AMENDMENT TO H.J. RES 59
OFFERED BY M. __________

Insert at the end of the House amendment the following:

1  DIVISION B—MEDICARE AND
2  OTHER HEALTH PROVISIONS
3  SECTION 1. SHORT TITLE; TABLE OF CONTENTS.
4  (a) Short Title.— This division may be cited as
5  the “Pathway for SGR Reform Act of 2013”.
6  (b) Table of Contents.—The table of contents for
7  this division is as follows:

DIVISION B—MEDICARE AND OTHER HEALTH PROVISIONS

Sec. 1. Short title; table of contents.
Sec. 2. Findings; purpose statement.

TITLE I—MEDICARE EXTENDERS

Sec. 101. Physician payment update.
Sec. 102. Extension of work GPCI floor.
Sec. 103. Extension of therapy cap exceptions process.
Sec. 104. Extension of ambulance add-ons.
Sec. 105. Medicare inpatient hospital payment adjustment for low-volume hospitals.
Sec. 106. Medicare-dependent hospital (MDH) program.
Sec. 107. 1-year extension of authorization for special needs plans.
Sec. 108. 1-year extension of Medicare reasonable cost contracts.
Sec. 109. Extension of existing funding for contract with consensus-based entity.
Sec. 110. Extension of funding outreach and assistance for low-income programs.

TITLE II—OTHER HEALTH PROVISIONS

Sec. 201. Extension of the qualifying individual (QI) program.
Sec. 203. Extension of funding for family-to-family health information centers.
Sec. 204. Delay of reductions to Medicaid DSH allotments.
Sec. 205. Realignment of the Medicare sequester for fiscal year 2023.
Sec. 206. Payment for inpatient services in long-term care hospitals (LTCHs).
Sec. 207. Enforcement delay of Medicare two-midnight rule to permit development of a new Medicare payment methodology for short inpatient hospital stays.

SEC. 2. FINDINGS; PURPOSE STATEMENT.

In order to support the provision of quality care for our nation’s seniors, Congress finds it appropriate to reform physician reimbursements under the Medicare program. SGR reform legislation provides such an opportunity, but not until next year. In order to facilitate such reform, Congress finds that the Centers for Medicare & Medicaid Services should continue to focus its efforts on the following areas:

(1) SIMPLIFY AND REDUCE ADMINISTRATIVE BURDEN ON PHYSICIANS.—The application and assessment of measures and other activities under SGR reform should be facilitated by the Centers for Medicare and Medicaid Services (CMS) in a way that accounts for the administrative burden such measurement places on physicians. Therefore, the Congress encourages CMS to identify and implement, to the extent practicable, mechanisms to ensure that the application and assessment of measures be coordinated across programs.

(2) TIMELY FEEDBACK FOR PHYSICIANS.—In order for measure and assessment programs to encourage the highest quality care for Medicare sen-
iors, the Congress finds it critical that CMS provide physicians with feedback on performance in as close to real time as possible. Such timely feedback will ensure that physicians can excel under a system of meaningful measurement.

(3) ENCOURAGE DEVELOPMENT OF NEW MODELS.—There is great need to test alternatives to Fee-For-Service reimbursement in the Medicare program. One option is the promotion and adoption of new models of care for physicians. To date, there has been significant development and testing of models for primary care. Congress supports these efforts and encourages them to continue in the future. Congress also encourages the development and testing of models of specialty care.

TITLE I—MEDICARE EXTENDERS

SEC. 101. PHYSICIAN PAYMENT UPDATE.

Section 1848(d) of the Social Security Act (42 U.S.C. 101395w–4(d)) is amended by adding at the end the following new paragraph:

“(15) UPDATE FOR JANUARY THROUGH MARCH OF 2014.—

“(A) IN GENERAL.—Subject to paragraphs (7)(B), (8)(B), (9)(B), (10)(B), (11)(B), (12)(B), (13)(B), and (14)(B), in lieu of the
update to the single conversion factor established in paragraph (1)(C) that would otherwise apply for 2014 for the period beginning on January 1, 2014, and ending on March 31, 2014, the update to the single conversion factor shall be 0.5 percent.

“(B) No effect on computation of conversion factor for remaining portion of 2014 and subsequent years.—The conversion factor under this subsection shall be computed under paragraph (1)(A) for the period beginning on April 1, 2014, and ending on December 31, 2014, and for 2015 and subsequent years as if subparagraph (A) had never applied.”.

