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United States Government Accountability Office
Washington, DC 20548

B-320423

August 30, 2010

The Honorable Max Baucus
Chairman
The Honorable Charles E. Grassley
Ranking Member
Committee on Finance
United States Senate

The Honorable Henry A. Waxman
Chairman
The Honorable Joe L. Barton
Ranking Member
Committee on Energy and Commerce
House of Representatives

The Honorable Sander M. Levin
Acting Chairman
The Honorable Dave Camp
Ranking Member
Committee on Ways and Means
House of Representatives

Subject: *Department of Health and Human Services, Centers for Medicare & Medicaid Services: Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System Changes and FY2011 Rates; Provider Agreements and Supplier Approvals; and Hospital Conditions of Participation for Rehabilitation and Respiratory Care Services; Medicaid Program: Accreditation for Providers of Inpatient Psychiatric Services*

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; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System Changes and FY2011 Rates; Provider Agreements and Supplier Approvals; and Hospital Conditions of Participation for Rehabilitation and Respiratory Care Services; Medicaid Program: Accreditation for

Providers of Inpatient Psychiatric Services" (RINs: 0938-AP80; 0938-AP33). We received the rule on August 2, 2010. It was published in the *Federal Register* as "final rules with interim final rule with comment period" on August 16, 2010. 75 Fed. Reg. 50,042. This rule has a stated effective date of October 1, 2010, except for certain provisions which have a stated effective date of June 25, 2010.

The final rule revises the Medicare hospital inpatient prospective payment systems (IPPS) for operating and capital-related costs of acute care hospitals to implement changes arising from CMS's continuing experience with these systems and to implement certain statutory provisions. In addition, the rule describes the changes to the amounts and factors used to determine the rates for Medicare acute care hospital inpatient services for operating costs and capital-related costs. The rule updates the rate-of-increase limits for certain hospitals excluded from the IPPS that are paid on a reasonable cost basis subject to these limits.

Further, this rule updates the payment policy and the annual payment rates for the Medicare prospective payment system (PPS) for inpatient hospital services provided by long-term care hospitals (LTCHs) and sets forth the changes to the payment rates, factors, and other payment rate policies under the LTCH PPS. In addition, the rule finalizes the implementation of statutory provisions relating to payments to LTCHs and LTCH satellite facilities and increases in beds in existing LTCHs and LTCH satellite facilities under the LTCH PPS.

With this rule, CMS is making changes affecting the Medicare conditions of participation for hospitals relating to the types of practitioners who may provide rehabilitation services and respiratory care services and the determination of the effective date of provider agreements and supplier approvals under Medicare. The rule offers psychiatric hospitals and hospitals with inpatient psychiatric programs increased flexibility in obtaining accreditation to participate in the Medicaid program.

This rule also contains an interim final rule with comment period which implements section 102 of the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010 (Section 102)[1] relating to Medicare payments for outpatient services provided prior to a Medicare beneficiary's inpatient admission.

The provisions of this rule implementing Section 102 are effective June 25, 2010. The Congressional Review Act requires a 60-day delay in the effective date of a major rule from the date of publication in the *Federal Register* or receipt by Congress, whichever is later. 5 U.S.C. § 801(a)(3)(A). However, notwithstanding the 60-day delay requirement, any rule that an agency for good cause finds that notice and public comment procedures are impractical, unnecessary, or contrary to the public

[1] Pub. L. No. 111-192, § 102, 124 Stat. 1280, 1281–82 (June 25, 2010).

interest is to take effect when the promulgating agency so determines. 5 U.S.C. §§ 553(d)(3), 808(2). CMS determined that notice and comment rulemaking would be unnecessary and contrary to the public interest in the case of these provisions of this rule because they are conforming regulatory language to self-implementing statutory language which became effective June 25, 2010.

Enclosed is our assessment of the 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. 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
Program Manager
Department of Health and
Human Services

ENCLOSURE

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; HOSPITAL INPATIENT PROSPECTIVE PAYMENT SYSTEMS FOR ACUTE CARE HOSPITALS AND THE LONG-TERM CARE HOSPITAL PROSPECTIVE PAYMENT SYSTEM CHANGES AND FY2011 RATES; PROVIDER AGREEMENTS AND SUPPLIER APPROVALS; AND HOSPITAL CONDITIONS OF PARTICIPATION FOR REHABILITATION AND RESPIRATORY CARE SERVICES; MEDICAID PROGRAM: ACCREDITATION FOR PROVIDERS OF INPATIENT PSYCHIATRIC SERVICES"
(RINS: 0938-AP80; 0938-AP33)

(i) Cost-benefit analysis

The Centers for Medicare & Medicaid Services (CMS) analyzed the costs and benefits of this final rule. CMS estimated that the final applicable percentage increase to the inpatient prospective payment systems (IPPS) rates required by the statute, in conjunction with other final payment changes in this final rule, will result in a $440 million decrease in fiscal year 2011 operating payments (or -0.4 percent decrease) and an estimated $21 million decrease in fiscal year 2011 capital payments (or -0.5 percent change). In addition, long-term care hospitals (LTCHs) are expected to experience an increase in payments by $22.3 million (or 0.5 percent).

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

CMS prepared a Regulatory Flexibility Analysis for this final rule.

(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 any requirements for state, local, or tribal governments, nor would it affect private sector costs.

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

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

CMS published a notice of proposed rulemaking May 4, 2010, a supplemental proposed rule on June 4, 2010, and a notice on June 2, 2010. 75 Fed. Reg. 23,852, 30,918, 31,118. CMS received over 700 public comments on the proposed rule and

approximately 33 public comments on the supplemental proposed rule, which were addressed in the final rule.

This rule contains an interim final rule implementing section 102 of the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010 (Section 102).[1] CMS determined that notice and comment rulemaking would be unnecessary and contrary to the public interest in the case of these provisions of this rule because they are conforming regulatory language to self-implementing statutory language which became effective June 25, 2010. In addition, CMS determined that Section 102 may be implemented as an interim final rule with comment period because it falls under the exception to notice and comment rulemaking contained in section 1871(b)(1)(B) of the Social Security Act. 42 U.S.C. § 1395(b)(1)(B).

Paperwork Reduction Act, 44 U.S.C. §§ 3501–3520

CMS determined that this rule contains information collection requirements under the Act. For all but one of the information collection requirements in the text of the regulation, CMS stated the burdens associated with the requirement are exempt from the Act. 5 C.F.R. §§ 1320.3(h)(6), 1320.4. One information collection requirement in the text of the regulation is approved under Office of Management and Budget (OMB) Control Number 0938-0573. The rule also references several associated information collection requirements, some of which have already received OMB approval.

Statutory authorization for the rule

CMS promulgated this rule under the authority of sections 1302, 1395d(d), 1395f(b), 1395g, 1395*l*, 1395v(v), 1395hh, 1395rr, 1395tt, and 1395ww of title 42, United States Code, and section 124 of appendix F of Public Law 106-113.[2]

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

CMS examined the impacts of this rule under the Order. CMS estimates that the final changes for fiscal year 2011 acute care hospital operating and capital payments will redistribute amounts in excess of $100 million among different types of inpatient cases. CMS submitted this rule to OMB for review.

Executive Order No. 13,132 (Federalism)

CMS determined that this final rule will not have a substantial effect on state and local governments.

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[1] Pub. L. No. 111-192, § 102, 124 Stat. 1280, 1281–82 (June 25, 2010).

[2] 113 Stat. 1501, 1501A-332 (Nov. 29, 1999).