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December 16, 2008

The Honorable Max Baucus
Chairman
The Honorable Charles E. Grassley
Ranking Minority Member
Committee on Finance
United States Senate

The Honorable Charles B. Rangel
Chairman
The Honorable Jim McCrery
Ranking Minority Member
Committee on Ways and Means
House of Representatives

Subject: *Department of Health and Human Services, Centers for Medicare and Medicaid Services: Medicaid Program; State Flexibility for Medicaid Benefit Packages*

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 "Medicaid Program; State Flexibility for Medicaid Benefit Packages" (RIN: 0938-AO48). We received the rule on December 3, 2008. It was published in the *Federal Register* as a final rule on December 3, 2008. 73 Fed. Reg. 73,694.

The final rule implements provisions of section 6044 of the Deficit Reduction Act of 2005 (Pub. L No. 109 – 171, 120 Stat. 4, 88 (Feb. 8, 2006)), which amends the Social Security Act by adding a new section 1937 related to the coverage of medical assistance under approved state plans. It also provides states increased flexibility under an approved state plan to define the scope of covered medical assistance by offering coverage of benchmark or benchmark-equivalent benefit packages to certain Medicaid recipients. The final rule has an effective date of February 2, 2009.

Enclosed is our assessment of the 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 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
Associate General Counsel

Enclosure

cc: Ann Stallion
Program Manager, ODRM
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 AND MEDICAID SERVICES
ENTITLED
"MEDICAID PROGRAM; STATE FLEXIBILITY FOR
MEDICAID BENEFIT PACKAGES"
(RIN: 0938-AO48)

(i) Cost-benefit analysis

CMS performed a cost-benefit analysis of the final rule. CMS projects that the use of benchmark plans under the final rule will result in $2.3 billion in federal savings from 2006 – 2010. The actual savings will depend on the number of states that implement these plans, the number of beneficiaries states cover with these plans, and the specific design and selection of benchmark plans.

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

CMS certified that the final rule would not have a significant impact on a substantial number of small entities, and, therefore, did not prepare a Final Regulatory Flexibility Analysis.

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

CMS concluded that, because the final rule does not mandate state participation in using beneficiary plans, there is no obligation for states to make any change in their Medicaid programs. For this reason, the final rule does not mandate expenditures in excess of the threshold in the Unfunded Mandates Reform Act of approximately $127 million.

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

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

The final rule was issued using the notice and comment procedures found at 5 U.S.C. § 553. CMS published a proposed rule in the *Federal Register* on February 22, 2008. 73 Fed. Reg. 9714. In response to the proposed rule, CMS received over 1,100 timely items of correspondence. The majority of the commenters represented transportation providers, medical providers, and Medicaid beneficiaries, particularly Medicaid beneficiaries who rely on dialysis treatments. Other commenters

represented state and local advocacy groups, national associations that represent various aspects of beneficiary groups, physician and provider groups, medical associations and hospitals, state Medicaid agency senior officials, and human services agencies. CMS responds to the comments in the final rule.

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

The final rule does not contain new information collection requirements subject to review by the Office of Management and Budget (OMB) under the Act.

Statutory authorization for the rule

The final rule implements provisions of sections 6044 of the Deficit Reduction Act of 2005, Pub. L No. 109 – 171, 120 Stat. 4, 88 (Feb. 8, 2006).

Executive Order No. 12,866

The final rule was reviewed by OMB and found to be an "economically significant" regulatory action under the Order.

Executive Order No. 13,132 (Federalism)

CMS determined that the final rule would not impose direct requirement costs on states or local governments or preempt state law. CMS noted that the final rule will provide states the option to implement alternative Medicaid benefits through a Medicaid state plan amendment.