Upper Limits

§ 447.271 Upper limits based on customary charges.

(a) Except as provided in paragraph (b) of this section, the agency may not pay a provider more for inpatient hospital services under Medicaid than the provider's customary charges to the general public for the services.

(b) The agency may pay a public provider that provides services free or at a nominal charge at the same rate that would be used if the provider's charges were equal to or greater than its costs.

§ 447.272 Upper limits based on Medicare payments.

(a) An agency may not pay more in the aggregate for inpatient hospital services or long-term care facility services than the amount that would be paid for the services under the Medicare principles of reimbursement under Part 405, Subpart D of this chapter. Payments meet this requirement—

(1) If, in a random sample of all Medicaid providers, the payment is not more than the amount that would have been paid under Medicare in at least 90 percent of the providers in the sample; or

(2) If the average payment to all providers in a class is not more than the average amount that would have been paid under Medicare.

(b) To determine what would have been paid for a class of providers under Medicare—

(1) For providers that participate in Medicare, the interim rate paid to the provider under Medicare (adjusted for services not included in the State plan and for the Medicare inpatient routine nursing salary cost differential paid under § 405.430 of this chapter) may be used to determine the upper limit; and

(2) For hospitals and SNFs that do not participate in Medicare and for ICFs, the agency must estimate the amounts Medicare would have paid those providers. These estimates must be consistent with the intent that payments do not exceed amounts (adjusted for services not included in the State plan and for the Medicare inpatient routine nursing salary cost differential paid under § 405.430 of this chapter) that would be determined using Medicare's principles.

2. A new heading is added before § 447.321, as follows:

Subpart D—Payment for Other Institutional and Noninstitutional Services

* * * * *

(Catalog of Federal Domestic Assistance Program No. 13.714, Medical Assistance Program)

Dated: September 23, 1981.

Carolyne K. Davis,

Administrator, Health Care Financing Administration.

Approved: September 24, 1981.

Richard S. Schweiker,

Secretary.

[FR Doc. 81-28323 Filed 9-29-81; 8:45 am]

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Wednesday
September 30, 1981

Part IV

Department of Health and Human Services

Health Care Financing Administration

Medicaid Eligibility and Coverage Criteria

DEPARTMENT OF HEALTH AND HUMAN SERVICES

42 CFR Parts 435, 436, 440, and 441

Medicaid Program; Medicaid Eligibility and Coverage Criteria

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

ACTION: Interim final rule with comment period.

SUMMARY: This rule amends current regulations that contain requirements States must follow in establishing eligibility criteria for the medically needy recipients under Medicaid (title XIX of the Social Security Act) and in providing services for those individuals. It also makes certain changes with respect to categorically needy persons. This rule implements sections 2171 and 2172 of the Omnibus Budget Reconciliation Act of 1981 (Pub. L. 97–35). That law gives States considerable flexibility in establishing eligibility criteria and scope of services for the medically needy.

These final regulations: (1) specify whom the State must include among the medically needy if it provides for that group in the Medicaid program: (2) provide the State with flexibility in determining what additional persons will be included among the medically needy; (3) specify what services must be provided for the medically needy; and (4) require the State to include specified groups of individuals (certain children, pregnant women, and persons in certain work programs) among the categorically needy.

DATES: These regulations are effective October 1, 1981. Although these regulations are final, comments may be submitted as described below. To assure consideration, comments should be mailed by December 29, 1981.

State agencies have until December 31, 1981, to submit their preprinted plan amendments and required attachments. HCFA will not hold a State to be out of compliance with the requirements of these final regulations if they submit the necessary preprint plan material by that date.

ADDRESS: Address comments in writing to: Administrator, Department of Health and Human Services, Health Care Financing Administration; P.O. Box 17076, Baltimore, Maryland 21235.

If you prefer, you may deliver your comments to Room 309–G Hubert H. Humphrey Building, 200 Independence Ave., S.W., Washington, D.C., or to Room 789, East High Rise Building, 6401 Security Boulevard, Baltimore, Maryland.

In commenting, please refer to BPP–179–FC. Agencies and organizations are requested to submit comments in duplicate.

Comments will be available for public inspection, beginning approximately two weeks after publication, in Room 309–G of the Department's office at 200 Independence Ave., S.W., Washington, D.C. 20201 on Monday through Friday of each week from 8:30 a.m. to 5:00 p.m. (202–245–7890).

Because of the large number of comments we receive, we cannot acknowledge or respond to them individually. However, if as a result of comments, we believe that changes are needed in these regulations, we will publish the changes in the **Federal Register** and respond to the comments in the preamble of that document.

FOR FURTHER INFORMATION CONTACT: Elmer Smith, (301) 594–9682.

SUPPLEMENTARY INFORMATION:

I. Introduction

The Medicaid program was enacted in 1965 under title XIX of the Social Security Act (the Act). States that establish Medicaid programs must provide for medical assistance to the categorically needy. These are persons eligible for Medicaid because, in general, they receive certain cash assistance—Aid to Families with Dependent Children (AFDC) (title IV–A of the Act) or Supplemental Security Income (SSI) (title XVI of the Act). States could also cover as categorically needy certain individuals who would be eligible to receive cash benefits and recipients of certain State Supplmentary Payments. States may also provide medical assistance to the medically needy. Before Pub. L. 97–35, this group consisted, in general, of persons who would have been categorically needy, except that their income or resources exceeded the financial eligibility requirements for the categorically needy, but were within limits set by the State.

States that chose to include the medically needy in their Medicaid programs had to meet, among others, the following requirements:

(1) States had to cover as medically needy all groups that were categorically related (the aged, blind and disabled, and families with dependent children).

(2) States had to offer a mix of institutional and noninstitutional services.

(3) States had to offer the same amount, duration, and scope of services to all medically needy—the comparability of services requirement.

Sections 2171 and 2172 of the Omnibus Budget Reconciliation Act of 1981 (the 1981 Amendments) revised title XIX of the Act by giving the States flexibility in determining which groups of individuals would be included in the medically needy and what services those groups would be offered under the State plan. Congress intended to enable each State, based on internal consideration of priorities, needs, and resources, to target Medicaid services for the optional groups more appropriately (H.R. Rept. No. 97–208, p. 971).

Under the 1981 Amendments, coverage of the medically needy continues to be optional. A State can choose not to have a medically needy program at all. (At the present time, all but 20 States have a medically needy program.) However, the 1981 Amendments enacted the following changes in the eligibility requirements for those States that choose to have a medically needy program:

1. The State is not required to cover all categorically related groups (for example, the aged and blind) under its medically needy program.

2. The State plan must include a description of criteria for determining eligibility of each covered group of medically needy individuals.

3. The States are given greater flexibility in coverage of individuals under age 21. However, there are some minimal requirements that States must meet, as discussed below.

4. If the State plan provides for the medically needy, the plan must provide for pregnant women who, but for income and resources, would be eligible for Medicaid as catergorically needy.

The new legislation also includes the following provisions related to the categorically needy:

1. States must include as categorically needy persons who are denied AFDC payment solely because the payment would be less than $10 a month.

2. The State must include as categorically needy individuals who participate in certain AFDC-related work programs and are deemed by the State to be receiving AFDC.

3. The State must include under the categorically needy certain pregnant women who are deemed by the State to be AFDC recipients.

The 1981 Amendments made the following changes that affect the services that are provided to the medically needy:

1. The State plan is no longer required to provide the same amount, duration,

and scope of services for all medically needy groups under the plan.

2. The State plan must indicate the amount, duration, and scope of services for each covered group of medically needy.

3. Ambulatory services must be offered to (a) eligible children under age 18 and (b) individuals entitled to institutional services.

4. A range of services specified in the statute must be offered to all medically needy if the State plan provides for services to the medically needy in an intermediate care facility for the mentally retarded (ICF–MR) or in an institution for mental diseases (IMD).

5. Prenatal care and delivery services must be offered to all eligible pregnant women.

These final regulations implement the changes enacted by the 1981 Amendments. For the most part, the regulations restate the provisions of these amendments, giving States the maximum flexibility provided for under the Act. In the discussions that follow we identify the significant changes and the fundamental issues that are involved. In addition, there are technical revisions in the regulations to bring them into conformity with the latest changes in the statute.

II. Categorically Needy Eligibility Provisions

A. Optional Categorically Needy Group

Previously, section 1902(a)(10)(C) defined the medically needy and contained language that enabled one to identify a group of individuals referred to as the "optional categorically needy". They were individuals for whom the State had the option of providing medical assistance as categorically needy. This group included, among others, persons eligible for but not receiving AFDC cash assistance because they chose not to receive such assistance, and persons who would have been eligible to receive cash assistance if they were not institutionalized.

Section 2171(a) of the 1981 Amendments has revised the definition of the medically needy so that a question arises as to whether the optional categorically needy can continue to be identified under Medicaid. Section 1902(a)(10)(C) of the Act now defines the medically needy as "any group of individuals described in section 1905(a) who are not described in subparagraph (A) [of section 1902(a)(10)]". Subparagraph (A) describes the mandatory categorically needy, that is, persons receiving cash assistance. Section 1905(a) lists general groups of individuals, such as persons under 21 years of age and persons who are blind or disabled. Therefore, the new definition of medically needy could be interpreted to mean that anyone not receiving cash assistance or aid is considered medically needy rather than categorically needy.

In the past, the optional categorically needy group afforded the States some flexibility. For example, if the State did not wish to adopt a full scale medically needy program, it was able to provide Medicaid for certain individuals, such as those who would be eligible for cash assistance if they were not institutionalized, by electing to cover them as optional categorically needy.

Now, however, given the extensive flexibility afforded the States as a result of the 1981 Amendments (as explained more fully below), it is possible that there is no longer any reason for maintaining the optional categorically needy classification, because the State could cover these persons under one of the medically needy classifications. However, in order not to inhibit the States' options and allow the States to implement their new authority with the least confusion and disruption possible, we have in these regulations maintained the previous provisions that provide for the optional categorically needy. We specifically invite comments from the public as to whether, in view of the 1981 Amendments, the optional categorically needy classification should continue to be provided for as a distinct group in Medicaid and the implications of its deletion.

B. Individuals in Work Supplementation Programs

The State plan must provide Medicaid eligibility as categorically needy for all individuals who (1) are participating in an AFDC work supplementation program (under section 414 of the Act) *and* (2) are deemed by the State to be AFDC recipients. (See 42 CFR 435.115 and 436.114, as added by this rule.) This provision implements section 1902(a)(10)(A) of the Act, as amended by section 2171(a)(1) of the 1981 Amendments.

Section 2308 of the 1981 Amendments added a new section 414 to title IV of the Act. That section allows States to institute work supplementation programs. These programs make jobs available to AFDC recipients, as an alternative to receiving AFDC. States with these programs have the option of considering individuals who participate in these programs as receiving AFDC for purposes of eligibility under title XIX (section 414(g) of the Act). Individuals who, under section 414(g) of the Act, are considered to be receiving AFDC must be included among the categorically needy classification under Medicaid (section 1902(a)(10)(A) of the Act). (Under the provisions of section 414(a) of the Act, the State may elect, for purposes of Medicaid, to deem the following to be AFDC recipients: the participant in the work program, any child or relative of the participant, or other individual living in the same household as the participant.)

C. Pregnant Women

Under section 406(g)(2) of the Act (as amended by the 1981 Amendments), a State may choose to extend Medicaid eligibility to pregnant women as soon as pregnancy is medically verified, even though eligibility for AFDC cash assistance is limited to the last four months of pregnancy. If a State chooses to do so, it must treat such individuals as categoricaly needy. The issues and regulations related to these individuals are discussed more fully below in section V, "Pregnant Women."

D. Individuals Denied AFDC Cash Payment

The State plan must provide Medicaid for individuals who are denied a cash payment from the title IV–A agency solely because the amount of the AFDC payment would be less than $10. (See 42 CFR 435.115 and 436.114, as added by this rule.)

Section 2316 of the 1981 Amendments added a new paragraph (32) to section 402(a) of the Act. The new paragraph denies an AFDC cash assistance payment to an individual if the payment would be less than $10. However, that same paragraph specifies that such an individual is deemed to be an AFDC recipient. Since the Medicaid plan must provide for an individual receiving (or deemed to be receiving) AFDC cash assistance, the individual deemed to be an AFDC recipient under Section 402(a)(32) of the Act must, if otherwise eligible, be included under the mandatory categorically needy in the State Medicaid plan.

E. Persons Under 21 Years of Age

There were several changes in the AFDC and Medicaid programs affecting children under age 21. In order to discuss these in an orderly and logical way, we have grouped the issues and regulations relevant to these individuals below in section IV, "Individuals Under 21 Years of Age."

F. Individuals Entitled to Benefits Under Section 1622 of the Act

Individuals entitled to benefits under section 1622 of the Act are not to be considered SSI recipients for purposes of determining Medicaid eligibility. (See 42 CFR 435.120 as revised by this rule.)

Section 2201 of the 1981 Amendments repeals the minimum benefit provisions of Social Security (title II of the Act: Federal Old-Age, Survivors, and Disability Insurance Benefits). At the same time, the 1981 Amendments added a new section 1622 to the Act to provide benefits under the SSI program (title XVI of the Act) for certain individuals formerly receiving minimum benefits under title II. Generally, persons receiving SSI benefits become eligible for Medicaid as a result of that status. However, the new statute also specifies that individuals entitled to benefits under section 1622 shall not be considered to be SSI beneficiaries for purposes of title XVI or any other title of the Act (see section 1622(d) of the Act). Consequently, individuals entitled to benefits under section 1622 of the Act, do not automatically become eligible for Medicaid by reason of receiving such benefits.

III. Medically Needy Eligibility Provisions

Prior to the 1981 Amendments, States had the option of including, or excluding, the medically needy; but if they chose to include any medically needy, they were required to provide for all the medically needy, that is, the aged, blind, disabled, and families with dependent children. The 1981 Amendments substantially changed those requirements by giving the States flexibility in determining what groups (for example, the aged, or the blind, or the disabled) would be eligible for Medicaid as medically needy. Along with that flexibility, however, there are certain requirements that a State must follow if it does choose to provide for the medically needy. The following provisions identify the Federally-established parameters within which a State must specify the "medically needy" in its Medicaid program.

A. Choice of Medically Needy Groups

1. *Provision:* Subject to specific requirements discussed later pertaining to children and pregnant women, a State has discretion to extend eligibility to any of the groups of individuals listed in section 1905(a) of the Act who are not eligible as categorically needy. The groups listed in section 1905(a) of the Act are:

a. Caretaker relatives (formerly identified in regulations as part of the families with dependent children group).
b. Aged.
c. Blind.
d. Disabled.
e. Persons under age 21 (discussed below in section IV, "Individuals Under Age 21").

Congress also indentified another medically needy group, certain pregnant women who would be eligible for Medicaid as categorically needy, except for income and resources. This specific group is discussed below in section V, "Pregnant Women".

This provision, regarding choice of medically needy groups, is provided for in this final rule by revising 42 CFR 435.301 and 436.301. Formerly, those sections required States to offer Medicaid to all medically needy groups if the medically needy option were chosen.

2. *Discussion:* The statutory basis for this provision is section 1902(a)(10)(C) of the Act, as amended by section 2171(a)(3) of the 1981 Amendments.

B. The "209(b) States"

1. *Provision:* The "209(b) States" have the same flexibility as other States in choosing which medically needy groups they provide for in the State plan. (This final rule provides for this by revising 42 CFR 435.321 and redesignating it as 435.330.)

2. *Discussion:* Section 209(b) of Pub. L. 92-603, which added section 1902(f) to the Act, gave States the option not to use SSI criteria for determining Medicaid eligibility for aged, blind or disabled individuals. Instead, a State could choose to determine eligibility for these groups according to more restrictive criteria used in their January 1, 1972 State Medicaid plan. States that choose this option are referred to as "209(b) States". The question arises whether a 209(b) State is allowed to drop portions of its medically needy program, that is, whether the 1981 Amendments give a 209(b) State the same option as other States in selecting the groups of medically needy that it will cover. Our current regulations at 42 CFR 435.121(b)(1) do not permit the 209(b) States to have more liberal standards for their categorically needy than the standards current in the SSI program. This regulation is based on the reading of section 1902(f) of the Act in conjunction with section 1902(a)(10)(A) of the Act.

"Notwithstanding any other provision of this title [(XIX) which requires States to provide Medicaid eligibility to all SSI recipients], no State * * * shall be required to provide medical assistance to any aged, blind, or disabled individual [unless the State would have been required to provide Medicaid to such individuals under its Medicaid plan in effect on January 1, 1972] * * *."

