

by §§ 226.6, 226.7, and 226.8 of Regulation Z.

It is further ordered, That the individual respondents named herein promptly notify the Commission of the discontinuance of their present business or employment and of their affiliation with any new business or employment which is located within the boundaries of the Navajo or Hopi Reservations or which involves the extension of or arranging for extension of "consumer credit" as defined in Regulation Z. Such notice shall include respondents' current business address and a statement as to the nature of the business or employment in which they are engaged as well as a description of their duties and responsibilities.

It is further ordered, That the respondent corporation, its successors and assigns, shall forthwith distribute a copy of this order to each of its operating divisions.

It is further ordered, That respondents notify the Commission at least thirty (30) days prior to any proposed change in the corporate respondent such as dissolution, assignment or sale resulting in the emergence of a successor corporation, the creation or dissolution of subsidiaries or any other change in the corporation which may affect compliance obligations arising out of this order.

It is further ordered, That the respondents herein shall within sixty (60) days after service upon them of this order, file with the Commission a report, in writing, setting forth in detail the manner and form in which they have complied with this order.

The Decision and Order was issued by the Commission, Oct. 8, 1974.

CHARLES A. TOBIN,
Secretary.

[FR Doc.75-4765 Filed 2-20-75;8:45 am]

[Docket C-2567]

PART 13—PROHIBITED TRADE PRACTICES, AND CORRECTIVE AFFIRMATIVE ACTIONS

Stokies, Inc., et al.

Subpart—Neglecting, unfairly or deceptively, to make material disclosure: § 13.1852 *Formal regulatory and statutory requirements*; § 13.1852-75 *Truth in Lending Act*; § 13.1905 *Terms and conditions*; § 13.1905-60 *Truth in Lending Act*.

(Sec. 6, 38 Stat. 721; (15 U.S.C. 46), Interpret or apply sec. 5, 38 Stat. 719, as amended; 82 Stat. 146, 147; (15 U.S.C. 45, 1601-1605)) [Cease and desist order, Stokies, Incorporated, et al. Tonolea, Ariz., Docket C-2567, Oct. 8, 1974]

In the Matter of Stokies, Incorporated, a Corporation Doing Business as Inscription House Trading Post, and Orange J. Carson, Individually and as an Officer of Said Corporation

Consent order requiring a Tonolea, Ariz., general merchandise retailer,

pawnbroker and money lender, among other things to cease violating the Truth in Lending Act by failing to disclose to consumers, in connection with the extension of consumer credit, such information as required by Regulation Z of the said Act.

The order to cease and desist, including further order requiring report of compliance therewith, is as follows:¹

It is ordered, That respondent Stokies, Incorporated, a corporation, its successors and assigns, and its officers, and Orange J. Carson, individually and as an officer of said corporation and respondents' agents, representatives and employees directly or through any corporation, subsidiary, division or other device in connection with the extension of "consumer credit" or arranging for "consumer credit" as defined in Regulation Z (12 CFR 226) of the Truth in Lending Act (P.L. 90-321 (15 U.S.C. 1601 et seq.)) do forthwith cease and desist from:

1. Failing to make disclosures required by § 226.8 of Regulation Z clearly, conspicuously and in a meaningful sequence, as prescribed by § 226.6(a) of Regulation Z.

2. Failing to print the terms "annual percentage rate" and "finance charge" more conspicuously than other required terminology, as prescribed by § 226.6(a) of Regulation Z.

3. Failing to disclose the finance charge expressed as an annual percentage rate, using the term "annual percentage rate", as prescribed by § 226.8(b) (2) of Regulation Z.

4. Failing to disclose the number, amount, and due dates or periods of payments scheduled to repay the indebtedness and the sum of such payments using the term "total of payments", as prescribed by § 226.8(b) (3) of Regulation Z.

5. Failing to disclose a description or identification of the type of any security interest held or to be retained or acquired by the creditor in connection with the extension of credit, and a clear identification of the property to which the security interest relates, as prescribed by § 226.8(b) (5) of Regulation Z.

6. Failing to disclose identification of the method of computing any unearned portion of the finance charge in the event of prepayment of the obligation and a statement of the amount or method of computation of any charge that may be deducted from the amount of any rebate of such unearned finance charge that will be credited to the obligation or refunded to the customer, as prescribed by § 226.8(b) (7) of Regulation Z.

7. Failing to disclose the amount of credit which will be paid to the customer including all charges, individually item-

¹Copies of the Complaint & decision and order filed with the original document.

ized which are included in the amount of credit extended but which are not part of the finance charge, using the term "amount financed", as prescribed by § 226.8(d) (1) of Regulation Z.

8. Failing to disclose the total amount of the finance charge, with description of each amount included, using the term "finance charge", as prescribed by § 226.8(d) (3) of Regulation Z.

9. Failing in any consumer credit transaction to make all disclosures determined in accordance with §§ 226.4 and 226.5 of Regulation Z at the time and in the manner, form, and amount required by §§ 226.6, 226.7, and 226.8 of Regulation Z.

It is further ordered, That the individual respondent named herein promptly notify the Commission of the discontinuance of his present business or employment and of his affiliation with a new business or employment. Such notice shall include respondent's current business address and a statement as to the nature of the business or employment in which he is engaged as well as a description of his duties and responsibilities.

It is further ordered, That the respondent corporation, its successors and assigns, shall forthwith distribute a copy of this order to each of its operating divisions.

It is further ordered, That respondents notify the Commission at least thirty (30) days prior to any proposed change in the corporate respondent such as dissolution, assignment or sale resulting in the emergence of a successor corporation, the creation or dissolution of subsidiaries or any other change in the corporation which may affect compliance obligations arising out of this order.

It is further ordered, That the respondents herein shall within sixty (60) days after service upon them of this order, file with the Commission a report, in writing, setting forth in detail the manner and form in which they have complied with this order.

The Decision and Order was issued by the Commission, Oct. 8, 1974.

CHARLES A. TOBIN,
Secretary.

[FR Doc.75-4706 Filed 2-20-75;8:45 am]

Title 20—Employees' Benefits CHAPTER III—SOCIAL SECURITY ADMINISTRATION, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

[Reg. No. 5, further amended]

PART 405—FEDERAL HEALTH INSURANCE FOR THE AGED AND DISABLED

Revisions in Carriers' Procedural Terminology and Coding

On February 22, 1974, there was published in the FEDERAL REGISTER (39 FR

6725) a notice of proposed rule making with a proposed amendment to Subpart E of Regulations No. 5 (20 CFR Part 405), regarding revisions in Medicare carriers' procedural terminology and coding systems. The Commissioner recognizes that revisions in Medicare carriers' procedural terminology and coding systems may be appropriate when such changes would result in more efficient and economical determinations with respect to Medicare coverage and reimbursement of physicians' services. The proposed amendment specified that such revisions would be approved if the Social Security Administration determined that the potential advantages of the proposed new system outweighed its disadvantages. The proposed amendment also listed certain considerations and guidelines that would be taken into account in evaluating a carrier's proposal for such a change. Interested persons were given through March 25, 1974, to submit written comments or suggestions thereon.

Comments were received from a number of private physicians and physicians' organizations. All the comments have been carefully considered. However, the amendment as announced under the notice of proposed rule making is being adopted without substantive change.

When a uniform, national terminology and coding system is developed and approved for use by all Medicare carriers, this regulation will, of course, be obsolesced.

Following is an explanation of the comments received and why they were considered inappropriate.

1. Many who commented proposed the use of the Current Procedural Terminology (CPT), Third Edition, published by the American Medical Association (AMA). However, it was decided to retain the original provisions in order to leave the initiative for any change in the hands of the carriers, subject to evaluation and approval by the Social Security Administration after consultation with the Assistant Secretary for Health.

2. A number of other comments were received. Many of these comments would entail rather significant changes in the proposed regulation and would remove some of the safeguards against increased costs resulting from conversions to different procedural terminology and coding systems, and also place the burden of justification on the Social Security Administration or the carriers if a change in a carrier's system is not initiated or approved. For example, it was proposed that the carriers be authorized to adopt the CPT, Third Edition, "without the necessity for the detailed approval process currently called for in the proposed rules." However, the approval process outlined in the guidelines is the safeguard provided against conversions whose costs or other disadvantages outweigh the potential advantages.

3. Also suggested were a number of changes in the proposed rule if the recommendation to adopt the CPT was not acceptable. One change recommended was that each of the Medicare carriers

be required to report, within 6 months of the effective date of the regulation, whether or not it wishes to modify its procedural terminology and coding system, and the reasons for its decision. Such a requirement would bring strong pressure on carriers to make early changes and might, therefore, result in undesirable changes.

4. The proposed regulation (§ 405.512 (b)) stated that "the Social Security Administration will evaluate the proposal in the light of the guidelines specified in paragraph (c) of this section and such other considerations as may be pertinent." A suggestion to delete the phrase, "and such other considerations as may be pertinent" was made on the ground that only "specific criteria" should be included. However, the inclusion of this phrase is necessary because not all criteria which may turn out to be important in the future can necessarily be anticipated.

5. Also recommended was revision of the language in the regulation providing that a proposed change in a carrier's procedural terminology and coding system will be approved if it is determined that the potential advantages of the proposed new system outweigh the disadvantages on the grounds that: (a) current coding systems in use by Medicare carriers are those which the carriers themselves developed or adopted, not ones mandated by the Social Security Administration; (b) effective and efficient administration of the Medicare program is intended by Congress to be a responsibility of a carrier; and (c) the Social Security Administration's voice in this facet of administration should be limited to a veto, not to control. It was, therefore, proposed that the Social Security Administration be permitted to disapprove such a revision only if it is determined that the potential disadvantages of the proposed new system outweigh the advantages; that such disapproval be stated and documented within 90 days of the carrier's proposal or the new system would be deemed approved; and that such disapproval, if stated within the 90-day period, be subject to a hearing if requested by either the carrier or practitioners who would be affected by the determination. This recommendation has not been accepted. It would subject the Social Security Administration to pressures for decisions more rapid than might always be appropriate and might give rise to formal hearings being initiated by a physician for almost any reason in case of denial and involve administrative difficulty and increased cost.

6. Another recommendation was that the proposed guideline which called for estimates of the short-run and long-run cost impact of the proposed change be deleted. It was suggested that since the Department of Health, Education, and Welfare has been involved in such studies for some 2 years, it is not necessary to obtain this information. However, these studies have been carried out in only a

few areas and a change in any given plan in a given area of the country would not have the identical effect to that shown in the study. It was suggested that if the cost-estimate requirement were retained, (1) an evaluation of their present systems be required of the carriers, and (2) the costs of such studies be borne by the Social Security Administration. However, such an evaluation and analysis of a carrier's existing terminology and coding system would be expected as part of the carrier's proposal to change to a new system.

7. One of the proposed guidelines referred to the degree of physician acceptance of a proposed new system. It was intended to assure a reasonable likelihood that a new system would, in fact, be used by the physicians in the carrier's service area. In this regard, it was recommended that the guideline be amended to provide that the carrier obtain opinions on the proposed change in terminology from the State medical association and from any Professional Standards Review Organizations (PSRO's) in the area. In order for a carrier to assess the degree to which physicians in its area would accept and utilize a new system, the carrier would have to contact local medical societies and other parties. These contacts would afford them an opportunity to express their opinions on the proposed change. Consequently, we think the point and concern of this comment is accommodated in paragraph (c) (4) of § 405.512 as presently written.

Use of a hearing procedure was recommended where the carrier opposes a change that has been endorsed by physicians. Endorsement of a particular system of procedural terminology and coding by a medical association or by other groups would be one of the factors to be taken into account under the proposed guideline. However, we do not believe that such endorsements can be accepted as conclusive evidence that the physicians in an area will actually use the new terminology, or as establishing a presumption that a physician-backed system is superior, from the point of view of the public, to the existing system.

8. There was also concern with the proposed guideline which called for the evaluation of a carrier's proposal in terms of the compatibility of the new terminology and coding system with other systems that the carrier and other carriers may utilize in the administration of the Medicare program—e.g., its compatibility with systems and statistical requirements and with the historical data in the carrier's claims processing system. The comment was that while it is an objective of the Medicare program to coordinate administration as far as possible, interpreting this requirement too rigidly could preclude the change of any terminology and coding system until all were changed. It was recommended that compatibility with other carriers' systems be an evaluation criterion only in comparison with whatever system the carrier is using, i.e., that this factor

should only be relevant if the proposed system is less compatible than the current system. However, this criterion would also be relevant where the proposed procedural terminology and coding system is more compatible than the current system, since this would be a factor in favor of making the change. Also, the proposed guideline would not preclude a revision solely because other carriers are not using the same system or because the proposed new system is not compatible with those used by other carriers. The proposed guideline was written so as to provide for testing whether a new procedural terminology and coding system proposed by a carrier will enable it to timely and accurately update its reasonable charge screens, and to meet program requirements related to utilization safeguards, and the collection of program statistical data.

9. It was also recommended that the reference to compatibility with "historical data in the carrier's processing system" be deleted from the guidelines as an evaluation factor on the ground that, while "historical data is of some importance, the major relevance of the new system should be its effectiveness in handling claims, and the proposal should not be disapproved on what may be, essentially, minor disadvantages." This recommendation cannot be adopted because, under the Medicare law, determinations regarding reasonable charge must take into account historical data (i.e., data on charges which physicians and others have made in prior periods). Inability to relate determinations regarding reasonable charges to historical data would make it impossible to determine reasonable charges under the provisions of section 1842(b) of the Act. Therefore, any plan to institute a new system which would make existing data unusable would have a fundamental flaw.

10. One comment related to the last proposed guideline, which called for consideration of the compatibility of the proposed system with the carrier's methods for determining reasonable charges for services which are identified by a single element of the terminology but which may vary in content. The comment was that, in effect, this guideline would be relevant only where the new system is less detailed and precise because a more detailed and precise system would, in fact, enable the carrier to distinguish differing services under the new system whereas previously such services might have been identified as a "single element". However, there are other circumstances in which it would be relevant. For example, surgeons have usually made one inclusive charge for the surgery and the preoperative and postoperative care rendered to patients. When charges are made separately for the individual components of such "packages", the total cost may rise. The carriers have been advised to base their reasonable charges in such situations on the charges that in sum are reasonable for the whole package. To implement this rule the carriers need to know whether any given

service charged for is only part of what is often reported as a package. More specifically, when a surgical service is paid for, it may have been expected to cover some specific duration of postoperative care. It may be necessary then to know whether a visit to a surgeon fell within the specified period. The proposed guideline was intended to assure that carriers which revise their systems of procedural terminology and coding can continue to implement this policy at least as well as they have in the past.

11. Finally, it was suggested that the proposed guidelines be changed so that they would apply only to "new and untested" systems, excluding the established, experienced, and predominant coding systems. However, proposed changes to such systems can also be expensive and should be evaluated. The approval process outlined in the proposed guidelines is, therefore, viewed as a necessary safeguard which must be retained.

The amendment as adopted is set forth below.

(Secs. 1102, 1169, 1814, 1833(a), 1842(b), and 1871; 49 Stat. 647, as amended; 79 Stat. 296, 297, 79 Stat. 302; 79 Stat. 331; 86 Stat. 1445; 42 U.S.C. 1302, 1320c-18, 1395f, 1395i(a), 1395u(b), and 1395hh.)

Effective date. This amendment shall be effective March 24, 1975.

(Catalog of Federal Domestic Assistance Program No. 13.801, Health Insurance for the Aged—Supplementary Medical Insurance.)

Dated: November 18, 1974.

J. B. CARDWELL,
Commissioner of Social Security.

Approved: February 14, 1975.

CASPAR W. WEINBERGER,
Secretary of Health, Education,
and Welfare.

Part 405 of Chapter III of Title 20 of the Code of Federal Regulations is amended by adding a new § 405.512 to read as follows:

§ 405.512 Carriers' procedural terminology and coding systems.

(a) **General.** Procedural terminology and coding systems are designed to provide physicians and third party payers with a common language that accurately describes the kinds and levels of services provided and that can serve as a basis for coverage and payment determinations.

(b) **Modification of terminology and/or coding systems.** A carrier that wishes to modify its system of procedural terminology and coding shall submit its request to the Social Security Administration with all pertinent data and information for approval before the revision is implemented. The Social Security Administration will evaluate the proposal in the light of the guidelines specified in paragraph (c) of this section and such other considerations as may be pertinent, and consult with the Assistant Secretary for Health. The Social Security Administration will approve such a revision if it

determines that the potential advantages of the proposed new system outweigh the disadvantages.

(c) **Guidelines.** The following considerations and guidelines are taken into account in evaluating a carrier's proposal to change its system of procedural terminology and coding:

(1) The rationale for converting to the new terminology and coding;

(2) The estimated short-run and long-run impact on the cost of the health insurance program, other medical care costs, administrative expenses, and the reliability of the estimates;

(3) The degree to which the conversion to the proposed new terminology and coding can be accomplished in a way that permits full implementation of the reasonable charge criteria in accordance with the provisions of this subpart;

(4) The degree to which the proposed new terminology and coding are accepted by physicians in the carrier's area (physician acceptance is assumed only if a majority of the Medicare and non-Medicare bills and claims completed by physicians in the area and submitted to the carrier can reasonably be expected to utilize the proposed new terminology and coding);

(5) The extent to which the proposed new terminology and coding system is used by the carrier in its non-Medicare business;

(6) The clarity with which the proposed system defines its terminology and whether the system lends itself to: (i) Accurate determinations of coverage; (ii) proper assessment of the appropriate level of payment; and (iii) meeting the carrier's or Professional Standards Review Organizations' review needs and such other review needs as may be appropriate;

(7) Compatibility of the new terminology and coding system with other systems that the carrier and other carriers may utilize in the administration of the Medicare program—e.g., its compatibility with systems and statistical requirements and with the historical data in the carrier's processing system; and

(8) Compatibility of the proposed system with the carrier's methods for determining reasonable charges for services which are identified by a single element of the terminology but which may vary in content.

