

5. *State of New York et al. v. United States Environmental Protection Agency*, Case No. 1:20-cv-10642; (United States Southern District of New York, April 12, 2021). Second Stipulation and Consent Order Further Extending Stay and Extending Injunction.
6. *State of New York et al. v. United States Environmental Protection Agency*, Case No. 1:20-cv-10642; (United States Southern District of New York, June 14, 2021). Third Stipulation and Consent Order Further Extending Stay and Extending Injunction.
7. *State of New York et al. v. United States Environmental Protection Agency*, Case No. 1:20-cv-10642; (United States Southern District of New York, August 12, 2021). Fourth Stipulation and Consent Order Further Extending Stay and Extending Injunction.
8. *State of New York et al. v. United States Environmental Protection Agency*, Case No. 1:20-cv-10642; (United States Southern District of New York, October 12, 2021). Fifth Stipulation and Consent Order Further Extending Stay and Extending Injunction.
9. *State of New York et al. v. United States Environmental Protection Agency*, Case No. 1:20-cv-10642; (United States Southern District of New York, December 14, 2021). Sixth Stipulation and Consent Order Further Extending Stay and Extending Injunction.
10. *State of New York et al. v. United States Environmental Protection Agency*, Case No. 1:20-cv-10642; (United States Southern District of New York, February 15, 2022). Seventh Stipulation and Consent Order Further Extending Stay and Extending Injunction.
11. EPA. Pesticides; Agricultural Worker Protection Standard Revisions; Final Rule. **Federal Register**. 80 FR 67496, November 2, 2015 (FRL-9931-81).

Authority: 7 U.S.C. 136-136y.

Dated: May 5, 2022.

Michal Freedhoff,

Assistant Administrator, Office of Chemical Safety and Pollution Prevention.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 447

[CMS-2444-F]

RIN 0938-AU73

Medicaid Program; Reassignment of Medicaid Provider Claims

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

ACTION: Final rule.

SUMMARY: This final rule reinterprets the scope of the general requirement that State payments for Medicaid services under a State plan must generally be made directly to the individual practitioner or institution providing services or to the beneficiary, in the case of a class of practitioners for which the Medicaid program is the primary source of revenue. Specifically, this final rule explicitly authorizes States to make payments to third parties on behalf of individual practitioners, for individual practitioners' health insurance and welfare benefits, skills training, and other benefits customary for employees, if the individual practitioner consents to such payments on their behalf.

DATES: These regulations are effective June 15, 2022.

FOR FURTHER INFORMATION CONTACT: Christopher Thompson, (410) 786-4044.

SUPPLEMENTARY INFORMATION:

I. Background

A. Prohibition on Payment Reassignment

Congress established the Medicaid program in 1965 to provide health care services for low-income beneficiaries and beneficiaries with disabilities. 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 generally that "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 or power of attorney or otherwise." This prohibition is followed by four enumerated exceptions. On September 29, 1978, we codified these exceptions under 42 CFR 447.10, the regulation implementing section 1902(a)(32) of the Act, in the "Payment for Services" final rule (43 FR 45253) (hereinafter referred to as the "1978 final rule"). The 1978 final rule simply reorganized and redesignated existing Medicaid regulations that previously appeared at 42 CFR 449.31. Since the 1990s, we have mostly understood this provision as governing only assignments and other similar Medicaid payment arrangements.

Consistent with this understanding, from 2012 to 2014, we engaged in rulemaking in the "State Plan Home and Community-Based Services, 5-Year Period for Waivers Provider Payment Reassignment, and Setting Requirements for Community First Choice" proposed rule published in the

May 3, 2012 **Federal Register** (77 FR 26362) (hereinafter referred to as the "2012 proposed rule") 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) (hereinafter referred to as the "2014 final rule"). In that rulemaking, we reasoned that the statute permitted this policy because the apparent purpose of section 1902(a)(32) of the Act was to prohibit factoring arrangements, the practice by which providers sold their 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.

We codified this policy 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 Informational Bulletin, 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.¹

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

B. Current Medicaid Payment Assignment Regulations

Medicaid regulations at § 447.10 (“Prohibition against reassignment of provider claims”) implement the requirements of section 1902(a)(32) of the Act by providing that State plans may 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 (the “provider”), the recipient (the “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.

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 reassignment under 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 doing so, we interpreted the statutory phrase “or otherwise” as encompassing any and all Medicaid 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) (hereinafter referred to as the “2018 proposed rule”) and finalized it in the “Reassignment of Medicaid Provider Claims” final rule in the May 6, 2019 **Federal Register** (84 FR 19718) (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 pre-2018 interpretation and the 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 a case that is currently in abeyance and captioned *California v. Becerra*, No. 21–15091 (9th 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, Congress changed the definition of medical assistance under section 1905(a) of the Act to permit States to offer coverage of categories of practitioner services in the Medicaid program that are not offered in other health insurance programs, such as personal care services and other HCBS. For these practitioners, who often provide services independently, rather than as employees of a service provider agency, 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 services and supports (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 increased to 58.6 percent in FY 2019.² HCBS represented a majority of LTSS expenditures in 28 States and the District of Columbia, and over 75 percent of expenditures in five States in FY 2018.

Several States have requested that we adopt additional exceptions to the direct payment policy to permit a State to withhold from a payment due to the individual practitioner 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. We believe that State Medicaid agencies can play a key role in influencing the stability of this workforce by determining payment rates and facilitating greater access to benefits that support this class of providers.³

II. Provisions of the Proposed Regulations

In the August 3, 2021 **Federal Register**, we published the “Medicaid Program; Reassignment of Medicaid Provider Claims” proposed rule (86 FR 41803) (hereinafter referred to as the “2021 proposed rule”). The following is a summary of those proposed provisions.

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 account for costs related to health and welfare benefits, training, and other benefits customary for employees. However, under our previous interpretation of the statutory provision at section 1902(a)(32) of the Act, as reflected in regulations at § 447.10 under the 2019 final rule, the entire rate was required to be paid to the individual practitioner who provided the service, unless certain exceptions applied. Under the 2019 final rule, none of the exceptions applied to payments for health and welfare benefits, training, and other benefits customary for employees when the practitioner is not in a direct employment or contractual relationship with a third party that submits claims on the practitioner’s behalf. While the 2019 final rule did not directly prevent practitioners from purchasing health insurance, enrolling in trainings, or paying dues to a union or other association, it did create an unnecessary administrative burden on practitioners, and may have increased costs for those practitioners by eliminating access to lower group rates.

Following the district court’s decision and analysis in *California v. Azar*, we re-examined the statutory language and legislative history, and now conclude

² <https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltssexpenditures2019.pdf>.

³ <https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/lts-rebalancing-toolkit.pdf>.

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 under an assignment, power of attorney, or other similar arrangement. In other words, and consistent with the longstanding title of the provision at § 447.10 (“Prohibition against reassignment of provider claims”), a title which the regulation has consistently had since at least 1978, the statutory prohibition is better viewed as an anti-reassignment provision that only governs assignment-like payment arrangements.⁴ We do not believe this provision should be interpreted as a broad prohibition on any and all types of Medicaid payment arrangements beyond payments made directly to Medicaid beneficiaries and providers or enumerated in the statutory exceptions. As such, we proposed to amend § 447.10 to add a new paragraph (i), which would incorporate similar language from the previous paragraph (g)(4), as a new provision clarifying that certain types of third-party payments on behalf of a particular category of practitioners are outside the scope of the statutory provision in section 1902(a)(32) of the Act, rather than describing those payments as an exception to that prohibition.

Specifically, § 447.10(i) as proposed specified that the payment prohibition in section 1902(a)(32) of the Act and § 447.10(d) would not apply to payments to a third party on behalf of, and with the consent 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.

As discussed in the 2021 proposed rule, the text of the statute addresses only assignments and related payment arrangements wherein a provider’s right to claim 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 2021 proposed rule included our reasoning that 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 also proposed to amend § 447.10(a) to include the phrase “under an assignment or power of attorney or a similar arrangement.” We stated that this change would align the regulation with the applicable statutory language and our reading of that language and would create a consistent framework for the proposed new paragraph (i).

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 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, to make payments to third parties on behalf of the provider.

A re-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 payment 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 enumerated exceptions to the general principle of direct payment to individual practitioners. As described in the proposed rule, these exceptions may appear to be largely unrelated; however, they all involve payment arrangements where third parties are submitting claims to the Medicaid agency 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 or to receive all payments otherwise due a provider for services furnished supports our 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 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 payment.

The legislative history of section 1902(a)(32) of the Act also 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.⁵ 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.⁶ 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.