In our view, the obligation to provide Medicaid to aged, blind, and disabled individuals who would have been eligible for Medicaid under the January 1, 1972 plan is limited to those individuals (such as SSI recipients) whom the State is currently required to make Medicaid eligible by virtue of some other provision of the law. In this case, section 1902(a)(10)(A) of the Act requires States to make all SSI recipients eligible for Medicaid as categorically needy.

Regarding the medically needy, the 1981 Amendments have revised section 1902(a)(10)(C) of the Act so that States with a medically needy program are no longer required to provide eligibility for the aged, blind, *and* the disabled. We believe that the 209(b) States which had a medically needy program in 1972 are no longer required to continue to cover all groups of medically needy and, therefore, may eliminate the medically needy program for any or all of their medically needy group.

We believe that this view is consistent with the intent of section 1902(f) of the Act that was to allow States flexibility in administering their Medicaid programs by being more restrictive in their policies than the SSI program, while providing a certain amount of protection to individuals adversely affected by this option. We do not believe the intent was to deny the 209(b) States the options otherwise available to all States. With this in mind, and in view of the flexibility clearly intended by Congress and expressed in the amended language of the Act, we believe that 209(b) States should have the same options for selection of medically needy groups as other States, and we provide for this in these regulations. (See 42 CFR 435.321 which is revised and redesignated in this rule as 435.330.)

We note, however, that these final regulations do not affect the current requirements governing "spend down" of the categorically needy in 209(b) States (see 42 CFR 435.732)—regardless of whether the State has a medically needy program. ("Spend down" means that an individual incurs medical expenses in the amount by which his income exceeds a prescribed financial eligibility level.)

C. All Individuals in a Group

1. *Provision:* If the State plan provides for Medicaid to any individuals in a

group, the agency must provide Medicaid benefits for all individuals eligible to be in that group. (See revised sections, 42 CFR 435.301 and 436.301 of this final rule.) The only time the State plan may provide for a classification, or subgroup, is in the case of individuals under 21 years of age. (See new sections 42 CFR 435.308 and 436.308 of this final rule.)

2. *Discussion:* This provision is based on the new section 1902(a)(10)(C) of the Act that defines the medically needy, in part, as any *group* of individuals described in section 1905(a) of the Act. The only subgroups specified in section 1905(a) are those under age 21. Section 1905(a)(i) of the Act describes individuals "under the age of 21, or, at the option of the State, under the age of 20, 19, or 18 as the State may choose, or *any reasonable category of such individuals"* (emphasis added).

The issue is whether the State can limit eligibility to subgroups of any of the other groups in section 1905(a) of the Act. The phrase "any reasonable category" is used in the provision that addresses the under age 21 group. Therefore, we believe that Congress intended that if the State plan provides for any other group specified in section 1905(a) of the Act, such as the aged, the plan must provide for all the individuals who are eligible to be in that group.

D. State-Established Criteria

1. *Provision:* The State plan must include a description of the criteria for determining the eligibility of each medically needy group.

2. *Discussion:* This provision implements section 1902(a)(10(C)(i) of the Act, as amended by the 1981 Amendments. That section of the Act requires States that choose the medically needy option to describe the eligibility criteria. Existing Federal regulations (42 CFR 435.10 and 436.10) contain a general requirement that State plans specify the eligibility criteria for the medically needy; and this final rule does not amend those sections. However, as discussed below, this final rule does contain new regulatory language that requires State plans to specify certain eligibility criteria, such as the medically needy income and resource standards.

E. Medically Needy Income Level (MNIL)

1. *Provisions:* The State plan must specify the MNIL. The MNIL—

a. May be the same for all covered groups, or vary from group to group;

b. Must be the same for all members within a group;

c. Must be based on family size; and

d. Must be reasonable, as described below.

(These provisions are contained in 42 CFR 435.811 through 435.814, 436.811, and 436.812, as revised by this final rule, and in the new § 436.814.)

2. *Discussion:* Before the 1981 Amendments, the States were required to use an income standard (referred to as the medically needy income level (MNIL)) that met the following requirements:

a. The MNIL had to be determined by family size.

b. There had to be one MNIL for all medically needy.

c. The level had to be at least equal to the highest of all the income levels used in the cash assistance programs.

d. If 133⅓ percent of the payment standard for AFDC cash assistance was lower than the standard arrived at in "c", the State could adjust the MNIL downward to 133⅓ percent of the AFDC standard. This was allowed because Federal financial participation (FFP) was not available for medical assistance to a medically needy individual with income in excess of 133⅓ percent of the AFDC standard. (See section 1903(f) of the Act.)

The 1981 Amendments did not remove the requirement in section 1903(f) of the Act that, for FFP purposes, the MNIL cannot be higher than 133⅓ percent of the AFDC payment standard. Because that section of the statute also relates the cap provision to family size, and this is reasonable under section 1902(a)(17) of the Act, these final regulations maintain the requirement that States continue to set their MNILs according to family size.

The 1981 Amendments gave flexibility to the States in determining the eligibility criteria for the medically needy. Those criteria need not be the same for all covered groups. The amendments, however, did not revise section 1902(a)(17) of the Act, which mandates that income eligibility requirements be reasonable and comparable. Therefore, these final regulations mandate that the MNIL standard be the same for all members within the same covered group of medically needy. However, given the intent of Congress to "provide States with flexibility in establishing eligibility criteria and scope of services within the medically needy program to address the needs of different population groups more appropriately" (H.R. Rep. 97–208, p. 971) and the statutory change that no longer requires eligibility for all medically needy groups, we are reinterpreting comparability to allow different standards for each medically needy group. Also, the standards must be reasonable.

These regulations do not mandate a specific MNIL that the State must use for a medically needy group. On the contrary, the State is free to select one that it believes is most appropriate, provided that the standard is based on family size and uniform for all members of a group, as discussed above. However, any standard that the agency provides for in its Medicaid plan must also meet the requirement of "reasonableness" of section 1902(a)(17) of the Act; and HCFA will review the State's standards against that norm. The following are MNILs that HCFA will presume to be reasonable:

a. The State plan may provide that one standard is used for all medically needy groups; and that standard at least equals the highest of the income standards used for any of the cash assistance programs related to those medically needy groups, or 133⅓ percent of the AFDC cash standard (the cap provision of section 1903(f) of the Act), if that amount is lower. (For example, in a State that provides only for medically needy that are AFDC-related and blind-related, the State would use a uniform MNIL, subject to the 1903(f) cap, at least as high as the highest standard derived from the cash assistance programs for the AFDC and the blind.) This is a continuation of the practice established under the previous regulations. It is reasonable standard for the medically needy since it is based on the highest cash assistance standard, subject to the cap of section 1903(f) of the Act.

b. The State plan may provide for multiple standards that vary by medically needy groups, and the level for each group at least equals the income standard of the appropriate cash assistance program related to that group, or 133⅓ percent of the AFDC cash standard (the cap provision of section 1903(f) of the Act), if that amount is lower. (For example, in a State that provides only for medically needy AFDC- and blind-related, the State would use MNILs at least as high as the standards of the AFDC cash assistance program and of the cash assistance program for the blind for their respective medically needy groups.) This is reasonable as well, given the fact that States are no longer required to cover all medically needy groups and that Congress expressed its intent that the needs of each group be addressed more appropriately (H.R. Rep. 97–208, p. 971).

c. In the case of "209(b) States", the State plan may provide that the MNIL for aged, blind, disabled, or AFDC-type

individuals is set as specified in "a" or "b". However, for the aged, blind, and disabled individuals, the MNIL in a 209(b) State may be set at a lower level, but not below the respective levels for those groups as provided for in the State's January 1, 1972 plan.

If a State wishes to use a MNIL lower than the options described above in "a", "b", and "c", HCFA will not presume it to be reasonable. Rather, the State must describe the standard chosen and explain why, in the State's view, the standard satisfies the requirement of section 1902(a)(17) of the Act. (For example, a State could show that the SSI level, which is set nationally, might be more generous in that State (where the State does not supplement SSI) given the cost of living in that State.) Although we intend to be deferential to the State's judgment as to what is reasonable, we have a statutory responsibility to review it carefully before approval. We also invite comments and suggestions regarding what criteria, other than those indicated above in "a" through "c", States might use in setting income levels for determining the eligibility of the medically needy.

F. Medically Needy Resource Standards

1. *Provision:* The State plan must specify the resource standards. Those standards:

a. Must be based on family size;

b. May be the same for all groups of medically needy, or vary by group; and

c. Must be reasonable, as discussed below.

(See 42 CFR 435.840, 435.841, 436.840 as revised by this final rule, and the new §§ 435.843, 436.841, and 436.843.)

2. *Discussion:* Resource standards are criteria that measure an individual's financial assets, such as personal property and bank accounts, to determine whether they are low enough to enable one to be eligible for assistance. Before the 1981 Amendments, States were required to apply resource standards according to requirements specified in Federal statute (1902(a)(17) of the Act) and regulations (for example, 42 CFR 435.840 and 435.841). The resource standards had to be (a) comparable for all medically needy, (b) related to family size, and (c) at least equal to the highest resource standard used in the related cash assistance programs.

These regulations give a State agency extensive discretion in establishing its resource standards for the medically needy. The rule on this point is analogous to the rule for MNILs. Thus, HCFA will presume each of the following options to be reasonable:

a. The State plan may provide for one resource standard for all medically needy groups, if that standard is at least equal to the highest resource standard used in the related cash assistance programs.

b. The State plan may provide for multiple resource standards that vary by medically needy group, if the level for each group is at least as high as the standards of the related cash assistance group.

c. In the case of "209(b) States", the State plan may provide that the resource standard be set as in "a" or "b". Moreover, the resource standard level may be set for the aged, blind, and disabled individuals at lower levels, but not below the respective levels for those groups, as provided for in the State's January 1, 1972 plan.

If a State plan provides for a resource standard lower than specified in "a", "b", and "c", HCFA will not presume reasonableness. Rather, the State agency must describe the standard chosen, and that standard must be reviewed and approved by HCFA against the test of reasonableness in section 1902(a)(17) of the Act. We also invite comments as to what options, other than those specified above, the State might select for resource standards.

G. Treatment of Income and Resources

1. *Provisions:* States are no longer required to apply a uniform methodology for treating income and resources in such matters as deemed income, interest, court-ordered support payments, and infrequent and irregular income. Rather, the State plan must specify the methodology that will be used; and that methodology must be reasonable. (See 42 CFR 435.850–435.852 and 436.850–436.852, as added by this final rule.)

2. *Discussion:* Before the 1981 Amendments, the methodology for treatment of income and resources of the medically needy depended on the individuals' relationship to a specific cash assistance program. For example, the methodology for deeming the income of medically needy aged, blind, and disabled was taken from the SSI program. This was based on the former wording of section 1902(a)(10) of the Act that described the medically needy, in part, as individuals who "except for income and resources" would be eligible for cash assistance and for Medicaid as categorically needy. Furthermore, section 1902(a)(17)(C) of the Act required that the methodology for the treatment of income and resources be reasonable and gave the Secretary authority to prescribe standards regarding that methodology.

Section 2171 of the 1981 Amendments revised the Medicaid statute so that the direct linkage between the cash assistance programs and the medically needy is no longer explicit. (The statute no longer defines the medically needy as those who would be categorically needy "except for income and resources.") Therefore, we have concluded that the State need not adopt the methodology of a related cash assistance program in treating income and resources of the medically needy. Rather, the State may develop its own. However, section 1902(a)(17)(C) of the Act has not been amended. Consequently, these final regulations require that the State must use a methodology for the treatment of income and resources that is reasonable.

The rule on this point is analogous to the rule for MNILS. Therefore, HCFA will presume the treatment of income and resources to be reasonable if the methodology is the same as that used in the cash assistance program related to the covered medically needy group. If the agency uses a different methodology, HCFA will not presume reasonableness. Rather, the agency must describe the methodology chosen, and that methodology must be reviewed and approved by HCFA.

Also, if a State uses the cash assistance level as the MNIL but wishes to use differing methodologies for the treatment of income and resources, the description must include information on the impact of the methodology. This is part of the information HCFA will use to review "reasonableness". We note that if a State uses a different methodology for determining income—and the MNIL is officially the same as the cash assistance level—the actual income levels for eligibility could be different because the components of the calculation differ.

At this time, we also invite comments and suggestions as to what methodologies for the treatment of income and resources, other than those specified above, would be reasonable.

We emphasize, at this point, that in determining eligibility, States must continue to disregard income and resources in the same manner as the related cash assistance programs. This is provided for in section 1902(a)(17)(B) of the Act, and is unchanged by this rule. (See 42 CFR 435.831 and 436.831.)

H. Individuals Under Age 21

1. *Provisions:* If the State adopts a medically needy program, the State plan must provide for individuals under age 21 (or, at State option, under the age of

20, 19, or 18) or any reasonable category of such individuals. (See 42 CFR 435.301 and 436.301 as revised by this rule, and 435.308 and 436.308 as added by this rule.)

2. *Discussion:* This provision implements sections 1902(a)(10)(C)(ii)(I) and 1905(a)(i) of the Act, and is discussed below in section IV, "Individuals Under Age 21".

I. Pregnant Women

1. *Provision:* If the State covers the medically needy, the State plan must provide services for pregnant women, during the course of their pregnancy, who but for income and resources would be eligible as categorically needy. (See 42 CFR 435.301 and 436.301 as revised by this rule.)

2. *Discussion:* This provision implements section 1902(a)(10)(C)(ii)(II) of the Act, and is discussed below in section V, "Pregnant Women".

IV. Individuals Under Age 21

A. Prior Legislation

Before the 1981 Amendments, States were permitted to limit coverage of "dependent children" under their AFDC plans to individuals under age 18. At State option, they could cover students age 18 through 20 who were regularly attending primary, secondary, or vocational school. Furthermore, they could cover individuals age 18 through 20 attending college.

For Medicaid purposes, States were required to cover as categorically needy all individuals under age 21 who were AFDC recipients. States also had to cover, as categorically needy, those who were not AFDC recipients, but would have been except they did not meet age and school attendance requirements. For example, States were required to make eligible for Medicaid as categorically needy a 19 year old who was deprived of parental support and who met the financial criteria for AFDC, but was not in school and thus did not receive AFDC. States could offer Medicaid to the caretaker relatives of these children.

States had the option to cover as categorically needy all individuals under age 21 who would have qualified for AFDC financially, but were not AFDC eligible because they were not deprived of parental support. Furthermore, States could provide Medicaid to all of these individuals or, under Federal regulations, could limit Medicaid eligibility to reasonable classifications of these individuals (42 CFR 435.222 and 436.222).

B. Legislative Changes

By the 1981 Amendments, Congress simultaneously changed the AFDC and the Medicaid programs, both to limit AFDC and to provide more flexibility for Medicaid. Section 2311 of this legislation amended the AFDC program to lower the age limit for coverage of children. States may now limit coverage of otherwise eligible children to individuals under age 18. States also have the option to extend this to individuals under age 19 for children who are attending a secondary school, or receiving the equivalent of technical or vocational training. States can no longer cover as a dependent child an individual 19 years of age or older. Furthermore, attendance at college can no longer be used to qualify an individual over age 18.

Sections 2171 and 2172 of the 1981 amendments made several changes in the Medicaid eligibility rules. States continue to be required to cover as categorically needy all AFDC recipient children. However, States are no longer required to cover, as categorically needy, individuals who are not AFDC recipients, but who would be eligible for AFDC except for age and school requirements. States continue to have the option to cover all individuals under age 21 if they meet certain financial criteria. They are now allowed, however, to limit coverage, by age, to individuals under age 20, or to individuals under age 19 or 18. (However, the State Medicaid agency cannot exclude the 18-year-olds who meet the definition of dependent child under the State AFDC plan.) Furthermore, the statute now specifies that States may limit Medicaid eligibility to "any reasonable category" of individuals within the age range chosen. However, since States must cover AFDC recipients, the "reasonable categories" of the categorically needy must include all AFDC recipient children.

With respect to the medically needy, in section 2171 of the 1981 amendments, Congress required all States which choose to have a medically needy program to make some provision for Medicaid coverage of individuals under age 21 who are not AFDC recipients. (See section 1902(a)(10)(C)(ii)(I) of the Act.) However, Congress gave the States discretion to target assistance for this group, based on the States' priorities for expenditure of Medicaid funds and their assessment of those most in need, by providing the age range and reasonable classification choices described above.

C. Provisions of These Regulations

In order to conform to the above legislative changes, the following provisions are included in this final rule.

1. The State plan must provide Medicaid to individuals under age 19 who receive AFDC assistance as dependent children under the State title IV–A plan. (See 42 CFR 435.3 and 436.2 as revised by this rule.)

