Elsewhere in today's **Federal Register**, EPA is proposing the redesignation requested by Tennessee and soliciting comment on the proposal.

EPA is withdrawing this action without providing prior notice and opportunity for comment. The Agency finds that it has good cause within the meaning of 5 U.S.C. 553(b) to proceed without notice and comment. Notice and comment would be impracticable in this case because EPA needs to withdraw its redesignation as quickly as possible in order to consider the comments which the public has submitted or may wish to submit. Moreover, further notice is not necessary because EPA has already informed the public that it would follow this procedure if it received a request for an opportunity to comment. For the same reasons, EPA finds that it has good cause under 5 U.S.C. 553(d) to make this withdrawal immediately effective.

Under Section 307(b)(1) of the Act, petitions for judicial review of this action must be filed in the United States Court of Appeals for the appropriate circuit by April 11, 1983.

Pursuant to the provisions of 5 U.S.C. 605(b) I hereby certify that the present rule will not have significant economic impact on a substantial number of small entities.

The Office of Management and Budget has exempted this rule from the requirements of Section 3 of Executive Order 12291.

List of Subjects in 40 CFR Part 81

Air pollution control, National parks, Wilderness areas.

(Sec. 107 of the Clean Air Act (42 U.S.C. 7407))

Dated: February 1, 1983.

Anne M. Gorsuch,

Administrator.

PART 81—[AMENDED]

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

Subpart C—Section 107 Attainment Status Designation

§ 81.343 [Amended]

In the Tennessee-TSP table of § 81.343, the entry for "That portion of Roane County within the Clymersville section of Rockwood" is removed.

[FR Doc. 83-3206 Filed 2-7-83; 8:45 am]

BILLING CODE 6560-50-M

40 CFR Part 761

[OPTS-62024B; BH-FRL No. 2277-8]

Polychlorinated Biphenyls (PCB's) Manufacturing, Processing, Distribution in Commerce and Use Prohibitions; Incorporations by Reference Revisions

AGENCY: Environmental Protection Agency (EPA).

ACTION: Final rule.

SUMMARY: This final rule incorporates by reference in EPA's Polychlorinated Biphenyls (PCBs) regulations certain revised test methods of the American Society for Testing and Materials (ASTM). These revisions are new methodology to be used in meeting the requirements of these PCB regulations.

DATES: This final rule is effective February 8, 1983.

FOR FURTHER INFORMATION CONTACT: Chris Tirpak, Acting Director, Industry Assistance Office (TS-799), Office of Toxic Substances, Environmental Protection Agency, Rm. E-511, 401 M St., SW., Washington, DC, 20460. Toll Free: (800-424-9065). In Washington, D.C.: (554-1404). Outside the USA: (Operator-202-554-1404).

SUPPLEMENTARY INFORMATION: In the **Federal Register** of May 21, 1982 (47 FR 22123), EPA proposed to amend 40 CFR 761.60 and 761.75 to provide that testing methodologies revised by the ASTM be used in meeting certain requirements of regulations affecting Polychlorinated Biphenyls (PCBs).

The designations of the revised methodologies and the equivalent old methodologies are as follows:

Old Designations	*New Designations*
ASTM D93-77	ASTM D93-80
ASTM D482-74	ASTM D482-80
ASTM D524-76	ASTM D524-81
ASTM D808-63	ASTM D808-81
ASTM D923-75	ASTM D923-81
ASTM D1266-70	ASTM D1266-80
ASTM D2158-65	ASTM D2158-80
ASTM D2784-70	ASTM D2784-80
ASTM D3278-73	ASTM D3278-78

The comment period ended June 21, 1982. To insure all interested persons an adequate opportunity to evaluate and comment on the proposed methodologies EPA announced reopening of the comment period in the **Federal Register** of July 13, 1982 (47 FR 30270). This second comment period ended August 12, 1982.

Neither comment period elicited comments of a substantive nature. The amendments are therefore adopted as proposed.

