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B-327297

August 27, 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; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System Policy Changes and Fiscal Year 2016 Rates; Revisions of Quality Reporting Requirements for Specific Providers, Including Changes Related to the Electronic Health Record Incentive Program; Extensions of the Medicare-Dependent, Small Rural Hospital Program and the Low-Volume Payment Adjustment for Hospitals*

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 Policy Changes and Fiscal Year 2016 Rates; Revisions of Quality Reporting Requirements for Specific Providers, Including Changes Related to the Electronic Health Record Incentive Program; Extensions of the Medicare-Dependent, Small Rural Hospital Program and the Low-Volume Payment Adjustment for Hospitals” (RIN: 0938-AS41). We received the rule on July 31, 2015. It was published in the *Federal Register* as a final rule; interim final rule with comment period on August 17, 2015. 80 Fed. Reg. 49,326.

The final rule and interim final rule revise 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 for fiscal year (FY) 2016. Some of these changes implement certain statutory provisions contained in the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively known as the Affordable Care Act), the Pathway for Sustainable Growth Reform Act of 2013, the Protecting Access to Medicare Act of 2014, the Improving Medicare Post-Acute Care Transformation Act of 2014, the Medicare Access and CHIP Reauthorization Act of 2015, and other legislation. This rule also updates the rate-of-increase limits for certain hospitals excluded from IPPS that are paid on a reasonable cost basis subject to these limits for

FY 2016. In the interim final rule with comment period, CMS is implementing the statutory extensions of the Medicare-dependent, small rural hospital (MDH) program and changes to the payment adjustment for low-volume hospitals under IPPS.

CMS is also updating the payment policies and the annual payment rates for the Medicare prospective payment system (PPS) for inpatient hospital services provided by long-term care hospitals (LTCHs) for FY 2016 and implementing certain statutory changes to the LTCH PPS under the Affordable Care Act and the Pathway for Sustainable Growth Rate Reform Act of 2013 and the Protecting Access to Medicare Act of 2014. In addition, CMS states this rule establishes new requirements or revises existing requirements for quality reporting by specific providers (acute care hospitals, PPS-exempt cancer hospitals, and LTCHs) that are participating in Medicare, including related provisions for eligible hospitals and critical access hospitals participating in the Medicare Electronic Health Record Incentive Program. CMS is also updating policies relating to the Hospital Value-Based Purchasing Program, the Hospital Readmissions Reduction Program, and the Hospital-Acquired Condition Reduction 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. Additionally, certain provisions of the interim rule concerning legislative extensions relating to the payment adjustment for low-volume hospitals and the MDH program have a stated applicability window of discharges on or after April 1, 2015, to on or before September 30, 2017. 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 published in the *Federal Register* on August 17, 2015. 80 Fed. Reg. 49,326. Therefore, this rule does not have a 60-day delay in effective date.

The 60-day delay in effective date can be waived, however, if the agencies find for good cause that delay is impracticable, unnecessary, or contrary to the public interest, and the agencies incorporate a statement of the findings and their reasons in the rule issued. 5 U.S.C. § 553(d)(3), 808(2). CMS found good cause to waive delays in effective date for certain changes to the payment adjustment for low-volume hospitals and the MDH program included as part of this rule as an interim rule. CMS also found good cause to waive notice-and-comment rulemaking for the provisions of this rule concerning certain average length of stay calculations. In both cases CMS based its good cause finding on its conclusion that these changes were statutorily required. For remaining portions of this rule for which CMS did not find good cause to waive the delay, 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 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 THEDEPARTMENT 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 POLICY CHANGES AND FISCAL YEAR 2016 RATES; REVISIONS OF QUALITY REPORTING REQUIREMENTS FOR SPECIFIC PROVIDERS, INCLUDING CHANGES RELATED TO THE ELECTRONIC HEALTH RECORD INCENTIVE PROGRAM; EXTENSIONS OF THE MEDICARE-DEPENDENT, SMALL RURAL HOSPITAL PROGRAM AND THE LOW-VOLUME PAYMENT ADJUSTMENT FOR HOSPITALS"

(RIN: 0938-AS41)

