



[Billing Code: 4120-01-P]

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 447

[CMS-2413-P]

RIN 0938-AT61

Medicaid Program; Reassignment of Medicaid Provider Claims

AGENCIES: Centers for Medicare & Medicaid Services, Department of Health and Human Services.

ACTION: Proposed rule.

SUMMARY: This proposed rule would remove the regulatory text that allows a state to make payments to third parties on behalf of an individual provider for benefits such as health insurance, skills training, and other benefits customary for employees. We are concerned that these provisions are overbroad, and insufficiently linked to the exceptions expressly permitted by the statute. As we noted in our prior rulemaking, section 1902(a)(32) of the Act provides for a number of exceptions to the direct payment requirement, but it does not authorize the agency to create new exceptions.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on [Insert date 30 days after date of publication in the **Federal Register**].

ADDRESSES: In commenting, please refer to file code CMS-2413-P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

Comments, including mass comment submissions, must be submitted in one of the following three ways (please choose only one of the ways listed):

1. Electronically. You may submit electronic comments on this regulation to <http://www.regulations.gov>. Follow the “Submit a comment” instructions.
2. By regular mail. You may mail written comments to the following address ONLY:
Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS-2413-P,
P.O. Box 8016,
Baltimore, MD 21244-8016.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. By express or overnight mail. You may send written comments to the following address ONLY:
Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS-2413-P,
Mail Stop C4-26-05,
7500 Security Boulevard,
Baltimore, MD 21244-1850.

FOR FURTHER INFORMATION CONTACT:

Christopher Thompson, (410) 786 -4044.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential

business information that is included in a comment. We post all comments received before the close of the comment period on the following Web site as soon as possible after they have been received: <http://www.regulations.gov>. Follow the search instructions on that Web site to view public comments.

I. Background

The Medicaid program was established by the Congress in 1965 to provide health care services for low-income and disabled beneficiaries. Section 1902(a)(32) of the Social Security Act (the Act) requires direct payment to providers who render services to Medicaid beneficiaries. It states that no payment under the plan for care and services provided to an individual shall be made to anyone other than such individual or the person or institution providing such care or service, under an assignment or power of attorney or otherwise.

We codified §447.10 implementing section 1902(a)(32) of the Act in the “Payment for Services” final rule published on September 29, 1978 (43 FR 45253). The statute provides several specific exceptions to the general principle of requiring that direct payment be made to the individual provider. The regulations implementing section 1902(a)(32) of the Act have generally tracked the plain statutory language and required direct payments absent a statutory exception.

In 2012, we proposed a new regulatory exception in the “Provider Payment Reassignment, and Setting Requirements for Community First Choice” proposed rule published on May 3, 2012 (77 FR 26361, 26406) for “a class of practitioners for which the Medicaid program is the primary source of service revenue” such as home health care providers. We recognized in the preamble to the proposed rule that section 1902(a)(32) of the Act does not authorize additional exceptions to the direct payment requirement (*See* 77 FR 26382).

We received a total of 7 comments on the proposed regulatory exception, all generally supportive of the proposed rule. This provision was finalized in the “Provider Payment Reassignment, and Home and Community-Based Setting Requirements for Community First Choice and Home and Community-Based Services (HCBS) Waivers” final rule published on January 16, 2014 (79 FR 2947, 3001) and authorized a state to make payments to third parties on behalf of the individual provider “for benefits such as health insurance, skills training, and other benefits customary for employees.”

We are concerned that §447.10(g)(4) is overbroad, and insufficiently linked to the exceptions expressly permitted by the statute. As we noted in our prior rulemaking, section 1902(a)(32) of the Act provides for a number of exceptions to the direct payment requirement, but it does not authorize the agency to create new exceptions. Therefore, the regulatory provision grants permissions that Congress has foreclosed, so we are proposing to remove the regulatory exception at §447.10(g)(4).

II. Provisions of the Proposed Regulations

This proposal would remove §447.10(g)(4), but leave in place the other provisions in §447.10 including the exceptions at §447.10(e), (f) and (g)(1) through (3). We seek comments regarding how we might provide further clarification on the types of payment arrangements that would be permissible assignments of Medicaid payments, such as arrangements where a state government withholds payments under a valid assignment. Specifically, we invite comments with examples of payment withholding arrangements between states and providers that we should address.

With regard to section 1915(c), 1915(i), 1915(j), and 1915(k) authority, this proposed rule will not impact a state’s ability to perform Financial Management Services (FMS) or secure

FMS through a vendor arrangement. However, we also request comments on whether and how the proposed removal of §447.10(g)(4) would impact self-directed service models, where the Medicaid beneficiary takes responsibility for retaining and managing his or her own services, and, in some cases, may be performing payroll and other employer-related duties. We are especially interested in comments that describe the additional flexibilities needed to support beneficiaries opting for self-directed service models, which may ensure stable, high-quality care for those beneficiaries.