Executive Order 12291

Under Executive Order 12291, issued February 17, 1981, EPA must judge whether a rule is a "major rule" and, therefore, subject to the requirement that a Regulatory Impact Analysis be prepared. EPA has determined that this rule is not a major rule as the term is defined in section 1(b) of the Executive Order. Therefore, EPA has not prepared a Regulatory Impact Analysis for this rule.

EPA has concluded that this final rule is not "major" under the criteria or section 1(b) because the annual effect of the rule on the economy will be less than $100 million; it will not cause a major increase in costs or prices for any sector of the economy or for any geographic region; and it will not result in any significant adverse effects in competition, employment, investment, productivity, or innovation, or on the ability of United States enterprises to compete with foreign markets. In fact, this rule simply provides for updating analytical test methodology to the state of the art. This rule was submitted to the Office of Management and Budget for review as required by E.O. 12291.

Regulatory Flexibility Act

Under section 605(b) of the Regulatory Flexibility Act, the Administrator may certify that a rule will not, if promulgated, have a significant impact on a substantial number of small entities, and therefore does not require a regulatory flexibility analysis. This rule merely updates certain American Society for Testing and Materials (ASTM) test methods cited in the PCB regulations to current ASTM standards. In fact, this revision will bring the analytical methods cited in the PCB regulations to the state of the art. Since no negative economic effect is expected upon any business entity from the promulgation of this rule, I certify that this rule will not have a significant economic impact on small entities.

Paperwork Reduction Act

EPA has determined that the Paperwork Reduction Act of 1980, 44 U.S.C. 3501 *et seq.*, does not apply to this Final Rule since no information collection or recordkeeping are involved.

(Sec. 6, 90 Stat. 2020, (15 U.S.C. 2065))

List of Subjects in 40 CFR Part 761

Environmental protection, Hazardous materials, Labeling, Polychlorinated biphenyls, Recordkeeping and reporting requirements, Incorporation by reference.

Dated: December 21, 1982.

John A. Todhunter,

Assistant Administrator for Pesticides and Toxic Substances.

PART 761—[AMENDED]

Therefore, Part 761 of Chapter I of Title 40, Subchapter R, is amended as follows:

1. In § 761.19, the entries for ASTM methods D–524, D–808, and D–923 in paragraph (b) are revised to read as follows:

§ 761.19 References.

* * * * *

(b) * * *

	CFR citation
* * * * *	
ASTM D–524–81 Standard Test Method for Ramsbottom Carbon Residue of Petroleum Products.	§ 761.60(a)(3)(iii)(B)(*6*).
ASTM D–808–81 Standard Test Method for Chlorine in New and Used Petroleum Products (Bomb Method).	§ 761.60(a)(3)(iii)(B)(*6*).
ASTM D–923–81 Standard Test Method for Sampling Electrical Insulating Liquids.	§ 762.60(g)(1)(ii); § 761.60(g)(2)(ii).
* * * * *	

2. In § 761.60, paragraph (a)(3)(iii)(B)(*6*) and paragraph (g)(1)(ii) and (2)(ii) are revised as follows:

§ 761.60 Disposal requirements.

(a) * * *

(3) * * *

(iii) * * *

(B) * * *

(*6*) The concentration of PCBs and of any other chlorinated hydrocarbon in the waste and the results of analyses using the American Society of Testing and Materials (ASTM) methods as follows: carbon and hydrogen content using ASTM D–3178–73 (reapproved 1979), nitrogen content using ASTM E–258–67, sulfur content using ASTM D–2784–80, D–1266–80, or D–129–64, chlorine content using ASTM D–808–81, water and sediment content using either ASTM D–2709–68 or D–1796–68, ash content using D–482–80, calorific value using ASTM D–240–76 (reapproved 1980), carbon residue using either ASTM D–2158–80 or D–524–81, and flash point using ASTM D–93–80.

* * * * *

(g) * * *

(1) * * *

(ii) For purposes of complying with the marking and disposal requirements, representative samples may be taken from either the common containers or the individual transformers to determine the PCB concentration, *Except that* if any PCBs at a concentration of 500 ppm or greater have been added to the container the total container contents must be considered as having a PCB concentration of 500 ppm or greater for purposes of complying with the disposal requirements of this subpart. For purposes of this paragraph, representative samples of mineral oil dielectric fluid are either samples taken in accordance with American Society of Testing and Materials method D–923–81 or samples taken from a container that has been thoroughly mixed in a manner such that any PCBs in the container are uniformly distributed throughout the liquid in the container.