SEC. 102. EXTENSION OF WORK GPCI FLOOR.

Section 1848(e)(1)(E) of the Social Security Act (42 U.S.C. 1395w-4(e)(1)(E)) is amended by striking “January 1, 2014” and inserting “April 1, 2014”.

SEC. 103. EXTENSION OF THERAPY CAP EXCEPTIONS PROCESS.

Section 1833(g) of the Social Security Act (42 U.S.C. 1395l(g)) is amended—
(1) in paragraph (5)(A), in the first sentence, by striking “December 31, 2013” and inserting “March 31, 2014”; and

(2) in paragraph (6)(A)—

(A) by striking “December 31, 2013” and inserting “March 31, 2014”; and

(B) by striking “or 2013” and inserting “, 2013, or the first three months of 2014”.

SEC. 104. EXTENSION OF AMBULANCE ADD-ONS.

(a) GROUND AMBULANCE.—Section 1834(l)(13)(A) of the Social Security Act (42 U.S.C. 1395m(l)(13)(A)) is amended—

(1) in the matter preceding clause (i), by striking “January 1, 2014” and inserting “April 1, 2014”; and

(2) in each of clauses (i) and (ii), by striking “January 1, 2014” and inserting “April 1, 2014” each place it appears.

(b) SUPER RURAL GROUND AMBULANCE.—Section 1834(l)(12)(A) of the Social Security Act (42 U.S.C. 1395m(l)(12)(A)) is amended by striking “January 1, 2014” and inserting “April 1, 2014”.
SEC. 105. MEDICARE INPATIENT HOSPITAL PAYMENT ADJUSTMENT FOR LOW-VOLUME HOSPITALS.

Section 1886(d)(12) of the Social Security Act (42 U.S.C. 1395ww(d)(12)) is amended—

(1) in subparagraph (B), in the matter preceding clause (i), by striking “fiscal year 2014 and subsequent fiscal years” and inserting “the portion of fiscal year 2014 beginning on April 1, 2014, fiscal year 2015, and subsequent fiscal years”;

(2) in subparagraph (C)(i)—

(A) by inserting “and the portion of fiscal year 2014 before” after “and 2013,” each place it appears; and

(B) by inserting “or portion of fiscal year” after “during the fiscal year”; and

(3) in subparagraph (D)—

(A) by inserting “and the portion of fiscal year 2014 before April 1, 2014,” after “and 2013,”; and

(B) by inserting “or the portion of fiscal year” after “in the fiscal year”.

SEC. 106. MEDICARE-DEPENDENT HOSPITAL (MDH) PROGRAM.

(a) IN GENERAL.—Section 1886(d)(5)(G) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(G)) is amended—
(1) in clause (i), by striking “October 1, 2013” and inserting “April 1, 2014”; and

(2) in clause (ii)(II), by striking “October 1, 2013” and inserting “April 1, 2014”.

(b) Conforming Amendments.—

(1) Extension of Target Amount.—Section 1886(b)(3)(D) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(D)) is amended—

(A) in the matter preceding clause (i), by striking “October 1, 2013” and inserting “April 1, 2014”; and

(B) in clause (iv), by inserting “and the portion of fiscal year 2014 before April 1, 2014” after “through fiscal year 2013”.

(2) Permitting Hospitals to Decline Reclassification.—Section 13501(e)(2) of the Omnibus Budget Reconciliation Act of 1993 (42 U.S.C. 1395ww note) is amended by striking “through fiscal year 2013” and inserting “through the first 2 quarters of fiscal year 2014”.

SEC. 107. 1-YEAR EXTENSION OF AUTHORIZATION FOR SPECIAL NEEDS PLANS.

Section 1859(f)(1) of the Social Security Act (42 U.S.C. 1395w–28(f)(1)) is amended by striking “2015” and inserting “2016”.
SEC. 108. 1-YEAR EXTENSION OF MEDICARE REASONABLE COST CONTRACTS.

Section 1876(h)(5)(C)(ii) of the Social Security Act (42 U.S.C. 1395mm(h)(5)(C)(ii)) is amended, in the matter preceding subclause (I), by striking “January 1, 2014” and inserting “January 1, 2015”.

SEC. 109. EXTENSION OF EXISTING FUNDING FOR CONTRACT WITH CONSENSUS-BASED ENTITY.

Section 1890(d) of the Social Security Act (42 U.S.C. 1395aaa(d)) is amended by adding at the end the following new sentence: “Amounts transferred under the preceding sentence shall remain available until expended.”.