[FR Doc.75-4792 Filed 2-20-75; 8:45 am]

[Regulations No. 16]

PART 416—SUPPLEMENTAL SECURITY INCOME FOR THE AGED, BLIND, AND DISABLED (1974—.....)

Subpart T—State Supplementation Provisions; Agreements; Payments

Subpart U—Medicaid Eligibility Determinations

On August 6, 1973, and October 3, 1973, there were published in the FEDERAL REGISTER (38 FR 21188 and 38 FR 27412) notices of proposed rule making with proposed amendments to the regulations

adding new Subparts T and U to Regulations No. 16. The proposed amendments provide policies regarding State supplementation and Federal determinations of Medicaid eligibility.

Proposed Subpart T defines State supplementary payments, and establishes the conditions under which the Secretary of Health, Education, and Welfare will enter into an agreement with States to make optional supplementary payments to persons eligible (or eligible but for income) for benefits under title XVI of the Social Security Act. It also establishes conditions for implementing the mandatory State supplementation provisions contained in Pub. L. 93-66. Proposed Subpart U (Medicaid Eligibility Determinations) sets forth the conditions under which the Secretary of Health, Education, and Welfare will enter into agreements with States to determine eligibility for medical assistance in the case of aged, blind, or disabled individuals under such State's plan approved under title XIX of the Social Security Act.

Interested parties were given the opportunity to submit data, views, or arguments with regard to the proposed regulations. All comments submitted with respect to proposed Subparts T and U were given due consideration.

The following is a discussion of the major substantive comments and the disposition of each:

(1) Questions were raised regarding the requirement that State funds must be on deposit with the Secretary in the month prior to the month of payment to recipients. Section 416.2090(a) of the regulations has been modified to state that the funds must be available to the Secretary on or before the date payment is to be received by the recipient unless otherwise provided by the Secretary (rather than in the prior month).

(2) Concern was expressed about the provision that an individual, aged 65 or over, was only eligible for federally administered supplementation as an aged individual. Section 416.2015(e) has been modified to permit a State, at its option, to allow an individual to elect to receive State supplementation in a category other than aged (e.g., blind) for which he may qualify and under which the payments are higher.

(3) Comments were received about limitations on State payment level variations. Some concern was expressed that the limit was inconsistent with mandatory State supplementation under Pub. L. 93-66. The reorganized regulations make it clear that the payment variations are applicable to optional supplementation rather than the supplementation required by Pub. L. 93-66. A few States expressed the opinion that variable costs of care in custodial homes required a greater number of variations. However the proposed limitation on variations has been retained for reasons of efficient and effective administration. Any State is free to administer additional supplements in those cases where it is deemed necessary and appropriate.

(4) There was criticism of the provisions (now appearing as § 416.2035(b)) which permit States to retain lien and relative responsibility provisions if the Secretary determines that (a) the specific State rules are consistent with the purpose of the supplemental security income program, (b) the Federal government is in no way involved in the enforcement or administration of the rules, and (c) no portion of any benefit payment which is financed from Federal funds will be subjected to the liens or encumbrances under the State rules. No change has been made in this section of the regulations since there does not appear to be any basis for precluding a State from itself carrying out, completely apart from the administration of the supplemental security income (and supplementation) program, those rules which meet the criteria described above.

(5) Comments were received pertaining to the limitations on a person's eligibility for federally administered optional State supplementary payments due to his confinement in a medical facility. The restriction in § 416.2040(b) against Federal administration of a State supplement to persons in medical facilities not certified under title XIX has been deleted. This is superseded by the broader issue raised by the enactment of section 14 of Pub. L. 93-233 which will be addressed in separate regulations, to be published in notice form.

In addition, the provision regarding the calculation of the adjusted payment level for couples has been changed to require the use of actual ratios (§ 416.2085(b)); and § 416.2025(c) (implementing section 1616(c)(2) of the Social Security Act pertaining to additional income disregards available to the State in connection with optional supplementation) has been modified to make clear that, in accordance with the Act, States may provide for excluding only additional amounts of income in determining the amount of supplementation payable, and may not vary the exclusions based on the type (or source) of income. Modifications required by the provisions of section 8 of Pub. L. 93-233 and Pub. L. 93-335 relative to the bonus value of food stamps have been incorporated (§§ 416.2050(b)(1) and 416.2085(a)). Further, the regulations have been reorganized for the sake of accuracy and clarity.

Additional changes have been made to more clearly reflect the intent of the original regulatory provisions. Most of these changes resulted from comments received.

Accordingly, the proposed amendments, with changes noted, are hereby adopted as set forth below.

(Secs. 1102, 1601, 1616, 1631, and 1634, Social Security Act, as amended, sec. 401 of Pub. L. 92-603, sec. 212 of Pub. L. 93-66, sec. 8 of Pub. L. 93-233, secs. 1 and 2 of Pub. L. 93-335, 49 Stat. 647, as amended, 86 Stat. 1465, 1474, 1475, 1478, and 1485, 87 Stat. 155 and 956, 88 Stat. 291; 42 U.S.C. 1302, 1381, 1382e, 1383, 1383c, 1382e, nts, 1382 nt (7 U.S.C. 2012 nts.))

Effective date. The amendments shall be effective on February 21, 1975.

(Catalog of Federal Domestic Assistance Program No. 13.807, Supplemental Security Income Program.)

Dated: December 20, 1974.

J. B. CARDWELL,
Commissioner of Social Security.

Approved: February 14, 1975.

CASPAR W. WEINBERGER,
Secretary of Health, Education,
and Welfare.

Part 416 of 20 CFR Chapter III is amended by adding thereto new Subparts T and U to read as follows:

Subpart T—State Supplementation Provisions; Agreements; Payments

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|----------|---|
| Sec. | |
| 416.2001 | State supplementary payments; general |
| 416.2005 | Administration agreements with the Secretary. |
| 416.2010 | Essentials of the administration agreements. |
| 416.2015 | Establishing eligibility. |
| 416.2020 | Federally administered supplementary payments. |
| 416.2025 | Optional supplementation: countable income. |
| 416.2030 | Optional supplementation: variations in payments. |
| 416.2035 | Optional supplementation: additional State options. |
| 416.2040 | Limitations on eligibility. |
| 416.2045 | Overpayments and underpayments. |
| 416.2047 | Waiver of State supplementary payments. |
| 416.2050 | Mandatory minimum State supplementation. |
| 416.2055 | Mandatory minimum supplementation reduced. |
| 416.2060 | Mandatory minimum supplementary payments not applicable. |
| 416.2065 | Mandatory minimum State supplementation: agreement deemed. |
| 416.2070 | Mandatory supplementation: State compliance not applicable. |
| 416.2075 | Monitoring of mandatory minimum supplementary payments. |
| 416.2080 | Limitation of fiscal liability of States. |
| 416.2082 | Non-Federal share of expenditures; defined. |
| 416.2085 | Adjusted payment level. |
| 416.2090 | State funds advanced for supplementary payments. |

Subpart U—Medicaid Eligibility Determinations

- | | |
|----------|---|
| 416.2101 | Authority to perform State Medicaid functions. |
| 416.2104 | Renewal, termination, or modification of agreement. |
| 416.2107 | Effect of agreement on existing Federal-State responsibilities. |
| 416.2111 | Conditions for agreement to determine eligibility for medical assistance. |
| 416.2112 | Limitations as to individuals covered by agreement to determine eligibility for medical assistance. |
| 416.2116 | Terms of agreement; functions performed by the Secretary. |
| 416.2118 | State requests for studies, evaluations, and other information or assistance. |
| 416.2119 | Functions performed by the State. |

Subpart T—State Supplementation Provisions; Agreements; Payments

§ 416.2001 State supplementary payments; general.

(a) *State supplementary payments; defined.* State supplementary payments, which will be excluded from income pursuant to § 416.1151, are any payments made by a State (or one of its political subdivisions) to a recipient of supplemental security income benefits (or to an individual who would be eligible for such benefits except for income), if the payments are made:

(1) In supplementation of the Federal supplemental security income benefits; i.e., as a complement to the Federal benefit amount, thereby increasing the amount of income available to the recipient to meet his needs; and

(2) Regularly, on a periodic recurring, or routine basis of at least once a quarter; or made to a specific group or class of individuals in similar circumstances or situations (such as burnouts, utility turnoffs, evictions); and

(3) In cash, which may be actual currency or any negotiable instrument, convertible into cash upon demand; and

(4) In an amount based on the need or income of an individual or couple.

