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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 438

[CMS–2402–F]

RIN 0938–AT10

Medicaid Program; The Use of New or Increased Pass-Through Payments in Medicaid Managed Care Delivery Systems

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

ACTION: Final rule.

SUMMARY: This rule finalizes changes to the pass-through payment transition periods and the maximum amount of pass-through payments permitted annually during the transition periods under Medicaid managed care contract(s) and rate certification(s). This final rule prevents increases in pass-through payments and the addition of new pass-through payments beyond those in place when the pass-through payment transition periods were established, in the final Medicaid managed care regulations effective July 5, 2016.

DATES: *Effective Date:* These regulations are effective on March 20, 2017.

FOR FURTHER INFORMATION CONTACT: John Giles, (410) 786–1255.

SUPPLEMENTARY INFORMATION:

I. Background

In the June 1, 2015 **Federal Register** (80 FR 31098), we published the ''Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability'' proposed rule (''June 1, 2015 proposed rule''). As part of the actuarial soundness proposals, we proposed to define actuarially sound capitation rates as those sufficient to provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract, including furnishing of covered services and operation of the managed care plan for the duration of the contract. Among the proposals was a general rule that the state may not direct the managed care organization's (MCO's), prepaid inpatient health plan's (PIHP's), or prepaid ambulatory health plan's (PAHP's) expenditures under the contract.

In the May 6, 2016 **Federal Register** (81 FR 27498), we published the ''Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability'' final rule (''May 6, 2016 final rule''), which finalized the June 1, 2015 proposed rule. In the final rule, we finalized, with some revisions, the proposal which limited state direction of payments, including pass-through payments as defined below.

In the November 22, 2016 **Federal Register** (81 FR 83777), we published the ''Medicaid Program; The Use of New or Increased Pass-Through Payments in Medicaid Managed Care Delivery Systems'' proposed rule (''November 22, 2016 proposed rule''). This rule finalizes the November 22, 2016 proposed rule as discussed below. This final rule is consistent with the intent of the May 6, 2016 final rule to provide transition periods for states that already use pass-through payments—these transition periods allow states to implement changes to existing pass-through payments over a period of time to minimize disruption and to ensure continued financial support for safety-net providers. As we discussed in the November 22, 2016 proposed rule, this final rule is also consistent with the CMCS Informational Bulletin (CIB) concerning ''The Use of New or Increased Pass-Through Payments in Medicaid Managed Care Delivery Systems,'' which was published on July 29, 2016.

A. Summary of the Medicaid Managed Care May 6, 2016 Final Rule

We finalized a policy to limit state direction of payments, including pass-through payments, at § 438.6(c) and (d) in the May 6, 2016 final rule (81 FR 27587 through 27592). Specifically, under the final rule (81 FR 27588), we defined pass-through payments at § 438.6(a) as any amount required by the state (and considered in calculating the actuarially sound capitation rate) to be added to the contracted payment rates paid by the MCO, PIHP, or PAHP to hospitals, physicians, or nursing facilities that is not for the following purposes: A specific service or benefit provided to a specific enrollee covered under the contract; a provider payment methodology permitted under § 438.6(c)(1)(i) through (iii) for services and enrollees covered under the contract; a subcapitated payment arrangement for a specific set of services and enrollees covered under the contract; graduate medical education (GME) payments; or federally-qualified health center (FQHC) or rural health clinic (RHC) wrap around payments. We noted that section 1903(m)(2)(A) of the Social Security Act (the Act) requires that capitation payments to managed care plans be actuarially sound; we interpret this requirement to mean that payments under the managed care contract must align with the provision of services to beneficiaries covered under the contract. We provided that these pass-through payments are not consistent with our regulatory standards for actuarially sound rates because they do not tie provider payments with the provision of services. The final rule contains a detailed description of the policy rationale (81 FR 27587 through 27592).

In an effort to provide a smooth transition for network providers, to support access for the beneficiaries they serve, and to provide states and managed care plans with adequate time to design and implement payment systems that link provider reimbursement with services covered under the contract or associated quality outcomes, we finalized transition periods related to pass-through payments for the specified provider types to which states make most pass-through payments under Medicaid managed care programs: Hospitals, physicians, and nursing homes (81 FR 27590 through 27592). As finalized, § 438.6(d)(2) and (3) provide a 10-year transition period for hospitals, subject to limitations on the amount of pass-through payments. For MCO, PIHP, or PAHP contracts beginning on or after July 1, 2027, states will not be permitted to require pass-through payments for hospitals. The final rule also provides a 5-year transition period for pass-through payments to physicians and nursing facilities. For MCO, PIHP, or PAHP contracts beginning on or after July 1, 2022, states will not be permitted to require pass-through payments for physicians or nursing facilities. These transition periods provide states, network providers, and managed care plans significant time and flexibility to integrate current pass-through payment arrangements into allowable payment structures under actuarially sound capitation rates, including enhanced fee schedules or the other approaches consistent with § 438.6(c).

As finalized in the May 6, 2016 final rule, § 438.6(d) limits the amount of pass-through payments to hospitals as a percentage of the ''base amount,'' which is defined in paragraph (a) and

calculated under rules in paragraph (d)(2). Section 438.6(d)(3) specifies a schedule for the phased reduction of the base amount, limiting the amount of pass-through payments to hospitals. For contracts beginning on or after July 1, 2017, the state may require pass-through payments to hospitals under the contract up to 100 percent of the base amount, as defined in the final rule. For subsequent contract years (contracts beginning on or after July 1, 2018 through contracts beginning on or after July 1, 2026), the portion of the base amount available for pass-through payments decreases by 10 percentage points per year. For contracts beginning on or after July 1, 2027, no pass-through payments to hospitals are permitted. The May 6, 2016 final rule noted that nothing would prohibit a state from eliminating pass-through payments to hospitals before contracts beginning on or after July 1, 2027. However, the final rule provided for a phased reduction in the percentage of the base amount that can be used for pass-through payments, because a phased transition would support the development of permissible and accountable payment approaches while mitigating any disruption to states and providers.

We believe that states will be able to more easily transition existing pass-through payments to physicians and nursing facilities to payment structures linked to services covered under the contract compared to the transition necessary for similar payments to hospitals. Consequently, the May 6, 2016 final rule, in § 438.6(d)(5), provided a shorter time period for eliminating pass-through payments to physicians and nursing facilities and did not prescribe a limit or phased reduction in these payments; states have the option to eliminate these payments immediately or phase down these payments over the 5 year transition period if they prefer. As noted in the May 6, 2016 final rule, the distinction between hospitals and nursing facilities and physicians was also based on the comments from stakeholders during the public comment period (81 FR 27590).

B. Questions About the May 6, 2016 Final Rule

Since publication of the May 6, 2016 final rule, we have received inquiries about states' ability to integrate new or increased pass-through payments into Medicaid managed care contracts. As explained in the CMCS Informational Bulletin (CIB) published on July 29, 2016,[1] adding new or increased pass-through payments for hospitals, physicians, or nursing facilities complicates the required transition of these pass-through payments to permissible provider payment models.

The transition periods under the May 6, 2016 final rule provide states, network providers, and managed care plans significant time and flexibility to move existing pass-through payment arrangements (that is, those in effect when the final rule was published) into different, permissible payment structures under actuarially sound capitation rates, including enhanced fee schedules or the other approaches consistent with § 438.6(c). We did not intend for states, after the May 6, 2016 final rule was published, to begin additional or new pass-through payments, or to increase existing pass-through payments; such actions are contrary to and undermine the policy goal of eliminating pass-through payments. We proposed in the November 22, 2016 proposed rule and finalize here that we will not permit a pass-through payment amount to exceed the lesser of the amounts calculated under paragraph (d)(3) of this final rule. For states to add new or to increase existing pass-through payments is inconsistent with longstanding CMS policy, the proposal made in the June 1, 2015 proposed rule, and the May 6, 2016 final rule, which reflects the general policy goal to effectively and efficiently transition away from pass-through payments.

Under the May 6, 2016 final rule, we provided a delayed compliance deadline for § 438.6(c) and (d); we will enforce compliance with § 438.6(c) and (d) no later than the rating period for Medicaid managed care contracts beginning on or after July 1, 2017. Our exercise of enforcement discretion in this respect was not intended to create new opportunities for states to add or increase existing pass-through payments before July 1, 2017. This delay was intended to address concerns articulated by commenters, among them states and providers, that an abrupt end to directed pass-through payments could cause damaging disruption to safety-net providers. As discussed in the May 6, 2016 final rule and this final rule, pass-through payments are inconsistent with our interpretation and implementation of the statutory requirement for actuarially sound capitation rates because pass-through payments do not tie provider payments to the provision of services under the contract (81 FR 27588). A distinguishing characteristic of a pass-through payment is that a managed care plan is contractually required by the state to pay providers an amount that is disconnected from the amount, quality, or outcomes of services delivered to enrollees under the contract during the rating period of the contract. When managed care plans only serve as a conduit for passing payments to providers independent of delivered services, such payments reduce managed care plans' ability to control expenditures, effectively use value-based purchasing strategies, implement provider-based quality initiatives, and generally use the full capitation payment to manage the care of enrollees. The May 6, 2016 final rule made clear our position on these payments and our intent that they be eliminated from Medicaid managed care delivery systems, except for the directed payment models permitted by § 438.6(c), or the payments excluded from the definition of a pass-through payment in § 438.6(a), such as FQHC wrap payments.

The transition periods provided under § 438.6(d) are for states to identify existing pass-through payments and begin either tying such payments directly to services and utilization covered under the contract or eliminating them completely in favor of other support mechanisms for providers that comply with the requirements in § 438.6(c). The transition periods for current pass-through payments minimize disruption to local health care systems and interruption of beneficiary access by permitting a gradual step down from current levels of pass-through payments: (1) At the schedule and subject to the limit announced in the May 6, 2016 final rule for hospitals under § 438.6(d)(3); and (2) at a schedule adopted by the state for physicians and nursing facilities under § 438.6(d)(5). By providing states, network providers, and managed care plans significant time and flexibility to integrate current pass-through payment arrangements into different payment structures (including enhanced fee schedules or the other approaches consistent with § 438.6(c)) and into actuarially sound capitation rates, we intended to address comments that the June 1, 2015 proposed rule would be unnecessarily disruptive and endanger safety-net provider systems that states have developed for Medicaid.

