interference with the other established areas. Vessels will be authorized to transit through this zone with approval from the COTP or designated authority. Zone ''C'' is essential to provide vessels the opportunity to transit along the city of San Francisco waterfront while maintaining the integrity of the regulated areas for the race event.

(6) *Zone ''D''* means the designated No Loitering or Anchoring Area. This Zone will allow vessels to transit along the waterfront throughout the duration of the Sail Grand Prix. All vessels shall maintain headway and shall not loiter or anchor within the area of Zone ''D''. Zone ''D'' minimizes the impact to the San Francisco Waterfront Area so mariners have the ability to transit during the times when Zone ''C'' is not in effect for transiting.

(c) *Special local regulation.* The following regulations apply between 10:30 a.m. and 3:00 p.m. on the race event days.

(1) Only support and race vessels may be authorized by the COTP or designated representative to enter Zone ''A'' during the race event. Vessel operators desiring to enter or operate within Zone ''A'' must contact the COTP or a designated representative to obtain permission to do so. Persons and vessels may request permission to transit Zone ''A'' on VHF–23A.

(2) Spectator vessels in Zone ''B'' must maneuver as directed by the COTP or designated representative. When hailed or signaled by the COTP or designated representative by a succession of sharp, short signals by whistle or horn, the hailed vessel must come to an immediate stop and comply with the lawful directions issues. Failure to comply with a lawful direction may result in additional operating restrictions, citation for failure to comply, or both.

(3) Spectator vessels in Zone ''B'' must operate at safe speeds which will create minimal wake.

(4) Vessel operators desiring to enter or operate within Zone ''C'', the designated waterfront transit area, must contact the COTP or a designated representative to obtain permission to do so. Vessel operators given permission to enter or operate in Zone ''C'' must comply with all directions given to them by the COTP or designated representative. Persons and vessels may request permission to transit Zone ''C'' on VHF–23A.

(5) Vessels operated in Zone ''D'' must maintain headway and shall not loiter or anchor within the Zone. Vessels in Zone ''D'' must comply with all directions given to them by the COTP or designated representative.

(6) Rafting and anchoring of vessels are prohibited within Zones ''A'', ''B'', ''C'' or ''D''.

(d) *Enforcement periods.* The special local regulation in paragraph (c) of this section will be enforced for race events on May 4, 2019 and May 5, 2019 from 10:30 a.m. until approximately 3:00 p.m. each day. The zones described in paragraph (b) of this section will be enforced from 10:30 a.m. until 3:00 p.m. on each of May 4, 2019 and May 5, 2019. At least 24 hours in advance of the race event, the Captain of the Port of San Francisco (COTP) will notify the maritime community of periods during which these zones will be enforced via Notice to Mariners and in writing via the Coast Guard Boating Public Safety Notice.

Dated: April 29, 2019.

Marie B. Byrd,

Captain, U.S. Coast Guard, Captain of the Port, San Francisco.

[FR Doc. 2019–09311 Filed 5–2–19; 4:15 pm]

BILLING CODE 9110–04–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 447

[CMS–2413–F]

RIN 0938–AT61

Medicaid Program; Reassignment of Medicaid Provider Claims

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

ACTION: Final rule.

SUMMARY: This final rule removes the regulatory text that allows a state to make Medicaid payments to third parties on behalf of an individual provider for benefits such as health insurance, skills training, and other benefits customary for employees. We have concluded that this provision is neither explicitly nor implicitly authorized by the statute, which identifies the only permissible exceptions to the rule that only a provider may receive Medicaid payments. As we noted in our prior rulemaking, section 1902(a)(32) of the Social Security Act (the Act) provides for a number of exceptions to the direct payment requirement, but it does not authorize the agency to create new exceptions.

DATES: These regulations are effective on July 5, 2019.

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

SUPPLEMENTARY INFORMATION:

I. Background

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

We first codified § 447.10 implementing section 1902(a)(32) of the Act in the ''Payment for Services'' final rule published in the September 29, 1978 **Federal Register** (43 FR 45253), and we have amended that regulation in the ensuing years. The 1978 final rule incorporated several specific statutory exceptions to the general principle requiring that direct payment be made to the individual provider. The regulations implementing section 1902(a)(32) of the Act have generally tracked the plain statutory language and required direct payments absent a statutory exception.

In 2012, we proposed a new regulatory exception in the ''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 26361, 26406) for ''a class of practitioners for which the Medicaid program is the primary source of service revenue'' such as home health care providers. We recognized in the proposed rule that section 1902(a)(32) of the Act does not specifically provide for additional exceptions to the direct payment requirement (77 FR 26364, 26382).

In response to the May 3, 2012 proposed rule, we received seven comments, all generally supportive of the proposed regulatory exception. We finalized the regulatory exception 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 2947, 3001)

authorizing a state to make payments to third parties on behalf of certain individual providers ''for benefits such as health insurance, skills training, and other benefits customary for employees.''

More recently, we have become concerned that § 447.10(g)(4) is neither explicitly nor implicitly authorized by the statute, which identifies the only permissible exceptions to the rule that only a provider may receive Medicaid payments. Unlike section 1902(a)(6) of the Act, that requires a State agency to make such reports, in such form and containing such information, as the Secretary may from time to time may require, section 1902(a)(32) of the Act provides for a number of exceptions to the direct payment requirement that we believe constitutes an exclusive list of exceptions and does not authorize the agency to create new exceptions. The regulatory provision at § 447.10(g)(4) granted permissions that Congress has not expressly authorized, and in our interpretation, has foreclosed. Therefore, we published the ''Reassignment of Medicaid Provider Claims'' proposed rule in the July 12, 2018 **Federal Register** (83 FR 32252 through 32255) where we proposed to remove the regulatory exception at § 447.10(g)(4).

II. Provisions of the Proposed Regulations

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

With regard to the authorities under sections 1915(c), 1915(i), 1915(j), 1915(k), and 1115 of the Act, we explained that this final rule will not impact a state's ability to perform Financial Management Services (FMS) or secure FMS through a vendor arrangement. FMS are services and functions that assist the Medicaid beneficiary or his/her family to: (1) Manage and direct the disbursement of funds contained in the participant-directed budget; (2) facilitate the employment of staff by the family or participant, by performing as the participant's agent such employer responsibilities as processing payroll, withholding Federal, state, and local tax and making tax payments to appropriate tax authorities; and (3) performing fiscal accounting and making expenditure reports to the Medicaid beneficiary or family and state authorities.

As discussed in response to comments below, the arrangements under FMS are not affected by the provisions of the final rule because this model involves the FMS vendor receiving monies from the state to administer the participant-directed budget and make payment to providers on behalf of the beneficiary. The budget furnished to the FMS vendor is not a ''payment under the plan for any care or service provided to an individual,'' and thus is not subject to the restrictions imposed by section 1902(a)(32) of the Act and § 447.10.

