



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

B-326169

August 21, 2014

The Honorable Ron Wyden
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 2015*

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 2015" (RIN: 0938-AS09). We received the rule on July 31, 2014. It was published in the *Federal Register* as a final rule on August 6, 2014. 79 Fed. Reg. 45,872.

The final rule updates the prospective payment rates for inpatient rehabilitation facilities (IRFs) for federal fiscal year (FY) 2015 as required by the statute. The rule finalizes a policy to collect data on the amount and mode of therapy provided in the IRF setting according to therapy discipline, revises the list of diagnosis and impairment group codes that presumptively meet the "60 percent rule" compliance criteria, provides a way for IRFs to indicate on the Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF-PAI) form whether the prior treatment and severity requirements have been met for arthritis cases to presumptively meet the "60 percent rule" compliance criteria, and revises and updates quality measures and reporting requirements under the IRF quality reporting program (QRP). This rule also delays the effective date for the revisions to the list of diagnosis codes that are used to determine presumptive

compliance under the “60 percent rule” that were finalized in the FY 2014 IRF prospective payment system final rule and adopts the revisions to the list of diagnosis codes that are used to determine presumptive compliance under the “60 percent rule” that are finalized in this rule.

The regulatory amendments in this rule are 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, 2014, although we received the rule on July 31, 2014. 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: Ann Stallion
Deputy Director
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 2015"
(RIN: 0938-AS09)

(i) Cost-benefit analysis

CMS performed a cost-benefit analysis and determined that the overall economic impact of the final rule will be a net estimated increase of \$180 million in payments to inpatient rehabilitation facility (IRF) providers. CMS derived this estimate from the application of the fiscal year (FY) 2015 Rehabilitation, Psychiatric, and Long-Term Care market basket increase factor, as reduced by a productivity adjustment, and a 0.2 percentage point reduction, which yields an estimated increase in aggregate payments to IRFs of \$165 million. In addition, there is an estimated \$15 million increase in aggregate payments to IRFs due to the update to the outlier threshold amount, which are estimated to increase from approximately 2.8 percent in FY 2014, to 3.0 percent in FY 2015.

(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 2.4 percent. However, CMS found that certain categories of IRF providers would be expected to experience revenue impacts in the 3 percent range. CMS estimates a 3.1 percent overall impact for 141 urban IRFs and 15 rural IRFs in the Middle Atlantic region, a 3.2 percent increase for 101 urban IRFs in the Pacific region, a 3.3 percent increase for 27 rural IRFs in the West North Central region, and a 4.4 percent increase for 4 rural IRFs in the Pacific region. 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 Social Security 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 165 rural units and 17 rural hospitals in CMS's database of 1,142 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 2014, that threshold level is approximately \$141 million. CMS determined 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 7, 2014, CMS published a proposed rule. 79 Fed. Reg. 26,308. CMS received 66 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 stated that the final rule does not impose any new information collection requirements. However, the final rule does make reference to associated information collection requirements, some of which have already received the Office of Management and Budget's (OMB) approval.

Statutory authorization for the rule

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

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

CMS determined that the final rule is an economically significant rule under the Executive Order and prepared a regulatory impact analysis in conjunction with the final rule. CMS also submitted the rule to OMB for review.

Executive Order No. 13,132 (Federalism)

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