



## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Centers for Medicare & Medicaid Services

#### 42 CFR Part 447

[CMS-2444-P]

RIN 0938-AU73

#### Medicaid Program; Reassignment of Medicaid Provider Claims

**AGENCY:** Centers for Medicare & Medicaid Services (CMS), HHS.

**ACTION:** Proposed rule.

**SUMMARY:** This proposed rule would reinterpret the scope of the general requirement that state payments for Medicaid services under a state plan must be made directly to the individual practitioner providing services, in the case of a class of practitioners for which the Medicaid program is the primary source of revenue. Specifically, this proposal, if finalized, would explicitly authorize states to make payments to third parties to benefit individual practitioners by ensuring health and welfare benefits, training, and other benefits customary for employees, if the practitioner consents to such payments to third parties on the practitioner's behalf.

**DATES:** To be assured consideration, comments must be received at one of the addresses provided below, by September 28, 2021.

**ADDRESSES:** In commenting, please refer to file code CMS-2444-P. 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–2444–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–2444–P,  
Mail Stop C4–26–05,  
7500 Security Boulevard,  
Baltimore, MD 21244–1850.

For information on viewing public comments, see the beginning of the “SUPPLEMENTARY INFORMATION” section.

**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 website as soon as possible after they have been received: <http://www.regulations.gov>. Follow the search instructions on that website to view public comments. CMS will not post on Regulations.gov public comments that make threats to individuals or institutions or suggest that the individual will take actions to harm the individual. CMS continues to encourage individuals not to submit duplicative comments. We will post

acceptable comments from multiple unique commenters even if the content is identical or nearly identical to other comments.

## **I. Background**

### A. Prohibition on Payment Reassignment

The Medicaid program was established by 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) imposes certain requirements on how states may make payments for services furnished to Medicaid beneficiaries. Section 1902(a)(32) of the Act provides that generally no payment under the plan for any care or service 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, power of attorney, or otherwise. This prohibition is followed by four enumerated exceptions. On September 29, 1978, CMS codified these exceptions under 42 CFR 447.10, the regulations implementing section 1902(a)(32) of the Act, in the “Payment for Services” final rule (43 FR 45253). The 1978 final rule simply reorganized and redesignated existing Medicaid regulations at § 449.31. Since the 1990s, we have mostly understood this provision as governing only assignments and other similar Medicaid reimbursement arrangements.

Consistent with this understanding, from 2012 to 2014, we engaged in rulemaking to make it explicit that section 1902(a)(32) of the Act did not apply to certain payments made by the state Medicaid program on behalf and for the benefit of individual Medicaid practitioners whose primary source of revenue is the state Medicaid program. We finalized this regulation in the “State Plan Home and Community Based Services, 5-Year for Waivers, 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 in the January 16, 2014 **Federal Register** (79 FR 2948 through 2949, 3001 through 3003, and 3039) (hereinafter referred to as the “2014 final rule”). In that rulemaking, we reasoned that this policy was permitted by the statute because the apparent purpose of section 1902(a)(32) of the Act was

to prohibit factoring arrangements, the practice by which providers sold reimbursement claims for a percentage of their value to companies that would then submit the claims to the state. The purpose was not to preclude a Medicaid program that is functioning as the practitioner's primary source of revenue from fulfilling the basic employer-like responsibilities that are associated with that role, a scenario that was not contemplated by section 1902(a)(32) of the Act and was outside of the intended scope of the statutory prohibition.

This policy was codified as a regulatory exception under § 447.10(g)(4) to permit withholding from the payment due to the individual practitioner for amounts paid by the state directly to third parties for health and welfare benefits, training costs and other benefits customary for employees. In an August 3, 2016 Center for Medicaid and CHIP Services (CMCS) Informational Bulletin (CIB), we outlined suggested approaches for strengthening and stabilizing the Medicaid home care workforce, including by supporting home care worker training and development. We noted that under § 447.10(g)(4), state Medicaid agencies could facilitate this goal by, with the consent of the individual practitioner, making payment on behalf of the practitioner to a third party that provides benefits to the workforce such as health insurance, skills training, and other benefits customary for employees.<sup>1</sup>

