PART 81—DESIGNATIONS OF AREAS FOR AIR QUALITY PLANNING PURPOSES

Part 81 of Chapter I, Title 40 of the Code of Federal Regulations is amended as follows:

Subpart C—Section 107 Attainment Status Designations

§ 81.330 [Amended]

1. In § 81.330, the table entitled "New Hampshire—TSP" is amended by deleting the "X" in the column entitled "Does Not Meet Secondary Standards" and by adding an "X" in the column entitled "Better than National Standards" on the line entitled "Keene".

2. In § 81.330, the table entitled "New Hampshire—O_x" is amended to read "New Hampshire—O_3".

3. In § 81.330, the table entitled "New Hampshire—O_3" is amended by striking the "X" in the column entitled "Does Not Meet Primary Standards" and by adding an "X" in the column entitled "Cannot be Classified or Better than National Standards" on the line entitled "Central N.H. Intrastate AQCR 149."

4. In § 81.330 the table entitled "New Hampshire—CO" is amended by adding a line beneath "Metropolitan Manchester" entitled "Nashua".

5. In § 81.330 the table entitled "New Hampshire—CO" is amended by adding an "X" in the column entitled "Does Not Meet Primary Standards" on the line entitled "Nashua".

[FR Doc. 80-11008 Filed 4-10-80; 8:45 am]

BILLING CODE 6560-01-M

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40 CFR Part 180

[FRL 1460-8; PP 9F2158/R-242]

Sodium Salt of Acifluorfen; Tolerances and Exemptions From Tolerances for Pesticide Chemicals in or on Raw Agricultural Commodities

AGENCY: Environmental Protection Agency (EPA).

ACTION: Final rule.

SUMMARY: This rule establishes a tolerance for residues of the herbicide sodium salt of acifluorfen and its metabolites (the corresponding acid, methyl ester, and amino analogues) in or on soybeans at 0.1 ppm; liver and kidney of cattle, goats, hogs, horses, and sheep at 0.02 ppm; meat, fat, and meat byproducts of poultry at 0.02 ppm; and milk and eggs at 0.02 ppm.

The regulation was requested by Rohm and Haas Co. This rule establishes a maximum permissible level for residues of sodium salt or acifluorfen.

EFFECTIVE DATE: Effective on April 11, 1980.

FOR FURTHER INFORMATION CONTACT: Willa Garner, Ph. D., Product Manager (23), Registration Division (TS-767), Office of Pesticide Programs, Environmental Protection Agency, 401 M Street, SW, Washington, DC 20460 (202-755-1397).

SUPPLEMENTARY INFORMATION: On March 24, 1980, the EPA published a notice of proposed rulemaking in the **Federal Register** (45 FR 18990) in response to a pesticide petition (PP9F2158) submitted to the Agency by Rohm & Haas Co., Independence Mall West, Philadelphia, PA 19105 under provisions of the Federal Food, Drug, and Cosmetic Act. The petition proposed that 40 CFR 180 be amended by establishing a tolerance for combined residues of the herbicide sodium salt of acifluorfen (sodium 5-[2-chloro-4-(trifluoromethyl)phenoxy]-2-nitrobenzoic acid) and its metabolites (the corresponding acid, methyl ester, and amino analogues) in or on the raw agricultural commodities soybeans at 0.1 part per million (ppm); liver and kidney of cattle, goats, hogs, horses, and sheep at 0.01 ppm; fat, meat, and meat byproducts of poultry at 0.01 ppm; milk and eggs at 0.01 ppm. No requests for referral to an advisory committee were received in response to this notice of proposed rulemaking. One comment was received from the Rachel Carson Council, Inc. to which the Agency will be responding directly.

It has been concluded, therefore, that the proposed amendment to 40 CFR 180 should be adopted without change, and it has been determined that this regulation will protect the public health.

Any person adversely affected by this regulation may, on or before May 12, 1980, file written objections with the Hearing Clerk, EPA, Rm. M-3708 (A-110), 401 M Street, SW, Washington, DC 20460. Such objections should be submitted in triplicate and specify the provisions of the regulation deemed to be objectionable and the grounds for the objections. If a hearing is requested, the objections must state the issues for the hearing. A hearing will be granted if the objections are supported by grounds legally sufficient to justify the relief sought.

Under Executive Order 12044, EPA is required to judge whether a regulation is "significant" and therefore subject to the procedural requirements of the Order or whether it may follow other specialized development procedures. EPA labels these other regulations "specialized." This regulation has been reviewed, and it has been determined that it is a specialized regulation not subject to the procedural requirement of Executive Order 12044.

Effective on April 11, 1980 Part 180, Subpart C, is amended by adding a tolerance for residues of Sodium Salt of acifluorfen as set forth below.

Part 180, Subpart C, is amended by adding a new § 180.383 to read as follows:

§ 180.383 Sodium salt of acifluorfen; tolerances for residues.

Tolerances are established for combined residues of the herbicide sodium salt of acifluorfen (sodium 5-[2-chloro-4-trifluoromethyl)phenoxy]-2-nitrobenzoic acid) and its metabolites (the corresponding acid, methyl ester, and amino analogues) in or on the following raw agricultural commodities;

Commodity	Parts per million
Cattle, kidney	0.02
Cattle, liver	0.02
Eggs	0.02
Goats, kidney	0.02
Goats, liver	0.02
Hogs, kidney	0.02
Hogs, liver	0.02
Horses, kidney	0.02
Horses, liver	0.02
Milk	0.02

Commodity	Parts per million
Poultry, fat	0.02
Poultry, mbyp	0.02
Poultry, meat	0.02
Sheep, kidney	0.02
Sheep, liver	0.02
Soybeans	0.1

(Sec. 408(e), 68 Stat. 514, (21 U.S.C. 346a(e))

Dated April 7, 1980.

Edwin L. Johnson,

Deputy Assistant Administrator for Pesticide Programs.

[FR Doc. 80-11115 Filed 4-10-80; 8:45 am]

BILLING CODE 6560-01-M

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Health Care Financing Administration

42 CFR Subchapter C

Medicaid Program; Miscellaneous Corrections

AGENCY: Health Care Financing Administration (HCFA), HEW.

ACTION: Final rule.

SUMMARY: This document corrects technical and wording errors in the rewritten Medicaid reguations published on September 29, 1978, and March 23, 1979. Those regulations redesignated and clarified, without substantive change, the rules for the Medicaid program (Title XIX, Social Security Act) previously published in 42 CFR Parts 446 through 452, and 45 CFR Parts 205, 206, and 208. We have received both technical and substantive comments; the former are resolved by this document, and the latter will be covered in future proposed rule making.

DATES: Effective September 29, 1978, except §§ 430.0(b)(2) and 432.10(c)(1) which were effective February 9, 1979, and §§ 431.230, 431.250, 435.905, 435.911, and 435.919 which were effective March 23, 1979.

FOR FURTHER INFORMATION CONTACT: Ann Watts, 202-245-8097.

SUPPLEMENTARY INFORMATION: On September 29, 1978 (43 FR 45176), and March 23, 1979 (44 FR 17926), HCFA published rewritten regulations for the Medicaid program, as part of HEW's "Operation Common Sense" effort. Under this effort, HEW agencies are reviewing all existing regulations to eliminate those found unnecessary, revise policies where appropriate, and rewrite regulations in a clearer, simpler manner.

As the first phase of this project for Medicaid, existing regulations were reorganized and rewritten in plain language with no substantive change intended, and they were, therefore, published as final rules. However, we invited comments from anyone who believed that the revision changed existing policy.

We have received a number of comments, some citing errors and others suggesting substantive changes in existing policy. The rules published today contain corrections either of technical errors (citations, spelling, cross-references, etc.) or of inadvertent omissions, improper wording, changes in the organizational structure of the regulations, and the like, which may have appeared to make substantive changes. The suggestions for substantive revisions will be considered in the second phase of the project for Medicaid—issuance during the next several years of proposed rules making policy changes in a number of the more significant subject areas.

Some of the technical corrections are self-explanatory and are not specifically addressed in the preamble. The following is an explanation of the other changes made in this document:

Merit system. In §§ 430.0(b)(2) and 432.10(c)(1), changes reflect the revocation of the merit system standards for State agencies previously contained in 45 CFR Part 70 and now incorporated in 5 CFR Part 900, Subpart F. See Office of Personnel Management regulations published February 9, 1979, (44 FR 8265) and HCFA-AT-79-23 (MMB), *Standards for a Merit System of Personnel Administration.*

Payment for out-of-State services. In § 431.52(b)(3), the reference to use of the "attending physician's" medical advice, in determining whether medical care is more readily available out-of-State, is deleted as an inadvertent addition to policy.

Fair Hearings

1. *Maintaining services.* In § 431.230(a), the Medicaid agency is required to continue assistance if the individual requests a hearing before the date of the adverse action. The words "applicant or" are deleted from paragraph (a) since the requirements for continuation of assistance pending a hearing decision can apply only to recipients.

2. *Federal Financial Participation.* Section 431.250 concerns Federal financial participation (FFP) for expenditures in services for individuals who are successful in their appeal. Paragraph (b) of this section is amended to continue from 45 CFR 205.10(b)(3) the authorization for FFP in payments within the scope of the Medicaid program made in accordance with a court order. The provision contained in 45 CFR 205.10(b)(3) was especially important since it restricted FFP to Medicaid services under the scope of the Federal program. For example, even when there is a court order against a State to provide services beyond the limits of the program, FFP is not available when there are other regulatory provisions which impose limitations (such as separate time limits or limitations on types of services) upon the receipt of Federal funds.