For 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 enhanced by the ability to deduct from Medicaid payments at the request or with the consent of a provider to make separate payment to a third party on behalf of the provider. Deductions for these purposes

⁵ 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).

⁶ 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(III), at 48–49 (1977), reprinted in 1977 U.S.C.C.A.N. 3039, 3051; S. REP. NO. 95–453, at 6–8 (1977).

⁴ See, for example, *Gorman v. Nat’l Transp. Safety Bd.*, 558 F.3d 580, 588 & n.5 (D.C. Cir. 2009) (holding that a regulatory heading confirmed the reasonableness of an agency’s reading of the rule in that case, and observing that as a general matter “a short and simple, if ambiguous, subsection of a regulation” may be “clarified by the heading,” and that headings “may be of use” “when they shed light on some ambiguous word or phrase.”) (internal citations omitted).

are an efficient and effective method for ensuring that the workforce has provisions for basic needs and is adequately trained for their functions as health care professionals, thus ensuring that beneficiaries have access to such practitioners and higher quality services. Requiring practitioner consent for such deductions ensures that 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 proposed that these deduction practices fall outside the scope of what the statute prohibits, we stated in the 2021 proposed rule that 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, we have long sought to ensure maximum State flexibility to design State-specific payment methodologies that help ensure a strong, committed, and well-trained workforce. 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.⁷ These issues often result in higher rates of institutional stays for beneficiaries. We also noted that the proposed rule would support our previous efforts to strengthen the home care workforce by specifying what actions are permitted to help foster a stable and high-performing workforce.⁸ As proposed, under the 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 payment to pay third parties for health and welfare benefit contributions, training costs, and other benefits customary for employees.

For States, the third-party payment arrangements authorized by the provisions in the proposed rule would be optional; States that choose to

implement them can use existing administrative processes to make deductions for certain benefits on behalf of the individual practitioner and with consent of the practitioner, from a practitioner's Medicaid payment. For practitioners, we stated that the proposed rule would enhance the ability of the practitioners, regardless of their employment arrangement, to perform their functions as health care professionals, and thus support beneficiary access to quality home 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. HCBS provides critical services to millions of individuals across the country, including people with disabilities and older Americans. As the COVID-19 pandemic continues to impact health care in the United States, it is crucial that Medicaid beneficiaries are able to receive the home-based care they need in their homes and communities. Section 9817 of the American Rescue Plan Act of 2021 (Pub. L. 117-2) reinforces 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, including those delivered by home care providers. As we explained in the proposed rule, the flexibility permitted under the rule would help protect the economic security for home care providers as well as protect and strengthen the HCBS workforce and accelerate LTSS reform and innovation. Facilitating access to benefits customary for employees for home care providers is critically important to improve workforce standards. Moreover, because the majority of home care workers are women and people of color,⁹ permitting this type of payment arrangement will directly benefit those populations and address inequities.

Further, as discussed in the proposed rule, 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 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 payment.¹⁰ Under the rule as proposed, State Medicaid agencies would be authorized to make deductions from a practitioner's Medicaid payment, with the consent of the individual practitioner, to pay a third party on behalf of the individual practitioner for benefits that provide the workforce with freedom to advocate for higher wages and career advancement, access to health insurance and necessary trainings, and 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 perform employer-like responsibilities without a formal relationship to a certain class 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 payments, with the consent of the individual practitioner, 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, gain or retain benefits which help them support themselves and their families, and subsequently benefit those individuals they care for.

We noted in the 2021 proposed rule that these provisions 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

⁷ 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>.

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

⁹ <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/>.

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

benefit contributions, training, and similar benefits customary for employees). As explained in 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 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, we noted that the rule would have little to no impact on Federal Medicaid funding levels as the 2014 final rule is the status quo in light of the district court's decision in *California v. Azar*.

As discussed in the 2014 final rule, the similar policies proposed in the 2021 proposed 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. As proposed, this rule would simply ensure flexibility for States to pay for such costs directly on behalf of practitioners and ensure access to benefits, such as health insurance, skills training, and other benefits customary for employees. We noted that should the rule be finalized as proposed, there may even be cost savings resulting from the collective purchase of such benefits and greater workforce stability.

We solicited public comments on the extent to which the payment arrangements that would be permitted under the 2021 proposed rule would benefit States and practitioners, particularly if and how a practitioner's access to benefits would be impacted, as well as any adverse impacts that may have not been anticipated. Additionally, we sought 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. Analysis of and Responses to Public Comments

We received 32 public comments in response to 2021 proposed rule. The following is a summary of the comments we received and our responses.

A. General

Comment: Most commenters stated support for the 2021 proposed rule. Commenters appreciated the flexibility provided by this rule, which would be optional for States to avail themselves

of, and view the rule as a beneficial policy for States and providers. Commenters believe the rule aligns with the previous 2014 final rule, and will enhance and strengthen HCBS programs. One commenter noted that the ability of States to process payroll and make deductions for taxes and other workplace benefits for independent provider home care workers provides parity between independent providers and agency-employed workers for whom such deductions are a standard practice. Some commenters opposed the rule and alleged that there is no or insufficient statutory authority to create this regulation and raised concerns about the inclusion of union dues in payments that may be made to third parties.

Response: We appreciate the support for the changes in the 2021 proposed rule. We wish to clarify an imprecise characterization of the rule regarding who and what entities the rule affects and what the rule authorizes. As clarified in a subsequent response, individual practitioners affected by this rule are individual providers of Medicaid services whose primary source of revenue is Medicaid. The rule does not authorize States to process payroll or make tax deductions for independent providers. This rule provides State Medicaid agencies with the authority to make deductions from Medicaid payments, with the consent of the individual practitioner, to make payment to a third party on behalf of the individual practitioner for benefits such as health insurance, skills training, and other benefits customary for employees. We address concerns regarding statutory authority and unions more specifically in subsequent responses.

Comment: One commenter supported the proposed revision to § 447.10(a) as the provision aligns with the court's ruling in *California v. Azar* and the interpretation of the statutory prohibition as extending only to assignments and assignment-like arrangements that involve a potential for factoring that the statute was intended to prevent.

Response: We agree with the district court's decision and analysis in *California v. Azar*. We appreciate the comment that expressed support for the proposed revision to § 447.10(a).

Comment: One commenter requested CMS define the term "individual practitioner" used in the rule.

Response: In the context of § 447.10, "individual practitioner" simply refers to an individual as opposed to an entity or institution providing Medicaid services. Individual practitioners can include individuals that have a

contractual employment relationship with the State agency. This rule pertains specifically to a class of practitioners who are not employees of the State, or a service agency that is paid by the State, such as a home health agency, but whose primary source of revenue is Medicaid. To make this determination, States may look only at revenue related to Medicaid-covered services furnished by the practitioner. Medicaid-covered service revenue does not include revenue related to unallowable facility costs, such as room and board or food. The proposed regulatory text, which we are finalizing, provides the necessary latitude for a State to determine whether it is acting in an employer-like role for a particular class of practitioners.

Comment: One commenter requested CMS modify the regulatory language in § 447.10(i) to explicitly include all providers of home and community-based services. Specifically, the commenter proposed using the term "providers of Home and Community Based Services" rather than "individual practitioner" in § 447.10(i).

Response: We are maintaining the term "individual practitioner" to prevent any unintentional exclusions of the types of providers affected by this rule. As stated in the 2012 proposed rule, we included the payment reassignment provisions in the HCBS proposed rule because State Medicaid programs often operate as the only or primary payer for a class of practitioners that includes HCBS providers. While the final rule does apply to a large number of HCBS workers, there are other provider types affected as well, such as personal care services and home health workers.

Comment: Several commenters offered lists of the types of benefits offered to practitioners affected by this rule: health insurance premiums, life insurance premiums, retirement plan contributions, union and association dues, job training (for example, CPR/first aid, dementia care, stress management, fall prevention, nutrition, and health) and education trusts. One commenter indicated that the health insurance premium for individual practitioners affected by this final rule in the State of Washington was \$25, deducted monthly. A few commenters provided single statistics regarding the number of providers affected by this final rule in their area or State. One commenter indicated there were 26,300 providers in Alameda County in California, while another commenter indicated a quarter of a million providers in California have elected voluntary deductions, and 24 percent of Wyoming's small, independent

providers of developmental disabilities waiver services offer health insurance to their employees.

Response: In the 2021 proposed rule, we sought public comments and data on the type and amount of benefit deductions broken down by benefit that may be included under § 447.10(i). We appreciate the commenter's submission of State-specific information about the types and amounts of benefits available to providers. Based on the public comments and data received, none of the information suggested a need to further revise § 447.10(i).