Note.—If the State AFDC agency chooses to limit the definition of dependent children to individuals under 18 years of age and limits cash assistance to that age group, the Medicaid agency is only required to offer medical assistance to those under 18 years of age. These persons are included among the mandated categorically needy.

2. The State plan may include under the optional categorically needy those individuals under age 21 (or, at the State option, under age 20, 19, or 18) who do not qualify as AFDC dependent children. In addition, States may limit coverage to reasonable classifications of these persons. (See 42 CFR 435.222 and 436.222, as revised by this rule.) Examples of reasonable classifications are as follows:

a. Individuals in foster homes or private institutions for whom a public agency is assuming a full or partial financial responsibility. If the agency covers these individuals, it may also provide Medicaid to individuals placed in foster homes or private institutions by private nonprofit agencies.

b. Individuals in adoptions subsidized in full or in part by a public agency.

c. Individuals in intermediate care facilities, if intermediate care facility services are provided under the plan. If the agency covers these individuals, it may also provide Medicaid to individuals in intermediate care facilities for the mentally retarded.

3. If the State plan includes the medically needy, the plan must provide medical assistance for individuals meeting the State's income standards who are under age 21 (or, at State option, under 20, 19, or 18), or reasonable classifications of these individuals. However, the statute does not specify whether these individuals must be provided for as medically needy or categorically needy. (As categorically needy, they would be identified as children who would be eligible for AFDC if they met the definition of dependent child. See 42 CFR 435.222 and 436.222. These individuals are also referred to as "Ribicoff children".) Accordingly, these regulations do not mandate the coverage group under which States are to provide for these persons. That decision rests with the

States. Therefore, the State plan may satisfy this requirement by providing for the under age 21 group as categorically needy (these are in addition to AFDC recipients under age 21 and are identified above in item 2) or as medically needy. (See 42 CFR 435.301 and 436.301, as amended by this rule.)

V. Pregnant Women

A. Prior Legislation

Before the 1981 Amendments, title IV–A of the Act (AFDC) did not specifically mention pregnant women. However, by Federal regulations, States were permitted to cover unborn children in their AFDC plans. This had the effect of also permitting States to provide for a pregnant woman, even if she had no other children, under AFDC.

For Medicaid purposes, States were required to cover all AFDC recipients; and, if States provided AFDC for unborn children, this included unborn children and their mothers. Furthermore, States could, at their option, cover unborn children and their mothers even if AFDC did not cover them. Under this option, States could extend Medicaid eligibility as categorically needy; and, if a State with a medically needy program covered unborn children as categorically needy, it was also required to cover them as medically needy.

B. Legislative Changes

The 1981 Amendments excluded payments to meet the needs of unborn children from the definition of AFDC. The statutory language now focuses on pregnant women. Furthermore, the effect of the Amendments is to limit AFDC coverage. AFDC now may be provided to a pregnant woman "only if it has been medically verified that the child is expected to be born in the month such payments are made or within the three-month period following such month of payment, and who if such child had been born and was living with her in the month of payment, would be eligible for aid to families with dependent children" (section 406(b) of the Act).

If a State opts to cover these pregnant women for AFDC, it must also cover them for Medicaid as categorically needy. Furthermore, in order to enable States to provide medical assistance to women throughout pregnancy, Congress added a new provision, section 406(g) of the Act. This section enables States, for purposes of Medicaid eligibility, to deem a woman to be an AFDC recipient, who would otherwise be eligible for AFDC if the child were born and living with her, as soon as pregnancy is medically verified. These deemed AFDC recipients must also be covered for Medicaid as categorically needy. If a State has chosen the "deemed AFDC option" and chooses to have a medically needy program, then the State must cover as medically needy all pregnant women who , but for income and resources, would be eligible as categorically needy, and who meet the medically needy financial requirements.

C. Provisions of These Regulations

1. *Categorically needy.* The State Medicaid plan must provide for all pregnant women who, at State option, are deemed to be recipients of AFDC under section 406(g)(2) of the Act. (See 42 CFR 435.115 and 436.114 which are added by this rule.) This provision implements section 1902(a)(10)(A) of the Act, as amended by section 2171(a)(1) of the 1981 Amendments. (It should be noted that neither the 1981 amendments nor these final regulations change the requirement that the Medicaid agency must provide Medicaid to pregnant women actually receiving AFDC or SSI.)

2. *Medically needy.* The State Medicaid plan must provide Medicaid to pregnant women during the course of their pregnancy who, but for income and resources, would be eligible for Medicaid as categorically needy. (This includes pregnant women who would have been eligible for AFDC, or for one of the other cash assistance programs, such as SSI.) (See 42 CFR 435.301 and 436.301, as amended by this rule.) This provision implements section 1902 (a)(10)(C)(i)(II) of the Act, as provided for by section 2171(a)(3) of the 1981 Amendments.

VI. Covered Services for the medically needy

A. Prior Legislation

Since the enactment of the Act in 1965, the coverage of services for the medically needy has been conditioned, in part, by the coverage provisions related to the categorically needy. Before the 1981 Amendments, the Act contained the following provisions regarding coverage of services for the categorically needy:

1. Under section 1902(a)(13)(B), State plans had to include services specified in section 1905(a)(1)–(5) and (17) of the Act for all categorically needy. These services include such items as physician services, inpatient and outpatient hospital services, and skilled nursing facility (SNF) services for individuals 21 years of age and older.

2. Under section 1902(a)(13)(B), States could provide any number of additional services, specified in section 1905(a)(6)–(16) and (18) of the Act, for the categorically needy. These include items such as dental services, intermediate-care facility services, and clinic services.

3. Under section 1902(a)(10)(B), all the categorically needy had to be entitled to the same amount, duration, and scope of services. (The law does specify, however, certain limitations in some cases. For example, SNF services in an institution for mental diseases are limited to persons 65 years of age and older (see section 1905(a)(14) and clause following section 1905(a)(18) of the Act).

4. Under section 1902 (a)(13)(A), States had to provide for the inclusion of some institutional and some noninstitutional services and to provide for home health services for any individual entitled to skilled nursing facility services. (These two requirements applied to both the categorically and medically needy under the State plan.)

Before the 1981 Amendments, the Act also contained the following provisions for services to the medically needy:

1. Under section 1902(a)(10)(B), the amount, duration, and scope of services offered to the medically needy could not be more than the amount, duration, or scope of services offered to the categorically needy.

2. Under section 1902(a)(10)(C), all the medically needy had to be entitled to the same amount, duration and scope of services, the comparability of services requirement.

3. Under 1902(a)(13)(C), States that chose the medically needy option were required, at a minimum, to offer the medically needy either all the services mandated for the categorically needy (sections 1905(a)(1)–(5) and (17) of the Act) or, as an alternative, the care and services listed in any 7 of the 17 paragraphs defining covered services under Medicaid (section 1905(a)(1)–(17) of the Act). If the State chose the latter option for the medically needy, it was required to provide physician services to individuals receiving covered inpatient hospital or SNF services.

B. Legislative Changes

The 1981 Amendments did not change the substance of the provisions regarding covered services for the categorically needy, although it moved the requirements formerly in section 1902(a)(13)(B) of the Act to section 1902(a)(10)(A). However, section 2171 of the 1981 Amendments deleted most of the requirements regarding coverage of services for the medically needy, thereby giving States greater flexibility in designing their Medicaid plans for this population group. In general, the States are permitted to choose the

services to be offered to the medically needy without being bound by requirements pertaining to a minimum number of services or a mix of institutional and noninstitutional services. Furthermore, the comparability of services provisions of the former statute have been deleted concerning services to different medically needy groups. (See section 2171(a)(3) of the 1981 Amendments.) States may now offer one set of services for a certain medically needy group, for example, the aged, without being required to offer them to all the medically needy groups. The amendments enable States to focus their resources on those services most urgently needed by specific population groups. These are the groups listed in section 1905(a) of the Act. The State is required, however, to furnish certain specified services to designated individuals. Thus, it is required to furnish ambulatory services to children under age 18, and to individuals entitled to institutional services. Also, the State must provide prenatal and delivery care to pregnant women. Third, if the State plan includes services either in institutions for mental diseases or in intermediate care facilities for the mentally retarded, it must offer a range of services specified in the statute. Finally, the State plan must include home health services for individuals entitled to SNF care.

C. Provisions of These Regulations

These provisions are taken directly from section 2171 of the 1981 Amendments, and they apply only if the State chooses to provide medical assistance for the medically needy:

1. The plan must describe the amount, duration, and scope of services for each covered group of the medically needy. (See 42 CFR 440.230, as amended by this rule.)

2. The State plan must provide that the services available to any member of a covered medically needy group are not less in amount, duration, and scope of services available to other members of that group. Exceptions to this rule are specified below in items 4 and 6. (See 42 CFR 440.240, as amended by this rule.)

3. The services provided for one group of medically needy (for example, the aged) need not be the same in amount, duration, and scope as the services for all medically needy groups. In other words, this rule deletes from current Federal regulations any reference to comparability of services for the medically needy groups. The statutory basis for this deletion is contained in section 2171(a)(3) of the 1981 Amendments which deletes the requirement (formerly section 1902(a)(10)(C)(ii) of the Act) that comparability of services be provided for the medically needy. (See 42 CFR 440.240, as amended by this rule.)

4. The State plan must provide ambulatory services to the following medically needy:

a. Children under 18.

b. Individuals entitled to institutional services. (See 42 CFR 440.220, as amended by this rule.)

We do not define "ambulatory services" in these regulations, but leave that to the States. This will afford States greater flexibility in designing a health care package that will best meet the needs of the population in question. At this time, however, we wish to note that, in the Conference Committee report on the 1981 Amendments, Congress indicated its view that the term ambulatory services means physician, clinic, nurse practitioner, dental, and preventive services (see H.R. Rep. No. 97-208, p. 971). (We believe that this is not to be understood as an all-inclusive list, but only a list of examples.) In the same conference report, the Congress also stated it expects the State to offer a service of sufficient amount, duration, and scope to achieve its purpose.

We further note that, in providing these ambulatory services, the State plan—

a. Must define ambulatory services (See 42 CFR 440.220, as revised by this rule);

b. Need not offer all of the ambulatory services that are offered to the categorically needy, or to other groups of medically needy; and

c. May not offer ambulatory services to the medically needy that are not also offered to the categorically needy.

5. If the plan includes services in institutions for mental diseases (see section 1905(a)(14) or (16) of the Act), or services in an intermediate care facility for the mentally retarded (see section 1905(a)(15) and (d) of the Act), it must offer a full range of services to all the medically needy. (See 42 CFR 440.220, as revised by this rule.) To fulfill this requirement, the State plan has the following options.

a. The State plan may offer those services specified in section 1905(a)(1) through (5) and (17). These are: inpatient hospital services; outpatient hospital services and rural health clinic services; other laboratory and x-ray services; skilled nursing facility services for individuals age 21 or older, early and periodic screening diagnosis and treatment of individuals under age 21, and family planning services and supplies for individuals of child-bearing age; physicians' services; and nurse-midwife services. (Section 965 of Pub. L. 96-499, the Omnibus Reconciliation Act of 1980, mandates payment under Medicaid for nurse-midwife services under certain circumstances. These services are being provided for in 42 CFR 440.165, and we are issuing a separate rule that defines nurse-midwife services.)

b. As an alternative, the State plan may offer any seven services specified in section 1905(a)(1) through (17) in the Act. Those include the services specified above in paragraph "a", plus the following: other practitioners' services; home health care; private duty nursing services; clinic services; dental services; physical therapy and related services; prescribed drugs, dentures, prosthetic devices, and eyeglasses; other diagnostic, screening, preventive, and rehabilitative services; inpatient hospital, skilled nursing facility, and intermediate care facility services for individuals age 65 and older in an institution for mental diseases or tuberculosis; intermediate care facility services (not in a mental institution); and inpatient services for individuals under age 21 in a psychiatric facility.

c. The State plan may offer option "a" to some medically needy groups, while offering option "b" to others.

The requirement that the State plan must offer this range of services is provided for in section 2171(a)(3) of the 1981 Amendments. It should be noted, however, that in accordance with item number 2, above, the amount, duration, and scope of these services need not be the same for all medically needy groups.

6. The plan must provide for prenatal care and delivery services for all eligible pregnant women. (See 42 CFR 440.220, as revised by this rule.)

7. Home health services must be offered to individuals entitled to skilled nursing facility services. (See 42 CFR 440.220, as revised by this rule.)

Some sections of these regulations are affected by statutory provisions that are implemented by other regulations documents also being published at this time. It would be confusing to present the same section with different wording in different documents (by making, in each document, only the particular changes called for by the statutory provisions implemented by that document). In order to avoid this problem, the sections affected by more than one provision are presented in each document with all the changes required by each of the provisions of law that affect them. However, each of the changes is explained only once, in the preamble of the regulations document that implements the provision which requires that particular change.

VII. Waiver of Proposed Rulemaking

We are publishing these regulations in final form without notice of proposed rulemaking procedures. We believe the rapid implementation of these regulations is desirable in order to give States maximum flexibility in their Medicaid programs. To delay the effective date of these regulations by following a proposed rulemaking procedure would be contrary to the public interest. Also, Congress expressly addressed the issuance of interim final regulations as an option for the development of regulations to implement changes in section 1902(a)(10(C) of the Act (section 2161 of the 1981 Amendments). Moreover, the provisions of these regulations follow closely the language of the statute which is clear.

We, therefore, find good cause to waive notice of proposed rulemaking procedures. However, we invite comments from States and others interested in the provisions of this rule, and we will publish in the **Federal Register** any changes to the regulations that are appropriate.

VIII. Dates

These regulations are effective October 1, 1981. However, that effective date does not permit States time to comply with the new State plan requirements, such as specifying whether the plan provides for participants in work supplementation programs are covered as categorically needy (see, for example 42 CFR 435.115). To accommodate this need, HCFA will not hold a State out of compliance with these requirements if the Medicaid agency submits the preprinted plan amendments and required attachments by December 31, 1981.

IX. Impact Analysis

A. Executive Order 12291

The Secretary has determined, in accordance with Executive Order 12291, that this rule does not constitute a major rule because it will not have an annual effect on the economy of $100 million or more; result in a major increase in costs or prices for consumers, any industries, any governmental agencies or any geographic regions; or otherwise meet the thresholds of the Executive Order. Any substantial economic impacts are attributable to the statute itself, rather than these regulations.

There are no data available on the actual cost impact of the provisions of the new statute. We anticipate the statutory amendments affecting Medicaid eligibility changes will result in fiscal year 1982 savings. However, it is not possible to project how many States (and to what extent) will actually take advantage of the options made available as a result of the amendments. We anticipate significant savings resulting from AFDC related caseload reductions, but these savings are not covered by these regulations.

B. Regulatory Flexibility Analysis

The Secretary certifies, under Section 605(b) of the Regulatory Flexibility Act (Pub. L. 96-354) that these regulations will not have a significant economic impact on a substantial number of small entities. (A small entity is a small business, a non-profit enterprise, or a small governmental jurisdiction.) As explained above, these regulations provide flexibility to States in determining population and services coverage for the "medically needy". We have no basis for predicting the specific decisions States will make, but these decisions may in some cases adversely impact particular providers in particular locations, through a reduction in coverage and hence income. However, we have no reason to believe that coverage limitations will be so substantial as to threaten the economic viability of health care providers or otherwise cause a "significant" impact on a "substantial" number of providers.

42 CFR Chapter IV is amended as set forth below:

PART 435—ELIGIBILITY IN THE STATES AND DISTRICT OF COLUMBIA

1. The authority citation for Part 435 reads as follows:

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

2. Section 435.1 is amended by adding a new paragraph (e) to read as follows:

§ 435.1 Introduction.

* * * * *

(e) Changes in Medicaid eligibility as a result of Pub. L. 97-35—

(1) *General purposes.* The intent of this legislation is to give States more flexibility in determining which individuals will be eligible for Medicaid.

(2) *Categorically needy.* If participants of a work supplementation program are deemed to be AFDC recipients under section 414 of the Act, the State must make them eligible for Medicaid. If certain pregnant women are deemed to be AFDC recipients under section 406 of the Act, the State must make them eligible for Medicaid. The State must provide Medicaid to individuals who are denied AFDC cash payment solely because the payment would be less than $10 a month (section 402(a) of the Act). The upper age limit of AFDC dependent children has been lowered from under age 21 to under age 19.