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

III. Analysis of and Responses to Public Comments

We received 7,166 timely comments from concerned citizens, parents of disabled individuals, health care providers, unions, state agencies, and advocacy groups. The comments ranged from general support to opposition to the proposed removal of § 447.10(g)(4) and included very specific questions or comments regarding the proposed change. For the purpose of addressing the comments in this final rule, the term ''provider(s)'' refers to the individual practitioner(s) that were subject to § 447.10(g)(4), and the term ''reimbursement'' refers to the payment of provider claims.

A. Statutory Authority

Comment: Several commenters indicated that CMS never had the statutory authority to add the exceptions that were detailed in § 447.10(g)(4). For instance, one commenter indicated that CMS lacked the authority to make an additional exception to the statute at section 1902(a)(32) of the Act in 2014.

Response: We agree with the commenters. After hearing from stakeholders since the publication of the 2014 final rule and engaging in a review of the statutory support for § 447.10(g)(4), we have determined that the regulatory provision is foreclosed by statute, which is the reason we have removed § 447.10(g)(4).

Comment: Several commenters stated CMS provided no other explanation to support the concern that § 447.10(g)(4) was not authorized by the statute at section 1902(a)(32) of the Act. Some commenters also suggested that CMS misunderstood the meaning of section 1902(a)(32) of the Act, which commenters stated was enacted to prevent abuses stemming from factoring, and that the statute does not support CMS' interpretation that it prohibits customary employee payroll deductions.

Response: We removed the provision at § 447.10(g)(4) due to the lack of any evidence of express or implied authority to implement new exceptions to section 1902(a)(32) of the Act. *See e.g.,, TRW Inc.* v. *Andrews,* 534 U.S. 19, 28 (2001) (''Where Congress explicitly enumerates certain exceptions to a general prohibition, additional exceptions are not to be implied, in the absence of evidence of a contrary legislative intent.''); *NRDC* v. *EPA,* 489 F.3d 1250, 1259–1260 (D.C. Cir. 2007) (holding that where Congress provides certain enumerated exceptions in a statute, an agency ''may not, consistent with Chevron, create an additional exception on its own''). We have not seen any evidence of such intent in the text, structure, purpose, and legislative history; rather those tools of statutory construction in our view collectively confirm that the list of exceptions in section 1902(a)(32) of the Act was intended to be exclusive, and that that list of exceptions does not encompass the circumstance outlined in § 447.10(g)(4). Thus, we believe that Congress has spoken to ''the precise question at issue,'' *Chevron, U.S.A., Inc.* v. *Natural Resources Defense Council, Inc.,* 467 U.S. 837, 842–43, 104 S.Ct. 2778, 81 L.Ed.2d 694 (1984), and thus the exception at § 447.10(g)(4) must be deleted.

We agree with the commenter that Congress had expressed concern about abusive factoring arrangements when it enacted section 1902(a)(32) of the Act. Congress sought to stem factoring and other abuses by enacting a broad prohibition that precludes states from making any payment for care or services to any person or entity *other than* the individual receiving care or services under the state plan, or the person or institution providing such care. Congress prohibited more than just

assignment of provider payment—it prohibited payments to anyone other than the beneficiary and the provider, whether made ''under an assignment or power of attorney *or otherwise.*'' Section 1902(a)(32) of the Act (emphasis added). Notwithstanding this broad prohibition, Congress did carve out certain exceptions, including an exception that explicitly allows a state to make payments to the employer of a provider when the provider is contractually required to turn over his or her right to payment to the employer as a condition of employment. Because Congress recognized the employer-employee relationship in its list of exceptions to the direct payment rule, we do not interpret section 1902(a)(32) of the Act as prohibiting employee payroll deductions that are made by a bona fide employer. But Congress did not create a similar exemption that would allow ''deductions'' to be taken from a provider's reimbursement check and diverted to a third party. While those dollars may ultimately go toward the same purpose—for example, health insurance coverage—it is the means by which those dollars are taken from the provider that run afoul of section 1902(a)(32) of the Act. The January 16, 2014 final rule impermissibly expanded upon the statutory exceptions to create a new category of entities that can receive all or part of a Medicaid provider's reimbursement. This rule restores the direct payment rule to what we believe is its proper scope, and puts Medicaid providers back in control of their reimbursements.

Comment: Many commenters indicated CMS conceded section 1902(a)(32) of the Act does not expressly provide for additional exceptions to the direct payment principle.

Response: We believe the commenters may have been referring to the following language from the preamble to the January 16, 2014 final rule (79 FR 2947, 2949) that implemented § 447.10(g)(4) which stated, ''[w]hile the statute does not expressly provide for additional exceptions to the direct payment principle, we believe the circumstances at issue were not contemplated under the statute.'' After hearing from stakeholders and engaging in further review of the statute, we determined that we lacked authority to enact a new exception not explicitly or implicitly authorized by section 1902(a)(32) of the Act.

Comment: One commenter recommended a new regulation to focus on payments to employees of beneficiaries. Specifically, the commenter suggested that a regulation should indicate that payments to individual practitioners who are employed, in whole or in part, by a beneficiary can be assigned only to a government agency, or entity, or by court order.

Response: This comment is outside of the scope of this rule; however, we will take into consideration whether a regulation or subregulatory guidance is needed to further clarify this issue.

Comment: One commenter indicated that courts have concluded that similar arrangements, such as payment to Health Maintenance Organizations (HMO) under a contract with a Medicaid enrolled provider, are valid and authorized by § 447.10(g)(3) despite the lack of corresponding statutory authority.

Response: The provision at § 447.10(g)(3) is outside the scope of this rulemaking. We will evaluate commenter concerns and may address the issues raised by the provision at § 447.10(g)(3) in future rulemaking.

Comments: Several commenters stated CMS should issue regulatory language or, at least clarify in the final rule, that section 1902(a)(32)(B) of the Act permits states to assign Medicaid monies owed to personal care providers only to government agencies or by court order, which will permit necessary tax deductions but eliminate a state's ability to reassign reimbursement to private third parties.

Response: Only a provider may reassign his or her payment. In addition, we agree that the statute does not preclude, and in fact expressly permits, a state to make a payment in accordance with a provider's assignment, if such assignment is made to a governmental agency or entity or is established by or under a court order. The statute also expressly permits the state to make payment to the employer of the provider, instead of making a direct payment to the provider, where the provider turns over his or her professional fees to the employer as a condition of employment. The employer may withhold taxes and other voluntary deductions for benefits like health insurance through the payroll process. Whether a particular assignment is permitted under section 1902(a)(32) of the Act will depend on the particular facts of the arrangement. We will take into consideration whether a regulation or further subregulatory guidance is needed to clarify the types of assignments permitted under section 1902(a)(32)(B) of the Act.