B. Statutory Authority

Comment: Several commenters agreed with the district court's decision in *California v. Azar*, which rejected HHS's arguments in that case that section 1902(a)(32) of the Act expressly and unambiguously prohibited the agency's pre-2018 interpretation, an interpretation which had been set forth in the 2014 final rule, and States' related practices. Several commenters also agreed with CMS' analysis that the statutory prohibition is better viewed as an anti-reassignment provision that only governs assignment-like payment arrangements. Commenters commended CMS' quick action to issue a proposed rule to amend the relevant regulations under the new statutory interpretation described in the 2021 proposed rule.

Response: We also agree with the district court's decision and analysis in *California v. Azar*. We appreciate the commenters' support of our statutory analysis described in the 2021 proposed rule and recognition of the agency's swift action in response to the district court's decision.

Comment: Nearly every commenter opposed to the rule cited a lack of CMS authority to add the § 447.10(i) language to the regulatory text under part 447. Those commenters stated that the language in section 1902(a)(32) of the Act both prohibited these types of deductions from Medicaid payments, and did not have ambiguity to allow us to interpret the statute differently than the way we interpreted it in the 2019 final rule. Most asserted that the principle of direct payments that begins section 1902(a)(32) of the Act does not leave room for interpretations that permit payment deductions outside of the subsequent enumerated exceptions. Some commenters stated that the 2021 proposed rule contradicted some of the agency's own prior interpretations of the statute, with one citing correspondence with a State seeking to formally permit such practices.

Response: Federal administrative agencies generally have authority from

Congress to regulate certain activities. An agency's authority often derives from specific statutory directives, which the agency is charged with interpreting. The Supreme Court has long noted Congress's delegation of "extremely broad regulatory authority to the Secretary in the Medicaid area."¹¹ Here, we are relying on our interpretation that section 1902(a)(32) of the Act does not prohibit payments made by the State Medicaid program for certain benefits on behalf of individual Medicaid practitioners whose primary source of revenue is the State Medicaid program, which we discuss in subsequent responses. From there, we are utilizing our general rulemaking authority at section 1102 of the Act, which authorizes the agency to publish regulations as necessary for the efficient function of, in relevant part, the Medicaid program. Ensuring that individual practitioners whose primary source of revenue is the State Medicaid program have the training and benefits necessary to remain in the workforce and to continue furnishing quality services, particularly to some of Medicaid's most vulnerable beneficiaries, is necessary for the Medicaid program's efficient operation, especially as more and more needy beneficiaries choose to receive care in their homes.¹²

Agencies are not bound by their prior interpretations of a statutory provision and may change their minds. Indeed, the Supreme Court has indicated that "an initial agency interpretation is not instantly carved in stone. On the contrary, the agency . . . must consider varying interpretations and the wisdom of its policy on a continuing basis,"¹³ and "an administrative agency is not disqualified from changing its mind."¹⁴

In the 2021 proposed rule, and in adherence to the order of the district court in *California v. Azar* to revisit the statutory question, we reviewed the statute anew, focusing on the language of the statute itself and the issues Congress sought to address as indicated by the legislative history. From this analysis, we determined that the payments to third parties addressed in this rulemaking fall outside of what is covered by the statute. Notably, when

we first enacted this policy as an exception in 2014, some States were already making the types of deductions and payments expressly authorized under that 2014 exception, based on a belief that it was permitted under the statute. While we did initially raise concerns with a State about whether deductions it was making from practitioner payments were in line with the statute, it was not until the 2012 proposed and 2014 final rules that we chose to use rulemaking to address these payment deductions under the statute. We concluded that the statute did not seek to limit administrative efficiency for a class of practitioners for which the Medicaid program is the primary source of revenue. In the present rule, we merely proposed, and are now finalizing, a different approach to the foundational principle we discerned from the intent of the statute, and from which our only deviation was in the 2019 final rule.

Comment: Some commenters suggested that this rulemaking is not the result of new evidence, but rather political motivations, citing the change in administration since CMS finalized the 2019 final rule.

Response: The cause of the change was our thorough statutory analysis conducted in compliance with a court order, and not the result of political interests. In *California v. Azar*, the court vacated the 2019 final rule and remanded to HHS for further consideration of the appropriate interpretation of the statute. Upon our re-examination of the statute, as well as consideration of the court's analysis that resulted in the remand, we determined that a wholly new statutory interpretation was appropriate and correct.

Comment: Many commenters agreed with CMS' conclusion that the purpose of section 1902(a)(32) of the Act was to prohibit factoring and that it extends only to assignments and assignment-like arrangements that involve a potential for the type of abuse that the statute was intended to prevent. One commenter stated that section 1902(a)(32) of the Act is not an unbounded prohibition on all third-party payments. Another commenter indicated that a provision of a statute should be understood in the context of the whole statute, and not read in isolation, citing *King v. St. Vincent's Hosp.*, 502 U.S. 215, 221 (1991) (referencing "the cardinal rule that a statute is to be read as a whole, since the meaning of statutory language, plain or not, depends on context"). The commenter stated that, in reading the statute in its entirety, the prohibition of "payments" prohibits assignments of

¹¹ See, for example, *Wisconsin Dep't of Health and Family Servs. v. Blumer*, 534 U.S. 473, 496, n. 13 (2002) (collecting authorities).

¹² See, for example, *Wisconsin Dept. of Health and Family Servs.*, 534 U.S. at 496, n. 13.

¹³ *Nat'l Cable & Telecomms. Ass'n v. Brand X internet Servs.*, 545 U.S. 967, 981 (2005) (quoting *Chevron U.S.A. Inc. v. Nat. Res. Def. Council, Inc.*, 467 U.S. 837, 863–64 (1984)).

¹⁴ *NLRB v. Local 103, Int'l Ass'n of Bridge Workers*, 434 U.S. 335, 351 (1978).

the right to payment and the words “or otherwise” refers to assignments in which claims for payment from individuals other than providers or agencies would occur. A third commenter stated that statutory interpretation canons of *nosctitur a sociis* (that is, “a word is known by the company it keeps”) and *ejusdem generis* (which limits general terms that follow specific ones to matters similar to those specified) supported CMS’ conclusions; therefore, payment deductions, including partial deductions, are not exceptions to the anti-assignment provision and fall outside of the scope of what the statute prohibits.

Response: We agree that section 1902(a)(32) of the Act was intended by Congress to prohibit factoring-type arrangements. For the reasons explained in the 2021 proposed rule and in our response to the next set of comments about the “or otherwise” language, we agree that the provision is not an unbounded prohibition on all third-party payments, but instead a prohibition that only extends to assignments and assignment-like arrangements that involve a potential for the type of abuse that the statute was intended to prevent. We also agree that both looking at the statute as a whole and applying the *ejusdem generis* canon of statutory construction support our conclusion that section 1902(a)(32) of the Act does not unambiguously prohibit all third-party payment arrangements that are not explicitly excepted by the statute, and that the canon *nosctitur a sociis* may apply as well.

Comment: Some opposing commenters stated the statute was clearly drafted in a way to end all payments to third parties, other than in the specific exceptions, with one pointing to the comma before “under an assignment or power of attorney or otherwise,” as evidence that those terms are non-essential rather than limiting. Two commenters closely scrutinized CMS’ assessment of the meaning of “or otherwise” in the Act, disagreeing with our conclusion and the associated change to § 447.10(a). Both stated the phrase is broadly inclusive, as supported by some cited case law, and therefore CMS’ more narrow interpretation was incorrect. One commenter noted CMS’ use of the principle of *ejusdem generis* did not apply because of the broad meaning of the phrase in question. One commenter stated if a court were to review our interpretation, the court would not find in our favor.

Response: We do not agree with these commenters. The Medicaid statute at

section 1902(a)(32) contains no clear prohibition on all non-excepted third-party payments as some commenters suggest. Viewing these commenters’ statements in the most favorable light, the statutory language is, at best, ambiguous about whether such payments are authorized. When considering the language of the statute as a whole, along with its legislative history and programmatic purpose, we have concluded that the best interpretation of the statute is that it does not bar payments to third parties for health and welfare benefits, training, and other benefits customary for employees for certain categories of individual practitioners who consent to such payments on their behalf. We believe the best reading of the anti-assignment statutory text suggests that the States’ payment arrangements with home care workers at issue in this rulemaking are authorized. While consideration of the legislative history is not strictly necessary to reach our conclusion, the legislative history further supports our narrow reading of the anti-reassignment provision.¹⁵ More specifically, 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 and provides important context to show that the opposing comments misunderstand the scope of section 1902(a)(32) of the Act. The legislative history shows that Congress acted specifically to address a problematic circumstance, factoring, and then to close a loophole it had missed when first enacting section 1902(a)(32).

