels as produce the same total dollar reduction under such paragraph as if this section had not been enacted; and

“(B) the thresholds and standards used for making additional payments under paragraph (5) of such section shall be the same as those in effect as of October 1, 1986.”

EXTENSION OF REGIONAL REFERRAL CENTER CLASSIFICATION

Section 6003(d) of Pub. L. 101-239 provided that: “Any hospital that is classified as a regional referral center

under section 1886(d)(5)(C) of the Social Security Act [subsec. (d)(5)(C) of this section] as of September 30, 1989, including a hospital so classified as a result of section 9302(d)(2) of the Omnibus Budget Reconciliation Act of 1986 [Pub. L. 99-509, set out below], shall continue to be classified as a regional referral center for cost reporting periods beginning on or after October 1, 1989, and before October 1, 1992.”

Section 9302(d)(2) of Pub. L. 99-509 provided that: “Any hospital that is classified as a regional referral center under section 1886(d)(5)(C)(i) of the Social Security Act [subsec. (d)(5)(C)(i) of this section] on the date of the enactment of this Act [Oct. 21, 1986] shall continue to be classified as a regional referral center for cost reporting periods beginning on or after October 1, 1986, and before October 1, 1989.”

BUDGET-NEUTRAL IMPLEMENTATION

Section 9302(d)(3) of Pub. L. 99-509 provided that: “Paragraph (2) [set out as a note above] and the amendment made by paragraph (1)(A) [amending this section] shall be implemented in a manner that ensures that total payments under section 1886 of the Social Security Act [this section] are not increased or decreased by reason of the classifications required by such paragraph or amendment.”

PROMULGATION OF NEW RATE

Section 9302(f) of Pub. L. 99-509 provided that: “The Secretary of Health and Human Services shall provide, within 30 days after the date of the enactment of this Act [Oct. 21, 1986], for the publication of the payments rates that will apply under section 1886 of the Social Security Act [this section], for discharges occurring on or after October 1, 1986, taking into account the amendments made by this section [amending this section], without regard to the provisions of chapter 5 of title 5, United States Code.”

MISCELLANEOUS ACCOUNTING PROVISION

Section 9307(d) of Pub. L. 99-509, as amended by Pub. L. 100-203, title IV, §4008(e), Dec. 22, 1987, 101 Stat. 1330-56, provided that: “Notwithstanding any other provision of law, for purposes of section 1886(d)(1)(A) of the Social Security Act [subsec. (d)(1)(A) of this section], in the case of a hospital that—

“(1) had a cost reporting period beginning on September 28, 29, or 30 of 1985,

“(2) is located in a State in which inpatient hospital services were paid in fiscal year 1985 pursuant to a Statewide demonstration project under section 402 of the Social Security Amendments of 1967 [section 402 of Pub. L. 90-248, enacting section 1395b-1 of this title and amending section 1395ll of this title] and section 222 of the Social Security Amendments of 1972 [section 222 of Pub. L. 92-603, amending sections 1395b-1 and 1395ll of this title and enacting provisions set out as a note under section 1395b-1 of this title], and

“(3) elects, by notice to the Secretary of Health and Human Services by not later than April 1, 1988, to have this subsection apply, during the first 7 months of such cost reporting period the ‘target percentage’ shall be 75 percent and the ‘DRG percentage’ shall be 25 percent, and during the remaining 5 months of such period the ‘target percentage’ and the ‘DRG percentage’ shall each be 50 percent.”

[Section 4008(e) of Pub. L. 100-203 provided that the amendment of section 9307(d) of Pub. L. 99-509, set out above, by section 4008(e) of Pub. L. 100-203 is effective as if included in the enactment of Pub. L. 99-509.]