(b) *State; defined.* For purposes of this subpart, "State" means a State of the United States or the District of Columbia.

(c) *Mandatory minimum supplementary payments.* In order for a State to be eligible for payments pursuant to title XIX of the Act with respect to expenditures for any quarter beginning after December 1973, such State must have in effect an agreement with the Secretary under which such State will provide to aged, blind, and disabled individuals (as defined in § 416.202) residing in the State who were recipients of aid or assistance for December 1973 as defined in § 416.121, under such State's plan approved under titles I, X, XIV, or XVI of the Act, mandatory minimum supplementary payments beginning in January 1974 in an amount determined in accordance with § 416.2050 in order to maintain their income levels of December 1973. (See §§ 416.2065 and 416.2070.)

§ 416.2005 Administration agreements with the Secretary.

(a) *Agreement—mandatory only.* Subject to the provisions of paragraph (d) of this section, any State having an agreement with the Secretary under § 416.2001(c) may enter into an administration agreement with the Secretary under which the Secretary will make the mandatory minimum supplementary payments on behalf of such State. An agreement under § 416.2001(c) and an administration agreement under this paragraph may be consolidated into one agreement.

(b) *Agreement—mandatory and optional payments.* Subject to the provisions of paragraph (d) of this section, any State may enter into an agreement

with the Secretary under which the State will provide both mandatory and optional State supplementary payments and elect Federal administration of such State supplementary payment programs. If the Secretary agrees to administer such State's optional supplementary payments, the State must also have the Secretary administer its mandatory minimum supplementary payments unless the State is able to provide sufficient justification for exemption from this requirement.

(c) *Administration—combination.* Any State may enter into an agreement with the Secretary under which the State will provide mandatory minimum supplementary payments and elect Federal administration of such payments while providing optional State supplementary payments which it shall administer itself. If the State chooses to administer such payment itself, it may establish its own criteria for determining eligibility requirements as well as the amounts.

(d) Conditions of administration agreement.

The State and the Secretary may, subject to the provisions of this subpart, enter into a written agreement, in such form and containing such provisions not inconsistent with this part as are found necessary by the Secretary, under which the Secretary will administer the State supplementary payments on behalf of a State (or political subdivision). Under such an agreement between the Secretary and a State, specific Federal and State responsibilities for administration and fiscal responsibilities will be stipulated. The regulations in effect for the supplemental security income program shall be applicable in the Federal administration of State supplementary payments except as may otherwise be provided in this subpart as found by the Secretary to be necessary for the effective and efficient administration of both the basic Federal benefit and the State supplementary payment.

§ 416.2010 Essentials of the administration agreements.

(a) *Payments.* Any agreement between the Secretary and a State made pursuant to § 416.2005 must provide that, if for optional supplementation, such State supplementary payments are made to all individuals and/or couples who are:

(1) Receiving (or at the option of the State would, but for the amount of their income, be eligible to receive) supplemental security income benefits under title XVI of the Social Security Act; and

(2) Within the variations and categories (as defined in § 416.2030) for which the State (or political subdivision) wishes to provide a supplementary payment; and

(3) Residing, subject to the provisions of § 416.2035(a), in such State (or political subdivision thereof).

(b) *Fiscal bases specified.* If, for any fiscal year, a State wishes to claim fiscal protection under the provisions of § 416.2080, the agreement between a State and the Secretary will specify the

dollar amount(s) of the adjusted payment level(s), as defined in § 416.2085. The non-Federal share of expenditures for calendar year 1972 as defined in § 416.2082 will also be stated in the agreement. These amounts, if not known at the time the agreement is entered into, may be provisionally agreed upon and subsequently verified by Department of Health, Education, and Welfare audits. If the State elects options available under this subpart (specified in §§ 416.2015-416.2035), such options must be specified in the administration agreement.

(c) *Administrative costs.* The agreement between the State and the Secretary shall specify that all administrative costs incurred by the Secretary will be borne by the Federal Government.

(d) *Agreement period.* The agreement period for a State which, prior to January 1, 1974, elects Federal administration of its supplement will extend from January 1, 1974, through June 30, 1974. The agreement will be automatically renewed for a period of 1 year unless either the State or the Secretary gives written notice not to renew, at least 90 days before the beginning of the new period. For a State to elect Federal administration after January 1, 1974, it must notify the Secretary of its intent to enter into an agreement, furnishing the necessary payment specifications, at least 120 days before the first day of the month for which it wishes Federal administration to begin, and have executed such agreement at least 30 days before such day. Such a State's initial agreement period will run until the following June 30 at which time its agreement will be automatically renewed for 1 year unless the State or the Secretary has given written notice not to renew at least 90 days before the end of that period.

(e) *Modification or termination.* The agreement may be modified at any time by mutual consent. The State or the Secretary may terminate the agreement upon 90 days written notice to the other party, provided the effective date of the termination is the last day of a quarter. However, the State may terminate the agreement upon 45 days written notice to the Secretary where: (1) the State does not wish to comply with a regulation promulgated by the Secretary subsequent to the execution of the agreement; and (2) the State provides such written notice within 30 days of the effective date of the regulation. The Secretary is not precluded from terminating the agreement in less than 90 days where he finds that a State has failed to materially comply with the provisions of paragraph (f) of this section or § 416.2090.

(f) *Mandatory minimum State supplementation.* Any administration agreement between the Secretary and a State under which the Secretary will make such States mandatory minimum State supplementary payments shall provide that the State will:

(1) *Certify income and payment amount.* Certify to the Secretary the

names of each individual who, for December 1973 was eligible for and a recipient of aid or assistance in the form of money payments under a plan of such State approved under title I, X, XIV, or XVI of the Act (§ 416.121), together with the amount of such aid or assistance payable to each such individual and the amount of such individual's other income (as defined in § 416.2050(b)(2)), and

(2) *Additional data.* Provide the Secretary with such additional data at such times as the Secretary may reasonably require in order to properly, economically, and efficiently carry out such administration agreement. This shall include required information on changes in countable income as well as changes in special needs and circumstances that would result in a decrease in the mandatory income level being maintained by the State, unless the State has specified in the agreement that the minimum income level shall not be lowered by such changes.

§ 416.2015 Establishing eligibility.

(a) *Applications.* Any person who meets the application requirements of Subpart C of this part is deemed to have filed an application for any federally administered State supplementation for which he may be eligible unless supplementation has been waived pursuant to § 416.2047. However, a supplemental statement will be required where additional information is necessary to establish eligibility or to determine the correct payment amount.

(b) *Evidentiary requirements.* The evidentiary requirements and developmental procedures of this part are applicable with respect to Federally administered State supplementary payments.

(c) *Determination.* Where not inconsistent with the provisions of this subpart, eligibility for and the amount of the State supplementary payment will be determined pursuant to the provisions of Subparts A through Q of this part.

(d) *Categories; aged, blind, disabled.* An applicant will be deemed to have filed for the State supplementary payment amount provided for the category under which his application for a Federal supplemental security income benefit is filed. As in the Federal supplemental security income program, an individual who establishes eligibility as a blind or disabled individual, and continually remains on the rolls, will continue to be considered blind or disabled after he attains age 65.

(e) *Concurrent categories.* (1) In States where the supplementary payment provided for the aged category is higher than for the blind or disabled category aged individuals will be paid the State supplement on the basis of age.

(2) If the administration agreement pursuant to § 416.2005(b) provides for higher supplementary payments to the blind or disabled than to the aged category, then, at the option of the State, the agreement may provide that individuals who are age 65 or over at time of application and who are blind or disabled

may elect to receive such higher supplementary payments.

§ 416.2020 Federally administered supplementary payments.

(a) *Payment procedures.* A Federally administered State supplementary payment will be made on a monthly basis and will be included in the same check as a Federal benefit that is payable. A State supplementary payment shall be for the same month as the Federal benefit.

(b) *Maximum amount.* There is no restriction on the amount of a State supplementary payment that the Federal Government will administer on behalf of a State.

(c) *Minimum amount.* The Federal Government will not administer optional State supplementary payments in amounts less than \$1 per month, i.e., \$3 per quarter. Hence, optional supplementary payment amounts of less than \$1 will be raised to a dollar.

(d) *Optional supplementation: nine categories possible.* A State may elect Federal administration of its supplementary payments for up to nine categories, depending on the assistance titles in effect in that State in January 1972 (i.e., titles I, X, XIV, or XVI). It can have no more than two categories (one for individuals and one for couples) for each title in effect for January 1972:

(1) Since a State with a title XVI program had just the one title in effect, it can supplement only to two categories, the individual (aged, blind, or disabled), the couple (both of whom are aged, blind, or disabled).

