U.S. GOVERNMENT ACCOUNTABILITY OFFICE

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

B-332432

August 21, 2020

The Honorable Chuck Grassley
Chairman
The Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate

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

The Honorable Richard Neal
Chairman
The Honorable Kevin Brady
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 2021*

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 2021" (RIN: 0938-AU05). We received the rule on August 12, 2020. It was published in the *Federal Register* as a final rule on August 10, 2020. 85 Fed. Reg. 48424. The effective date of the final rule is October 1, 2020.

According the CMS, the final rule updates the prospective payment rates for inpatient rehabilitation facilities (IRFs) for fiscal year (FY) 2021. CMS states the final rule includes the classification and weighting factors for the IRF prospective payment system's case-mix groups and a description of the methodologies and data used in computing the prospective payment rates for FY 2021, which CMS states is required by statute. CMS further stated the final rule adopts more recent Office of Management and Budget statistical area delineations and applies a 5 percent cap on any wage index decreases compared to FY 2020 in a budget neutral manner. CMS also stated the final rule amends the IRF coverage requirements to remove the post-admission physician evaluation requirement and codifies existing documentation

instructions and guidance. In addition, CMS stated the final rule amends the IRF coverage requirements to allow, beginning with the second week of admission to the IRF, a non-physician practitioner who is determined by the IRF to have specialized training and experience in inpatient rehabilitation to conduct 1 of the 3 required face-to-face visits with the patient per week, provided that such duties are within the non-physician practitioner's scope of practice under applicable state law.

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 60-day delay in effective date can be waived, however, if the agency finds for good cause that 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. 5 U.S.C. § 808(2). CMS determined it had good cause to waive the 60-day delay because the United States is responding to an outbreak of respiratory disease caused by a novel (new) coronavirus that has now been detected in more than 190 locations internationally, including in all 50 states and the District of Columbia. The virus has been named "SARS-CoV-2" and the disease it causes has been named "coronavirus disease 2019" (COVID-19). According to CMS, due to prioritizing efforts in support of containing and combatting the COVID-19 public health emergency (PHE), and devoting significant resources to that end, CMS determined it was impracticable to complete the work needed on the IRF Prospective Payment System (PPS) final rule in accordance with its usual schedule for this rulemaking, which aims for a publication date providing for at least 60 days of public notice before the start of the fiscal year to which it applies. CMS stated the IRF PPS final rule is necessary to annually review and update the payment system, and it is critical to ensure that the payment policies for this payment system are effective on the first day of the fiscal year to which they are intended to apply. Therefore, in light of the COVID-19 PHE and the resulting strain on CMS's resources, CMS determined it was impracticable to publish the IRF PPS final rule 60 days before the 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. 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 Shari Brewster, Assistant General Counsel, at (202) 512-6398.

Shirley A. Jones
Managing Associate General Counsel

Enclosure

cc: Calvin E. Dukes II
Regulations Coordinator
Department of Health and Human Services

ENCLOSURE

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 2021"
(RIN: 0938-AU05)

(i) Cost-benefit analysis

The Centers for Medicare & Medicaid Services (CMS) estimated the final rule would result in an increase to transfer payments from the federal government to inpatient rehabilitation facilities (IRFs) during fiscal year 2021 in the amount of $260 million.

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

CMS stated the agency uses a revenue impact threshold of 3 to 5 percent to determine significance to small entities under RFA. For purposes of its analysis, CMS assumed all IRFs were small entities because it did not have the data on individual hospital receipts. CMS estimated most IRFs would see a 2.8 percent impact but that some categories of IRFs would reach the threshold. CMS estimated a 3 percent overall impact for rural IRFs. Additionally, CMS estimated a 3.1 percent overall impact for teaching IRFs with a resident to average daily census ratio of less than 10 percent, a 3.4 percent overall impact for teaching IRFs with a resident to average daily census ratio of 10 to 19 percent, and a 3.1 percent overall impact for teaching IRFs with a resident to average daily census ratio greater than 19 percent. Also, CMS estimated a 3.2 percent overall impact for IRFs with a disproportionate share hospital patient percentage of 0 percent and a 3.1 percent overall impact for IRFs with a disproportionate share hospital patient percentage greater than 20 percent. As a result, CMS anticipates this final rule will have a positive impact on a substantial number of small entities.

As for small rural hospitals, CMS estimated that the net revenue impact of this final rule on rural IRFs is to increase estimated payments by approximately 3 percent based on the data of the 132 rural units and 11 rural hospitals in its database of 1,118 IRFs for which data were available. CMS estimated an overall impact for rural IRFs in all areas except Rural South Atlantic and Rural East South Central of between 3 percent and 5 percent. As a result, CMS anticipates this final rule would have a positive impact on 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 this final rule 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 April 21, 2020, CMS published a proposed rule. 85 Fed. Reg. 22065. CMS received 2,668 comments from various trade associations, inpatient rehabilitation facilities, individual physicians, therapists, clinicians, health care industry organizations, health care consulting firms, individual beneficiaries, and beneficiary groups. CMS responded to the comments in the final rule.

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

CMS determined that the information collection requirements of the final rule have no burden, as, according to CMS, the requirement reflects customary and usual business and medical practice. Accordingly, CMS stated the burden is not subject to the Act.

Statutory authorization for the rule

CMS promulgated the final rule pursuant to sections 1302 and 1395hh of title 42, United States Code.

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

CMS determined the final rule was economically significant and stated it was reviewed by the Office of Management and Budget.

Executive Order No. 13,132 (Federalism)

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