U.S. GOVERNMENT ACCOUNTABILITY OFFICE

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

B-335009

February 13, 2023

The Honorable Ron Wyden
Chairman
The Honorable Mike Crapo
Ranking Member
Committee on Finance
United States Senate

The Honorable Cathy McMorris Rodgers
Chair
The Honorable Frank Pallone
Ranking Member
Committee on Energy and Commerce
House of Representatives

The Honorable Jason Smith
Chairman
The Honorable Richard Neal
Ranking Member
Committee on Ways and Means
House of Representatives

Subject: *Department of Health and Human Services, Centers for Medicare & Medicaid Services: Medicare and Medicaid Programs; Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Program of All-Inclusive Care for the Elderly (PACE), Medicaid Fee-For-Service, and Medicaid Managed Care Programs for Years 2020 and 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 and Medicaid Programs; Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Program of All-Inclusive Care for the Elderly (PACE), Medicaid Fee-For-Service, and Medicaid Managed Care Programs for Years 2020 and 2021" (RIN: 0938-AT59). We received the rule on February 1, 2023. It was published in the *Federal Register* as a final rule on February 1, 2023. 88 Fed. Reg. 6643. The effective date is April 3, 2023.

The final rule, according to CMS, announces policies to improve program integrity and payment accuracy in the Medicare Advantage (MA) program. CMS stated the purpose of the rule is to outline audit methodology and related policies for the contract-level MA Risk Adjustment Data Validation (RADV) program. Specifically, according to CMS, the rule codifies in regulation that, as part of the RADV audit methodology, CMS will extrapolate RADV audit findings beginning with payment year 2018 and will not extrapolate RADV audit findings for payment years 2011

through 2017. CMS stated it is also finalizing a policy whereby CMS will not apply an adjustment factor (known as a Fee-For-Service Adjuster) in RADV audits. Further, CMS stated it is codifying in regulation the requirement that MA organizations remit improper payments identified during RADV audits in a manner specified by CMS.

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 AND MEDICAID PROGRAMS; POLICY AND TECHNICAL CHANGES TO THE MEDICARE ADVANTAGE, MEDICARE PRESCRIPTION DRUG BENEFIT, PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE), MEDICAID FEE-FOR-SERVICE, AND MEDICAID MANAGED CARE PROGRAMS FOR YEARS 2020 AND 2021"
(RIN: 0938-AT59)

(i) Cost-benefit analysis

The Department of Health and Human Services (HHS), Centers for Medicare & Medicaid Services (CMS) conducted an economic analysis of this final rule. CMS estimated that from 2022 through 2031, the rule will generate federal annualized monetized transfers of $410 million and $443 million, at the 7 percent and 3 percent discount rates, respectively, from Medicare Advantage Organizations back to the Medicare Trust Fund. CMS also stated that it expects to be more effective in identifying improper payments in future audit years.

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

CMS stated that the Secretary of HHS certified that this final rule will not have a significant economic impact on a substantial number of small entities. CMS further stated that the Secretary certified that the rule will not have a significant impact on the operations of 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 that this final rule would not impose a mandate that will result in the expenditure by state, local, and tribal governments, in the aggregate, or by the private sector, of more than $165 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.*

On November 1, 2018, CMS issued a proposed rule. 83 Fed. Reg. 54982. CMS stated it received approximately 154 timely pieces of correspondence in response to the 2018 proposed rule and the subsequent notices and data releases. CMS responded to comments in the final rule.

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

CMS stated that this final rule does not impose any new or revised collection of information requirements or related burden within the meaning of PRA.

Statutory authorization for the rule

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

Executive Order No. 12866 (Regulatory Planning and Review)

CMS stated that the Office of Management and Budget (OMB) determined that this final rule is economically significant as measured by the $100 million threshold under the Order, and that OMB reviewed the rule.

Executive Order No. 13132 (Federalism)

CMS determined that the Order does not apply to this final rule because the rule does not impose any substantial costs on state or local governments.