



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

B-330965

April 30, 2019

The Honorable Chuck Grassley
Chairman
The Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate

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

The Honorable Richard Neal
Chairman
The Honorable Kevin Brady
Ranking Member
Committee on Ways and Means
House of Representatives

Subject: Department of Health and Human Services, Centers for Medicare and Medicaid Services: Medicare and Medicaid Programs; Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Programs 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 and Medicaid Services (CMS) entitled “Medicare and Medicaid Programs; Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Programs 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 April 10, 2019. It was published in the *Federal Register* as a final rule on April 16, 2019. 84 Fed. Reg. 15680. The *Congressional Record* does not indicate when either house of Congress received the rule. The effective date of the rule is generally January 1, 2020; however, some provisions take effect June 17, 2019, and others take effect January 1, 2021.

CMS stated the final rule will revise the Medicare Advantage (MA) program (Part C) regulations and Prescription Drug Benefit program (Part D) regulations to implement certain provisions of the Bipartisan Budget Act of 2018; improve quality and accessibility; clarify certain program integrity policies for MA, Part D, and cost plans and Programs of All-Inclusive Care for the

Elderly organizations; reduce burden on providers, MA plans, and Part D sponsors through providing additional policy clarification; and implement other technical changes regarding quality improvement. The agency further stated the final rule will also revise the appeals and grievances requirements for certain Medicaid managed care and MA special needs plans for dual eligible individuals to implement certain provisions of the Bipartisan Budget Act of 2018.

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 Janet Temko-Blinder, Assistant General Counsel, at (202) 512-7104.

signed

Shirley A. Jones
Managing Associate General Counsel

Enclosure

cc: Vanessa Jones
Deputy Director, Office of Documents
and Regulations Management
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 AND MEDICAID SERVICES
ENTITLED
“MEDICARE AND MEDICAID PROGRAMS; POLICY AND
TECHNICAL CHANGES TO THE MEDICARE ADVANTAGE,
MEDICARE PRESCRIPTION DRUG BENEFIT, PROGRAMS 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, Centers for Medicare and Medicaid Services, (CMS) stated that the final rule provides additional Medicare Advantage (MA) telehealth benefits that are expected to produce a \$557 million savings for enrollees over 10 years from reduced travel time to and from providers. The agency also stated that the unified grievance and appeals procedures will create a \$0.7 million savings for plans due to increased efficiency over 10 years and that these savings will be passed onto the Medicare Trust Fund.

CMS, however, also stated that the telehealth provisions of the rule will result in a transfer of cost from enrollees to the Medicare Trust Fund of about \$80 million over 10 years. CMS stated that this is due to a reclassification of the benefit from supplemental benefit to basic benefit. The agency also stated that the integration requirements for dual eligible special needs plans will result in a \$3.4 million cost to MA plans and a \$0.5 million cost to state Medicaid agencies, half of which will be transferred to the federal government. Finally, CMS stated that the unified grievance and appeals procedure will result in a \$4.2 million cost to the Medicare Trust Fund for providing benefits while appeals are pending, and enrollees will incur an extra \$0.7 million in cost sharing for benefits while appeals are pending.

The agency stated that all other provisions will have a negligible impact.

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

CMS certified that the rule does not have a significant economic impact on a substantial number of small entities. CMS further certified the rule does not have a significant economic impact on a substantial number of 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 stated that the final rule is not anticipated to have an effect on state, local, or tribal governments, in the aggregate, or on the private sector of \$154 million or more.

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

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

CMS stated that it published a notice of proposed rulemaking on November 1, 2018. 83 Fed. Reg. 54982. The agency further stated that it received approximately 180 timely pieces of correspondence containing multiple comments, and it addressed these comments in the rule.

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

CMS stated that the rule contained a collection of information request as defined by the Act. The agency estimated the aggregate total burden hours to be 14,744 and the aggregate total burden cost to be \$1,222,814.

Statutory authorization for the rule

CMS stated that it promulgated the rule under 42 U.S.C. §§ 1302, 1320a-7j, 1395w-1 through 1395w-152, and 1395hh.

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

CMS stated that the final rule was reviewed by the Office of Management and Budget.

Executive Order No. 13,132 (Federalism)

CMS stated that the final rule does not impose any substantial costs on state or local governments.