Contracts. Section 431.503 (i), (j), and (k) requires that a contract "specify procedures and criteria for" extending, renegotiating, and terminating the contract. This wording is more stringent than the previous regulation which merely required a contract to "establish provisions and criteria for * * *" Therefore, the section is amended to restore the previous wording and simplify the structure of the section.

Relations with standard-setting and survey agencies. Section 431.610(g)(3) specifies that the survey agency of the State must have on-site inspections of skilled nursing and intermediate care facilities performed within certain time frames if there is a question of compliance with requirements. Paragraph (g)(3)(ii) is changed to clarify that an additional set of time frames applies only to intermediate care facilities certified under special correction plans as specified in §§ 442.112 and 442.113, but not to skilled nursing facilities.

Eligibility (States and District of Columbia) (Part 435)

1. *Definitions and use of terms.* Section 435.4 is revised to clarify that the term "categorically needy" applies to some groups that are not recipients of cash assistance.

2. *Termination from AFDC because of increased earnings or hours of employment.* Section 435.112(b) delineates the 4-month period during which Medicaid is available for individuals whose eligibility for Aid to Families with Dependent Children (AFDC) is terminated. The previous regulation specified the period as "4 calendar months". In order to avoid misinterpretation, the word "calendar" is restored to the regulation.

3. *Individuals in States using more restrictive requirements for Medicaid than the supplemental security income (SSI) requirements.* Sections 435.121 and 435.731 deal with the requirements for determining eligibility in States using more restrictive requirements for aged, blind, or disabled individuals than the standards used under SSI ("209(b)"

States). These sections are being corrected to conform to the language of the statute (sec. 1902(f)) which refers only to eligibility requirements more restrictive than SSI, not to optional State supplement programs.

In § 435.121(b)(2) the reference to § 435.230 is deleted, since there previously was no requirement in the regulations that an optional State supplement must meet the Federal requirements in § 435.230(b), in order to permit an agency not to count the supplement as part of an individual's income when financial eligibility is being computed.

4. *Increase in OASDI benefits.* Section 435.134(b) is amended to clarify that certain individuals, whose Old Age, Survivors, and Disability Insurance (OASDI) benefits make them ineligible for Medicaid, must continue Medicaid coverage if they would meet SSI or State supplement income limits except for OASDI benefits.

5. *Individuals who would be eligible for cash assistance except for their institutional status.* Section 435.211 is revised to restore wording clarifying that the option for Medicaid coverage of these individuals applies to those in title XIX reimbursable medical institutions.

The headings of §§ 435.231 and 435.722, "Institutionalized individuals who would not be eligible for cash assistance if they were not institutionalized" are changed to "Individuals in institutions who are eligible under a special income level" in order to describe the content more clearly.

6. *Unemployed parents.* Sections 435.223 and 435.1004(a) are revised to change references to "unemployed father" to "unemployed parent", reflecting the Supreme Court's decision in *Califano* v. *Westcott*, 443 U.S. 76 (1979), that sec. 407 of the Act (Dependent Children of Unemployed Fathers) is unconstitutional because of the discriminatory nature of its gender distinction. The Court ruled that benefits of the AFDC-Unemployed Fathers program must be extended to similarly situated unemployed mothers.

7. *Medically needy coverage of the aged, blind, and disabled in States that impose more restrictive eligibility requirements.* In § 435.321(b)(1), the reference to a State supplementary payment under § 435.230 is deleted. Previous regulations did not require that individuals meet requirements for the type of supplement described in § 435.230 in order to be considered categorically needy; they could meet requirements for any type of State supplement.

8. *Financial responsibility of spouses.* In § 435.723, the term "eligible spouse" is changed to read "ineligible spouse" to correct a typographical error which appeared to change policy.

9. *Income Standards—institutionalized and non-institutionalized.* Sections 435.725(a), 435.733(a), and 435.832(a) are corrected to clarify the deductions made from the agency's payment to an institution.

Also, §§ 435.731, 435.733, 435.812, 435.814, 435.831, and 435.832 have been revised, and §§ 435.813 and 435.815 have been removed, to clarify that the income levels that are used to determine eligibility for the institutionalized are the same levels that are used for non-institutionalized individuals of the same family size. The determination of the amount, if any, that an institutionalized individual must contribute towards the cost of the institutional care is determined as a second step (independent from the determination of eligibility). This change restores the use of a two-step method for making these determinations and reflects the policy recognized in *Friedman* v. *Berger*, 547 F.2d 724 (2d Cir. 1976).

10. *Procedures for determining income eligibility.* In § 435.732(c)(2), the provision for agencies to set limits on "types" of medical expenses to be deducted from income has been changed to "amounts" to correct an inadvertent policy change. In paragraph (d) of this section, the term "countable income" is changed to "remaining income" to express more accurately the concept that eligibility is based on the income remaining after specific deductions.

11. *Medically needy income standards; General requirement.* Section 435.811 is revised to restore wording clarifying that, for purposes of medically needy income levels, "families" includes both eligible and ineligible financially responsible relatives living in the home regardless of actual contribution.

12. *Medically needy income standards—use of AFDC standards.* In §§ 435.812(a)(1), 435.814(a)(1), 435.816, and 435.832, references to standards used under a State's AFDC plan are changed to "approved" AFDC plan to correct an inadvertent policy change.

13. *Medically needy income standard for one person.* In § 435.812, paragraph (a)(4) is deleted and a new paragraph (c) is inserted. These changes will clarify that a State using more restrictive standards for the aged, blind, and disabled than the standards used under SSI ("209(b)" States) may have separate medically needy income levels for those aged, blind, and disabled individuals.

14. *Income eligibility.* Section 435.831 deals with income eligibility of all medically needy individuals. The section is amended by (1) revising the introductory paragraph to clarify that the 6-month prospective period for computing income applies to all medically needy individuals *including* the institutionalized, (2) revising paragraph (c)(2) to specify what incurred medical expenses the agency may limit, and (3) revising paragraph (d) to clarify the individual's entitlement to Medicaid benefits when his incurred medical expenses reduce his income to the income standard. Previous wording relating to eligibility "for the rest of the period for which eligibility is determined" implied that the agency need not pay a "split" claim (one for which both the agency and the recipient are partially responsible because the amount of the claim is greater than the individual's remaining spend-down liability).

15. *Medically needy resource eligibility.* In § 435.845, paragraph (e) is amended to clarify that the paragraph, which deals with the value of resources deducted in determining eligibility, applies in States using any requirements more restrictive than SSI.

16. *Availability of program information.* Section 435.905(a) is amended to clarify that information must be furnished in written form and may be furnished orally only as appropriate.

17. *Timely determination of eligibility.* Section 435.911(c) lists examples of circumstances in which the agency is not required to meet time standards for determining eligibility. Paragraph (c)(3), relating to delays in receipt of eligibility information, is removed because it was not previously in regulations.

18. *Recipients of optional State supplements only.* In order to clarify in § 435.1006 that SSI budget methodology is to be used in determining income, before deductions, for State supplement recipients, the words "as determined by SSI budget methodology" are added to that section.

Eligibility (Guam, Puerto Rico, and the Virgin Islands) (Part 436). Similar changes to those made under Part 435 are being made to Part 436. See the corresponding sections under Part 435 as listed below for explanation of the specific changes.

§ 435.4	§ 436.3
435.112	436.116
435.211	436.211
435.223	436.212
435.811	436.811
435.812	436.812
435.813	436.813
435.816	436.812
435.831	436.831
435.832	436.832
435.1004	436.1003

Home health services. Section 440.70(b) is revised to clarify that the first 3 items listed (nursing services, home health aide services, and medical supplies, equipment and appliances) are mandatory parts of home health services, while the fourth item (physical therapy, occupational therapy and speech pathology and audiology services) is optional.

Dental services. In § 440.100, paragraph (a) defines dental services as certain procedures provided by or under the direction of a dentist and includes treatment of the teeth and other structures of the oral cavity. The wording of the previous regulation on dental services is being restored to clarify that there has been no substantive change in this definition. The words "direction" and "other" [structures] are being replaced by "supervision" and "associated", respectively.

Hearing and language disorders. Section 440.110 is revised to restore wording indicating that a patient must be referred by a physician for services provided by or under the direction of a speech pathologist or audiologist.

Services of Christian Science nurses. In paragraph (b)(2)(ii) of § 440.170, the word "own" is inserted in the phrase "in his home" to restore previous wording regarding the provision of private duty Christian Science nursing services.

Required services for categorically needy. Section 440.210, which lists minimum services for categorically needy, is corrected by adding a cross-reference to home health services, which was inadvertently omitted from the recodified regulations.

Limits on comparability of services. The age limit in § 440.250(e), concerning inpatient psychiatric services, is changed to include a cross reference to § 441.151(c), which explains the age requirement for these services. This does not constitute a policy change; it merely clarifies the existing regulation.

EPSDT services from title V grantees. Section 441.60, Identifying, informing and referring eligible recipients to title V programs (Maternal and Child Health and Crippled Children's Services), is revised to correct in paragraph (a) an inadvertent change made when the EPSDT regulations were revised in the **Federal Register** of May 18, 1979, (44 FR 29425). The wording of the September 29, 1978 (43 FR 45230) recodification, which required Medicaid agencies to identify all EPSDT eligibles, including those eligible for services from title V, is restored. The May 18 publication had limited the identification requirement to the latter group.

Intermediate care facilities for the mentally retarded. In § 442.441, paragraph (d) is revised to restore wording clarifying that the one-hour limit on use of "time-out" devices and aversive stimuli in behavior modification programs applies when the retarded person is removed from a situation. In § 442.499, paragraph (b) is revised to clarify that an individual who makes entries in the retarded person's record must sign his name and job title or professional capacity (referred to as "identification" in the previous regulation).