(2) * * *

(ii) For purposes of complying with the marking and disposal requirements, representative samples may be taken from either the common container or individual containers to determine the PCB concentration *Except that* if any PCBs at a concentration of 500 ppm or greater have been added to the container then the total container contents must be considered as having a PCB concentration of 500 ppm or greater for purposes of complying with the disposal requirements of this subpart. For purposes of this subparagraph, representative samples of waste oil are either samples taken in accordance with American Society of Testing and Materials D–923–81 method or samples taken from a container that has been thoroughly mixed in a manner such that any PCBs in the container are uniformly distributed throughout the liquid in the container.

3. In § 761.75, paragraph (b)(8)(iii) is revised to read as follows:

§ 761.75 Chemical waste landfills.

* * * * *

(b) * * *

(8) * * *

(iii) Ignitable wastes shall not be disposed of in chemical waste landfills. Liquid ignitable wastes are wastes that have a flash point less than 60 degrees C (140 degrees F) as determined by the following method or an equivalent method: Flash point of liquids shall be determined by a Pensky-Martens Closed Cup Tester, using the protocol specified in ASTM Standard D–93–80, or the Setaflash Closed Tester using the protocol specified in ASTM Standard D–3278–78.

* * * * *

[FR Doc. 83–3291 Filed 2–7–83; 8:45 am]

BILLING CODE 6560–50–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Part 431, 435, 436, 440, and 447

Medicaid Program; Imposition of Cost Sharing Charges Under Medicaid

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

ACTION: Final rule with comment period.

SUMMARY: This final rule revises regulations concerning imposition of cost sharing amounts on Medicaid recipients. Section 131 of the Tax Equity and Fiscal Responsibility Act of 1982 (Pub. L. 97–248) amended the Medicaid cost sharing requirements. This final rule revises the Medicaid regulations to remove the prohibition on States from imposing deductibles, coinsurance or copayments on categorically or medically needy individuals with certain exceptions. Under the law, States are precluded from imposing such charges with respect to services furnished to individuals under 18, services furnished to pregnant women, if the services relate to the pregnancy, or to any condition which may complicate the pregnancy, and services furnished to certain institutionalized patients who are required to spend all of their income for medical care costs except for a personal needs allowance. The law also prohibits imposition of deductions, cost sharing or similar charges on emergency services, and family planning services and supplies to any individual. Finally, services furnished by a health maintenance organization (HMO) to a categorically needy individual who is enrolled in the HMO are also exempt from cost sharing. States may also exempt medically needy HMO enrollees if they desire. The law also establishes a waiver authority under which cost-sharing amounts may be increased for nonemergency services in hospital emergency rooms. This rule reflects these changes in the law.

DATES: The rules are amended as of February 8, 1983. See section II.E. of the preamble for discussion of effective date.

Comment date: Although these regulations are final, comments may be submitted. To assure consideration, comments should be mailed by April 11, 1983.

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

In commenting, please refer to BPP–509–FC.

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 132, East High Rise Building, 6325 Security Boulevard, Baltimore, Maryland.

Comments will be available for public inspection, beginning approximately two weeks after publication, in Room 309–G of the Department's offices 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).

FOR FURTHER INFORMATION CONTACT: Marinos Svolos, (301) 594–9051.

SUPPLEMENTARY INFORMATION:

I. General Background

A. Legislative History

The original Medicaid legislation prohibited the imposition of any cost sharing for inpatient hospital services for all Medicaid eligibles. Cost sharing arrangements that were related to income and resources were permitted on any other service for both the categorically and medically needy. The 1967 amendments to the Social Security Act (section 235 of Pub. L. 90–248) amended the original legislation by permitting cost sharing for any services for the medically needy including inpatient hospital services. However, all cost sharing on services furnished to the categorically needy became prohibited.

The 1972 amendments to the Social Security Act (section 208(a) of Pub. L. 92–603) changed the cost sharing rules. