G A O
Accountability * Integrity * Reliability

United States Government Accountability Office
Washington, DC 20548

B-324121

November 30, 2012

The Honorable Max Baucus
Chairman
The Honorable Orrin G. Hatch
Ranking Member
Committee on Finance
United States Senate

The Honorable Fred Upton
Chairman
The Honorable Henry A. Waxman
Ranking Member
Committee on Energy and Commerce
House of Representatives

The Honorable Dave Camp
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 and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Electronic Reporting Pilot; Inpatient Rehabilitation Facilities Quality Reporting Program; Revision to Quality Improvement Organization Regulations*

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 and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Electronic Reporting Pilot; Inpatient Rehabilitation Facilities Quality Reporting Program; Revision to Quality Improvement Organization Regulations" (RIN: 0938-AR10). We received the rule on November 2, 2012. It was published in the *Federal Register* as a final rule with comment period on November 15, 2012. 77 Fed. Reg. 68,210.

The final rule with comment period revises the Medicare hospital outpatient prospective payment system (OPPS) and the Medicare ambulatory surgical center (ASC) payment system for calendar year (CY) 2013 to implement applicable statutory requirements and changes arising from CMS's continuing experience with these systems. In addition, the final rule with comment period updates and refines the requirements for the Hospital Outpatient Quality Reporting (OQR) Program, the ASC Quality Reporting (ASCQR) Program, and the Inpatient Rehabilitation Facility (IRF) Quality Reporting Program. CMS is continuing the electronic reporting pilot for the Electronic Health Record (EHR) Incentive Program and revising the various regulations governing Quality Improvement Organizations (QIOs), including the secure transmittal of electronic medical information, beneficiary complaint resolution and notification processes, and technical changes.

The rule has an effective date of January 1, 2013. 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). We received the rule on November 2, 2012, but it was not published in the *Federal Register* until November 15, 2012. Therefore, the final rule with comment period does not have the required 60-day delay in its 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. 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 AND MEDICAID PROGRAMS: HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT AND AMBULATORY SURGICAL CENTER PAYMENT SYSTEMS AND QUALITY REPORTING PROGRAMS; ELECTRONIC REPORTING PILOT; INPATIENT REHABILITATION FACILITIES QUALITY REPORTING PROGRAM; REVISION TO QUALITY IMPROVEMENT ORGANIZATION REGULATIONS"
(RIN: 0938-AR10)

(i) Cost-benefit analysis

CMS performed a cost-benefit analysis in conjunction with the final rule with comment period. CMS estimated that the policies in the final rule will result in a 1.9 percent overall increase in Outpatient Prospective Payment System (OPPS) payments to providers. CMS estimated that the increase in OPPS expenditures, including beneficiary cost-sharing, will be approximately $600 million, not taking into account potential changes in enrollment, utilization, and case-mix. Taking into account estimated spending changes that are attributable to these factors, CMS estimated an increase of approximately $4.571 billion in OPPS expenditures, including beneficiary cost-sharing, for CY 2013 compared to CY 2012 OPPS expenditures. CMS estimated that total OPPS payments, including beneficiary cost-sharing, will be $48.1 billion for CY 2013. CMS estimated the isolated impact of the OPPS policies on Community mental health centers (CMHCs). Continuing the provider-specific structure that CMS adopted for CY 2011 and basing payment fully on the type of provider furnishing the service, CMS estimated a 4.4 percent decrease in CY 2013 payments to CMHCs relative to their CY 2012 payments.

CMS estimated that the policy in the final rule to base the Ambulatory Payment Classification (APC) relative payment weights on the geometric mean costs rather than the median costs of services within an APC will not significantly impact most providers. Payments to very low volume urban hospitals and to hospitals for which disproportionate share hospital (DSH) data are not available will increase by an estimated 2.5 and 4.3 percent, respectively. The hospitals for which DSH data are not available are largely non-IPPS psychiatric hospitals. In contrast, payments to CMHCs will decrease by an estimated 3.9 percent due to basing the relative payment weights on the geometric mean costs of services rather than the median costs of services.