Acceptance of State payment as payment in full. Section 447.15 cites sec. 1902(a)(4) of the Social Security Act as the basis of the "payment in full" requirement because it authorizes the Secretary to prescribe requirements as necessary for proper and efficient administration of the State plan, and the acceptance by providers of Medicaid payment as "payment in full" is such a requirement. An additional cite to sec. 1902(a)(14), which prohibits cost sharing or similar charges for mandatory services provided to categorically needy individuals, is added to § 447.15 as further authority for this regulation.

Cost-sharing. Section 447.52 contains rules on the minimum and maximum enrollment fees, premiums and similar charges that may be imposed on the medically needy. With respect to minimum charges, the previous regulation [§ 449.40(a)(2)(i)] provided that, above the basic charge of $1.00 per month for families of a specified size and income, an appropriately higher charge must be imposed on each family with higher income. This requirement was omitted in the rewritten regulation and is now restored by adding a new § 447.52(c).

Drugs: Upper limits of payment: Paragraph (a) of § 447.331 is amended by adding the word "reasonable" before "dispensing fee". This restores language inadvertently omitted when the regulations were rewritten.

Individual practitioners: Upper limits of payment. In § 447.341, paragraph (c) is revised to restore wording to allow the median charge for a service to be determined not only from claims submitted but also from services furnished during a calendar year. This wording was inadvertently omitted.

Comments Not Accepted

Comment. The elimination of the words "adequate" and "meaningful" in describing the Medical Care Advisory Committee's participation in policy development and program administration (§ 431.12(e)) seriously diminished the Committee's role.

Response. The rewritten regulations require Medical Care Advisory committee "participation" in policy development and program administration. We do not view this as a sham requirement. It is intended that the participation be "adequate" and "meaningful", and, therefore, no substantive change was intended by the elimination of these words from § 431.12(e).

Comment. Under § 431.230(a), if the Medicaid agency mails a notice of adverse action 10 days (or 5 days) before the date of action, as required under §§ 431.211 or 431.214, and the recipient requests a hearing *before the date of action,* the agency may not terminate or reduce services until a decision is given after the hearing (with one exception). Under the old regulation (§ 205.10(a)(6)(i)), if the recipient requested a hearing *within the timely notice period,* the agency could not terminate or reduce services. Thus, if an agency sent a notice 15 or 20 days before the date of action, and the recipient did not request a hearing within the 10-day notice period although he did request it before the date of action, services could be ended or reduced.

Response. The recodified regulation does not represent a change in policy. Under both the old and new regulations, the notice must be mailed *at least* 10 (or 5) days before the date of action. A State may choose to give more notice if it wishes, but this does not affect the requirement that services be continued until after the hearing if the recipient requests one. The requirement in § 431.230(a) applies to whatever period the Medicaid agency uses for giving notice.

Comment. Under the old regulations, the requirements relating to transportation were in the section on amount, duration, and scope of services (an administrative requirement under § 449.10(a)(5)(ii), and an optional service under § 449.10(b)(17)(i)). Why is the administrative requirement for assurance of transportation (§ 431.53) now separated from the optional service?

Response. The requirement to assure transportation, which is both an administrative requirement and mandatory on all States, is distinct from the provision of transportation, and optional Medicaid service. Therefore, each has been placed in the appropriate part of the reorganized regulations.

Comment. Section 435.112(b) provides that, for certain families who continue under Medicaid coverage although they

have lost AFDC eligibility, the 4-month continued coverage begins on the date AFDC is terminated. The use of the word "terminated" is confusing and might be interpreted as a policy change.

Response. Section 4–20–10 D.2. *Increased Earnings or Hours of Employment,* (pp. 4–6) of the Medical Assistance Manual explains this policy in greater detail. No change in policy results from the recodification.

Comment. Section 435.135(c) is obsolete and should be deleted. This paragraph covers procedures in a 209(b) State for providing Medicaid to individuals who receive OASDI cost-of-living increases. (A "209(b)" State is one using eligibility standards more restrictive than SSI standards.)

Response. This section is applicable to 209(b) States and must be retained. Since 209(b) States do not tie eligibility for Medicaid to receipt of supplemental security income benefits (SSI), this section is necessary in order for those States to understand how they may treat the provisions of section 503 of Pub. L. 94–566 with regard to maintaining Medicaid eligibility. Section 503 concerns the preservation of Medicaid eligibility for individuals who cease to be eligible for SSI on account of cost-of-living increases in Social Security benefits.

Comment. The regulations language previously found at § 448.3(b)(1) has been recodified in Part 435, Subparts H and I, except for a clause which stated "(For both the categorically needy and * * * the medically needy, a State plan must) provide that only such income and resources as are considered available under the provisions of this section may be considered as an applicant's or recipient's * * *" This omission may be interpreted as license to be more restrictive in consideration of income and resources.

Response. The language is not necessary under the new format of the recodified regulations. Subparts H and I set out the requirements for financial eligibility for the categorically and the medically needy respectively. Specific requirements for the consideration of income and resources are then dealt with in these subparts. There has been no change in policy.

Comment. Section 435.520(b)(2) changes policy on determining birthdates for aged, blind, and disabled individuals.

Response. Since SSI uses the "common law" method for determining birthdates, the recodified regulations simply say plainly what was required, but not clearly specified, by the previous regulations.

Comment. In § 435.700, "Scope" of Subpart H on Financial Requirements for the Categorically Needy, the third sentence is not necessary and should be deleted. The sentence states that the financial requirements of AFDC, SSI, or the State supplement apply to individuals receiving those payments.

Response. This statement is not necessary to express accurately what the subpart contains. However, it answers the obvious question which is raised by the first two sentences in the section, i.e., what standards apply to cash assistance recipients.

Comment. In § 435.821, which deals with circumstances under which a Medicaid agency must consider contributions from an individual's relatives as his own income, language was added to paragraph (c) stating that the State's AFDC procedures must be used to determine whether the individual is living with his relatives or considered as living apart. This language did not appear in the old regulation and is an addition to policy.

Response. The new language in § 435.821(c) explains existing policy, in effect prior to the recodification and required by statute (sec. 1902(a)(10)(C)).

Comment. The differences and relationships between determining countable income (§ 435.831) and total available income (§ 435.832) are confusing. Rather than attempting to tie these sections together at § 435.831(b), § 435.832 should be expanded to stand independently.

Response. Section 435.831(a), as corrected, deals with determining countable income for all medically needy including institutionalized persons. For the institutionalized, § 435.832 as corrected, explains post-eligibility treatment of income and resources of institutionalized individuals, including contribution toward cost of care. We have attempted to avoid confusion by clearly labeling these sections and keeping them structurally simple.

Comment. Section 440.90, definition of "clinic services", refers to services provided to an outpatient *by* a facility while the old regulation (§ 449.10(b)(9)) referred to services furnished to an outpatient *in* a facility. Does this mean that services may be furnished outside the facility?

Response. This change is a technical clarification to reflect the fact that a number of clinics include, in the array of services for which they are reimbursed under their Medicaid provider agreements, services that may occasionally be provided at a site outside the clinic itself. For example, the clinic may have a contract for nutritional counseling services to be provided at a community center in a different geographical location. Services provides by clinics in this way are appropriately reimbursed as clinic services. The change in no way authorizes reimbursement for any other services that would not routinely be provided as clinic services (for example, services in a patient's home that should be furnished by a home health agency).

Comment. We should clarify that there is no age or other limitation on inpatient psychiatric services (§ 440.160) furnished in a general hospital.

Response. This section is a definition of a specific optional service—inpatient psychiatric services for individuals under age 21. We do not believe it appropriate to include within this definition a concept that does not define this particular service.

Comment. The phrase in § 440.170(a)(1) on transportation-related travel expenses "* * * determined to be necessary by the agency * * * [to provide medical treatment]" implies that the agency's expenses are covered. Better wording would be "* * * determined by the agency to be necessary * * *"

Response. We believe that the section makes it clear that the expenses referred to are those related to securing the treatment. The types of expenses intended are spelled out in § 440.170(a)(3).

Comment. Clarify why § 440.250 (b), (c), and (e), Limits on comparability of services, use the mandatory word "must" instead of the permissive "may".

Response. We use "must" to eliminate the previous ambiguity of these regulations and to conform to the statute which mandates these limitations.

Comment. In § 441.15, the wording was changed to "the agency provides home health services * * *" from "home health services must be provided * * *" in the previous regulation. This change could be construed to eliminate providers such as rural health clinics and visiting nurses from those qualified to furnish home health services.

Response. The word "agency" is used in this regulation merely to indicate the Medicaid agency's ultimate responsibility for assuring that required services are provided. Section 440.70 specifies who may provide them.

Comment. Include a provision in § 442.404, "Resident's bill of rights", which concerns the rights of recipients in intermediate care facilities, for another person to exercise these rights on behalf of a recipient who is not capable of requesting such help.

Response. This provision is covered by § 442.405, "Delegation of rights and

responsibilities", which provides for a guardian, next of kin, or sponsoring agency to exercise these rights.

Comment. The rewrite has eliminated from § 442.404(f), "Freedom from abuse and restraints", the requirement that a Qualified Mental Retardation Professional (QMRP) authorize the use of chemical or physical restraints, in the case of a mentally retarded person.

Response. This authorization requirement is contained in § 442.404(f)(2)(iii)(A).

