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August 20, 2012

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 Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2013*

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 2013" (RIN: 0938-AR21). We received the rule on August 6, 2012. It was published in the *Federal Register* as a notice on July 30, 2012. 77 Fed. Reg. 44,618.

The final rule updates the payment rates for inpatient rehabilitation facilities (IRFs) for federal fiscal year (FY) 2013 (for discharges occurring on or after October 1, 2012, and on or before September 30, 2013) as required under section 1886(j)(3)(C) of the Social Security Act (the Act). Section 1886(j)(5) of the Act requires the Secretary of Health and Human Services to publish in the *Federal Register* on or

before the August 1 that precedes the start of each fiscal year, the classification and weighting factors for the IRF prospective payment system's (PPS) case-mix groups and a description of the methodology and data used in computing the prospective payment rates for that fiscal year.

The updated IRF prospective payment rates are effective for IRF discharges occurring on or after October 1, 2012, and on or before September 30, 2013 (FY 2013). 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 July 30, 2012, but we did not receive the rule until August 6, 2012. Therefore, the final rule does not have the required 60-day delay in its effective date. However, notwithstanding the 60-day delay requirement, any rule that an agency for good cause finds that notice and comment public procedures are impractical, unnecessary, or contrary to the public interest is to take effect on when the promulgating agency so determines. §§ 553(d)(3), 808(2). Accordingly, CMS believes it has good cause for making the final rule effective for IRF discharges occurring on or after October 1, 2012, and on or before September 30, 2013 (FY 2013).

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 PROGRAM; INPATIENT REHABILITATION FACILITY
PROSPECTIVE PAYMENT SYSTEM
FOR FEDERAL FISCAL YEAR 2013"
(RIN: 0938-AR21)

(i) Cost-benefit analysis

CMS performed an economic analysis, and determined that the overall economic impact of the final rule is an estimated \$140 million in increased payments to IRFs during FY 2013. CMS also determined that the benefits of the final rule include a net increase in payments to IRF providers. Overall, CMS states that no IRFs are estimated to experience a net decrease in payments as a result of the updates in the final rule.

(ii) Agency actions relevant to the Regulatory Flexibility Act, 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 2.1 percent, with three categories of IRFs (6 rural IRFs in the New England region, 29 rural IRFs in the West North Central region, and 8 rural IRFs in the Mountain region) estimated to receive an increase in estimated payments of 3 percent or more (3.2 percent, 3.0 percent, and 3.1, respectively). As a result, CMS anticipates that the final rule would have a positive impact on a substantial number of small entities. CMS does not consider Medicare fiscal intermediaries, Medicare Administrative Contractors, and carriers to be small entities, nor are individuals and states included in the definition of a small entity.

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. This analysis must conform to the provisions of section 604 of the RFA. 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. As discussed in the final rule, 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 169 rural units and 20 rural hospitals in CMS's database of 1,139 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 also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any one year of \$100 million in 1995 dollars, updated annually for inflation. In 2012, that threshold level is approximately \$139 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 \$139 million.

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

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

CMS states that it would ordinarily publish a notice of proposed rulemaking in the *Federal Register* to provide a period for public comment, followed by a final rule, but is waiving this procedure because it has found good cause to forego such procedures. CMS found that it was unnecessary to undertake notice and comment rulemaking for the updates in the final rule because the updates contained in the final rule do not make any substantive changes in policy, but merely reflect the application of previously established methodologies. In addition, CMS applied the statutorily-required adjustments to the update to the IRF PPS increase factor in sections 1886(j)(3)(C) and (D) of the Act in the final rule. CMS found that notice and comment rulemaking was unnecessary to implement these statutory provisions because they are self-implementing provisions of law, not requiring the exercise of any discretion on the part of the Secretary. Finally, in accordance with 1886(e)(5)(B), CMS noted MEDPAC's recommendations regarding an appropriate update for the FY 2013 IRF PPS, and the Secretary's inability to implement those recommendations due to the requirements in 1886(j) regarding the establishment of an update factor. As such, CMS states that the Secretary's recommendation (to follow the statutory requirements thereby applying a 1.9 percent update rather than MEDPAC's recommended 0 percent update) need not be published in a proposed and final rule as such publication is unnecessary in the absence of any discretion regarding the establishment of the update factor. Therefore, under 5 U.S.C. 553(b)(3)(B), for good cause, CMS waived notice and comment procedures.

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

CMS states that the final rule does not impose any new information collection requirements. However, it does provide detailed information about a currently approved information collection request pertaining to the IRF PPS, dealing with the Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF-PAI). CMS states that IRFs are required to complete the IRF-PAI upon the admission and

discharge of a Medicare Part A fee-for-service patient and upon admission and discharge of each Medicare Part C (Medicare Advantage) patient. CMS notes that the IRF–PAI is currently approved under OMB control number: 0938–0842.

Statutory authorization for the rule

The final rule is authorized by section 3004 of the Patient Protection and Affordable Care Act, Pub. L. No. 111-152 (March 30, 2010), and section 1886(j) of the Social Security Act.

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

CMS states that the final rule is designated as economically “significant” under section 3(f)(1) of Executive Order 12,866, and hence is a major rule under the Congressional Review Act.

Executive Order No. 13,132 (Federalism)

Executive Order 13,132 establishes certain requirements that an agency must meet when it promulgates a final rule that imposes substantial direct requirement costs on state and local governments, preempts state law, or otherwise has federalism implications. As stated above, the final rule will not have a substantial effect on state and local governments, preempt state law, or otherwise have a federalism implication.