TREATMENT OF CAPITAL-RELATED REGULATIONS

Section 9321(c) of Pub. L. 99-509, as amended by Pub. L. 100-119, title I, §107(a)(2), Sept. 29, 1987, 101 Stat. 783; Pub. L. 100-203, title IV, §4009(j)(6)(D), (F), Dec. 22, 1987, 101 Stat. 1330-59, provided that:

“(1) PROHIBITION OF ISSUANCE OF FINAL REGULATIONS ON CAPITAL-RELATED COSTS AS PART OF PAYMENT FOR OP-

ERATING COSTS BEFORE NOVEMBER 21, 1987.—Notwithstanding any other provision of law (except as provided in paragraph (3)), the Secretary of Health and Human Services may not issue, in final form, after September 1, 1986, and before November 21, 1987, any regulation that changes the methodology for computing the amount of payment for capital-related costs (as defined in paragraph (4)) for inpatient hospital services under part A of title XVIII of the Social Security Act [part A of this subchapter]. Any regulation published in violation of the previous sentence is void and of no effect.

“(2) NOT INCLUDING CAPITAL-RELATED REGULATIONS IN BUDGET BASELINE.—Any reference in law to a regulation issued in final form or proposed by the Health Care Financing Administration pursuant to sections 1886(b)(3)(B), 1886(d)(3)(A), and 1886(e)(4) of the Social Security Act [subsecs. (b)(3)(B), (d)(3)(A), and (e)(4) of this section] shall not include any regulation issued or proposed with respect to capital-related costs (as defined in paragraph (4)).

“(3) EXCEPTION.—Paragraph (1) shall not apply to any regulation issued for the sole purpose of implementing section 1861(v)(1)(O) and 1886(g)(2) of the Social Security Act [section 1395x(v)(1)(O) of this title and subsec. (g)(2) of this section] and section 1886(g)(3)(A) and (B) of the Social Security Act [subsec. (g)(3)(A) and (B) of this section] (as amended by section 9303(a) of this Act).

“(4) CAPITAL-RELATED COSTS DEFINED.—In this subsection, the term ‘capital-related costs’ means those capital-related costs that are specifically excluded, under the second sentence of section 1886(a)(4) of the Social Security Act [subsec. (a)(4) of this section], from the term ‘operating costs of inpatient hospital services’ (as defined in that section) for cost reporting periods beginning prior to October 1, 1987.”

LIMITATION ON AUTHORITY TO ISSUE CERTAIN FINAL REGULATIONS AND INSTRUCTIONS RELATING TO HOSPITALS OR PHYSICIANS

Section 9321(d) of Pub. L. 99-509 provided that: “Notwithstanding any other provision of law, except as required to implement specific provisions required under statute and except as provided under subsection (c) [set out above] with respect to a regulation described in that subsection, the Secretary of Health and Human Services is not authorized to issue in final form after the date of the enactment of this Act [Oct. 21, 1986] and before September 1, 1987, any regulation, instruction, or other policy which is estimated by the Secretary to result in a net reduction in expenditures under title XVIII of the Social Security Act [this subchapter] in fiscal year 1988 of more than \$50,000,000, and which relates to hospitals or physicians.”

STUDY OF METHODOLOGY FOR AREA WAGE ADJUSTMENT FOR CENTRAL CITIES; REPORT TO CONGRESS

Section 9103(b) of Pub. L. 99-272 provided that:

“(1) The Secretary of Health and Human Services, in consultation with the Prospective Payment Assessment Commission, shall collect information and shall develop one or more methodologies to permit the adjustment of the wage indices used for purposes of sections 1886(d)(2)(C)(ii), 1886(d)(2)(H), and 1886(d)(3)(E) of the Social Security Act [subsec. (d)(2)(C)(ii), (H), and (3)(E) of this section], in order to more accurately reflect hospital labor markets, by taking into account variations in wages and wage-related costs between the central city portion of urban areas and other parts of urban areas.

“(2) The Secretary shall report to Congress on the information collected and the methodologies developed under paragraph (1) not later than May 1, 1987. The report shall include a recommendation as to the feasibility and desirability of implementing such methodologies.”