The commenters’ statement that “or otherwise” is broadly inclusive would mean Congress had intended their statutory restriction to apply almost unbounded, a position not supported by the legislative history of the original statutory provision nor the reasons for the expansion of the statutory language to include “an assignment or power of attorney or otherwise.” Because “or otherwise” is non-specific, it is by its very nature ambiguous. Where statutory language is ambiguous, we must arrive at a reasonable interpretation of the statute by applying general canons of statutory construction and examining the legislative history of the provision. Under the canon of *ejusdem generis*, 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

¹⁵ See *Samantar v. Yousuf*, 560 U.S. 305, 316 n.9, 130 S.Ct. 2278, 176 L.Ed.2d 1047 (2010).

specific words.”¹⁶ We believe that approach is appropriately applied to the list structure of this statutory language. 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. To interpret “or otherwise” as an all-encompassing term would make meaningless the illustrative examples Congress listed before it.

This interpretation is further supported by the legislative history of section 1902(a)(32) of the Act discussed previously in this response. As we explained in the 2021 proposed rule, when Congress adopted the original version of this provision in 1972, it was focused on the practice of factoring, based on concerns that the factoring industry was a breeding ground for Medicaid fraud.¹⁷ Then in 1977, when Congress amended the anti-reassignment provision, it did so specifically to close what it perceived to be a loophole that factoring companies were exploiting.¹⁸ The legislative history demonstrates that the statutory language was tailored to address certain issues, rather than the phrase “under an assignment or power of attorney or otherwise” being added as a nonessential descriptor. To interpret the scope of the statute as extending beyond that goal is to make it overburdensome on the very providers whose payments Congress sought to protect.

Finally, we note that our interpretation is largely consistent with the court’s analysis in *California v. Azar*. No court has held otherwise.

Comment: One commenter, citing a desire for environments where practitioners can thrive, agreed with CMS’ reinterpretation of the scope of section 1902(a)(32) of the Act as long as a practitioner voluntarily consented to such payments to third parties on the practitioner’s behalf, as described in the 2021 proposed rule under § 447.10.

¹⁶ Sutherland Statutory Construction section 47:17 (1991); *Circuit City Stores, Inc. v. Adams*, 532 U.S. 105 (2001).

¹⁷ 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).

¹⁸ 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(III), at 48–49 (1977), reprinted in 1977 U.S.C.C.A.N. 3039, 3051; S. REP. NO. 95–453, at 6–8 (1977).

Response: We acknowledge the importance of practitioner consent in § 447.10(i), which we are finalizing as proposed.

Comment: Several opposed commenters referred to the new language in § 447.10(i) as an additional exception to the direct payment provision in the Act and its specific enumerated exceptions. They pointed to those specific exceptions as evidence that there was not room or authority to make an additional exception, a principle with which CMS agreed in our 2019 final rule. One commenter acknowledged that the new provision is not an exception, but functionally is the same.

Response: The final rule does not create a new exception under section 1902(a)(32) of the Act. In the 2021 proposed rule, we reinterpreted the scope of the statute and concluded that these deductions from Medicaid payments as authorized by the individual practitioner fell outside of that scope. As discussed in Section II.A., the intent of the statutory provision was to prohibit factoring arrangements. 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. The statute refers to assignments of claims and the exceptions describe permissible assignments of claims. The payment arrangements authorized under this rule do not involve an assignment of a claim to a third party, and are neither covered by the statute nor are they sufficiently similar to the enumerated exceptions as to be considered one as well.

Comment: A few of the commenters who disagreed with the 2021 proposed rule cited various court decisions to support the assertion that the authorization by the provider to make third party payment deductions is necessarily a form of assignment and therefore covered by the anti-assignment language of the Act.

Response: It is true that some case law exists indicating some payment deduction scenarios may constitute legal assignment. However, the case law is varied and suggests that the wording and intent of contracts is pertinent to the question of whether the "assignment" has transferred a right, the form of assignment relevant here.¹⁹ We

have found numerous decisions that make clear that, in many circumstances, a person may consent to have an amount deducted from their pay without conferring a right through an assignment.²⁰ Furthermore, the statute specifically makes impermissible the assignment of claims (and through such assignment, the right to collect on those claims). Even if the deduction of benefit payments could, in certain circumstances, be labeled an "assignment" under some case law definitions, such an assignment would not confer the right to the claim and therefore is outside the statute's scope. Our interpretation does not create a new type of assignment or exception, but instead creates an avenue for the same type of payment arrangements enjoyed by other practitioners, but for those without a formal employment relationship. When re-examining the statute and the problems Congress sought to address when expanding the language of its direct payment provision, it is clear that the focus was on instances where providers assigned claims or created workarounds to do so.

right that the obligee manifest an intention to transfer the right to another person without further action or manifestation of intention by the obligee.").

²⁰ See, for example, *California v. Azar*, 501 F. Supp. 3d 830, 840 n.8 (N.D. Cal. 2020) (the argument "that authorizing deductions for union dues is an 'assignment' (or something very close to an assignment) because of the way union dues are described in other contexts—is barely worth mentioning. Unlike the types of assignments involved in factoring and the statute's exceptions, unions cannot step into the shoes of the worker and pursue independent claims against the State for Medicaid reimbursement based on the worker's decision to authorize deductions for union dues. The fact that union dues are sometimes referred to as 'assignments' in a few judicial opinions and Federal statutes in distinct contexts does not mean that they are 'assignments' within the meaning of the anti-reassignment provision and in the context of assigning the right to submit a claim for reimbursement of health services."); see also, for example, *United Broth. of Carpenters and Joiners of Am. v. Ohio Carpenters Health and Welfare Fund*, 926 F.2d 550, 553, 557 (6th Cir. 1991) (finding that a form that had "authorized and directed [their employers] to pay and remit to [a union]' dues deducted from the payroll" when "properly construed, is the employee's consent to the employer's role as agent for the union in the collection of dues," but "is not a true common law assignment, since it creates no rights in any assignee."); *Dialysis Newco, Inc. v. Cmty. Health Sys. Group Plan*, 938 F.3d 246, 253–255 (5th Cir. 2019) (explaining that "a direct-payment authorization and a prohibition against the assignment of benefits are distinct concepts"); *Brown v. Blue Cross Blue Shield of Tenn., Inc.*, No. 1:14-CV-00223, 2015 WL 3622338, at *3–*7 (E.D. Tenn. June 9, 2015) (collecting cases and noting that "[t]here is no consensus among the Federal courts regarding whether language providing for direct payment of benefits constitutes an assignment for purposes of ERISA," but explaining that "[t]he cases holding that forms providing for direct payment do not constitute an assignment have the better end of the argument.")

Assigning the right to collect on a claim is not the same as granting an authorization to deduct for benefits, and the statute was not intended to preclude State agencies from providing their non-employee providers benefits of their employment-like relationships. Therefore, it is reasonable to conclude that in this context, assignment refers to the assignment of a claim for a whole Medicaid payment.

Comment: Several commenters opposed to the rule pointed out the distinction CMS drew between an assignment of a full payment claim and a partial payment deduction. They indicated the distinction was irrelevant, and a couple of commenters indicated that such a distinction could give rise to scenarios in which Medicaid providers would see their payments reduced by any amount regardless of surrounding circumstances so long as it was a portion of the payment.

Response: As previously discussed, we concluded that the intent of the statute is to address scenarios of claim assignment that had given rise to fraud, particularly through factoring, and therefore the distinction between partial payment deductions and assignment of the right to the full payment is relevant. However, we clarify that the true test is not whether the payment to the third party is partial or full, but instead whether the arrangement is the transfer of the rights to a claim versus the redirection of monies due to the practitioner to directly cover costs that would otherwise be paid by the practitioner, with the practitioner's consent. We also note that this rule very narrowly applies only to individual practitioners for whom the Medicaid program is the primary source of revenue and have provided consent for such deductions. In developing this rule, we sought to both describe and address a specific arrangement that we are confident was not intended to be curtailed by the language of the Act. We reiterate that this rule would simply ensure flexibility for States to pay for such costs directly on behalf of practitioners and ensure access to benefits, such as health insurance, skills training, and other benefits customary for employees.

C. Consent Requirement

Comment: Several commenters opposed to the 2021 proposed rule did not agree that the consent requirement included in the rule, which the prior similar regulation did not make explicit, would be sufficient to overcome the perceived risks of allowing for deductions for benefits directly from a provider's payment. The risks cited by

¹⁹ See Restatement (Second) of Contracts section 324 (1981) ("It is essential to an assignment of a

commenters centered mainly around examples of unions that had engaged in fraudulent or questionable practices, such as high-pressure enrollment meetings, when obtaining or using dues. One commenter cited a concern that an individual practitioner might not know what he or she is consenting to, for example if English was not the practitioner's first language. One commenter requested that the voluntary consent requirement include a requirement that the consent be communicated directly to the State agency.

