



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

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December 11, 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 Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs*

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 Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs" (RIN: 0938-AT03). It was published in the *Federal Register* as a final rule with comment period on November 13, 2017. 82 Fed. Reg. 52,356.

The final rule with comment period revises the Medicare hospital outpatient prospective payment system (OPPS) and the Medicare ambulatory surgical center (ASC) payment system for CY 2018 to implement changes arising from CMS's continuing experience with these systems. In this final rule with comment period, CMS describes the changes to the amounts and factors used to determine the payment rates for Medicare services paid under OPPS and those paid under the ASC payment system. In addition, the final rule with comment period updates and refines the requirements for the Hospital Outpatient Quality Reporting (OQR) Program and the ASC Quality Reporting (ASCQR) 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). The rule was received on November 3, 2017 (181 Cong. Rec. H8595, 181 Cong. Rec. S7060 (Nov. 7, 2017)), and was published in the *Federal Register* on November 13, 2017. 82 Fed. Reg. 52,356. It has a stated effective date of January 1, 2018. 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 OUTPATIENT  
PROSPECTIVE PAYMENT AND AMBULATORY SURGICAL CENTER  
PAYMENT SYSTEMS AND QUALITY REPORTING PROGRAMS”  
(RIN: 0938-AT03)

(i) Cost-benefit analysis

The Centers for Medicare and Medicaid Services (CMS) prepared a regulatory impact analysis that presents the costs and benefits of the final rule with comment period. This cost and benefits summary section of the agency's submission did not appear in the published version in the *Federal Register*; however, it was included in the version submitted to us. CMS included a table in the final rule with comment period that shows the distributional impact of all the Medicare hospital outpatient prospective payment system (OPPS) changes on various groups of hospitals and Community Mental Health Centers (CMHCs) for calendar year (CY) 2018 compared to all estimated OPPS payments in CY 2017. CMS estimated that policies in the final rule with comment period will result in a 1.4 percent overall increase in OPPS payments to providers. CMS estimated that total OPPS payments for CY 2018, including beneficiary cost-sharing, to the approximate 3,900 facilities paid under OPPS (including general acute care hospitals, children's hospitals, cancer hospitals, and CMHCs) will increase by approximately \$690 million compared to CY 2017 payments, excluding the estimated changes in enrollment, utilization, and case-mix. CMS estimated the isolated impact of OPPS policies on CMHCs because CMHCs are only paid for partial hospitalization services under OPPS. Continuing the provider-specific structure that was adopted beginning in CY 2011 and basing payment fully on the type of provider furnishing the service, CMS estimated a 17.2 percent increase in CY 2018 payments to CMHCs relative to their CY 2017 payments.

CMS further estimated that, for most hospitals, the application of the outpatient department (OPD) fee schedule increase factor of 1.35 percent to the conversion factor for CY 2018 will mitigate the impacts of the budget neutrality adjustments. As a result of the OPD fee schedule increase factor and other budget neutrality adjustments, CMS estimated that rural and urban hospitals will experience increases of approximately 1.3 percent for urban hospitals and 2.7 percent for rural hospitals. Classifying hospitals by teaching status, CMS estimated nonteaching hospitals will experience increases of 2.9 percent, minor teaching hospitals will experience increases of 1.7 percent, and major teaching hospitals will experience decreases of -0.9 percent. CMS also classified hospitals by type of ownership. It estimated that hospitals with voluntary ownership will experience increases of 1.3 percent, hospitals with proprietary ownership will experience increases of 4.5 percent and hospitals with government ownership will experience no change in payments.

CMS states that for impact purposes, the surgical procedures on the ambulatory surgical center (ASC) list of covered procedures are aggregated into surgical specialty groups using current procedural terminology (CPT) and healthcare common procedure coding system (HCPCS) code range definitions. The percentage change in estimated total payments by specialty groups

under the CY 2018 payment rates, compared to estimated CY 2017 payment rates, generally range between an increase of 1 to 5 percent, depending on the service, with some exceptions. CMS estimated that the total increase (from changes to the ambulatory surgical center (ASC) provisions in this final rule with comment period as well as from enrollment, utilization, and case-mix changes) in Medicare expenditures under the ASC payment system for CY 2018 compared to CY 2017 to be approximately \$130 million. Because the provisions for the ASC payment system are part of a final rule that is economically significant as measured by the \$100 million threshold, CMS prepared a regulatory impact analysis of the changes to the ASC payment system that, according to CMS, best presents the costs and benefits of this portion of this final rule with comment period.