#### B. Current Medicaid Payment Assignment Regulations

Medicaid regulations at § 447.10 implement the requirements of section 1902(a)(32) of the Act by providing that state plans can allow payments to be made only to certain individuals or entities. Specifically, payment may only be made to the individual practitioner that provided the service (provider) or the recipient (beneficiary), if he or she is a non-cash recipient eligible to receive payment under § 447.25, or under one of the limited exceptions. The regulations specifically state that payment for any service furnished to a recipient by a provider may not be made to or through a factor, either directly or by power of attorney.

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<sup>1</sup> <https://www.medicaid.gov/federal-policy-guidance/downloads/cib080316.pdf>.

The exceptions to the general direct payment principle at § 447.10 generally mirror those enumerated in the statute. They include payment in accordance with a reassignment to a government agency, or pursuant to a court order. There are also exceptions permitting payments to third parties for services furnished by individual practitioners where certain employment or contractual conditions are met. Additionally, there is another exception for payment to a business agent, such as a billing service or accounting firm, that furnishes statements and receives payments in the name of the individual practitioner, if the business agent's compensation for this service is related to the cost of processing the billing, and not dependent on the collection of the payment.

In 2018 and 2019, in a departure from our prior interpretation of this statute, we engaged in rulemaking to interpret the statutory prohibition as applying more broadly to prohibit any type of Medicaid payment to a third party other than the four exceptions enumerated in the statute. In so doing, we interpreted the statutory phrase “or otherwise” as encompassing any and all Medicaid reimbursement payment arrangements involving third parties. We proposed this broad interpretation of the statutory language in the “Reassignment of Medicaid Provider Claims” proposed rule in the July 12, 2018 **Federal Register** (83 FR 32252 through 32255) and finalized in “Reassignment of Medicaid Provider Claims” final rule in the May 6, 2019 **Federal Register** (84 FR 19718 through 19728) (hereinafter referred to as the “2019 final rule”). This rulemaking eliminated the regulatory exception added by the 2014 final rule.

### C. *California v. Azar*

Six states and 11 intervenors challenged the 2019 final rule. In *California v. Azar*, 501 F. Supp. 3d 830 (N.D. Cal. 2020), the district court rejected the Department of Health and Human Services' (HHS') arguments that section 1902(a)(32) of the Act expressly prohibited the agency's previous interpretation of section 1902(a)(32) and states' related practices, remanded the case to HHS for further proceedings, and vacated the 2019 final rule. Secretary Azar then

appealed to the U.S. Court of Appeals for the Ninth Circuit in *California v. Becerra*, No. 21-15091 (9<sup>th</sup> Cir.).

#### D. Individual Practitioner Workforce Stability and Development Concerns

Since the direct payment principle was originally enacted in statute in 1972 and expanded in 1977, the definition of medical assistance under section 1905(a) of the Act has been changed to permit states to offer coverage of categories of practitioner services, such as personal care services, that may be viewed as unique to the Medicaid program. For these practitioners, who often provide services independently, rather than as employees of a service provider, the Medicaid program may be their primary, or only, source of payment. Some states have sought methods to improve and stabilize the workforce by offering health and welfare benefits to such practitioners, and by requiring that such practitioners pursue periodic training.

Within Medicaid, long-term support services (LTSS) expenditures are shifting from institutional care (hospitals, nursing facilities, etc.) to HCBS. In FY 2013, HCBS LTSS expenditures reached 51 percent of total Medicaid LTSS expenditures and have generally increased to 56.1 percent in FY 2018. HCBS represented a majority of LTSS expenditures in 29 states, including the District of Columbia, and over 75 percent of expenditures in five states in FY 2018.