Response: We make every effort to ensure we do not create avenues for fraud, and to protect against instances where those might occur. In the time between our 2014 final rule, which permitted these types of payment deductions as an exception to the Act, and the 2021 proposed rule, there have been two noteworthy cases regarding payment deductions, specifically in the context of union dues. The First Amendment principles regarding consent for the deduction of union dues outlined by the Supreme Court in *Harris v. Quinn*, 573 U.S. 616 (2014), and *Janus v. Am. Fed'n of State, Cnty., & Mun. Emps., Council 31*, 138 S. Ct. 2448 (2018), are binding on States regardless of any rules we may issue, and we are mindful of the fact that these rules must be consistent with those decisions. Furthermore, for clarity, and because this rule applies to deductions for a variety of benefits, not simply union dues, we believed it was important to include an explicit voluntary consent requirement in the regulatory text (and not limited to the context of union dues) to ensure that Medicaid payments are handled in accordance with the wishes of the provider to which the Medicaid payments are owed, both for public policy reasons and to address any possible First Amendment concerns which may arise both within and outside of the union dues context. The existence of bad actors governed under other laws and regulated by other agencies should not preclude the creation of our policy intended to benefit providers. Many workplaces allow employees to deduct union dues from their paychecks, and the union practices cited by some commenters do not justify distinguishing this aspect of an employment-like relationship from any other benefits deduction. In addition, while we appreciate the desire to guard against erroneous or involuntary deductions, we determined it is appropriate to defer to States regarding which methods of obtaining and documenting consent are sufficient

or suitable, and to rely on States to ensure third parties are not furnishing fraudulent practitioner consent for deductions. States and third parties are expected to adhere to the applicable laws regarding contractual capacity to ensure practitioners with limited English proficiency are providing informed, voluntary consent.

Comment: Many commenters advised CMS against requiring 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 and could be unduly burdensome on State programs and workers within those programs. One commenter urged CMS not to be too prescriptive about the format of consent to avoid conflicting with existing laws and employment contracts. Another commenter explained that some State laws and policies regarding consent for deductions require a ministerial form while other States include consent as a component to a contractual agreement among other methods used to collect consent: Electronic, online, voice-recorded assent, or traditional penned signatures. Commenters recommended that CMS defer to State Medicaid agencies' determination on how to obtain consent from providers affected by this rule. One commenter supported also deferring to State Medicaid agencies' determinations on how to implement provider payment deductions consistent with State law and regulations for State employee benefit deductions, as indicated in the 2021 proposed rule. A few commenters opposed to the rule overall requested that, should CMS nevertheless proceed with its policy, the consent requirement include a written requirement and also include CMS authorization.

Response: Based on some of the concerns raised by commenters as well as our original concerns that codifying a requirement for written consent could unintentionally result in a conflict with State law, we have decided to not impose a Federal regulatory requirement for explicit written provider consent for deductions or to insist that States submit their proposed consent forms to us for review. While we appreciate the desire of some commenters to have more rigorous safeguards, we are confident the inclusion of a consent requirement, while allowing States flexibility for compliance with that requirement, creates the right balance between addressing problematic situations and respecting the rights of State agencies to administer their State Medicaid plans.

Comment: Two commenters advised CMS against requiring 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. The commenters indicated this additional requirement is unnecessary and already addressed by State law or employee contracts.

Response: Based on the concerns raised by commenters, as well as our original concerns that rulemaking may not accurately capture all of the employee benefits practitioners believe should require consent, and our interest in ensuring that Medicaid payments are handled in accordance with the wishes of the provider to whom such payments are owed, we have decided not to limit the practitioner consent requirement to only specific types of deductions. Thus, we are finalizing the rule as proposed, to require consent for all deductions for benefits that may be deducted and paid to a third party under § 447.10(i).

D. Impact to Stakeholders

Comment: The commenters opposed to the rule largely disagreed with CMS about the benefits this rule would have for individual practitioners. A couple of commenters cited the lack of availability of varied trainings or benefits for which an individual practitioner may wish to enroll. Some referenced the 2019 final rule which stated that the lack of this flexibility did not preclude a practitioner from being able to participate in such benefits, and instead just changed the process. One commenter noted that the rule does not prescribe any sort of standard for the benefits for which payment deductions may be made. A few commenters also cited a lack of meaningful evidence that providers in fact benefit from such practices.

Response: We reaffirm our belief that this final rule will enhance the ability of the affected practitioners, regardless of their employment arrangements, to perform their functions as health care professionals and thus support beneficiary access to quality home care. While the types and availability of trainings and benefits varies across States, we want to encourage access to benefits for individuals effectively acting as employees, such as health insurance, skills training, and other benefits customary for employees. It is true that this policy applies to a narrow class of providers for one specific procedural step of enrolling in benefits. However, it addresses a situation where individuals with an employment-like relationship with the State agency cannot currently benefit from that

relationship in the same manner an actual employee can. While this policy has evolved over time, the consistent theme remains that there are States that wish to offer individual practitioners this type of flexibility, enough to initiate litigation in the aforementioned *California v. Azar* case in response to the rescission of the policy in 2019. Furthermore, some States had already implemented payment deduction arrangements before we issued the 2014 final rule. With the appropriate safeguards in place, despite commenters' assertions of only a minimal benefit, the policy nevertheless responds to a known demand.

Comment: Some commenters expressed concern that this policy would in fact harm individual practitioners. They stated that the benefits paid by the State on behalf of the practitioner would result in a reduced payment to that practitioner, and concluded this could take money away from providing services to the needy. They also cited concerns about Medicaid monies being taken from providers inappropriately.

Response: We want to ensure that providers receive the monies they are owed for the provision of Medicaid services to beneficiaries. That is why we proposed, and are now finalizing, a voluntary consent requirement, as we wanted to ensure that individual practitioners' payments are handled in accordance with their wishes. As such, under this rule, the only deductions that may be made from Medicaid payments due an individual practitioner are those that are specifically authorized by that practitioner to pay for certain benefits on their behalf. Furthermore, permitting State Medicaid agencies to deduct from the practitioner's payment, at the direction of that practitioner, does not impact the services provided to a beneficiary any more than if the practitioner was paying these third-party costs on their own. We note that State Medicaid agencies have the option to develop State plan payment rates that account for costs related to benefits customary for employees. Moreover, we believe that this policy may in fact benefit beneficiaries receiving services from practitioners by improving and stabilizing the workforce.

Comment: Several commenters advised CMS against including a defined list of allowable benefits or excluded benefits within the regulatory text. Commenters indicated that providers have access to a wide variety of benefits, depending on the State the provider works in. Commenters also indicated that benefits continue to expand and regulatory text that codifies

the list of benefits could possibly conflict with available benefits and interfere with the efficiency of State Medicaid programs by creating barriers for States and providers. One commenter indicated that a final rule could provide examples of certain purposes and benefits for which payroll deductions may be utilized, but such a list should be illustrative and neither definitive nor limiting.

Response: We share the concerns raised by commenters that such a list may not accurately reflect all employee benefits available to practitioners and would need frequent updates through the rulemaking process to remain relevant. Thus, we have decided not to include a defined list of allowable benefits or excluded benefits within the regulatory text or for illustrative purposes in the final rule, and States that choose to make deductions under this regulation will have flexibility to determine the types of benefits that are eligible for payment via such deductions.

E. Impact to States

Comment: Many commenters indicated that States and local governments have been making third party payments for benefits (that is, health, dental, and vision insurance, training, union dues) on behalf of individual practitioners for decades. Many commenters stated that California first began this process in the 1990s, Washington in 2002, Illinois in 2003, and Oregon in 2011. Many commenters emphasized that the scope and form of third-party payments on behalf of individual practitioners is a matter of State law or employee contracts and advised CMS not to regulate this area in the final rule to avoid conflicting with existing laws and contracts.

Response: We reiterate that this rule would simply reassure States of the flexibility to pay for certain benefits directly on behalf of certain practitioners, as our interpretation of the statute is that these payment arrangements are outside the scope of the statutory prohibition.

Comment: Two commenters raised concerns about a State's administrative burden and additional administrative costs for implementing the 2021 proposed rule. Specifically, one commenter urged CMS to reconsider the existing requirements and administrative burden faced by State Medicaid Agencies because CMS stated in the 2021 proposed rule that the time, effort, and financial resources necessary for States to exercise this optional flexibility would be incurred by the State during the normal course of their

activities. Another commenter indicated the 2021 proposed rule may have unintended consequences by not allowing States to claim additional administrative costs to implement this optional rule, such as reducing payment rates to cover new State costs of implementation for the singular subset of direct care workers.