CONTINUATION OF MEDICARE REIMBURSEMENT WAIVERS FOR CERTAIN HOSPITALS PARTICIPATING IN REGIONAL HOSPITAL REIMBURSEMENT DEMONSTRATIONS

Section 9108 of Pub. L. 99-272 provided that:

“(a) CONTINUATION OF WAIVERS.—A hospital reimbursement control system which, on January 1, 1985, was carrying out a demonstration under a contract which had been approved by the Secretary of Health and Human Services pursuant to section 222(a) of the Social Security Amendments of 1972 [section 222(a) of Pub. L. 92-603, set out as a note under section 1395b-1 of this title], or under section 402 of the Social Security Amendments of 1967 (as amended by section 222(b) of the Social Security Amendments of 1972) [section 1395b-1 of this title], shall be deemed to meet the requirements of section 1886(c)(1)(A) of the Social Security Act [subsec. (c)(1)(A) of this section] if such system applies—

“(1) to substantially all non-Federal acute care hospitals (as defined by the Secretary) in the geographic area served by such system on January 1, 1985, and

“(2) to the review of at least 75 percent of—

“(A) all revenues or expenses in such geographic area for inpatient hospital services, and

“(B) revenues or expenses in such geographic area for inpatient hospital services provided under the State’s plan approved under title XIX [subchapter XIX of this chapter].

“(b) APPROVAL.—In the case of a hospital cost control system described in subsection (a), the requirements of section 1886(c) of the Social Security Act [subsec. (c) of this section] which apply to States shall instead apply to such system and, for such purposes, any reference to a State is deemed a reference to such system.

“(c) EFFECTIVE DATE.—This section shall become effective on the date of the enactment of this Act [Apr. 7, 1986].”

INFORMATION ON IMPACT OF PPS PAYMENTS ON HOSPITALS

Section 9114 of Pub. L. 99-272 provided that:

“(a) DISCLOSURE OF INFORMATION.—The Secretary of Health and Human Services shall make available to the Prospective Payment Assessment Commission, the Congressional Budget Office, the Comptroller General, and the Congressional Research Service the most current information on the payments being made under section 1886 of the Social Security Act [this section] to individual hospitals. Such information shall be made available in a manner that permits examination of the impact of such section on hospitals.

“(b) CONFIDENTIALITY.—Information disclosed under subsection (a) shall be treated as confidential and shall not be subject to further disclosure in a manner that permits the identification of individual hospitals.”

SPECIAL RULES FOR IMPLEMENTATION OF HOSPITAL REIMBURSEMENT

Section 9115 of Pub. L. 99-272 provided that:

“(a) WAIVER OF PAPERWORK REDUCTION.—Chapter 35 of title 44, United States Code, shall not apply to information required for purposes of carrying out this subpart and implementing the amendments made by this subpart [subpart A (§§ 9101-9115) of part 1 of subtitle A of title IX of Pub. L. 99-272, see Tables for classification].

“(b) USE OF INTERIM FINAL REGULATIONS.—The Secretary of Health and Human Services shall issue such regulations (on an interim or other basis) as may be necessary to implement this subpart and the amendments made by this subpart.”

APPOINTMENT OF ADDITIONAL MEMBERS TO PROSPECTIVE PAYMENT ASSESSMENT COMMISSION

Section 9127(b) of Pub. L. 99-272, as amended by Pub. L. 99-514, title XVIII, §1895(b)(8), Oct. 22, 1986, 100 Stat. 2933, provided that: “The Director of the Congressional Office of Technology Assessment shall appoint the two additional members of the Prospective Payment Assessment Commission, as required by the amendment made by subsection (a) [amending this section], no later than 60 days after the date of the enactment of this Act [Apr. 7, 1986], for terms of three years, except

that the Director may provide initially for such terms as will insure that (on a continuing basis) the terms of no more than eight members will expire in any one year.”

STUDIES BY SECRETARY; GAO STUDY; REPORT ON UNIFORMITY OF APPROVED FTE RESIDENT AMOUNTS; STUDY ON FOREIGN MEDICAL GRADUATES; ESTABLISHING PHYSICIAN IDENTIFIER SYSTEM; PAPERWORK REDUCTION

Section 9202(c)-(h) of Pub. L. 99-272, as amended by Pub. L. 100-203, title IV, §4085(f), Dec. 22, 1987, 101 Stat. 1330-131; Pub. L. 101-508, title IV, §4118(i)(2), Nov. 5, 1990, 104 Stat. 1388-70, provided that:

“(c) STUDIES BY SECRETARY.—(1) The Secretary of Health and Human Services shall conduct a study with respect to approved educational activities relating to nursing and other health professions for which reimbursement is made to hospitals under title XVIII of the Social Security Act [this subchapter]. The study shall address—

“(A) the types and numbers of such programs, and number of students supported or trained under each program;

“(B) the fiscal and administrative relationships between the hospitals involved and the schools with which the programs and students are affiliated; and

“(C) the types and amounts of expenses of such programs for which reimbursement is made, and the financial and other contributions which accrue to the hospital as a consequence of having such programs.