Several states have requested that CMS adopt additional exceptions to the direct payment policy to permit a state to withhold from a payment due to the individual practitioner for amounts that the practitioner is obligated to pay for health and welfare benefits, training costs, and other benefits customary for employees. These amounts would not be retained by the state, but would be paid to third parties on behalf of the practitioner for the stated purpose. We recognize that HCBS workforce issues, such as workforce shortages and staff turnover, have a direct and immediate impact on the quality of and access to services available to beneficiaries, and believe

that state Medicaid agencies play a key role in influencing the stability of the workforce by determining wages and benefits, and provider reimbursement.<sup>2</sup>

## **II. Provisions of the Proposed Rule**

### A. Prohibition Against Reassignment of Provider Claims (§ 447.10)

Under title XIX of the Act, state Medicaid programs generally pay for Medicaid-covered practitioner services through direct payments to the treating practitioners. States may develop state plan payment rates that include considerations for costs related to health and welfare benefits, training, and other benefits customary for employees. However, consistent with our previous interpretation of the statutory provision at section 1902(a)(32) of the Act, and reflected in regulations at § 447.10 under the 2019 final rule, the entire rate must be paid to the individual practitioner who provided the service, unless certain exceptions apply.

Following the district court's decision in *California v. Azar*, we examined the statutory language and legislative history, and now conclude that the prohibition in section 1902(a)(32) of the Act is better read to be limited in its applicability to Medicaid payments to a third party pursuant to an assignment, power of attorney, or other similar arrangement. In other words, the statutory prohibition is better viewed as an anti-reassignment provision that only governs assignment-like payment arrangements. We do not believe this provision should be interpreted as a broad prohibition on any and all types of Medicaid payment arrangements beyond those provided directly to Medicaid beneficiaries and providers or enumerated in the statutory exceptions. As such, we propose to amend § 447.10 to add a new paragraph (i), which would incorporate similar language from paragraph (g)(4) as a new provision describing who may receive payment, rather than as an exception to the statutory prohibition in section 1902(a)(32) of the Act.

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<sup>2</sup> <https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltss-rebalancing-toolkit.pdf>.

Specifically, § 447.10(i) would specify that the payment prohibition in section 1902(a)(32) of the Act and § 447.10(d) does not apply to payments to a third party on behalf of an individual practitioner for benefits such as health insurance, skills training, and other benefits customary for employees, in the case of a class of practitioners for which the Medicaid program is the primary source of revenue.<sup>3</sup>

The text of the statute addresses only assignments and related payment arrangements wherein a provider's right to claim and/or receive full payment for services furnished to Medicaid beneficiaries is transferred to a third party. The statute includes examples of the types of payment arrangements intended to be prohibited, "under an assignment or power of attorney or otherwise." The general term "or otherwise" is listed following two specific and related phrases. Statutory interpretation principles suggest that when general words follow specific words in a statutory enumeration, "the general words are construed to embrace only objects similar in nature to those objects enumerated by the preceding specific words." Sutherland Statutory Construction §47:17; *Circuit City Stores, Inc. v. Adams*, 532 U.S. 105 (2001). Accordingly, the language "or otherwise" is best read as referencing payments made under arrangements that are similar to an "assignment" and a "power of attorney" such that the reach of the prohibition under section 1902(a)(32) of the Act does not extend to payment arrangements that are wholly distinct from such types of arrangements. Consistent with this interpretation, we are also proposing to amend § 447.10(a) to include the phrase "under an assignment or power of attorney or a similar arrangement." This change aligns the regulation with the applicable statutory language and our reading of that language, and creates a consistent framework for proposed new paragraph (i).

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<sup>3</sup> We note that, to the extent state agencies utilize this option to deduct union dues, union dues may only be deducted from Medicaid payments with the affirmative consent of the practitioner; to do otherwise would be in violation of the First Amendment. *See Janus v. Am. Fed'n of State, Cty., and Mun. Emps., Council 31*, 138 S.Ct. 2448, 2486 (2018) ("Neither an agency fee nor any other payment to the union may be deducted from a nonmember's wages, nor may any other attempt be made to collect such a payment, unless the employee affirmatively consents to pay.").



