



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

B-325479

January 30, 2014

The Honorable Max Baucus
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

Subject: *Department of Health and Human Services, Centers for Medicare & Medicaid Services: Medicaid Program; State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Home and Community-Based Setting Requirements for Community First Choice and Home and Community-Based Services (HCBS) Waivers*

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; State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Home and Community-Based Setting Requirements for Community First Choice and Home and Community-Based Services (HCBS) Waivers" (RIN: 0938-AO53; 0938-AP61). We received the rule on January 13, 2014. It was published in the *Federal Register* as a final rule on January 16, 2014, with an effective date of March 17, 2014. 79 Fed. Reg. 2948.

The final rule amends the Medicaid regulations to define and describe state plan section 1915(i) home and community-based services (HCBS) under the Social Security Act (the Act) amended by the Affordable Care Act. This rule offers states new flexibilities in providing necessary and appropriate services to elderly and disabled populations. This rule describes Medicaid coverage of the optional state plan benefit to furnish home and community-based services and draw federal matching funds. This rule also provides for a 5-year duration for certain demonstration projects or waivers at the discretion of the Secretary of Health and Human Services, when they provide medical assistance for individuals dually eligible for Medicaid and Medicare benefits, includes payment reassignment provisions because state Medicaid programs often operate as the primary or only payer for the class of practitioners that includes HCBS providers, and amends Medicaid regulations to provide home and community-based setting requirements related to the Affordable Care Act for Community First Choice state plan

option. This final rule also makes several important changes to the regulations implementing Medicaid 1915(c) HCBS waivers.

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.

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
Program Manager
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
"MEDICAID PROGRAM; STATE PLAN HOME AND COMMUNITY-BASED SERVICES,
5-YEAR PERIOD FOR WAIVERS, PROVIDER PAYMENT REASSIGNMENT,
AND HOME AND COMMUNITY-BASED SETTING REQUIREMENTS
FOR COMMUNITY FIRST CHOICE AND HOME AND
COMMUNITY-BASED SERVICES (HCBS) WAIVERS"
(RIN: 0938-AO53; 0938-AP61)

(i) Cost-benefit analysis

CMS examined the impacts of the final rule and estimates that, as a result of this final rule, the Medicaid cost impact for provisions under 1915(i) for fiscal year 2014 will be \$150 million for the federal share and \$115 million for the state share. CMS notes that the estimates are adjusted for a phase-in period during which states gradually elected to offer the state plan HCBS benefit. Furthermore, CMS explains that the estimated total annual collection of information requirements cost (including fringe benefits and overhead) to states is \$21,805. CMS states that provisions in this rule pertaining to section 2601 of the Affordable Care Act: 5-Year Period for Demonstration Projects (Waivers), Provider Payment Reassignments; section 2401 of the Affordable Care Act: 1915(k) Community First Choice State Plan Option: Home and Community-Based Setting Requirements; and section 1915(c) Home and Community-Based Services Waivers will not impact federal or state Medicaid funding. While states may incur costs in coming into compliance with these provisions in this rule, CMS believes that given the variability in state programs, and the varying extent to which some are already complying, it is difficult to estimate these costs.

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

The RFA requires agencies to analyze options for regulatory relief of small entities, if a rule has a significant impact on a substantial number of small entities. CMS states that for purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. According to CMS, most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of less than \$7.0 million to \$34.5 million in any 1 year. CMS explains that Medicaid providers are required, as a matter of course, to follow the guidelines and procedures as specified in state and federal laws and regulations. Furthermore, CMS notes that this final rule imposes no requirements or costs on providers or suppliers for their existing activities. According to CMS, the final rule implements a new optional state plan benefit established in section 1915(i) of the Act. CMS believes that small entities that meet provider qualifications and choose to provide HCBS under the state plan will have a business opportunity under this final rule. CMS states that the Secretary has determined that this final rule will not have a significant economic impact on a substantial number of small entities. In addition, section 1102(b) of the 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. This analysis must conform to the provisions of

section 604 of the RFA. 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. According to CMS, this final rule does not offer a change in the administration of the provisions related to small rural hospitals. Therefore, the Secretary has determined that this final 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

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 spending in any 1 year of \$100 million in 1995 dollars, updated annually for inflation. In 2013, that threshold is approximately \$141 million. CMS states that this final rule does not mandate any spending by state, local, or tribal governments, in the aggregate, or by the private sector, of \$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 3, 2012, CMS published a proposed rule in the *Federal Register* entitled “Medicaid Program; State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Setting Requirements for Community First Choice.” 77 Fed. Reg. 26,362. CMS received a total of 401 timely comments from state agencies, advocacy groups, health care providers, employers, health insurers, health care associations, and the general public. After consideration of comments received in response to the Community First Choice (CFC) proposed rule published in the *Federal Register* on February 25, 2011, CMS revised the setting provision and published its proposed definition as a new proposed rule to allow for additional public comment before this final rule. Since CFC and section 1915(i) both pertain to home and community-based services, CMS aligned this CFC proposed language with the section 1915(i) proposed home and community-based setting requirements also included in this final rule.

Additionally, on April 15, 2011, CMS published a proposed rule entitled, “Medicaid Program: Home and Community-Based Services (HCBS) Waivers.” 76 Fed. Reg. 21311. CMS received a total of 1653 comments from state Medicaid agencies, advocacy groups, health care providers, employers, health insurers, and health care associations, but did not respond to comments in the final rule because they did not address any specific regulatory provisions in the proposed rule.

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

CMS solicited public comments on information collection regarding: (1) individuals receiving state plan home and community-based services; (2) eligibility for state plan HCBS; (3) needs-based criteria and evaluation; (4) independent assessments, and (5) state plan HCBS administration: state responsibilities and quality improvement. CMS outlined the applicable burden for each in the final rule.

Statutory authorization for the rule

CMS states that the final rule is authorized by the Social Security Act as amended by the Patient Protection and Affordable Care Act of 2010.

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

CMS states that this final rule has been designated as “economically significant,” and, accordingly, the rule has been reviewed by the Office of Management and Budget.

Executive Order No. 13,132 (Federalism)

CMS states that since this final rule does not impose any costs on state or local governments, the requirements of the Order are not applicable.