Comment: Multiple commenters claimed CMS' action regarding the removal of § 447.10(g)(4) may be arbitrary and capricious as related to the Administrative Procedure Act (Pub. L. 79–404, enacted on June 11, 1946) (APA). For example, one commenter indicated that hostility to union membership is an arbitrary and capricious reason for an agency action.

Response: We disagree with the commenter. We previously believed that we had authority to enact the exception at § 447.10 (g)(4) because the statute did not contemplate the circumstances at issue. However, upon further review, we have determined that we did not have such authority, because section 1902(a)(32) of the Act neither explicitly nor implicitly authorized us to enact additional exceptions. Section 1902(a)(32) of the Act broadly prohibits states from making Medicaid payments to anyone other than the beneficiary or the provider furnishing items or services, unless one of certain enumerated exceptions are met. Accordingly, we believe that the statutory exceptions are exclusive and that we lacked the authority to create a new regulatory exception. Under the APA, neither change nor the presence of some reliance interests are fatal. As the courts have noted, there is ''no basis in the [APA] or in our opinions for a requirement that all agency change be subjected to more searching review'' and an agency ''need not demonstrate to a court's satisfaction that the reasons for the new policy are *better* than the reasons for the old one; it suffices that the new policy is permissible under the statute, that there are good reasons for it, and that the agency *believes* it to be better, which the conscious change of course adequately indicates.'' *FCC* v. *Fox Television Stations, Inc.,* 556 U.S. 502, 514–15 (2009) (emphasis in original). Although an agency must ''display awareness that it is changing position,'' it must only ''provide a more detailed justification than what would suffice for a new policy created on a blank slate'' when its ''its new policy rests upon factual findings that contradict those which underlay its prior policy; or when its prior policy has engendered serious reliance interests that must be taken into account.'' *Id.* In this case, we have acknowledged that we have changed position but believe that we have good reasons for doing so under the circumstances. We do not believe that our new policy rests upon new or different factual findings but solely a new legal analysis. And we believe that the reliance interests at issue are not serious—and in any event, even if they are for the sake of argument, deemed to be serious—we believe that we have justified moving forward with our

proposal notwithstanding those reliance interests.

Comment: Several commenters stated there was no need for a change to § 447.10(g)(4) or that there was no evidence that stakeholders wanted a change to § 447.10(g)(4). Commenters also indicated that states, providers, and other stakeholders have acted in reliance on the previous policy.

Response: As previously discussed, we are removing § 447.10(g)(4) because, after revisiting our previous interpretation, we have determined that we lacked statutory authority to implement § 447.10(g)(4). We understand that stakeholders may have relied on the provision at § 447.10(g)(4) to ease administrative burden on certain providers by withholding a portion of the providers' Medicaid reimbursement and redirecting those payments to third parties on the providers' behalf. However, we note that the rescission of this provision simply eliminates one method by which such payments to third parties may be made—it does not, and surely cannot—eliminate a provider's right to make such payments to third parties by other legal means. Providers remain free to purchase health insurance, training, and other benefits after receiving their Medicaid reimbursements.

Comment: One commenter stated that reassignment of provider reimbursement under § 447.10(g)(4) was an option, not a requirement.

Response: We agree with the commenter that the regulations did not require providers to assign their right to payments to third parties. An assignment is typically a voluntary act where one party intentionally transfers a right, such as a right to future payment, to another party.[1] Although providers had the option to utilize § 447.10(g)(4), our lack of statutory authority to promulgate this regulation requires us to rescind it.

B. Impact to Stakeholders

Comment: Several commenters noted that the rescission of § 447.10(g)(4) would facilitate the proper use of Medicaid funds.

Response: We appreciate the commenters' support. As previously discussed, we are removing § 447.10(g)(4) because, after revisiting our previous interpretation, we have determined that we lacked statutory authority to implement § 447.10(g)(4).

Comment: Many commenters stated that removal of § 447.10(g)(4) would result in a loss or disruption of benefits for home care workers, specifically health insurance coverage, and may lead to increases in uncompensated care costs and/or Medicaid enrollment, which may create downstream negative impacts. Commenters expressed concern that the proposed rule would prohibit automatic paycheck deductions and that Congress did not intend to affect healthcare deductions and deductions for voluntary union dues with the anti-reassignment provisions in statute. Several commenters stated that, as a result of this rule, home health workers will lose health insurance coverage.

Response: We disagree with the commenters. The effect of this final rule is the elimination of one method of getting payment from A to B. It in no way prevents health care workers from purchasing health insurance, enrolling in trainings, or paying dues to a union or other association. Further, as previously described, the statute expressly allows payments to employers, and nothing in this rule would interfere with an employer's ability to make payroll deductions that are required by law or voluntary deductions for things like health and life insurance, contributions to charitable causes, retirement plan contributions, and union dues. Moreover, nothing in this rule would prevent a provider from affirmatively assigning his or her right to payment to a government agency.

We also note that there is a distinction between payroll deductions made by an employer and diversions of Medicaid payments as a result of a valid assignment. Section 1902(a)(32) of the Act specifically allows the state to make Medicaid payments to a home care worker's employer, and any deductions made by the employer are outside the scope of the statutory direct payment rule. Section 447.10(g)(4) pertained to payment diversion, not to voluntary wage deductions made under a bona fide employment arrangement. Specifically, it pertained to the class of practitioners for which the Medicaid program is the primary source of service revenues, such as home health workers, who are *not* employees of the state. As non-employees, such practitioners do not receive salaries or wages from the state. Instead, they are the recipients of Medicaid payment for services they furnish. Certain assignments or other transfers of such payments are permitted under section 1902(a)(32) of the Act; however, the diversion to other third parties not otherwise identified in the statute is not.

Comment: Several commenters indicated that the removal of paragraph (g)(4) from § 447.10 would result in potential harm to the Medicaid program, including to stakeholders. For example, commenters indicated that the removal of the paragraph would result in a reduction in the number of individual practitioners, leading to a decrease in access and quality of care for beneficiaries and an increase in more expensive institutional care. One commenter noted that government has a role to promote quality care and improve effectiveness and efficiency of care.

Several commenters stated that the proposed rule was not consistent with the mandates set forth in the Americans with Disabilities Act of 1990 (Pub. L. 101–336, enacted on July 26, 1990) (ADA), as it would result in destabilization of the workforce that provides in-home care, and it would increase the likelihood of an individual being institutionalized.