III. Collection of Information Requirements

To the extent a state changes its payment as a result of this rule, the state would be required to notify entities of the pending change in payment and update its payment system. We believe the associated burden is exempt from the Paperwork Reduction Act (PRA) in accordance with 5 CFR 1320.3(b)(2). We believe that the time, effort, and financial resources necessary to comply with the aforementioned requirement would be incurred by the state during the normal course of their activities and, therefore, should be considered usual and customary business practices.

IV. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the “DATES” section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

V. Regulatory Impact Analysis

A. Statement of Need

We are concerned that §447.10(g)(4) is overbroad, and insufficiently linked to the exceptions expressly permitted by the statute. Therefore, the regulatory provision grants permissions that Congress has foreclosed. As we noted in our prior rulemaking published on January 16, 2014 (79 FR 2947, 3001), section 1902(a)(32) of the Act provides for a number of exceptions to the direct payment requirement, but the language does not explicitly authorize the agency to create new exceptions. Therefore, we are proposing to remove the regulatory exception at §447.10(g)(4). To the extent a state increased reimbursement levels to reassign portions of a provider's reimbursement to a third party, implementation of this rule may affect the rates that are set by the state in the future.

B. Overall Impact

We have examined the impacts of this proposed rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96-354), section 1102(b) of the Act, section 202 of the Unfunded Mandates Reform Act of 1995 (March 22, 1995; Pub. L. 104-4), Executive Order 13132 on Federalism (August 4, 1999), and the Congressional Review Act (5 U.S.C. 804(2)).

Executive Orders 12866 and 13563 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). Section 3(f) of Executive Order 12866 defines a “significant regulatory action” as an action that is likely to result in a rule that may: (1) Have an annual effect on the economy of \$100 million or more in any 1 year, or adversely and materially affecting a sector of the economy, productivity, competition, jobs, the environment, public health

or safety, or state, local or tribal governments or communities (also referred to as “economically significant”); (2) create a serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially alter the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raise novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in the Executive Order.

A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects (\$100 million or more in any 1 year). We estimate that this proposed rule could be “economically significant” as it may have an annual effect on the economy in excess of the \$100 million threshold of Executive Order 12866, and hence that this proposed rule is also a major rule under the Congressional Review Act. However there is considerable uncertainty around this estimate and the Department invites public comments to help refine this analysis.

As discussed above, in the “Provider Payment Reassignment, and Home and Community-Based Setting Requirements for Community First Choice and Home and Community-Based Services (HCBS) Waivers” final rule published on January 16, 2014 (79 FR 2947, 3001), we authorized a state to make payments to third parties on behalf of the individual provider “for benefits such as health insurance, skills training, and other benefits customary for employees.” We lack information with which to quantify the potential impacts of this policy on these types of payments as the Department does not formally track the amount of reimbursement that is being reassigned to third parties by states. To offer one example, one such potential impact of the proposed rulemaking would be that states stop reassigning homecare workers’ dues to unions. We estimate that unions may currently collect as much as \$71 million from such

assignments.¹ While we have not similarly quantified the amount of other authorized reassignments, such as health insurance, skills training, or other benefits, we believe that the amount of payments made to third parties on behalf of individual providers for the variety of benefits within the scope of this rulemaking is likely in excess of \$100 million. We seek comment on this estimate, and particularly on the type and amount of payments currently being reassigned under the exceptions in §447.10(g).

The potential direct financial impact to providers of this policy change could be affected by many factors, such as the nature and amounts of the types of payments currently being reassigned and decisions made by homecare providers after a final policy takes effect about whether or not to resume payments to third parties for these types of benefits. The Department is unable to quantify these direct financial impacts in the absence of specific information about the types and amount of payments being reassigned. Even where it may be possible to derive such estimates, such as with the example of union dues, the Department lacks information to reliably estimate the proportion of homecare providers likely to stop making payments versus those likely to continue making payments through alternative means. We request comments on the factors that might influence the direct financial impacts to providers and recipients of

¹ Dues payments potentially associated with policies of the type being proposed for revision have been reported to be \$8 million in Pennsylvania and \$10 million in Illinois (<https://www.fairnesscenter.org/cases/detail/protecting-the-vulnerable> and <https://www.washingtonexaminer.com/illinois-politicians-forced-home-care-workers-into-union-that-donates-heavily-to-them/article/2547368>). The total population is approximately 26 million in these two states and 102 million across the states that have been reported by the State Policy Network to have relevant third-party payment policies (California, Connecticut, Illinois, Maryland, Massachusetts, Minnesota, Missouri, New Jersey, Oregon, Vermont and Washington) (<https://www2.census.gov/programs-surveys/popest/tables/2010-2017/state/totals/nst-est2017-01.xlsx> and <https://spn.org/dues-skimming-faqs/>). Factoring the \$18 million (= \$8 million + \$10 million) proportionately by population yields a nationwide total of approximately \$71 million in union dues payments potentially affected by this proposed rule. This transfer estimate could be over- or understated if other states pay home care workers different average wages than Pennsylvania and Illinois, if dues payments are collected at different rates, or if participation in Medicaid home care programs is not proportionate to total population.

reassignments of this policy change for the varied types and amount of payments currently being reassigned under the exceptions in §447.10(g).

