



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

B-328583

November 28, 2016

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 Kevin Brady
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; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2017; Medicare Advantage Bid Pricing Data Release; Medicare Advantage and Part D Medical Loss Ratio Data Release; Medicare Advantage Provider Network Requirements; Expansion of Medicare Diabetes Prevention Program Model; Medicare Shared Savings Program Requirements*

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; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2017; Medicare Advantage Bid Pricing Data Release; Medicare Advantage and Part D Medical Loss Ratio Data Release; Medicare Advantage Provider Network Requirements; Expansion of Medicare Diabetes Prevention Program Model; Medicare Shared Savings Program Requirements” (RIN: 0938-AS81). We received the rule on November 3, 2016. It was published in the *Federal Register* as a final rule on November 15, 2016, with an effective date of January 1, 2017. 81 Fed. Reg. 80,170.

The final rule addresses changes to the physician fee schedule and other Medicare Part B payment policies to ensure that the CMS payment systems are updated to reflect changes in medical practice and the relative value of services, as well as changes in the statute.

The Congressional Review Act 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 on November 3, 2016. It was published in the *Federal Register* on November 15, 2016, and has a stated effective date of January 1, 2017. 81 Fed. Reg. 80,170. 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. With the exception of the 60-day delay in effective date 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: Agnes Thomas
Regulations Coordinator
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
"MEDICARE PROGRAM; REVISIONS TO PAYMENT POLICIES UNDER THE
PHYSICIAN FEE SCHEDULE AND OTHER REVISIONS TO PART B FOR
CY 2017; MEDICARE ADVANTAGE BID PRICING DATA RELEASE;
MEDICARE ADVANTAGE AND PART D MEDICAL LOSS RATIO DATA RELEASE;
MEDICARE ADVANTAGE PROVIDER NETWORK REQUIREMENTS;
EXPANSION OF MEDICARE DIABETES PREVENTION PROGRAM MODEL;
MEDICARE SHARED SAVINGS PROGRAM REQUIREMENTS"
(RIN: 0938-AS81)

(i) Cost-benefit analysis

The Centers for Medicare & Medicaid Services (CMS) summarized the costs and benefits of the final rule. CMS provided a table in the rule accompanied with an explanation that showed the payment impact by Medicare specialty. To the extent that there are year-to-year changes in the volume and mix of services provided by practitioners, CMS stated that the actual impact on total Medicare revenues will be different from those shown in the table. CMS also provided a table that discussed the 5-year and 10-year fiscal cost estimates from switching from a Medicare Economic Index-Adjusted Base Payment rate to a Federally Qualified Health Center Prospective Payment System Market Basket-Adjusted Base Payment rate. Finally, CMS provided a table that discussed the payment adjustments and distributions based on the size of eligible professionals.

CMS found that this final rule, in particular the regulations intended to improve accuracy in payment, will have a positive impact and improve the quality and value of care provided to Medicare beneficiaries. CMS also found that this rule will improve care coordination and provided more effective treatment, particularly to beneficiaries with behavioral health conditions.

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

CMS found that 95 percent of practitioners, other providers, and suppliers are considered to be small entities based upon the Small Business Administration's standards. Therefore, CMS determined that this rule will have a significant impact on a substantial number of small entities. CMS stated that its discussion and analysis in the regulatory impact analysis section of the rule, as well as elsewhere in the rule, is intended to comply with the Act's requirements.

CMS determined that this final rule will not have a significant impact on the operations of a substantial number of 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 this final rule will not impose mandates 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 July 15, 2016, CMS issued a proposed rule. 81 Fed. Reg. 46,162. CMS received many comments from across the industry, including a number of comments from Medicare Advantage Organizations and their trade associations. CMS responded to comments in the final rule.

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

The final rule contains information collection requirements (ICRs) as defined under the Paperwork Reduction Act, which CMS described and also summarized in a table in the rule. These ICRs include:

- ICRs regarding the Physician Quality Reporting System,
- ICRs regarding appropriate use criteria for Advanced Diagnostic Imaging Services,
- ICRs regarding the enrollment of Medicare Advantage providers, suppliers, and first-tier downstream and related entities,
- ICRs regarding the release of Medicare Advantage bid pricing data and the release of Part C and Part D Medical Loss Ratio Data,
- ICRs regarding application requirements and termination of contract by CMS, and
- ICRs regarding payment to organizations that provide Medicare Diabetes Prevention Program services.

CMS found that this final rule will cost 288,000 burden hours at a cost of \$20,530,140.72.

Statutory authorization for the rule

CMS stated that this rule was promulgated under 42 U.S.C. §§ 405(a), 1302, 1395x, 1395y(a), 1395ff, 1395hh, 1395kk, 1395rr, 1395ww(k), and 263a.

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

CMS determined that the final rule is economically significant under the Executive Order. CMS prepared a regulatory impact analysis that presents the costs and benefits of the rule.

Executive Order No. 13,132 (Federalism)

CMS determined that this rule does not impose any costs on state or local governments.