Black’s Law Dictionary defines “assignment” in relevant part as “[t]he transfer of rights or property,” and “power of attorney” as “[a]n instrument granting someone authority to act as agent or attorney-in-fact for the grantor.”<sup>4</sup> Thus, the inclusion of these examples of the types of arrangements intended to be prohibited under section 1902(a)(32) of the Act supports the conclusion that the statute was intended to address scenarios where the right to a provider’s Medicaid receivables or the right to submit claims on behalf of the provider are transferred to a third party.

Moreover, the introductory language in section 1902(a)(32) of the Act specifies that no payment under the plan for any care or service furnished to an individual shall be made to anyone other than such individual or the person or institution providing such care or service. This prohibition applies only to payments “for any care or service,” which we interpret to prohibit full diversion of the right to claim and/or receive such payments to third parties absent an exception, but not to apply to partial deductions from payments at the request or with the consent of the provider, in order to make payments to third parties on behalf of the provider.

An examination of the statutory exceptions to the general prohibition also supports the conclusion that the prohibition under section 1902(a)(32) of the Act does not extend to payment arrangements that are outside the category of payments with assignments or assignment-like arrangements. The excepted arrangements or transactions are all similar to assignments in that they involve third parties submitting claims directly to the state Medicaid agency for reimbursement or having the right to receive the full amount of all payments due to the provider for services furnished to Medicaid beneficiaries. More specifically, section 1902(a)(32) of the Act contains several specific exceptions to the general principle of direct payment to individual practitioners. There are exceptions for payments for practitioner services where payment is made

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<sup>4</sup> See Black’s Law Dictionary (11th ed. 2019); see also Merriam Webster, available at <https://www.merriam-webster.com/dictionary/assignment> (defining the term “assignment” in the “law” as “the transfer of property”); Merriam Webster, available at <https://www.merriam-webster.com/dictionary/power%20of%20attorney> (defining the term “power of attorney” as “a legal instrument authorizing one to act as the attorney or agent of the grantor”).

to the employer of the practitioner, and the practitioner is required as a condition of employment to turn over fees to the employer; payments for practitioner services furnished in a facility when there is a contractual arrangement under which the facility bills on behalf of the practitioner; reassignments to a governmental agency, through a court order, or to a billing agent; payments to a practitioner whose patients were temporarily served by another identified practitioner; and payments for a childhood vaccine administered before October 1, 1994. While these exceptions may appear to be largely unrelated, they all involve payment arrangements where third parties are submitting claims to the Medicaid agency and/or where the right to receive all of the payments due to a provider for services furnished to Medicaid beneficiaries is transferred to a third party.

The fact that the only types of transactions that are explicitly excepted by the statute are assignment-like transactions that involve the transfer to a third party of either a provider's right to submit claims directly to the state and/or to receive all payments otherwise due a provider for services furnished supports our proposed interpretation that the scope of the statutory prohibition extends only to payments to a third party that involve similar types of arrangements. By contrast, partial deductions from Medicaid payments requested by a provider in order to make separate payment to a third party on behalf of the provider for benefits customary for employees does not involve third parties receiving direct payment from the state for care or services provided to Medicaid beneficiaries. Nor does this arrangement allow such third parties to pursue independent claims against the state for Medicaid reimbursement.

The legislative history of section 1902(a)(32) of the Act supports our conclusion that the statutory text is best read as an anti-assignment prohibition. When Congress adopted the original version of this statute in 1972, it was focused on the practice of factoring—a practice which often led to the submission of inflated or false claims, raising concerns that the factoring industry

was a breeding ground for Medicaid fraud.<sup>5</sup> When Congress amended this provision in 1977, it reiterated that it understood the provision simply as a response to and an attempt to prevent factoring. Indeed, in 1977, Congress amended the anti-reassignment provision to close what it perceived to be a loophole that factoring companies were exploiting.<sup>6</sup> This legislative history supports our proposed interpretation of the statutory prohibition as extending only to assignments and assignment-like arrangements that involve a potential for the type of abuse that the statute was intended to prevent.

