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September 17, 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 Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2013 Rates; Hospitals' Resident Caps for Graduate Medical Education Payment Purposes; Quality Reporting Requirements for Specific Providers and for Ambulatory Surgical Centers*

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 and Fiscal Year 2013 Rates; Hospitals' Resident Caps for Graduate Medical Education Payment Purposes; Quality Reporting Requirements for Specific Providers and for Ambulatory Surgical

Centers" (RIN: 0938-AR12). We received the rule on August 1, 2012. It was published in the *Federal Register* as a final rule on August 31, 2012. 77 Fed. Reg. 53,258.

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. The rule also 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. It also updates 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).

In addition, the rule implements changes relating to determining a hospital's full-time equivalent (FTE) resident cap for the purpose of graduate medical education (GME) and indirect medical education (IME) payments. The rule establishes new requirements or revises existing requirements for quality reporting by specific providers (acute care hospitals, PPS-exempt cancer hospitals, LTCHs, and inpatient psychiatric facilities (IPFs)) that are participating in Medicare. The rule also establishes new administrative, data completeness, and extraordinary circumstance waivers or extension requests requirements, as well as a reconsideration process, for quality reporting by ambulatory surgical centers (ASCs) that are participating in Medicare. Finally, the rule establishes requirements for the Hospital Value-Based Purchasing (VBP) Program and the Hospital Readmissions 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 was received by the House of Representatives on August 1, 2012.[1] 158 Cong. Rec. H5727 (August 7, 2012). However, it was not published in the *Federal Register* until August 31, 2012. The rule has a stated effective date of October 1, 2012. Therefore it 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. Our review of the procedural steps taken indicates that CMS complied with the applicable requirements.

[1] It is not clear when the Senate received this rule. According to the *Congressional Record*, the Senate received this rule on August 31, 2012. 158 Cong. Rec. S5975 (Aug. 2, 2012). However, the announcement of receipt appeared in the *Congressional Record* on August 2, 2012, well before the reported receipt date.

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: Annie Lamb
Regulations Coordinator
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 AND FISCAL YEAR 2013 RATES; HOSPITALS' RESIDENT CAPS FOR GRADUATE MEDICAL EDUCATION PAYMENT PURPOSES; QUALITY REPORTING REQUIREMENTS FOR SPECIFIC PROVIDERS AND FOR AMBULATORY SURGICAL CENTERS"
(RIN: 0938-AR12)

(i) Cost-benefit analysis

For acute care hospitals, the Centers for Medicare & Medicaid Services (CMS) estimates that operating payments will increase by approximately $2.45 billion in fiscal year (FY) 2013 relative to FY 2012. In addition, CMS estimates a savings of $24 million associated with the hospital acquired conditions (HACs) policies in FY 2013, which is an additional $2 million in savings than in FY 2012. In FY 2012, pursuant to section 1109 of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively known as the Affordable Care Act), CMS distributed an additional $250 million to qualifying hospitals resulting in a decrease of $250 million in payments to hospitals in FY 2013 relative to FY 2012. Furthermore, CMS estimates that the expiration of the expansion of low-volume payments in FY 2013 will result in a decrease in payments of approximately $318 million compared to low-volume payments made in FY 2012. CMS estimates that new technology add-on payments will increase payments by approximately $46.1 million. Finally, CMS estimates that the finalized policies to count labor and delivery bed days in the available bed day count for IME and DSH payments will reduce indirect medical education payments by approximately $40 million for FY 2013. These estimates, combined with the FY 2013 operating estimate of $2.45 billion, will result in an increase of approximately $1.87 billion for FY 2013. CMS estimates that capital payments will experience a 1.8 percent increase in payments per case. The agency projects that there will be a $154 million increase in capital payments in FY 2013 compared to FY 2012. CMS expects these cumulative operating and capital payments to result in a net increase of approximately $2.04 billion to inpatient prospective payment systems (IPPS) providers.

Overall, CMS projects long-term care hospitals (LTCHs) to experience an increase in estimated payments per discharge in FY 2013. Accordingly, based on the best

available data for the 428 LTCHs in its database, CMS estimates that FY 2013 LTCH PPS payments will increase approximately $92 million relative to FY 2012. In addition, CMS estimates that extension of the moratorium on the application of the "25 percent threshold" payment adjustment policy for cost reporting periods beginning on or after October 1, 2012, and before October 1, 2013, will result in a payment impact of approximately $170 million to LTCHs.

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

CMS determined that a regulatory impact analysis was required for this final rule. In its analysis, CMS discussed, among other things, the need for the rule, objectives of the rule, limitations of the analysis, hospitals included and excluded from the rule, effects of the rule, and alternatives considered.

(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 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 May 11, 2012, CMS published a proposed rule. 77 Fed. Reg. 27,870. The proposed rule set forth changes to the Medicare IPPS for operating costs and for capital-related costs of acute care hospitals in FY 2012. CMS responded to comments on the proposed rule in this final rule.

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

CMS determined that this final rule contains 11 information collection requirements. In the proposed rule CMS solicited comments on the need for the information collection; the accuracy of the agency's burden estimate; the quality, utility, and clarity of the information to be collected; and recommendations to minimize the burden. CMS responded to comments received on these issues in the final rule.

Statutory authorization for the rule

CMS promulgated this final rule under the authority of sections 1814(l), 1820, 1834(g), 1886(a)(4), 1886(b)(3)(B)(viii), 1886(d), 1886(m)(1), 1886(o), and 1886(q) of the Social Security Act. 42 U.S.C. §§ 1395f(l), 1395i-4, 1395m(g), 1395ww(a)(4), 1395ww(b)(3)(B)(viii), 1395ww(d), 1395ww(m)(1), 1395ww(o), 1395ww(q).

Executive Order Nos. 12,866 and 13,563 (Regulatory Planning and Review)

CMS determined that this final rule is an economically significant rule because it will redistribute amounts in excess of $100 million to acute care hospitals. OMB reviewed this final rule under the Order.