(2) Other States could supplement up to nine categories, depending on the plans they had in effect. Six of these categories would be for:

- (i) Aged Individual,
- (ii) Aged Couple,
- (iii) Blind Individual,
- (iv) Blind Couple,
- (v) Disabled Individual,
- (vi) Disabled Couple

(3) In addition to those enumerated in paragraph (d)(2) of this section, there are three additional couple categories for which a State may elect to provide a Federally administered supplement. These categories are created when one individual in the couple is:

- (1) Aged and the other blind, or
- (2) Aged and the other disabled, or
- (3) Blind and the other disabled.

§ 416.2025 Optional supplementation: countable income.

(a) *Earned and unearned income.* No less than the amounts of earned or unearned income which were excluded in determining eligibility for or amount of a title XVI supplemental security income benefit must be excludable by a State in the Federal-State agreement for purposes of determining eligibility for or amount of the State supplementary payment.

(b) *Effect of countable income on payment amounts.* "Countable income" of an eligible individual or eligible couple is determined in the same manner as such

income is determined under the title XVI supplemental security income program. Countable income will affect the amount of the State supplementary payments as follows:

(1) As provided in § 416.420, countable income will first be deducted from the Federal benefit rate applicable to an eligible individual or eligible couple.

(2) If countable income is equal to or less than the amount of the Federal benefit rate, the full amount of the State supplementary payment as specified in the Federal agreement will be made.

(3) If countable income exceeds the amount of the Federal benefit rate, the State supplementary payment will be reduced by the amount of such excess.

(4) No State supplementary payment will be made where countable income is equal to or exceeds the sum of the Federal benefit rate and the State supplementary payment rate.

(c) *Effect of additional income exclusions on payment amounts.* A State has the option of excluding amounts of earned and unearned income in addition to the amounts it is required to exclude under paragraph (a) of this section in determining a person's eligibility for State supplementary payments. Such additional income exclusions affect the amount of the State supplementary payments as follows:

(1) Countable income (as determined under the Federal eligibility rules) will first be deducted from the Federal benefit rate applicable to an eligible individual or eligible couple.

(2) Such countable income is then reduced by the amount of the additional income exclusion specified by the State.

(3) If the remaining countable income is equal to or less than the amount of the Federal benefit rate, the full amount of the State supplementary payment will be made.

(4) If the remaining countable income exceeds the amount of the Federal benefit rate, the State supplementary payment will be reduced by the amount of such excess.

§ 416.2030 Optional supplementation: variations in payments.

(a) *Payment level.* The level of State supplementary payments may vary for each category the State elects to include in its Federally administered supplement. These categorical variations of payment levels must be specified in the agreement between the Secretary and the State. If any State has in effect for July 1974 an agreement which provides for variations in addition to those specified in this section, the State may, at its option, continue such variations but only for periods ending before July 1, 1976.

(1) *Geographical variations.* A State may elect to include two different geographical variations. A third may be elected if adequate justification, e.g., substantial differences in living costs, can be demonstrated. All such variations must be readily identifiable by county or ZIP code or other readily identifiable factor.

(2) *Living arrangements.* In addition, a State may elect no more than five variations in recognition of the different needs which result from various living arrangements. Types of living arrangements for which variations may be allowed include arrangements such as:

- (i) Living alone,
- (ii) Living with an ineligible spouse,
- (iii) Personal care facility,
- (iv) Domiciliary or congregate care facility.

(b) *Relationship to actual cost differences.* Under the agreement, variations in State supplementary payment levels will be permitted for each living arrangement the State elects. These differences must be based on rational distinctions between both the types of living arrangements and the costs of those arrangements.

§ 416.2035 Optional supplementation: additional State options.

(a) *Residency requirement.* A State or political subdivision may impose, as a condition of eligibility, a residency requirement which excludes from eligibility for State supplementary payment any individual who has resided in such State (or political subdivision thereof) for less than a minimum period prescribed by the State. Any such residency requirement will be specified in the agreement.

(b) *Lien and relative responsibility.* A State which elects Federal administration of its supplementary payments may place a lien upon property of an individual as a consequence of the receipt of such payments or may require that a relative of the individual contribute to a reasonable extent to the support of the individual, providing it is stated in the agreement that:

(1) The Secretary has determined that the specific State laws and their enforcement are consistent with the supplemental security income program purpose of providing unencumbered cash payments to recipients; and

(2) The Federal Government is not involved in the administration of such laws and will not vary the State supplementary payment amount it makes to comply with such laws; and

(3) Neither the basic Federal benefit nor any part of the State supplementary payment financed by Federal funds will be subject to the liens or encumbrances of such laws.

§ 416.2040 Limitations on eligibility.

Notwithstanding any other provision of this subpart, the eligibility of an individual (or couple) for optional State supplementary payments administered by the Federal Government in accordance with this subpart shall be limited as follows:

(a) *Inmate of public institution.* No person who is ineligible for a Federal benefit pursuant to § 416.231(a)(1) shall be eligible for such State supplementation for that month.

(b) *Supported by title XIX funds.* No person who is, throughout any month, in a medical facility receiving payments with respect to such person under a

State plan approved under title XIX at a level exceeding 50 percent of the cost of such person's care, shall be eligible for such State supplementation for that month.

(c) *Ineligible persons.* No person who is ineligible for a Federal benefit for any month under sections 1611(e)(1)(A), (2), (3), or (f) of the Act (failure to file; refuses treatment for drug addiction or alcoholism; outside the United States) or section 1615 of the Act (refuses vocational rehabilitation) or other reasons (other than the amount of income) shall be eligible for such State supplementation for such month.

§ 416.2045 Overpayments and underpayments; federally administered supplementation.

(a) *Overpayments.* Upon determination that an overpayment has been made, adjustments will be made against future federally administered State supplementary payments for which the person is entitled. Rules and requirements (see §§ 416.550-416.572) in effect for recovery (or waiver) of supplemental security income benefit overpayments shall also apply to the recovery (or waiver) of federally administered State supplementary overpaid amounts. If the overpaid person's entitlement to the State supplementary payments is terminated prior to recoupment of the overpaid State supplementary payment amount, and the overpayment cannot be recovered from a Federal benefit payable under this part, the person's record will be annotated (specifying the amount of the overpayment) to permit recoupment if the person becomes reentitled to supplementary payments of such State or to a Federal benefit under this part.

(b) *Underpayments.* Upon determination that an underpayment of State supplementary payments is due and payable, the underpaid amount shall be paid to the underpaid claimant directly, or his representative. If the underpaid person dies before receiving the underpaid amount of State supplementary payment the underpaid amount shall be paid to the claimant's eligible spouse. If the deceased claimant has no eligible spouse, no payment of the underpaid amount shall be made. (See §§ 416.538-416.543.)

§ 416.2047 Waiver of State supplementary payments.

(a) *Waiver request in writing.* Any person who is eligible to receive State supplementary payments or who would be eligible to receive such State supplementary payments may waive his right to receive such payments if such person makes a written request for waiver of State supplementary payments. Any such request made at time of application for the Federal benefit shall be effective immediately. Any such request filed after the application is filed shall be effective the month the request is received in a social security office, or earlier if the recipient refunds to the Social Security Administration the amount of any supplementary payment(s) made to him for the subject period.

(b) *Revocation of waiver.* Any individual who has waived State supplementary payments may revoke such waiver at any time by making a written request to any social security office. The revocation will be effective the month in which it is filed. The date such request is received in a social security office or the postmarked date, if the written request was mailed, will be the filing date, whichever is earlier.

§ 416.2050 Mandatory minimum State supplementation.

(a) *Determining the amount.* The amount of a mandatory State supplementary payment in the case of any eligible individual or couple for any month is equal to:

(1) The amount by which such individual or couple's December 1973 income (as defined in paragraph (b) of this section) exceeds the amount of such individual or couple's title XVI benefit plus other income which would have been used by such State in computing the assistance payable under the State's approved plan for such month or;

(2) Such greater amount as the State may specify.

(b) *December 1973 income.* "December 1973 income" means an amount equal to the aggregate of:

(1) *Money payments.* The amount of the aid or assistance in the form of money payments (as defined in 45 CFR § 234.11(a)) which an individual would have received (including any part of such amount which is attributable to meeting special needs or special circumstances) under a State plan approved under title I, X, XIV, or XVI of the Act in accordance with the terms and conditions of such plan relating to eligibility for and amount of such aid or assistance payable thereunder which were in effect for the month of June 1973 together with the bonus value of food stamps for January 1972 (as defined in § 416.2085(e)) if for such month such individual resides in a State which the Secretary has determined provides supplementary payments the level of which has been found by the Secretary pursuant to section 8 of Pub. L. 93-233 (87 Stat. 956) to have been specifically increased so as to include the bonus value of food stamps, and

(2) *Income.* The amount of the income of such individual other than aid or assistance, received by such individual in December 1973, remaining after application of all appropriate income exclusions and used in computation of the amount of aid or assistance, minus any such income which did not result, but which if properly reported, would have resulted in a reduction in the amount of such aid or assistance. Income, which because a State paid less than 100% of its standard of need, did not cause a reduction in the amount of aid or assistance is included.