With respect to classes of practitioners for whom the state's Medicaid program is the only or primary payer, the ability of the state to ensure a stable and qualified workforce may be adversely affected by the inability to deduct from Medicaid payments at the request or with the consent of a provider in order to make separate payment to a third party on behalf of the provider. Deductions for these purposes are an efficient and effective method for ensuring that the workforce has provisions for basic needs and is adequately trained for their functions, thus ensuring that beneficiaries have greater access to such practitioners and higher quality services. Requiring practitioner consent for such deductions ensures Medicaid provider payments are treated appropriately, and in a manner consistent with the wishes of the practitioner, for purposes of receiving benefits such as health insurance, skills training, and other benefits customary for employees.

Although we propose that these deduction practices fall outside the scope of what the statute prohibits, we consider it important to document the flexibility in regulation to ensure confidence in the provider community, particularly for front line workers during the Coronavirus Disease 2019 (COVID-19) pandemic. Within broad federal Medicaid law and regulation, CMS

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<sup>5</sup> See, for example, H.R. REP. NO. 92-231, at 104 (1972), reprinted in 1972 U.S.C.C.A.N. 4989, 5090; H.R. REP. NO. 92-231, at 205, reprinted in 1972 U.S.C.C.A.N. at 5090; S. REP. NO. 92-1230, at 204 S. REP. NO. 92-1230, at 204 (1972); *Professional Factoring Service Association v. Mathews*, 422 F. Supp. 250, 251-52 (S.D.N.Y. 1976).

<sup>6</sup> See, for example, H. REP. NO. 95-393(II), at 43, reprinted in 1977 U.S.C.C.A.N. at 3045; H. REP. NO. 95-393(II), at 46, reprinted in 1977 U.S.C.C.A.N. at 3048; H. REP. NO. 95-393(II), at 48-49 (1977), reprinted in 1977 U.S.C.C.A.N. 3039, 3051; S. REP. NO. 95-453, at 6-8 (1977).

has long sought to ensure maximum state flexibility to design state-specific payment methodologies that help ensure a strong, committed, and well-trained work force. Currently, certain categories of Medicaid covered services, for which Medicaid is a primary payer, such as home and personal care services, suffer from especially high rates of turnover and low levels of participation in Medicaid which negatively impact access to and quality of providers available to Medicaid beneficiaries<sup>7</sup>. These issues often result in higher rates of institutional stays for beneficiaries. This proposed rule would support previous CMS efforts to strengthen the home care workforce by specifying what actions are permitted, to help foster a stable and high-performing workforce.<sup>8</sup> Under our proposed amendment to § 447.10, state Medicaid programs would be permitted, as authorized under state law and with the consent of the individual practitioner, to deduct from the practitioner's reimbursement in order to pay third parties for health and welfare benefit contributions, training costs, and other benefits customary for employees.

In late 2017, we requested input from states indicating whether they had implemented the types of payment arrangements permitted under § 447.10(g)(4) after publication of the 2014 final rule. Of the states that voluntarily responded to CMS, we found that some states had entered into third party payment arrangements on behalf of individual practitioners, while others had not. This input is the most current state stakeholder feedback we have; therefore, we anticipate the impact of such payment arrangements to be positive for both states and practitioners. For states, the third-party payment arrangements authorized by this proposed rule would be optional and if a state chooses to implement them, then states can use existing administrative processes to make deductions, with consent of the individual practitioner, from a practitioner's Medicaid reimbursement for benefits. For practitioners, this proposed rule will enhance the ability of the

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<sup>7</sup> Kim J. (2020). Occupational Credentials and Job Qualities of Direct Care Workers: Implications for Labor Shortages. *Journal of labor research*, 1–18. Advance online publication. <https://doi.org/10.1007/s12122-020-09312-5>.

<sup>8</sup> <https://www.medicaid.gov/federal-policy-guidance/downloads/cib080316.pdf>.

practitioners, regardless of their employment arrangement, to perform their functions as health care professionals, and thus, support beneficiary access to quality home health care. The Medicaid program, at both the state and federal levels, has a strong interest in ensuring the development and maintenance of a committed, well-trained workforce.