SEC. 110. EXTENSION OF FUNDING OUTREACH AND ASSISTANCE FOR LOW-INCOME PROGRAMS.

(a) ADDITIONAL FUNDING FOR STATE HEALTH INSURANCE PROGRAMS.—Subsection (a)(1)(B) of section 119 of the Medicare Improvements for Patients and Providers Act of 2008 (42 U.S.C. 1395b–3 note), as amended by section 3306 of the Patient Protection and Affordable Care Act Public Law 111–148) and section 610 of the American Taxpayer Relief Act of 2012 (Public Law 112–240), is amended—

(1) in clause (ii), by striking “and” at the end;  
(2) in clause (iii), by striking the period at the end and inserting “; and”; and
(3) by inserting after clause (iii) the following new clause:

“(iv) for the portion of fiscal year 2014 before April 1, 2014, of $3,750,000.”.

(b) ADDITIONAL FUNDING FOR AREA AGENCIES ON AGING.—Subsection (b)(1)(B) of such section 119, as so amended, is amended—

(1) in clause (ii), by striking “and” at the end;

(2) in clause (iii), by striking the period at the end and inserting “; and”; and

(3) by inserting after clause (iii) the following new clause:

“(iv) for the portion of fiscal year 2014 before April 1, 2014, of $3,750,000.”.

(c) ADDITIONAL FUNDING FOR AGING AND DISABILITY RESOURCE CENTERS.—Subsection (e)(1)(B) of such section 119, as so amended, is amended—

(1) in clause (ii), by striking “and” at the end;

(2) in clause (iii), by striking the period at the end and inserting “; and”; and

(3) by inserting after clause (iii) the following new clause:
“(iv) for the portion of fiscal year 2014 before April 1, 2014, of $2,500,000.”.

(d) ADDITIONAL FUNDING FOR CONTRACT WITH THE NATIONAL CENTER FOR BENEFITS AND OUTREACH ENROLLMENT.—Subsection (d)(2) of such section 119, as so amended, is amended—

(1) in clause (ii), by striking “and” at the end;

(2) in clause (iii), by striking the period at the end and inserting “; and”;

(3) by inserting after clause (iii) the following new clause:

“(iv) for the portion of fiscal year 2014 before April 1, 2014, of $2,500,000.”.

TITLE II—OTHER HEALTH PROVISIONS

SEC. 201. EXTENSION OF THE QUALIFYING INDIVIDUAL (QI) PROGRAM.


"
(b) **Extending total amount available for allocation.**—Section 1933(g) of the Social Security Act (42 U.S.C. 1396u–3(g)) is amended—

(1) in paragraph (2)—

(A) in subparagraph (S), by striking “and” after the semicolon;

(B) in subparagraph (T), by striking the period at the end and inserting “; and”; and

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

“(U) for the period that begins on January 1, 2014, and ends on March 31, 2014, the total allocation amount is $200,000,000.”.

**Sec. 202. Temporary extension of transitional medical assistance (TMA).**

Sections 1902(e)(1)(B) and 1925(f) of the Social Security Act (42 U.S.C. 1396a(e)(1)(B), 1396r–6(f)) are each amended by striking “December 31, 2013” and inserting “March 31, 2014”.

**Sec. 203. Extension of funding for family-to-family health information centers.**

Section 501(c)(1)(A) of the Social Security Act (42 U.S.C. 701(c)(1)(A)) is amended—

(1) in clause (ii), by striking at the end “and”;

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(2) in clause (iii), by striking the period at the end and inserting “; and”; and

(3) by adding at the end the following new clause:

“(iv) $2,500,000 for the portion of fiscal year 2014 before April 1, 2014.”.

SEC. 204. DELAY OF REDUCTIONS TO MEDICAID DSH ALLOTMENTS.

(a) IN GENERAL.—Section 1923(f) of the Social Security Act (42 U.S.C. 1396r–4(f)) is amended—

(1) in paragraph (7)(A)—

(A) in clause (i), by striking “2014” and inserting “2016”; and

(B) in clause (ii)—

(i) by striking subclauses (I) and (II);

(ii) by redesignating subclauses (III) through (VII) as subclauses (I) through (V), respectively; and

(iii) in subclause (I) (as redesignated by clause (ii)), by striking “$600,000,000” and inserting “$1,200,000,000”; and

(2) in paragraph (8)—

(A) by redesignating subparagraph (C) as subparagraph (D);
(B) by inserting after subparagraph (B) the following new subparagraph:

“(C) Fiscal Year 2023.—Only with respect to fiscal year 2023, the DSH allotment for a State, in lieu of the amount determined under paragraph (3) for the State for that year, shall be equal to the DSH allotment for the State for fiscal year 2022, as determined under subparagraph (B), increased, subject to subparagraphs (B) and (C) of paragraph (3), and paragraph (5), by the percentage change in the consumer price index for all urban consumers (all items; U.S. city average), for fiscal year 2022.”; and

(C) in subparagraph (D) (as redesignated by subparagraph (A)), by striking “fiscal year 2022” and inserting “fiscal year 2023”.

(b) Effective Date.—The amendments made by subsection (a) shall be effective as of October 1, 2013.


Paragraph (6) (relating to implementing direct spending reductions, as redesignated by section 101(d)(2)(C), and as amended by section 101(c), of the Bipartisan Budget Act of 2013) of section 251A of the
Balanced Budget and Emergency Deficit Control Act of 1985 (2 U.S.C. 901a) is amended by adding at the end the following new subparagraph:

“(C) Notwithstanding the 2 percent limit specified in subparagraph (A) for payments for the Medicare programs specified in section 256(d), the sequestration order of the President under such subparagraph for fiscal year 2023 shall be applied to such payments so that—

“(i) with respect to the first 6 months in which such order is effective for such fiscal year, the payment reduction shall be 2.90 percent; and

“(ii) with respect to the second 6 months in which such order is so effective for such fiscal year, the payment reduction shall be 1.11 percent.”.

SEC. 206. PAYMENT FOR INPATIENT SERVICES IN LONG-TERM CARE HOSPITALS (LTCHS).

(a) Establishment of Criteria for Application of Site Neutral Payment.—

(1) In general.—Section 1886(m) of the Social Security Act (42 U.S.C. 1395ww(m)) is amended by adding at the end the following:
(6) Application of site neutral IPPS payment rate in certain cases.—

(A) General application of site neutral IPPS payment amount for discharges failing to meet applicable criteria.—

(i) In general.—For a discharge in cost reporting periods beginning on or after October 1, 2015, except as provided in clause (ii) and subparagraph (C), payment under this title to a long-term care hospital for inpatient hospital services shall be made at the applicable site neutral payment rate (as defined in subparagraph (B)).

(ii) Exception for certain discharges meeting criteria.—Clause (i) shall not apply (and payment shall be made to a long-term care hospital without regard to this paragraph) for a discharge if—

(I) the discharge meets the ICU criterion under clause (iii) or the ventilator criterion under clause (iv); and
“(II) the discharge does not have a principal diagnosis relating to a psychiatric diagnosis or to rehabilitation.

“(iii) INTENSIVE CARE UNIT (ICU) CRITERION.—

“(I) IN GENERAL.—The criterion specified in this clause (in this paragraph referred to as the ‘ICU criterion’), for a discharge from a long-term care hospital, is that the stay in the long-term care hospital ending with such discharge was immediately preceded by a discharge from a stay in a subsection (d) hospital that included at least 3 days in an intensive care unit (ICU), as determined by the Secretary.

“(II) DETERMINING ICU DAYS.—

In determining intensive care unit days under subclause (I), the Secretary shall use data from revenue center codes 020x or 021x (or such successor codes as the Secretary may establish).
“(iv) **Ventilator criterion.**—The criterion specified in this clause (in this paragraph referred to as the ‘ventilator criterion’), for a discharge from a long-term care hospital, is that—

“(I) the stay in the long-term care hospital ending with such discharge was immediately preceded by a discharge from a stay in a subsection (d) hospital; and

“(II) the individual discharged was assigned to a Medicare-Severity-Long-Term-Care-Diagnosis-Related-Group (MS–LTC–DRG) based on the receipt of ventilator services of at least 96 hours.

“(B) **Applicable site neutral payment rate defined.**—

“(i) **In general.**—In this paragraph, the term ‘applicable site neutral payment rate’ means—

“(I) for discharges in cost reporting periods beginning during fiscal year 2016 or fiscal year 2017, the
blended payment rate specified in clause (iii); and

“(II) for discharges in cost reporting periods beginning during fiscal year 2018 or a subsequent fiscal year, the site neutral payment rate (as defined in clause (ii)).

