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September 6, 2007

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

The Honorable John D. Dingell
Chairman
The Honorable Joe Barton
Ranking Minority Member
Committee on Energy and Commerce
House of Representatives

The Honorable Charles B. Rangel
Chairman
The Honorable Jim McCrery
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; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates*

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; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates" (RIN: 0938-AO70). We received the rule on August 1, 2007. It was published in the *Federal Register* as a final rule on August 22, 2007. 72 Fed. Reg. 47,130.

The final rule revises the Medicare hospital inpatient prospective payment system for operating and capital-related costs. These changes arise from CMS's continuing experience with these systems and implement provisions of the Deficit Reduction Act of 2005, Pub. L. No. 109-171, 120 Stat. 4 (Feb. 8, 2006), the Pandemic and All-Hazards Preparedness Act, Pub. L. No. 109-417, 120 Stat. 2831 (Dec. 19, 2006), and

the Tax Relief and Health Care Act of 2006, Pub. L. No. 109-432, 120 Stat. 2922 (Dec. 20, 2006). This rule also describes changes to the amounts and factors used to determine the rates for Medicare hospital inpatient services for operating costs and capital-related costs. Further, the rule sets limits on the rate of increase for certain hospitals and hospital units that are excluded from the inpatient prospective payment system and that are paid on a reasonable cost basis or are paid under the inpatient prospective payment system with a portion of that payment based on reasonable cost principles.

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 indicates that, with the exception of the delay in the rule's effective date discussed below, CMS complied with the applicable requirements.

This rule has a stated effective date of October 1, 2007. The Congressional Review Act (CRA) requires a 60-day delay in the effective date of major rules from the date of publication in the *Federal Register* or Congress's receipt of the rule, whichever is later. 5 U.S.C. § 801(a)(3)(A). Congress received this rule on August 1, 2007, and it was published on August 22, 2007. The 60-day delay does not apply when "an agency for good cause finds (and incorporates the finding and a brief statement of reasons therefore in the rule issued) that notice and public procedure thereon are impractical, unnecessary, or contrary to the public interest." 5 U.S.C. § 808(2).

CMS found good cause to waive notice-and-comment procedures for a technical correction that includes Medicare Advantage days when calculating the Medicare Fraction for the Medicare disproportionate share hospital determination. CMS determined that this change was merely technical and does not make any substantive changes in policy. 72 Fed. Reg. 47,409. CMS also found good cause to waive notice-and-comment procedures for the part of this final rule that changes long-term care diagnostic-related group classification system into Medicare Severity long-term care diagnostic-related group for long-term care hospital prospective payment systems. *Id.* CMS discussed this change in the preamble to the proposed rule, but omitted the changes from the text of the proposed regulation. CMS concludes that the description in the preamble is sufficient for notice-and-comment purposes. Indeed, CMS received and responded to comments on this portion of the rule in the final rule. 72 Fed. Reg. 47,279—47,300 (Aug. 22, 2007). For the portions of the rule for which CMS found good cause to waive the notice-and-comment procedures, the 60-day delay in the effective date does not apply.

CMS did not state a finding of good cause to waive the notice-and-comment procedures for the remaining portions of the rule, which constitute the majority of the rule. Therefore, since the rule was published August 22, 2007, and has a stated effective date October 1, 2007, the remaining portions of the rule do not have the required 60-day delay in the effective date.

If you have any questions about this report, please contact Michael R. Volpe, Assistant General Counsel, at (202) 512-8236. The official responsible for GAO evaluation work relating to the subject matter of the rule is Marjorie Kanof, Managing Director, Health Care. Ms. Kanof can be reached at (202) 512-7114.

signed

Robert J. Cramer
Associate General Counsel

Enclosure

cc: Ann Stallion
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 AND MEDICAID SERVICES
ENTITLED
"MEDICARE PROGRAM; CHANGES TO THE HOSPITAL INPATIENT
PROSPECTIVE PAYMENT SYSTEMS AND FISCAL YEAR 2008 RATES"
(RIN: 0938-AO70)

(i) Cost-benefit analysis

The Centers for Medicare and Medicaid Services (CMS) determined that this rule will result in an approximately $3.8 billion increase in fiscal year 2008 operating and capital payments.

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

CMS prepared a Final Regulatory Flexibility Analysis in connection with this final rule. CMS considers most hospitals and other providers and suppliers to be small entities.

(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, it examined the impacts of this final rule as required by the Act. CMS concluded that this final rule will not mandate any requirements for state, local, or tribal governments, nor will it affect private sector costs.

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

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

CMS promulgated parts of this final rule using the notice-and-comment procedures found in the Administrative Procedure Act. 5 U.S.C. § 553. CMS published a proposed rule on May 3, 2007. 72 Fed. Reg. 24,680. CMS received approximately 900 comments, to which they responded in the final rule. 72 Fed. Reg. 47,138–47,407.

CMS found good cause to waive notice-and-comment procedures for a technical correction to include Medicare Advantage days when calculating the Medicare Fraction for the Medicare disproportionate share hospital determination. CMS determined that this change was merely technical and does not make any substantive changes in policy. 72 Fed. Reg. 47,409. CMS also found good cause to

waive notice-and-comment procedures for the part of this final rule that changes long-term care diagnostic-related group classification system into Medicare Severity long-term care diagnostic-related group for long-term care hospital prospective payment systems. *Id.* CMS discussed this change in the preamble to the proposed rule, but omitted the changes from the text of the proposed regulation. CMS concludes that the description in the preamble is sufficient for notice-and-comment purposes. Indeed, CMS received and responded to comments on these changes in the final rule. 72 Fed. Reg. 47,279-47,300 (Aug. 22, 2007).

CMS published this final rule as a final rule with comment period. CMS will only consider public comments on section V of the rule entitled, "Changes to the IPPS for Capital-Related Costs."

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

This final rule contains information collections that are subject to review by the Office of Management and Budget (OMB) under the Act. This rule requires physician-owned hospitals to notify patients that the hospital is a physician-owned hospital. CMS estimates the annual burden of these reporting and recordkeeping requirements to be 50,960 hours for outpatient visits and 3,185 for inpatient visits. The final rule also requires that hospitals notify patients in cases where a doctor of medicine or osteopathy is not present in the hospital at all times. CMS estimates the annual burden of these reporting and recordkeeping requirements to be 729,165 hours. Also under this rule, hospitals located in urban areas that apply for reclassification as rural will be subject to an information collection. CMS determined that this information collection is exempt from the Act because it will impact less than 10 entities.

Statutory authorization for the rule

This final rule is promulgated under the authority found in sections 1102 and 1871 of the Social Security Act (42 U.S.C. §§ 1302, 1395hh).

Social Security Act, 42 U.S.C. § 1302(b)

CMS prepared a regulatory impact analysis under this statute and determined that this final rule will have a significant impact on a substantial number of rural hospitals.

Executive Order No. 12,866

According to CMS, it examined the impacts of this final rule as required by the order. CMS determined that this rule will result in an approximately $3.8 billion increase in fiscal year 2008 operating and capital payments. This rule is a significant rule under the order and was reviewed by OMB.

Executive Order No. 13,132 (Federalism)

According to CMS, this final rule will not have a substantial effect on state or local governments.