



441 G St. N.W.
Washington, DC 20548

B-329324

August 25, 2017

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

The Honorable Greg Walden
Chairman
The Honorable Frank Pallone, Jr.
Ranking Member
Committee on Energy and Commerce
House of Representatives

The Honorable Kevin Brady
Chairman
The Honorable Richard Neal
Ranking Member
Committee on Ways and Means
House of Representatives

Subject: *Department of Health and Human Services, Centers for Medicare and Medicaid Services: Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2018 Rates; Quality Reporting Requirements for Specific Providers; Medicare and Medicaid Electronic Health Record (EHR) Incentive Program Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals; Provider-Based Status of Indian Health Service and Tribal Facilities and Organizations; Costs Reporting and Provider Requirements; Agreement Termination Notices*

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 and 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 Policy Changes and Fiscal Year 2018 Rates; Quality Reporting Requirements for Specific Providers; Medicare and Medicaid Electronic Health Record (EHR) Incentive Program Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals; Provider-Based Status of Indian Health Service and Tribal Facilities and Organizations; Costs Reporting and Provider Requirements; Agreement Termination Notices” (RIN: 0938-AS98). We received the rule on August 3, 2017. It was published in the *Federal Register* as a final rule on August 14, 2017. 82 Fed. Reg. 37,990.

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 for fiscal year (FY) 2018. Some of these changes implement certain statutory provisions contained in the Pathway for Sustainable Growth Rate Reform Act of 2013, the Improving Medicare Post-Acute Care Transformation Act of 2014, the Medicare Access and CHIP Reauthorization Act of 2015, the 21st Century Cures Act, and other legislation. The rule also makes

changes relating to the provider-based status of the Indian Health Service (IHS) and tribal facilities and organizations and to the low-volume hospital payment adjustment for hospitals operated by the IHS or a tribe. In addition, the rule provides the market basket update that will apply to the rate-of-increase limits for certain hospitals excluded from the IPPS that are paid on a reasonable cost basis subject to these limits for FY 2018. The rule 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) for FY 2018.

In addition, the rule establishes new requirements and revises existing requirements for quality reporting by specific Medicare providers (acute care hospitals, PPS-exempt cancer hospitals, LTCHs, and inpatient psychiatric facilities). The rule also establishes new requirements or revising existing requirements for eligible professionals, eligible hospitals, and critical access hospitals participating in the Medicare and Medicaid Electronic Health Record Incentive Programs. The rule updates policies relating to the Hospital Value-Based Purchasing Program, the Hospital Readmissions Reduction Program, and the Hospital-Acquired Condition Reduction Program. Further, the rule makes changes relating to transparency of accrediting organization survey reports and plans of correction of providers and suppliers; electronic signature and electronic submission of the Certification and Settlement Summary page of the Medicare cost reports; and clarification of provider disposal of assets.

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 rule was received on August 3, 2017, and was published in the *Federal Register* on August 14, 2017. 82 Fed. Reg. 37,990. It has a stated effective date of October 1, 2017. Therefore, the final rule 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, other than the 60-day delay requirement, 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: Vanessa Jones
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 AND MEDICAID SERVICES

ENTITLED

“MEDICARE PROGRAM; HOSPITAL INPATIENT PROSPECTIVE PAYMENT SYSTEMS
FOR ACUTE CARE HOSPITALS AND THE LONG-TERM CARE HOSPITAL
PROSPECTIVE PAYMENT SYSTEM AND POLICY CHANGES AND FISCAL YEAR 2018
RATES; QUALITY REPORTING REQUIREMENTS FOR SPECIFIC PROVIDERS;
MEDICARE AND MEDICAID ELECTRONIC HEALTH RECORD (EHR) INCENTIVE
PROGRAM REQUIREMENTS FOR ELIGIBLE HOSPITALS, CRITICAL ACCESS HOSPITALS,
AND ELIGIBLE PROFESSIONALS; PROVIDER-BASED STATUS OF INDIAN HEALTH
SERVICE AND TRIBAL FACILITIES AND ORGANIZATIONS; COSTS REPORTING AND
PROVIDER REQUIREMENTS; AGREEMENT TERMINATION NOTICES”
(RIN: 0938-AS98)

(i) Cost-benefit analysis

The Centers for Medicare and Medicaid Services (CMS) analyzed the costs and benefits of this final rule. CMS estimated that the changes to the inpatient prospective payment systems (IPPS) will result in transfers of \$2.4 billion from the federal government to IPPS Medicare providers. CMS also estimated that the payments rates and factors in this final rule under the long-term care hospital (LTCH) PPS payments will result in a decrease in transfers from the federal government to LTCH Medicare providers of \$110 million. CMS also estimated this final rule has information collection savings of \$3,854,344 and regulatory review costs of \$9,707,951.

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

CMS believes that the provisions of this final rule relating to acute care hospitals will have a significant impact on small entities. This final rule discussed a range of policies, provided descriptions of the statutory provisions that are addressed, identified the finalized policies, and presents rationales for CMS's decisions and, where relevant, alternatives that were considered. CMS identified these discussions as constituting its Regulatory Flexibility Analysis.

(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, and that it will not 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 28, 2017, CMS published a proposed rule. 82 Fed. Reg. 19,796. In the final rule, CMS summarized public comments received, presented responses, and stated its final determinations on those issues.

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

CMS determined that this final rule contains information collection requirements. CMS concluded that some of these requirements are exempt from the Act. 42 U.S.C. § 1395ww(m)(6)(F)(iii). For the other information collection requirements in this final rule, CMS estimated: (1) a burden reduction of 15,400 hours and a total cost reduction of \$563,332 for the FY 2019 payment determination; (2) a burden reduction of 21,733 hours and a total cost reduction of \$794,993 for the FY 2020 payment determination; and (3) a burden reduction of 6,400 hours and a total cost reduction of \$234,112 for the FY 2021 payment determination. CMS therefore estimated a total burden reduction of 43,533 hours and \$1,592,437 across all hospitals as a result of the finalized proposals in this final rule. CMS is requesting Office of Management and Budget (OMB) approval of these burden estimate updates under OMB number 0938-1022.

Statutory authorization for the rule

CMS promulgated this final rule under the authority of sections 205(a), 1102, 1128I, 1138, 1142, 1812, 1814(b), 1815, 1833, 1861, 1862(a), 1864, 1865, 1869, 1871, 1874, 1875, 1881, 1883, and 1886 of the Social Security Act (42 U.S.C. 405(a), 1302, 1320a-7, 1320b-12, 1395d(d), 1395f(b), 1395g, 1395l, 1395x, 1395y(a), 1395aa, 1395bb, 1395ff, 1395hh, 1395kk, 1395ll, 1395rr, 1395tt, and 1395ww); sections 353 and 371 of the Public Health Service Act (42 U.S.C. 263a); section 124 of Public Law 106-113; section 3201 of Public Law 112-96; section 632 of Public Law 112-240; section 1206 of Public Law 113-67; sections 112 and 217 of Public Law 113-93; section 204 of Public Law 113-295; section 808 of Public Law 114-27; section 231 of Public Law 114-113; and sections 15004, 15006, 15007, 15008, 15009, and 15010 of Public Law 114-255.

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

This rule was reviewed by OMB under the Order.