Response: While we agree that the government has a role in promoting high-quality, efficient healthcare, these commenter did not explain how or why these alleged harms would occur, nor did they cite to any evidence as to how the proposed change would cause harm to the Medicaid program, its beneficiaries, or the health care workforce that cares for the beneficiaries. Section 1902(a)(30)(A) of the Act requires states to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area. As long as the requirements of section 1902(a)(30)(A) of the Act are met, states have the flexibility to address concerns regarding access and quality of care utilizing economic and efficient payment methodologies. Additionally, as noted previously, this rule does not prevent individual practitioners from purchasing or receiving any benefits, memberships, or trainings using the income they earn from the Medicaid program. It simply ensures that Medicaid reimbursement is paid directly to the practitioner (or, as permitted by law, to the practitioner's employer, business agent, or facility where the care or service was furnished) and not impermissibly redirected to third parties. That is, this rule does not restrict what Medicaid providers may do with their Medicaid reimbursement once it is paid to them. As such, we do

[1] *See, for example,* Restatement 2d of Contracts, section 317. Certain types of wage assignments may be involuntary, and are typically called garnishments. *See generally,* 15 U.S.C. 1672; H.R. Conf. Rep. No. 1280 at 280, 93d Cong., 2d Sess. (1974).

not expect that this rule would adversely affect access to, or quality of, care.

Comment: Several commenters opposed the proposed rule and mentioned that eliminating the automatic payment of retirement or health care premiums from a provider's pay could cause a financial hardship if they had to purchase those benefits separately and not collectively through their employment.

Response: This rule does not affect voluntary wage deductions for employer-sponsored benefits. Section 1902(a)(32) of the Act specifically allows the state to make Medicaid payments to a home care worker's employer, and any deductions made by the employer are outside the scope of the statutory direct payment rule.

Comment: Several commenters opposed the proposed rule and stated that the removal of § 447.10(g)(4) would eliminate a worker's ability to participate in a health plan and is likely to cause those beneficiaries to shift to the state Medicaid program or other publicly subsidized coverage that will likely lead to higher rather than lower costs for the state.

Response: We believe the commenters are asserting that the loss of the ability to reassign a portion of an individual practitioner's Medicaid payment will ultimately result in that individual practitioner becoming a Medicaid beneficiary, which will likely result in increased costs for the state. As noted previously, we are removing § 447.10(g)(4) due to the lack of express or implicit statutory authority to implement new exceptions to section 1902(a)(32) of the Act. To the extent that the commenter is suggesting that practitioners will become uninsured as a result of this rule, we again reiterate that nothing in this rule prevents an individual practitioner from purchasing health insurance. Depending on a practitioner's particular circumstances, he or she may be eligible to purchase or obtain insurance coverage through a number of channels, including group coverage through an employer or an association, individual insurance coverage that is Affordable Care Act-compliant and guaranteed available to the general public, or, if the practitioner meets eligibility criteria, through Medicaid. As required by section 1902(a)(30)(A) of the Act, states must ensure that provider reimbursement rates are ''consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.''

C. Administrative Burden and State Flexibility

Comment: Several commenters that opposed the proposed rule noted the removal of this provision may result in administrative burden created by eliminating automatic payroll deductions for items such as health insurance, skills training, and other benefits customary for employees.

Response: While we acknowledge that automatic payroll deductions may reduce administrative burden for some health care workers who would otherwise need to make a separate payment, we again note that elimination of § 447.10(g)(4) will not disrupt payroll deductions that are made under a bona fide employment relationship and are otherwise permissible under state and federal law. Section 447.10(g)(4) pertained to the class of practitioners for which the Medicaid program is the primary source of service revenues, such as home health workers, who are not employees of the state or a home health agency that is paid by the state for its employees' services. As non-employees, such practitioners do not receive salaries or wages from the state. Instead, they are the recipients of Medicaid payments, and the state must directly pay them for their services. The removal of § 447.10(g)(4) eliminates the regulatory exception that purported to allow states to ''deduct'' or withhold portions of a provider's Medicaid reimbursement and re-direct the payment to third parties. However, individual practitioners can decide to use their payments for items like health and life insurance coverage and skills training. To the extent allowed by state and federal laws, states may also continue to allow individual practitioners to receive healthcare coverage from or through the state. Individual practitioners may also seek employment with home health agencies or other employers that offer benefit packages.

Comment: Many commenters stated that the proposed rule would impact the flexibility states have to administer their Medicaid programs, resulting in potential harm to providers because certain individual Medicaid practitioners would not be able to have items such as health insurance, skills training, and other benefits customary for employees reassigned from their reimbursement.

Response: States retain the flexibility to operate their Medicaid programs within existing Medicaid statutes and regulations. Nothing in this rule prevents a state from investing in its health care workforce, such as through strategies to ensure that the workforce is appropriately trained and that reimbursement rates are set at levels adequate to ensure beneficiaries have access to necessary care. As long as the requirements of section 1902(a)(30)(A) of the Act are met, states have flexibility to address concerns regarding access and quality of care utilizing economic and efficient payment methodologies.

D. Financial Management Services Under Self-directed Care

Comment: We received several comments that varied from support to opposition of the proposed rule's impact on self-directed care and FMS.

Response: The removal of § 447.10(g)(4) eliminates a state's ability to redirect provider reimbursement for the delivery services under section 1905(a) of the Act to third parties that are not recognized under the statute. However, 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), and 1915(k) and 1115 authorities of the statute.

Comment: One commenter requested that CMS codify, within the regulation text, the clarification included in the proposed rule regarding FMS under sections 1915(c), 1915(i), 1915(j), 1915(k) and 1115 authorities of the statute, to allow FMS vendors to reassign reimbursement with the expressed intent of paying for the services rendered by the FMS vendor.

Response: We note that payment to the FMS vendor for services is not affected by the provisions of the final rule because this model involves the FMS vendor receiving monies from the state to administer the participant-directed budget and make payment to providers on behalf of the beneficiary. As noted previously, the budget furnished to the FMS vendor is not a ''payment under the plan for any care or service provided to an individual,'' and thus, is not subject to the restrictions imposed by section 1902(a)(32) of the Act and § 447.10.

Under the authorities in sections 1915(c), 1915(i), 1915(j), 1915(k) and 1115 of the Act, FMS vendors are service providers. As such, depending on the authority, the state has the option to claim the cost it incurs for the provision of FMS as either a direct medical service, claimable via the applicable FMAP rate or, as a state program administrative expenditure. Therefore, we do not believe it is necessary to include regulation text outlining the ability of states to

reimburse entities for their contracted service provider functions, but we do reiterate that states may continue to do so. This was the case prior to the inclusion of § 447.10(g)(4).

E. Factoring

Comment: Several commenters noted that the original intent of section 1902(a)(32) of the Act was to eliminate the practice of selling Medicaid accounts receivables to ''factors,'' and not to prevent union dues and benefits from being deducted from the provider's reimbursement.