Response: We wish to clarify our intent regarding State program administrative costs incurred by the State when implementing the 2021 proposed rule. To expend Federal, State, and local resources in the most cost-effective manner possible, States may not claim expenditures for the costs of allowable administrative activities that should have been reimbursed as direct medical services, as this would result in duplicative claiming. States that wish to account for the cost of benefits, skills training, and other benefits customary for employees in their expenditures need to include these costs as part of the rate paid for the service to be eligible for Federal financial participation.

States that wish to account for any additional State program administrative costs incurred by the State when implementing the 2021 proposed rule, such as the cost of payment system updates, must claim such administrative costs in accordance with Federal requirements. In accordance with section 1903(a)(7) of the Act and implementing regulations at §§ 430.1 and 431.15, activities must be found necessary by the Secretary for the proper and efficient administration of the plan. Administrative costs must also be reasonable, allowable, and allocable in compliance with 2 CFR part 200 and 45 CFR 75.402 through 75.411. States are also required to maintain a Public Assistance Cost Allocation Plan, as required by § 433.34 and subpart E of 45 CFR part 95.

Comment: One commenter requested CMS revise the rule to provide clarity about a Financial Management Services (FMS) entity's authority to make mandatory deductions from wages that are required by law to be made by an employer, such as deductions for Federal and State taxes, without requiring the provider's consent.

Response: This rule does not impact a State's ability to perform FMS or secure FMS through a vendor arrangement provided under sections 1915(c), 1915(i), 1915(j), 1915(k), and 1115 of the Act. Rather, this rule pertains to payments for State plan services under section 1905(a) of the Act. Section 447.10(i), as finalized, explicitly authorizes 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. These payment deductions are distinct from mandatory payments under State and Federal law, which are outside the scope of this rulemaking.

Comment: Two commenters requested CMS issue guidance on offering employee benefits in participant direction programs that do not have a union or other third party that offers benefits. Specifically, the commenters requested Federal guidance about how the cost of employee benefits should be built into an individual budget when a beneficiary opts to self-direct their care under HCBS.

Response: To reiterate, this rule does not impact a State's ability to perform FMS or secure FMS through a vendor arrangement provided under sections 1915(c), 1915(i), 1915(j), 1915(k), and 1115 of the Act. The question of how the cost of employee benefits should be built into an individual budget when a beneficiary opts to self-direct their care under HCBS is outside the scope of this rulemaking.

Comment: One commenter indicated that the 2021 proposed rule will not support the stability of HCBS without significant investment in the entire direct care workforce and necessary protections and oversight to ensure there are no further funding shortfalls.

Response: This rulemaking is narrowly tailored to respond to recent litigation and interest from States in the flexibility to enter into the types of payment arrangements discussed in this rule. Stabilizing HCBS with a significant investment in the entire direct care workforce and providing necessary protections and oversight to ensure there are no further funding shortfalls is outside the scope of this rulemaking. We will evaluate the commenter's concerns and continue to partner with States, consumers and advocates, providers, and other stakeholders to create a sustainable, person-driven long-term support system in which people with disabilities and chronic conditions have choice, control, and access to a full array of quality services that assure optimal outcomes, such as independence, health, and quality of life. We expect that this final rule will contribute some stabilization of HCBS by offering States the opportunity to pay for such costs directly on behalf of practitioners and ensure access to benefits, such as health insurance, skills training, and other benefits customary for employees.

Comment: One commenter requested CMS clarify the oversight process it intends to implement after finalization of the 2021 proposed rule. Specifically, the commenter sought clarification about if and how CMS will request data from States about the individual practitioners affected by this rule and the type and amount of third-party payments made on behalf of individual practitioners, if third party payments will be subject to Federal audit, and what documentation about these third-party payments that States need to maintain. The commenter also questioned if CMS consulted with the Internal Revenue Service regarding how deductions should be reported on an individual practitioner's income or earnings form. Lastly, the commenter questioned CMS about States' ability to incorporate costs related to health and welfare benefits, training, and other benefits customary for employees or other costs which are not otherwise eligible for Federal financial participation.

Response: We expect States to comply with applicable Federal requirements. States are expected to maintain supporting documentation for Medicaid expenditures reported on the quarterly Form CMS-64 to claim Federal financial participation. In instances where the State is making payments to a third party on behalf of an individual practitioner, States are expected to maintain relevant documentation of these transactions, including documentation demonstrating the deductions are voluntary. We may conduct quarterly reviews of Medicaid expenditures claimed on the Form CMS-64 and associated State documentation to ensure State compliance with this final rule. While the Form CMS-64 itself would not reflect changes as a result of this rule, we may request documentation from a State to support its Form CMS-64 claims, including evidence that the consent requirement is met and the individual practitioner funds are being handled appropriately. Additionally, we may initiate additional oversight activities to ensure State compliance with the requirements in this final rule.

Requirements regarding how a practitioner should report deductions on income and earnings forms relating to Federal and State tax requirements are outside the scope of this rulemaking. We would like to reiterate that should a State wish to recognize such costs, they would need to be included as part of the rate paid for the service 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.

Comment: One commenter disagreed that this 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. The commenter went on to cite various figures regarding the collection of union dues in some States that have exercised the ability to make third party payment deductions, and stated that the benefits to individual practitioners we cited in the 2021 proposed rule contradict the budget neutral assessment.

Response: The commenter's assessments assume that the 2019 rule remains in effect, the 2014 rule is not in effect, or both. With this premise, the commenter seems to suggest that the baseline for determining the impact of this rulemaking should not reflect the 2014 final rule (that is, the existence of the authority previously codified at § 447.10(g)(4)). This reasoning is incorrect. In our current circumstance, the court's vacatur of the 2019 rule, which the commenter did not acknowledge, means that the 2014 rule is now back in effect by operation of law, with no new round of rulemaking necessary to bring about this result. It is a well settled principle that "[t]he effect of invalidating an agency rule is to reinstate the rule previously in force."²¹ Therefore, relative to this analytic baseline, the present rule, which closely mirrors the prior regulatory language under the 2014 final rule, but under a more appropriate statutory analysis, creates very little difference from the scenario where § 447.10(g)(4) is in effect. The unique feature of the present rule is the consent requirement, which as discussed previously, is already a requirement for the deduction of union dues under the First Amendment. As such, our proposed rule reflected our assessment that the effect, when compared against the present regulatory and legal landscape, is budget neutral.

However, we acknowledge that the appeal related to *California v. Azar* is still outstanding, and as such, our present circumstance is not guaranteed. Therefore, we have now included data in the Regulatory Impact Analysis section examining the impact of this

²¹ *Paulsen v. Daniels*, 413 F.3d 999, 1008 (9th Cir. 2005) (citing *Action on Smoking & Health v. Civil Aeronautics Bd.*, 713 F.2d 795, 797 (D.C. Cir. 1983) (per curiam)). As the district court noted in *California v. Azar*, "vacating the agency's action simply preserves a status quo that has existed since at least the early 1990[is] while the agency takes the time it needs to give proper consideration to the matter." 501 F. Supp. 3d at 843.

policy against a potential alternate scenario where the 2019 final rule is once again in effect.

F. Union Dues

Comment: Nearly all the commenters who were opposed to the rule raised the fact that union dues are included among the benefits for which payments may be deducted. Many commenters pointed to and expressed concern about the potential for “dues skimming,” wherein a State automatically deducts union dues from payments, a concern which was raised in the 2019 final rule. They pointed to the cases of *Harris v. Quinn* and *Janus v. AFSCME* as examples of the impermissibility and First Amendment implications of the practice. In addition, some commenters provided examples of questionable or improper actions taken by unions in various States. Commenters indicated finalizing this rule would roll back protections and permit States to divert Medicaid money to unions and political campaigns. Some commenters identified coercive practices that they claim unions use despite consent requirements, such as “captive audience” pitches and a limited ability to disenroll.

Response: We proposed and are finalizing this policy with its consent requirement to align with relevant case law surrounding union dues and consent, and to address related concerns cited in the 2019 final rule. Even though this protection is already founded in the cited case law, we believed it was important to include it as a regulatory requirement as well to provide an additional layer of protection for providers specifically. We also note that regardless of whether a State is able to make third party payment deductions, a number of the commenters’ concerns could still exist. For example, “captive audience” union pitches and limited disenrollment periods are outside the scope of this rulemaking, and HHS is not the agency that would address how unions use their dues once received. Facilitating a transfer between consenting providers and third parties does not affect, either positively or negatively, the practices of unions, and therefore those concerns do not warrant a change in this policy. This rule allows States to make deductions to pay for benefits such as health insurance, skills training, and other benefits customary for employees from an individual practitioner’s payment, with their consent. We reiterate that we want to ensure providers receive the monies they are owed for the provision of Medicaid services to beneficiaries by finalizing a voluntary consent

requirement. None of the concerns cited demonstrated a sufficient reason or evidence as to why the practitioners impacted by this rule should have more limited access to union dues deductions than those in formal employment relationships.