The Secretary shall report the results of such study to the Committee on Finance of the Senate and the Committees on Ways and Means and Energy and Commerce of the House of Representatives prior to December 31, 1987.

“(2) The Secretary shall conduct a separate study of the advisability of continuing or terminating the exception under section 1886(h)(5)(F)(ii) of the Social Security Act [subsec. (h)(5)(F)(ii) of this section] for geriatric residencies and fellowships, and of expanding such exception to cover other educational activities, particularly those which are necessary to meet the projected health care needs of Medicare beneficiaries. Such study shall also examine the adequacy of the supply of faculty in the field of geriatrics. The Secretary shall report the results of such study to the committees described in paragraph (1) prior to July 1, 1990.

“(d) GAO STUDY.—(1) The Comptroller General shall conduct a study of the variation in the amounts of payments made under title XVIII of the Social Security Act [this subchapter] with respect to patients in different teaching hospital settings and in the amounts of such payments which are made with respect to patients who are treated in teaching and nonteaching hospital settings. Such study shall identify the components of such payments (including payments with respect to inpatient hospital services, physicians’ services, and capital costs, and, in the case of teaching hospital patients, payments with respect to direct and indirect teaching costs) and shall account, to the extent feasible, for any variations in the amounts of the payment components between teaching and nonteaching settings and among different teaching settings.

“(2) In carrying out such study, the Comptroller General may utilize a sample of hospital patients and any other data sources which he deems appropriate, and shall, to the extent feasible, control for differences in severity of illness levels, area wage levels, levels of physician reasonable charges for like services and procedures, and for other factors which could affect the comparability of patients and of payments between teaching and nonteaching settings and among teaching settings. The information obtained in the study shall be coordinated with the information obtained in conducting the study of teaching physicians’ services under section 2307(c) of the Deficit Reduction Act of 1984 [section 2307(c) of Pub. L. 98-369, set out as a note under section 1395u of this title].

“(3) The Comptroller General shall report the results of the study to the committees described in subsection (c)(1) prior to December 31, 1987.

“(e) REPORT ON UNIFORMITY OF APPROVED FTE RESIDENT AMOUNTS.—The Secretary of Health and Human Services shall report to the committees described in subsection (c)(1), not later than December 31, 1987, on whether section 1886(h) of the Social Security Act [subsec. (h) of this section] should be revised to provide for greater uniformity in the approved FTE resident amounts established under paragraph (2) of that section, and, if so, how such revisions should be implemented.

“(f) STUDY ON FOREIGN MEDICAL GRADUATES.—The Secretary of Health and Human Services shall study, and report to the committees described in subsection (c)(1), not later than December 31, 1987, respecting the use of physicians who are foreign medical graduates (within the meaning of section 1886(h)(5)(D) of the Social Security Act [subsec. (h)(5)(D) of this section]) in the provision of health care services (particularly inpatient and outpatient hospital services) to medicare beneficiaries. Such study shall evaluate—

“(1) the types of services provided;

“(2) the cost of providing such services, relative to the cost of other physicians providing the services or other approaches to providing the services;

“(3) any deficiencies in the quality of the services provided, and methods of assuring the quality of such services; and

“(4) the impact on costs of and access to services if medicare payment for hospitals' costs of graduate medical education of foreign medical graduates were phased out.

“(g) Repealed. Pub. L. 101-508, title IV, §4118(i)(2), Nov. 5, 1990, 104 Stat. 1388-70.]