Response: We agree with the commenters that one of the original intents of section 1902(a)(32) of the Act, perhaps even the main one, was to address concerns relating to the sale of receivables to factors. But we do not believe that this was necessarily Congress' only concern, and we note that factoring is not specifically mentioned in the statute and CMS found it necessary to subsequently emphasize via regulation that payments to factors are not permitted. *See* § 447.10(h). In any event, Congress chose to address its concern about factoring with a broad prohibition and only limited exceptions. It could have done it in a more targeted way, but it did not. Notably, Congress did not limit itself to addressing payments to third parties that involving reassignment and powers of attorney; it also amended the statute to include ''or otherwise'' language, expanding its application to situations that did not involve factoring. While a commenter stated that, in the context of the sentence, ''or otherwise'' refers only to mechanisms similar to an ''assignment'' or ''power of attorney'' that permit third parties to act in the provider's stead in seeking Medicaid payments, and thus present a similar potential for abuse, we do not believe that the statute or legislative history makes this clear. Congress addressed its concern by requiring direct payment to providers in all circumstances, unless one of the limited statutory exceptions is met. As explained previously, we are removing § 447.10(g)(4) because the payment diversions it authorizes are neither explicitly nor implicitly authorized by the statute.

F. Reassignment of Union Dues

Comment: A large number of commenters, both in opposition and support of the proposed rule, mentioned unions and/or union dues, and some commenters mentioned the benefits workers receive from union membership. Other commenters noted that there are existing state laws surrounding union membership.

Response: We are removing § 447.10(g)(4) due to the lack of statutory authority to implement additional exceptions to section 1902(a)(32) of the Act. It is well outside the scope of our authority to regulate how an individual practitioner chooses to use the income he or she receives from the Medicaid program. While we realize some states relied on § 447.10(g)(4) as a mechanism to transfer contributions from practitioners to unions or other organizations, practitioners may continue contributing to unions or other organizations. This rule merely forecloses the ability of a practitioner to assign a portion of his or her Medicaid payment to a union. However, other means remain available. A provider may voluntarily agree to automatic credit card or bank account deductions to pay for union dues once 100 percent of reimbursement has been received. In regard to existing state laws surrounding union membership, if state law(s) and/or regulation(s) conflict with § 447.10 after the removal of paragraph (g)(4), the state Medicaid agency will need to take corrective action to comply with current federal statute and regulations. We are available to answer any questions states may have or to provide additional technical assistance to states.

Comment: Several commenters referenced state attempts to privatize providers or make providers state employees in order to reassign portions of the provider's reimbursement. Specifically, two commenter referenced states that passed legislation to privatize all homecare givers and force them to pay union dues.

Response: As the comments are not directly applicable to the removal § 447.10(g)(4), they are outside the scope of this final rule. However, we note that § 447.10(g)(4) was specifically applicable to Medicaid enrolled individual practitioners who provided services on a contractual basis.

Comment: One commenter noted that the proposed removal of § 447.10(g)(4) conflicts with National Labor Relations Act which allows home care worker agencies to deduct union dues from a provider's paycheck.

Response: The provisions of the final rule do not affect home care worker agencies that make payroll deductions as authorized by their employees, provided that the requirements in § 447.10(g)(1) are met. We do not see any conflict between removal of § 447.10(g)(4) and the National Labor Relations Act.

Comment: Multiple commenters stated the proposed removal of § 447.10(g)(4) will, in no way, prevent home care workers from voluntarily joining unions.

Response: We agree. This rule does not prohibit an individual practitioner from using his or her income to pay dues to a union.

Comment: One commenter indicated that authorized deductions of union dues or other benefit payments from their paycheck should not require a statutory exception to the anti-reassignment provision because such a deduction does not constitute a reassignment. Another commenter suggested that payroll deductions meet the qualification for third party payments provided in the current statute.

Response: Aside from certain enumerated exceptions at section 1902(a)(32) of the Act, Medicaid payments must be paid directly to the individual or institution that furnished the care or service to a Medicaid beneficiary. For Medicaid payments, a distinction must be made between payroll deductions and payment reassignment. Section 447.10(g)(4) pertained to the class of practitioners for which the Medicaid program is the primary source of service revenues, such as home health workers, who are not employees of the state. As non-employees, such practitioners do not receive salaries/wages from the state. Instead, they are the recipients of Medicaid payments, and only certain reassignments are permitted.

In addition, the existing third party payments permitted in the statute are not payroll deductions. Specifically, section 1902(a)(32) of the Act contains several specific exceptions to the general principle requiring direct payment to individual practitioners. There are exceptions for payments for practitioner services where payment is made to the employer of the practitioner, and the practitioner is required as a condition of employment to turn over fees to the employer; payments for practitioner services furnished in a facility when there is a contractual arrangement under which the facility bills on behalf of the practitioner; reassignments to a governmental agency or entity, or through a court order, or to a billing agent; payments to a practitioner whose patients were temporarily served by another identified practitioner; or payments for a childhood vaccine administered before October 1, 1994. None of these exceptions allow for the type of payments transfers requested by the commenters.

Comment: Several commenters stated that their rights will be impacted by this rule. They referenced examples such as

an individual's right to join/support a union, workers' rights, and individual rights under the Constitution.

Response: It should be noted that we are removing paragraph (g)(4) due to the lack of authority to implement additional exceptions to section 1902(a)(32) of the Act. The removal of § 447.10(g)(4) does not prevent individuals from exercising their individual rights. It only prevents the state from redirecting payments that, per the statute, must be paid directly to the practitioner. However, individual practitioners can purchase or contribute to the items previously allowed under paragraph (g)(4) through transactions separate from their Medicaid reimbursement.

With regard to workers' rights, § 447.10(g)(4) pertained to the class of practitioners for which the Medicaid program was the primary source of service revenues, who were not employees.

Comment: One commenter indicated § 447.10(g)(4) has been rescinded due to a bias against Unions.

Response: The intent of the rule is to ensure that Medicaid practitioners paid fully and directly for their services as required by law. The Department, in no way, intends to prevent or discourage union membership. Although rescission of § 447.10(g)(4) will eliminate a provider's ability to reassign portions of their reimbursement to contribute to union dues, we would like to note that providers remain free to contribute to union dues and other benefits through methods other than assignment of their right to payment.

G. Economic Impact

Comment: One commenter indicated that the agency lacked any data to justify the rescission of § 447.10(g)(4). This commenter also indicated that the agency lacked any analysis of this rule's impact on home care workers, beneficiaries, or states.

Response: During the 30-day comment period, we suggested stakeholders to provide comments and analyses with regard to the economic significance of this rule. While we received comments that provided estimates of the potential impact of this rule, those estimates were not supported by any substantive analysis. As the agency has no authority to create additional exceptions to section 1902(a)(32) of the Act, the provision at § 447.10(g)(4) must be removed regardless of its economic significance.

