U.S. GOVERNMENT ACCOUNTABILITY OFFICE
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December 18, 2014

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

The Honorable Fred Upton
Chairman
The Honorable Henry 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: Medicaid Program; Disproportionate Share Hospital Payments—Uninsured Definition*

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 "Medicaid Program; Disproportionate Share Hospital Payments—Uninsured Definition" (RIN: 0938-AQ37). We received the rule on December 3, 2014. It was published in the *Federal Register* as a final rule on December 3, 2014. 79 Fed. Reg. 71,679.

The final rule addresses the hospital-specific limitation on Medicaid disproportionate share hospital (DSH) payments under the Social Security Act (the Act). Under this limitation, DSH payments to a hospital cannot exceed the uncompensated costs of furnishing hospital services by the hospital to individuals who are Medicaid-eligible or "have no health insurance (or other source of third party coverage) for the services furnished during the year." The final rule provides that, in auditing DSH payments, the quoted test will be applied on a service-specific basis; so that the calculation of uncompensated care for purposes of the hospital-specific DSH limit will include the cost of each service furnished to an individual by that hospital for which the individual had no health insurance or other source of third-party coverage.

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). The final rule has an announced effective date of December 31, 2014. We received the rule and it was published in the *Federal Register* on December 3, 2014. Therefore, the final rule does not have the required 60-day delay in effective date. The 60-day delay in effective date can be waived, however, if the agency finds for good cause that the delay is impracticable, unnecessary, or contrary to the public interest, and the agency incorporates a statement of the findings and its reasons in the rule issued. CMS found good cause to waive the 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. 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
"MEDICAID PROGRAM; DISPROPORTIONATE SHARE
HOSPITAL PAYMENTS—UNINSURED DEFINITION"
(RIN: 0938-AQ37)

(i) Cost-benefit analysis

CMS determined that the final rule may result in transfer costs that exceed $100 million in a given year to hospitals whose disproportionate share hospital payments (DSH) limits increase from other disproportionate share hospitals. CMS determined that it does not anticipate the final rule having a significant financial impact on state Medicaid programs, because the limits on the federal share allotted to states for the DSH program are not affected by the final rule. Hospitals, if directly affected by the final rule, should have higher DSH eligible costs. This increase in eligible costs would result in an increase in the hospital-specific DSH limit of these affected hospitals. However, CMS notes that states may reduce Medicaid DSH payments to certain providers and increase DSH payments to other providers as a result of changes to the hospital-specific DSH limit. According to CMS, states alone are responsible in the management of their DSH allotment, retain the same flexibility to design DSH payment methodologies under the state plan, and are not required to increase or to decrease payments to providers as a result of this rule. CMS stated that it does not have national data that isolates the impact of this rule on hospital-specific DSH limits or national DSH payments, and based on the lack of data and the factors described above, CMS cannot predict an accurate estimate of the impact on individual hospitals or groups of hospitals.

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

CMS determined that the final rule may have a significant economic impact on a substantial number of small entities. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $7.5 million to $38.5 million in any 1 year. HHS uses a change in revenue of more than 3 to 5 percent as its measure of significant economic impact on a substantial number of small entities. The final rule affects the calculation of the hospital-specific DSH limit, and states may reduce Medicaid DSH payments to certain providers and increase DSH payments to other providers as a result of changes to the hospital-specific DSH limit. Therefore, CMS determined that it is possible that the final rule could result in a change of more than 3 to 5 percent of total hospital revenue due to the overall size of the Medicaid DSH program. However, states alone are responsible in the management of their DSH allotment, and CMS does not have national data that isolates the impact of the final rule on hospital-specific DSH limits or national DSH payments. Based on the lack of data and the factors described above, CMS stated that it cannot predict an accurate estimate of the impact on individual hospitals.

In addition, section 1102(b) of the Social Security Act requires CMS to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number

of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, CMS defines a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area for Medicare payment regulations and has fewer than 100 beds. As stated above, the final rule affects the calculation of the hospital-specific DSH limit. States may reduce Medicaid DSH payments to certain providers and increase DSH payments to other providers as a result of changes to the hospital-specific DSH limit, so it is possible that the final rule may have a significant impact on small rural hospitals due to the overall size of the Medicaid DSH program. However, states alone are responsible for the management of their DSH allotment, retain the same flexibility to design DSH payment methodologies under the state plan, and are not required to increase or to decrease payments to providers as a result of this rule. CMS states that they do not have national data that isolates the impact of this rule on hospital-specific DSH limits or national DSH payments, and they cannot predict an accurate estimate of the impact on small rural hospitals.

(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 the final rule has no consequential mandate on state, local, or tribal governments or on 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 January 18, 2012, CMS published a proposed rule in the *Federal Register*. 77 Fed. Reg. 2500. In response to the proposed rule, CMS received 71 public comments from state Medicaid agencies, provider associations, providers, and other interested parties. CMS included a summary of the public comments received, and CMS's responses to the comments in the final rule. 79 Fed. Reg. 71,679.

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

The final rule does not contain any information collection requirements under the Paperwork Reduction Act.

Statutory authorization for the rule

The final rule is authorized by section 1923(g) of the Social Security Act.

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

The final rule has been designated an "economically significant" rule under section 3(f)(1) of Executive Order 12,866, since it may have an economic impact in excess of $100 million. Accordingly, CMS prepared a Regulatory Impact Analysis (RIA) that presents the costs and benefits of the rulemaking. In accordance with the provisions of Executive Order 12,866, the final rule was reviewed by the Office of Management and Budget.

Executive Order No. 13,132 (Federalism)

CMS determined that since the final rule does not impose any costs on state or local governments, the requirements of Executive Order 13,132 are not applicable.