Corrected Redesignation Table

Part 449

Old section	New section
448.2(b)	435.401(c)(1).
448.3(c)(1)(iv)	435.840.
448.3(c)(3)(ii)	435.831(a) (2), (3), 435.845(d), (e).
449.33(a)(5)	431.610(g).
449.33(b)(2)	431.610(h).

Part 450

450.25	431.800.
450.30(a)(2) (words "provide for . . .").	447.251.
450.30(a)(3) (introductory paragraph, words after "cost-related basis").	447.301.
450.30(a)(3) (words "provide for")	447.251.
450.30(a)(4) (words "provide for")	447.251.
450.30(a)(10)	447.371.
450.30(b)(4)(i)	447.351.
450.30(b)(4)(ii), and (iii)	447.352.
450.30(b)(5)	447.321, 447.325.
450.100	431.610 except (g) & (h).
450.310	455.300.

Corrected Derivation Table

Part 431

New section	Old section
431.610 except (g) & (h)	450.100.
431.610(g)	449.33(a)(5).
431.610(h)	449.33(b)(2).
431.800	450.25.

Part 435

435.110	448.1(b)(1)(i).
435.401	448.2(a) & (b).
435.831	448.1(a)(2)(ii), (b)(3)(v), (5)(iv), (c)(2), (3), (4).

Part 447

447.251 (covers the previous State Plan requirement in 450.30(a)(2), hospitals, (a)(3), long term care services, and (a)(4), upper limits for all services.	450.30(a)(2). 450.30(a)(3). 460.30(a)(4).
447.301	450.30(a)(3). Introductory paragraph, words after "cost-related basis," and 450.30(a)(3)(iv).
447.325	450.30(b)(5).
447.351	450.30(b)(5)(i).
447.352	450.30(b)(4)(ii) and (iii).
447.361	450.30(b)(7).
447.371	450.30(a)(10).

42 CFR Chapter IV, Subchapter C, is amended as set forth below:

A. In the authority citations throughout the subchapter, the references to ", 49 Stat. 647" are deleted wherever they occur.

B. The words "Medicaid" and "Medicare" are capitalized wherever they occur.

C. In Part 430, § 430.0 is amended by—

1. Changing the numbering of paragraph (b)(2) to (b)(2)(ii) and adding a new (b)(2)(i); and

2. Deleting "Part 70 Standards for a Merit System of Personnel Administration" from the list of applicable regulations in paragraph (b)(2)(ii).

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* * * * *

(b) *Federal regulations.* * * *

(2) Other regulations applicable to State medicaid programs include:

(i) 5 CFR Part 900, Subpart F, Administration of the Standards for a Merit System of Personnel Administration; and

(ii) the following HEW Regulations in 45 CFR Subtitle A:

Part 16—Department Grant Appeals Process.
Part 19—Limitations on Payment or Reimbursement for Drugs.
Part 74—Administration of Grants.
Part 80—Nondiscrimination Under Programs Receiving Federal Assistance Through the Department of Health, Education, and Welfare: Effectuation of Title VI of the Civil Rights Act of 1964.
Part 81—Practice and Procedure for Hearings Under 45 CFR Part 80.
Part 84—Nondiscrimination on the Basis of Handicap in Programs and Activities Receiving or Benefiting From Federal Financial Assistance.

* * * * *

D. Part 431 is amended as follows:

1. Section 431.52 is amended by deleting the reference to "the attending physician's" in paragraph (b)(3).

§ 431.52 Payments for services furnished out of State.

* * * * *

(b) *Payment for services.* * * *

(3) The State determines, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more readily available in the other State; or

* * * * *

2. Section 431.230(a) is revised by deleting the words "applicant or":

§ 431.230 Maintaining services.

(a) If the agency mails the 10-day or 5-day notice as required under § 431.211 or § 431.214 of this subpart, and the recipient requests a hearing before the date of action, the agency may not terminate or reduce services until a decision is rendered after the hearing unless—

(1) It is determined at the hearing that the sole issue is one of Federal or State law or policy; and

(2) The agency promptly informs the recipient in writing that services are to be terminated or reduced pending the hearing decision.

* * * * *

3. Section 431.250 is amended by revising paragraph (b) as follows:

§ 431.250 Federal financial participation.

FFP is available in expenditures for—

* * * * *

(b) Payments made—

(1) To carry out hearing decisions; and

(2) For services provided within the scope of the Federal Medicaid program and made under a court order.

* * * * *

4. Section 431.503 is amended by revising paragraph (i) and vacating and reserving paragraphs (j) and (k) as follows:

§ 431.503 All contracts.

A State plan must provide that contracts under this subpart—

* * * * *

(i) Establish provisions and criteria for—

(1) Extending the contract;

(2) Renegotiating the contract;

(3) Terminating the contract, including a requirement that the contractor promptly supply all information necessary for the reimbursement of any outstanding medical claims;

(j) [Reserved]

(k) [Reserved]

* * * * *

5. Section 431.521 is amended by correcting the citation in paragraph (a)(2) as follows:

§ 431.521 HMO's with provisional status.

(a) The agency may determine that an entity is an HMO with provisional status if—

* * * * *

(2) The Assistant Secretary for Health has not determined whether the entity meets the definition of section 1903(m)(1)(A) of the Social Security Act.

* * * * *

6. The centered heading above § 431.565 is revised to read as follows:

Prepaid Health Plans: Contract Requirements—Non-Risk Basis

7. Section 431.610 is amended by revising paragraph (g)(3)(ii) as follows:

§ 431.610 Relations with standard-setting and survey agencies.

* * * * *

(g) *Responsibilities of survey agency.* The plan must provide that, in certifying skilled nursing and intermediate care facilities, the survey agency designated under paragraph (e) of this section will—

* * * * *

(3) Have qualified personnel perform on-site inspections—

* * * * *

(ii) For intermediate care facilities with deficiencies as described in §§ 442.112 and 442.113 of this subchapter, within 6 months after initial correction plan approval and every 6 months thereafter as required under those sections.

* * * * *

E. Part 432 is amended by deleting and reserving § 432.10(c)(1), as follows:

§ 432.10 Standards of personnel administration.

* * * * *

(c) *Methods of personnel administration.* Methods of personnel administration must be established and maintained, in the medicaid agency and in local agencies administering the propgram, in conformity with:

(1) [Reserved]

* * * * *

F. Part 433 is amended by correcting § 433.34, (c), (d), (e), and (f) as follows:

§ 433.34 Cost allocation.

* * * * *

(c) *Filing cost allocation plan.* The Medicaid agency must have a cost allocation plan approved by the Division of Cost Allocation (DCA), Regional Administrative Support Center, and on file with the HCFA Regional Office.

(d) *Content of plan.* The cost allocation plan must include—

(1) Methods and procedures for properly charging the costs of administration, medical assistance, and training incurred under the plan, in accordance with 45 CFR Part 74, Appendix C and any other requirements specified by HEW;

(2) Descriptions of functions and activities, by organizational units;

(3) Estimated costs for one year, by cost centers or pools, including costs of all organizational units of the State department in which the Medicaid agency is located (unless specifically waived by the DCA);

* * * * *

(e) *Revision and approval.* (1) The agency must revise the plan whenever the allocation method is outdated because of organizational changes within the agency, changes in Federal law or regulations, or other similar changes.

(2) Approval of the cost allocation plan does not constitute approval of the plan's estimated cost for purposes of calculating claims for FFP.

(f) *Federal financial participation.* (1) FFP is not available in expenditures for administration, medical assistance, and training for any quarterly period unless the State's claims for those expenditures are in accord with a cost allocation plan approved by the DCA for that period and on file with HCFA.

* * * * *

(4) Any costs disallowed under paragraphs (f) (2) and (3) of this section may be reclaimed after the DCA approves a cost allocation plan for the quarter for which the expenditures were claimed, to the extent that the reclaimed amounts are supported by the approved plan.

* * * * *

G. Part 435 is amended as follows:

1. Section 435.4 is amended by revising the definitions of "Categorically needy" and "Families and children" as follows:

§ 435.4 Definitions and use of terms.

As used in this part—

* * * * *

"Categorically needy" means aged, blind or disabled individuals or families and children (1) who are otherwise eligible for medicaid and who meet the financial eligibility requirements for AFDC, SSI, or an optional State supplement; or

(2) Whose categorical eligibility is protected by statute (e.g., persons receiving cost of living increases under § 435.135).

"Families and children" refers to eligible members of families with children who are financially eligible under AFDC or medically needy rules and who are deprived of parental support or care as defined under the AFDC program (see 45 CFR 233.90, 233.100). In addition, this group includes individuals under age 21 who are not deprived of parental support or care but are financially eligible under AFDC rules or medically needy rules (see optional coverage group, § 435.222). It does not include individuals under age 21 whose eligibility for medicaid is based on blindness or disability—for these individuals, SSI rules govern;

* * * * *

2. Section 435.112 is amended by adding the word "calendar" to paragraph (b) as follows:

§ 435.112 Families terminated from AFDC because of increased earnings or hours of employment.

* * * * *

(b) The 4 calendar month period begins on the date AFDC is terminated. If AFDC benefits are terminated retroactively, the 4 calendar month period also begins retroactively with the first month in which AFDC was erroneously paid.

3. Section 435.121 is amended by revising paragraphs (a) and (b)(2) and correcting the cross-reference in paragraph (c)(2) as follows:

§ 435.121 Individuals in States using more restrictive requirements for medicaid than the SSI requirements.