(3) *Medically needy.* The State is no longer required to include among the medically needy all those groups formerly mandated under the statute, that is the aged, blind, disabled, and families with dependent children, who do not receive cash assistance and whose income and resources are insufficient to enable them to pay for the cost of necessary health care. Rather, the State may restrict participation in the State Medicaid program to some of those groups. However, if the State chooses to provide for medically needy under the State plan, it must provide medical assistance to individuals under age 21, or a younger age, or reasonable classifications, as determined by the State (section 1905(a)(i) of the Act), and to pregnant women who, but for income and resources, would be included among the cagetorically needy (section 1902(a)(10)(C)(ii) of the Act).

3. Section 435.3 is amended to read as follows:

§ 435.3 Basis.

This part implements the following sections of the Act, which state eligibility requirements and standards:

* * * * *

1902(b) Prohibited conditions for eligibility:

* * * * *

Age requirement excluding children under age 19 who meet the definition of dependent child under the State title IV-A plan;

* * * * *

1905(a)(i)-(vii) List of eligible individuals.

* * * * *

4. In § 435.4 the definition "medically needy" is revised to read as follows:

§ 435.4 Definitions and use of terms.

As used in this part—

* * * * *

"Medically needy" means aged, blind, or disabled individuals or families and children who are otherwise eligible for Medicaid, who are not categorically needy, and whose income and resources are within limits set under the Medicaid State plan;

* * * * *

5. The table of contents is amended by removing § 435.111 and adding a new § 435.115 to read as follows:

Subpart B—Mandatory Coverage of the Categorically Needy

* * * * *

435.115 Individuals deemed to be receving AFDC.

* * * * *

§ 435.111 [Removed]

6. Section 435.111 is removed.

7. A new § 435.115 is added to read as follows:

§ 435.115 Individuals deemed to be receiving AFDC.

(a) The Medicaid agency must provide Medicaid to individuals deemed to be receiving AFDC, as specified in this section.

(b) The State must deem individuals to be receiving AFDC who are denied a cash payment from the title IV–A State agency solely because the amount of the AFDC payment would be less than $10.

(c) The State may deem pregnant women to be receiving AFDC under section 406(g)(2) of the Act. This section permits States, for purposes of title XIX, to deem a pregnant woman to be receiving AFDC if—

(1) She would be eligible for AFDC cash payments if the child had been born and was living with her in the month of payment; and

(2) The pregnancy has been medically verified.

(d) The State may deem participants in a work supplementation program to be receiving AFDC under section 414(g) of the Act. This section permits States, for purposes of title XIX, to deem an individual and any child or relative of the individual (or other individual living in the same household) to be receiving AFDC, if the individual—

(1) Participates in a State-operated work supplementation program under section 414 of the Act; and

(2) Would be eligible for an AFDC cash payment if the individual were not participating in the work supplementation program.

8. Section 435.120 is revised to read as follows:

§ 435.120 Individuals receiving SSI.

(a) *General provisions.* Except as allowed under § 435.121, the agency must provide Medicaid to aged, blind, and disabled individuals or couples who receive SSI, including—

(1) Individuals receiving SSI pending a final determination of blindness or disability;

(2) Individuals receiving SSI under an agreement with the Social Security Administration to dispose of resources that exceed the SSI dollar limits on resources; and

(3) From January 1, 1981 until December 31, 1983, individuals considered to be receiving SSI under 1619(b) of the Act (blind individuals or those with disabling impairments whose income equals or exceeds a specific SSI limit). (See 20 CFR 416.263–416.269 for determinations of eligibility under this provision.)

(b) *Exclusion.* Individuals entitled to benefits under section 1622 of the Act are not to be considered individuals receiving SSI. Section 1622 of the Act provides for certain individuals whose minimum benefits under title II of the Act were reduced by section 2201 of Pub. L. 97–35.

9. Section 435.121 is amended by revising paragraph (c) to read as follows:

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

* * * * *

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

(1) Section 435.135, treatment of individuals who receive OASDI cost-of-living increases.

(2) Section 435.330, medically needy coverage.

(3) Section 435.530, more restrictive definitions of blindness.

(4) Section 435.540, more restrictive definitions of disability.

(5) Sections 435.731 through 435.733, more restrictive income and resource requirements.

(6) Sections 435.812, 435.823, 435.831, and 435.841, medically needy financial eligibility requirements.

10. The table of contents is amended by removing § 435.221.

§ 435.221 [Removed]

11. Section 435.221 is removed.

12. Section 435.222 is revised to read as follows:

§ 435.222 Individuals under age 21 who would be eligible for AFDC but do not qualify as dependent children.

(a) The agency may provide Medicaid to individuals under age 21 (or, at State option, under age 20, 19 or 18) who would be eligible for AFDC if they met the definition of dependent child. (See 45 CFR 233.90(c)(1).)

(b) The agency may cover all individuals described in paragraph (a) of this section or in reasonable classifications of those individuals. Examples of reasonable classifications are as follows:

(1) Individuals in foster homes or private institutions for whom a public agency is assuming a full or partial financial responsibility. If the agency covers these individuals, it may also provide Medicaid to individuals of the same age placed in foster homes or private institutions by private nonprofit agencies.

(2) Individuals in adoptions subsidized in full or part by a public agency.

(3) Individuals in intermediate care facilities, if intermediate care facility services are provided under the plan. If the agency covers these individuals, it may also provide Medicaid to individuals in intermediate care facilities for the mentally retarded.

(4) Individuals under age 21 receiving active treatment as inpatients in pyschiatric facilities or programs, if inpatient psychiatric services for individuals under 21 are provided under the plan.

13. Section 435.223 is revised to read 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 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.

(b) The agency may cover any AFDC optional group without covering all such groups.

14. The table of contents is amended by adding §§ 435.308, 435.322, 435.324, 435.330, and 435.340, revising §§ 435.310 and 435.320, and removing §§ 435.321 and 435.325 as follows:

Subpart D—Optional Coverage of the Medically Needy

435.300 Scope.
435.301 General rule.
* * * * *
435.308 Medically needy coverage of individuals under age 21.
435.310 Medically needy coverage of caretaker relatives.
435.320 Medically needy coverage of aged in States that cover individuals receiving SSI.
435.322 Medically needy coverage of the blind in States that cover individuals receiving SSI.
435.324 Medically needy coverage of the disabled in States that cover individuals receiving SSI.
435.330 Medically needy coverage of aged, blind, and disabled individuals in States that impose more restrictive eligibility requirements.
435.340 Protected medically needy coverage for blind and disabled individuals eligible in December 1973.
* * * * *

15. Sections 435.301 is revised to read as follows:

§ 435.301 General rules.

(a) A medicaid agency may provide Medicaid to individuals specified in this subpart who—

(1) Either—

(i) Have income that meets the applicable standards in §§ 435.812 through 435.814; or

(ii) If their income is more than allowed under those standards, have incurred medical expenses at least equal to the difference between their income and the applicable income standard; and

(2) Have resources that meet the applicable standards in §§ 435.840 through 435.843.

(b) If the agency chooses this option, the following provisions apply:

(1) The agency must provide Medicaid to—

(i) All pregnant women during the course of their pregnancy who, but for income and resources, would be eligible for Medicaid as categorically needy; and

(ii) All individuals under age 21 (or, at State option, under age 20, 19, or 18), as specified in § 435.308. For purposes of this requirement, the agency may provide for individuals under age 21 as—

(A) Categorically needy, as specified in § 435.222; or

(B) Medically needy, as specified in § 435.308.

(2) The agency may provide Medicaid to any of the following groups of individuals:

(i) Individuals under age 21 (§ 435.308).

(ii) Caretaker relatives (§ 435.310).

(iii) Aged (§§ 435.320 and 435.330).

(iv) Blind (§§ 435.322, 435.330 and 435.340).

(v) Disabled (§§ 435.324, 435.330 and 435.340).

(3) If the agency provides Medicaid to any individual in a group specified in paragraph (b)(2) of this section, the agency must provide Medicaid to all individuals eligible to be members of that group.

16. A new § 435.308 is added to read as follows:

§ 435.308 Medically needy coverage of individuals under age 21.

(a) If the agency provides Medicaid to the medically needy, it must provide Medicaid to individuals under age 21 (or, at State option, under age 20, 19, or 18), as specified in paragraph (b) of this section, who meet the income and resource standards in Subpart I of this part. (See § 435.301 for required coverage as either categorically or medically needy.)

(b) The agency may cover all individuals described in paragraph (a) of this section or reasonable classifications of those individuals. Examples of reasonable classifications are as follows:

(1) Individuals in foster homes or private institutions for whom a public agency is assuming a full or partial financial responsibility. If the agency covers these individuals, it may also provide Medicaid to individuals placed in foster homes or private institutions by private nonprofit agencies.

(2) Individuals in adoptions subsidized in full or in part by a public agency.

(3) Individuals in intermediate care facilities, if intermediate care facility services are provided under the plan. If the agency covers these individuals, it may also provide Medicaid to individuals in intermediate care facilities for the mentally retarded.

(4) Individuals receiving active treatment as inpatients in psychiatric facilities or programs, if inpatient psychiatric services for individuals under 21 are provided under the plan.

17. Section 435.310 is revised to read as follows:

§ 435.310 Medically needy coverage of caretaker relatives.

(a) If the agency provides for the medically needy, it may provide Medicaid to caretaker relatives, as specified in paragraph (b) of this section, who meet the income and resource standards of Subpart I of this part.

(b) "Caretaker relatives" mean individuals who—

(1) Meet the definition of a caretaker relative under 45 CFR 233.90(c)(1)(v)(A); and

(2) Have in their care an individual who is determined to be dependent, as specified in § 435.510.

18. Section 435.320 is revised to read as follows:

§ 435.320 Medically needy coverage of the aged in States that cover individuals receiving SSI.

If the agency provides Medicaid to individuals receiving SSI and elects to cover the medically needy, it may provide Medicaid to individuals who—

(a) Are 65 years of age and older, as specified in § 435.520; and

(b) Meet the income and resource requirements of Subpart I of this part.

19. A new § 435.322 is added to read as follows:

§ 435.322 Medically needy coverage of the blind in States that cover individuals receiving SSI.

If the agency provides Medicaid to individuals receiving SSI and elects to cover the medically needy, it may provide Medicaid to blind individuals who meet—

(a) The requirements for blindness, as specified in §§ 435.530 and 435.531; and

(b) The income and resource requirements of Subpart I of this part.

20. A new § 435.324 is added to read as follows:

§ 435.324 Medically needy coverage of the disabled in States that cover individuals receiving SSI.

If the agency provides Medicaid to individuals receiving SSI and elects to cover the medically needy, it may provide Medicaid to disabled individual who meet—

(a) The requirements for disability, as specified in §§ 535.540 and 435.541; and

(b) The income and resource requirements of Subpart I of this part.

21. Section 435.321 is redesignated as § 435.330 and revised to read as follows:

§ 435.330 Medically needy coverage of the aged, blind, and disabled in States that impose eligibility requirements more restrictive than used under SSI.

(a) If an agency provides Medicaid as categorically needy only to those aged, blind, or disabled individuals who meet more restrictive requirements than used under SSI and elects to cover the medically needy, it may provide Medicaid as medically needy to those aged, blind, or disabled individuals who—

(1) Are not categorically needy, as specified in paragraph (b) of this section;

(2) Have income and resources within the standards established under Subpart I of this part; and

(3) If applying as blind or disabled, meet the blindness or disability requirements established under § 435.121.

(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.

(2) Consider as medically needy all other individuals.

22. Section 435.325 is redesignated as § 435.340 and revised to read as follows:

§ 435.340 Protected medically needy coverage for blind and disabled individuals eligible in December 1973.

If an agency provides Medicaid to the medically needy, it must cover individuals who—

(a) Where eligible as medically needy under the Medicaid plan in December 1973 on the basis of the blindness or disability criteria of the AB, APTD, or AABD plan;

(b) For each consecutive month after December 1973, continue to meet—

(1) Those blindness or disability criteria; and

(2) The eligibility requirements for the medically needy under the December 1973 Medicaid plan; and

(c) Meet the current requirements for eligibility as medically needy under the Medicaid plan except for blindness or disability criteria.

23. Section 435.520 is amended by revising paragraph (a) to read as follows:

§ 435.520 Age requirements for the aged and children.

(a) The agency must not impose—

(1) An age requirement of more than 65 years;

(2) An age requirement that excludes an individual under age 19 who meets the definition of dependent child under the State title IV–A plan; or

(3) A lower age requirement than that under the State's AFDC plan.

* * * * *

24. The table of contents for Subpart I is revised as follows:

Subpart I—Financial requirements for the medically needy

435.800 Scope.

Medically Needy Income Standards

435.811 Medically needy income standards: General requirements.
435.812 Medically needy income standards: Reasonableness.
435.813 [Reserved]
435.814 Medically needy income standards: State plan requirements.
435.815 [Reserved]

Financial Responsibility of Relatives

435.821 Financial responsibility of relatives: Individuals under the age 21 and caretaker relatives.
435.822 Financial responsibility of relatives of aged, blind, or disabled individuals in States using SSI eligibility requirements.
435.823 Financial responsibility of relatives of aged, blind, or disabled individuals in States using more restrictive requirements than SSI.

Medically Needy Income Eligibility

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

Medically Needed Resource Standards

435.840 Medically needy resource standards: General requirements.
435.841 Medically needy resource standards: Reasonableness.
435.843 Medically needy resource standards: State plan requirements.

Determining Eligibility on the Basis of Resources

435.845 Medically needy resource eligibility.

Treatment of Income and Resources

435.850 Treatment of income and resources: General requirements.
435.851 Treatment of income and resources: Reasonableness.
435.852 Treatment of income and resources: State plan requirements.

25. Section 435.811 is revised to read as follows:

Medically Needy Income Standards

§ 435.811 Medically needy income standards: General requirements.

To determine eligibility of medically needy individuals, a Medicaid agency must use an income standard under this subpart that is—

(a) Based on family size;

(b) Uniform for all individuals in a covered group;

(c) For FFP purposes, not in excess of 133⅓ percent of the highest money payment that ordinarily would be made in the State AFDC program to an individual or a family of comparable size (see § 435.1007); and

(d) Reasonable (see § 435.812).

26. Section 435.812 is revised to read as follows:

§ 435.812 Medically needy income standards: Reasonableness.

(a) The agency must use a medically needy income standard that is reasonable.

(b) The following medically needy income standards are presumed to be reasonable:

(1) The agency provides one medically needy income standard for all covered medically needy groups. Except as provided in paragraphs (c) and (d) of this section, the standard must at least equal the highest income or payment standard used to determine eligibility in the cash assistance programs (or an optional State supplement, if the agency provides Medicaid under § 435.230) related to the covered medically needy groups.

(2) The agency provides a different medically needy income standard for each covered medically needy group. Except as provided in paragraphs (c) and (d) of this section, the standard for each covered group must at least equal the income or payment standard used to determine eligibility in the cash assistance program (or an optional State supplement, if the agency provides Medicaid under § 435.230) related to that covered medically needy group.

(c) The agency may use a lower medically needy income standard than the standards specified in paragraph (b) of this section if—

(1) The income standard used under paragraph (b) of this section exceeds the maximum dollar amount on income allowed for purposes of FFP under § 435.1007; and

(2) The lower income standard at least equals the maximum amount allowed for purposes of FFP.

(d) In the case of an agency that provides Medicaid for the aged, blind, or disabled individuals only if they meet more restrictive requirements than used under SSI, the following provisions apply:

(1) The agency may use an income standard for those individuals that is lower than the standard specified in paragraph (b) of this section.

(2) The lower standard must at least equal the medically needy income standard for those aged, blind, or disabled individuals under the State's plan on January 1, 1972.

(e) If the agency uses a medically needy income standard not specified in paragraphs (b) through (d) of this section—

(1) That standard is not presumed to be reasonable; and

(2) HCFA must approve the standard.

27. Section 435.814 is revised to read as follows:

§ 435.814 Medically needy income standards: State plan requirements.

(a) The State plan must specify the income standard for each covered medically needy group.

(b) If the agency uses an income standard that is not presumed to be reasonable under § 435.812, the State plan must describe that standard.

§ 435.816 [Removed]

28. Section 435.816 is removed.

29. Section 435.821 is revised to read as follows:

§ 435.821 Financial responsibility of relatives: Individuals under age 21 and caretaker relatives.

(a) The agency must meet the requirements of this section in determining eligibility—

(1) Under § 435.308 of medically needy individuals under age 21; and

(2) Under § 435.310 of medically needy caretaker relatives.

(b) The agency must consider income and resources that are actually contributed by the spouse or parent as available to the individual.

(c) The agency may consider income and resources of spouses or parents as available to the individual even if they are not actually contributed to the individual.