Comment: Several commenters indicated this rule would result in a significant economic impact. For example, one commenter indicated that assignments to unions amounted to $99.2 million in 2017, with cumulative total of $924,174,007 from 2000 to 2017. Another commenter indicated that assignments to unions amount to $150 million in 2017 and totaled approximately $1.4 billion since 2000.

Response: In the proposed rule, we estimated the dues related portion of the economic impact of this rule to be between $0 and approximately $71 million. While we received comments that provided estimates of the potential impact of this rule, those estimates were not supported by any documentation or analysis.

Comment: One commenter recommended that CMS to conduct and publish an analysis of the issues pertaining to reassignment before finalizing this rule.

Response: As mentioned in the proposed rule, we did not formally track the amount of reimbursement that was being reassigned to third parties under § 447.10(g)(4), although one state submitted a state plan amendment as a direct result of that provision. In the proposed rule, we estimated that the financial impact of removing § 447.10(g)(4) could range from $0–71 million. We also suggested that stakeholders provide comment and analysis with regard to the economic significance of this rule during the comment period. While we received comments that focused on the union dues aspect of this rule and estimated the potential impact to be $150 million in 2017 and $1.4 billion from 2000 to 2017 these estimates were not supported by any substantive analysis.

Comment: Several commenters stated that § 447.10(g)(4) helped to facilitate improper use of Medicaid funds.

Response: With the removal of the regulatory provision, these concerns should be alleviated. It is also important to note that through all aspects of the Medicaid program, we work to ensure that Medicaid funds are properly used by states.

Comment: Several commenters noted that the statement in the proposed rule, ''designed to ensure that taxpayer dollars dedicated to providing healthcare services for low-income vulnerable Americans are not siphoned away for other purposes,'' is false. Several commenters also noted that as union dues are deducted from already earned income, the state is merely a pass-through entity as it relates to the reassignment of items such as health insurance, skills training, and other benefits customary for employees.

Response: Outside of the exceptions listed in the statute, section 1902 (a)(32) of the Act requires direct payment to individual practitioners for the rendering of Medicaid services. A state agency is not permitted to ''pass through'' Medicaid reimbursement for healthcare services to third parties not recognized under the Medicaid statute.

Comment: One commenter stated that CMS mischaracterized and misunderstood the flow of payments to individual Medicaid practitioners. The commenter further elaborated by indicating that the proposed rule's regulatory impact analysis reflected a similar misunderstanding as it suggested that states may have increased reimbursement levels in order to reassign portions of a provider's payment to a third party. The commenter suggested that the removal of § 447.10(g)(4) may result in the lowering of rates if states are no longer able to make reassignments to third parties. Other commenters, however, stated rates would not be negatively affected.

Response: To our knowledge, one state submitted a state plan amendment to increase rates as a direct result of the ability to redirect a portion of individual practitioners' reimbursement for the items outlined in § 447.10(g)(4). We note that, as indicated in the proposed rule, we did not formally track states' diversion of provider reimbursement to third parties. As such, we cannot comment on other actions states may have taken in response to the issuance of § 447.10(g)(4). States are obligated to adopt payment methods that assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area as specified in section 1902(a)(30) of the Act. To the extent that any state has developed provider reimbursement rates to take into account a provider's reasonable overhead expenses, we do not anticipate that a state would reduce rates simply because it can no longer perform an administrative function for a provider. However, to the extent a state wishes to reduce documented payment levels, it must submit a State plan amendment and assure the proposed payment level does not trigger concerns regarding access to, or quality of, care.

H. 30-Day Comment Period

Comment: Many commenters took exception to the 30-day comment period for the proposed rule and requested a 60-day comment period instead.

Response: The APA requires the agency to provide at least a 30-day comment period for Medicaid

regulations. Because the removal of § 447.10(g)(4) is a straightforward rule change, we concluded that 30 days was ample time to respond. Commenters may be confused by section 1871(b)(1) of the Act, which requires a 60-day comment period for Medicare rulemaking. However, this regulation has no effect on the Medicare program, and thus is not subject to the requirements in section 1871 of the Act.

I. General

Comment: Multiple commenters noted that the removal of § 447.10(g)(4) has federalism implications and violates state sovereignty. Specifically, one commenter claimed that implementation of the proposed rule would disrupt states' established laws and would commandeer State governments and their subsidiaries in violation of the Tenth Amendment by regulating the ''States in their sovereign capacity.'' Another commenter claimed the agency is in violation of Executive Order 13132, which requires that the agency consult with the affected states, engage in real consideration of alternative policies, use the least restrictive means possible to achieve its results, and comply with other rules.

Response: We disagree with the commenters. While the removal of § 447.10(g)(4) may have an indirect effect on the way that states pay certain providers, it does not have the kind of ''substantial direct effect'' on states that would implicate Executive Order 13132. The provision at § 447.10(g)(4) was added in the interest of administrative efficiency and convenience for states and certain classes of providers.

As discussed previously, removal of § 447.10(g)(4) eliminates a state's ability to redirect a portion of provider reimbursement for items such as health insurance, skills training, and other benefits customary for employees to third parties (apart from government agencies or under a court order under § 447.10(e)) and federal law is clear that Medicaid payment may only be made to the individual beneficiary or person or entity furnishing the service, except in limited circumstances. Neither state law nor the federalism concerns raised by comments can override this federal statutory directive.

Comment: One commenter noted this rule is in direct conflict with the August 3, 2016 Center for Medicaid and CHIP Services (CMCS) Informational Bulletin (CIB) entitled ''Suggested Approaches for Strengthening and Stabilizing the Medicaid Home Care Workforce.''

Response: We believe the commenter is referring to the following language on the second page of the CIB: ''State Medicaid Agencies may, with the consent of the individual practitioner, 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 (§ 447.10(g)(4)).'' The language in the CIB will be revised to align with the language in this final rule.

IV. Provisions of the Final Regulations

After consideration of the public comments, we are finalizing our proposal to remove § 447.10(g)(4).

V. Collection of Information Requirements

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

VI. Regulatory Impact Analysis

A. Statement of Need

As outlined in the proposed rule, we were concerned that § 447.10(g)(4) was insufficiently linked to the exceptions expressly permitted by the statute and violated the statute. As noted in the January 16, 2014 final rule (79 FR 2947, 3001), section 1902(a)(32) of the Act provides for a number of exceptions to the direct payment requirement, but the language does not explicitly or implicitly authorize the agency to create new exceptions. Therefore, the regulatory provision grants permissions that Congress has foreclosed. Accordingly, we removed the regulatory exception at § 447.10(g)(4).

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). We estimate that this final rule could be ''economically significant'' as it may have an annual effect on the economy in excess of the $100 million threshold of Executive Order 12866, and hence that this final rule is also a major rule under the Congressional Review Act. However, there was considerable uncertainty around this estimate. As such, the Department invited public comments to help refine this analysis, but no substantive analysis of the economic impact of this rule was provided.

