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February 1, 2017

The Honorable Orrin G. Hatch  
Chairman  
The Honorable Ron Wyden  
Ranking Member  
Committee on Finance  
United States Senate

The Honorable Greg Walden  
Chairman  
The Honorable Frank Pallone, Jr.  
Ranking Member  
Committee on Energy and Commerce  
House of Representatives

Subject: *Department of Health and Human Services, Centers for Medicare & Medicaid Services: Medicaid Program; The Use of New or Increased Pass-Through Payments in Medicaid Managed Care Delivery 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 & Medicaid Services (CMS) entitled “Medicaid Program; The Use of New or Increased Pass-Through Payments in Medicaid Managed Care Delivery Systems” (RIN: 0938-AT10). We received the rule on January 18, 2017. It was published in the *Federal Register* as a final rule on January 18, 2017, with an effective date of March 20, 2017. 82 Fed. Reg. 5415.

The final rule finalizes changes to the pass-through payment transition periods and the maximum amount of pass-through payments permitted annually during the transition periods under the Medicaid managed care contract(s) and rate certification(s). This final rule prevents increases in pass-through payments and the addition of new pass-through payments beyond those in place when the pass-through payment transition periods were established, in the final Medicaid managed care regulations effective July 5, 2016.

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: Agnes Thomas  
Regulations Coordinator  
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; THE USE OF NEW OR INCREASED  
PASS-THROUGH PAYMENTS IN MEDICAID MANAGED  
CARE DELIVERY SYSTEMS"  
(RIN: 0938-AT10)

(i) Cost-benefit analysis

The Centers for Medicare and Medicaid Services (CMS) included a cost benefit analysis in the final rule. According to CMS, a number of states have integrated some form of pass-through payments into their managed care contracts for hospitals, nursing facilities, and physicians. In general, according to CMS, the size and number of the pass-through payments for hospitals has been more significant than for nursing facilities and physicians. CMS noted in a May 6, 2016, final rule (81 Fed. Reg. 27,589) that there were a number of reasons provided by states for using pass-through payments in their managed care contracts. Since the publication of the May 6, 2016, final rule, CMS received a formal proposal from one state regarding \$250 to \$275 million in pass-through payments to hospitals. CMS states that it has been working with the state to identify permissible implementation options for their proposal, including under § 438.6(c), and tie such payments to the utilization and delivery of services (as well as the outcomes of delivered services). CMS heard informally that two additional states are working to develop pass-through payment mechanisms to increase total payments to hospitals by approximately \$10 billion cumulatively. CMS also heard informally from one state regarding a \$200 million proposal for pass-through payments to physicians. CMS states that it also continues to receive inquiries from states, provider associations, and consultants who are developing formal proposals to add new pass-through payments, or increase existing pass-through payments, and incorporate such payments into Medicaid managed care rates. These state proposals have not been approved to date. CMS states that while it is difficult to conduct a detailed quantitative analysis given this considerable uncertainty and lack of data, it believes that without the final rule, states will continue to ramp-up pass-through payments in ways that are not consistent with the pass-through payment transition periods established in the May 6, 2016, final rule.

Since CMS cannot produce a detailed quantitative analysis, CMS developed a qualitative discussion for the Regulatory Impact Analysis. CMS believes there are many benefits with the final rule, including consistency with its interpretation and implementation of the statutory requirements in section 1903(m) of the Social Security Act and regulations for actuarially sound capitation rates, improved transparency in rate development processes, permissible and accountable payment approaches that are based on the utilization and delivery of services to enrollees covered under the contract, or the quality and outcomes of such services, and improved support for delivery system reform that is focused on improved care and quality for Medicaid beneficiaries. CMS also states that it believes that the costs of this regulation to state and federal governments will not be significant. CMS currently reviews and works with states on managed care contracts and rates, and because pass-through payments exist today, any additional costs to state or federal governments should be negligible.

Relative to the current baseline, the final rule builds on the May 6, 2016, final rule and may further reduce the likelihood of increases in or the development of new pass-through payments, which could reduce state and federal government transfers to hospitals, physicians, and nursing facilities. However, states may instead increase or develop actuarially sound payments that link provider reimbursement with services covered under the contract or associated quality outcomes. Because CMS lacks sufficient information to forecast the eventual overall impact of the May 6, 2016, final rule on state pass-through payments, it provided only a qualitative discussion of the impact of the final rule on avoided transfers.

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

CMS states that it does not believe that this final rule will have a significant economic impact on a substantial number of small businesses. CMS further certified that the 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 in comparison to total revenues of these entities.

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

CMS states that the final rule does not mandate any costs (beyond the \$100 million established in 1995 dollars, updated annually for inflation to \$146 million threshold in 2016) resulting from imposing enforceable duties on state, local, or tribal governments, or on the private sector, or increasing the stringency of conditions in, or decreasing the funding of, state, local, or tribal governments under entitlement programs.

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

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

On November 22, 2016, CMS published a proposed rule in the *Federal Register*. 81 Fed. Reg. 83,777. CMS received 46 timely comments from the public, including comments from hospitals, hospital associations, state Medicaid agencies, Medicaid managed care plans, and other healthcare providers and associations. CMS responded and summarized the comments received that were within the scope of the final rule.

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

According to CMS, the final rule will not impose any new or revised information collection, reporting, recordkeeping, or third-party disclosure requirements or burden. CMS states that its revision of § 438.6(d) will not impose any new or revised IT system requirements or burden because the existing regulation at § 438.7 requires the rate certification to document special contract provisions under § 438.6. Consequently, according to CMS, there is no need for review by the Office of Management and Budget (OMB) under the authority of PRA.

Statutory authorization for the rule

The final rule was promulgated under the authority of section 1102 of the Social Security Act (42 U.S.C. § 1302).

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

CMS estimated that the final rule is economically significant as measured by the \$100 million threshold because of the potential for avoided transfers, and hence a major rule under the Congressional Review Act. CMS stated that the final rule was reviewed by OMB.

Executive Order No. 13,132 (Federalism)

CMS states that since the final rule does not impose any costs on state or local governments, the requirements of Executive Order 13,132 are not applicable.