30. Section 435.822 is revised to read as follows:

§ 435.822 Financial responsibility of relatives of aged, blind, or disabled individuals in States using SSI eligibility requirements.

(a) The agency must meet the requirements of this section in determining eligibility—

(1) Under § 435.320 of medically needy aged individuals;

(2) Under § 435.322 of medically needy blind individuals; and

(3) Under § 435.324 of medically needy disabled individuals.

(b) For aged, blind, or disabled individuals with spouses, the agency—

(1) Must consider income and resources that are actually contributed by one spouse to another; and

(2) May consider income and resources of spouses as available to each other even if they are not actually contributed.

(c) For blind or disabled individuals under age 21—

(1) The agency must consider the parent's or spouse's income and resources as available if they are actually contributed to the individual; and

(2) The agency may consider the parent's or spouse's income and resources as available even if they are not actually contributed.

31. Section 435.823 is revised to read as follows:

§ 435.823 Financial responsibility of relatives of aged, blind, or disabled individuals in States using more restrictive requirements than SSI.

(a) The agency must meet the requirements of this section in determining eligibility under § 435.330 of medically needy aged, blind, and disabled individuals.

(b) For aged, blind, or disabled individuals with spouses, the agency—

(1) Must consider income and resources as available if they are actually contributed by one spouse to the other; and

(2) May consider income and resources of spouses as available to each other even if they are not actually contributed.

(c) For blind or disabled individuals under age 21, the agency—

(1) Must consider the parent's or spouse's income and resources as available if they are actually contributed to the individual; and

(2) May consider the parent's or spouse's income and resources as available even if they are not actually contributed.

32. In § 435.831, paragraphs (a)(1), (b), and (d) are revised 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.

(1) For individuals under age 21 and caretaker relatives, the agency must deduct amounts that would be deducted in determining eligibility under the State's AFDC 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 under § 435.814, the individual or family is eligible for Medicaid.

* * * * *

(d) *Eligibility based on incurred medical expenses.* Once deduction of incurred medical expenses reduces income to the income standard, the individual is eligible for Medicaid.

33. Section 435.832(c) (2)(iii) and (3) are revised as follows:

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

* * * * *

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

* * * * *

(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—

* * * * *

(iii) The amount of the highest medically needy income standards for one person established under § 435.814.

(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 highest of the following need standards for a family of the same size:

(A) The standard used to determine eligibility under the State's approved AFDC plan.

(B) The standards used to determine eligibility under the State's Medicaid plan, as provided for in § 435.814.

* * * * *

34. Section 435.840 is revised to read as follows:

§ 435.840 Medically needy resource standards: General requirements.

To determine eligibility of medically needy individuals, a Medicaid agency must use a resource standard under this subpart that is—

(a) Based on family size;

(b) Uniform for all individuals in a group; and

(c) Reasonable.

35. Section 435.841 is revised to read as follows:

§ 435.841 Medically needy resource standards: Reasonableness.

(a) The agency must use a medically needy resource standard that is reasonable, according to the provisions of this section.

(b) The following medically needy resource standards are presumed to be reasonable:

(1) The agency provides one medically needy resource standard for all covered medically needy groups. Except as provided in paragraph (c) of this section, the standard must at least equal the highest resource standard used to determine eligibility in the cash assistance programs (or an optional State supplement, if the agency provides Medicaid under § 430.230) related to the covered medically needy groups.

(2) The agency provides a different medically needy resource standard for each covered medically needy group. Except as provided in paragraph (c) of this section, the standard for each covered group must at least equal the resource standard used to determine eligibility in the cash assistance program

(or an optional State supplement, if the agency provides Medicaid under § 435.230) related to that covered medically needy group.

(c) In the case of an agency that provides Medicaid for the aged, blind, or disabled individuals only if they meet more restrictive requirements than used under SSI, the following provisions apply:

(1) The agency may use a resource standard for those individuals that is lower than the standard specified in paragraph (b) of this section.

(2) The lower standard must at least equal the medically needy resource standard for those aged, blind, or disabled individuals under the State's plan on January 1, 1972.

(d) If the Agency uses a medically needy resource standard not specified in paragraphs (b) and (c) of this section—

(1) That standard is not presumed to be reasonable; and

(2) HCFA must approve the standard.

36. A new § 435.843 is added to read as follows:

§ 435.843 Medically needy resource standards: State plan requirements.

(a) The State plan must specify the resource standard for each covered medically needy group.

(b) If the agency uses a resource standard that is not presumed to be reasonable under § 435.841, the State plan must describe that standard.

37. Section 435.845 is amended by revising paragraphs (c) and (f) to read as follows:

§ 435.845 Medically needy resource eligibility.

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

* * * * *

(c) For individuals under age 21 and caretaker relatives, deduct the value of resources that would be deducted in determining eligibility under the State's AFDC plan;

* * * * *

(f) Apply the resource standards established under § 435.843.

38. A new § 435.850 is added to read as follows:

Treatment of Income and Resources

§ 435.850 Treatment of income and resources: General requirements.

To determine eligibility of medically needy individuals, a Medicaid agency must use a methodology for the treatment of income and resources that is—

(a) Uniform for all individuals in a covered group; and

(b) Reasonable (see § 435.851).

39. A new § 435.851 is added to read as follows:

§ 435.851 Treatment of income and resources: Reasonableness.

(a) The agency must use a methodology for the treatment of income and resources, to determine eligibility of the medically needy, that is reasonable.

(b) The methodology used to determine eligibility of individuals in the cash assistance program related to the covered medically needy group is presumed to be reasonable.

(c) If the agency provides Medicaid for the aged, blind, or disabled individuals who meet more restrictive requirements than used under SSI, the methodology for the treatment of income and resources of those aged, blind, or disabled individuals under the State's plan on January 1, 1972, is presumed to be reasonable.

(d) If the agency uses a methodology not described in paragraphs (b) and (c) of this section—

(1) The methodology is not presumed to be reasonable; and

(2) HCFA must approve that methodology.

40. A new § 435.852 is added to read as follows:

§ 435.852 Treatment of income and resources: State plan requirements.

(a) The State's plan must specify the methodology used to treat the income and resources for each covered medically needy group.

(b) If the agency uses a methodology that is not presumed to be reasonable under § 435.851, the State plan must describe that methodology.

PART 436—ELIGIBILITY IN GUAM, PUERTO RICO, AND THE VIRGIN ISLANDS

41. The authority citation for Part 436 reads as follows:

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

42. Section 436.2 is amended by changing the wording of the second item listed under 1902(b) as follows:

§ 436.2 Basis.

This part implements the following sections of the Act, which state requirements and standards for eligibility:

* * * * *

1902(b) Prohibited conditions for eligibility: Age requirement of more than 65 years; Age requirement excluding children under age 19 who meet the definition of dependent child under the State title IV–A plan;

* * * * *

43. Section 436.3 is amended by revising the definition for "medically needy" as follows:

§ 436.3 Definitions and use of terms.

As used in this part—

* * * * *

"Medically needy" means aged, blind, or disabled individuals or families and children who are otherwise eligible for Medicaid, who are not categorically needy and whose income and resources are within limits set under the Medicaid State plan.

* * * * *

44. The Table of Contents is amended by adding a new § 436.114 and by removing § 436.115 as follows:

Subpart B—Mandatory Coverage of the Categorically Needy

* * * * *

436.114 Individuals deemed to be AFDC recipients.

* * * * *

45. A new § 436.114 is added to read as follows:

§ 436.114 Individuals deemed to be receiving AFDC.

(a) The Medicaid agency must provide Medicaid to individuals deemed to be receiving AFDC, as specified in this section.

(b) The State must deem individuals to be receiving AFDC who are denied a cash payment from the title IV–A State agency solely because the amount of the AFDC payment would be less than $10.

(c) The State may deem pregnant women to be receiving AFDC under section 406(g)(2) of the Act. This section permits States, for purposes of title XIX, to deem a pregnant woman to be receiving AFDC if—

(1) She would be eligible for AFDC cash payments if the child had been born and was living with her in the month of payment; and

(2) The pregnancy has been medically verified.

(d) The State may deem participants in a work supplementation program to be receiving AFDC under section 414(g) of the Act. This section permits States, for purposes of title XIX, to deem an individual and any child or relative of the individual (or other individual living in the same household) to be receiving AFDC, if the individual—

(1) Participates in a State-operated work supplementation program under section 414 of the Act; and

(2) Would be eligible for an AFDC cash payment if the individual were not participating in the work supplementation program.

§ 436.115 [Removed]

46. Section 436.115 is removed.

47. The Table of Contents is amended by removing § 436.221.

48. Section 436.212(a)(1) is revised 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 members of families with an unemployed parent even though the State's AFDC plan does not include them); or

* * * * *

§ 436.221 [Removed]

49. Section 436.221 is removed.

50. Section 436.222 is revised to read as follows:

§ 436.222 Individuals under age 21 who would be eligible for AFDC but do not qualify as dependent children.

(a) The agency may provide Medicaid to individuals under age 21 (or, at State option, under age 20, 19 or 18) who would be eligible for AFDC if they met the definition of dependent child. (See 45 CFR 233.90(c)(1).)

(b) The agency may cover all individuals described in paragraph (a) of this section or reasonable classifications of those individuals. Examples of reasonable classifications are as follows:

(1) Individuals in foster homes or private institutions for whom a public agency is assuming a full or partial financial responsibility. If the agency covers these individuals, it may also provide Medicaid to individuals of the same age in foster homes or private institutions by private nonprofit agencies.

(2) Individuals in adoptions subsidized in full or in part by a public agency.

(3) Individuals in intermediate care facilities, if intermediate care facility services are provided under the plan. If the agency covers these individuals, it may also provide Medicaid to individuals in intermediate care facilities for the mentally retarded.

(4) Individuals receiving active treatment as inpatients in psychiatric facilities or programs, if inpatient psychiatric services for individuals under 21 are provided under the plan.

51. The Table of Contents for Subpart D of Part 436 is revised as follows:

Subpart D—Optional Coverage of the Medically Needy

436.300 Scope.
436.301 General rules.
436.308 Medically needy coverage of individuals under age 21.
436.310 Medically needy coverage of caretaker relatives.
436.320 Medically needy coverage of the aged.
436.321 Medically needy coverage of the blind.
436.322 Medically needy coverage of the disabled.

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

52. Section 436.301 is revised to read as follows:

§ 436.301 General rules.

(a) A Medicaid agency may provide Medicaid to individuals specified in this subpart who—

(1) Either—

(i) Have income that meets the standards in § 436.814; or

(ii) If their income is more than allowed under those standards, have incurred medical expenses at least equal to the difference between their income and the applicable income standards; and

(2) Have resources that meet the standards in § 436.843.

(b) If the agency chooses this option, the following provisions apply:

(1) The agency must provide Medicaid to—

(i) All pregnant women during the course of their pregnancy who, but for income and resources, would be eligible for Medicaid as categorically needy; and

(ii) All individuals under age 21 (or, at State option, under age 20, 19, or 18), or specified in § 436.308. For purposes of this requirement, the agency must provide for individuals under age 21 as—

(A) Categorically needy, as specified in § 436.222; or

(B) Medically needy, as specified in § 436.308.

(2) The agency may provide Medicaid to any or all of the following groups of individuals:

(i) Individuals under age 21 (§ 436.308).

(ii) Caretaker relatives (§ 436.310).

(iii) Aged (§ 436.320).

(iv) Blind (§ 436.321).

(v) Disabled (§ 436.322).

(3) If the agency provides Medicaid to any individual in a group specified in paragraph (b)(2) of this section, the agency must provide Medicaid to all individuals eligible to be members of that group.

53. A new § 436.308 is added to read as follows:

§ 436.308 Medically needy coverage of individuals under age 21.

(a) If the agency provides Medicaid to the medically needy, it must provide Medicaid to individual under age 21 (or, at State option, under age 20, 19, or 18), as specified in paragraph (b) of this section, who meet the income and resource standards in Subpart I of this part. (See § 436.301 for required coverage as either categorically or medically needy.)

(b) The agency may cover all individuals in paragraph (a) of this section or individuals in reasonable classifications. Examples of reasonable classifications are as follows:

(1) Individuals in foster homes or private institutions for whom a public agency is assuming a full or partial financial responsibility. If the agency covers these individuals, it may also provide Medicaid to individuals placed in foster homes or private institutions by private nonprofit agencies.

(2) Individuals in adoptions subsidized in full or in part by a public agency.

(3) Individuals in intermediate care facilities, if intermediate care facility services are provided under the plan. If the agency covers these individuals, it may also provide Medicaid to individuals in intermediate care facilities for the mentally retarded.

(4) Individuals receiving active treatment as inpatients in psychiatric facilities or programs, if inpatient psychiatric services for individuals under 21 are provided under the plan.

54. Section 436.310 is revised to read as follows:

§ 436.310 Medically needy coverage of caretaker relatives.

(a) If the agency provides for the medically needy, it may provide Medicaid to caretaker relatives, as specified in paragraphs (b), (c), and (d) of this section, who meet the income and resource standards of Subpart I of this part.

(b) "Caretaker relatives" mean individuals who—

(1) Meet the definition of a caretaker relative under 45 CFR 233.90(c)(1)(v)(A); and

(2) Have in their care an individual who is determined to be dependent, as specified in § 436.510.

55. Section 436.320 is revised to read as follows:

§ 436.320 Medically needy coverage of the aged.

If the agency provides Medicaid to the medically needy, it may provide Medicaid to individuals who—

(a) Are 65 years of age and older, as provided for in § 436.520; and

(b) Meet the income and resource requirements of Subpart I of this part.

56. A new § 436.321 is added to read as follows:

§ 436.321 Medically needy coverage of the blind.

If the agency provides Medicaid to the medically needy, it may provide Medicaid to blind individuals who meet—

(a) The requirements for blindness, as specified in §§ 436.530 and 436.531; and

(b) The income and resource requirements of Subpart I of this part.

57. A new § 436.322 is added to read as follows:

§ 436.322 Medically needy coverage of the disabled.

If the agency provides Medicaid to the medically needy, it may provide Medicaid to disabled individuals who meet—

(a) The requirements for disability, as specified in §§ 436.540 and 436.541; and

(b) The income and resource requirements of Subpart I of this part.

§ 436.330 [Removed]

58. Section 436.330 is removed.

59. Section 436.520 is amended by revising paragraph (a) to read as follows:

§ 436.520 Age requirements for the aged and children.

(a) The agency must not impose—

(1) An age requirement of more than 65 years;

(2) An age requirement that excludes an individual under age 19 who meets the definition of dependent child under the State title IV–A plan; or

(3) A lower age requirement than that under the State AFDC plan.

* * * * *

60. Section 436.811 is revised to read as follows:

§ 436.811 Medically needy income standards: General requirements.

To determine eligibility of medically needy individuals, the agency must use an income standard under this subpart that is—

(a) Based on family size;

(b) Uniform for all individuals in a covered group;

(c) Reasonable; and

(d) For FFP purposes, not in excess of 133⅓ percent of the highest money payment that ordinarily would be made in the State AFDC program to an individual or a family of comparable size (see § 435.1007).

61. Section 436.812 is revised to read as follows:

§ 436.812 Medically needy income standards: Reasonableness.

(a) The agency must use a medically needy income standard that is reasonable, according to the provisions of this section.

(b) The following medically needy income standards are presumed to be reasonable:

(1) The agency provides for one medically needy income standard for all covered medically needy groups. Except as provided in paragraph (c) of this section, that standard must at least equal the highest income standard used on or after January 1, 1966, to determine eligibility for the OAA, AFDC, AB, APTD, and AABD programs that are related to the covered medically needy groups.

(2) The agency provides for a different medically needy income standard for each covered medically needy group. Except as provided in paragraph (c) of this section, the standard for each covered group must at least equal the income standard used on or after January 1, 1966, to determine eligibility for the OAA, AFDC, AB, APTD, or AABD program that is related to that covered medically needy group.

(c) The agency may use a medically needy income standard, that is lower than the standards specified in paragraph (b) of this section, if—

(1) The medically needy income standard in paragraph (b) of this section exceeds the maximum dollar amount or income allowed for purposes of FFP under §435.1007; and

(2) The lower income standard at least equals the maximum amount allowed for purposes of FFP.

(d) If the agency provides for a medically needy income standard not specified in paragraphs (b) or (c) of this section—

(1) That standard is not presumed to be reasonable; and

(2) HCFA must approve that standard.

62. A new § 436.814 is added to read as follows:

§ 436.814 Medically needy income standard: State plan requirements.

(a) The State plan must specify the income standard for each covered medically needy group.

(b) If the agency provides for an income standard that is not presumed to be reasonable under § 435.812, the State plan must describe that standard.