(c) *Special needs or circumstances.* Special needs or circumstances include needs of essential persons (as defined in § 416.243), special allowances for housing, and such other situations for which

money payments to or for an eligible individual were made under a State plan approved under title I, X, XIV, or XVI of the Act as in effect for June 1973.

(d) *Optional supplement payable.* A recipient meeting the requirements of paragraph (a) of this section who would otherwise qualify for a payment under a State's program of optional State supplementation (provided for by § 416.2010) which is greater than the amount required by paragraph (a) of this section, shall be paid such greater amount.

§ 416.2055 Mandatory minimum supplementation reduced.

If for any month after December 1973 there is a change with respect to any special need or special circumstance which, if such change had existed in December 1973, would have caused a reduction in the amount of such individual's aid or assistance payment, then, for such month and for each month thereafter, the amount of the mandatory minimum supplement payable to such individual may, at the option of the State, be reduced in accordance with the terms and conditions of the State's plan approved under title I, X, XIV, or XVI of the Act in effect for the month of June 1973.

§ 416.2060 Mandatory minimum supplementary payments not applicable.

An individual eligible for mandatory minimum supplementary payments from a State beginning in January 1974 shall not be eligible for such payments:

(a) *Month after the month of death.* Beginning with the month after the month in which the individual dies; or

(b) *Not aged, blind, or disabled.* Beginning with the first month after the month in which such individual ceases to be an aged, blind, or disabled individual (as defined in § 416.202); or

(c) *Not entitled to a Federal payment.* During any month in which such individual was ineligible to receive supplemental income benefits under title XVI of the Social Security Act by reason of the provisions of Section 1611(e) (1) (A), (2) or (3), 1611(f), or 1615(c) of such Act; or

(d) *Month of change in residence.* During any full month such individual is not a resident of such State.

§ 416.2065 Mandatory minimum State supplementation: agreement deemed.

A State shall be deemed to have entered into an agreement with the Secretary under which such State shall provide mandatory minimum supplementary payments if such State has entered into an agreement with the Secretary under section 1616 of the Act under which:

(a) *Other eligible individuals.* Supplementary payments are made to individuals other than those aged, blind, and disabled individuals who were eligible to receive aid or assistance in the form of money payments for the month of December 1973 under a State plan approved under title I, X, XIV, or XVI of the Act, under terms and conditions of such plan in effect for June 1973, and

(b) *Minimum requirements.* Supplementary payments which meet the mandatory minimum requirements of this subpart are payable to all aged, blind, or disabled individuals who were eligible to receive aid or assistance in the form of money payments for the month of December 1973 under a State plan approved under title I, X, XIV, or XVI of the Act, under terms and conditions of such plan in effect for June 1973.

§ 416.2070 Mandatory supplementation: State compliance not applicable.

The requirement that a State must have in effect an agreement with the Secretary whereby such State shall provide individual aged, blind, and disabled recipients residing in the State mandatory minimum supplementary payments beginning in January 1974 shall not be applicable in the case of any State where:

(a) *State constitution.* The State constitution limits expenditures that may be paid as public assistance to, or on behalf of, any needy person to an amount that does not exceed the amount of State public assistance payments that are matched by Federal funds under titles I, IV, X, XIV, XVI, or XIX of the Social Security Act making it impossible for such State to enter into and commence carrying out (on January 1, 1974) such agreement with the Secretary, and

(b) *Attorney General decision.* The Attorney General (or other appropriate State official) has, prior to July 1, 1973, made a finding that the State constitution of such State contains limitations which prevent such State from making supplementary payments of the type described in section 1616 of the Act.

§ 416.2075 Monitoring of mandatory minimum supplementary payments.

(a) *Access to records.* Any State entering into an agreement with the Secretary whereby such State will provide mandatory minimum supplementary payments in accordance with § 416.2001(c) shall agree that the Secretary shall have access to and the right to examine any directly pertinent books, documents, papers, and records of the State involving transactions related to this agreement.

(b) *Additional data.* Any State entering into an agreement in accordance with § 416.2005 shall provide the Secretary with such additional data at such times as the Secretary may reasonably require in order to properly, economically, and efficiently be assessed of such State's compliance with such State agreements.

§ 416.2080 Limitation of fiscal liability of States.

(a) *Fiscal limits.* The amount payable to the Secretary by a State for the amount of the supplementary payments made on its behalf for any fiscal year pursuant to the administration agreement with the Secretary as described in § 416.2005 shall not exceed the total amount of the State's calendar year 1972 non-Federal share of expenditures as aid or assistance under the State plan(s) approved under title I, X, XIV, or XVI of the Act, as set forth in § 416.2082.

(b) *Less than full fiscal year period.* Should the agreement cover less than a full fiscal year, the limitation on the amount of the State's fiscal liability protection is the same as described in paragraph (a) of this section. The only exception is the fiscal liability protection for States for January through June of 1974 which will be determined by dividing the calendar year 1972 non-Federal share of expenditures as described in § 416.2082 by two.

(c) *State fiscal protection.* Except as provided in paragraph (e) of this section, the provisions of paragraphs (a) and (b) of this section shall apply only to that portion of the State supplementary payments made by the Secretary on behalf of a State under an agreement for any month which does not exceed, in the case of any individual (or couple), the difference between:

(1) The adjusted payment level as defined in § 416.2085 under the appropriate approved State plan(s) as in effect for January 1972, and

(2) The benefits paid for such month under title XVI plus any income not excluded under the provisions of section 1612 of the Act.

(d) *Unprotected payments.* Except as provided in paragraph (e) of this section, the portion of the State supplementary payment which is, in the case of any individual, in excess of this difference between the State's January 1972 adjusted payment level and the Federal benefit (plus income counted under Federal eligibility rules) will be made entirely at State expense.

(e) *Credits and debits.* For purposes of determining the extent of protected payments where State supplementary payments are paid at varying levels, to the extent that payments above the adjusted payment level do not exceed the difference by which variations in payment levels (variant payment levels) are established below the adjusted payment level, payments count toward the amount of a State's fiscal liability protection. This provision is explained as follows:

(1) The variant payment levels must be both above and below the adjusted payment level. The variant payment level is the sum of the Federal benefit plus income counted under Federal eligibility rules plus the State supplementary payment.

(2) In each case where the variant payment level is below the adjusted payment level and a State supplementary payment is made, a credit will be given to the extent of the difference between the adjusted payment level and the variant payment level. While countable income affects the amount of the State's supplementary payment, it has no effect on the amount of credit given. Cumulative credit will be given for the number of cases in each variation below the adjusted payment level. The credit given to each case within such a variation is always the same because it is not adjusted to reflect payments that are reduced due to income.

(3) In each case where the variant payment level is above the adjusted payment level and a State supplementary

payment is made which equals either the full or partial difference between the variant payment level and the adjusted payment level, a debit will be given to the extent of such difference. A cumulative debit amount will be given for such cases in each variation that exceeds the adjusted payment level.

(4) Neither a credit nor a debit is applicable to those cases where a State's variant payment level is equal to the adjusted payment level.

(5) For those States which apply additional income exclusions as explained in § 416.2025(c), the computation of credits and debits will be made as if supplementary payments had been made without regard to such additional income exclusions.

(6) For purposes of paragraph (c) (4) of this section, credits may be applied to debits at any time within a fiscal year. The amount that would count toward a State's fiscal liability protection once the non-Federal share of 1972 expenditures has been met will be determined by the extent to which total credits within each category of supplementation equal total debits within each category of supplementation in a fiscal year. The amount by which total debits exceed total credits will be borne entirely at State expense.

(f) *Fiscal limit not applicable.* The limitation on fiscal liability provision will not apply to any State supplementary payments which are made to individuals or couples within any category for which the adjusted payment level is less than, or equal to, the Federal monthly benefit rate for an eligible individual or eligible couple as specified in §§ 416.410 and 416.412. Further, the provisions of paragraph (a) of this section shall not apply to the amount of any State supplementary payment which results from the application of additional income exclusions specified by the State in its agreement with the Secretary (see § 416.2025(c)). In addition, the provisions of paragraph (a) of this section shall not apply with respect to supplementary payments to any individual or couple who is both:

(1) Not required to be included in the agreement administered by the Secretary (see § 416.2010(a)), and

(2) Would have been ineligible (for reasons other than income) for payments under the appropriate approved State plan as in effect for January 1972.

§ 416.2082 Non-Federal share of expenditures; defined.