“(h) PAPERWORK REDUCTION.—Chapter 35 of title 44, United States Code, shall not apply to information required for purposes of carrying out this section and the amendments made by this section [amending this section and section 1395x of this title and enacting notes set out under this section and section 1395x of this title].”

SPECIAL TREATMENT OF STATES FORMERLY UNDER WAIVER

Section 9202(j) of Pub. L. 99-272, as amended by Pub. L. 99-514, title XVIII, §1895(b)(10), Oct. 22, 1986, 100 Stat. 2933, provided that: “In the case of a hospital in a State that has had a waiver approved under section 1886(c) of the Social Security Act [subsec. (c) of this section] or section 402 of the Social Security Amendments of 1967 [section 1395b-1 of this title], for cost reporting periods beginning on or after January 1, 1986, if the waiver is terminated—

“(1) the Secretary of Health and Human Services shall permit the hospital to change the method by which it allocates administrative and general costs to the direct medical education cost centers to the method specified in the medicare cost report;

“(2) the Secretary may make appropriate adjustments in the regional adjusted DRG prospective payment rate (for the region in which the State is located), based on the assumption that all teaching hospitals in the State use the medicare cost report; and

“(3) the Secretary shall adjust the hospital-specific portion of payment under section 1886(d) of such Act [subsec. (d) of this section] for any such hospital that actually chooses to use the medicare cost report.

The Secretary shall implement this subsection based on the best available data.”

MORATORIUM ON LABORATORY PAYMENT DEMONSTRATIONS; COOPERATION IN STUDY; REPORT TO CONGRESS

Section 9204 of Pub. L. 99-272, as amended by Pub. L. 99-509, title IX, §9339(e), Oct. 21, 1986, 100 Stat. 2037; Pub. L. 100-203, title IV, §4085(c), Dec. 22, 1987, 101 Stat. 1330-130; Pub. L. 100-647, title VIII, §8426, Nov. 10, 1988, 102 Stat. 3803, provided that:

“(a) MORATORIUM.—Prior to January 1, 1990, the Secretary of Health and Human Services shall not conduct any demonstration projects relating to competitive bidding as a method of purchasing laboratory services under title XVIII of the Social Security Act [this subchapter]. The Secretary may contract for the design of, and site selection for, such demonstration projects.

“(b) COOPERATION IN STUDY.—The Secretary of Health and Human Services and the Comptroller General shall assist representatives of clinical laboratories in the industry's conduct of a study to determine whether methods exist which are better than competitive bidding for purposes of utilizing competitive market forces in setting payment levels for laboratory services under title XVIII of the Social Security Act [this subchapter]. If such a study is conducted by the clinical laboratory industry, the Secretary and the Comptroller General shall comment on such study and submit such comments and the study to the Senate Committee on Finance and the House Committees on Ways and Means and Energy and Commerce.”

MEDICARE HOSPITAL AND PHYSICIAN PAYMENT PROVISIONS; EXTENSION PERIOD

Pub. L. 99-107, §5, Sept. 30, 1985, 99 Stat. 479, as amended by Pub. L. 99-155, §2(d), Nov. 14, 1985, 99 Stat. 814; Pub. L. 99-181, §4, Dec. 13, 1985, 99 Stat. 1172; Pub. L. 99-189, §4, Dec. 18, 1985, 99 Stat. 1184; Pub. L. 99-201, §2, Dec. 23, 1985, 99 Stat. 1665; Pub. L. 99-272, title IX, §§9101(a), 9301(a), Apr. 7, 1986, 100 Stat. 153, 184, provided that:

“(a) MAINTAINING EXISTING HOSPITAL PAYMENT RATES.—Notwithstanding any other provision of law, the amount of payment under section 1886 of the Social Security Act [this section] for inpatient hospital services for discharges occurring (and cost reporting periods beginning) during the extension period (as defined in subsection (c)) shall be determined on the same basis as the amount of payment for such services for a discharge occurring on (or the cost reporting period beginning immediately on or before) September 30, 1985.