(a) The agency may use medicaid eligibility requirements for the aged, blind, or disabled that are more restrictive than the eligibility requirements for SSI. The agency may be more restrictive in defining blindness or disability, more restrictive in setting financial requirements for income or resources, or both. The requirements may apply to the aged or the blind or the disabled, or to any combination. For example, the agency may use a more restrictive definition of disability for those applying for medicaid as disabled and a more restrictive income requirement for those who apply as aged, but provide medicaid to all individuals receiving SSI on the basis of blindness.

(b) If an agency uses more restrictive requirements under this section—

* * * * *

(2) In determining financial eligibility of an individual in the category to which the more restrictive requirements apply, the agency must deduct, from the individual's income, his SSI payment, any optional State supplement, and incurred medical expenses as specified in § 435.732.

(c) The following sections of this part apply to the agency's use of more restrictive eligibility requirements:

* * * * *

(2) Section 435.321, medically needy coverage.

* * * * *

4. Section 435.134 is amended by revising paragraph (b) as follows:

§ 435.134 Individuals who would be eligible except for the increase in OASDI benefits under Pub. L. 92-336 (July 1, 1972).

The agency must provide medicaid to individuals who meet the following conditions:

* * * * *

(b) The individual would currently be eligible for SSI or a State supplement except that the increase in OASDI under Pub. L. 92-336 raised his income over the limit allowed under SSI. This includes an individual who—

(1) Meets all current SSI requirements except for the requirement to file an application; or

(2) Would meet all current SSI requirements if he were not in a medical institution or intermediate care facility, and the State's medicaid plan covers this optional group.

5. Section 435.211 is revised as follows:

§ 435.211 Individuals who would be eligible for cash assistance except for their institutional status.

The agency may provide medicaid to individuals in title XIX reimbursable medical institutions and intermediate care facilities who are ineligible for AFDC, SSI, or an optional State supplement because of lower income standards used under these programs to determine eligibility for institutionalized individuals, but who would be eligible for AFDC, SSI, or an optional State supplement as specified in § 435.230 if they were not institutionalized.

6. Section 435.223 is amended by revising paragraph (a) as follows:

§ 435.223 Individuals who would be eligible for AFDC if coverage under the State's AFDC plan were as broad as allowed under title IV-A.

(a) The agency may provide medicaid to individuals who—

(1) Would be eligible for AFDC if the State's AFDC plan included individuals whose coverage under title IV-A is optional (for example, medicaid may be provided to unborn children or members of families with an unemployed parent even though AFDC is not available to them under the State's AFDC plan); or

(2) Would be eligible for AFDC if the State's AFDC plan did not contain eligibility requirements more restrictive than, or in addition to, those required under title IV-A.

* * * * *

7. Section 435.231 is amended by changing the heading as follows:

§ 435.231 Individuals in institutions who are eligible under a special income level.

8. In § 435.321, paragraph (b)(1) is revised by deleting the first cross reference as set forth below:

§ 435.321 Medically needy coverage of the aged, blind, and disabled in States that impose more restrictive eligibility requirements.

* * * * *

(b) To determine whether an individual is covered as categorically needy or medically needy, the agency must—

(1) Consider as categorically needy those individuals who meet the State's categorically needy financial standard and (i) who, before their incurred medical expenses are deducted from income, meet the financial eligibility requirements for SSI or a State supplement; or (ii) whose OASDI increases are not counted under §§ 435.134 and 435.135.

* * * * *

9. Section 435.722 is amended by changing the heading as follows:

§ 435.722 Individuals in institutions who are eligible under a special income level.

10. In § 435.723, paragraph (d) is revised by changing the first reference to "eligible spouse" to read "ineligible spouse" as follows:

§ 435.723 Financial responsibility of spouses.

* * * * *

(d) If only one spouse in a couple applies or is eligible and they cease to live together, the agency must consider only the income and resources of the ineligible spouse that are actually contributed to the eligible spouse after the month in which they cease to live together.

11. Paragraph (a) of § 435.725 is corrected by adding the phrase "the amount that remains after" as follows:

§ 435.725 Post-eligibility treatment of income and resources of institutionalized individuals: Application of patient income to the cost of care.

(a) The agency must reduce its payment to an institution, for services provided to an individual specified in paragraph (b) of this section, by the amount that remains after deducting the amounts specified in paragraph (c) from the individual's income.

* * * * *

12. Section 435.731 is amended by revising paragraph (a) and deleting paragraph (b) as follows:

§ 435.731 General requirements for determining income eligibility in States using more restrictive requirements than SSI.

Requirements applicable to all individuals. If the agency, under § 435.121, uses any requirement for aged, blind, or disabled individuals more restrictive than an eligibility requirement under SSI, the agency must determine income in accordance with § 435.732 with respect to any category for which more restrictive requirements are imposed. The agency must use the procedures in § 435.732 regardless of the type of restrictive eligibility factor imposed.

13. Section 435.732 is revised to read as follows:

§ 435.732 Procedures for determining income eligibility.

The agency must determine income eligibility of individuals in the categories specified in § 435.731 in the following manner:

(a) *Determining countable income.* The agency must deduct the following amounts from income to determine the individual's countable income:

(1) Any SSI benefit the individual receives.

(2) Any optional State supplement the individual receives.

(3) Increases in OASDI that are deducted under §§ 435.134 and 435.135(c) for individuals specified in those sections.

(4) Other deductions from income applied under the medicaid plan.

(b) *Eligibility based on countable income.* If countable income determined under paragraph (a) of this section is equal to or less than the applicable income standard established under § 435.121 the individual is eligible for medicaid.

(c) *Deduction of incurred medical expenses.* (1) If countable income exceeds the income standard, the agency must deduct from income expenses incurred by the individual or financially responsible relatives for necessary medical and remedial services that are recognized under State law and are not subject to payment by a third party, including medicare and other health insurance premiums, deductibles or coinsurance charges, and co-payments or deductibles imposed under §§ 447.51 or 447.53 of this subchapter.

(2) The agency may set reasonable limits on the amounts of incurred medical expenses to be deducted from income.

(d) *Eligibility based on incurred medical expenses.* If, after incurred medical expenses are deducted, remaining income is equal to or less than the income standard, the individual is eligible for medicaid.

14. Section 435.733 is revised to read as follows:

§ 435.733 Post-eligibility treatment of income and resources of institutionalized individuals: Application of patient income to the cost of care.

(a) The agency must reduce its payment to an institution, for services provided to an individual specified in paragraph (b) of this section, by the amount that remains after deducting the amounts specified in paragraph (c) from the individual's income.

(b) This section applies to the following individuals in medical

institutions and intermediate care facilities:

(1) Individuals receiving cash assistance under AFDC who are eligible for medicaid under § 435.110 and individuals eligible under § 435.121.

(2) Individuals who would be eligible for AFDC, SSI, or an optional State supplement except for their institutional status and who are eligible for medicaid under § 435.211.

(3) Aged, blind, and disabled individuals who are eligible for medicaid, under § 435.231, under a higher income standard than the standard used in determining eligibility for SSI or optional State supplements.

(c) The agency must deduct the following amounts, in the following order, from the individual's total income including amounts disregarded in determining eligibility:

(1) A personal needs allowance that is reasonable in amount for clothing and other personal needs of the indvidual while in the institution. This protected personal needs allowance must be at least—

(i) $25 a month for an aged, blind, or disabled individual, including a child applying for medicaid on the basis of blindness or disability;

(ii) $50 a month for an institutionalized couple if both spouses are aged, blind, or disabled and their income is considered available to each other in determining eligibility; and

(iii) For other individuals, a reasonable amount set by the agency, based on a reasonable difference in their personal needs from those of the aged, blind, and disabled. Although the personal needs allowance is protected for his use, the individual must use it to pay for any cost-sharing charges the agency imposes under §§ 447.50 through 447.59 of this subchapter, if he has no other income.

(2) For an individual with only a spouse at home, an additional amount for the maintenance needs of the spouse. This amount must be based on a reasonable assessment of need but must not exceed the higher of—

(i) The more restrictive income standard established under § 435.121; or

(ii) The medically needy standard for an individual;

(3) For an individual with a family at home, an additional amount for the maintenance needs of the family. This amount must—

(i) Be based on a reasonable assessment of their financial need;

(ii) Be adjusted for the number of family members living in the home; and

(iii) Not exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's AFDC plan or the medically needy income standard established under subpart I of this part for a family of the same size.

(4) Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party, including—

(i) Medicare and other health insurance premiums, deductibles, or coinsurance charges; and

(ii) Necessary medical or remedial care recognized under State law but not covered under the State's medicaid plan, subject to reasonable limits the agency may establish on amounts of these expenses.

(d) In determining the amount of the individual's income to be used to reduce the agency's payment to the institution, the agency may, for single individuals, deduct an amount (in addition to the personal needs allowance) for maintenance of the individual's home if—

(1) The amount is deducted for not more than a 6-month period; and

(2) A physician has certified that the individual is likely to return to his home within that period.

15. Section 435.811 is revised as follows:

§ 435.811 General requirement.

To determine eligibility of medically needy individuals and families, a medicaid agency must use an income standard under this subpart based on family size. "Family size" includes all individuals in the family for whom medically needy Medicaid eligibility is being determined and any financially responsible relative living in the home regardless of actual contribution.

16. Section 435.812 is amended by deleting "non-institutionalized" from the heading, by revising the introductory language in paragraph (a) and (a) (1) and (2), by deleting and reserving paragraph (a)(4), and by adding a new paragraph (c), as follows:

§ 435.812 Medically needy income standard for one person.

(a) Except as provided in paragraphs (b) and (c) of this section, the agency must use an income standard to determine eligibility for one individual that at least equals the highest of the following amounts:

(1) The amount of the payment standard for an individual that is generally used to determine eligibility under the State's approved AFDC plan.