“(ii) SITEMEUTRAL PAYMENT RATE DEFINED.—In this paragraph, the term ‘site neutral payment rate’ means the lower of—

“(I) the IPPS comparable per diem amount determined under paragraph (d)(4) of section 412.529 of title 42, Code of Federal Regulations, including any applicable outlier payments under section 412.525 of such title; or

“(II) 100 percent of the estimated cost for the services involved.

“(iii) BLENDED PAYMENT RATE.— The blended payment rate specified in this clause, for a long-term care hospital for inpatient hospital services for a discharge, is comprised of—
“(I) half of the site neutral payment rate (as defined in clause (ii)) for the discharge; and

“(II) half of the payment rate that would otherwise be applicable to such discharge without regard to this paragraph, as determined by the Secretary.

“(C) LIMITING PAYMENT FOR ALL HOSPITAL DISCHARGES TO SITE NEUTRAL PAYMENT RATE FOR HOSPITALS FAILING TO MEET APPLICABLE LTCH DISCHARGE THRESHOLDS.—

“(i) NOTICE OF LTCH DISCHARGE PAYMENT PERCENTAGE.—For cost reporting periods beginning during or after fiscal year 2016, the Secretary shall inform each long-term care hospital of its LTCH discharge payment percentage (as defined in clause (iv)) for such period.

“(ii) LIMITATION.—For cost reporting periods beginning during or after fiscal year 2020, if the Secretary determines for a long-term care hospital that its LTCH discharge payment percentage for the period is not at least 50 percent—
“(I) the Secretary shall inform the hospital of such fact; and

“(II) subject to clause (iii), for all discharges in the hospital in each succeeding cost reporting period, the payment amount under this subsection shall be the payment amount that would apply under subsection (d) for the discharge if the hospital were a subsection (d) hospital.

“(iii) Process for reinstatement.—The Secretary shall establish a process whereby a long-term care hospital may seek to have the provisions of subclause (II) of clause (ii) discontinued with respect to that hospital.

“(iv) LTCH discharge payment percentage.—In this subparagraph, the term ‘LTCH discharge payment percentage’ means, with respect to a long-term care hospital for a cost reporting period beginning during or after fiscal year 2020, the ratio (expressed as a percentage) of—

“(I) the number of discharges for such hospital and period for which
payment is not made at the site neutral payment rate, to

“(II) the total number of discharges for such hospital and period.

“(D) INCLUSION OF SUBSECTION (D) PUERTO RICO HOSPITALS.—In this paragraph, any reference in this paragraph to a subsection (d) hospital shall be deemed to include a reference to a subsection (d) Puerto Rico hospital.”.

(2) MEDPAC STUDY AND REPORT ON IMPACT OF CHANGES.—

(A) STUDY.—The Medicare Payment Assessment Commission shall examine the effect of applying section 1886(m)(6) of the Social Security Act, as added by the amendment made by paragraph (1), on—

(i) the quality of patient care in long-term care hospitals;

(ii) the use of hospice care and post-acute care settings;

(iii) different types of long-term care hospitals; and

(iv) the growth in Medicare spending for services in such hospitals.
(B) Report.—Not later than June 30, 2019, the Commission shall submit to Congress a report on such study. The Commission shall include in such report such recommendations for changes in the application of such section as the Commission deems appropriate as well as the impact of the application of such section on the need to continue applying the 25 percent rule described under sections 412.534 and 412.536 of title 42, Code of Federal Regulations.

(3) Calculation of Length of Stay Excluding Cases Paid on a Site Neutral Basis.—

(A) In General.—For discharges occurring in cost reporting periods beginning on or after October 1, 2015, subject to subparagraph (B), in calculating the length of stay requirement applicable to a long-term care hospital or satellite facility under section 1886(d)(1)(B)(iv)(I) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)(iv)(I)) and section 1861(ccc)(2) of such Act (42 U.S.C. 1395x(ccc)(2)), the Secretary of Health and Human Services shall exclude the following:
(i) **Site Neutral Payment.**—Any patient for whom payment is made at the site neutral payment rate (as defined in section 1886(m)(6)(B)(ii) of such Act, as added by paragraph (1)).

(ii) **Medicare Advantage.**—Any patient for whom payment is made under a Medicare Advantage plan under part C of title XVIII of such Act.

(B) **Limitation on Converting Subsection (D) Hospitals.**—Subparagraph (A) shall not apply to a hospital that is classified as of December 10, 2013, as 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)) for purposes of determining whether the requirements of section 1886(d)(1)(B)(iv)(I) or 1861(ccc)(2) of such Act (42 U.S.C. 1395ww(d)(1)(B)(iv)(I), 1395x(ccc)(2)) are met.