With the majority of LTSS expenditures spent on HCBS, rather than institutional services, the importance of a strong home care workforce in Medicaid cannot be understated. Under section 9817 of the American Rescue Plan, we continue to reinforce the importance of HCBS in Medicaid and during the COVID-19 pandemic by providing a temporary 10 percentage point increase to the federal medical assistance percentage for certain HCBS delivered by home care providers, as these services are crucial to some of the most vulnerable individuals in our country. The proposed rule would help protect the economic security for home care providers. The ability of home care providers to choose how deductions are made is critically important to improvements in workforce standards. Moreover, since the majority of home health care workers are women and people of color,<sup>9</sup> permitting this type of payment arrangement will directly benefit those populations and address inequities.

Further, the increasing shortage of home care providers due to high turnover, low participation in Medicaid, low wages, and lack of benefits and training has significantly reduced access to home health care services for older adults and people with disabilities. State Medicaid agencies can play a key role in increasing such access by improving workforce stability of these practitioners by addressing training, wages and benefits, and provider reimbursement.<sup>10</sup> Under this proposed rule, state Medicaid agencies would be authorized to deduct from a practitioner's Medicaid payment, with the consent of the individual practitioner, in order to pay a third party on behalf of the individual practitioner for benefits that provide the workforce with freedom to

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<sup>9</sup> <https://www.kff.org/coronavirus-covid-19/event/march-30-web-event-unsung-heroes-the-crucial-role-and-tenuous-circumstances-of-home-health-aides-during-the-pandemic/>.

<sup>10</sup> <https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltss-rebalancing-toolkit.pdf>.

advocate for higher wages and career advancement, access necessary trainings, and options for other customary employee benefits.

States typically have an established administrative process for their own employees' deductions for benefits that can also be applied to classes of practitioners for whom Medicaid is the only or primary payer. Additionally, state Medicaid agencies often act as employers without a formal relationship to classes of practitioners for whom Medicaid is the only or primary payer, such as home care providers or personal care assistants. Using the state's established administrative processes to deduct funds to pay third parties on behalf of the practitioner, with the consent of the individual practitioner, may simplify administrative functions and program operations for the state and provide advantages to practitioners. For example, a practitioner could receive continuous health care coverage because the state automatically deducts funds for health insurance premiums on behalf of the practitioner. Providing state Medicaid agencies with the authority to make deductions from Medicaid reimbursements, with the consent of the individual practitioner, in order to make payments to a third party on behalf of the individual practitioner for benefits such as health insurance, skills training and other benefits customary for employees will ensure many of the country's most vulnerable workers, who care for the country's most vulnerable individuals, retain benefits which help them support themselves and their families.

We note that this proposed rule would not authorize a state to claim as a separate expenditure under its approved Medicaid state plan, amounts that are deducted from payments to individual practitioners (that is, health and welfare benefit contributions, training, and similar benefits customary for employees). Under the proposed rule, should a state wish to recognize such costs, they would need to be included as part of the rate paid for the service in order to be eligible for federal financial participation. No federal financial participation would be available for such amounts apart from the federal match available for a rate paid by the state for the medical assistance service. These costs also could not be claimed by the Medicaid agency

separately as an administrative expense. As a result, this proposed rule would have little to no impact on federal Medicaid funding levels.

As discussed in the January 16, 2014 final rule (79 FR 2947, 3039), the policies proposed within this rule would not require any change in state funding to the extent that practitioner rates have already factored in the cost of benefits, skills training, and other benefits customary for employees. This rule would simply ensure flexibility for states to pay for such costs directly on behalf of practitioners and ensure uniform access to benefits, such as health insurance, skills training and other benefits customary for employees. Indeed, should this proposed rule be finalized, there may be cost savings resulting from the collective purchase of such benefits and greater workforce stability.

We are specifically soliciting public comments on the extent to which the proposed payment arrangements would benefit states and practitioners, particularly if and how practitioner's access to benefits would be impacted, as well as any adverse impacts that may have not been anticipated. Additionally, we are seeking comments on other permissible actions based on our proposed statutory interpretation that might similarly simplify and streamline states' operations of their Medicaid state plans and payment processes.