As discussed previously, in the January 16, 2014 final rule (79 FR 2947, 3039), we authorized states to make payments to third parties on behalf of individual providers ''for benefits such as health insurance, skills training, and other benefits customary for employees.'' We lacked information with which to quantify the potential impacts of this policy on these types of payments as the Department does not formally track the amount of reimbursement that is being reassigned to third parties under the regulatory provision that we are now removing. To offer one example, one likely impact of this rulemaking is that states will stop redirecting a portion of homecare workers' payments to unions for

membership dues. We estimated that unions may currently collect as much as $71 million from such assignments.[2] While we have not similarly quantified the amount of other authorized reassignments, such as health insurance, skills training, or other benefits, we estimated that the amount of payments made to third parties on behalf of individual providers for the variety of benefits within the scope of this rulemaking could potentially be in excess of $100 million. While we sought comments on this estimate, and particularly on the type and amount of payments currently being reassigned under the exceptions in § 447.10(g), we did not receive any comments that provided a substantive analysis with regard to the economic significance of this rule.

The potential direct financial impact to providers of this policy change could be affected by many factors, such as the nature and amounts of the types of payments currently being reassigned and decisions made by homecare providers after a final policy takes effect about whether or not to voluntarily make payments to third parties for these types of benefits once the payments are no longer automatically withheld from their reimbursement checks. The Department was unable to quantify these direct financial impacts in the absence of specific information about the types and amount of payments being reassigned. Even where it may have been possible to derive such estimates, such as with the example of union dues, the Department lacks information to reliably estimate the proportion of homecare providers likely to stop making payments versus those likely to continue making payments through alternative means. While we requested comments on the factors that might influence the direct financial impacts to providers and recipients of reassignments of this policy change for the varied types and amount of payments currently being reassigned under the exceptions in § 447.10(g), we did not receive any substantive analysis regarding this issue.

Although states will no longer be able to withhold and redirect portions of a provider's payment to third parties not recognized by the statute, states are expected to maintain provider rates at levels necessary to ensure access to care. It may be the case that some states have set provider rates by taking into account the costs of health and welfare benefits, training costs, and other benefits. This rule does not alter the costs of those benefits to the provider, but may alter the means by which the provider remits payments to cover those costs—that is, instead of the state making payments to third parties on a provider's behalf, the provider would make the payments directly to the third parties. We requested comments, particularly from states, on potential state behavior under the proposed policy; however, we did not receive any substantive analysis or useful information regarding this issue.

As described above, it was difficult for us to conduct a detailed quantitative analysis given this considerable uncertainty and lack of data. However, we believe that without this final rule, states may be engaging in practices that do not comport with section 1902(a)(32) of the Act. We welcomed comments with regard to the quantitative impact of the elimination of states' ability to reassign Medicaid payment for items such as health insurance, skills training and other benefits customary for employees. We also sought comments identifying impacts to states and the federal government as a result of this final rule, including on the assumption that the time, effort and financial resources necessary to comply with the proposed requirement would be incurred by states during the normal course of their activities, and therefore, would not impose additional costs. While commenters provided estimates of the potential impacts of this rule, the estimates only focused on the union dues aspect of the rule and they were not supported by any substantive analysis. For example, one commenter indicated that assignments to unions amounted to $99.2 million in 2017, with cumulative total of $924,174,007 from 2000 to 2017. Another commenter indicated that assignments to unions amount to $150 million in 2017 and totaled approximately $1.4 billion since 2000.

C. Anticipated Effects

The RFA requires agencies to analyze options for regulatory relief of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of less than $7.5 million to $38.5 million in any 1 year. Individual employees 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 will not have a significant economic impact on a substantial number of small entities. The significance on small business entities refers to the potential impact on the providers. Though we received comments that claimed the removal of § 447.10(g)(4) would create an administrative burden for providers, these comments lacked any substantive data or supporting detail. We currently do not possess sufficient data to quantify administrative burden associated with the removal of the regulatory text at § 447.10(g)(4), however, we do not believe the burden would be significant for any provider as any burden associated with this rescission would be due to the provider making arrangements to pay for items that were previously purchased or contributed to via the assignments allowed under § 447.10(g)(4). Those providers with a bank account at a financial institution, or another financial product such as a prepaid debit card, could elect an automatic electronic payment for items previously reassigned by the state. In those instances, the burden cost would be one time and negligible since deductions can be set up through financial institutions and can often easily be set up online. For those providers without a bank account, the burden would be the cost of mailing payments directly to a third party or opening a bank account or an alternative financial product. In those instances, the associated cost of mailing payments each month would be negligible and would not exceed the 3 percent threshold of revenue earned by the vast majority of non-employer entities that render Home Health Care Services under the Census Bureau's North American Industry Classification System (NAICS) 62161, as reflected in Table 1, most of which earn revenue that does not exceed $25,000 per year.

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

For instance, a $10 box of envelopes and $6.60 for 12 stamps equals $17 total per year, which is less than 3 percent of $25,000 or $750. With regard to providers on the low end of the revenue spectrum with revenues of $5,000 per year, 3 percent of their revenue equates to $150, which far exceeds the cost of $17 per year for postage. We also assume that the actual items purchased through third parties (existing union dues, training programs, health premiums) would be unaffected by the regulatory change as § 447.10(g)(4) did not establish new items, but merely allowed for the state to reassign payments for these items.

TABLE 1—NON-EMPLOYER ESTABLISHMENTS BY REVENUE CATEGORY, 2016

2012 NAICS code	Meaning of 2012 NAICS code	Meaning of receipt size of establishments	Number of nonemployer establishments
62161	Home health care services	Establishments with sales or receipts less than $5,000	83,679
62161	Home health care services	Establishments with sales or receipts of $5,000 to $9,999	74,158
62161	Home health care services	Establishments with sales or receipts of $10,000 to $24,999	122,219

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 will 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 2019, that threshold is approximately $154 million. This rule is not expected to have an impact that exceeds the $154 million threshold, and therefore, will not have a significant 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 issuing guidance to require states to formally document consent to reassign portions of a provider's payment. We also considered limiting the items for which provider reassignment could be made. However, we had become concerned that § 447.10(g)(4) was insufficiently linked to the exceptions expressly permitted by the statute and violated the statute. Therefore, we believed that removing the regulatory exception was the best course of action.