(b) **Extension of Certain LTCH Payment Rules and Moratorium on the Establishment of Certain Hospitals and Facilities.**—

(1) **Extension of Certain Payment Rules.**—
(A) PAYMENT FOR HOSPITALS-WITHIN-HOSPITALS.—Paragraph (2)(C) of section 114(c) of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (42 U.S.C. 1395ww note), as amended by sections 3106(a) and 10312(a) of Public Law 111–148, is amended by striking “5-year period” and inserting “9-year period”.

(B) 25 PERCENT PATIENT THRESHOLD PAYMENT ADJUSTMENT; MAKING THE GRAND-FATHERED EXEMPTION FOR LONG-TERM CARE HOSPITALS PERMANENT.—Section 114(c)(1) of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (42 U.S.C. 1395ww note), as amended by sections 3106(a) and 10312(a) of Public Law 111–148, is amended—

(i) in the matter preceding subparagraph (A), by striking “for a 5-year period”; and

(ii) in subparagraph (A), by inserting “for a 9-year period,” before “section 412.536”.

(C) REPORT ASSESSING CONTINUED SUSPENSION OF 25 PERCENT RULE.—Not later than 1 year before the end of the 9-year period
referred to in section 114(c)(1) of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (42 U.S.C. 1395ww note), as amended by sub-
paragraph (B), the Secretary of Health and Human Services shall submit to Congress a re-
port on the need for any further extensions (or modifications of the extensions) of the 25 per-
cent rule described in sections 412.534 and 412.536 of title 42, Code of Federal Regula-
tions, particularly taking into account the appli-
cation of section 1886(m)(6) of the Social Secu-

rity Act, as added by subsection (a)(1).

(2) Extension of Moratorium on Estab-

lishment of and Increase in Beds for 

LTCHs.—Section 114(d) of the Medicare, Medicaid, 
and SCHIP Extension Act of 2007 (42 U.S.C. 
1395ww note), as amended by sections 3106(b) and 
10312(b) of Public Law 111–148, is amended—

(A) in paragraph (1), in the matter pre-
ceding subparagraph (A), by inserting after “5-
year period” the following: “(and for the period 
beginning January 1, 2015, and ending Sep-
tember 30, 2017)”; and

(B) by adding at the end the following new 
paragraph:
“(6) LIMITATION ON APPLICATION OF EXCEPTIONS.—Paragraphs (2) and (3) shall not apply during the period beginning January 1, 2015, and ending September 30, 2017.”.

(c) ADDITIONAL QUALITY MEASURE.—Section 1886(m)(5)(D) of the Social Security Act (42 U.S.C. 1395ww(m)(5)(D)) is amended by adding at the end the following new clause:

“(iv) ADDITIONAL QUALITY MEASURES.—Not later than October 1, 2015, the Secretary shall establish a functional status quality measure for change in mobility among inpatients requiring ventilator support.”.

(d) REVIEW OF TREATMENT OF CERTAIN LTCHS.—

(1) EVALUATION.—As part of the annual rulemaking for fiscal year 2015 or fiscal year 2016 to carry out the payment rates under subsection (d) of section 1886 of the Social Security Act (42 U.S.C. 1395ww), the Secretary shall evaluate both the payment rates and regulations governing hospitals which are classified under subclause (II) of subsection (d)(1)(B)(iv) of such section.

(2) ADJUSTMENT AUTHORITY.—Based upon such evaluation, the Secretary may adjust payment
rates under subsection (b)(3) of section 1886 of the Social Security Act (42 U.S.C. 1395ww) for a hospital so classified (such as payment based upon the TEFRA-payment model) and may adjust the regulations governing such hospitals, including applying the regulations governing hospitals which are classified under clause (I) of subsection (d)(1)(B) of such section.

SEC. 207. ENFORCEMENT DELAY OF MEDICARE TWO-MIDNIGHT RULE TO PERMIT DEVELOPMENT OF A NEW MEDICARE PAYMENT METHODOLOGY FOR SHORT INPATIENT HOSPITAL STAYS.

(a) DELAY IN ENFORCEMENT OF TWO-MIDNIGHT RULE.—

(1) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the “Secretary”) shall not enforce the provisions of the two-midnight rule (as defined in paragraph (2)) with respect to admissions to a hospital (as defined in subsection (d)) for which payment is made under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) for admissions occurring before October 1, 2014.