The term "non-Federal" share of expenditures as aid or assistance for quarters in the calendar year 1972 under the plans of a State approved under titles I, X, XIV, or XVI of the Act means the difference between:

(a) The total matchable expenditures as aid or assistance for such plans (excluding expenditures authorized under section 1119 of the Act as in effect prior to October 30, 1972, for repairing the home of an individual who was receiving aid or assistance under one of the appropriate approved State plans); and

(b) The total of the amounts determined under sections 3, 1003, 1118, 1403, and 1803 of the Act and under section 9 of the Act of April 19, 1950, for such State with respect to such expenditures in such quarters.

§ 416.2085 Adjusted payment level.

(a) *Adjusted payment level; defined.* "Adjusted payment level" means the amount of the money payment under the appropriate State plan(s) approved under titles I, X, XIV, or XVI of the Social Security Act to individuals (or couples) within a category who had no other income (excluding eligible recipients who received no payments) for the month of January 1972; plus (at State option) an amount no greater than the sum of a payment level modification (as described in paragraph (d) of this section) and (at State option) beginning July 1, 1975, the bonus value of food stamps in the State for January 1972 (as described in paragraph (e) of this section). Also, prior to July 1, 1975, those States which the Secretary has determined provide supplementary payments the level of which has been found by the Secretary pursuant to section 8 of Pub. L. 93-233 (87 Stat. 956) to have been specifically increased so as to include the bonus value of food stamps may include such bonus value in the computation of the adjusted payment level. (See 7 CFR § 271.10 published at 39 FR 3812, January 30, 1974.)

(1) *Amount of money payment.* The amount of the money payment will be determined by computing the average of the cash payments made for basic needs and special needs, (but excluding cases involving only personal needs payments to recipients residing in medical facilities, and payments that included an amount for the needs of an "essential person") to individuals who were not living in the household of another, whose support and maintenance was not contributed to by another, and who had no other income. In addition, States may include domiciliary care payments to individuals with no other income (within each category).

(2) *No other income.* Cases in which income which was totally disregarded by a State in determining the amount of the money payment will be considered cases in which there was "no other income." For these purposes, in-kind or imputed income will be treated the same as cash income.

(b) *Adjusted payment levels for couples; computation method.* If the State's records do not contain sufficient information to compute the actual amount of the money payment for couples for January 1972, then the adjusted payment level for couples may be computed by multiplying the sum of the average money payment to individuals in the appropriate category (as defined in § 416.2020(d)) and the payment level modification for that category by the ratio of the payment standard for a couple to the payment standard for an individual in that category, and then

in accordance with paragraph (a) of this section, adding the bonus value of food stamps to the result. With respect to adjusted payment levels used for the period January 1, 1974, through June 30, 1974, the ratio of the payment standards, if less than 1.5 shall be raised to 1.5; ratios in excess of 2.0 shall be lowered to 2.0.

(c) *Payment standard.* "Payment standard" (PS) means the amount specified as the "payment standard" in the approved State plan as in effect for January 1972 under titles I, X, XIV, or XVI of the Act.

(d) *Payment level modification.* "Payment level modification (PLM) with respect to any State plan means the amount by which a State which paid less than 100 percent of its standard of need could have increased its January 1972 money payments for basic needs to persons with no other income by reducing the need standard and raising the maximum amount payable so that the increased payments equal 100 percent of the new standard without increasing the non-Federal share of expenditures under titles I, X, XIV, and XVI of the Act for calendar year 1972.

(1) *Maximum amount payable.* The "maximum amount payable" (M) means the amount specified as the largest amount payable for basic needs in the approved State plan as in effect for January 1972 under title I, X, XIV, or XVI of the Act.

(2) *Computing the payment level modification.* The payment level modification shall be determined by computing a Reduced Payment Standard (RS) and subtracting the maximum amount payable (PLM-RS-M).

(i) The Reduced Payment Standard shall be computed (within a category) by use of the following formula:

$$RS = \frac{TP + TCI}{TR}$$

(TP=Total Payments for January 1972 for basic needs,
TCI=Total Countable Incomes of recipients for January 1972, and
TR=Total Number of Recipients for January 1972.)

(ii) For a State entitled to a payment level modification and for which State total countable incomes of recipients for January 1972 cannot be determined, TCI may be estimated using the following formula:

$$TCI = TN - TP \quad (PS) \quad M$$

TN=PS×TR=Total Needs for January 1972.)

(e) *Bonus value of food stamps.* (1) The term "bonus value of food stamps in a State for January 1972" means (with respect to any individual) the difference between:

(i) The face value of the coupon allotment which would have been provided to such individual under the Food Stamp Act of 1964 (7 U.S.C. 2011 ff.) for January 1972, and

(ii) The charge which such individual would have paid for such coupon allotment.

(2) *Income schedules.* The total face value of such coupon allotment and the cost thereof for January 1972 shall be determined in accordance with the schedules prescribed by the Secretary of Agriculture. Such schedules for 48 States and the District of Columbia are those published in the FEDERAL REGISTER on January 26, 1972 (37 FR 1180). Such schedules for Alaska and Hawaii are those published in the FEDERAL REGISTER on March 3, 1972 (37 FR 4456-58). The schedule as applicable to a household of one shall be used with respect to an individual, and the schedule as applicable to a household of two shall be used with respect to a couple.

(3) *Determining bonus value.* In determining the charge such individual (or couple) would have paid for such coupon allotment, the individual's (or couple's) monthly net income will be considered to equal the State's January 1972 adjusted payment level as set forth in paragraph (a) of this section including the results of any payment level modification as described in paragraph (d) of this section but excluding the bonus value of food stamps. If such amount exceeds the maximum allowable monthly income for food stamp eligibility (as published for non-public assistance households), the bonus value is the difference between the monthly coupon allotment and the monthly purchase requirement listed in the schedule for households with the maximum allowable monthly income. (This situation may occur since public assistance households are eligible for food stamps regardless of income.)

§ 416.2090 State funds advanced for supplementary payments.

(a) *Advance payment and adjustment.* Any State which has entered into an agreement with the Secretary which provides for Federal administration of such State's supplementary payments shall pay to the Secretary either: (1) An amount equal to the Secretary's estimate of State supplementary payments for any month which shall be made by the Secretary on behalf of such State; or (2) where the provisions of § 416.2080 are applicable, an amount equal to one-twelfth of the State's non-Federal share of expenditures (as described in § 416.2082) plus the unprotected payments which are payable for the month for which funds are provided. In order for the Secretary to make State supplementary payments as provided by the agreement, the necessary amount of State funds must be on deposit with the Secretary on or before the date payments are to be received by the recipients, unless otherwise agreed to by the Secretary. The amount of State funds paid to the Secretary for State supplementary payments will be adjusted as necessary to maintain the balance with State supplementary payments paid out by the Secretary on behalf of the State.

(b) *Accounting of State funds.* (1) As soon as feasible, after the end of each calendar month, the Secretary will provide the State with a statement showing, cumulatively, the total amounts paid by

the Secretary on behalf of the State during the current fiscal year; the State's total liability, therefore; and the end-of-month balance of the State's cash on deposit with the Secretary.

(2) The Secretary shall provide an accounting of State funds received and paid as State supplementary payments within 3 calendar months following the termination of an agreement under § 416.2005.

(3) Adjustment will be made because of State funds due and payable or amounts of State funds recovered for calendar months for which the agreement was in effect. No interest shall be charged or payable by the Secretary or the State with respect to the adjustment and accounting of State supplementary funds.

(c) *State audit.* Any State entering into an agreement with the Secretary which provides for Federal administration of the State's supplementary payments has the right to an audit (at State expense) of the payments made by the Secretary on behalf of such State. The Secretary and the State shall mutually agree upon a satisfactory audit arrangement to verify that supplementary payments paid by the Secretary on behalf of the State were made in accordance with the terms of the administration agreement under § 416.2005. Resolution of audit findings shall be made in accordance with the provisions of the State's agreement with the Secretary.

Subpart U—Medicaid Eligibility Determinations

§ 416.2101 Authority to perform State Medicaid functions.

(a) *Section 1634 of the Act.* Pursuant to section 1634 of the Act, the Secretary may, should a State so desire, enter into an agreement with that State to determine the eligibility for medical assistance on behalf of such State in the case of aged, blind, and disabled individuals under such State's medical assistance plan approved for Federal financial participation under title XIX of the Act.

(b) *Data exchange.* Pursuant to authority under the Intergovernmental Cooperation Act (42 U.S.C. 4222), the Secretary will enter into an agreement with a State, if the State so desires, to provide information obtained through the administration of the title XVI program and other additional assistance or support related to the administration of the State's medical assistance programs where administratively feasible and subject to such limitations as may be necessary for the efficient and effective administration of the title XVI program.

§ 416.2104 Renewal, termination, or modification of agreement.