63. Section 436.821 is amended by revising the introductory text and paragraph (a) as follows:

§ 436.821 Financial responsibility of spouses and parents.

In determining eligibility of medically needy individuals, the agency may use the rules for determining whether the income of a spouse or parent is available to the individual that would be used if he were applying for OAA, AFDC, AB, APTD or AABD. However—

(a) For individuals under age 21 and caretaker relatives, the agency must consider parental income and resources available to a child who is living with the parent until he becomes 21, even if State law confers adult status below age 21; and

* * * * *

64. Section 436.831 is amended by revising paragraphs (b) and (d) to read 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.

* * * * *

(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 § 436.814, the individual is eligible for Medicaid.

* * * * *

(d) *Eligibility based on incurred medical expenses.* Once deduction of incurred medical expenses reduces income to the income standard, the individual is eligible for Medicaid.

* * * * *

65. Section 436.832(c) (2) and (3) are revised 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.

* * * * *

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

* * * * *

(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 highest medically needy income standard for one person established under § 436.814.

(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 highest of the following need standards for a family of the same size:

(A) The standard used to determine eligibility under the State's Medicaid plan, as provided for in § 436.814.

(B) The standard used to determine eligibility under the State's approved AFDC plan.

* * * * *

66. Section 436.840 is revised to read as follows:

§ 436.840 Medically needy resource standards: General requirements.

To determine eligibility of medically needy individuals, the Medicaid agency must use a resource standard under this subpart that is—

(a) Based on family size;

(b) Uniform for all individuals in a group; and

(c) Reasonable.

67. A new § 436.841 is added to read as follows:

§ 436.841 Medically needy resource standards: Reasonableness.

(a) The agency must use a medically needy resource standard that is reasonable, according to the provisions of this section.

(b) The following medically needy resource standards are presumed to be reasonable:

(1) The agency provides one medically needy resource standard for all covered medically needy groups. The standard must at least equal the highest resource standard used on or after January 1, 1966, to determine eligibility for the OAA, AFDC, AB, APTD, and AABD programs that are related to the covered medically needy groups.

(2) The agency provides for a different medically needy resource standard for each covered medically needy group. The standard for each covered group must at least equal the resource standard used on or after January 1, 1966, to determine eligibility for the OAA, AFDC, AB, APTD, or AABD program that is related to that covered medically needy group.

(c) If the agency provides for a medically needy resource standard not specified in paragraph (b) of this section—

(1) That standard is not presumed to be reasonable; and

(2) HCFA must approve the standard.

68. A new § 436.843 is added to read as follows:

§ 436.843 Medically needy resource standards: State plan requirements.

(a) The State plan must specify the resource standard for each covered medically needy group.

(b) If the agency provides for a resource standard that is not presumed reasonable under § 435.841, the State plan must describe that standard.

69. Section 436.845 is amended by revising paragraph (d) to read as follows:

§ 436.845 Medically needy resource eligibility.

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

* * * * *

(d) Apply the resource standards established under § 436.843.

70. A new § 436.850 is added to read as follows:

Treatment of Income and Resources

§ 436.850 Treatment of income and resources: General requirements.

To determine eligibility of medically needy individuals, a Medicaid agency must use a methodology for the treatment of income and resources that is—

(a) Uniform for all individuals in a covered group; and

(b) Reasonable (see § 436.851).

71. A new § 436.851 is added to read as follows:

§ 436.851 Treatment of income and resources: Reasonableness.

(a) The agency must use a methodology for the treatment of income and resources, to determine eligibility of the medically needy, that is reasonable.

(b) The methodology used to determine eligibility of cash assistance program related to the covered medically needy group is presumed to be reasonable.

(c) If the agency uses a methodology not described in paragraph (b) of this section—

(1) The methodology is not presumed to be reasonable; and

(2) HCFA must approve that methodology.

72. A new § 436.852 is added to read as follows:

§ 436.852 Treatment of income and resources: State plan requirements.

(a) The State plan must specify the methodology used to treat the income and resources for each covered medically needy group.

(b) If the agency uses a methodology that is not presumed to be reasonable under § 436.851, the State plan must describe that methodology.

PART 440—SERVICES: GENERAL PROVISIONS

73. The Table of Contents is amended by adding a new § 440.165 to read as follows:

Subpart A—Definitions

* * * * *

440.165 Nurse-midwife services. [Reserved]

* * * * *

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

74. A new § 440.165 is added to read as follows:

§ 440.165 Nurse-midwife services. [Reserved]

75. Section 440.200 is revised to read as follows:

§ 440.200 Basis, purpose, and scope.

(a) This subpart implements—

(1) Section 1902(a)(10), regarding comparability of services for groups of recipients, and the amount, duration, and scope of services described in 1905(a) of the Act that the State plan must provide for recipients;

(2) Section 1902(a)(22)(D), which provides for standards and methods to assure quality of services; and

(3) Section 1907 on observance of religious beliefs.

(b) The requirements and limits of this subpart apply for all services defined in Subpart A of this part.

76. Section 440.220 is revised to read as follows:

§ 440.220 Required services for the medically needy.

Except as limited in § 440.250, a State plan that includes the medically needy must specify that the medically needy are provided, as a minimum, the following services:

(a) Prenatal care and delivery services for pregnant women.

(b) Ambulatory services, as defined in the State plan, for—

(1) Individuals under age 18; and

(2) Individuals entitled to institutional services.

(c) Home health services (§ 440.70) to any individual entitled to skilled nursing facility services.

(d) If the State plan includes services in an institution for mental diseases (§§ 440.140 and 440.160) or in an intermediate care facility for the mentally retarded (§ 440.150(c)) for any group of medically needy, either of the following sets of services to each of the medically needy groups:

(1) The services contained in §§ 440.10–440.50 and 440.165; or

(2) The services contained in any seven of the sections in §§ 440.10–440.165.

77. Section 440.230 is revised to read as follows:

§ 440.230 Sufficiency of amount, duration, and scope.

(a) The plan must specify the amount, duration, and scope of each service that it provides for—

(1) The categorically needy; and

(2) Each covered group of medically needy.

(b) Each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose.

(c) The Medicaid agency may not arbitrarily deny or reduce the amount, duration, or scope of a required service under §§ 440.210 and 440.220 to an otherwise eligible recipient solely because of the diagnosis, type of illness, or condition.

(d) The agency may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures.

78. Section 440.240 is revised to read as follows:

§ 440.240 Comparability of services for groups.

Except as limited in § 440.250—

(a) The plan must provide that the services available to any categorically needy recipient under the plan are not less in amount, duration, and scope than those services available to a medically needy recipient; and

(b) The plan must provide that the services available to any individual in the following groups are equal in amount, duration, and scope for all recipients within the group:

(1) The categorically needy.

(2) A covered medically needy group.

79. Section 440.250 is amended by adding new paragraphs (h) through (k) to read as follows:

§ 440.250 Limits on comparability of services.

* * * * *

(h) Ambulatory services for the medically needy (§ 440.220(b)) may be limited to—

(1) Individuals under age 18; and

(2) Individuals entitled to institutional services.

(i) Services provided under an exception to requirements allowed under § 431.54 may be limited as provided under that exception.

(j) If HCFA has approved a waiver of Medicaid requirements under § 431.55, services may be limited as provided by the waiver.

(k) If the agency has been granted a waiver of the requirements of § 440.240 (Comparability of services) in order to provide home or community-based services under § 440.180, the services provided under the waiver need not be comparable for all individuals within a group.

PART 441—SERVICES: REQUIREMENTS AND LIMITS APPLICABLE TO SPECIFIC SERVICES

80. The authority citation for Part 441 reads as follows:

Authority. Sec. 1102 of the Social Security Act, (42 U.S.C. 1302), unless otherwise noted.

81. Section 441.10 is amended by revising paragraph (a) to read as follows:

Subpart A—General Provisions

§ 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.

(a) Sections 1902(a)(10)(D) and 1905(a)(7) for home health services (§ 441.15).

* * * * *

(Catalog of Federal Domestic Assistance Program No. 13.714 Medical Assistance Program)

Dated: September 16, 1981.

Carolyne K. Davis,

Administrator, Health Care Financing Administration.

Approved: September 24, 1981.

Richard S. Schweiker,

Secretary.

[FR Doc. 81-28324 Filed 9-29-81; 8:45 am]

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Wednesday
September 30, 1981

Part V

Department of Health and Human Services

Health Care Financing Administration

Medicaid Program; Reductions in Payments to States

DEPARTMENT OF HEALTH AND HUMAN SERVICES

42 CFR Part 433

45 CFR Part 201

Medicaid Program; Reductions in Payments to the States

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

ACTION: Interim Final Rule with Comment Period.

SUMMARY: This rule amends current Medicaid regulations to implement section 2161 of the Omnibus Budget Reconciliation Act of 1981 (Pub. L. 97–35) which imposes reductions in Federal matching payments for fiscal years 1982 through 1984. In the regulations, we describe the conditions and specify minimum criteria under which States may lower the reduction. The conditions are the existence of a qualified hospital cost review program, a specific level of unemployment in a State, and a specific amount of fraud and abuse recoveries by a State or, for fiscal year 1982 only, a combination of fraud and abuse and third party liability recoveries. We intend these regulations to provide guidance as to when the reductions, and offsets against the reductions, will be made and how States can qualify for the offsets.

In addition, we have issued a notice of proposed rulemaking elsewhere in this issue of the **Federal Register** that contains proposed policies concerning recoveries from liable third parties for purposes of implementing section 2161.

DATES: This rule is effective September 30, 1981. It is being issued as a final rule for reasons explained in Waiver of Proposed Rulemaking in the Supplementary Information section below. However, we will consider any comments mailed by November 30, 1981, and revise the regulations, if necessary.

Sections 433.209 and 433.213 of these regulations contain reporting or recordkeeping requirements that have not been approved by the Office of Management and Budget (OMB). The reporting or recordkeeping referenced in these sections is not required until OMB approval has been obtained. HCFA will publish a further notice in the **Federal Register** when OMB approves or disapproves these requirements.

ADDRESS: Address comments in writing to: Administrator, Department of Health and Human Services, Health Care Financing Administration, P.O. Box 17076, Baltimore, Maryland 21235.

If you prefer, you may deliver your comments to Room 309–G Hubert H. Humphrey Building, 200 Independence Ave., S.W., Washington, D.C., or to Room 789, East High Rise Building, 6325 Security Boulevard, Baltimore, Maryland.

In commenting, please refer to BPO–26–FC. Agencies and organizations are requested to submit comments in duplicate.

Comments will be available for public inspection, beginning approximately two weeks after publication, in Room 309–G of the Department's office at 200 Independence Ave., S.W., Washington, D.C. 20201 on Monday through Friday of each week from 8:30 a.m. to 5:00 p.m. (202–245–7890).

Because of the large number of comments we receive, we cannot acknowledge or respond to them individually. However, if as a result of comments, we believe that changes are needed in these regulations, we will publish the changes in the **Federal Register** and respond to the comments in the preamble of that document.

FOR FURTHER INFORMATION CONTACT: Charles Schreibeis, 301–597–1702.

SUPPLEMENTARY INFORMATION:

I. Background

A. Program Description

Medicaid, authorized under title XIX of the Social Security Act, is a program that provides medical assistance to certain categories of individuals and families with low income. The program is funded by both the Federal government and the States, but is administered by the individual States. Each State designs its own program within certain Federal guidelines. Thus, there is substantial variation among the States in the nature of the program itself and in the way in which the program is administered. For example, eligibility requirements, the range of medical services provided to beneficiaries, and the policies governing the ways in which providers of health care services are reimbursed may differ extensively from State to State. Additionally, because of differing levels of administrative resources and the scope of individual programs, the various States emphasize specific administrative aspects of their program, such as fraud and abuse activities, to varying degrees.

Under current law, as noted above, Medicaid is financed jointly with Federal and State funds. Generally, the Federal government shares in the cost of health care services covered under each State's Medicaid program, with the Federal contribution determined under a statutory formula (sections 1903(a) and 1905(b) of the Social Security Act) that is designed to have the Federal government pay a proportionally larger share of the program in States with lower per capita income as compared to the national per capita income. The Federal government also shares in the cost of the administration of each State's Medicaid program (section 1903(a) of the Act).

B. Section 2161 of the Omnibus Budget Reconciliation Act of 1981

On August 13, 1981, the President signed the Omnibus Budget Reconciliation Act of 1981 (Pub. L. 97–35). Section 2161 of that Act added sections 1903(s) and (t) to the Social Security Act and mandated progressive reductions in total Federal Medicaid payments to the States for fiscal years 1982 through 1984. Under the law, Federal matching payments to which a State is entitled are to be reduced by three percent of each quarter's payment in fiscal year (FY) 1982, four percent in FY 83, and four and one half percent in FY 84. However, Congress provided that a State may lower the amount of its reduction by one percentage point for each quarter in the year for each of the following conditions:

- The State has in operation a qualified hospital cost review program.
- The State has an unemployment rate equal to or exceeding 150 percent of the national average.
- The State demonstrates recoveries of Medicaid funds, as a result of fraud and abuse initiatives, equal to one percent of the Federal share of total expenditures. With respect to FY 82 only, States may qualify for this decrease if the combination of recoveries from fraud and abuse and third party liability efforts is equal to one percent of the Federal share of total expenditures.

The legislation further provides that a State will be entitled to a dollar for dollar offset in the reductions if total Federal Medicaid funding of the State's program in a year falls below a specified target amount. However, the amount recovered by a State in this manner may not exceed the total amount of the original reduction for the fiscal year. Congress established the target amount for 1982 as equal to 109 percent of each State's estimate of the amount of Federal funding it needed for FY 81, and stipulated that the State estimates to be used would be those that were submitted to HCFA before April 1, 1981. For FY 83 and FY 84, the target amounts are equal to the FY 82 target amount increased or decreased by the same percentage as the increase or decrease in the index of the medical care

expenditure component of the consumer price index over the same period.

A review of the legislative history of section 2161 and the language of the section itself clearly indicate what Congress intends regarding the existence of a hospital cost review program. Section 2161 states the specific conditions (see section II A of this Preamble) that must be met, including requirements for the effective date of the program, its scope, its treatment of affected groups, and its results in terms of cost containment.

Regarding the offset for States with high unemployment, the statute provides that a State qualifies for the one percent offset in the reduction if the monthly average of unemployment for the quarter immediately preceding the quarter in which the offset is to be applied is equal to or greater than 150 percent of the national average for the same period.

For purposes of the offset gained by fraud and abuse recoveries, and for 1982 only, both fraud and abuse and third party liability recoveries, the statute simply provides that the recoveries for a quarter must equal or exceed one percent of the amount of Federal payments to the State in that quarter.

These provisions, and how we will apply them, are discussed in greater detail below.

Congress specifically applied the reductions, and the offset against the reductions, to the State with Medicaid plans approved as of July 1, 1981. This means that the reductions apply to all States and the District of Columbia, with the exception of Arizona, which does not participate in Medicaid. Other provisions of the Budget Act (section 2162) set limits on Federal funding for Medicaid programs in the other jurisdictions (Guam, Puerto Rico, the Virgin Islands and the Northern Mariana Islands).

Reductions in Medicaid payments to the States under section 2161 were made contingent on approval and publication of regulations by the Secretary implementing several other provisions of law, by the first day of the quarter in which the reductions are applied. First, Congress required that final regulations implementing section 1902(a)(10)(C) of the Social Security Act, as amended by section 2171 of the Omnibus Budget Reconciliation Act of 1981, relating to flexibility in Medicaid eligibility requirements, be published in the **Federal Register**. Second, Congress required that regulations implementing section 1902(a)(13)(A) of the Social Security Act, as amended by section 962 of the Omnibus Reconciliation Act of 1980 and section 2173 of the Omnibus Budget Reconciliation Act of 1981, relating to modifications in requirements for hospital, skilled nursing facility and intermediate care facility reimbursement, be published. The first set of regulations were published elsewhere in this issue, and the second set published elsewhere in this issue.

II. Provisions of the Regulations

A. Location and General Content

We have amended the existing Medicaid regulations in 42 CFR Part 433, State Fiscal Administration, by adding a new Subpart E, Reductions in Total Federal Payments to the States for fiscal years 1982–1984. The new subpart spells out the rules that will govern HCFA's administration of the statutory requirements. Specific provisions are explained below. In addition, we have made conforming changes in 42 CFR Part 433, Subpart A and 45 CFR Part 201. These changes are cross-references to the new subpart.