(2) TWO-MIDNIGHT RULE DEFINED.—In this section, the term “two-midnight rule” means the fol-
ollowing numbered amendments to 42 CFR Chapter IV contained in the IPPS FY 2014 Final Rule (and includes any sub-regulatory guidance issued in the implementation of such amendments and any portion of the preamble of section XI.C. of such rule relating to such amendments):

(A) Amendment 2 (on page 50965), which adds a section 412.3 of title 42, Code of Federal Regulations (relating to admissions).

(B) Amendment 3 (on page 50965), which revises section 412.46 of such title (relating to medical review requirements).

(C) Amendment 23 (on page 50969), which amends paragraphs (d) and (e)(2) of section 424.11 of such title (relating to conditions of payment: General procedures).

(D) Amendment 24 (on pages 50969 and 50970), which revises section 424.13 of such title (relating to requirements for inpatient services of hospitals other than inpatient psychiatric facilities).

(E) Amendment 25 (on page 50970), which revises paragraphs (a), (b), (d)(1), and (e) of section 424.14 of such title (relating to
requirements for inpatient services of inpatient psychiatric facilities).

(F) Amendment 26 (on page 50970), which revises section 424.15 of such title (relat-
ing to requirements for inpatient CAH serv-
ices).

(3) IPPS FY 2014 FINAL RULE DEFINED.—In
this section, the term “IPPS FY 2014 Final Rule”
means the final rule (CMS-1599-F, CMS–1455–F)
published by the Centers for Medicare & Medicaid
Services in the Federal Register on August 19,
2013, entitled “Medicare Program; Hospital Inpa-
tient Prospective Payment Systems for Acute Care
Hospitals and the Long-Term Care Hospital Pro-
spective Payment System and Fiscal Year 2014
Rates; Quality Reporting Requirements for Specific
Providers; Hospital Conditions of Participation; Pay-
ment Policies Related to Patient Status” (78 Fed-
eral Register 50496 et seq.).

(4) APPLICATION TO MEDICARE REVIEW CON-
TRACTORS.—

(A) IN GENERAL.—Paragraph (1) shall
also apply to Medicare review contractors (as
defined in subparagraph (B)). No medicare re-
view contractor may deny a claim for payment
for inpatient hospital services furnished by a hospital, or inpatient critical access hospital services furnished by a critical access hospital, for which payment may be made under title XVIII of the Social Security Act for discharges occurring before the date specified in paragraph (1)—

(i) for medical necessity due to the length of an inpatient stay in such hospital or due to a determination that the services could have been provided on an outpatient basis; or

(ii) for requirements for orders, certifications, or recertifications, and associated documentation relating to the matters described in clause (i).

(B) Medicare review contractor defined.—In subparagraph (A), the term “Medicare review contractor” means any contractor or entity that has entered into a contract or subcontract with the Centers for Medicare & Medicaid Services with respect to the Medicare program to review claims for items and services furnished for which payment is made under
title XVIII of the Social Security Act, including—

(i) Medicare administrative contractors under section 1874A of the Social Security Act (42 U.S.C. 1395kk–1); and

(ii) recovery audit contractors under section 1893(h) of such Act (42 U.S.C. 1395ddd(h)).

(5) CONTINUATION OF MEDICARE PROBE AND EDUCATE PROGRAM FOR INPATIENT HOSPITAL ADMISSIONS.—

(A) IN GENERAL.—Subject to subparagraph (B), nothing in this subsection shall be construed to preclude the Secretary from continuing the conduct by Medicare administrative contractors of the Medicare Probe and Educate program (as defined in subparagraph (C)) for hospital admissions during the delay of enforcement under paragraph (1).

(B) MAINTENANCE OF SAMPLE PREPAYMENT RECORD LIMITS.—The Secretary may not increase the sample of claims selected for prepayment review under the Medicare Probe and Educate program above the number and type established by the Secretary under such pro-
gram as of November 4, 2013, such as 10 claims for most hospitals and 25 claims for large hospitals.

(C) Medicare Probe and Educate Program Defined.—In this paragraph, the term “Medicare Probe and Educate program” means the program established by the Secretary as in effect on November 4, 2013 (and described in a public document made available by the Centers for Medicare & Medicaid Services on its Website entitled “Frequently Asked Questions 2 Midnight Inpatient Admission Guidance & Patient Status Reviews for Admissions on or after October 1, 2013”) under which Medicare administrative contractors—

(i) conduct prepayment patient status reviews for inpatient hospital claims with dates of admission on or after October 1, 2013, and before March 31, 2014; and

(ii) based on the results of such prepayment patient status reviews, conduct educational outreach efforts during the following 3 months.

