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Washington, DC 20548

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August 20, 2013

The Honorable Max Baucus
Chairman
The Honorable Orrin G. Hatch
Ranking Member
Committee on Finance
United States Senate

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; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2014*

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; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2014" (RIN: 0938-AR66). We received the rule on August 2, 2013. It was published in the *Federal Register* as a final rule on August 6, 2013. 78 Fed. Reg. 47,860.

The final rule updated the prospective payment rates for inpatient rehabilitation facilities (IRFs) for federal fiscal year (FY) 2014 (for discharges occurring on or after October 1, 2013, and on or before September 30, 2014) as required by the statute. This final rule also revised the list of diagnosis codes that may be counted toward an IRF's "60 percent rule" compliance calculation to determine "presumptive compliance," updated the IRF facility-level adjustment factors using an enhanced estimation methodology, revised sections of the Inpatient Rehabilitation Facility-Patient Assessment Instrument, revised requirements for acute care hospitals that have IRF units, clarified the IRF regulation text regarding limitation of review, updated references to previously changed sections in the regulations text, and revised and updated quality measures and reporting requirements under the IRF quality reporting program.

The regulatory amendments in this rule are effective October 1, 2013, except for the amendment to 42 C.F.R. § 412.25, which is effective October 1, 2014. 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 published in the *Federal Register* on August 6, 2013,

although we received the rule on August 2, 2013. 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 CMS complied with the applicable requirements, with the exception of the 60-day delay in effective date requirement.

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

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; INPATIENT REHABILITATION
FACILITY PROSPECTIVE PAYMENT SYSTEM FOR
FEDERAL FISCAL YEAR 2014"
(RIN: 0938-AR66)

(i) Cost-benefit analysis

CMS performed an economic analysis, and determined that the overall economic impact of the final rule is an estimated \$170 million in increased payments to IRFs during FY 2014. Overall, CMS states that the estimated payments per discharge for IRFs in FY 2014 are projected to increase by 2.3 percent, compared with the estimated payments in FY 2013. IRF payments per discharge are estimated to increase 2.5 percent in urban areas and decrease 0.2 percent in rural areas, compared with 2013 payments. Payments per discharge to rehabilitation units are estimated to increase 2.8 percent in urban areas, whereas CMS estimates no change in payments per discharge to rehabilitation units in rural areas. Payments per discharge to freestanding rehabilitation hospitals are estimated to increase 2.1 percent in urban areas and decrease 1.3 percent in rural areas. Overall, IRFs are estimated to experience a net increase in payments as a result of the policies in this final rule.

The total costs in FY 2015 for IRFs as a result of the new quality reporting requirements are estimated to be \$9.2 million.

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

CMS estimates that the net revenue impact of the final rule on all IRFs is to increase estimated payments by approximately 2.3 percent. However, CMS found that certain categories of IRF providers would be expected to experience revenue impacts in the 3 to 5 percent range. CMS estimates a 5.0 percent overall impact for teaching IRFs with a resident to average daily census ratios of 10 to 19 percent, a 10.1 percent overall impact for teaching IRFs with a resident to average daily census ratio greater than 19 percent, and a 4.1 percent overall impact for IRFs with a Disproportionate Share Hospital patient percentage of 0 percent. As a result, CMS anticipates this final rule would have a net positive impact on a substantial number of small entities.

In addition, section 1102(b) of the 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. 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 and has fewer than 100 beds. CMS states that the rates and policies set forth in the final rule will not have an adverse impact on rural hospitals based on the data of the 167 rural units and 18 rural hospitals in CMS's database of 1,134 IRFs for which data were available.

(iii) Agency actions relevant to sections 202-205 of the Unfunded Mandates Reform Act of 1995, 2 U.S.C. §§ 1532-1535

Section 202 of the Unfunded Mandates Reform Act of 1995 requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require the spending in any one year of \$100 million in 1995 dollars, updated annually for inflation. In 2013, that threshold level is approximately \$141 million. CMS states that the final rule will not impose spending costs on state, local, or tribal governments, in the aggregate, or by the private sector, of greater than \$141 million.

(iv) Other relevant information or requirements under acts and executive orders

Administrative Procedure Act, 5 U.S.C. §§ 551 et seq.

On May 8, 2013, CMS published a proposed rule. 78 Fed. Reg. 26,880. CMS received 47 timely comments from various trade associations, inpatient rehabilitation facilities, individual physicians, therapists, clinicians, health care industry organizations, law firms, and health care consulting firms. CMS responded to the comments in the final rule.

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

CMS states that the final rule does not impose any new information collection requirements as outlined in the regulation text. However, the final rule does make reference to associated information collections that are not discussed in the regulation text. The final rule discusses those information collections, some of which have already received Office of Management and Budget (OMB) approval.

Statutory authorization for the rule

CMS promulgated this rule under the authority of section 3004(b) of the Patient Protection and Affordable Care Act, Pub. L. No. 111-152 (Mar. 30, 2010), and section 1886(j)(7) of the Social Security Act.

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

CMS states that the final rule is economically significant under the Executive Orders and has been reviewed by OMB.

Executive Order No. 13,132 (Federalism)

CMS determined that this final rule will not have a substantial effect on state and local governments, preempt state law, or otherwise have federalism implications.