(i) Cost-benefit analysis

The Centers for Medicare & Medicaid Services (CMS) included an economic analyses appendix with this final rule; interim final rule with comment period. For acute care hospitals, CMS estimates that operating payments will increase by approximately \$378 million in fiscal year (FY) 2016 relative to FY 2015. However, when CMS accounts for the impact of the changes in Medicare disproportionate share hospital payments and the impact of the new additional payments based on uncompensated care in accordance with section 3133 of the Affordable Care Act, based on estimates provided by the CMS Office of the Actuary, CMS estimates that operating payments will increase by approximately \$75 million relative to FY 2015. CMS currently estimates that the changes in new technology add-on payments for FY 2016 will increase spending by approximately \$9.5 million due to the expiration of three new technology add-on payments and the additional approval of two new technology add-on payments. This estimate, combined with its estimated increase in the FY 2016 operating payment of \$75 million, results in an estimated increase of approximately \$85 million for FY 2016. CMS estimates that hospitals will experience a 2.3 percent increase in capital payments per case. CMS projects that there will be a \$187 million increase in capital payments in FY 2016 compared to FY 2015. CMS estimates that the cumulative operating and capital payments will result in a net increase of approximately \$272 million to inpatient prospective payment system (IPPS) providers. For long-term care hospitals (LTCHs), based on the best available data in CMS's database, CMS estimates that FY 2016 LTCH prospective payment system payments will decrease approximately \$250 million relative to FY 2015 as a result of the payment rates and factors presented in this final rule.

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

CMS estimates that most hospitals and most other providers and suppliers are small entities as that term is used in the Act. CMS believes that the provisions of this final rule relating to acute care hospitals would have a significant impact on small entities. Further, CMS assumes all LTCHs are considered small entities. CMS also stated that Medicare Administrative Contractors are not considered to be small entities. CMS discussed the need for this rule, the objectives of IPPS, limitations of its analysis, quantitative effects of the policy changes under

IPPS for operating costs, the effects of other changes in this rule, and alternatives considered, among other topics.

(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; interim final rule with comment period will not mandate any requirements for state, local, or tribal governments, nor will 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.

On April 30, 2015, CMS published a proposed rule that set forth proposed changes in Medicare IPPS for operating costs and for capital-related costs of acute care hospitals for FY 2016, for certain hospitals that continue to be excluded from IPPS and paid on a reasonable cost basis, and that set forth proposed changes to the payment rates, factors, and other payment rate policies under LTCH PPS for FY 2016. 80 Fed. Reg. 24,324. CMS received approximately 361 timely pieces of correspondence containing multiple comments on the proposed rule. CMS noted that some of these public comments were outside of the scope of the proposed rule. CMS responded to comments within the scope of the proposed rule in the final rule.

CMS found good cause to waive notice-and-comment rulemaking for certain changes to the payment adjustment for low-volume hospitals and the Medicare-dependent, small rural hospital (MDH) program included as part of this rule as an interim rule and for the provisions of this rule concerning certain average length of stay calculations. In both cases CMS based its good cause finding on its conclusion that these changes were statutorily required. CMS also requested public comment on the provisions of this rule concerning legislative extensions relating to the payment adjustment for low-volume hospitals and the MDH program published as an interim final rule with request for comment.

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

CMS identified nine information collection requirements (ICRs) related to this final rule; interim final rule with comment period. CMS concluded that in three instances, the information collection requirement was currently approved or prior approval was still applicable and in two instances there was no additional burden. In two instances CMS concluded that the Act's requirements did not apply because the requirement did not impact 10 or more entities in a 12-month period or because it was a modification in order to achieve the standardization of patient assessment data. In one instance, CMS concluded that this rule resulted in a reduction in burden. CMS estimates that in the final instance, ICRs for the Hospital Inpatient Quality Reporting Program, this rule would impose a total burden of 2,289 hours per hospital and 7.6 million hours across approximately 3,300 participating hospitals. CMS has requested the Office of Management and Budget's approval for this information collection requirement.

Statutory authorization for the rule

CMS stated that it 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; interim final rule with comment period will redistribute amounts in excess of \$100 million to acute care hospitals, and therefore has economically significant effects. CMS stated that the Office of Management and Budget reviewed this rule.