



441 G St. N.W.
Washington, DC 20548

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August 20, 2015

The Honorable Orrin G. Hatch
Chairman
The Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate

The Honorable Fred Upton
Chairman
The Honorable Frank Pallone, Jr.
Ranking Member
Committee on Energy and Commerce
House of Representatives

The Honorable Paul Ryan
Chairman
The Honorable Sander M. Levin
Ranking Member
Committee on Ways and Means
House of Representatives

Subject: *Department of Health and Human Services, Centers for Medicare & Medicaid Services: Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2016*

Pursuant to section 801(a)(2)(A) of title 5, United States Code, this is our report on a major rule promulgated by the Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) entitled "Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2016" (RIN: 0938-AS45). We received the rule on July 31, 2015. It was published in the *Federal Register* as a final rule on August 6, 2015. 80 Fed. Reg. 47,036.

This final rule updates the prospective payment rates for inpatient rehabilitation facilities (IRFs) for federal fiscal year (FY) 2016. This rule includes the classification and weighting factors for the IRF Prospective Payment System's case-mix groups and a description of the methodologies and data used in computing the prospective payment rates for FY 2016. This final rule also finalizes policy changes, including the adoption of an IRF-specific market basket that reflects the cost structures of only IRF providers, a 1-year phase-in of the revised wage index changes, a 3-year phase-out of the rural adjustment for certain IRFs, and revisions and updates to the quality reporting program.

The Congressional Review Act (CRA) requires a 60-day delay in the effective date of a major rule from the date of publication in the *Federal Register* or receipt of the rule by Congress, whichever is later. 5 U.S.C. § 801(a)(3)(A). This final rule has a stated effective date of October 1, 2015. The rule was received by the House of Representatives on July 31, 2015, and by the Senate on August 3, 2015. 161 Cong. Rec. H5787 (Aug. 4, 2015); 161 Cong. Rec. S6292 (Aug. 4, 2015). It was then published in the *Federal Register* on August 6, 2015. 80 Fed. Reg. 47,036. Therefore, this rule does not have the required 60-day delay in effective date.

Enclosed is our assessment of CMS's compliance with the procedural steps required by section 801(a)(1)(B)(i) through (iv) of title 5 with respect to the rule. With the exception of the 60-day delay requirement, our review of the procedural steps taken indicates that CMS complied with the applicable requirements.

If you have any questions about this report or wish to contact GAO officials responsible for the evaluation work relating to the subject matter of the rule, please contact Shirley A. Jones, Assistant General Counsel, at (202) 512-8156.

signed

Robert J. Cramer
Managing Associate General Counsel

Enclosure

cc: Ann Stallion
Deputy Director/ODRM
Department of Health and Human Services

REPORT UNDER 5 U.S.C. § 801(a)(2)(A) ON A MAJOR RULE
ISSUED BY THE
DEPARTMENT OF HEALTH AND HUMAN SERVICES,
CENTERS FOR MEDICARE & MEDICAID SERVICES
ENTITLED
“MEDICARE PROGRAM; INPATIENT REHABILITATION FACILITY
PROSPECTIVE PAYMENT SYSTEM FOR FEDERAL FISCAL YEAR 2016”
(RIN: 0938-AS45)

(i) Cost-benefit analysis

The Centers for Medicare & Medicaid Services (CMS) did an economic analysis of this final rule. CMS estimates that the overall economic impact of this final rule will be \$135 million in increased payments from the federal government to inpatient rehabilitation facilities (IRFs) during fiscal year (FY) 2016. CMS also estimated that the total costs in FY 2016 for IRFs as a result of the new quality reporting requirements to be \$24,042,291.01. CMS projects payments per discharge for IRFs in FY 2016 will increase by 1.8 percent, compared with the estimated payments in FY 2015. CMS estimates IRF payments per discharge will increase by 1.8 percent in both urban and rural areas, compared with estimated FY 2015 payments. CMS estimates payments per discharge to rehabilitation units will increase 1.9 percent in urban areas and 2.0 in rural areas. CMS estimates payments per discharge to freestanding rehabilitation hospitals will increase 1.7 percent in urban areas and 0.9 percent in rural areas. Overall, CMS estimates IRFs will experience a net increase in payments as a result of the policies in this final rule. CMS estimates the largest payment increase will be a 3.0 percent increase for rural IRFs located in the Pacific region.