Questions from states following the May 6, 2016 final rule indicated that the transition period and delayed enforcement date have caused some

[1] The Use of New or Increased Pass-Through Payments in Medicaid Managed Care Delivery Systems; available at *https://www.medicaid.gov/federal-policy-guidance/downloads/cib072916.pdf.* CMCS also noted in this CIB that it intended to further address in future rulemaking the issue of adding new or increased pass-through payments to managed care contracts.

confusion regarding our intent for increased and new pass-through payments for contracts prior to July 1, 2017, because the final rule did not explicitly prohibit such additions or increases. While we assumed such a prohibition was implicit in the May 6, 2016 final rule, as our discussion of § 438.6(d) made clear that pass-through payments were to be discontinued, we believe that this additional rulemaking is necessary to clarify this issue in light of the recent questions. Under this final rule, we are linking pass-through payments permitted during the transition period to the aggregate amounts of pass-through payments that were in place at the time the May 6, 2016 final rule became effective on July 5, 2016, which is consistent with the intent under the May 6, 2016 final rule to phase out pass-through payments under Medicaid managed care contracts.

II. Provisions of the Proposed Regulations and Analysis of and Responses to Public Comments

We received 46 timely comments from the public, including comments from hospitals, hospital associations, state Medicaid agencies, Medicaid managed care plans, and other healthcare providers and associations. The following sections, arranged by subject area, are a summary of the comments we received. In response to the November 22, 2016 proposed rule, some commenters chose to raise issues that were beyond the scope of our proposals. In this final rule, we are not summarizing or responding to those comments.

We proposed to revise § 438.6(d) to better effectuate the intent of the May 6, 2016 final rule. In the November 22, 2016 proposed rule, we first proposed to limit the availability of the transition periods in § 438.6(d)(3) and (5) (that is, the ability to continue pass-through payments for hospitals, physicians, or nursing facilities) to states that can demonstrate that they had such pass-through payments in either: (A) Managed care contract(s) and rate certification(s) for the rating period that includes July 5, 2016, and that were submitted for our review and approval on or before July 5, 2016; or (B) if the managed care contract(s) and rate certification(s) for the rating period that includes July 5, 2016 had not been submitted to us on or before July 5, 2016, the managed care contract(s) and rate certification(s) for a rating period before July 5, 2016 that had been most recently submitted to us for review and approval as of July 5, 2016.

Second, we proposed to prohibit retroactive adjustments or amendments to managed care contract(s) and rate certification(s) to add new pass-through payments or increase existing pass-through payments defined in § 438.6(a). In the proposed rule, we noted that we would not permit a pass-through payment amount to exceed the lesser of the amounts calculated under paragraph (d)(3).

Third, we proposed to establish a new maximum amount of permitted pass-through payments for each year of the transition period. For hospitals, a state would be limited (in the total amount of permissible pass-through payments) during each year of the transition period to the lesser of either: (A) The percentage of the base amount applicable to that contract year; or (B) the pass-through payment amount identified in proposed paragraph (d)(1)(i). Thus, the amount of pass-through payments identified by the state in order to satisfy proposed paragraph (d)(1)(i) would be compared to the amount representing the applicable percentage of the base amount that is calculated for each year of the transition period. For pass-through payments to physicians and nursing facilities, we also proposed to limit the amount of pass-through payments during the transition period to the amount of pass-through payments to physicians and nursing facilities under the contract and rate certification identified in proposed paragraph (d)(1)(i).

In making these comparisons to the pass-through payments under the managed care contract(s) in effect for the rating period covering July 5, 2016 as identified in proposed paragraph (d)(1)(i)(A), or the rating period before July 5, 2016 as identified in proposed paragraph (d)(1)(i)(B), we noted that we would look at total pass-through payment amounts for the specified provider types. Past aggregate amounts of hospital pass-through payments will be used in determining the maximum amount for hospital pass-through payments during the transition period; past aggregate amounts of physician pass-through payments will be used in determining the maximum amount for physician pass-through payments during the transition period; and past aggregate amounts of nursing facility pass-through payments will be used in determining the maximum amount for nursing facility pass-through payments during the transition period.

Under the November 22, 2016 proposed rule, the aggregate amounts of pass-through payments in each provider category would be used to set applicable limits for the provider type during the transition period, without regard to the specific provider(s) that received a pass-through payment. For example, if the pass-through payments in the contract identified under paragraph (d)(1)(i) were to 5 specific hospitals, the aggregate amount of pass-through payments to those hospitals would be relevant in establishing the limit during the transition period, but different hospitals could be the recipients of pass-through payments during the transition. We requested comment on our proposed approach as a whole, as well as our specific proposals to amend the existing regulation text and revise paragraph (d)(1) (adding new (d)(1)(i) and (ii)), revise paragraph (d)(3) (adding new (d)(3)(i) and (ii)), and revise paragraph (d)(5).

A. General Comments

Comment: Some commenters stated concerns with the overall proposal and stated that the current proposal would limit state flexibility for pass-through payments beyond what was finalized in the May 6, 2016 final rule; these commenters recommended that we not finalize the November 22, 2016 proposed rule and recommended that we ensure that states continue to have the flexibility permitted in the May 6, 2016 final rule for pass-through payments in Medicaid managed care programs.

Response: We do not agree with commenters that states should have more flexibility in this area than this final rule provides. We believe that this final rule flows from the intent of the May 6, 2016 final rule to phase out pass-through payments under Medicaid managed care contracts and ensure that the transition periods be used by states that had pass-through payments in their MCO, PIHP, or PAHP contracts when we finalized the May 6, 2016 final rule. While we recognize that the regulation text finalized in the May 6, 2016 final rule was not explicit on this point and have taken steps to amend this final rule here to rectify that, this final rule is consistent with the policy and goals of the May 6, 2016 final rule in adopting transition periods. This final regulation maintains the significant time and flexibility provided to states, network providers, and managed care plans during the transition periods to move existing pass-through payment arrangements (those in effect when the May 6, 2016 final rule was published) into different, permissible payment structures under actuarially sound capitation rates, including enhanced fee schedules or the other approaches consistent with § 438.6(c) that tie managed care payments to services and utilization (and outcomes) covered under the contract.

Comment: Some commenters recommended that we not finalize this rule and that we not further restrict or limit pass-through payments beyond what was included in the May 6, 2016 final rule to support safety-net providers that provide care to Medicaid managed care enrollees. These commenters stated that states and providers have already begun to plan for the transition periods beginning in July 2017 and that additional constraints will add significant burden on safety-net providers.

Response: We do not agree that the proposed provisions, finalized here, restrict or limit states from continuing to use pass-through payments to support safety-net providers that provide care to Medicaid managed care enrollees during the transition periods adopted in the May 6, 2016 final rule. The May 6, 2016 final rule provided transition periods designed and finalized to enable *affected* providers, states, and managed care plans—meaning those that already had pass-through payments in place—to transition away from existing pass-through payments and limit disruption to safety-net providers. We believe such payments can be transitioned into permissible and accountable payment models that are tied to covered services, value-based payment structures, or delivery system reform initiatives without undermining access for Medicaid managed care enrollees. This rule flows from and reinforces the intent of the May 6, 2016 final rule by ensuring that the transition periods are used by states that had pass-through payments in their MCO, PIHP, or PAHP contracts when we finalized the May 6, 2016 final rule. These are the states for which we were concerned, based on the comments to the June 1, 2015 proposed rule, that an abrupt end to pass-through payments could be disruptive to their health care delivery system and safety-net providers. While we recognize that the regulation text finalized in the May 6, 2016 final rule was not explicit on this point and have taken steps to amend this final rule here to rectify that, this final rule is consistent with the policy and goals of the May 6, 2016 final rule in adopting transition periods.

If states do not currently have pass-through payments in their managed care contracts, we believe that the transition periods are unnecessary to avoid disruption. States that do not have pass-through payments in their managed care contracts that wish to pursue delivery system and provider payment initiatives are already in a strong position to design and implement allowable payment structures under actuarially sound capitation rates, including enhanced fee schedules or the other approaches consistent with § 438.6(c) that tie managed care payments to services and utilization covered under the contract.

We understand that states and providers have already begun to plan for the transition periods beginning in July 2017, but we do not believe that this rule will create substantially more constraints or add significant burden on safety-net providers. Under the May 6, 2016 final rule, we did not intend to permit or encourage states to add new pass-through payments or to ramp-up pass-through payments in ways that are not consistent with the elimination of pass-through payments during the transition periods. Adding new or increased pass-through payments would substantially complicate the required transition away from pass-through payments, potentially creating more disruption for safety-net providers by increasing dependence on these payments and then compressing the actual amount of time available to eliminate them.

Comment: Some commenters recommended that the proposed rule not be finalized until the new administration has the opportunity to review and ensure that the policy in the November 22, 2016 proposed rule is consistent with the new administration's Medicaid policy and goals. These commenters stated that such an approach is congruent with the general practice and policy that significant new rules should not be issued shortly before a change in the administration.

Response: A delay in finalizing this rule is contrary to our goals and policy so we do not accept this recommendation. This final rule flows from and reinforces the intent of the May 6, 2016 final rule to phase out pass-through payments under Medicaid managed care contracts; any delay would undermine the goals of that rule and make the transition to an actuarially sound approach more difficult. We discussed in the June 1, 2015 proposed rule, the May 6, 2016 final rule, the July 29, 2016 CIB, and the November 22, 2016 proposed rule the rationale for our position that pass-through payments are not consistent with our regulatory standards for actuarially sound rates; specifically, because they do not tie provider payments with the provision of services. While we recognize that the regulation text finalized in the May 6, 2016 final rule was not explicit on the point that this final rulemaking addresses (for example, that the transition periods were not for the initial adoption of and then elimination of new or increased pass-through payments), this final rule is consistent with the policy and goals of the May 6, 2016 final rule in adopting transition periods. This final rule is congruent with established and published policy guidance, is not a new policy being implemented at the last minute, and is timely as states prepare for the July 1, 2017 implementation date.