B. Notice of Proposed Rulemaking on Third Party Liability Recoveries

We issued a notice of proposed rulemaking elsewhere in this issue of the **Federal Register** containing a proposed description of what we mean by recoveries from liable third parties. We are providing the public with a 30 day period in which to comment on the proposal and will issue a final rule as soon as possible after the comment period is over. The final rule will consist of definitions of "third party" and "third party liability" to be included in § 433.203 and a new § 433.215 that will describe the use of recoveries from liable third parties in determining the offset against the FY82 reductions.

C. States with Qualified Hospital Cost Review Programs

Sections 433.207(a) and 433.209 of the new regulations are based on sections 1903 (s)(2)(A) and (s)(3) of the Social Security Act (as enacted by section 2161 of Pub. L. 97–35). Section 1903(s)(2)(A) specifies that the percentage reduction in FFP for a State that is required by the amendment for a quarter is to be decreased by one percentage point if the State has a qualified hospital cost review program for the quarter. Section 1903(s)(3) specifies that a program will be considered to be "qualified" if specific criteria are met. These criteria are as follows:

- The program must have been established by statute, and have been in effect on July 1, 1981, and at the beginning of the quarter in which offset against the reduction is granted;
- The program must be operated directly by the State;
- The program just apply to substantially all non-Federal acute care hospitals;
- Under the program, the State must review all non-Medicare revenues or expenses for inpatient hospital services, or at least 75 percent of all revenues or expenses for inpatient hospital services, including those under Medicare;
- The State must make satisfactory assurances to the Secretary that the program provides substantially equitable treatment to all payors, hospital employees and hospital patients; and
- The State's rate of increase in aggregate inpatient hospital costs per capita or per admission on a calendar year basis must be at least two percentage points lower than the rate of increase in all States without qualifying programs. The period of comparision is the most recent calendar year or, at the State's option, the two or three calendar year period ending at least nine months before the quarter covered by the Federal payment.

These conditions are set forth in § 433.209 of the new regulations as the criteria we will use to determine whether a State is entitled to a decrease in the reduction based on the existence of a qualified hospital cost review program. Since we believe these criteria are largely self-explanatory, we have not included any further description of our interpretation of them in § 433.209. To avoid any confusion as to how we intend to implement § 433.209, however, we are providing an explanation of the meaning of certain key phrases used in that section, as follows:

- *Established by statute.* We will consider a program to be "established by statute" if the statutory laws of the State provide a basis for the operation of the program.
- *In effect.* We will consider a program to have been "in effect" on July 1, 1981 if, on that date, rules or regulations for the conduct of the program had been issued and were in effect.
- *Operated directly by the State.* This means that the State must be directly involved in the operation of the program, or that final decisions under the program must be made by a State employee or by an individual or a commission (or similar body) appointed by the State
- *Substantially all.* We will consider a program to apply to "substantially all" non-Federal acute care hospitals in a State if it applies to all non-Federal acute care hospitals, with possible,

occasional exceptions for the purpose of dealing with extraordinary circumstances.

• *Review.* For purposes of § 433.209, we will consider review of revenue or expenses to mean an examination of:

(1) The reasonableness of a hospital's proposed revenue, expenses, or rate request for a prospective period that results in a determination that is binding on the hospital; or

(2) A hospital's past expenses, rates or revenue for purposes of establishing rates or restricting the revenue to be received by the hospital for services in future periods.

If a State does not review hospitals when their proposed expenses, revenues or rate increases are less than specified target levels, those hospitals would be considered to have been reviewed by the State for purposes of determining whether the program was qualified under this section.

• *Assurances regarding equitable treatment.* To meet this requirement, we are requiring that the State assure HCFA, in a letter signed by the administrator of the Medicaid State agency, that the State's review program provides for equitable treatment of all entities that pay hospitals for inpatient hospital services, all hospital employees, and all hospital patients. In the absence of a significant question about whether all entities are being treated equitably, we will not require the State to specify the basis for its assurances, or to provide further information regarding its manner of ensuring that payers, hospital employees, and patients are treated equitably.

• *Calculation of annual rates of increase in aggregate hospital inpatient costs on a calendar year basis.* In determining whether this requirement is met, we will use the best available national data base. However, no national data bases currently exist with individual or Statewide hospital expense data reported on a calendar year basis. Medicare cost reports, for example, are filed by hospitals based on their own fiscal years which vary throughout the calendar year.

The best available data base currently available is the American Hospital Association's Annual Survey of Hospitals. The expenses reported by AHA are total expense figures (outpatient as well as inpatient expenses). To compute inpatient admission expenses, adjustments are made for outpatient costs by using a ratio of outpatient revenue to total revenue to derive an adjusted admissions figure. HCFA will make a similar adjustment to compute an inpatient expense per capita.

For purposes of this Annual Survey, hospitals are requested by the American Hospital Association (AHA) to report each year's expenses based on their fiscal years ending closest to September 30. AHA then makes the data available from its Annual Survey in September of the year following the reporting date. (Approximately one-half of the hospitals report to AHA on the basis of fiscal years ending on September 30, one quarter on June 30, and the remainder vary throughout the calendar year.) This means that data reported to AHA for hospital reporting periods closest to September 30, 1980 will be available in late September, 1981.

In addition, in order to prepare a national data base for *calendar year* 1980, it is necessary to have available for *all* hospitals both their FY80 and FY81 expenditure data (except those with fiscal years ending on December 31). For example, a hospital whose fiscal year ended on September 30, 1980 would report to AHA its expenditure data for the period October 1, 1979 through September 30, 1980. At the end of its FY81, that hospital would report to AHA its expenditure data for the period October 1, 1980 through September 30, 1981. This latter data would, of course, be included in AHA's Annual Survey available in September, 1982. Therefore, data from both fiscal years would be used to construct a *calendar year* 1980 expenditure file for the hospital because FY81 expenditure reports would be needed to provide the data for the period October through December, 1980.

As a result of this delay in the availability of complete data for calendar year 1980, and in order to avoid an unreasonable delay in the application of the hospital cost review offset against the reduction, we will use the data available by the end of October 1981 in the AHA Annual Survey. We will determine in this manner which States tentatively meet the criterion and apply the offset against the reduction in grants for all quarters of FY81. We anticipate that we will make a supplementary grant award in November to States that qualify for the offset. For subsequent quarters, we will make the adjustment in the initial grant award. We will review the AHA Annual Survey published in September 1982 and make any necessary retroactive adjustments to the grant awards of the States determined to have qualified for the reduction. We will follow these same procedures in FY 83 and FY 84.

D. States with High Unemployment Rates

Section 433.207(b) of the new regulations is based on sections 1903(s)(2)(B) and (4) of the Social Security Act, as enacted by section 2161. Those sections specify that the percentage reduction in FFP required by the amendment for a calendar quarter is to be decreased by one percentage point if the State's average monthly unemployment rate for the immediately preceding calendar quarter, as determined by the Bureau of Labor Statistics (BLS), was at least 50 percent higher than the national average unemployment rate for the same period. To determine whether a State's average monthly unemployment rate is high enough to permit the State to qualify for this decrease, we plan to use the unemployment data in *Employment and Earnings* (table E–1), which is published monthly by the BLS and includes unemployment data for all States. The unemployment data for the 10 largest States are based on the *Current Population Survey*, which is the same survey used to derive estimates of national unemployment rates. Unemployment data for other States are based on State-administered unemployment insurance surveys. The unemployment data for each quarter generally are available by the middle of the following quarter. We will issue a supplementary grant award as soon as the data is available.

E. Fraud and Abuse and Third Party Liability Recoveries

Under section 1903(s)(2)(C) of the Act, as enacted by section 2161, the States will be entitled for each quarter to a decrease of one percentage point in the applicable reduction if the total amount of the State's recoveries against expenditures for the previous quarter, that are the result of third party liability or fraud and abuse activities, is equal to or exceeds one percent of the total Federal Medicaid payments due the State for the quarter. The statute goes on to define "recoveries" and further provides that recoveries from liable third parties may be considered for FY 82 only. In addition, the provision specifies that recoveries exceeding one percent of the Federal payment can be carried over for crediting against the succeeding quarter's reduction.

Third party and fraud and abuse recoveries are defined by section 1903(s)(5)(A)(i) as the total amount that the "State demonstrates to the Secretary that it has recovered or diverted * * *" We believe that Congress intended that

the States must be able to document their recoveries and must report them to HCFA before we include them in our determinations concerning the decrease in the reduction of Federal payments. In itself, the phrase "demonstrates to the Secretary" necessarily implies that the recoveries must be auditable and have been reported. Additionally, however, in the Report of the House Committee on the Budget on H.R. 3982 (97th Congress, 1st Sess. 290 (1981)), clear reference is made to the view that the recoveries must be documented. The report goes on to note that claims by the States of reduced expenditures because fraud and abuse has been discouraged are too subjective to establish the right to a smaller reduction through application of the offset. We find nothing in the legislative history of Pub. L. 97-35 to indicate a shift in Congressional intent away from that view. Therefore, in the regulation we do not consider expenditures that may have been reduced because fraud and abuse have been discouraged. We defined recoveries to include funds actually collected or diverted by a Medicaid State agency or Medicaid Fraud Control Unit, and which have been reported to the Federal government.

Furthermore, the statute makes use of the term "diverted" funds. We take the view that Congress intended that diverted funds, as well as recoveries, should be documented by the State before being included in determinations by HCFA concerning decreases in the reduction mandated by Pub. L. 97-35. We included in the definition of diverted funds amounts saved as a result of a State's having applied prepayment screens to all claims submitted by a specifically identified provider, and also savings realized from the application of special prepayment utilization screens in a mechanized or automated claims processing system. With respect to general screens, we distinguish between routine monitoring or screening edits in automated or mechanized claims systems and those put in place by the States as a result of surveillance and utilization review program actions or fraud control unit actions.

We will include savings from the latter source in deteminations about the fraud and abuse effect, and we will designate categories of screens that qualify in our reporting instructions for completion of the quarterly expenditure report (Form HCFA-64). Examples of qualified categories of screens are one time only procedures, inappropriate services for speciality and inappropriate place of service. More generally, diverted funds do not, for example, include amounts—

- Recovered as a result of routine audit activities or review of cost reports;
- Recovered or avoided as a result of detecting duplicate payments or applying normal utilization claims processing screens;
- Saved from claims that are denied as a result of prior authorization or general application of mechanized prepayment screens;
- Recovered as a result of overpayments based on State agency or fiscal agent administrative error;
- Amounts estimated by the States as future savings based on the conviction or suspension of a provider from Medicaid because of fraud or abusive practices;
- Amounts saved as a result of programs that restrict recipients to receive services from certain providers.

Generally, the regulations (§ 433.213) provide that HCFA will grant, on a quarter by quarter basis, the one percent decrease in the applicable reduction based on the total amounts a State can demonstrate as having been recovered or diverted through operation of its fraud control unit or through other fraud or abuse control activities. HCFA will make adjustments based on the decrease after it has received and reviewed the applicable data and determined that a State qualifies for the offset. This normally will occur toward the end of the quarter, or in the next succeeding quarter, depending on the timeliness of receipt and review of the necessary data.

For fiscal year 1982 only, Congress provided that recoveries from liable third parties will be included in determinations regarding the applicability of the one percent decrease in the reduction. This provision is covered in the proposed § 433.215, published in the notice of proposed rulemaking mentioned above.

We also provide in § 433.213 that amounts of third party liability (fiscal year 1982 only) and fraud and abuse recoveries in a quarter that exceed one percent of the total Federal Medicaid payments due a State for that quarter, will be carried forward for one quarter, as provided in section 1903(s)(5)(B).

For the purpose of establishing a tracking system to determine whether a State achieves the requisite level of third party liability and fraud and abuse recoveries, we are requiring that States report the data on existing forms. We will extract the data from these forms. Additionally, it is important to note here that the forms must be properly completed in order to facilitate a timely determination regarding the level of recoveries.

E. Target Amounts

Section 433.217 of the regulations implements section 1903(t) of the Social Security Act, as added by section 2161(b) of Pub. L. 97-35. Section 1903(t) provides for establishment of target amounts of Federal Medicaid expenditures for each State for fiscal years 1982, 1983 and 1984. A State is entitled to a dollar-for-dollar offset of the reductions made under section 2161 if the total Federal Medicaid expenditures fall under its target amount, but the offset applies only up to the total amount of the reductions.

The target amounts are established as follows:

FY 82—109 percent of the State's estimate of the Federal share of expenditures for FY 81, as reflected in the estimate received by the Department before April 1, 1981;

FY 83 and *FY 84*—The FY 82 target amount adjusted by the percentage increase or decrease in the index of the medical care expenditure category of the consumer price index for all urban consumers, between September 1982 and the end of the respective fiscal year (September 1983 or September 1984).

The calculation of the target amounts does not take into account interest paid under section 1903(d)(5) on disallowances of State claims, reductions in payments under section 1903(s) as enacted by section 2161, supplementary payments received by the State for spending less than the target in the previous year, or adjustments for claims relating to expenditures before October 1, 1981.

Under sections 1905(b) and 1101(a)(8) of the Social Security Act, the percentage of the Federal share of each State's medical assistance expenditures is recalculated each two years according to a specified formula. There will be a recalculation of the formula for FY 84. In recognition of this, section 1903(t)(3) provides that any change in this percentage for a State for FY 84 will be disregarded for purposes of computing target amounts. The Conference Report (H.R. Rep. No. 97-208, 97th Cong., 1st Sess. (1981)) points out (p. 960) that this provision was included to avoid rewarding a State simply because of a change in the share of its expenditures paid by the Federal government.

It should be noted that, under section 2165 of Pub. L. 97-35, Congress directed the Comptroller General, in consultation with the Advisory Commission on Intergovernmental Relations, to conduct a study of (1) the statutory formula for

computing the Federal medical assistance percentage (the Federal share of State Medicaid expenditures), and (2) the validity and equity of adjustments that should be made to the States' FY 83 and FY 84 target rates to reflect economic and demographic factors affecting the State but not under the State's ordinary sphere of control. The report is due to Congress by October 1, 1982.

III. Implementation of the Regulations

A. HCFA Grant Awards Process

We will impose the reductions mandated by Congress through our grant awards process. As noted above, the Federal government's share of a State's Medicaid program is determined by a formula based on the State's per capita income, with special provisions for administrative expenditures. Regulations governing the process are located in 45 CFR Part 201. To obtain the Federal government's share (which is called Federal financial participation, or FFP), each State submits to HCFA, 45 days prior to the beginning of each quarter in the fiscal year, an estimate (Form HCFA–25) of the amount of FFP the State will need for that quarter. This estimate includes the amounts the State believes it will need from the Federal government to cover program expenditures (that is, medical services covered under the State plan) and administrative expenditures. After reviewing the estimates, we advance funds by awarding a grant about 15 days before the beginning of the quarter. This grant authorizes States to obtain Federal cash as a payment of estimated expenses. Within 30 days after the end of the quarter, the State submits a quarterly expenditure report (Form HCFA–64) that reflects the actual expenditures incurred by the State. We review the report and determine whether the State has claimed reimbursement for any expenditures that are not allowable. (See **Federal Register** issues of January 15, 1981 (46 FR 3527) and September 17, 1981 (46 FR 46134) for clarification of "expenditures".) If we determine that any adjustments (that is, deferral, disallowance, suspension or other financial actions) are necessary in the amount of FFP advanced to the State before the quarter, the adjustment is made at the same time that the award for the next succeeding quarter is granted or shortly thereafter as a supplemental grant award.

B. Effect of Section 2161 on the Grants Process

The grant award computation form we use (Form HCFA–152) shows the amount of the estimate for the ensuing quarter, and the amounts by which the estimate is reduced or increased because of over- or under-estimates for a prior quarter and for other adjustments. We will use this form to show the applicable reduction to the amount of payments to the State and any of the three offsets against the reduction for which the State qualifies.

Of the three conditions allowing offsets against the reduction, two are not dependent on the budget and awards process followed by HCFA and the States. That is, unemployment offset and the hospital rate review program offset are controlled by factors extrinsic to the grant awards process. On the other hand, we will implement the fraud and abuse and third party liability offset based on information gathered and reported by the States, as explained below, to support their estimates of the amount of FFP needed for a given quarter.

Included in the State's expenditure reports are expenditures for current and prior year activities, as well as collections and adjustment actions. Part of the data reported covers the State's collection efforts in recovering funds through third party payments. In these instances, claims paid under the Medicaid program are collected from insurance companies or others found to have the legal liability to pay for care and services. Also reported are recovered amounts that result from fraud and abuse control actions. State Medicaid fraud control units or other fraud control entities are responsible for collecting payments that were made improperly. Through the efforts of these units, funds are returned to the program.