E. Accounting Statement

As required by OMB Circular A–4 under Executive Order 12866 (available at *https://www.whitehouse.gov/sites/whitehouse.gov/files/omb/circulars/A4/a-4.pdf*) in Table 2, we have prepared an accounting statement showing the classification of transfers associated with the provisions in this final 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 2—ACCOUNTING STATEMENT

Category	Low estimate	High estimate	Units		
			Year dollars	Discount rate (%)	Period covered
Transfers					
Annualized Monetized $ millions/year	0	$71	2017	3	2019
	0	71	2017	7	2019
From whom to whom?	From third parties to home health providers.				

F. Regulatory Reform Analysis Under E.O. 13771

Executive Order 13771, entitled ''Reducing Regulation and Controlling Regulatory Costs,'' was issued on January 30, 2017 and requires that the costs associated with significant new regulations ''shall, to the extent permitted by law, be offset by the elimination of existing costs associated with at least two prior regulations.'' This final rule is considered an E.O. 13771 regulatory action.

G. Conclusion

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

List of Subjects in 42 CFR Part 447

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

For the reasons set forth in the preamble, the Centers for Medicare &

Medicaid Services amends 42 CFR chapter IV as set forth below:

PART 447—PAYMENTS FOR SERVICES

■ 1. The authority citation for part 447 is revised to read as follows:

Authority: 42 U.S.C. 1302.

§ 447.10 [Amended]

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

Dated: March 13, 2019.

Seema Verma,

Administrator, Centers for Medicare & Medicaid Services.

Dated: April 9, 2019.

Alex M. Azar II,

Secretary, Department of Health and Human Services.

[FR Doc. 2019–09118 Filed 5–2–19; 11:15 am]

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DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 622

[Docket No. 130312235–3658–02]

RIN 0648–XH011

Fisheries of the Caribbean, Gulf of Mexico, and South Atlantic; Snapper-Grouper Resources of the South Atlantic; 2019 Vermilion Snapper Commercial Trip Limit Reduction

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

ACTION: Temporary rule; commercial trip limit reduction.

SUMMARY: NMFS issues this temporary rule to reduce the commercial trip limit for vermilion snapper in or from the exclusive economic zone (EEZ) of the South Atlantic to 500 lb (227 kg), gutted weight, 555 lb (252 kg), round weight. This trip limit reduction is necessary to protect the South Atlantic vermilion snapper resource.

DATES: This rule is effective 12:01 a.m., local time, May 6, 2019, until 12:01 a.m., local time, July 1, 2019.

FOR FURTHER INFORMATION CONTACT: Nikhil Mehta, NMFS Southeast Regional Office, telephone: 727–824–5305, email: *nikhil.mehta@noaa.gov.*

SUPPLEMENTARY INFORMATION: The snapper-grouper fishery in the South Atlantic includes vermilion snapper and is managed under the Fishery Management Plan for the Snapper-Grouper Fishery of the South Atlantic Region (FMP). The South Atlantic Fishery Management Council prepared the FMP. The FMP is implemented by NMFS under the authority of the Magnuson-Stevens Fishery Conservation and Management Act (Magnuson-Stevens Act) by regulations at 50 CFR part 622.

The commercial ACL (commercial quota) for vermilion snapper in the South Atlantic is divided equally among two 6-month fishing seasons, January through June and July through December. For the January 1 through June 30, 2019, fishing season, the commercial quota is 388,703 lb (176,313 kg), gutted weight, 431,460 lb (195,707 kg), round weight (50 CFR 622.190(a)(4)(i)(D)). On May 9, 2019, upon implementation of the final rule for Abbreviated Framework 2 to the FMP (84 FR 14021; April 9, 2019), the commercial quota for each vermilion snapper 6-month fishing season will be increased to 483,658 lb (219,384 kg), gutted weight; 536,860 lb (243,516 kg), round weight.

Under 50 CFR 622.191(a)(6)(ii), NMFS is required to reduce the commercial trip limit for vermilion snapper from 1,000 lb (454 kg), gutted weight, 1,110 lb (503 kg), round weight, to 500 lb (227 kg), gutted weight, 555 lb (252 kg), round weight, when 75 percent of the applicable commercial quota is reached or projected to be reached, by filing a notification to that effect with the Office of the Federal Register. Based on the best scientific information available, NMFS has determined that the trip limit should be reduced based on the current commercial quota for the January 1 through June 30, 2019, fishing season for vermilion snapper. Additionally, NMFS has determined that 75 percent of the available commercial quota that will be effective on May 9, 2019, for the January 1 through June 30, 2019, fishing season for vermilion snapper will be reached by May 2, 2019. Accordingly, NMFS is reducing the commercial trip limit for vermilion snapper to 500 lb (227 kg), gutted weight, 555 lb (252 kg), round weight, in or from the South Atlantic EEZ at 12:01 a.m., local time, 5 calendar days after this notice files with the Office of the Federal Register. This reduced commercial trip limit will remain in effect until the start of the next fishing season on July 1, 2019, or until the applicable commercial quota is reached and the commercial sector closes, whichever occurs first. The next vermilion snapper season in the South Atlantic will open on July 1, 2019, with a commercial trip limit of 1,000 lb (454 kg), gutted weight; 1,110 lb (503 kg), round weight (50 CFR 622.191(a)(6)(i)).

Classification

The Regional Administrator, Southeast Region, NMFS, has determined this temporary rule is necessary for the conservation and management of South Atlantic vermilion snapper and is consistent with the Magnuson-Stevens Act and other applicable laws.

This action is taken under 50 CFR 622.191(a)(6)(ii) and is exempt from review under Executive Order 12866.

These measures are exempt from the procedures of the Regulatory Flexibility Act because the temporary rule is issued without opportunity for prior notice and comment.

This action responds to the best scientific information available. The Assistant Administrator for Fisheries, NOAA (AA), finds that the need to immediately implement this commercial trip limit reduction constitutes good cause to waive the requirements to provide prior notice and opportunity for public comment pursuant to the authority set forth in 5 U.S.C. 553(b)(B), because prior notice and opportunity for public comment on this temporary rule is unnecessary and contrary to the public interest. Such procedures are unnecessary because the rule establishing and providing for a reduction in the commercial trip limit has already been subject to notice and comment, and all that remains is to notify the public of the commercial trip limit reduction. Providing prior notice and opportunity for public comment is contrary to the public interest because any delay in reducing the commercial trip limit could result in the commercial quota being exceeded. There is a need to immediately implement this action to protect the vermilion snapper resource, since the capacity of the fishing fleet allows for rapid harvest of the commercial quota. Providing prior notice and opportunity for public comment on this action would require time and increase the likelihood that the commercial sector could exceed its quota.

For the aforementioned reasons, the AA also finds good cause to waive the 30-day delay in the effectiveness of this action under 5 U.S.C. 553(d)(3).

Authority: 16 U.S.C. 1801 *et seq.*

Dated: April 30, 2019.

Jennifer M. Wallace,

Acting Director, Office of Sustainable Fisheries, National Marine Fisheries Service.

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