In addition to comments on the proposal generally, we received comments about specific provisions in the proposal. We address and respond to those comments below.

B. Comments on § 438.6(d)(1)

We proposed to revise paragraph (d)(1) to clarify that a state may continue to require an MCO, PIHP, or PAHP to make pass-through payments (as defined in § 438.6(a)) to network providers that are hospitals, physicians, or nursing facilities under the contract, provided the requirements of paragraph (d) are met. We proposed retaining the regulation text that provides explicitly that states may not require MCOs, PIHPs, or PAHPs to make pass-through payments other than those permitted under paragraph (d). We received the following comments in response to our proposal to revise § 438.6(d)(1).

Comment: Some commenters recommended that we remove the regulation text that provides explicitly that states may not require MCOs, PIHPs, or PAHPs to make pass-through payments other than those permitted under paragraph (d); these commenters recommended that we reconsider the pass-through payment policy finalized in the May 6, 2016 final rule.

Response: Since commenters did not raise any new issues for our consideration in paragraph (d)(1), we do not agree with commenters that we should remove the regulation text that provides explicitly that states may not require MCOs, PIHPs, or PAHPs to make pass-through payments other than those permitted under paragraph (d). The May 6, 2016 final rule provided a detailed description of the policy rationale (81 FR 27587 through 27592) for why we established pass-through payment transition periods and limited pass-through payments to hospitals, physicians, and nursing facilities, and this policy rationale has not changed. With the proposal to amend the regulation text to more explicitly reflect our intent for the transition periods and the limits on pass-through payments, we did not intend to revisit our rationale for establishing the pass-through payment transition periods. We continue to believe that pass-through payments are not consistent with the statutory

requirements that capitation rates be actuarially sound.

After considering the comments, we are finalizing § 438.6(d)(1) as proposed without revision.

C. Comments on § 438.6(d)(1)(i)

Under proposed paragraph (d)(1)(i), a state would be able to use the transition period for pass-through payments to hospitals, physicians, or nursing facilities only if the state can demonstrate that it had pass-through payments for hospitals, physicians, or nursing facilities, respectively, in *both* the managed care contract(s) *and* rate certification(s) that meet the requirements in either proposed paragraph (d)(1)(i)(A) or (B).

We proposed in paragraph (d)(1)(i)(A) that the managed care contract(s) and rate certification(s) must be for the rating period that includes July 5, 2016 and have been submitted for our review and approval on or before July 5, 2016. If the state had not yet submitted MCO, PIHP, or PAHP contract(s) and rate certification(s) for the rating period that includes July 5, 2016, we proposed in paragraph (d)(1)(i)(B) that the state must demonstrate that it required the MCO, PIHP, or PAHP to make pass-through payments for a rating period before July 5, 2016 in the managed care contract(s) and rate certification(s) that were most recently submitted for our review and approval as of July 5, 2016.

We proposed to use the date July 5, 2016 for the purpose of identifying the pass-through payments in managed care contract(s) and rate certification(s) that are eligible for the pass-through payment transition period because it is consistent with the intent of the May 6, 2016 final rule that the transition period be used by states that had pass-through payments in their MCO, PIHP, or PAHP contracts when that rule was finalized. The transition period was intended to address concerns, articulated in the comments to the June 1, 2015 proposed rule, that an abrupt end to pass-through payments could be disruptive to state health care delivery systems and safety-net providers. We noted in the November 22, 2016 proposed rule that limiting the use of the transition period to states that had pass-through payments in effect as of the effective date of the May 6, 2016 final rule facilitates elimination of these types of payments. We did not intend for the May 6, 2016 final rule to incentivize or encourage states to add new pass-through payments, as we believe that these payments are inconsistent with actuarially sound rates. We received the following comments in response to our proposal to revise § 438.6(d)(1)(i), including new paragraphs (d)(1)(i)(A) and (B).

Comment: Some commenters recommended that we not finalize paragraph (d)(1)(i) because this new provision will be administratively burdensome on states and has the potential to delay our approval of managed care contracts and rate certifications. Other commenters recommended that we add regulatory text to address scenarios in which states had not submitted managed care contracts or rate certifications to us by July 5, 2016, but states had already executed contracts with their managed care plans. These commenters recommended that we permit states to produce these executed contracts and allow these states to use these managed care contracts and rate certifications for the purpose of the transition period.

Response: We believe that the requirements under § 438.6(d)(1)(i) will not be significantly more burdensome on states and will not cause delays in the approval of managed care contracts and rate certifications. To the contrary, we believe that the proposed requirements under § 438.6(d)(1)(i) will streamline the process for documenting and demonstrating pass-through payments and will facilitate a quicker approval process because the pass-through payments will be more transparently identified. In addition, we currently review and work with states on managed care contracts and rates, and because pass-through payments exist today, any additional burden to state or federal governments should be minimal.

We also do not agree that additional regulatory text is necessary to address scenarios in which states had not submitted managed care contracts or rate certifications to us by July 5, 2016, but states had already executed contracts with their managed care plans. As proposed in § 438.6(d)(1)(i), we will permit states to demonstrate pass-through payments in two ways: (1) Pass-through payments for hospitals, physicians, or nursing facilities were in managed care contracts *and* rate certifications for the rating period that includes July 5, 2016 and were submitted for our review and approval before July 5, 2016; or (2) if the managed care contracts and rate certifications for the rating period that includes July 5, 2016 had not been submitted to us on or before July 5, 2016, pass-through payments for hospitals, physicians, or nursing facilities were in managed care contracts *and* rate certifications for a rating period before July 5, 2016 that had been most recently submitted for our review and approval as of July 5, 2016. We believe these requirements strike the appropriate balance between administrative simplicity and flexibility.

Comment: Some commenters recommended that we withdraw this proposal. These commenters stated that establishing value-based payment arrangements, delivery system reform, minimum fee schedules, and payment rate increases require substantial time and attention. These commenters believed that the fact that some states had established pass-through payments before the effective date of the May 6, 2016 final rule (July 5, 2016) should not preclude other states from receiving similar reasonable flexibilities to implement permissible payment arrangements under Medicaid managed care.

Response: We do not agree with commenters that we should withdraw this proposal. While we understand that establishing value-based payment arrangements, delivery system reform, minimum fee schedules, and payment rate increases require substantial time and attention, we see no rationale to provide transition periods for states to phase out and transition away from pass-through payments if they have not previously implemented such payments. Unlike states that already have pass-through payments in place and need to reverse those actions, states that have not already used such pass-through payments are starting from a clean slate in terms of adopting payment mechanisms and systems described in § 438.6(c). To permit new and increased pass-through payments is contrary to the policy adopted in the May 6, 2016 final rule of eliminating pass-through payments and is not consistent with our regulatory standards for actuarially sound rates. Further, encouraging or enabling states to add or increase such pass-through payments during the transition periods only exacerbates the challenges of eliminating them and transitioning to actuarially sound rates, or establishing value-based payment arrangements, delivery system reform, and fee schedule and payment rate reforms. For states with existing pass-through payments, the transition periods provide significant time and flexibility to integrate existing pass-through payment arrangements into permissible payment structures that tie provider payments to the provision of services (or outcomes) under the contract. For states that currently do not have pass-through payments in their managed care contracts that wish to pursue delivery system and provider payment initiatives, we believe such states are already in a better and superior position to design and

implement allowable payment structures within actuarially sound capitation rates, including enhanced fee schedules or the other approaches consistent with § 438.6(c) that tie managed care payments to services and utilization covered under the contract.

Comment: Some commenters did not agree with the use of the July 5, 2016 date and characterized the use of that date as finalizing a rule that applies retroactively. These commenters stated that the use of the July 5, 2016 date and retroactive rulemaking is not consistent with the intent of notice and comment rulemaking under the Administrative Procedure Act (APA) and makes it impossible for states and providers to plan for the potential impact of such rulemaking. Some commenters recommended that we withdraw the proposed rule immediately and stated that our proposals would significantly and retroactively change the compliance date for the pass-through payment phase-down and would effectively move-up the start of the phase-out period a full year from July 1, 2017 to July 5, 2016. These commenters stated that such a change in the compliance date would result in substantial new payment restrictions with little time for states and hospitals to make adjustments. These commenters stated concern that further limiting pass-through payments could adversely affect hospitals and the patients they serve.

Response: This final rule will not and does not apply retroactively to July 5, 2016, and we have followed all notice and comment procedures for rulemaking under the APA. This final rule only affects future action of states and does not penalize or invalidate past actions taken by states, which is permissible rulemaking.[2] We provided our detailed rationale in the proposed rule for using the July 5, 2016 date; we are only using the July 5, 2016 date for the purpose of identifying the pass-through payments in managed care contracts and rate certifications that are eligible for the pass-through payment transition period. That date was chosen because it is consistent with our intent that the transition period be used by states that had pass-through payments in their MCO, PIHP, or PAHP contracts when we finalized that rule. Limiting the use of the transition period to states that had pass-through payments in effect as of the effective date of the May 6, 2016 final rule (July 5, 2016) supports the policy goal of eliminating these types of payments, while ensuring that an abrupt end to pass-through payments will not be disruptive to state health care delivery systems and safety-net providers. Using this past date as the point by which to determine eligibility for the transition period eliminates the possibility that the transition period itself encourages states to create new or increase pass-through payments.