The following example illustrates how we will reduce Federal payments in accordance with section 2161 of the Pub. L. 97–35. The example contains dates for FY 82, but the process described will apply equally to FY 83 and FY 84. Separate grant awards procedures and forms are used for grants to the States for the Federal share of the costs of State programs for survey and certification of health facilities, and for certified State Medicaid fraud control units authorized under 42 CFR 455.300, but the reductions and offsets apply to FFP for these costs as well. The following illustration also applies generally to our survey and certification grant procedures.

Funding needs for the first quarter of FY 82 were to be submitted by August 15, 1981. For our example, we are using a State funding estimate of $1,000,000. By August 30, 1981 the HCFA Regional Administrator had reviewed the State's estimate and submitted a recommendation of $800,000 as the State's funding need. Both the State estimates and Regional Administrator's recommendation were forwarded to the HCFA central office for use in preparing the first quarter grant award. The initial grant award was issued before the beginning of the quarter and was for the amount that HCFA estimates as the State's need for the quarter, less the three percent reduction. We will apply offsets for unemployment and for third party liability/fraud and abuse recoveries and collections when data is reviewed by HCFA indicating that States qualify for those offsets. In like manner, we will apply the hospital cost review offset when supporting data become available. In the first quarter of FY 82, we expect to apply this offset in November, 1981, and thereafter in the initial grant awards. We will make these adjustments by preparing supplemental grant awards during the quarter, or as soon as possible thereafter.

The States are to submit their expenditure reports 30 days after the end of the quarter, which would be January 30, 1982, for the purpose of our example. The HCFA Regional Administrator reviews the expenditures reported by the State and submits a recommendation on the allowability of the expenditures to the HCFA central office two weeks after the State submits the expenditure report. Based on the State expenditure report and the HCFA Regional Administrator's recommendations, the HCFA central office calculates the final expenditures amount and prepares the final grant award adjustment. This action is to occur together with the initial award for the third quarter; however, due to timing difficulties, the final adjustment will normally occur in the third quarter. As an example, we will assume that the initial HCFA determination of funds required is $800,000 and that $900,000 is the final expenditure amount. In addition, we will assume that the State qualified for the hospital cost review and the third party liability/fraud and abuse offsets. The final award adjustment calculation, including offsets, will be as follows:

HCFA Initial Funding Determination	$800,000
3% reduction—Sec. 2161	−24,000
Initial Grant Award	776,000
Adjusted Expenditures	900,000
3% reduction—Sec. 2161	−27,000
1% TPL/FA offset	9,000
1% Hospital Cost Review Offset	9,000
Final First Quarter Adjusted Expenditure	891,000
Initial Grant Award Funding	−776,000
Final Grant Award Adjustment	115,000

The quarterly cycle continues as described above for the remainder of the fiscal year. At the end of the fiscal year, before the issuance of the initial award for the first quarter of FY 83, the State's total expenditures for the fiscal year are estimated by the HCFA central office based on the available actual expenditure data and the State's budget estimate. To the extent that the State's total estimated expenditures are under the target amount and expenditure reductions have not been offset, the State is entitled to a supplemental adjustment. If, in this case, we use $3,600,000 as the State's estimated FY 82 expenditures, a target amount of $3,650,000 and $36,000 as reductions that have not been offset, we have the following calculation:

Target amount—FY 82	$3,650,000
Estimated Annual Expenditures	−3,600,000
Under Targeted Expenditures	50,000
Reductions not offset	36,000
Less Amount used as supplement award adjustment	36,000

Since $36,000 is the lower of the two amounts that are compared (the amount by which the State's expenditures are under its target amounts, and the amount of reductions not offset), this is the supplemental figure awarded to the State. Upon determination of the final expenditure amount for FY 82, an adjustment will be made as described above in the appropriate grant award.

IV. Impact Analyses

A. Executive Order 12291

The Secretary had determined, in accordance with Executive Order 12291, that this rule does not constitute a major rule. We are required by the Amendment to reduce FFP in Medicaid by more than $100 million per year. However, because the reduction is mandated by law and we are required by the amendment to adopt the specific implementation approach set forth in the regulations, the reduction is not attributable to this regulation.

B. Regulatory Flexibility Analysis

The Secretary certifies, under section 605(b) of the Regulatory Flexibility Act (Pub. L. 96–354), that these regulations will not have a significant economic impact on a substantial number of small businesses, nonprofit entities or small local governments.

One major objective of the revised regulations is to give States financial incentives for more efficient purchasing of health care services under Medicaid. We are aware that, in responding to these incentives, individual States may take actions that have a significant economic impact on some physicians, hospitals, long term care facilities, or other providers of services that meet the definition of "small entities" in Pub. L. 96–345. However, we do not now have any basis for predicting either the specific actions States will take, or the effect these actions will have on small entities. Moreover, apart from the budget reductions involved, which are not attributable to these regulations, State decisions are as likely to have a favorable as adverse impact on small entities, or to affect a less than "substantial" number. Accordingly, these regulations do not meet the thresholds established in the Regulatory Flexibility Act.

V. Waiver of Proposed Rulemaking

As explained earlier in this preamble, the major provisions of the new regulations are based on requirements that are set forth explicitly in section 2161. Because we are required by that amendment to adopt those rules, we believe it is unnecessary to publish a notice of proposed rulemaking. Further, we believe it would be both impractical and contrary to the public interest to delay implementation of section 2161 by the amount of time that would be needed to obtain and analyze public comments. As a practical matter, we would not be able to make any reductions in FFP for the first quarter of fiscal year 1982 if we delayed implementation of these rules by even the minimum amount of time (60 days) usually allowed for public comment and the time (30 days) usually provided for delay in the effective date. Therefore, we find good cause to waive the requirement for publication of a notice of proposed rulemaking and a delayed effective date. However, as stated previously, we will accept any comments mailed within the specified period and will make any changes in the regulations we believe necessary as a result of the comments.

Title 42—Public Health

PART 433—STATE FISCAL ADMINISTRATION

A. 42 CFR Part 433 is amended as set forth below:

1. The table of contents for Part 433 is amended as follows:

a. Subpart A of Part 433 is amended by adding a new § 433.8 as follows:

Subpart A—Federal Matching Provisions

* * * * *

433.8 Application of progressive reductions during fiscal years 1982–1984.

* * * * *

b. A new Subpart E is added to Part 433 as follows:

Subpart E—Reduction in Total Federal Payments to the States for Fiscal Years 1982–1984

Sec.

433.201 Statutory basis and scope.
433.203 Definitions.
433.205 Reductions in total Federal payments.
433.207 Offsets against reductions.
433.209 Qualifications for offset based on hospital cost review programs.
433.213 Offset based on fraud and abuse recoveries.
433.215 Third party liability recoveries [Reserved].
433.217 Use of target amounts to decrease reductions.

2. The authority citation for Part 433 is revised to read as follows:

Authority: Secs. 1102, 1902(a)(25), 1903(d)(2), 1903(o), 1903(p), 1903(s), 1903(t) and 1912 of the Social Security Act (42 U.S.C. 1302, 1396a(a)(25), 1396b(d)(2), 1396b(o), 1396b(p), 1396b(s), 1396b(t) and 1396(k), unless otherwise noted.

3. Subpart A is amended by adding a new § 433.8 as follows:

§ 433.8 Application of progressive reductions to FFP during fiscal years 1982–1984.

Under sections 1903 (s) and (t) of the Act, HCFA will reduce the FFP described in §§ 433.10 and 433.15 in accordance with the procedures described in Subpart D of this part.

4. A new Subpart E is added to read as follows:

Subpart E—Reduction in Total Federal Payments to the States for Fiscal Years 1982–1984

§ 433.201 Statutory basis and scope.

(a) *Basis.* Sections 1903 (s) and (t) of the Act (as enacted by section 2161 of Pub. L. 97–35) provide for progressive reductions in Federal payments to the States, in fiscal years 1982 through 1984.

(b) *Scope.* The reductions apply only to the 49 States with Medicaid programs approved by HCFA as of July 1, 1981, and to the District of Columbia. Special funding provisions in § 433.10 apply to Puerto Rico, Guam, the Virgin Islands, and the Northern Mariana Islands.

§ 433.203 Definitions.

For purposes of this subpart—

"Abuse" means provider practices that are inconsistent with sound fiscal, business or medical practices, and result in unnecessary cost to the Medicaid program, or in reimbursement for

services that are not medically necessary or that fail to meet professionally recognized standards for health care.

"Diverted funds" means those amounts saved from claims that are denied or reduced in amount—

(1) As a result of applying prepayment screens to all or a particular portion of the claims submitted by a specifically identified provider; and

(2) By the application of special prepayment utilization screens in a mechanized or automated claims processing system, designed to detect fraud and abuse, to all claims submitted for payment from all providers or from a general category of providers. The term does not include amounts estimated by the States as future savings based on the conviction or suspension of a provider from Medicaid because of fraud or abusive practices.

"Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or herself or to some other person or entity. It includes any act that constitutes fraud under applicable State law.

"Recoveries" means Medicaid funds a provider of services has been paid in excess of amounts payable under title XIX of the Act, applicable regulations and the State plan that are actually collected or diverted by a State agency or Medicaid Fraud Control Unit, and which have been reported to the Federal Government. Fines, penalties and unexecuted judgments established by, Federal, State, or local courts or administrative bodies are not considered recoveries.

§ 433.205 Reductions in total Federal payments.

(a) *Amount of the reductions.* HCFA will reduce total Federal payments to which a State is otherwise entitled under the Medicaid program by the following percentages:

(1) Three percent in fiscal year 1982.

(2) Four percent in fiscal year 1983.

(3) Four and one half percent in fiscal year 1984.

(b) *Effective date and date reductions end.* HCFA will impose the reductions effective October 1, 1981 for the first quarter in fiscal year 1982. No reductions will be imposed for quarters after the last quarter of fiscal year 1984, which ends on September 30, 1984. However, adjustments relating to the final computations for fiscal years 1982–1984 expenditures will continue to be made until the States have submitted all expenditure reports and all outstanding issues have been resolved.

(c) *Amounts not affected by reductions.* HCFA will not apply the progressive reduction to—

(1) Payments to the State for expenditures made before fiscal year 1981; or

(2) Supplementary payments made to a State resulting from its having incurred fewer expenditures than its target amount, described in § 433.217.

§ 433.207 Offsets against reductions.

HCFA will decrease the reduction specified in § 433.205 by one percentage point for a quarter for a State, for each of the following three conditions that the State meets:

(a) *Hospital cost review program.* Operation by the State of a hospital cost review program that meets the criteria, described in § 433.209, for the quarter covered by the Federal payment.

(b) *Unemployment levels.* An unemployment rate in the State, for the quarter before the quarter covered by the Federal payment, that is equal to or greater than 150 percent of the national unemployment rate for the same period, as determined by the Bureau of Labor Statistics.

(c) *Fraud and abuse and third party liability recoveries.* For the quarter before the quarter covered by the Federal payment, recovery through fraud and abuse initiatives, described in § 433.213, of an amount equal to one percent of the FFP for the quarter covered by the payment. For fiscal year 1982 only, this total may include recoveries from liable third parties (see § 433.215).

§ 433.209 Qualifications for offset based on hospital cost review programs.

(a) A state has a qualified hospital cost review program if the qualifications in the following paragraph (b) of this section are met.

(b) The State must provide HCFA with assurances of equitable treatment, under its cost review program, for hospital employees and patients, and for all payers, including Federal and State programs, that pay hospitals for inpatient hospital services. In addition, in order to qualify, a hospital cost review program must—

(1) Be established by statute;

(2) Have been in effect on July 1, 1981 and at the beginning of the quarter covered by the Federal payment;

(3) Be directly operated by the State;

(4) Apply to substantially all non-Federal acute care hospitals in the State;

(5) Provide for review of all non-Medicare revenues or expenses for inpatient hospital services, or at least 75 percent of all revenues or expenses for inpatient hospital services including those under Medicare; and

(6) Result in an annual rate of increase in aggregate hospital inpatient costs per capita, or per admission, in the State on a calendar year basis that is at least two percentage points less than the rate of increase in all States without qualifying programs. A State may meet this requirement based on performance during the most recent one, two, or three calendar year period ending at least nine months before the quarter covered by the Federal payment.

§ 433.213 Offset based on fraud and abuse recoveries.

(a) *General policy.* HCFA will decrease the reduction under § 433.205 by one percentage point for each quarter in which the State demonstrates that its fraud and abuse recoveries (and third party liability recoveries for fiscal year 1982 only (see § 433.215)), for the quarter before the quarter covered by the Federal payment, are equal to one percent of the total Federal Medicaid payments due to the State in that previous quarter. For purposes of calculating the one percent, HCFA will not include in this total any supplementary payments due to a State resulting from the State's having spent less than its target amount, described in § 433.217.

(b) *Fraud and abuse recoveries.* For purposes of paragraph (a) of this section, fraud and abuse recoveries—

(1) Must be documented by the State; and

(2) May include diverted funds or funds recovered as a result of—

(i) The operation of a State Medicaid fraud control unit, as defined in Part 455, Subpart D, of this chapter;

(ii) Audit activities that are initiated as a result of a suspicion or complaint of fraud or abuse (including any amounts recovered as restitution in civil or criminal litigation resulting from these audit activities, but not including fines, penalties, unexecuted judgments established by Federal, State, or local courts or administrative bodies (and fraud and abuse uncovered through routine audits); and

(iii) State determinations of overutilization or furnishing of unnecessary care.

(c) *Procedures for carrying forward fraud and abuse recoveries.* For purposes of paragraph (a) of this section, HCFA will carry forward, to the next quarter only, the amount by which a State demonstrates that its fraud and abuse recoveries exceed one percent of the total Federal Medicaid expenditures

for the quarter covered by the Federal payment.

§ 433.215 Third party liability recoveries [Reserved].

§ 433.217 Use of target amounts to decrease reductions.

(a) *Purpose of the target amount.* HCFA will issue supplemental grants for fiscal years 1982–1984 based on the amount by which a State's total Federal Medicaid expenditures are under the State's target amount, described in paragraph (b) of this section, for the fiscal year. However, the supplemental grant may not exceed the amount of the reduction, described in § 433.205, for the fiscal year under consideration.

(b) *Method for determining target amounts.*—(1) *Fiscal year 1982.* The target amount for a State for fiscal year 1982 is 109 percent of the State's estimate of the Federal share of all Medicaid expenditures for fiscal year 1981, in the latest estimate received by HCFA central office before April 1, 1981. The estimate may not include Federal expenditures resulting from adjustments made during fiscal year 1981 based on expenditures made before October 1, 1980.

(2) *Fiscal year 1983.* HCFA will derive the target amount for each State for fiscal year 1983 by increasing or decreasing the 1982 target amounts by a percentage equal to the percentage increase or decrease, between September 1982 and September 1983, in the index of the medical care expenditure category of the consumer price index for all urban consumers, as determined by the Bureau of Labor Statistics.

(3) *Fiscal year 1984.* HCFA will derive the target amount for each State for fiscal year 1984 by the same method used for the 1983 targets, except that the 1982 target amounts will be increased or decreased based on medical care expenditure data for the period between September 1982 and September 1984. For purposes of calculating the fiscal year 1984 target amount, HCFA will deem the FMAP for 1984 to be equal to the percentage for 1983.

(c) *Exclusions from target amount determinations.* HCFA will exclude the following from each year's target amount determinations:

(1) Adjustments with respect to prior year claims (see paragraph (b)(1) of this section);

(2) Interest paid on disallowances of disputed claims;

(3) Any offset payments the State receives for spending less than its target amount in the previous year; and

(4) Any reductions in Federal funds under § 433.205.

Title 45—Public Welfare

PART 201—GENERAL ADMINISTRATION—PUBLIC ASSISTANCE PROGRAMS

B. 45 CFR 201.5 is amended by revising the introductory language as set forth below. The authority citation for Part 201 reads as follows:

Authority: Sec. 1102, 49 Stat. 647; 42 U.S.C. 1302.

§ 201.5 Grants.

To States with approved plans, grants are made each quarter for expenditures under the plan for assistance, services, training and administration. The determination as to the amount of a grant to be made to a State is based upon documents submitted by the State agency containing information required under the Act and such other pertinent facts as may be found necessary.

Progressive reductions in Federal Medicaid payments to the States under sections 1903 (s) and (t) of the Act for fiscal years 1982–1984 are described in 42 CFR Part 433, Subpart E.

* * * * *

(Catalog of Federal Domestic Assistance Programs No. 13.714, Medical Assistance Program)

Dated: September 16, 1981.

Carolyne K. Davis

Administrator, Health Care Financing Administration.

Approved: September 24, 1981.

Richard S. Schweiker,

Secretary.

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