Comment: One opposed commenter made several suggestions for how to address union dues should CMS choose to proceed with finalizing this policy. The suggestion included an opt-in requirement, multifactor authorization, additional notice regarding the individual’s rights, an expiration of authorization for deductions, and open disenrollment.

Response: The suggestions are outside the scope of this rulemaking or outside the authority of what HHS can regulate. To the extent we can address the concerns raised by commenters, our regulatory consent requirement appropriately balances the case law around the First Amendment and union dues, the concerns about bad actors, and the ability of States to exercise flexibility in their State Medicaid programs. In section VI.D., we detail the alternatives we considered, but did not adopt based on the feedback of commenters and our assessment of the most effective approach.

IV. Provisions of the Final Regulation

After consideration of the public comments, we are finalizing as proposed our additional language in § 447.10(a) and the new paragraph at § 447.10(i).

V. Collection of Information Requirements

Our August 3, 2021 (86 FR 41803) proposed rule solicited public comment on, among other things, the rule’s “collection of information” assumptions. For the purpose of this section of the preamble, collection of information is defined under 5 CFR 1320.3(c) of OMB’s implementing regulations. We received one comment addressing this section, urging CMS to reconsider the exempt classification should CMS find the amount of necessary State effort to be understated. We stated in the 2021 proposed rule that the time, effort, and financial resources necessary for States to exercise this optional flexibility are exempt from the requirements of the Paperwork Reduction Act of 1995 (PRA) (44 U.S.C. 3501 *et seq.*) as they would be incurred by the State during the normal course of their activities, and therefore should be deemed as a usual and customary business practice under 5 CFR 1320.3(b)(2). That assessment remains unchanged. This rule codifies a policy

option that exists regardless of this rule, both through our interpretation that this policy is beyond the scope of the statute, and due to the *California v. Azar* decision vacating the 2019 final rule. The consent requirement is new to the present rule, but as we are not establishing a specific method to obtain consent, and because consent is already required for union dues deductions under the First Amendment, our determination is that the consent requirement will likely be met through usual and customary business practices, and does not produce a measurable impact.

We also believe that the proposed and finalized requirements have no impact on our currently approved State plan amendment (SPA) requirements and burden estimates. While CMS–64 (OMB control number: 0938–1265) is mentioned elsewhere in this final rule, this rule has no impact on the form’s currently approved requirements and burden estimates. Any effort to request documentation from a State to support its CMS–64 claims, including evidence that the consent requirement is met and the individual practitioner funds are being handled appropriately, would be on a case-by-case basis using non-standardized questions that are exempt from the PRA under 5 CFR 1320.3(h). Consequently, this rule does not have any collection of information implications that are subject to the PRA.

VI. Regulatory Impact Analysis

A. Statement of Need

In *California v. Azar*, the district court vacated the 2019 final rule and remanded to HHS for further proceedings. Although this remand left broad discretion for next steps, we chose to examine the relevant 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 under an assignment, power of attorney, or other similar arrangement. Although the court vacated the 2019 final rule, our current statutory interpretation requires this rulemaking to reclassify the policy previously codified as an exception at § 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 certain 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 final 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). In the 2021 proposed rule, we estimated that this final rule would be budget neutral, but could have broader economic impact that is unlikely to have an annual effect on the economy more than the \$100 million threshold of Executive Order 12866. We maintain that position for the final rule, under the current regulatory landscape at the time of finalization. However, we acknowledge that an appeal of the district court decision that gave rise to this rulemaking is currently pending. As such, it may be appropriate to provide

an analysis for each of the possible baseline scenarios: One where § 447.10(g)(4) is in effect, and one where the 2019 final rule is in effect.²² We will examine each baseline analysis in turn.

Presently, as a result of the district court decision, the 2019 final rule is nullified and the 2014 final rule implementing § 447.10(g)(4) represents current policy. When the district court vacated the 2019 final rule and remanded the case to HHS for further proceedings, we had broad discretion as to how to address the remand. Because the vacatur reestablished the policy from the 2014 rule, we could have simply published a final rule in the **Federal Register** waiving notice of proposed rulemaking and public comment and informing the public that § 447.10(g)(4) was in effect due to the district court’s decision, and instructing the Office of the Federal Register to republish § 447.10(g)(4), had we determined that was the best approach. Our other potential options, which were not mutually exclusive, included the option to appeal the court’s decision, to issue sub-regulatory guidance, or engage in rulemaking to either reinstate the 2019 final rule relying on a legal basis different from that rejected by the court, or to implement the same or similar policy as in the previously codified § 447.10(g)(4) pursuant to a different legal analysis. As stated by the district court, “vacating the agency’s action simply preserves a status quo that has existed since at least the early 1990’s while the agency takes the time it needs to give proper consideration to the matter.”²³ We initially appealed, then chose to review the statute anew, eventually determining that the payments to third parties addressed in this rulemaking fall outside the scope of the statute.

For the economic analysis in the 2021 proposed rule, we believed that this rule offered State Medicaid programs additional operational flexibilities to ensure a strong provider workforce, which resulted in a proposed rule that was preliminarily designated as not economically significant.

With regard to the impact on State operations, we believe State budgets will not likely be significantly affected because the operational flexibilities in this final rule only facilitate the transfer

of funds between participating entities, rather than the addition or subtraction of new funds. As noted by multiple commenters, some States had implemented this flexibility decades before the 2014 final rule which is currently the status quo. To the extent that those States may have continued or resumed exercising such flexibility following the district court’s decision, those States will experience no change to their operations under this current rule. States that have not already implemented this policy option are not required to implement it under the current rule and their operations will remain unchanged, unless the State takes specific actions to implement this policy option. Therefore, using the established baseline assumption of the 2019 final rule not occurring and defaulting to the 2014 final rule, we anticipate the minimal impact on State budget and operations.

We believe the current rule may have an annual effect on the economy in excess of the \$100 million threshold of Executive Order 12866. While the effect may be similar in magnitude to the impact analysis in the 2019 final rule, we believe the effect will be opposite in sign where States are allowed to deduct payments from a provider’s payment with their consent under certain circumstances described in the 2021 proposed rule, thereby shifting portions of Medicaid payments from home care workers to third parties. Since the 2014 and 2019 final rules, we are not aware of any SPAs submitted by State Medicaid agencies that intended to modify provider payments rates in response to these previous regulatory changes. In addition, we do not track the payment amounts that State Medicaid agencies pay to third parties as affected by this regulatory provision, although we could obtain such information through review of a State’s Medicaid expenditures claimed on the Form CMS–64. 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. In the current rulemaking, we again sought comments 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). We did not receive comments with compelling data specific to the economic impact of this policy, and we did not receive comprehensive data about the types and amounts of deductions broken down by benefit.

²² See https://www.whitehouse.gov/wp-content/uploads/legacy_drupal_files/omb/circulars/A4/a-4.pdf. (Circular A–4 (2003) at 15 (“When more than one baseline is reasonable and the choice of baseline will significantly affect estimated benefits and costs, you should consider measuring benefits and costs against alternative baselines.”).

²³ *California v. Azar*, 501 F. Supp. 3d at 843 (N.D. Cal. 2020).

Alternatively, due to the outstanding appeal of the district court decision, it may be appropriate to consider a scenario in which the 2019 final rule is still in effect, as the district court decision may not be the final outcome of *California v. Azar*. If the 2019 final rule were in effect, then this current rulemaking would mark a significant policy shift, with a measurable impact. We have added a discussion of this alternate baseline in our regulatory impact analysis comment response, and included estimates in Table 1 of section VI.E. of this final rule.

Based on our estimates, OMB's OIRA has determined that this rulemaking is "economically significant" under Executive Order 12866 and "major" under Subtitle E of the Small Business Regulatory Enforcement Fairness Act of 1996 (also known as the Congressional Review Act).

Comment: One commenter disagreed with our assessment in the proposed rule that a regulatory impact analysis was unnecessary. That commenter pointed to our language in the 2021 proposed rule that included positive benefits associated with stabilizing the home care workforce. The commenter also noted the fact the deductions are already occurring should have no bearing on the estimated economic impact of this rule. The commenter cited figures from a report that solely focused on quantifying the amount of third-party payments made to unions to demonstrate the economic significance.