For commenters concerned about compliance dates, we want to clarify that this rule does not change the original compliance date for § 438.6(d) from the May 6, 2016 final rule. We will still enforce compliance with the requirements in § 438.6(d) no later than the rating period for Medicaid managed care contracts beginning on or after July 1, 2017. As discussed in the November 22, 2016 proposed rule and this final rule, our exercise of enforcement discretion in permitting delayed compliance of the May 6, 2016 final rule with § 438.6(d) was not intended to create new opportunities for states to add or increase existing pass-through payments either before or after July 1, 2017. This delay was intended to address concerns articulated by commenters, among them states and providers, that an abrupt end to directed pass-through payments could cause damaging disruption to safety-net providers. The delay was also intended to give states and managed care plans time to appropriately address any contract or rate issues needed to implement and comply with § 438.6(d). This final rule amends the parameters for the transition periods that begin with rating periods for contracts starting on or after July 1, 2017. As that date is still several months in the future, this final rule is not retroactive.

We understand the need for states and providers to have adequate time to make adjustments in complying with the requirements at § 438.6(d)—that is why the May 6, 2016 final rule provided transition periods to phase-down pass-through payments. We agree and noted in the May 6, 2016 final rule (81 FR 27589) and the November 22, 2016 proposed rule (81 FR 83782) that the transition from one payment structure to another often requires robust provider and stakeholder engagement, agreement on approaches to care delivery and payment, establishing systems for measuring outcomes and quality, planning efforts to implement changes, and evaluating the potential impact of change on Medicaid financing mechanisms. However, for states that do not currently have pass-through payments in their managed care contracts, transition periods are unnecessary. States that do not have pass-through payments in their managed care contracts that wish to pursue delivery system and provider payment initiatives can design and implement allowable payment structures under actuarially sound capitation rates tying managed care payments to services and utilization covered under the contract without concern that modifying existing pass-through payments could potentially undermine access for Medicaid managed care enrollees or adversely impact hospitals.

Comment: Some commenters stated that for many states, the capitation rates and contracts submitted as of or prior to July 5, 2016 were for prior rating periods when both enrollment numbers and the cost of providing care would be substantially less than the total enrollments and costs for current and future rating periods. These commenters stated that the limitation on setting pass-through payments based on a prior submitted date (July 5, 2016) of capitation rates and contracts deviates from the longstanding practice of states making retroactive adjustments and amendments to actuarially sound capitation rates. These commenters stated that the setting of an aggregate pass-through payment amount limit based on capitation rates and contracts submitted by states as of July 5, 2016 has the added effect of speeding up the transition periods established under the May 6, 2016 final rule and that states should be provided additional time to submit for our approval new managed care capitation rates, including pass-through payments, because states and providers had no notice prior to this cutoff date; some of these commenters recommended that we modify the rule to allow the use of the most recent rate year for demonstrating previous pass-through payments.

Response: We understand that for some states, the capitation rates and contracts submitted as of or prior to July 5, 2016 would be for prior rating periods; it is for this reason that under the proposed requirements in § 438.6(d)(1)(i), we permitted states to demonstrate pass-through payments in the two ways described in paragraphs (d)(1)(i)(A) and (B).

We do not believe that the limitation on setting pass-through payments based on a prior submitted date deviates from the practice of retroactive amendments

[2] Here, the rule only affects future action and limits future choices available to states. Retroactive rules ''alter[ ] the *past* legal consequences of past actions.'' Bowen v. Georgetown Univ. Hosp., 488 U.S. 204, 219, 109 S. Ct. 468 (1988) (Scalia, J., concurring) (emphasis in original). When an agency takes action to alter the future effect but not the past legal consequences of an activity, the agency has not taken a retroactive action; similarly, when agency action upsets expectations for future activity that are based on prior law, it has not taken a retroaction action. *Mobile Relay Assocs.* v. *F.C.C.,* 457 F.3d 1, 10–11 (D.C. Cir. 2006).

to capitation rates. Under this final rule, we are not generally restricting states from adjusting or amending their actuarially sound capitation rates; the requirements for retroactive adjustments to capitation rates are specified at § 438.7(c)(2) and those requirements are not changed with this final rule. Since we will enforce compliance with the requirements of § 438.7(c)(2) for rating periods for contracts beginning July 1, 2017, we also note that before the May 6, 2016 final rule, states were permitted to adjust and amend actuarially sound capitation rates retroactively under § 438.6(c)(1). This final rule does not change these policies in permitting states to adjust and amend actuarially sound capitation rates retroactively.

Under paragraph (d)(1)(ii), as proposed and as finalized, we will not approve a retroactive adjustment or amendment to managed care contracts and rate certifications to add new pass-through payments or increase existing pass-through payments, as defined in § 438.6(a). This limit only applies to retroactive adjustments to capitation rates related to new or increased pass-through payments; other retroactive adjustments to rates are not affected by this final rule. The existing policy permitting states flexibility to make other changes in capitation rates, subject to the limits on filing claims for FFP under 45 CFR 95.7 and, for contracts for rating periods after July 1, 2017, subject to the requirements in § 438.7(c)(2), remains in effect for all other changes to capitation rates.

We also do not agree that this proposal has the added effect of speeding up the transition periods established under the May 6, 2016 final rule. We indicated in the proposed rule that we did not intend to speed up the rate of a state's phase down of pass-through payments; rather, the proposed rule intended only to prevent increases in pass-through payments and the addition of new pass-through payments beyond what was already in place when the pass-through payment limits and transition periods were finalized in the May 6, 2016 final rule. The length of the transition periods remains the same under this final rule: 10 years for hospital pass-through payments and 5 years for physician and nursing facility pass-through payments. States that were reliant on and using pass-through payments at the time we finalized the May 6, 2016 final rule will continue to be eligible for the full transition periods under this final rule. Further, this final rule will permit states to continue pass-through payments in the same amount as before the beginning of the transition period, unless and until, that amount exceeds the percentage of the base amount available for the applicable year of the transition period for hospital pass-through payments. Our amendments to § 438.6(d) only serve to prevent states from adding new pass-through payments, or increasing the total amount of pass-through payments, in the Medicaid managed care context.

We also do not agree that states should be provided additional time to submit new managed care capitation rates to include new or increased pass-through payments, because such an approach is contrary to our policy goal of eliminating pass-through payments. We believe that limiting the use of the transition period to states that had pass-through payments in effect as of the effective date of the May 6, 2016 final rule (July 5, 2016) supports the policy goal of eliminating these types of payments, while ensuring that an abrupt end to already existing pass-through payments will not be disruptive to state health care delivery systems and safety-net providers. Using the date of July 5, 2016 as the point by which to determine eligibility for the transition period eliminates concern that the transition period itself encourages states to create new or increase pass-through payments despite our policy concerns that such payments are inconsistent with actuarial soundness and may compromise a managed care plan's ability to effectively direct care and implement quality improvement strategies.

Comment: Some commenters recommended that we include specific regulatory text at § 438.6(d)(1)(i) to also specify that in order to use a transition period described under paragraph (d), a state must demonstrate that it had pass-through payments for hospitals, physicians, or nursing facilities ''in managed care contracts and rate certifications for the rating period beginning before October 1, 2016, regardless of the date of submission to CMS, if the state can demonstrate that funding for the pass-through payment was approved by the state's legislature prior to July 5, 2016, and that corresponding supplemental payments were made under Medicaid fee-for-service (FFS) or section 1115 demonstration programs for at least 10 consecutive years prior to July 5, 2016.'' These commenters stated that this language would ensure that a specific pass-through payment would meet the criteria under the proposed rule.

Response: We understand the commenters' concerns regarding a specific pass-through payment that was recently approved by their state legislature; however, including the commenters' suggested regulatory text at § 438.6(d)(1)(i) would not comport with our policy goals. The pass-through payment transition periods included in the May 6, 2016 final rule were intended to be used by states that already had pass-through payments in place and would face significant disruption if immediate compliance with § 438.6(c) were required. Under the proposed rule and this final rule, we are linking pass-through payments permitted during the transition period to the aggregate amounts of pass-through payments that were in place at the time the May 6, 2016 final rule became effective on July 5, 2016, which is consistent with the intent under the May 6, 2016 final rule to eliminate pass-through payments but provide a transition period to limit disruption to safety net providers. Changing our proposal to include ''managed care contracts and rate certifications for the rating period beginning before October 1, 2016 regardless of the date of submission to CMS'' is not consistent with the rationale in the May 6, 2016 final rule or the November 22, 2016 proposed rule and would permit certain new or increased pass-through payments beyond those already in place at the time the May 6, 2016 final rule became effective on July 5, 2016.

Further, we do not believe that we should allow new or increased pass-through payments for states with corresponding supplemental payments that were made under Medicaid FFS or section 1115 demonstration programs prior to July 5, 2016. As we have described throughout this rule, pass-through payments are not consistent with our regulatory standards for actuarially sound rates because they do not tie provider payments with the provision of services. For states with supplemental payments that were made under Medicaid FFS or section 1115 demonstration programs prior to July 5, 2016, we believe that as part of a state's transition to a managed care delivery system, the state needs to integrate such FFS supplemental payments into allowable payment structures that tie managed care payments to services and utilization covered under the contract. Integrating the FFS supplemental payments into allowable payment structures at the time of the transition will ensure that the state can hold managed care plans accountable for the cost and quality of services delivered under the contract.

After considering the comments, we are finalizing § 438.6(d)(1)(i) as proposed without revision.

D. Comments on § 438.6(d)(1)(ii)

We proposed in paragraph (d)(1)(ii) that we would not approve a retroactive adjustment or amendment to managed care contract(s) and rate certification(s) to add new pass-through payments or increase existing pass-through payments defined in § 438.6(a). We noted that we would not permit a pass-through payment amount for hospitals to exceed the lesser of the amounts calculated under paragraph (d)(3) in the proposed rule. We also proposed, in paragraph (d)(5), that pass-through payment amounts to physicians and nursing facilities would be limited to the amount in place in the managed care contracts and rate certifications submitted pursuant to paragraph (d)(1)(i). We proposed paragraph (d)(1)(ii) to prevent states from undermining the policy goal of limiting the use of the transition period to states that had pass-through payments in effect as of the effective date of the May 6, 2016 final rule. This proposed change also aligns with the policy rationale under the May 6, 2016 final rule and the July 29, 2016 CMCS Informational Bulletin (CIB) by prohibiting new or increased pass-through payments in Medicaid managed care contract(s), notwithstanding the adjustments to the base amount permitted in § 438.6(d)(2). We received the following comments in response to our proposal to revise § 438.6(d)(1)(ii).