“(b) MAINTAINING EXISTING PAYMENT RATES FOR PHYSICIANS' SERVICES.—Notwithstanding any other provision of law, the amount of payment under part B of title XVIII of the Social Security Act [part B of this subchapter] for physicians' services which are furnished during the extension period (as defined in subsection (c)) shall be determined on the same basis as the amount of payment for such services furnished on September 30, 1985, and the 15-month period, referred to in section 1842(j)(1) of such Act [section 1395u(j)(1) of this title], shall be deemed to include the extension period.

“(c) EXTENSION PERIOD DEFINED.—

“(1) HOSPITAL PAYMENTS.—For purposes of subsection (a), the term ‘extension period’ means the period beginning on October 1, 1985, and ending on April 30, 1986.

“(2) PHYSICIAN PAYMENTS.—For purposes of subsection (b), the term ‘extension period’ means the period beginning on October 1, 1985, and ending on April 30, 1986.”

[Amendment of section 5 of Pub. L. 99-107, set out above, by section 9101(a) of Pub. L. 99-272 effective Mar. 15, 1986, see section 9101(d) of Pub. L. 99-272, set out above.]

DEFINITION OF HOSPITAL SERVING SIGNIFICANTLY DISPROPORTIONATE NUMBER OF LOW-INCOME PATIENTS OR PATIENTS ENTITLED TO HOSPITAL INSURANCE BENEFITS FOR AGED AND DISABLED; IDENTIFICATION

Section 2315(h) of Pub. L. 98-369 provided that: “The Secretary of Health and Human Services shall, prior to December 31, 1984—

“(1) develop and publish a definition of ‘hospitals that serve a significantly disproportionate number of patients who have low income or are entitled to benefits under part A’ of title XVIII of the Social Security Act [part A of this subchapter] for purposes of section 1886(d)(5)(C)(i) of that Act [subsec. (d)(5)(C)(i) of this section], and

“(2) identify those hospitals which meet such definition, and make such identity available to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate.”

PROSPECTIVE PAYMENT WAGE INDEX; STUDIES AND REPORTS TO CONGRESS

Section 2316 of Pub. L. 98-369, as amended by Pub. L. 99-272, title IX, §9103(a)(1), Apr. 7, 1986, 100 Stat. 156, provided that:

“(a) The Secretary of Health and Human Services, in consultation with the Secretary of Labor, shall conduct a study to develop an appropriate index for purposes of adjusting payment amounts under section 1886(d) of the Social Security Act [subsec. (d) of this section] to reflect area differences in average hospital wage levels, as required under paragraphs (2)(H) and (3)(E) of such section [subsec. (d)(2)(H) and (3)(E) of this section], taking into account wage differences of full time and part time workers. The Secretary of Health and Human Services shall report the results of such study to the Congress not later than 30 days after the date of the enactment of this Act [July 18, 1984], including any changes which the Secretary determines to be necessary to provide for an appropriate index.

“(b) The Secretary shall adjust the payment amounts for hospitals for discharges occurring on or after May 1, 1986, to reflect the changes the Secretary has promulgated in final regulations (on September 3, 1985) relating to the hospital wage index under section 1886(d)(3)(E) of the Social Security Act [subsec. (d)(3)(E) of this section]. For discharges occurring after September 30, 1986, the Secretary shall provide for such periodic adjustments in the appropriate wage index used under that section as may be necessary, taking into account changes in the wage levels and relative proportions of full-time and part-time workers.

“(c) The Secretary shall conduct a study and report to the Congress on proposed criteria under which, in the case of a hospital that demonstrates to the Secretary in a current fiscal year that the adjustment being made under paragraph (2)(H) or (3)(E) of section 1886(d) of the Social Security Act [subsec. (d)(2)(H) or (3)(E) of this section] for that hospital's discharges in that fiscal year does not accurately reflect the wage levels in the labor market serving the hospital, the Secretary, to the extent he deems appropriate, would modify such adjustment for that hospital for discharges in the subsequent fiscal year to take into account a difference in payment amounts in that current fiscal year to the hospital that resulted from such inaccuracy.”

[Section 9103(a)(2) of Pub. L. 99-272 provided that: “The amendment made by paragraph (1) [amending this note] shall be effective as if it had been included in the Deficit Reduction Act of 1984 [Pub. L. 98-369].”]

