



GAO

Accountability * Integrity * Reliability

United States General Accounting Office
Washington, DC 20548

B-292405

June 23, 2003

The Honorable Charles E. Grassley
Chairman
The Honorable Max Baucus
Ranking Minority Member
Committee on Finance
United States Senate

The Honorable William M. Thomas
Chairman
The Honorable Charles B. Rangel
Ranking Minority Member
Committee on Ways and Means
House of Representatives

Subject: *Department of Health and Human Services, Centers for Medicare and Medicaid Services: Medicare Program; Change in Methodology for Determining Payment for Extraordinarily High-Cost Cases (Cost Outliers) Under the Acute Care Hospital Inpatient and Long-Term Care Hospital Prospective Payment Systems*

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; Change in Methodology for Determining Payment for Extraordinarily High-Cost Cases (Cost Outliers) Under the Acute Care Hospital Inpatient and Long-Term Care Hospital Prospective Payment Systems" (RIN: 0938-AM41). We received the rule on June 6, 2003. It was published in the Federal Register as a final rule on June 9, 2003. 68 Fed. Reg. 34494.

The final rule revises the methodology for determining payments for extraordinarily high-cost cases (cost outliers) made to Medicare-participating hospitals under the acute care hospital inpatient prospective payment system (IPPS). A similar revision in methodology for the payment for high-cost outlier and short-stay outlier cases that are made to Medicare-participating long-term care hospital prospective payment system (LTCH PPS) is included in the rule.

Enclosed is our assessment of the 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 indicates that the CMS complied with the applicable requirements.

If you have any questions about this report, please contact James W. Vickers, Assistant General Counsel, at (202) 512-8210. The official responsible for GAO evaluation work relating to the subject matter of the rule is William Scanlon, Managing Director, Health Care. Mr. Scanlon can be reached at (202) 512-7114.

signed

Kathleen E. Wannisky
Managing Associate General Counsel

Enclosure

cc: Ann Stallion
Regulations Coordinator
Department of Health and
Human Services

ANALYSIS UNDER 5 U.S.C. § 801(a)(1)(B)(i)-(iv) OF A MAJOR RULE
ISSUED BY THE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERVICES
ENTITLED
"MEDICARE PROGRAM; CHANGE IN METHODOLOGY FOR DETERMINING
PAYMENT FOR EXTRAORDINARILY HIGH-COST CASES (COST OUTLIERS)
UNDER THE ACUTE CARE HOSPITAL INPATIENT AND LONG-TERM CARE
HOSPITAL PROSPECTIVE PAYMENT SYSTEMS"
(RIN: 0938-AM41)

(i) Cost-benefit analysis

CMS estimates that the total impact of the policies implemented by the final rule will be to reduce outlier payments for the remainder of Fiscal Year 2003 by \$150 million.

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

CMS has prepared a combined Regulatory Impact Analysis and Regulatory Flexibility Analysis that contains the information required by the Act, including the economic impact on hospitals which will receive reduced payments and a discussion of the alternatives considered.

(iii) Agency actions relevant to sections 202-205 of the Unfunded Mandates Reform Act of 1995, 2 U.S.C. §§ 1532-1535

The final rule does not contain either an intergovernmental or private sector mandate, as defined in title II, of more than \$100 million in any one year.

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

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

The final rule was issued using the notice and comment procedures found at 5 U.S.C. 553. On March 5, 2003, CMS published a Notice of Proposed Rulemaking in the Federal Register regarding the methodology for payment under the IPPS. 68 Fed. Reg. 10420. On March 7, CMS published a proposed rule to make similar changes in the methodology for payments under the LTCH PPS. 68 Fed. Reg. 11234.

In response to the proposals, CMS received a total of 604 comments that are discussed in the preamble to the final rule.

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

The final rule contains an information collection that is subject to review by the Office of Management and Budget (OMB) under the Paperwork Reduction Act.

CMS estimates that the information collection would be used by 120 hospitals to request a different cost-to-charge ratio and that it would take 8 hours to complete the request for an annual burden of 960 hours.

Statutory authorization for the rule

The final rule is promulgated pursuant to the authority contained in section 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

Executive Order No. 12866

The final rule has been reviewed by OMB and found to be an “economically significant” regulatory action under the order.

Executive Order No. 13132 (Federalism)

CMS has determined that the final rule does not have sufficient federalism implications under the order.