CMS estimated no significant impacts related to updating the wage indices and applying the frontier state wage index. CMS determined that adjustments to the wage indices other than the frontier state wage adjustment will not significantly affect most hospitals. The updated wage indices will most affect urban hospitals in the Pacific and East South Central regions and rural hospitals in the Mountain and Pacific regions.

CMS determined that there are no significant impacts of the CY 2013 payment policies for hospitals that are eligible for the rural adjustment or for the cancer hospital payment adjustment. CMS did not make any change in policies for determining the rural and cancer hospital payment adjustments, and the adjustment amounts do not significantly impact the budget neutrality adjustments for these policies.

CMS estimated that, for most hospitals, the application of the Outpatient Department (OPD) fee schedule increase factor of 1.8 percent to the conversion factor for CY 2013 will mitigate the small negative impacts of the budget neutrality adjustments. Certain low volume hospitals and hospitals for which DSH data are not available will experience larger increases ranging from 4.5 percent to 8.2 percent. As a result of the OPD fee schedule increase factor and other budget neutrality adjustments, CMS estimated that rural and urban hospitals will experience similar increases of approximately 1.8 percent for urban hospitals and 2.1 percent for rural hospitals.

For impact purposes, CMS aggregated the surgical procedures on the Ambulatory surgical center (ASC) list of covered procedures into surgical specialty groups using Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) code range definitions. The percentage change in estimated total payments by specialty groups under the CY 2013 payment rates compared to estimated CY 2012 payment rates ranges between -3 percent for respiratory system procedures, integumentary system procedures, and cardiovascular system procedures and 3 percent for nervous system procedures.

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

CMS estimated that the final rule with comment period may have a significant impact on approximately 2,053 hospitals with voluntary ownership. CMS further estimated that the final rule with comment period may have a significant impact on approximately 708 small rural hospitals. CMS included the information required for its regulatory flexibility analysis as part of its regulatory impact analysis.

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

CMS stated in the final rule with comment period that the rule does not mandate any requirements for state, local, or tribal governments, or for the private sector.

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

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

On July 30, 2012, CMS published a notice of proposed rulemaking for the CY 2013 PPS/ASC in the *Federal Register*. 77 Fed. Reg. 45,061. CMS received approximately 668 timely comments and responded to those comments in the final rule with comment period. CMS also responded in the final rule with comment period to 61 comments received in response to the CY 2012 OPPS/ASC final rule with comment period, which was published on November 30, 2011. 76 Fed. Reg. 74,122.

CMS found good cause to waive the notice of proposed rulemaking for the establishment of payment amounts for selected HCPCS codes and is providing a 60-day comment period for those portions of the final rule. CMS found that because the HCPCS codes are released by the American Medical Association the fall immediately preceding the annual January update, it is impracticable for CMS to provide prior notice and solicit comments on these codes in advance of the publication of the final rule that implements the OPPS and the ASC payment system.

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

The final rule contains information collection requirements.

The final rule with comment period requires eligible hospitals and critical access hospitals (CAHs) to report on core and menu set criteria for Stage 1 of meaningful use. CMS estimated that it would take an eligible hospital or CAH 0.5 hour to submit the required clinical quality measure (CQM) information via the proposed 2013 Medicare HER Incentive Program Electronic Reporting Pilot. The estimated total burden for all 4,922 Medicare eligible hospitals and CAHs participating in the Pilot is 2,461 hours. CMS stated that an eligible hospital or CAH might assign a computer and information systems manager to submit the CQM information on its behalf. CMS estimated the cost burden for an eligible hospital or CAH to submit the CQMs and hospital quality requirements is $30.21 (0.5 hour × $60.41 (mean hourly rate for a computer and information systems manager based on the 2011 Bureau of Labor Statistics)) and the total estimated annual cost burden for all eligible hospitals and CAHs to submit the required CQMs is $148,694 ($30.21 × 4,922 hospitals and CAHs).

Statutory authorization for the rule

The final rule with comment period is authorized by sections 1833(i) and 1833(t) of the Social Security Act.

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

CMS determined that the final rule is an economically significant rule under the Executive Order. The final rule with comment period has been reviewed by the Office of Management and Budget.

Executive Order No. 13,132 (Federalism)

CMS determined that the final rule with comment period will not have a substantial direct effect on state, local, or tribal governments, preempt state law, or otherwise have federalism implications under the Order.