(b) Short Inpatient Hospital Stay Payment Methodology.—
(1) In general.—The Secretary shall develop a payment methodology under the Medicare program for hospitals for short inpatient hospital stays (as defined in paragraph (2)). Such payment methodology may be a reduced payment amount for such inpatient hospital services than would otherwise apply if paid for under section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)) or may be an alternative payment methodology. The Secretary shall promulgate such payment methodology as part of the annual regulations implementing the Medicare hospital inpatient prospective payment system for fiscal year 2016.

(2) Short inpatient hospital stay defined.—In this section, the term “short inpatient hospital stay” means, with respect to an inpatient admission of an individual entitled to benefits under part A of title XVIII of the Social Security Act to a hospital, a length of stay that is less than the length of stay required to satisfy the 2-midnight benchmark described in section 412.3 of title 42, Code of Federal Regulation, as amended under the Amendment 2 referred to in subsection (a)(2)(A).

(c) Crosswalk of ICD-10 codes and CPT codes;

Crosswalk of DRG and CPT codes.—
(1) ICD10–to–CPT CROSSWALK.—

(A) IN GENERAL.—Not later than 2 years after the date of the enactment of this Act, the Secretary shall develop general equivalency maps (referred to in this subsection as an “crosswalks”) to link the relevant ICD-10 codes to relevant CPT codes, and the relevant CPT codes to relevant ICD-10 codes, in order to permit comparisons of inpatient hospital services, for which payment is made under section 1886 of the Social Security Act (42 U.S.C. 1395ww), and hospital outpatient department services, for which payment is made under section 1833(t) of such Act (42 U.S.C. 1395l(t)). In this subsection the terms “ICD–10 codes” and “CPT codes” include procedure as well as diagnostic codes.

(B) PROCESS.—

(i) IN GENERAL.—In carrying out subparagraph (A), the Secretary shall develop a proposed ICD10–to–CPT crosswalk which shall be made available for public comment for a period of not less than 60 days.
(ii) NOTICE.—The Secretary shall
provide notice of the comment period
through the following:

(I) Publication of notice of pro-
posed rulemaking in the Federal Reg-
ister.

(II) A solicitation posted on the
Internet Website of the Centers for
Medicare & Medicaid Services.

(III) An announcement on the
Internet Website of the Centers for
Medicare & Medicaid Services of the
availability of the proposed crosswalk
and the deadline for comments.

(IV) A broadcast through an ap-
propriate Listserv operated by the
Centers for Medicare & Medicaid
Services.

(iii) USE OF THE ICD–9–CM COORDI-
NATION AND MAINTENANCE COMMITTEE.—
The Secretary also shall instruct the ICD–
9–CM Coordination and Maintenance
Committee to convene a meeting to receive
input from the public regarding the pro-
posed ICD10–to–CPT crosswalk.
(iv) Publication of final crosswalks.—Taking into consideration comments received on the proposed crosswalk, the Secretary shall publish a final ICD10-to-CPT crosswalk under subparagraph (A) and shall post such crosswalk on the Internet Website of the Centers for Medicare & Medicaid Services.

(v) Updating.—The Secretary shall update such crosswalk on an annual basis.

(2) DRG–to–APC crosswalk.—

(A) In general.—The Secretary shall, using the ICD10-to-CPT crosswalk developed under paragraph (1), develop a second crosswalk between diagnosis-related group (DRG) codes for inpatient hospital services and Ambulatory Payment Class (APC) codes for outpatient hospital services.

(B) Data to be used.—In developing such crosswalk, the Secretary shall use claims data for inpatient hospital services for discharges occurring in fiscal years beginning with fiscal year 2015 and for outpatient hospital services furnished in years beginning with 2015.
(C) PUBLICATION.—Not later than June 30, 2017, the Secretary shall publish the DRG-to-APC crosswalk developed under this paragraph.

(d) HOSPITAL DEFINED.—For purposes of this section, the term “hospital” means the following (insofar as such terms are used under title XVIII of the Social Security Act):

(1) An acute care hospital.
(2) A critical access hospital.
(3) A long-term care hospital.
(4) An inpatient psychiatric facility.