Comment: Some commenters recommended that we address scenarios in which states are already paying pass-through payments through their managed care plans and were currently in the process of amending managed care contracts and rate certifications when the proposed rule was issued; these commenters recommended that we permit such retroactive adjustments and amendments. Some commenters provided that states have historically implemented retroactive rate adjustments to capitation rates and processed routine adjustments and amendments every year; these commenters recommended that we permit these adjustments and amendments and address how such routine activities would fit with this rule. Other commenters recommended that we permit retroactive adjustments and amendments through July 1, 2017 to account for potential increases in pass-through payments that were put into place before this rule was issued.

Response: We do not agree that additional regulatory text is needed to address scenarios in which states are already paying pass-through payments through their managed care plans and were in the process of amending managed care contracts and rate certifications at the time of the May 6, 2016 final rule or the November 22, 2016 proposed rule. It is unclear to us what standard we could use to implement this recommendation while preventing new or increased pass-through payments. We note that § 438.6(d)(1)(ii), as proposed and as finalized here, will not be a barrier to the approval of retroactive changes to managed care contracts and rate certifications when the retroactive change does not purport to add or increase a pass-through payment to hospitals, physicians, or nursing facilities. Therefore, states that were in the process of amending contracts or rates for other purposes should not be affected by § 438.6(d)(1)(ii).

States will need to meet the requirements in § 438.6(d)(1)(i) in order to use a transition period described in § 438.6(d). That means that states must be able to demonstrate pass-through payments in managed care contracts and rate certifications under the requirements in proposed § 438.6(d)(1)(i)(A) and (B). For commenters concerned about general adjustments and amendments unrelated to new or increased pass-through payments, this rule does not impact those routine activities that states undertake each year; the requirements in § 438.6(d)(1)(ii), as proposed and finalized here, only limit retroactive adjustments and amendments intended to add new pass-through payments or increase existing pass-through payments defined in § 438.6(a). Without this provision limiting retroactive changes to pass-through payments, a state could retroactively change a prior, submitted managed care contract and rate certification to increase or add pass-through payments and eliminate the restrictions on the use of the transition periods that were proposed in the November 22, 2016 proposed rule and finalized in this rule. Further, the adjustments to the base amount under § 438.6(d)(2) are still permitted upon finalization of this rule; therefore, the base amount will be calculated annually and increases in Medicaid and Medicare FFS rates will be taken into account even though a smaller percentage of the base amount will be available for pass-through payments. However, we would not permit a pass-through payment amount to exceed the lesser of the amounts calculated under paragraph (d)(3) in this rule. We are not generally restricting states from adjusting or amending their actuarially sound capitation rates that are unrelated to new or increased pass-through payments; the general requirements for retroactive adjustments to capitation rates are specified at § 438.7(c)(2) and those requirements are not changed with this final rule. Only contract actions to add or increase pass-through payments on a retroactive basis will be denied under § 438.6(d)(1)(ii); other retroactive rate changes will be evaluated and approved pursuant to other applicable rules adopted prior to this rulemaking.

Finally, we do not believe that we should permit retroactive adjustments and amendments through July 1, 2017 to account for potential increases in pass-through payments that were put into place before this rule. This approach is not consistent with our policy, which has been discussed in the May 6, 2016 final rule and throughout this final rule, to eliminate pass-through payments, which are inconsistent with our regulatory standards for actuarially sound capitation rates.

After considering the comments, we are finalizing § 438.6(d)(1)(ii) as proposed without revision.

E. Comments on § 438.6(d)(3)

In paragraph (d)(3), we proposed to amend the cap on the amount of pass-through payments to hospitals that may be incorporated into managed care contract(s) and rate certification(s) during the transition period for hospital payments, which will apply to rating periods for contract(s) beginning on or after July 1, 2017. Specifically, we proposed to revise § 438.6(d)(3) to require that the limit on pass-through payments each year of the transition period be the lesser of: (A) The sum of the results of paragraphs (d)(2)(i) and (ii),[3] as modified under the schedule in this paragraph (d)(3); or (B) the total dollar amount of pass-through payments to hospitals identified by the state in the managed care contract(s) and rate certification(s) used to meet the requirement in paragraph (d)(1)(i). This proposed language would limit the amount of pass-through payments each contract year to the lesser of the calculation adopted in the May 6, 2016 final rule (the ''base amount''), as decreased each successive year under

[3] The portion of the base amount calculated in § 438.6(d)(2)(i) is analogous to performing UPL calculations under a FFS delivery system, using payments from managed care plans for Medicaid managed care hospital services in place of the state's payments for FFS hospital services under the state plan. The portion of the base amount calculated in § 438.6(d)(2)(ii) takes into account hospital services and populations included in managed care during the rating period that includes pass-through payments which were in FFS two years prior.

the schedule in this paragraph (d)(3), or the total dollar amount of pass-through payments to hospitals identified by the state in managed care contract(s) and rate certification(s) described in paragraph (d)(1)(i). For example, if a state had $10 million in pass-through payments to hospitals in the contract and rate certification used to meet the requirement in paragraph (d)(1)(i), that $10 million figure would be compared each year to the base amount as reduced on the schedule described in this paragraph (d)(3); the lower number would be used to limit the total amount of pass-through payments to hospitals allowed for that specific contract year.

We noted that this proposed language would prevent increases of aggregate pass-through payments for hospitals during the transition period beyond what was already in place when the pass-through payment limits and transition periods were finalized in the May 6, 2016 final rule. We also noted that our proposal was not intended to speed up the rate of a state's phase down of pass-through payments; rather, the proposed rule intended to prevent increases in pass-through payments and the addition of new pass-through payments beyond what was already in place when the pass-through payment limits and transition periods were finalized given that this was the final rule's intent.

In addition, we proposed to amend paragraph (d)(3) to provide that states must meet the requirements in paragraph (d)(1)(i) to make pass-through payments for hospitals during the transition period. We noted that this additional text was necessary to be consistent with our intent, explained above, for the proposed revisions to paragraph (d)(1). As in the May 6, 2016 final rule, we noted that pass-through payments to hospitals must be phased out no longer than on the 10-year schedule, beginning with rating periods for contracts that start on or after July 1, 2017. We proposed to add the phrase ''rating periods'' to be consistent with our approach in the May 6, 2016 final rule; we made this revision throughout proposed paragraphs (d)(3) and (d)(5). We received the following comments in response to our proposal to revise § 438.6(d)(3), including new paragraphs (d)(3)(i) and (ii).

Comment: Some commenters recommended that we not finalize proposed paragraph (d)(3). Some commenters recommended that we permit increases in pass-through payments over the 10-year transition period to give states the maximum amount of flexibility in phasing down pass-through payments for hospitals. Some commenters recommended that we permit new or increased pass-through payments for states that are currently in the process of moving hospital FFS supplemental payments into managed care, or that we provide states that had received federal approval to transition to managed care before this rule, the opportunity to implement their managed care programs using the pass-through payment transition periods and amounts established in the May 6, 2016 final rule. Some commenters similarly recommended that we permit new or increased pass-through payments for states with Medicaid state plan approved UPL payments for hospitals as of July 5, 2016 and allow such states to utilize the transition periods and amounts outlined in the May 6, 2016 final rule.

Response: We do not agree with commenters that we should not finalize proposed paragraph (d)(3). We have explained throughout this rule our rationale to prevent increases of pass-through payments for hospitals during the transition period beyond what was already in place when the pass-through payment limits and transition periods were finalized in the May 6, 2016 final rule.

We also do not believe that we should permit increased pass-through payments through the 10-year transition period. The 10-year transition period provides states with significant flexibility and time to phase down existing pass-through payments for hospitals. We believe that we should not allow new or increased pass-through payments for states that are currently in the process of moving hospital FFS supplemental payments into managed care, and that we should not permit new or increased pass-through payments for states with Medicaid state plan approved UPL payments for hospitals as of July 5, 2016. As we have reiterated throughout this rule, pass-through payments are not consistent with our regulatory standards for actuarially sound rates because they do not tie provider payments with the provision of services. When pass-through payments guarantee a portion of a provider's payment and divorce the payment from service delivery, there is little accountability for the payment and it is more challenging for managed care plans to negotiate provider contracts with incentives focused on outcomes and managing individuals' overall care. Consequently, for states that are currently in the process of moving hospital FFS supplemental payments into managed care, we believe that integrating the FFS supplemental payments into allowable payment structures at the time of the transition will facilitate a state's ability to hold managed care plans accountable for the cost and quality of services delivered under the contract. To date, we have already provided technical assistance to states who are seeking to implement these types of allowable payment structures and remain available to provide future technical assistance. We will work with states to integrate FFS supplemental payments into allowed payment structures as states undertake transitions to managed care.

Comment: Some commenters recommended that we withdraw all caps and limits on the ''base amount'' for hospitals and allow states the flexibility to adjust pass-through payment amounts to reflect significant programmatic changes and increases in the managed care population. These commenters provided that if the base amount increases from one year to the next, the ''total dollar amount'' limit should also be permitted to increase at the same percentage. Some commenters similarly recommended a ''per-member per-month'' (PMPM) basis rather than a total dollar amount limitation on the maximum amount of pass-through payments for hospitals. Other commenters stated the concern that this proposed rule is effectively limiting the maximum amount of pass-through payments to the amount in place prior to the final rule's compliance date and would give state Medicaid programs and hospitals no time to transition these payments.

Response: We do not agree that we should withdraw all caps and limits on the base amount for hospitals, and we do not agree that the ''total dollar amount'' limit should be permitted to increase, or that we should permit PMPM increases, as these approaches could have the effect of permitting increased pass-through payments for hospitals, which would be counter to our stated policy goals. We believe that adopting these recommendations would complicate the required transition of pass-through payments to permissible provider payment models and delay the development of permissible and accountable payment approaches that are based on the utilization and delivery of services or the quality and outcomes of services. We also note that states can implement allowed payment structures to reflect significant programmatic changes and increases in the managed care population.

