U.S. GOVERNMENT ACCOUNTABILITY OFFICE

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May 28, 2024

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, Jr.
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: Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality*

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 "Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality" (RIN: 0938-AU99). We received the rule on April 15, 2024. It was published in the *Federal Register* as a final rule on May 10, 2024. 89 Fed. Reg. 41002. The effective date of the rule is July 9, 2024.

According to CMS, this final rule addresses standards for timely access to care for Medicaid and Children's Health Insurance Program (CHIP) managed care enrollees and states' monitoring and enforcement efforts, reduces state burdens for implementing some state-directed payments and certain quality reporting requirements, adds new standards that will apply when states use in lieu of services and settings (ILOSs) to promote effective utilization and that specify the scope and nature of ILOSs, specifies medical loss ratio (MLR) requirements, and establishes a quality rating system for Medicaid and CHIP managed care plans.

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 Charlie McKiver, Assistant General Counsel, at (202) 512-5992.

Shirley A. Jones
Managing Associate General Counsel

Enclosure

cc: Wilma Robinson
Deputy Executive Secretary
HHS Executive Secretariat
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
"MEDICAID PROGRAM; MEDICAID AND CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) MANAGED CARE ACCESS, FINANCE, AND QUALITY"
(RIN: 0938-AU99)

(i) Cost-benefit analysis

The Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) prepared a Regulatory Impact Analysis (RIA) for this final rule. CMS analyzed the impact of the rule over a five-year period and estimated that the rule will result in the following transfers:

- Transfers from the federal government to health care providers of $3.45 billion to $16.404 billion per year, at a 3 percent discount rate, and $3.358 billion to $15.912 billion per year, at a 7 percent discount rate;
- Transfers from states to health care providers of $1.842 billion to $8.922 billion per year, at a 3 percent discount rate, and $1.792 billion to $8.649 billion per year, at a 7 percent discount rate;
- Transfers from the federal government to beneficiaries (in the form of additional services) of $0 to $1.03 billion per year, at a 3 percent discount rate, and $0 to $991 million per year, at a 7 percent discount rate;
- Transfers from states to beneficiaries (in the form of additional services) of $0 to $583 million per year, at a 3 percent discount rate, and $0 to $561 million per year, at a 7 percent discount rate;
- Transfers from managed care plans to the federal government of $0 to $48 million per year, at a 3 percent discount rate, and $0 to $47 million per year, at a 7 percent discount rate;
- Transfers from managed care plans to states of $0 to $26 million per year, at 3 and 7 percent discount rates.

CMS also discussed non-quantified benefits of the rule to the Medicaid program, including aligning state and federal efforts to improve timely access to care for Medicaid managed care enrollees, enhancing and improving quality-based provider payments to better support care delivery, and supporting better quality improvement throughout the Medicaid managed care program.

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

The Secretary of Health and Human Services certified that this final rule will not have a significant economic impact on a substantial number of small entities or 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 will not impose any mandates on state, local, or tribal governments, in the aggregate, or on the private sector, of $100 million or more, adjusted annually for inflation, in any one year.

(iv) Agency actions relevant to the Administrative Pay-As-You-Go-Act of 2023, Pub. L. No. 118-5, div. B, title III, 137 Stat 31 (June 3, 2023)

Section 270 of the Administrative Pay-As-You-Go-Act of 2023 amended 5 U.S.C. § 801(a)(2)(A) to require GAO to assess agency compliance with the Act, which establishes requirements for administrative actions that affect direct spending, in GAO's major rule reports. In guidance to Executive Branch agencies, issued on September 1, 2023, the Office of Management and Budget (OMB) instructed that agencies should include a statement explaining that either: "the Act does not apply to this rule because it does not increase direct spending; the Act does not apply to this rule because it meets one of the Act's exemptions (and specifying the relevant exemption); the OMB Director granted a waiver of the Act's requirements pursuant to section 265(a)(1) or (2) of the Act; or the agency has submitted a notice or written opinion to the OMB Director as required by section 263(a) or (b) of the Act" in their submissions of rules to GAO under the Congressional Review Act. OMB, *Memorandum for the Heads of Executive Departments and Agencies,* Subject: Guidance for Implementation of the Administrative Pay-As-You-Go Act of 2023, M-23-21 (Sept. 1, 2023), at 11–12. OMB also states that directives in the memorandum that supplement the requirements in the Act do not apply to proposed rules that have already been submitted to the Office of Information and Regulatory Affairs, however agencies must comply with any applicable requirements of the Act before finalizing such rules.

CMS stated that the Director of OMB granted a waiver of the Act's requirements pursuant to section 265(a)(2) of the Act.

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

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

On May 3, 2023, CMS published a proposed rule. 88 Fed. Reg. 28092. CMS received 415 timely comments from state Medicaid and Children's Health Insurance Program (CHIP) agencies, advocacy groups, health care providers and associations, health insurers, managed care plans, health care associations, and the general public. CMS responded to comments in this final rule but stated that it did not respond to comments raising issues that were beyond the scope of the proposed rule.

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

CMS determined that this final rule contains information collection requirements under the Act. CMS identified numerous information collections that will be affected by the rule. CMS estimated that the rule will result in a total burden of 1,880,356 burden hours and costs of $168,947,129. The burden hour and cost estimates reflect the annual burden and annual costs associated with annual requirements as well as the total burden hours and costs associated with one-time requirements.

Statutory authorization for the rule

CMS promulgated this final rule pursuant to section 1302 of title 42, United States Code.

Executive Order No. 12866 (Regulatory Planning and Review)

OMB determined that this final rule is significant under the Order, and CMS submitted it to OMB for review.

Executive Order No. 13132 (Federalism)

CMS determined that this final rule does not have federalism implications and will not impose substantial direct requirement costs on state or local governments or preempt state law.