Although states will no longer be able to withhold portions of a provider's payment, states may elect to maintain the same level of payment, thus affording the provider the opportunity to purchase the items that were previously funded through the reassignment of reimbursement. Conversely, states may elect to decrease payment levels because rescission of §447.10(g)(4) will limit their ability to reassign payment to third parties. In other words, states may have previously factored their ability to reassign provider payments into their payment rates and might choose to revise their rates in response to this regulatory change. We request comments, particularly from states, on potential state behavior under the proposed policy.

If a state elected to maintain the same level of payment, and if homecare providers opt to continue all voluntary payments presently being reassigned, then the rule may have no impacts. However, if a state elected to reduce payment levels and/or if homecare providers opt to discontinue all voluntary payments, then the impacts of the rule may be close to the full amount of current reassignments, thus making the rule economically significant.

While it is difficult for us to conduct a detailed quantitative analysis given this considerable uncertainty and lack of data, we believe that without this proposed rulemaking, states may apply the exceptions at §447.10(g) in ways that do not comport with section 1902(a)(32) of the Act and we welcome comment with regard to the quantitative impact of the elimination of states' ability to reassign Medicaid payment for items such as health insurance, skills training and other benefits customary for employees. We also seek comments identifying impacts to states and the federal government as a result of this proposed rule, including on the assumption that the time, effort and financial resources necessary to comply with the proposed

requirement would be incurred by states during the normal course of their activities and, therefore, does not impose incremental costs.

C. Anticipated Effects

The RFA requires agencies to analyze options for regulatory relief of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of less than \$7.5 million to \$38.5 million in any 1 year. Individuals and states are not included in the definition of a small entity. We are not preparing an analysis for the RFA because we have determined, and the Secretary proposes to certify, that this proposed rule would not have a significant economic impact on a substantial number of small entities.

In addition, section 1102(b) of the Act requires us to prepare an RIA 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 603 of the RFA. For purposes of section 1102(b) of the Act, we define 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. We are not preparing an analysis for section 1102(b) of the Act because we have determined, and the Secretary proposes to certify, that this proposed rule would not have a significant impact on the operations of a substantial number of small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 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 2018, that

threshold is approximately \$150 million. This rule will have no consequential effect on state, local, or tribal governments or on the private sector.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates 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. Since this regulation does not impose any costs on state or local governments, the requirements of Executive Order 13132 are not applicable.

D. Alternatives Considered

We considered issuing guidance to require states to formally document consent to reassign portions of a provider’s payment. We also considered limiting the items for which provider reassignment could be made. However, we are concerned that §447.10(g)(4)) is overbroad, and insufficiently linked to the exceptions expressly permitted by the statute. Therefore, we believe removing the regulatory exception is the best course of action.

E. Accounting Statement

As required by OMB Circular A–4 under Executive Order 12866 (available at <https://www.whitehouse.gov/sites/whitehouse.gov/files/omb/circulars/A4/a-4.pdf>) in Table 1, we have prepared an accounting statement showing the classification of transfers associated with the provisions in this proposed rule. The accounting statement is based on estimates provided in this regulatory impact analysis and omits categories of impacts for which partial quantification has not been possible.

TABLE 1: Accounting Statement

| Category | Low Estimate | High Estimate | Units | | |
|------------------|--------------|---------------|--------------|---------------|----------------|
| | | | Year Dollars | Discount Rate | Period Covered |
| Transfers | | | | | |

| | | | | | |
|---------------------------------------|---|------|------|----|------|
| Annualized Monetized \$ millions/year | 0 | \$71 | 2017 | 3% | 2019 |
| | 0 | \$71 | 2017 | 7% | 2019 |
| From whom to whom? | From third parties to home health providers | | | | |

F. Regulatory Reform Analysis under EO 13771

Executive Order 13771, entitled “Reducing Regulation and Controlling Regulatory Costs,” was issued on January 30, 2017 and requires that the costs associated with significant new regulations “shall, to the extent permitted by law, be offset by the elimination of existing costs associated with at least two prior regulations.” This proposed rule is not expected to be subject to the requirements of EO 13771 because this proposed rule is expected to result in no more than *de minimis* costs.

G. Conclusion

In accordance with the provisions of Executive Order 12866, this proposed rule was reviewed by the Office of Management and Budget.

List of Subjects in 42 CFR Part 447

Accounting, Administrative practice and procedure, Drugs, Grant programs-health, Health facilities, Health professions, Medicaid, Reporting and recordkeeping requirements, Rural areas.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services proposes to amend 42 CFR chapter IV as set forth below:

PART 447— PAYMENTS FOR SERVICES

1. The authority citation for part 447 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

§447.10 [Amended]

2. Section 447.10 is amended by removing paragraph (g)(4).

CMS-2413-P

Dated: May 3, 2018.

Seema Verma,

Administrator,

Centers for Medicare & Medicaid Services.

Dated: May 7, 2018.

Alex M. Azar II,

Secretary,

Department of Health and Human Services.

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