



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

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December 17, 2013

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 and Medicaid Programs; Home Health Prospective Payment System Rate Update for CY 2014, Home Health Quality Reporting Requirements, and Cost Allocation of Home Health Survey Expenses*

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 and Medicaid Programs; Home Health Prospective Payment System Rate Update for CY 2014, Home Health Quality Reporting Requirements, and Cost Allocation of Home Health Survey Expenses" (RIN: 0938-AR52). We received the rule on December 2, 2013. It was published in the *Federal Register* as a final rule on December 2, 2013. 78 Fed. Reg. 72,256.

The final rule will update the Home Health Prospective Payment System (HH PPS) rates, including the national, standardized 60-day episode payment rates, the national per-visit rates, the low-utilization payment adjustment (LUPA) add-on, and the non-routine medical supply (NRS) conversion factor under the Medicare prospective payment system for home health agencies (HHAs), effective January 1, 2014. As required by the Affordable Care Act, this rule establishes rebasing adjustments, with a 4-year phase-in, to the national, standardized 60-day episode payment rates; the national per-visit rates; and the NRS conversion factor. In addition, this final rule will remove 170 diagnosis codes from assignment to diagnosis groups within the

HH PPS Grouper, effective January 1, 2014. Finally, the rule will establish home health quality reporting requirements for CY 2014 payment and subsequent years and will clarify that a state Medicaid program must provide that, in certifying HHAs, the state's designated survey agency carry out certain other responsibilities that already apply to surveys of nursing facilities and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID), including sharing in the cost of HHA surveys. For that portion of costs attributable to Medicare and Medicaid, 50 percent will be assigned to Medicare and 50 percent to Medicaid, the standard method that CMS and states use in the allocation of expenses related to surveys of nursing homes.

The final rule, a major rule under the Congressional Review Act (CRA), has an announced effective date of January 1, 2014. 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 60-day delay in effective date can be waived, however, if the agency finds for good cause that the delay is impracticable, unnecessary, or contrary to the public interest, and the agency incorporates a statement of the findings and its reasons in the rule issued. We received the rule on December 2, 2013, and it was published in the *Federal Register* on December 2, 2013. Therefore, the final rule does not have the required 60-day delay in effective date. However, CMS noted that in the absence of an appropriation for FY 2014 or a Continuing Resolution, the federal government shut down on October 1, 2013. During the funding lapse, which lasted from October 1, 2013, through October 16, 2013, only excepted operations continued, which largely excluded work on this final rule. Accordingly, most of the work on this final rule was not completed in accordance with the usual schedule for final calendar-year-based payment rules, which aims for an issuance date of November 1 followed by an effective date of January 1 to ensure that the policies are effective at the start of the calendar year to which they apply. CMS incorporated a statement of its findings along with its reasons that a delayed effective date is both impracticable and contrary to the public interest, and waived the delay in the effective date of this final rule.

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.

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
Program Manager
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 AND MEDICAID PROGRAMS; HOME HEALTH PROSPECTIVE
PAYMENT SYSTEM RATE UPDATE FOR CY 2014, HOME HEALTH
QUALITY REPORTING REQUIREMENTS, AND COST ALLOCATION
OF HOME HEALTH SURVEY EXPENSES"
(RIN: 0938-AR52)

(i) Cost-benefit analysis

CMS prepared a cost-benefit analysis in conjunction with the final rule. CMS estimates that the overall economic impact of the HH PPS payment rate update proposals in this rule is an estimated \$200 million in decreased payments (transfers) to HHAs, and that the benefits include paying more accurately for the delivery of home health services. If implemented in the beginning of FY 2014, CMS estimates that the aggregate Medicare and Medicaid home health survey costs in FY 2014 would be approximately \$37.2 million (in transfers). As these costs would be assigned 50 percent to Medicare and 50 percent to Medicaid for each state, the anticipated aggregate Medicaid share would amount to \$18.6 million. The cost of surveys is treated as a Medicaid administrative cost, reimbursable at the professional staff rate of 75 percent. At this rate the maximum net state costs for Medicaid matching funds incurred in FY 2014 would be approximately \$4.65 million, spread out across all states and two territories. However, the proposed adherence date of July FY 2014 would reduce the Medicaid aggregate share to \$4.65 million and the state Medicaid share to approximately \$1.16 million. The federal Medicaid share will reflect the remaining \$3.49 million, with an adherence date of July FY 2014. Some state Medicaid programs may currently pay for HHA surveys to some extent, but the amount is unknown. The benefits of this provision include clarifying that state Medicaid programs must share in the cost of HHA surveys. For that portion of costs attributable to Medicare and Medicaid, CMS would assign 50 percent to Medicare and 50 percent to Medicaid.

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

CMS determined that this final rule will not have a significant economic impact on a substantial number of small entities. In addition, CMS determined that because the final rule applies to HHAs, the final rule will not have a significant economic impact on the operations 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 the final rule is not anticipated to have an effect on state, local, or tribal governments in the aggregate, or by the private sector, of \$141 million or more in CY 2014.

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

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

CMS published a proposed rule in the *Federal Register* on July 3, 2013. 78 Fed. Reg. 40,272. CMS received approximately 84 timely responses from various trade associations, HHAs, individual registered nurses, physicians, clinicians, health care industry organizations, and health care consulting firms and responded to comments on the proposed rule in the final rule. 78 Fed. Reg. 72,256.

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

CMS determined that this final rule contains information collection requirements and has submitted a copy of the final rule to the Office of Management and Budget (OMB) for its review of the rule's information collection and recordkeeping requirements. These requirements are not effective until they have been approved by the OMB. CMS further invited public comments on the information collection requirements. In the proposed rule, CMS solicited public comment on a number of information collection requirements and responded to the comments received. In this final rule, CMS states that the final rule does not revise any of the proposed rule's PRA-related requirements or burden estimates, except to clarify that existing state plan provisions already address Medicaid coverage for state survey costs and states will not have the burden of submitting a State Plan amendment when they ensure that Medicaid contributes its fair share to the cost of Home Health Agency surveys. The OMB Control Numbers thus far associated with the rule and related forms are 0938-0760 and 0938-1066 (CMS-10275). CMS explained that in two instances, the final rule does not revise any of its ICRs or burden estimates, and therefore does not require additional OMB review under PRA, and, in another instance, the burden hours have been previously accounted for under 0938-1066. However, CMS has revised OCN 0938-1066 by adding a form and an estimated a burden of 1,170 hours at a total estimated cost of \$36,400 for 2,000 home health agencies in this final rule.

Statutory authorization for the rule

The final rule is authorized by section 1895 of the Social Security Act, as amended.

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

CMS determined that the final rule is economically significant under the Order, prepared a regulatory impact analysis, and the rule has been reviewed by the OMB.

Executive Order No. 13,132 (Federalism)

CMS determined that the final rule would not have substantial direct effects on the rights, roles, and responsibilities of states, local, or tribal governments.