In the June 1, 2015 proposed rule and the May 6, 2016 final rule, we discussed how the payment structures permitted under § 438.6(c) tied payments to services while permitting states to reward quality in the provision of

services, assure minimum payment rates, or develop delivery system reform. One advantage of using an allowed payment mechanism to address changes in the managed care population is that such a structure would allow states and managed care plans to link payments to significant programmatic changes. Linking provider payments to utilization and outcomes under a managed care plan's control facilitates a state's ability to hold managed care plans accountable for the quality, utilization, and cost of care provided to beneficiaries.

We agree with commenters that this final rule limits the maximum amount of pass-through payments to the amount in place on the effective date of the May 6, 2016 final rule (July 5, 2016). However, we do not agree that this final rule eliminates the transition period for existing pass-through payments. This final rule does not change the transition periods established under the May 6, 2016 final rule. This final rule provides a new maximum amount of pass-through payments for hospitals in order to prevent new or increased pass-through payments. States that were reliant on and using pass-through payments at the time we finalized the May 6, 2016 final rule will continue to be eligible for the full transition periods under this final rule. This final rule does not accelerate the transition period for states compared to the May 6, 2016 final rule.

Comment: Some commenters stated that § 438.6(d) of the May 6, 2016 final rule allowed for specific calculations and adjustments to the base amount to determine the upper limit of pass-through payments for hospitals. These commenters stated that § 438.6(d) allowed states to account for changes in the demographics, service mix, enrollment, and utilization of Medicaid managed care beneficiaries beginning July 1, 2017. These commenters stated concerns that the proposed rule eliminates these flexibilities by artificially limiting ''the total dollar amount'' of pass-through payments without accounting for the permitted adjustments in the May 6, 2016 final rule.

Response: We understand commenters' concerns regarding the base amount calculations and permitted adjustments at § 438.6(d)(2) in the May 6, 2016 final rule. This final rule does not modify the adjustments to the base amount permitted under § 438.6(d)(2); however, this final rule does not permit a pass-through payment amount to exceed the lesser of the amounts calculated under paragraph (d)(3) in this final rule, as we believe such a flexibility could have the effect of permitting increased pass-through payments for hospitals. We believe that increasing pass-through payments will complicate the required transition of pass-through payments to permissible provider payment models and delay the development of permissible and accountable payment approaches that are based on the utilization and delivery of services or the quality and outcomes of services.

Under § 438.6(d)(2), states can account for changes in the demographics, service mix, enrollment, and utilization in their Medicaid managed care programs (see 81 FR 27591). States can also account for changes in the demographics, service mix, enrollment, and utilization through permissible payment mechanisms. One advantage of using an allowed payment mechanism to address changes in the managed care population (such as demographics, service mix, enrollment, or utilization) is that such a structure would allow states and managed care plans to link new and increased funding to the corresponding increase in services that result from the programmatic changes or increased population. Linking provider payments to utilization and outcomes under a managed care plan's control facilitates a state's ability to hold managed care plans accountable for the quality, utilization, and cost of care provided to beneficiaries. Therefore, we do not agree that the proposed rule, which is finalized here, eliminates these flexibilities. Also, as described throughout this final rule, the ''total dollar amount'' limit for pass-through payments was established under paragraphs (d)(3) and (d)(5) for hospitals, physicians, and nursing facilities because we did not intend states to begin additional or new pass-through payments, or to increase existing pass-through payments.

After considering the comments, we are finalizing § 438.6(d)(3) as proposed without revision.

F. Comments on § 438.6(d)(5)

We proposed to revise § 438.6(d)(5) to be consistent with the proposed revisions in § 438.6(d)(1)(i) and to limit the total dollar amount of pass-through payments that is available each contract year for physicians and nursing facilities. We noted that we were not proposing to implement a phase-down for pass-through payments to physicians or nursing facilities. We proposed that for states that meet the requirements in paragraph (d)(1)(i), rating periods for contracts beginning on or after July 1, 2017 through rating periods for contracts beginning on or after July 1, 2021, may continue to require pass-through payments to physicians or nursing facilities under the MCO, PIHP, or PAHP contract; such pass-through payments may be no more than the total dollar amount of pass-through payments for each category identified in the managed care contracts and rate certifications used to meet the requirement in paragraph (d)(1)(i). We proposed to add the phrase ''rating periods'' to be consistent with our approach in the May 6, 2016 final rule; we made this revision throughout proposed paragraphs (d)(3) and (d)(5). We received the following comments in response to our proposal to revise § 438.6(d)(5).

Comment: Some commenters recommended that we not finalize the ''total dollar amount'' limit on pass-through payments over the 5-year transition period for physicians and nursing facilities because such a limit does not recognize significant programmatic changes and increases in the managed care population. Commenters recommended that we continue to allow increases over the 5-year transition period to give states the maximum amount of flexibility in phasing down pass-through payments. Some commenters also recommended that we permit new or increased pass-through payments for states that are currently in the process of moving physician or nursing facility FFS supplemental payments into managed care, or that we provide states that had received federal approval to transition to managed care before this rule, the opportunity to implement their managed care programs using the pass-through payment transition periods and amounts established in the May 6, 2016 final rule.

Response: As noted above, we believe the lack of an affirmative limit on pass-through payments at the total amount of prior pass-through payments identified under paragraph (d)(1)(i) will permit states to increase pass-through payments to physicians and nursing facilities, which is contrary to our policy goals for eliminating these types of payments. This final rule will encourage states to use the other, permissible payment types described in § 438.6(c) in directing payments to nursing facilities and physicians. We explained throughout this final rule our rationale for prohibiting increases of pass-through payments during the transition period beyond what was already in place when the pass-through payment limits and transition periods were finalized in the May 6, 2016 final rule. We reiterate that states can

implement allowed, accountable payment structures to reflect significant programmatic changes and increases in the managed care population. One advantage of using an allowed payment mechanism to address the changes is that such a structure would allow states and managed care plans to link new and increased funding to the corresponding increased utilization resulting from the programmatic changes or increased population. Additionally, the 5-year transition period provides states with significant flexibility and time to phase down existing pass-through payments for physicians and nursing facilities.

Consistent with our response for hospital FFS supplemental payments, we do not believe that we should allow new or increased pass-through payments for states that are currently in the process of moving physician or nursing facility FFS supplemental payments into managed care. As we have provided throughout this rule, pass-through payments are not consistent with our interpretation of the statutory requirement for actuarial soundness and our regulatory standards for actuarially sound rates because they do not tie provider payments with the provision of services. For states that are currently in the process of moving physician or nursing facility FFS supplemental payments into managed care, we believe that integrating the FFS supplemental payments into allowable payment structures at the time of the transition will ensure that the state can hold managed care plans accountable for the cost and quality of services delivered under the contract.

We did not receive any comments on our proposal to use the phrase ''rating period'' in § 438.6(d)(3) and (5). After considering the comments, we are finalizing § 438.6(d)(5) as proposed without revision.

III. Provisions of the Final Regulations

As a result of the public comments received under the proposed rule, this final rule incorporates the provisions of the proposed rule without revision.

IV. Collection of Information Requirements

This final rule will not impose any new or revised information collection, reporting, recordkeeping, or third-party disclosure requirements or burden. Our revision of § 438.6(d) will not impose any new or revised IT system requirements or burden because the existing regulation at § 438.7 requires the rate certification to document special contract provisions under § 438.6. Consequently, there is no need for review by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*).

V. Regulatory Impact Analysis

A. Statement of Need

As discussed in the May 6, 2016 final rule, the proposed rule, and this final rule, we have significant concerns that pass-through payments have negative consequences for the delivery of services in the Medicaid program. The existence of pass-through payments may affect the amount that a managed care plan is willing or able to pay for the delivery of services through its base rates or fee schedule. In addition, pass-through payments may make it more difficult to implement quality initiatives or to direct beneficiaries' utilization of services to higher quality providers because a portion of the capitation rate under the contract is independent of the services delivered and outside of the managed care plan's control. Put another way, when the fee schedule for services is set below the normal market, or negotiated rate, to account for pass-through payments, moving utilization to higher quality providers can be difficult because there may not be adequate funding available to incentivize the provider to accept the increased utilization. When pass-through payments guarantee a portion of a provider's payment and divorce the payment from service delivery, it is more challenging for managed care plans to negotiate provider contracts with incentives focused on outcomes and managing individuals' overall care.

We realize that some pass-through payments have served as a critical source of support for safety-net providers who provide care to Medicaid beneficiaries. Several commenters raised this issue in response to the June 1, 2015 proposed rule.[4] Therefore, in response to some commenters' request for a delayed implementation of the limitation on directed payments and to address concerns that an abrupt end to these payments could create significant disruptions for some safety-net providers who serve Medicaid managed care enrollees, we included in the May 6, 2016 final rule a delay in the compliance date and a transition period for existing pass-through payments to hospitals, physicians, and nursing facilities. These transition periods begin with the compliance date, and were designed and finalized to enable affected providers, states, and managed care plans to transition away from existing pass-through payments. Such payments could be transitioned into payments tied to covered services, value-based payment structures, or delivery system reform initiatives without undermining access for the beneficiaries; alternatively, states could step down such payments and devise other methods to support safety-net providers to come into compliance with § 438.6(c) and (d).

However, as noted previously, the transition period and delayed enforcement date caused some confusion regarding increased and new pass-through payments. The May 6, 2016 final rule inadvertently created a strong incentive for states to move swiftly to put pass-through payments into place in order to take advantage of the pass-through payment transition periods established in the May 6, 2016 final rule. Contrary to our discussion in the May 6, 2016 final rule regarding the statutory requirements in section 1903(m) of the Act and regulations for actuarially sound capitation rates, some states expressed interest in developing new and increased pass-through payments for their respective Medicaid managed care programs as a result of the May 6, 2016 final rule. In response to this interest, we published the July 29, 2016 CMCS Informational Bulletin (CIB) to quickly address questions regarding the May 6, 2016 final rule's intent regarding states' ability to increase or add new pass-through payments under Medicaid managed care plan contracts and capitation rates, and to describe our plan for monitoring the transition of pass-through payments to approaches for provider payment under Medicaid managed care programs that are based on the delivery of services, utilization, and the outcomes and quality of the delivered services.