(2) The amount of the income standard used to determine eligibility under SSI of an individual in his home.

(3) If the agency provides medicaid, under § 435.230, to individuals receiving only optional State supplements, the amount of the highest income standard generally used to determine eligibility for an optional State supplement of an individual in his home.

* * * * *

(4) [Reserved]

(c) The provisions of this section do not require an agency that has elected to apply more restrictive requirements to the aged, blind, or disabled to extend Medicaid coverage to any aged, blind, or disabled individual who would not have been covered under the State's plan on January 1, 1972. The agency may have a separate standard for the aged, blind, and disabled which is more restrictive than the standard for AFDC.

17. Section 435.813 is deleted and reserved.

§ 435.813 [Reserved]

18. Section 435.814 is amended by deleting "non-institutionalized" from the heading, by revising the introductory language in paragraph (a) and paragraph (a)(1), by deleting and reserving paragraph (a)(4), and by adding a new paragraph (c) as follows:

§ 435.814 Medically needy income standard for two persons.

(a) Except as provided in paragraphs (b) and (c) of this section, the agency must use an income standard to determine eligibility for two persons that at least equals the highest of the following amounts:

(1) The amount of the payment standard for a family of two that is generally used to determine eligibility under the State's approved AFDC plan.

(2) The amount of the income standard used to determine eligibility under SSI of a couple in which both spouses apply as aged, blind, or disabled and live in the same household.

(3) If the agency provides medicaid, under § 435.230, to individuals receiving only optional State supplements, the amount of the highest income standard generally used to determine eligibility for an optional State supplement for couples in which both spouses apply as aged, blind, or disabled and live in the same household.

(4) [Reserved]

* * * * *

(c) The provisions of this section do not require an agency that has elected to apply more restrictive requirements to the aged, blind, or disabled to extend Medicaid coverage to any aged, blind, or disabled individual who would not have been covered under the State's plan on January 1, 1972. The agency may have a separate standard for the aged, blind, and disabled which is more restrictive than the standard for AFDC.

19. Section 435.815 is deleted and reserved:

§ 435.815 [Reserved]

20. Section 435.816 is revised by changing the reference in the first sentence from "the State's AFDC plan" to "the State's approved AFDC plan."

§ 435.816 Medically needy income standards for three or more persons.

The agency must use an income standard to determine eligibility of families of three or more that at least equals the amount of the payment standard generally used to determine eligibility under the State's approved AFDC plan for families of the same size. This rule also applies in determining eligibility of an individual under age 21 living with his parents who is not eligible as a dependent child and whose parents' income and resources are considered available to him under § 435.821.

21. Section 435.831 is amended by revising the introductory paragraph and paragraphs (a), (b), (c) (2), and (d) to read as follows:

§ 435.831 Income eligibility.

The agency must determine income eligibility of medically needy individuals in accordance with this section. The agency must use a prospective period of not more than 6 months to compute income.

(a) *Determining countable income.* The agency must deduct the following amounts from income to determine the individual's countable income.

* * * * *

(b) *Eligibility based on countable income.* If countable income determined under paragraph (a) of this section is equal to or less than the applicable income standard under §§ 435.812 through 435.816, the individual or family is eligible for medicaid.

(c) *Deduction of incurred medical expenses*

* * * * *

(2) The agency may set reasonable limits on the amounts of incurred medical expenses to be deducted from income under paragraphs (c) (1) (i) and (ii) of this section.

(d) *Eligibility based on incurred medical expenses.* Once deduction of incurred medical expenses reduces income to the income standard, the individual or family is eligible for the full amount, duration and scope of services under the plan.

22. Section 435.832 is revised to read as follows:

§ 435.832 Post-eligibility treatment of income and resources of institutionalized individuals: Application of patient income to the cost of care.

(a) The agency must reduce its payment to an institution, for services provided to an individual specified in paragraph (b) of this section, by the amount that remains after deducting the amounts specified in paragraph (c) from the individual's income.

(b) This section applies to medically needy individuals in medical institutions and intermediate care facilities.

(c) The agency must deduct the following amounts, in the following order, from the individual's total income including amounts disregarded in determining eligibility:

(1) A personal needs allowance that is reasonable in amount for clothing and other personal needs of the individual while in the institution. This protected personal needs allowance must be at least—

(i) $25 a month for an aged, blind, or disabled individual, including a child applying for medicaid on the basis of blindness or disability;

(ii) $50 a month for an institutionalized couple if both spouses are aged, blind, or disabled and their income is considered available to each other in determining eligibility; and

(iii) For other individuals, a reasonable amount set by the agency, based on a reasonable difference in their personal needs from those of the aged, blind, and disabled. Although the personal needs allowance is protected for his use, the individual must use it to pay for any cost-sharing charges the agency imposes under §§ 447.50 through 447.59 of this subchapter, if he has no other income.

(2) For an individual with only a spouse at home, an additional amount for the maintenance needs of the spouse. This amount must be based on a reasonable assessment of need but must not exceed the highest of—

(i) The amount of the income standard used to determine eligibility for SSI for an individual living in his own home;

(ii) The amount of the highest income standard, in the appropriate category of age, blindness, or disability, used to determine eligibility for an optional State supplement for an individual in his own home, if the agency provides medicaid to optional State supplement recipients under § 435.230; or

(iii) The amount of the medically needy income standard for one person established under § 435.812.

(3) For an individual with a family at home, an additional amount for the maintenance needs of the family. This amount must—

(i) Be based on a reasonable assessment of their financial need;

(ii) Be adjusted for the number of family members living in the home; and

(iii) Not exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under subpart I of this part for a family of the same size.

(4) Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party, including—

(i) Medicare and other health insurance premiums, deductibles, or coinsurance charges; and

(ii) Necessary medical or remedial care recognized under State law but not covered under the State's medicaid plan, subject to reasonable limits the agency may establish on amounts of these expenses.

(d) In determining the amount of the individual's income to be used to reduce the agency's payment to the institution, the agency may, for single individuals, deduct an amount (in addition to the personal needs allowance) for maintenance of the individual's home if—

(1) The amount is deducted for not more than a 6-month period; and

(2) A physician has certified that the individual is likely to return to his home within that period.

23. Section 435.845 is amended by removing the words "resource" and "at least" from paragraph (e), dividing paragraph (e) into subparagraphs (1) and (2), and adding a phrase to paragraph (e)(2) as follows:

§ 435.845 Medically needy resource eligibility.

To determine eligibility on the basis of resources for medically needy individuals, the agency must—

* * * * *

(e)(1) For aged, blind, or disabled individuals in States using requirements more restrictive than SSI, deduct the value of resources in an amount no more restrictive than those deducted under the medicaid plan on January 1, 1972 and no more liberal than those deducted in determining eligibility under SSI.

(2) However, the amounts specified in paragraph (e)(1) of this section must be the same as those that would be deducted in determining, under § 435.121, the eligibility of the categorically needy; and

* * * * *

24. The introductory phrase of § 435.905(a) is amended to read as follows:

§ 435.905 Availability of program information.

(a) The agency must furnish the following information in written form, and orally as appropriate, to all applicants and to all other individuals who request it. * * *

* * * * *

25. In § 435.911 paragraph (c) is revised by adding the word "or" to the end of paragraph (c)(1), removing "or" from the end of paragraph (c)(2), and deleting paragraph (c)(3) as follows:

§ 435.911 Timely determination of eligibility.

* * * * *

(c) The agency must determine eligibility within the standards except in unusual circumstances, for example—

(1) When the agency cannot reach a decision because the applicant or an examining physician delays or fails to take a required action, or

(2) When there is an administrative or other emergency beyond the agency's control.

* * * * *

26. In § 435.919, paragraph (b) is amended by changing the reference to Subpart J to Subpart E:

§ 435.919 Timely and adequate notice.

* * * * *

(b) The notice must meet the requirements of Subpart E of Part 431 of this subchapter.

27. Section 435.1004 is amended by revising paragraph (a) to read as follows:

§ 435.1004 Recipients overcoming certain conditions of eligibility.

(a) FFP is available, as specified in paragraph (b) of this section, in expenditures for services provided to recipients who are overcoming certain eligibility conditions, including blindness, disability, continued absence or incapacity of a parent, or unemployment of a parent.

* * * * *

28. Section 435.1006 is revised to read as follows:

§ 435.1006 Recipients of optional State supplements only.

FFP is available in expenditures for services provided to individuals receiving optional State supplements but not receiving SSI, if their income before deductions, as determined by SSI budget methodology, does not exceed 300 percent of the SSI benefit amount payable under section 1611(b)(1) of the Act to an individual who has no income and resources.

H. Part 436 is amended as follows:

1. Section 436.3 is amended by revising the definition of "Categorically needy" as follows:

§ 436.3 Definitions and use of terms.

As used in this part—

* * * * *

"Categorically needy" means aged, blind, or disable individuals or families and children (1) who are otherwise eligible for medicaid and who meet the financial eligibility requirements for OAA, AFDC, AB, APTD, or AABD; or,

(2) Whose categorical eligibility is protected by statute (e.g., persons who received increased OASDI payments. See § 436.112).

* * * * *

2. Section 436.116 is amended by adding the word "calendar" to paragraph (b) as follows:

§ 436.116 Families terminated from AFDC because of increased earnings or hours of employment.

* * * * *

(b) The 4 calendar month period begins on the date AFDC is terminated. If AFDC benefits are terminated retroactively, the 4 calendar month period also begins retroactively with the first month in which AFDC was erroneously paid.