### **III. Collection of Information Requirements**

To the extent a state changes its payment as a result of finalizing this proposed rule, the state would be required to obtain practitioner consent 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 exercise this flexibility 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 would

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 would respond to the comments in the preamble to that document.

## **V. Regulatory Impact Analysis**

### A. Statement of Need

In *California v. Azar*, the district court vacated the 2019 rule and remanded to HHS for further proceedings. Accordingly, we examined the statute anew, and determined that the prohibition in section 1902(a)(32) of the Act is better read to be limited in its applicability to Medicaid payments to a third party pursuant to an assignment, power of attorney, or other similar arrangement. Although the court vacated the 2019 rule, our current statutory interpretation requires this rulemaking in order to reclassify the exception in § 447.10(g)(4) as instead describing arrangements that are beyond the scope of prohibition in section 1902(a)(32) of the Act. Furthermore, while we now believe these arrangements are beyond the scope of the statute, we nevertheless consider it important to document and ensure clarity and flexibility for individual practitioners. Finally, this rule provides us an opportunity to reinforce the important caveat that such deductions may only be made with the consent of the individual practitioner.

### 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 direct 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 will be budget neutral or have a minimal economic impact that is unlikely to have an annual effect on the economy in excess of the \$100 million threshold of Executive Order 12866. Based on our estimates, the Office of Management and Budget’s Office of Information and Regulatory Affairs has determined that this rulemaking is “significant” and “not major” under Subtitle E of the Small Business Regulatory Enforcement Fairness Act of 1996 (also known as the Congressional Review Act).

Although we are establishing a new regulatory provision, the change is merely in the statutory approach, while the effect is largely the same as under § 447.10(g)(4). As such, as discussed in the January 16, 2014 final rule (79 FR 2947, 3039) that initially established the authority for these arrangements, we believe that this proposed rule ensures Medicaid funding additional operational flexibilities for states to ensure a strong provider workforce. There is also no impact on individual practitioners, even though the proposed rule would allow states to deduct payments from provider’s payment with their consent under the specific circumstances described in the proposed rule. State budgets will not likely be significantly affected because the

operational flexibilities in the proposed rule would only facilitate the transfer of funds between participating entities, rather than the addition or subtraction of new funds.

Since the 2014 and 2019 final rules, we are not aware of any state plan amendments submitted by state Medicaid agencies that intended to modify provider payments rates in response to these previous regulatory changes. In addition, we do not formally track the payment amounts that state Medicaid agencies pay to third parties as affected by the proposed regulatory provision. As such, the Department invited public comments to help refine this analysis in the 2018 proposed rule, but no substantive analysis of the economic impact of this rule was provided as noted in the 2019 final rule. Again, we are seeking comment on this estimate, and particularly on types and amounts deducted from individual providers for payment to third parties, broken down by benefit that may be included under § 447.10(i).

### 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 \$8.0 million to \$41.5 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 2021, that threshold is approximately \$158 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 incorporating additional regulatory text under § 447.10(i) requiring explicit written consent from a practitioner before state Medicaid agencies may make a payment on behalf of the practitioner to a third party that provides benefits to the workforce such as health insurance, skills training, and other benefits customary for employees. We also considered identifying specific employee benefits for which payments may be deducted and paid to a third party in the regulatory text under § 447.10(i), such as federal income taxes, Federal Insurance Contributions Act (FICA) taxes, state and local taxes, retirement benefits (for example, 401k, profit-sharing), health insurance, dental insurance, vision insurance, long-term care insurance, disability insurance, life insurance, gym memberships, health savings accounts (HSA), job-related expenses (for example, union dues with affirmative consent, uniforms, tools, meals, and mileage), and charitable contributions. Rather than listing the universe of benefits for which payments may be deducted and paid by state Medicaid agencies to third parties with consent of the provider, we also considered whether to exclude certain benefit deductions from the scope of

this proposed rule. Finally, we considered requiring practitioner consent only for specific types of deductions, rather than all types of benefits, for which Medicaid payment amounts may be deducted and paid to a third party in the regulatory text under § 447.10(i).