We noted in the CIB that the transition from one payment structure to another requires robust provider and stakeholder engagement, agreement on approaches to care delivery and payment, establishing systems for measuring outcomes and quality, planning efforts to implement changes, and evaluating the potential impact of change on Medicaid financing mechanisms. Whether implementing value-based payment structures, implementing other delivery system reform initiatives, or eliminating pass-through payments, there will be transition issues for states coming into compliance; adequately working through transition issues, including ensuring adequate base rates, is central to both delivery system reform and to strengthening access, quality, and efficiency in the Medicaid program. We

[4] Available at: *https://www.gpo.gov/fdsys/pkg/FR-2015-06-01/pdf/2015-12965.pdf.*

stressed that the purpose and intention of the transition periods is to acknowledge that pass-through payments existed prior to the May 6, 2016 final rule and to provide states, network providers, and managed care plans time and flexibility to integrate existing pass-through payment arrangements into permissible payment structures.

As we noted in the CIB and throughout this final rule, we believe that adding new or increased pass-through payments for hospitals, physicians, or nursing facilities, beyond what was included as of July 5, 2016, into Medicaid managed care contracts exacerbates a problematic practice that is inconsistent with our interpretation of statutory and regulatory requirements, complicates the required transition of these pass-through payments to permissible and accountable payment approaches that are based on the utilization and delivery of services to enrollees covered under the contract, or the quality and outcomes of such services, and reduces managed care plans' ability to effectively use value-based purchasing strategies and implement provider-based quality initiatives. In the CIB, we signaled the possible need, and our intent, to further address this policy in future rulemaking and link pass-through payments through the transition period to the amounts of pass-through payments in place at the time the Medicaid managed care rule was effective on July 5, 2016.

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: (1) Having 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) creating a serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raising 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 is ''economically significant'' as measured by the $100 million threshold, and hence a major rule under the Congressional Review Act.

The May 6, 2016 final rule included a RIA (81 FR 27830). During that analysis, we did not project a significant fiscal impact for § 438.6(d). When we reviewed and analyzed the May 6, 2016 final rule, we concluded that states would have other mechanisms to build in the amounts currently provided through pass-through payments in approvable ways, such as approaches consistent with § 438.6(c). If a state was currently building in $10 million in pass-through payments to hospitals under their current managed care contracts, we assumed that the state would incorporate the $10 million into their managed care rates in permissible ways rather than spending less in Medicaid managed care. While it is possible that this would be more difficult for states with relatively larger amounts of pass-through payments, the long transition period provided under the May 6, 2016 final rule to phase out pass-through payments should help states to integrate existing pass-through payments into actuarially sound capitation rates through permissible Medicaid financing structures, including enhanced fee schedules or the other approaches consistent with § 438.6(c) that tie managed care payments to services and utilization covered under the contract.

A number of states have integrated some form of pass-through payments into their managed care contracts for hospitals, nursing facilities, and physicians. In general, the size and number of the pass-through payments for hospitals has been more significant than for nursing facilities and physicians. We noted in the May 6, 2016 final rule (81 FR 27589) a number of reasons provided by states for using pass-through payments in their managed care contracts. As of the effective date of the May 6, 2016 final rule, we estimate that at least eight states have implemented approximately $105 million in pass-through payments for physicians annually; we estimate that at least three states have implemented approximately $50 million in pass-through payments for nursing facilities annually; and we estimate that at least 16 states have implemented approximately $3.3 billion in pass-through payments for hospitals annually. These estimates are somewhat uncertain, as before the final rule, we did not have regulatory requirements for states to document and describe pass-through payments in their managed care contracts or rate certifications. The amount of pass-through payments often represents a significant portion of the overall capitation rate under a managed care contract. We have seen pass-through payments that have represented 25 percent, or more, of the overall managed care contract and 50 percent of individual rate cells. The rationale for these pass-through payments in the development of the capitation rates is often not transparent, and it is not clear what the relationship of these pass-through payments is to the provision of services or the requirement for actuarially sound rates.

Since the publication of the May 6, 2016 final rule, we received a formal proposal from one state regarding $250 to $275 million in pass-through payments to hospitals; we have been working with the state to identify permissible implementation options for their proposal, including under § 438.6(c), and tie such payments to the utilization and delivery of services (as well as the outcomes of delivered services). We heard informally that two additional states are working to develop pass-through payment mechanisms to increase total payments to hospitals by approximately $10 billion cumulatively. We also heard informally from one state regarding a $200 million proposal for pass-through payments to physicians. We also continue to receive inquiries from states, provider associations, and consultants who are developing formal proposals to add new pass-through payments, or increase existing pass-through payments, and incorporate such payments into Medicaid managed care rates. These state proposals have not been approved to date. While it is

difficult for us to conduct a detailed quantitative analysis given this considerable uncertainty and lack of data, we believe that without this final rulemaking, states will continue to ramp-up pass-through payments in ways that are not consistent with the pass-through payment transition periods established in the May 6, 2016 final rule.

Since we cannot produce a detailed quantitative analysis, we have developed a qualitative discussion for this RIA. We believe there are many benefits with this regulation, including consistency with our interpretation and implementation of the statutory requirements in section 1903(m) of the Act and regulations for actuarially sound capitation rates, improved transparency in rate development processes, permissible and accountable payment approaches that are based on the utilization and delivery of services to enrollees covered under the contract, or the quality and outcomes of such services, and improved support for delivery system reform that is focused on improved care and quality for Medicaid beneficiaries. We believe that the costs of this regulation to state and federal governments will not be significant; we currently review and work with states on managed care contracts and rates, and because pass-through payments exist today, any additional costs to state or federal governments should be negligible.

Relative to the current baseline, this final rule builds on the May 6, 2016 final rule and may further reduce the likelihood of increases in or the development of new pass-through payments, which could reduce state and federal government transfers to hospitals, physicians, and nursing facilities. However, states may instead increase or develop actuarially sound payments that link provider reimbursement with services covered under the contract or associated quality outcomes. Because we lack sufficient information to forecast the eventual overall impact of the May 6, 2016 final rule on state pass-through payments, we provide only a qualitative discussion of the impact of this final rule on avoided transfers. Given the potential for avoided transfers, we believe this final rule is economically significant as defined by Executive Order 12866.

We received the following comment on the proposed overall impact and regulatory impact analysis.

Comment: One commenter stated concern that we did not provide, in the proposed rule and to the public, a careful and transparent analysis of the anticipated quantitative consequences of this economically significant regulatory action. This commenter recommended that we withdraw the proposed rule until such a quantitative analysis is completed.

Response: The commenter did not provide any substantive information with which to conduct such an analysis. As stated in the proposed rule, it is difficult for us to conduct a detailed quantitative analysis given the considerable uncertainty and lack of data discussed above; however we continue to believe that without this final rulemaking, states will continue to ramp-up pass-through payments in ways that are not consistent with the pass-through payment transition periods established in the May 6, 2016 final rule. We solicited and received no substantive suggestions on doing such an analysis. Since we cannot produce a detailed quantitative analysis, we have developed a qualitative discussion for this final rule.

After considering the comments, we are finalizing the regulatory impact analysis as proposed without revision.

C. Anticipated Effects

The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Small entities are those entities, such as health care providers, having revenues between $7.5 million and $38.5 million in any 1 year. Individuals and states are not included in the definition of a small entity. We do not believe that this final rule will have a significant economic impact on a substantial number of small businesses.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis for any rule that 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 a Metropolitan Statistical Area and has fewer than 100 beds. We do not anticipate that the provisions in this final rule will have a substantial economic impact on small rural hospitals. We are not preparing analysis for either the RFA or section 1102(b) of the Act 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 or a significant impact on the operations of a substantial number of small rural hospitals in comparison to total revenues of these entities.

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) 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 2016, that is approximately $146 million. This final rule does not mandate any costs (beyond this threshold) resulting from (A) imposing enforceable duties on state, local, or tribal governments, or on the private sector, or (B) increasing the stringency of conditions in, or decreasing the funding of, state, local, or tribal governments under entitlement programs.

Executive Order 13132 establishes certain requirements that an agency must meet when it issues a rule that imposes substantial direct requirements or costs on state and local governments, preempts state law, or otherwise has federalism implications. Since this final rule does not impose any costs on state or local governments, the requirements of Executive Order 13132 are not applicable. In accordance with the provisions of Executive Order 12866, this final rule was reviewed by the Office of Management and Budget.

We did not receive comments on the proposed anticipated effects for the revisions to § 438.6(d) and finalize our analysis in this rule.

D. Alternatives Considered

During the development of this final rule, we assessed all regulatory alternatives and discussed in the preamble of the proposed rule a few alternatives that we considered. First, in discussing our revisions to paragraphs (d)(1)(i) and (ii) in the proposed rule, we considered linking eligibility for the transition period to those states with pass-through payments for hospitals, physicians, or nursing facilities that were in approved (not just submitted for our review and approval) managed care contract(s) and rate certification(s) only for the rating period covering July 5, 2016. We noted in the proposed rule that we believed such an approach was not administratively feasible for states or us because it did not recognize the nuances of the timing and approval processes. We believe our approach under this final rule provides the appropriate parameters and conditions for pass-through payments in managed care contract(s) and rate certification(s) during the transition period.

Second, in discussing our revisions to paragraphs (d)(3) and (d)(5) in the proposed rule, we described that the

aggregate amounts of pass-through payments in each provider category would be used to set applicable limits for the provider type during the transition period, without regard to the specific provider(s) that received a pass-through payment. We considered proposing that the state should be limited by amount and recipient during the transition period; however, this narrower policy would be more limiting than originally intended under the May 6, 2016 final rule when the pass-through payment transition periods were finalized. We requested comment on our alternative proposals.

We did not receive comments on the alternative proposals to revise § 438.6(d) and, as noted above, are finalizing the proposed amendments to § 438.6(d).