DIFFERENT TREATMENT OF CAPITAL-PROJECTS-RELATED COSTS BEFORE AND AFTER IMPLEMENTATION OF SYSTEM FOR INCLUDING SUCH COSTS UNDER PROSPECTIVELY DETERMINED PAYMENT RATE

Section 601(a)(3) of Pub. L. 98-21 provided that: “It is the intent of Congress that, in considering the implementation of a system for including capital-related costs under a prospectively determined payment rate for inpatient hospital services, costs related to capital projects for which expenditures are obligated on or after the effective date of the implementation of such a system, may or may not be distinguished and treated differently from costs of projects for which expenditures were obligated before such date.”

NEW ENGLAND HOSPITALS; CLASSIFICATION AS URBAN OR RURAL

Section 601(g) of Pub. L. 98-21 provided that: “In determining whether a hospital is in an urban or rural area for purposes of section 1886(d) of the Social Security Act [subsec. (d) of this section], the Secretary of Health and Human Services shall classify any hospital located in New England as being located in an urban

area if such hospital was classified as being located in an urban area under the Standard Metropolitan Statistical Area system of classification in effect in 1979.”

REPORTS, EXPERIMENTS, AND DEMONSTRATION PROJECTS RELATED TO INCLUSION IN PROSPECTIVE PAYMENT AMOUNTS OF INPATIENT HOSPITAL SERVICE CAPITAL-RELATED COSTS

Section 603(a) of title VI of Pub. L. 98-21, as amended by Pub. L. 98-369, div. B, title III, §2317, July 18, 1984, 98 Stat. 1081; Pub. L. 99-509, title IX, §9305(i)(1), Oct. 21, 1986, 100 Stat. 1993; Pub. L. 104-66, title I, §1061(d), Dec. 21, 1995, 109 Stat. 720, directed Secretary of Health and Human Services to report to Congress within 18 months after Apr. 20, 1983, on legislation by which capital-related costs associated with inpatient hospital services could be included within the prospective payment amounts computed under subsec. (d) of this section, further provided that the Secretary was to study and report to Congress on reimbursement of sole community hospitals based on variations in occupancy, on coordination of an information transfer between parts A and B of this subchapter, on treatment of uncompensated care costs and adjustments appropriate for large rural teaching hospitals, and on advisability of having hospitals make cost-of-care information to certain patients, and further provided that the Secretary was to study and report to Congress on a method for including hospitals outside the 50 States and the District of Columbia under a prospective payment system.

INAPPLICABILITY OF COORDINATION OF FEDERAL INFORMATION POLICY TO THE COLLECTION OF INFORMATION

Section 101(b)(2)(B) of Pub. L. 97-248, as amended by Pub. L. 97-448, title III, §309(a)(1), Jan. 12, 1983, 96 Stat. 2408, provided that: “Chapter 35 of title 44, United States Code, shall not apply, until January 1, 1984, to collection of information and information collection requests which the Secretary of Health and Human Services determines to be necessary to carry out the amendments made by this section [amendments by section 101(a) of Pub. L. 97-248, enacting this section and amending section 1395x of this title].”

§ 1395xx. Payment of provider-based physicians and payment under certain percentage arrangements

(a) Criteria; amount of payments

(1) The Secretary shall by regulation determine criteria for distinguishing those services (including inpatient and outpatient services) rendered in hospitals or skilled nursing facilities—

(A) which constitute professional medical services, which are personally rendered for an individual patient by a physician and which contribute to the diagnosis or treatment of an individual patient, and which may be reimbursed as physicians' services under part B, and

(B) which constitute professional services which are rendered for the general benefit to patients in a hospital or skilled nursing facility and which may be reimbursed only on a reasonable cost basis or on the bases described in section 1395ww of this title.

(2)(A) For purposes of cost reimbursement, the Secretary shall recognize as a reasonable cost of a hospital or skilled nursing facility only that portion of the costs attributable to services rendered by a physician in such hospital or facility which are services described in paragraph (1)(B), apportioned on the basis of the amount of time actually spent by such physician rendering such services.