Response: As stated in section III.E. of this final rule, the effect of the vacatur in *California v. Azar* is that the 2014 final rule is our current policy, and the commenter failed to acknowledge the effect of the court decision. However, we acknowledge litigation is still pending, and furthermore there is value in understanding the effect of this policy under a possible alternate trajectory where the 2019 final rule is in effect. We lack direct information with which to quantify those impacts, as the Department does not track the amount of Medicaid payments that are being assigned to third parties. However, we can surmise from the *California v. Azar* case that at least six States²⁴ are currently utilizing this policy. We also believe it is reasonable to conclude some additional States have already or in the future may adopt these practices to provide individual practitioners administrative convenience, but as we do not have a means to assess that amount, we have not included them in

²⁴ Named plaintiff States included California, Connecticut, Oregon, Massachusetts, Washington, and Illinois.

this exercise. As States are the Medicaid program operators, enroll providers in their programs, and determine economic and efficient payment rates for providers, we believe States are better situated to quantify the amount of Medicaid payments that may be transferred to third parties under the policy discussed in this rule.

We utilized example data provided in comments to the 2021 proposed rule to extrapolate an approximate estimate for health insurance transfers within the six plaintiff States. We estimate that individual practitioners may be offered a \$25 monthly premium for health insurance²⁵ and there may be approximately 270,000 individual practitioners affected by this rule within those six States.²⁶ We then estimated 88 percent,²⁷ or 237,600 of eligible individual practitioners will enroll in an offered health insurance plan; therefore, we expect transfers of \$71,280,000 annually from the 6 States who already adopted this policy option to one or more third party health insurance plans on behalf of individual practitioners. This estimate assumes all six States have the same number of providers and offer health insurance plans with the same monthly premium. We also acknowledge that a large portion of home care workers obtain their health insurance through publicly funded programs, such as Medicaid,²⁸ and may or may not have a health insurance premium, depending on the State's program, which adds an additional caveat to this estimate. While we have not similarly quantified the amount of other authorized deductions, such as for skills training or other benefits, we estimate that the amount of payments made to third parties on behalf of individual providers for the variety of benefits addressed in this rulemaking could potentially be in excess of \$100 million. We have included some

²⁵ Health insurance premium amount was sourced from Public Comment CMS-2021-0130-0013 located at <https://www.regulations.gov/comment/CMS-2021-0130-0013>.

²⁶ The number of individual practitioners in a single State who has already adopted this policy option was sourced from Public Comment CMS-2021-0130-0013 located at <https://www.regulations.gov/comment/CMS-2021-0130-0013>. This number was used to extrapolate an estimate for the six States who has already adopted this policy option.

²⁷ <https://www.bls.gov/news.release/pdf/ehs2.pdf>.

²⁸ https://www.nelp.org/publication/surveying-the-home-care-workforce/#_ednref2; see also, for example, <https://www.kff.org/medicaid/press-release/combined-federal-and-state-spending-on-medicare-home-and-community-based-services-hcbs-totaled-116-billion-in-fy-2020-serving-millions-of-elderly-adults-and-people-with-disabilities/>; <https://www.kff.org/medicaid/issue-brief/state-policy-choices-about-medicare-home-and-community-based-services-amid-the-pandemic/>.

financial impact estimates from the policy generally in Table 1 in section VI.E. of this regulatory impact analysis.

The potential direct financial impact on the individual practitioners is similarly difficult to quantify due to the absence of specific information about the types and amount of payments being reassigned. The 2019 final rule acknowledged potential, but minor negative financial impacts on practitioners related to mailing payments, and we can conclude this policy, where available, avoids those potential 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 \$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 certifies that this final 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 604 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 certifies, that this final 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 2022, that threshold is approximately \$165 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 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. 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 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, 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 final 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). Based on additional analysis and commenter feedback, we are not amending any proposals to reflect these variations.

We also considered but did not propose or finalize requiring 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. We 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 requested public comments 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 sought comments on what constitutes appropriate consent (that is, letter, email, form), descriptions of State law that require consent, and how we 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 provided in the 2021 proposed rule that a provider must voluntarily consent to payments to third parties on the provider's behalf, but decided to defer to each State to determine the best means of confirming the provider's consent in each case.

We also considered but did not propose or finalize codifying 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 to remain relevant. We discussed in the 2021 proposed rule that the available benefits may vary between States and we would, again, defer to specific State laws and regulations as the basis for implementing the provisions of the 2021 proposed rule. We solicited 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 also solicited 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 sought 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 requested that commenters further explain why the benefits they provide as examples within their comments are permissible or impermissible as we proposed at § 447.10(i).

We considered but did not propose or finalize a consent requirement 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 to remain relevant. We solicited 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 also solicited 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. Accounting Statement

As discussed previously, the outstanding appeal related to *California v. Azar* means it may be appropriate to examine the impact of the policy described in this final rule against two, alternate baselines. The first baseline considers this final rule to reclassify a current policy using a new statutory interpretation, due to the vacatur of the 2019 final rule. In this case, we would not be required to prepare an accounting statement as would otherwise be required by OMB Circular A-4 under Executive Order 12866 (available at https://www.whitehouse.gov/wp-content/uploads/legacy_drupal_files/omb/circulars/A4/a-4.pdf).

However, the second baseline considers an alternative scenario where the 2019 final rule, or its relative impact, is in effect. Therefore, we prepared an analysis of the impact of the policy described in this final rule, to the extent we can estimate based on contributions sourced from public commenters on the 2021 proposed rule and reasonable estimates of policy adoption, in the absence of actual data. Those impacts are discussed in a comment response in section VI.B. of this final rule. 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	Transfers		Units		
	Low estimate	High estimate	Year dollars	Discount rate (%)	Period covered
Annualized monetized \$ millions/year	0	\$71.3	2021	3	2022
	0	71.3	2021	7	2022
From whom to whom?	From States to third parties on behalf of individual practitioners.				

F. Conclusion

In accordance with the provisions of Executive Order 12866, this final 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 March 16, 2022.

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 amends 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 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) 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: May 5, 2022.

Andrea Palm,

Deputy Secretary, Department of Health and Human Services.

[FR Doc. 2022–10225 Filed 5–12–22; 11:15 am]

BILLING CODE 4120–01–P

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 660

[Docket No. 220510–0113]

RIN 0648–BK78

Fisheries Off West Coast States; West Coast Salmon Fisheries; 2022 Specifications and Management Measures

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Final rule.

SUMMARY: Through this final rule, NMFS establishes fishery management measures for the 2022 ocean salmon fisheries off Washington, Oregon, and California, and the 2023 salmon seasons opening earlier than May 16, 2023, under the authority of the Magnuson-Stevens Fishery Conservation and Management Act (MSA). The fishery management measures vary by fishery and by area and establish fishing areas, seasons, quotas, legal gear, recreational fishing days and catch limits, possession and landing restrictions, and minimum lengths for salmon taken in the U.S. Exclusive Economic Zone (EEZ) (3–200 nautical miles (nmi)) (5.6–370.4 kilometers (km)) off Washington, Oregon, and California. The management measures are intended to prevent overfishing and to apportion the ocean harvest equitably among treaty

Indian, non-Indian commercial, and recreational fisheries. The measures are also intended to allow a portion of the salmon runs to escape the ocean fisheries in order to provide for spawning escapement, comply with applicable law, and to provide fishing opportunity for inside fisheries (fisheries occurring in state waters).

DATES: This final rule is effective from 0001 hours Pacific Daylight Time, May 16, 2022, until the effective date of the 2023 management measures, as published in the **Federal Register**.

ADDRESSES: The documents cited in this document are available on the Pacific Fishery Management Council’s (Council’s) website (www.pcouncil.org).

FOR FURTHER INFORMATION CONTACT: Shannon Penna at 562–676–2148.

SUPPLEMENTARY INFORMATION:

Background

The ocean salmon fisheries in the EEZ off the coasts of Washington, Oregon, and California are managed under a framework fishery management plan (FMP). Regulations at 50 CFR part 660, subpart H, provide the mechanism for making preseason and inseason adjustments to the management measures, within limits set by the FMP, by notification in the **Federal Register**. Regulations at 50 CFR 660.408 govern the establishment of annual management measures.

The management measures for the 2022 and early 2023 ocean salmon fisheries that are implemented in this final rule were recommended by the Council at its April 6 to 13, 2022, meeting.

Process Used To Establish 2022 Management Measures

The Council announced its annual preseason management process for the 2022 ocean salmon fisheries on the Council’s website at www.pcouncil.org (December 3, 2021), and in the **Federal Register** on December 9, 2021 (86 FR 70114). NMFS published an additional notice of opportunity to submit public comments on the 2022 ocean salmon