E. Accounting Statement

As discussed in this RIA, the benefits, costs, and transfers of this final regulation are identified in table 1 as qualitative impacts only.

TABLE 1—ACCOUNTING STATEMENT

Category	Primary estimate	Low estimate	High estimate	Units			Notes
				Year dollars	Discount rate	Period covered	
Benefits							
Non-Quantified	Benefits include: Consistency with the statutory requirements in section 1903(m) of the Act and regulations for actuarially sound capitation rates; improved transparency in rate development processes; greater incentives for payment approaches that are based on the utilization and delivery of services to enrollees covered under the contract, or the quality and outcomes of such services; and improved support for delivery system reform that is focused on improved care and quality for Medicaid beneficiaries.						
Costs							
Non-Quantified	Costs to state or federal governments should be negligible.						
Transfers							
Non-Quantified	Relative to the current baseline, this final rule builds on the May 6, 2016 final rule and may further reduce the likelihood of increases in or the development of new pass-through payments, which could reduce state and federal government transfers to hospitals, physicians, and nursing facilities. Given the potential for avoided transfers, we believe this final rule is economically significant as defined by Executive Order 12866.						

List of Subjects in 42 CFR Part 438

Grant programs—health, Medicaid, Reporting and recordkeeping requirements.

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

PART 438—MANAGED CARE

■ 1. The authority citation for part 438 continues to read as follows:

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

■ 2. Section 438.6 is amended by revising paragraphs (d)(1), (3), and (5) to read as follows:

§ 438.6 Special contract provisions related to payment.

* * * * *

(d) * * * (1) *General rule.* States may continue to require MCOs, PIHPs, and PAHPs to make pass-through payments (as defined in paragraph (a) of this section) to network providers that are hospitals, physicians, or nursing facilities under the contract, provided the requirements of this paragraph (d) are met. States may not require MCOs, PIHPs, and PAHPs to make pass-through payments other than those permitted under this paragraph (d).

(i) In order to use a transition period described in this paragraph (d), a State must demonstrate that it had pass-through payments for hospitals, physicians, or nursing facilities in:

(A) Managed care contract(s) and rate certification(s) for the rating period that includes July 5, 2016, and were submitted for CMS review and approval on or before July 5, 2016; or

(B) If the managed care contract(s) and rate certification(s) for the rating period that includes July 5, 2016 had not been submitted to CMS on or before July 5, 2016, the managed care contract(s) and rate certification(s) for a rating period before July 5, 2016 that had been most recently submitted for CMS review and approval as of July 5, 2016.

(ii) CMS will not approve a retroactive adjustment or amendment, notwithstanding the adjustments to the base amount permitted in paragraph (d)(2) of this section, to managed care contract(s) and rate certification(s) to add new pass-through payments or increase existing pass-through payments defined in paragraph (a) of this section.

* * * * *

(3) *Schedule for the reduction of the base amount of pass-through payments for hospitals under the MCO, PIHP, or PAHP contract and maximum amount of permitted pass-through payments for each year of the transition period.* For States that meet the requirement in paragraph (d)(1)(i) of this section, pass-through payments for hospitals may continue to be required under the contract but must be phased out no longer than on the 10-year schedule, beginning with rating periods for contract(s) that start on or after July 1, 2017. For rating periods for contract(s) beginning on or after July 1, 2027, the State cannot require pass-through payments for hospitals under a MCO, PIHP, or PAHP contract. Until July 1, 2027, the total dollar amount of pass-through payments to hospitals may not exceed the lesser of:

(i) A percentage of the base amount, beginning with 100 percent for rating periods for contract(s) beginning on or after July 1, 2017, and decreasing by 10 percentage points each successive year; or

(ii) The total dollar amount of pass-through payments to hospitals identified in the managed care contract(s) and rate certification(s) used to meet the requirement of paragraph (d)(1)(i) of this section.

* * * * *

(5) *Pass-through payments to physicians or nursing facilities.* For States that meet the requirement in paragraph (d)(1)(i) of this section, rating

periods for contract(s) beginning on or after July 1, 2017 through rating periods for contract(s) beginning on or after July 1, 2021, may continue to require pass-through payments to physicians or nursing facilities under the MCO, PIHP, or PAHP contract of no more than the total dollar amount of pass-through payments to physicians or nursing facilities, respectively, identified in the managed care contract(s) and rate certification(s) used to meet the requirement of paragraph (d)(1)(i) of this section. For rating periods for contract(s) beginning on or after July 1, 2022, the State cannot require pass-through payments for physicians or nursing facilities under a MCO, PIHP, or PAHP contract.

Dated: January 3, 2017.

Andrew M. Slavitt,

Acting Administrator, Centers for Medicare & Medicaid Services.

Dated: January 10, 2017.

Sylvia M. Burwell,

Secretary, Department of Health and Human Services.

[FR Doc. 2017–00916 Filed 1–17–17; 8:45 am]

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DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 665

[Docket No. 160811726–6999–02]

RIN 0648–XE809

Pacific Island Fisheries; 2016–17 Annual Catch Limit and Accountability Measures; Main Hawaiian Islands Deep 7 Bottomfish

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

ACTION: Final specifications.

SUMMARY: In this final rule, NMFS specifies an annual catch limit (ACL) of 318,000 lb of Deep 7 bottomfish in the main Hawaiian Islands (MHI) for the 2016–17 fishing year. As an accountability measure (AM), if the ACL is projected to be reached, NMFS would close the commercial and non-commercial fisheries for MHI Deep 7 bottomfish for the remainder of the fishing year. The ACL and AM support the long-term sustainability of Hawaii bottomfish.

DATES: The final specifications are effective from February 17, 2017, through August 31, 2017.

ADDRESSES: The environmental assessment and finding of no significant impact for this action, identified as NOAA–NMFS–2016–0112, is available at *www.regulations.gov,* or from Michael D. Tosatto, Regional Administrator, NMFS Pacific Islands Region (PIR), 1845 Wasp Blvd. Bldg. 176, Honolulu, HI 96818.

The Fishery Ecosystem Plan for the Hawaiian Archipelago is available from the Western Pacific Fishery Management Council (Council), 1164 Bishop St., Suite 1400, Honolulu, HI 96813, tel 808–522–8220, fax 808–522–8226, or *www.wpcouncil.org.*

FOR FURTHER INFORMATION CONTACT: Sarah Ellgen, NMFS PIR Sustainable Fisheries, 808–725–5173.

SUPPLEMENTARY INFORMATION: Through this action, NMFS is specifying an ACL of 318,000 lb of Deep 7 bottomfish in the MHI for the 2016–17 fishing year. The fishing year began September 1, 2016, and ends on August 31, 2017. The Council recommended this ACL, based on the best available scientific, commercial, and other information, taking into account the associated risk of overfishing. This ACL is 8,000 lb lower than the ACL that NMFS specified for the 2015–16 fishing year, and is the second annual reduction in a phased approach to lower the ACL incrementally over three years, as recommended by the Council.

The MHI Management Subarea is the portion of U.S. Exclusive Economic Zone around the Hawaiian Archipelago east of 161°20′ W. The Deep 7 bottomfish are onaga (*Etelis coruscans*), ehu (*E. carbunculus*), gindai (*Pristipomoides zonatus*), kalekale (*P. sieboldii*), opakapaka (*P. filamentosus*), lehi (*Aphareus rutilans*), and hapuupuu (*Hyporthodus quernus*).

The MHI bottomfish fishing year started September 1, 2016, and is currently open. NMFS will monitor the fishery and, if we project that the fishery will reach the ACL before August 31, 2017, we would, as an AM authorized in 50 CFR 665.4(f), close the non-commercial and commercial fisheries for Deep 7 bottomfish in Federal waters through August 31, 2017. During a fishery closure for Deep 7 bottomfish, no person may fish for, possess, or sell any of these fish in the MHI Management Subarea. There is no prohibition on fishing for, possessing, or selling other (*non*-Deep 7) bottomfish during such a closure. All other management measures continue to apply in the MHI bottomfish fishery. If NMFS and the Council determine that the final 2016–17 Deep 7 bottomfish catch exceeds the ACL, NMFS would reduce the Deep 7 bottomfish ACL for 2017–18 by the amount of the overage.

You may review additional background information on this action in the preamble to the proposed specifications (81 FR 75803; November 1, 2016); we do not repeat that information here.

Comments and Responses

The comment period for the proposed specifications ended on November 16, 2016. NMFS received comments from four individuals, and responds, as follows:

Comment 1: The 2016–2017 ACL serves as a precautionary measure for bottomfish stocks that supports healthy fisheries. The proposed ACL is greater than recent annual catches, so it would not significantly inconvenience fishermen.

Response: NMFS agrees. We assessed the potential beneficial and adverse impacts of the ACL and AM on the environment, including the fishery itself, and concluded that the action is necessary to prevent overfishing while supporting the long-term sustainability of Hawaii bottomfish.

Comment 2: We need to punish anyone who harms the ocean and any of our waters.

Response: While the comment is not specific to the proposed action, violations of Federal fishery regulations are subject to penalties pursuant to Section 308 of the Magnuson-Stevens Fishery Conservation and Management Act (Magnuson-Stevens Act).

Comment 3: Legislation is needed to reduce overfishing and to protect marine life in Hawaiian waters.

Response: Federal laws and regulations already protect Hawaii fish stocks from overfishing pressure. The Magnuson-Stevens Act includes requirements for ACLs and AMs and other provisions for preventing and ending overfishing and rebuilding fisheries. Unless exempted by law, all fisheries in Federal waters must have ACLs and AMs. Fishery scientists and managers use the best scientific information available, including catch, fishing effort, biological information, etc., to determine the maximum catch that would not harm the conservation needs of the fish stock, and ACLs must be set at or below the levels that account for uncertainty about the fishery information.

AMs are management controls to prevent ACLs from being exceeded, and to correct or mitigate overages when they occur. For the MHI bottomfish fishery, one AM would close the fishery before the scheduled end of the fishing year to prevent exceeding the ACL, and