We considered but did not propose to require explicit written provider consent for deductions out of concern that codifying a requirement for written consent could unintentionally result in a conflict with state law. As proposed, we would defer to state Medicaid agencies to ensure consent is obtained and for further implementation of provider payment deductions consistent with state law and regulation for state employee benefit deductions. We are requesting public comment on whether to include a CMS requirement for written provider consent or to remain silent on the form such consent must take and to defer to existing state law and regulation. Specifically, we are seeking comments on what constitutes appropriate consent (that is, letter, email, form), descriptions of state law that require consent, and how CMS could minimize burden on state Medicaid agencies and prevent conflict with state laws and regulations if specific consent requirements were finalized within the regulatory text. Thus, we are providing in this proposed rule that a provider must voluntarily consent to payments to third parties on the provider's behalf, but propose to leave to each state to determine the best means of confirming the provider's consent in each case.

We also considered but did not propose to codify a defined list of allowable benefits or excluded benefits within the regulatory text based on concerns that such a list may not accurately reflect all employee benefits available to practitioners and would need frequent updates through the rulemaking process in order to remain relevant. The available benefits may vary between states and we would, again, defer to specific state laws and regulations as the basis for implementing the proposed rule. We are soliciting public comments on whether to codify a defined list of benefits that may be deducted from a provider's payment and, on behalf of the provider, be made to third parties. We are also soliciting public comments on whether there are additional types of benefits that state Medicaid agencies make to third parties on behalf of a

provider receiving benefits that were not contemplated in the examples described in this section. In particular, we are seeking comments on whether the described list of benefits is generally permissible and consistent with deductions or payments made by states on behalf of state employees, as well as examples of potential impermissible arrangements we may exclude from the final rule. Finally, we are requesting that commenters further explain why the benefits they provide as examples within their comments are permissible or impermissible under the proposed § 447.10(i). As noted in the Overall Impact section, we are also seeking public comments, as well as data on the type and amount of benefit deductions broken down by benefit that may be included under § 447.10(i).

We considered but did not propose to require consent only for specific types of deductions, rather than all types of benefits, for which Medicaid payment amounts may be deducted and paid to a third party in the regulatory text based on the concern that we may not accurately capture all of the employee benefits practitioners believe should require consent. Additionally, identifying certain types of employee benefits for which payments may be deducted and paid to a third party in the regulatory text would also need frequent updates through the rulemaking process in order to remain relevant. We are soliciting public comments on whether to codify that consent is only required for deductions for certain types of employee benefits, which benefits, and why those benefits should require consent from the practitioner. We are also soliciting public comments on whether requiring consent for certain types of employee benefits is advantageous or disadvantageous for the state and practitioner rather than requiring consent for all types of employee benefits.

#### E. Conclusion

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

**Chiquita Brooks-LaSure, Administrator of the Centers for Medicare & Medicaid Services, approved this document on July 21, 2021.**

**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:** 42 U.S.C. 1302 and 1396r-8.

2. Amend § 447.10 by revising paragraph (a) and adding new paragraph (i) to read as follows:

**§ 447.10 Prohibition against reassignment of provider claims.**

(a) *Basis and purpose.* This section implements section 1902(a)(32) of the Act which prohibits State payments for Medicaid services to anyone other than a provider or beneficiary, under an assignment, power of attorney, or similar arrangement, except in specified circumstances.

\* \* \* \* \*

(i) *Payment prohibition.* The payment prohibition in section 1902(a)(32) of the Act and paragraph (d) of this section does not apply to payments to a third party on behalf of an individual practitioner for benefits such as health insurance, skills training, and other benefits customary for employees, in the case of a class of practitioners for which the Medicaid program is the primary source of revenue, if the practitioner voluntarily consents to such payments to third parties on the practitioner's behalf.

**Dated:** July 28, 2021.

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**Andrea Palm,**

Deputy Secretary,

Department of Health and Human Services.

[FR Doc. 2021-16430 Filed: 7/30/2021 4:15 pm; Publication Date: 8/3/2021]