(a) *Terms of agreement.* An agreement between the Secretary and a State described in § 416.2101 remains in effect for the term specified in the agreement and shall be automatically renewed for a period of 1 year except that the Secretary or the State may terminate the agreement by written notice at least 120 days in advance of the proposed termination date.

(b) *Modification or termination of agreement.* The Secretary or the State may modify or terminate the agreement at any time by mutual consent.

§ 416.2107 Effect of agreement on existing Federal-State responsibilities.

The terms and conditions for approval of a State's medical assistance plan under title XIX of the Act and the State's responsibility under such plan remain unchanged except to the extent otherwise specifically provided for in the agreement. Thus, a State will continue to be responsible for any aspects of medical assistance eligibility determinations and other functions not specifically undertaken to be performed by the Secretary pursuant to the agreement. Functions permitted or required by title XIX of the Act that shall remain as State responsibilities include, but are not limited to:

(a) Issuance of emergency authorizations for medical service pending processing of applications;

(b) Outstationing of medical assistance eligibility workers at providers of medical services to receive Medicaid applications;

(c) Establishment, administration, and operation of the cost-sharing systems (including spend-down computations) for medical assistance recipients;

(d) Issuance, control, and termination of medical assistance identification cards and other notices to individuals within the purview of the agreement;

(e) Determination of retroactive eligibility for medical assistance.

§ 416.2111 Conditions for agreement to determine eligibility for medical assistance.

As a condition for having the Secretary agree to determine or redetermine eligibility for medical assistance under a State's approved plan, the plan must specify that:

(a) Such eligibility is to be determined using the criteria established under title XVI of the Act to determine eligibility for benefits as a disabled, blind, or aged individual; and

(b) Such Medicaid eligibility is provided to all individuals of a particular category (i.e., aged, blind, or disabled) eligible for benefits under title XVI of the Act.

§ 416.2112 Limitations as to individuals covered by agreement to determine eligibility for medical assistance.

Determinations of Medicaid eligibility pursuant to an agreement are limited to individuals who have been determined to be eligible individuals under title XVI of the Act or who are receiving a State supplementary payment which is federally administered, or both (see § 416.2003 and § 416.2052 in connection with federally administered State supplementary payments).

§ 416.2116 Terms of agreement; functions performed by the Secretary.

Under the agreement the Secretary may perform the following:

(a) *Determinations and redeterminations.* (1) Make determinations of eligibility for medical assistance pursuant to

the agreement on behalf of a State so requesting;

(2) Make redeterminations of eligibility for medical assistance as frequently and to the same extent that redeterminations of eligibility for benefits are made under the title XVI program or as frequently and to the same extent as may be mutually agreed upon.

(b) *Notification to States.* Notify the State in a manner mutually agreed upon concerning:

(1) Individuals determined or redetermined to be eligible to receive a benefit under title XVI or a federally administered State supplementary payment, or both;

(2) Changes in status of individuals covered under the agreement;

(3) Individuals determined or redetermined to be ineligible to receive a benefit under title XVI or a federally administered State supplementary payment, or both.

(c) *Quality reviews and program integrity reviews.* Apply the same procedures established for the performance of quality assurance reviews and program integrity reviews for the title XVI program to determinations made under the agreement and to notify the State of findings that affect the status of individuals covered under the agreement.

(d) *Other items of mutual concern.* Other matters of mutual concern relevant to the purpose of the agreement or related functions may, in the Secretary's discretion, be incorporated into its terms.

§ 416.2118 State requests for studies, evaluations, and other information or assistance.

(a) *Studies and evaluations.* The Secretary may, in a separate agreement, agree to conduct such studies and evaluations as the State may request, provided that:

(1) The costs of such studies and evaluations shall be borne by the State, and

(2) The Secretary determines that any such study or evaluation requested by the State is consistent with effective and efficient administration of the title XVI program and does not interfere with the administration of that program.

(b) *Information sharing.* The Secretary may provide the State with information obtained upon an application for title XVI benefits which may be relevant to medical assistance eligibility determinations in a manner mutually agreed upon.

(c) *Coordination with title XVI program.* The Secretary may provide such other assistance with respect to coordination between the State medical assistance programs and the title XVI program, such as the gathering of additional information required by a State to make eligibility determinations for medical assistance, the referral of applicants under the title XVI program to the appropriate State agency, and the placement of State medical assistance workers in offices of the Social Security Administration, as may be administra-

tively feasible and subject to such limitations as may be necessary for the efficient and effective administration of the title XVI program.

§ 416.2119 Functions performed by the State.

(a) *Agreements for Federal determination of eligibility for medical assistance.* The State shall make a timely payment to the Secretary as specified in the agreement of an amount equal to one-half of the administrative costs incurred in carrying out the agreement. In determining such administrative costs only the costs that are necessitated by the agreement and that are additional to the Secretary's costs incurred in administering the title XVI program shall be included.

(b) *Agreements for data exchange.* The State shall make a timely payment to the Secretary, as specified in the agreement of the identifiable costs incurred in carrying out the agreement. Only those costs, necessitated by the agreement that are additional to the Secretary's costs incurred in administering the title XVI program shall be included.

[FR Doc. 75-4793 Filed 2-20-75; 8:45 am]

Title 23—Highways

CHAPTER I—FEDERAL HIGHWAY ADMINISTRATION, DEPARTMENT OF TRANSPORTATION

SUBCHAPTER A—GENERAL MANAGEMENT AND ADMINISTRATION

PART 1—GENERAL

SUBCHAPTER G—ENGINEERING AND TRAFFIC OPERATIONS

PART 646—RAILROADS

Railroad-Highway Insurance Protection; Revocation and Corrections

The matters affected relate to grants benefits, or contracts within the purview of 5 U.S.C. 553(a) (2), therefore general notice of proposed changes is not required. The changes will become effective on the date of issuance.

A revocation and corrections are hereby published as set forth below.

§ 1.14 [Removed]

§ 1.14 (Project Agreements) is hereby revoked. The provisions of this section have been codified in Part 630, Subpart C of this title.

Appendix A [Amended]

1. The last line in Item 1 of paragraph 10 in Appendix A should be corrected by placing a close parenthesis symbol after the word "State."

2. The reference to the "Atomic Energy Act of 1964" in the third full subparagraph of paragraph 4 under "Exclusions" in Appendix A should be changed to "Atomic Energy Act of 1954."

3. In paragraph 11 under "Conditions" in Appendix A, after the words in the seventh line "competent appraiser, and"

insert the words "the appraisers shall select a".

Issued on February 12, 1975.

NORBERT T. TIEMANN,
Federal Highway Administrator.

[FR Doc. 75-4723 Filed 2-20-75; 8:45 am]

Title 24—Housing and Urban Development

CHAPTER X—FEDERAL INSURANCE ADMINISTRATION

SUBCHAPTER B—NATIONAL FLOOD INSURANCE PROGRAM

PART 1915—IDENTIFICATION OF SPECIAL HAZARD AREAS

[Docket No. FI-321]

List of Communities; Correction

On August 6, 1974, in 39 FR 28252, the Federal Insurance Administrator published a list of communities with Special Flood Hazard Areas and the map number and locations where Flood Insurance Rate Maps were available for public inspection. This list included the City of Tallahassee, Florida, as an eligible community and included map No. H 120144 10 which indicates that Lots No. 12-25 of Block F, Lots No. 1, 2, 16-26 of Block G, and Lots No. 1-12 and 14-26 of Block J, Apalachee Ridge Subdivision Unit No. 4, Tallahassee, Florida, as recorded in Plat Book 4, Page 18, in the Office of the Clerk of the Circuit Court, Leon County, Florida, are in their entirety within the Special Flood Hazard Area. It has been determined by the Federal Insurance Administration, after further technical review of the above map in the light of additional, recently acquired flood information, that the above property is not within the Special Flood Hazard Area. Accordingly, effective June 28, 1974, Map No. H 120144 10 is hereby corrected to reflect that the above property is not within the Special Flood Hazard Area.

(National Flood Insurance Act of 1968 (Title XIII of Housing and Urban Development Act of 1968), effective January 28, 1969 (33 FR 17804, November 28, 1968), as amended (secs. 408-410, Pub. L. 91-152, December 24, 1969), (42 U.S.C. 4001-4127); and Secretary's delegation of authority to Federal Insurance Administrator 34 FR 2680, February 27, 1969, as amended by 39 FR 2787, January 24, 1974).

Issued: February 6, 1975.

J. ROBERT HUNTER,
Acting Federal Insurance
Administrator.

[FR Doc. 75-4763 Filed 2-20-75; 8:45 am]

PART 1915—IDENTIFICATION OF SPECIAL HAZARD AREAS

List of Communities; Correction

On January 8, 1972, in 37 FR 281, the Federal Insurance Administrator published a list of communities with Special Flood Hazard Areas and the map number and locations where Flood Insurance Rate Maps were available for public inspection. This included Fairfax County, Virginia as an eligible community and