U.S. GOVERNMENT ACCOUNTABILITY OFFICE

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Washington, DC 20548

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September 27, 2013

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 Waxman
Ranking Member
Committee on Energy and Commerce
House of Representatives

The Honorable Dave Camp
Chairman
The Honorable Sander Levin
Ranking Member
Committee on Ways and Means
House of Representatives

Subject: *Department of Health and Human Services, Centers for Medicare & Medicaid Services: Medicaid Program; State Disproportionate Share Hospital Allotment Reductions*

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 Disproportionate Share Hospital Allotment Reductions" (RIN: 0938-AR31). We received the rule on September 18, 2013. It was published in the *Federal Register* as a final rule on September 18, 2013, with an effective date of November 18, 2013. 78 Fed. Reg. 57,293.

The final rule delineates a methodology to implement the annual reductions to state Medicaid Disproportionate Share Hospital (DSH) allotments for fiscal year (FY) 2014 and FY 2015. The rule also includes additional DSH reporting requirements for use in implementing the DSH health reform methodology. The Social Security Act (the Act), as amended by the Affordable Care Act, requires aggregate reductions to state Medicaid DSH allotments annually from FY 2014 through FY 2020.

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

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; STATE DISPROPORTIONATE
SHARE HOSPITAL ALLOTMENT REDUCTIONS"
(RIN: 0938-AR31)

(i) Cost-benefit analysis

Section 1923(f)(7)(B) of the Act establishes five factors that must be considered in the development of the DSH Health Reform Methodology (DHRM). CMS states that taking these five factors into account for each state, the DHRM will generate a state-specific DSH allotment reduction amount for FY 2014 and FY 2015. According to CMS, the total of all DSH allotment reduction amounts will equal the aggregate annual reduction amounts identified in the statute for FY 2014 and FY 2015. To determine the effective annual DSH allotment for each state, CMS states that the state-specific annual DSH allotment reduction amount will be applied to the unreduced DSH allotment amount for its respective state.

(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. CMS states that for purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. CMS notes that 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 $35.5 million in any 1 year, but individuals and states are not included in the definition of a small entity. As its measure of significant economic impact on a substantial number of small entities, CMS uses a change in revenue of more than 3 to 5 percent. Since states are responsible in the management of the reduced allotments, CMS cannot predict the exact impact on individual hospitals. However, CMS notes that the aggregate estimated reduction of DSH allotment reductions at the state level is generally less than 6 percent of total Medicaid DSH allotment amounts. CMS estimates that the reduction in payments resulting from the DSH allotment reductions will account for significantly less than 3 to 5 percent of total hospital revenue. Therefore, CMS does not believe that this threshold will be reached by the requirements in this final rule.

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 for Medicare payment regulations and has fewer than 100 beds. As its measure of significant economic impact on a substantial number of small entities, CMS uses a change in revenue of more than 3 to 5 percent. CMS is not preparing an analysis for section 1102(b) of the Act because it does not believe that this threshold will be reached by the requirements in the final rule.

(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 (UMRA) also 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 the final rule contains reporting requirements on states that would be $8,136.54 annually.

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

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

On May 15, 2013, CMS published a proposed rule entitled, "Medicaid Program; State Disproportionate Share Hospital Allotment Reductions." 78 Fed. Reg. 28,551. CMS states that in response to the publication of the proposed rule, it received 87 public comments from state Medicaid agencies, provider associations, providers, and other interested parties. In the final rule, CMS provided a brief summary of each proposed provision, a summary of the public comments that it received related to that proposal, and its responses to the comments.

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

Under PRA, CMS is required to provide a 60-day notice in the *Federal Register* and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. To derive average costs, CMS used data from the U.S. Bureau of Labor Statistics for all salary estimates. CMS states that the salary estimates include the cost of fringe benefits based on the December 2012 Employer Costs for Employee Compensation report by the Bureau. In its proposed rule, CMS solicited public comment on each of the section 3506(c)(2)(A)-required issues for the following information collection requirements (ICRs) to which CMS received one comment.

Beginning with each state's Medicaid state plan rate year 2005, for each Medicaid state plan rate year, CMS explains that the state must submit to CMS, at the same time as it submits the completed DSH audit required under § 455.204, the following information for each DSH hospital to which the state made a DSH payment to permit verification of the appropriateness of such payments. The ongoing burden associated with the requirements under 42 C.F.R. § 447.299 is the time and effort it would take each of the 50 state Medicaid Programs and the District of Columbia to complete the annual Medicaid DSH reporting requirements. Based on the information in this rule, CMS estimates that it will take an additional 4 hours per state (from 38 approved hours to 42 total hours) to complete the DSH reporting spreadsheets. Consequently, CMS also estimates an additional 204 (4 hr × 51 respondents) annual hours for all states and the District of Columbia and an additional aggregate cost of $8,136.54 (51 × [$51 × 2 hr] + [$28.77 × 2 hr]). According to CMS, the requirements and burden estimates will be added to the existing PRA-related requirements and burden estimates that have been approved by OMB under OCN 0938–0746 (CMS–R–266). CMS states that the revised total burden estimates equal 51 annual respondents, 51 annual responses, and 2,142 annual hours. CMS has submitted a copy of this rule to OMB for its review of the rule's information collection and recordkeeping requirements, which are not effective until approved. CMS invites public comments on the final rule's information collection requirements.

Statutory authorization for the rule

CMS states that the final rule is authorized by sections 1902(a)(13)(A)(iv) and 1923 of the Social Security Act, as amended by section 2551 of the Affordable Care Act.

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

The final rule has been designated an ''economically significant'' rule measured by the $100 million threshold, under section 3(f)(1) of Executive Order 12,866. Accordingly, CMS has prepared a Regulatory Impact Analysis (RIA) that, to the best of its ability, presents the costs and benefits of the rulemaking. In accordance with the provisions of the Order, the final regulation was reviewed by OMB.

Executive Order No. 13,132 (Federalism)

Executive Order 13,132 establishes certain requirements that an agency must meet when it issues a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on state and local governments, preempts state law, or otherwise has Federalism implications. According to CMS, since this rule does not impose any costs on state or local governments, the requirements of Executive Order 13,132 are not applicable.