(ii) Agency actions relevant to the Regulatory Flexibility Act (RFA), 5 U.S.C. §§ 603-605, 607, and 609

CMS did not determine the number of small proprietary IRFs or the proportion of IRFs' revenue that is derived from Medicare payments because it lacks data on individual hospital receipts. Therefore, CMS assumed that all IRFs (an approximate total of 1,100 IRFs, of which approximately 60 percent are nonprofit facilities) are considered small entities and that Medicare payment constitutes the majority of their revenues. CMS generally uses a revenue impact of 3 to 5 percent as a significance threshold under the Act. CMS estimates that the net revenue impact of this final rule on all IRFs will be an increase in estimated payments by approximately 1.8 percent. However, CMS found that certain individual IRF providers would be expected to experience revenue impacts greater than 3 percent. CMS estimated that approximately three IRFs would transition from urban to rural status as a result of the changes to the delineation of Core-Based Statistical Areas issued in the Office of Management and Budget (OMB) Bulletin No. 13-01, will gain the 14.9 percent rural adjustment, and will therefore experience net increases in IRF PPS payments of 16.4 percent. As a result, CMS anticipates this final rule will have a net positive impact on small entities.

(iii) Agency actions relevant to sections 202-205 of the Unfunded Mandates Reform Act of 1995, 2 U.S.C. §§ 1532-1535

CMS determined that this final rule will not mandate spending costs on state, local, or tribal governments, in the aggregate, or by the private sector of greater than \$144 million (\$100 million in 1995 dollars, adjusted for inflation).

(iv) Other relevant information or requirements under acts and executive orders

Administrative Procedure Act, 5 U.S.C. §§ 551 et seq.

On April 27, 2015, CMS published a proposed rule. 80 Fed. Reg. 23,332. CMS received 85 timely responses from the public, many of which, according to CMS, contained multiple comments. CMS received comments from various trade associations, inpatient rehabilitation facilities, individual physicians, therapists, clinicians, health care industry organizations, and health care consulting firms. CMS responded to comments in the final rule.

Paperwork Reduction Act (PRA), 44 U.S.C. §§ 3501-3520

This final rule finalized two quality measures that have already been adopted for the IRF Quality Reporting Program. CMS concluded that there will be no additional impact or burden associated with these measures because the first measure can be calculated based on data that are already reported to the Medicare program for payment purposes and IRFs are already submitting quality data related to the second measure. CMS also finalized adoption of six additional quality measures to be collected and reported using the IRF Patient Assessment Instrument (IRF-PAI) (version 1.4). CMS estimates the additional elements for the six newly adopted measures will take 25.5 minutes of nursing/clinical staff time to report data on admission and 16.0 minutes of nursing/clinical staff time to report data on discharge, for a total of 41.5 minutes with a cost of \$21,239.33 per IRF annually, or \$22,529,560.74 to \$24,042,291.01 for all IRFs annually.

While CMS acknowledged that the reporting of data on quality measures is an information collection, CMS stated that it believes that the burden associated with modifications to the IRF-PAI discussed in this final rule fall under exceptions to PRA provided in section 1899B(m) of the Social Security Act because they are required to achieve the standardization of patient assessment data. Section 1899B(m) of the Act provides that PRA does not apply to section 1899B and the sections referenced in section 1899B(a)(2)(B) of the Social Security Act that require modification to achieve the standardization of patient assessment data. CMS stated that it will, however, submit the requirement and burden to OMB for review and approval when the modifications to the IRF-PAI or other applicable post-acute care assessment instrument are not used to achieve the standardization of patient assessment data.

Statutory authorization for the rule

CMS promulgated this final rule under the authority of sections 1102 and 1871 of the Social Security Act, section 124 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, section 1206 of the Bipartisan Budget Act of 2013, and section 112 of the Protecting Access to Medicare Act of 2014. 42 U.S.C. §§ 1302, 1395hh; Public Law 106-113, app. F, § 124, 113 Stat. 1501, 1501A-332 (Nov. 29, 1999); Pub. L. No. 113-67, § 1206, 127 Stat. 1165, 1200-1204 (Dec. 26, 2013); Pub. L. No. 113-93, § 112, 128 Stat. 1040, 1044-1045 (Apr. 1, 2014).

Executive Order No. 12,866 (Regulatory Planning and Review)

CMS determined that this final rule is an economically significant under the Order. CMS stated that OMB has reviewed this rule.

Executive Order No. 13,132 (Federalism)

CMS determined that this final rule will not have a substantial effect on state and local governments, preempt state law, or otherwise have a federalism implication.