3. Section 436.211 is revised by inserting "title XIX reimbursable" after "individual's * * *" and before "medical institutions * * *".

§ 436.211 Individuals who would be eligible for cash assistance except for their institutional status.

The agency may provide medicaid to individuals in title XIX reimbursable medical institutions and intermediate care facilities who are ineligible for OAA, AFDC, AB, APTD, or AABD because of lower income standards used under those programs to determine eligibility for institutionalized individuals, but who would be eligible for those programs if they were not institutionalized.

4. Section 436.212 is amended by revising paragraph (a) as follows:

§ 436.212 Individuals who would be eligible for cash assistance if the State plan for OAA, AFDC, AB, APTD, or AABD were as broad as allowed under the Act.

(a) The agency may provide medicaid to individuals who—

(1) Would be eligible for OAA, AFDC, AB, APTD, or AABD if the State's plan under those programs included individuals whose coverage under title I, IV–A, X, XIV, or XVI is optional (for example, the agency may provide medicaid to unborn children or members of families with an unemployed parent even though the State's AFDC plan does not include them); or

Would qualify for OAA, AFDC, AB, APTD, or AABD if the State's plan under those programs did not contain eligibility requirements more restrictive than, or in addition to, those required under the appropriate title of the Act. (For example, the agency may provide medicaid to individuals who would meet the Federal definition of disability, 45 CFR 233.80, but who do not meet the State's more restrictive definitions.)

* * * * *

5. Section 436.811 is revised to read as follows:

§ 436.811 General requirement.

To determine eligibility of medically needy individuals and families, the agency must use an income standard under this subpart based on family size. "Family size" includes all individuals in the family for whom medically needy Medicaid eligibility is being determined and any financially responsible relative living in the home regardless of actual contribution.

6. Section 436.812 is amended by deleting "Non-institutionalized individuals" from the heading and by changing the reference in the first sentence of paragraph (b) from "the State's AFDC plan" to "the State's approved AFDC plan" as follows:

§ 436.812 Medically needy income standard.

To determine eligibility the agency must use—

* * * * *

(b) For families of three or more, an income standard that at least equals the amount of the payment standard generally used to determine eligibility under the State's approved AFDC plan for families of the same size. This rule also applies in determining eligibility of an individual under age 21 living with his parents who is not eligible as a dependent child and whose parents' income and resources are considered available to him under § 436.821.

7. Section 436.813 is deleted and reserved:

§ 436.813 [Reserved]

8. Section 436.831 is amended by revising the introductory paragraph, and paragraphs (a), (c)(2), and (d) as follows:

§ 436.831 Income eligibility.

The agency must determine income eligibility of medically needy individuals in accordance with this section. The agency must use a prospective period of not more than 6 months to compute income.

(a) *Determining countable income.* The agency must, to determine countable income, deduct amounts that would be deducted in determining eligibility under the State's approved plan for OAA, AFDC, AB, APTD, or AABD.

(b) *Eligibility based on countable income.* If countable income determined under paragraph (a) of this section is equal to or less than the applicable income standard under § 436.812, the individual is eligible for Medicaid.

(c) *Deduction of incurred medical expenses: Order of deduction.* * * *

(2) The agency may set reasonable limits on the amounts of incurred medical expenses to be deducted from income under paragraph (c)(1)(i) and (ii) of this section.

(d) *Eligibility based on incurred medical expenses.* Once deduction of incurred medical expenses reduces income to the income standard, the individual or family is eligible for the full amount, duration and scope of services under the plan.

9. Section 436.832 is revised to read as follows:

§ 436.832 Post-eligibility treatment of income and resources of institutionalized individuals: Application of patient income to the cost of care.

(a) The agency must reduce its payment to an institution, for services provided to an individual specified in paragraph (b) of this section, by the amount that remains after deducting the amounts specified in paragraph (c) from the individual's income.

(b) This section applies to medically needy individuals in medical institutions and intermediate care facilities.

(c) The agency must deduct the following amounts, in the following order, from the individual's total income including amounts disregarded in determining eligibility:

(1) A personal needs allowance that is reasonable in amount for clothing and other personal needs of the individual while in the institution. Although the personal needs allowance is protected for his use, the individual must use it to pay for any cost-sharing charges the agency imposes under §§ 447.50 through 447.59 of this subchapter, if he has no other income.

(2) For an individual with only a spouse at home, an additional amount for the maintenance needs of the spouse. This amount must be based on a reasonable assessment of need but must not exceed the higher of—

(i) The amount of the highest need standard for an individual without income and resources under the State's approved plan for OAA, AFDC, AB, APTD, or AABD; or

(ii) The amount of the medically needy income standard for one person established under § 436.812.

(3) For an individual with a family at home, an additional amount for the maintenance needs of the family. This amount must—

(i) Be based on a reasonable assessment of their financial need;

(ii) Be adjusted for the number of family members living in the home; and

(iii) Not exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under § 436.812 for a family of the same size.

(4) Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party, including—

(i) Medicare and other health insurance premiums, deductibles, or coinsurance charges; and

(ii) Necessary medical or remedial care recognized under State law but not covered under the State's medicaid plan, subject to reasonable limits the agency may establish on amounts of these expenses.

(d) In determining the amount of the individual's income to be used to reduce the agency's payment to the institution, the agency may, for single individuals, deduct an amount (in addition to the personal needs allowance) for maintenance of the individual's home if—

(1) The amount is deducted for not more than a 6-month period; and

(2) A physician has certified that the individual is likely to return to his home within that period.

10. Section 436.1003 is revised to read as follows:

§ 436.1003 Recipients overcoming certain conditions of eligibility.

FFP is available for a temporary period specified in the State plan in expenditures for services provided to recipients who are overcoming certain eligibility conditions, including blindness, disability, continued absence or incapacity of a parent, or unemployment of a parent.

I. Part 440 is amended as follows:

1. Section 440.70 is amended by revising paragraph (b) to read as follows:

§ 440.70 Home health services.

* * * * *

(b) Home health services include the following services and items. Those listed in paragraphs (b) (1), (2) and (3) are required services; those in paragraph (b)(4) are optional.

(1) Nursing service, as defined in the State Nurse Practice Act, that is provided on a part-time or intermittent basis by a home health agency as defined in paragraph (d) of this section, or if there is no agency in the area, a registered nurse who—

(i) Is currently licensed to practice in the State;

(ii) Receives written orders from the patient's physician;

(iii) Documents the care and services provided; and

(iv) Has had orientation to acceptable clinical and administrative recordkeeping from a health department nurse.

(2) Home health aide service provided by a home health agency,

(3) Medical supplies, equipment, and appliances suitable for use in the home, and

(4) Physical therapy, occupational therapy, or speech pathology and audiology services, provided by a home health agency or by a facility licensed by the State to provide medical rehabilitation services. (See § 441.15 of this subchapter.)

* * * * *

2. Section 440.100 is amended by revising paragraph (a) to change the word "direction" to "supervision" and to change the reference to "other" structures of the oral cavity to "associated", as follows:

§ 440.100 Dental services.

(a) "Dental services" means diagnostic, preventive, or corrective procedures provided by or under the supervision of a dentist in the practice of his profession, including treatment of—

(1) The teeth and associated structures of the oral cavity; and

(2) Disease, injury, or impairment that may affect the oral or general health of the recipient.

* * * * *

3. Section 440.110 is amended by revising paragraph (c)(1) to restore a requirement for physician referral, as follows:

§ 440.110 Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.

* * * * *

(c) *Services for individuals with speech, hearing, and language disorders.* (1) "Services for individuals with speech, hearing, and language disorders" means diagnostic, screening, preventive, or corrective services provided by or under the direction of a speech pathologist or audiologist, for

which a patient is referred by a physician. It includes any necessary supplies and equipment.

* * * * *

4. Section 440.170 is amended by correcting the spelling of "Church" in paragraph (b), restoring the word "own" before "home" in paragraph (b)(2)(ii), and restoring "plan of treatment" in paragraph (f), as follows:

§ 440.170 Any other medical care or remedial care recognized under State law and specified by the Secretary.

* * * * *

(b) *Services of Christian Science nurses.* "Services of Christian Science nurses" mean services provided by nurses who are listed and certified by the First Church of Christ, Scientist, Boston, Mass., if—

* * * * *

(2) The services are provided—

* * * * *

(ii) As private duty services to a recipient in his own home or in a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Mass., if the recipient requires individual and continuous care beyond that available from a visiting nurse or that routinely provided by the nursing staff of the sanatorium.

* * * * *

(f) *Personal care services in a recipient's home.* "Personal care services in a recipient's home" means services prescribed by a physician in accordance with the recipient's plan of treatment and provided by an individual who is—

* * * * *

5. Section 440.210 is revised by adding "and 440.70" after §§ 440.10–440.50".

§ 440.210 Required services for the categorically needy.

A State plan must specify that, as a minimum, categorically needy recipients are provided the services as specified in § 440.10–440.50, and 440.70.

6. Section 440.250 is amended by revising paragraph (e) to clarify the age limit, and paragraph (f) to add "part or all of the [deductibles]", as follows:

§ 440.250 Limits on comparability of services.

* * * * *

(e) If covered under the plan, inpatient psychiatric services (§ 440.160) must be limited to recipients under age 22 as specified in § 441.151(c) of this subchapter.

(f) If medicare benefits under Part B of title XVIII are made available to recipients through a buy-in agreement or payment of premiums, or part or all of the deductibles, cost sharing or similar charges, they may be limited to recipients who are covered by the agreement or payment.