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

For purposes of RFA, CMS estimated that most hospitals, ASCs, and CMHCs are small entities as that term is used in RFA. For purposes of RFA, most hospitals are considered small businesses according to the Small Business Administration's size standards with total revenues of \$38.5 million or less in any single year or by the hospital's not-for-profit status. Most ASCs and most CMHCs are considered small businesses with total revenues of \$15 million or less in any single year. In addition, section 1102(b) of the Social Security Act (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. This analysis must conform to the provisions of section 604 of RFA. For purposes of section 1102(b) of the Act, CMS defined a small rural hospital as a hospital that is located outside of a metropolitan statistical area and has 100 or fewer beds. CMS estimated that this final rule with comment period will increase payments to small rural hospitals by less than 3 percent; therefore, CMS states that it should not have a significant impact on approximately 626 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

According to CMS, the final rule with comment period does not mandate any requirements for state, local, or tribal governments, or for 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 20, 2017, CMS published a proposed rule (CY 2018 OPPS/ASC) in the *Federal Register*. 82 Fed. Reg. 33,558. On November 14, 2016, CMS published a final rule with comment period (CY 2017 OPPS/ASC) in the *Federal Register*. 81 Fed. Reg. 79,562. In the CY 2018 OPPS/ASC proposed rule, CMS solicited public comments on the regulatory impact analysis and addressed any public comments received in the final rule with comment period.

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

CMS solicited public comment on the sections of this final rule with comment period that contain information collection requirements (ICRs).

## Statutory authorization for the rule

CMS states that it promulgated this final rule under the authority of the Balanced Budget Act of 1997 (BBA) (Pub. L. 105-33) which added section 1833(t) to the Social Security Act, the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA) (Pub. L. 106-113), the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) (Pub. L. 106-554), the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108-173), the Deficit Reduction Act of 2005 (DRA) (Pub. L. 109-171), the Medicare Improvements and Extension Act under Division B of title I of the Tax Relief and Health Care Act of 2006 (MIEA-TRHCA) (Pub. L. 109-432), the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) (Pub. L. 110-173), the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) (Pub. L. 110-275), the Patient Protection and Affordable Care Act (Pub. L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (collectively the Affordable Care Act) (Pub. L. 111-152), the Medicare and Medicaid Extenders Act of 2010 (MMEA) (Pub. L. 111-309), the Temporary Payroll Tax Cut Continuation Act of 2011 (TPTCCA) (Pub. L. 112-78), the Middle Class Tax Relief and Job Creation Act of 2012 (MCTRJCA) (Pub. L. 112-96), the American Taxpayer Relief Act of 2012 (Pub. L. 112-240), the Pathway for SGR Reform Act of 2013 (Pub. L. 113-67), the Protecting Access to Medicare Act of 2014 (PAMA) (Pub. L. 113-93), the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (Pub. L. 114-10), the Bipartisan Budget Act of 2015 (Pub. L. 114-74), the Consolidated Appropriations Act, 2016 (Pub. L. 114-113), and the 21st Century Cures Act (Pub. L. 114-255). The statutory authorization section of the agency's submission did not appear in the published version in the *Federal Register*; however, it was included in the version submitted to us.

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

According to CMS, the final rule with comment period has been designated as an economically significant rule under section 3(f)(1) of Executive Order 12,866 and a major rule under the Congressional Review Act. Accordingly, the final rule with comment period was reviewed by the Office of Management and Budget.

## Executive Order No. 13,132 (Federalism)

CMS states that it examined the OPPI and ASC provisions included in this final rule with comment period in accordance with the Order and determined that they will not have a substantial direct effect on state, local, or tribal governments, preempt state law, or otherwise have a federalism implication.