* * * * *

J. Part 441 is amended as follows:

1. In § 441.10, paragraph (e) is revised by changing the parenthetical cite from "§ 441.12" to "441.13".

§ 441.10 Basis.

This subpart is based on the following sections of the Act which state requirements and limits on the services specified or provide Secretarial authority to prescribe regulations relating to services:

* * * * *

(e) Section 1905(a) (following (a)(17)), which prohibits FFP in expenditures for certain services (§ 441.13).

2. Section 441.15 is amended by revising the introductory paragraph as follows:

§ 441.15 Home health services.

With respect to the services defined in § 440.70 of this subchapter, a State plan must provide that—

* * * * *

3. Section 441.60 is revised to read as follows:

§ 441.60 Identifying, informing, and referring eligible recipients to title V services.

The agency must—

(a) Identify all recipients eligible for EPSDT services, including those who are in need of medical or remedial services furnished through title V grantees; and

(b) Ensure that recipients eligible for title V services are informed of available services, and referred if they desire to title V grantees that offer services appropriate to the recipients' needs.

K. Part 442 is amended as follows:

1. Section 442.441 is amended by revising paragraph (d) to read as follows:

§ 442.441 Behavior modification programs.

* * * * *

(d) Time-out devices and aversive stimuli may not be used for longer than one hour for time-out purposes involving removal from a situation, and then only during the behavior modification program and only under the supervision of the trainer.

2. Section 442.499 is amended by revising paragraph (b) as follows:

§ 442.499 Maintenance of resident records.

* * * * *

(b) Any individual who makes an entry in a resident's record must make it legibly, date it, and sign his name and job title or professional capacity.

* * * * *

L. Part 447 is amended as follows:

1. The table of contents is amended by renumbering § 447.351 to read § 447.352 and adding a new heading for § 447.351 as follows:

447.351 Selected medical services, supplies, and equipment: Upper limits.
447.352 Other noninstitutional services: Upper limits.

2. Section 447.15 is amended as follows:

§ 447.15 Acceptance of State payment as payment in full.

A State plan must provide that the medicaid agency must limit participation in the medicaid program to providers who accept, as payment in full, the amounts paid by the agency. (Secs. 1902(a)(4) and (14) of the Act.)

3. Section 447.52 is amended by adding a new paragraph (c) to read as follows:

§ 447.52 Minimum and maximum income-related charges.

For the purpose of relating the amount of an enrollment fee, premium, or similar charge to total gross family income, as required under § 447.51(d), the following rules apply:

* * * * *

(c) *Income-related charges.* The agency must impose an appropriately higher charge for each higher level of family income, within the maximum amounts specified in paragraph (b) of this section.

4. Section 447.331 is amended by adding the word "reasonable" to paragraph (a) as follows:

§ 447.331 Drugs: Upper limits of payment.

(a) The agency may not pay more for prescribed drugs than the lower of ingredient cost plus a reasonable dispensing fee or the provider's usual and customary charge to the general public.

* * * * *

5. Section 447.341 is amended by revising paragraph (c) to add "or services furnished," as follows:

§ 447.341 Individual practitioners: Upper limits of payment.

* * * * *

(c) The median charge for a given service is determined from claims submitted or services furnished during all of the calendar year preceding the

fiscal year in which the determination is made.

* * * * *

(Section 1102 of the Social Security Act (42 U.S.C. 1302)). (Catalog of Federal Domestic Assistance Program No. 13.714, Medical Assistance Program).

Dated: March 1, 1980.

Leonard D. Schaeffer,

Administrator, Health Care Financing Administration.

Approved: April 4, 1980.

Patricia Roberts Harris,

Secretary.

[FR Doc. 80-10959 Filed 4-10-80; 8:45 am]

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DEPARTMENT OF THE INTERIOR

Bureau of Land Management

43 CFR Public Land Order 5716

Alaska; Partial Revocation of Public Land Order Nos. 5653 and 5654

AGENCY: Bureau of Land Management, Interior.

ACTION: Public Land Order.

SUMMARY: This public land order revokes Public Land Order Nos. 5653 and 5654 as far as they affect the lands described in this order to clear the land status records because the lands have been conveyed out of Federal ownership pursuant to the Alaska Native Claims Settlement Act.

EFFECTIVE DATE: April 11, 1980.

FOR FURTHER INFORMATION CONTACT:
Beau McClure, 202-343-6511

Bob Arnold, 907-271-5768, Bureau of Land Management, Alaska State Office, 701 C Street, Box 13, Anchorage, Alaska 99513

By virtue of the authority vested in the Secretary of the Interior by section 204 of the Federal Land Policy and Management Act of 1976, 90 Stat. 2751, 43 U.S.C. 1714, it is ordered as follows:

1. Public Land Order No. 5653 of November 16, 1978, as amended by Public Land Order No. 5654 of November 17, 1978, withdrawing lands from settlement, sale, location, entry, or selection under the operation of the public land laws, including but not limited to the mining laws (30 U.S.C. Ch. 2), and section 6 of the Alaska Statehood Act (72 Stat. 339) for the public purpose of preserving, protecting and maintaining the resource values that would otherwise be lost are hereby revoked as far as they affect the following described lands:

Kateel River Meridian, Alaska (Unsurveyed)

T. 34 N., R. 16 E.
Secs. 19 to 24, inclusive, all.
Containing approximately 3,819 acres.

T. 34 N., R. 17 E.
Secs. 7 to 24, inclusive, all.
Containing approximately 11,299 acres.

T. 34 N., R. 18 E.
Secs. 7 and 8, all;
Secs. 17 to 20, inclusive, all.
Containing approximately 3,727 acres.

Umiat Meridian, Alaska (Unsurveyed)

T. 10 S., R. 5 W.
Secs. 22 to 27, inclusive, all;
Secs. 34, 35, and 36, all.
Containing approximately 5,760 acres.

T. 11 S., R. 5 W.
Secs. 1, 2, and 3, all;
Secs. 10 to 15, inclusive, all.
Containing approximately 15,336 acres.

T. 12 S., R. 12 W.
Secs. 1 to 12, inclusive, all;
Secs. 17 to 20, inclusive, all;
Secs. 29 and 30, all.
Containing approximately 11,475 acres.

T. 12 S., R. 13 W.
Secs. 1 to 30, inclusive, all.
Containing approximately 19,313 acres.
Aggregating approximately 76,489 acres.

2. The lands described in paragraph 1 have been conveyed out of Federal ownership pursuant to the Alaska Native Claims Settlement Act in accordance with the terms and conditions of the agreement of June 29, 1979, between the Department of the Interior and the Arctic Slope Regional Corporation. The purpose of this order is to clear the Federal land status records; therefore, it is determined that the promulgation of this public land order is not a major Federal action significantly affecting the quality of the human environment and that no detailed statement pursuant to Section 102(2)(C) of the National Environmental Policy Act of 1969, 42 U.S.C. 4332 (2)(C), is required.

Guy R. Martin,

Assistant Secretary of the Interior.

April 8, 1980.

[FR Doc. 80-11005 Filed 4-10-80; 8:45 am]

BILLING CODE 4310-84-M

INTERSTATE COMMERCE COMMISSION

49 CFR Part 1033

[Second Rev. S.O. No. 1439]

Union Pacific Railroad Co. Authorized To Operate Over Tracks of Chicago, Rock Island and Pacific Railroad Co., Debtor (William M. Gibbons, Trustee)

AGENCY: Interstate Commerce Commission.

ACTION: Second Revised Service Order No. 1439.

SUMMARY: This order authorizes the Union Pacific Railroad Company to operate over tracks of Chicago, Rock Island and Pacific Railroad Company (RI) at the following locations for the purpose of serving industries located adjacent to such tracks, and provides for continuation of service to shippers which would otherwise be deprived of essential railroad service.

1. Beatrice, Nebraska.

2. Between Colby and Goodland, Kansas.

3. Approximately 36.5 miles of trackage extending from Fairbury, Nebraska, to RI milepost 581.5 north of Hallam, Nebraska.

4. At Topeka, Kansas, between former RI milepost 88.99 and former milepost 85.25.

5. Between Goodland and Caruso, Kansas.

EFFECTIVE DATE: 12:01 a.m., March 24, 1980, and continuing in effect until 11:59 p.m., May 31, 1980.

FOR FURTHER INFORMATION CONTACT:
J. Kenneth Carter, (202) 275-7840.

Decided: March 20, 1980.

The embargo of the lines of Chicago, Rock Island and Pacific Railroad Company (RI) is depriving shippers located adjacent to those tracks of essential railroad service. The Union Pacific Railroad Company (UP) connects with the RI and has consented to operate over these tracks in order to serve the industries.

It is the opinion of the Commission that an emergency exists requiring the operation by UP over tracks formerly operated by RI in the interest of the public; that notice and public procedure are impracticable and contrary to the public interest; and that good cause exists for making this order effective upon less than thirty days' notice.

It is ordered,

§ 1033.1439 Service Order No. 1439.

(a) *Union Pacific Railroad Company authorized to operate over tracks of Chicago, Rock Island and Pacific Railroad Company, debtor (William M. Gibbons, trustee).* The Union Pacific Railroad Company (UP) is authorized to operate over tracks of the Chicago, Rock Island and Pacific Railroad Company (RI) at the following locations for the purpose of serving industries located adjacent to such tracks.

(1) Beatrice, Nebraska.

(2) Between Colby and Goodland, Kansas.

(3) Approximately 36.5 miles of trackage extending from Fairbury, Nebraska, to RI milepost 581.5 north of Hallam, Nebraska.

(4) At Topeka, Kansas, between former RI milepost 88.99 to former milepost 85.25.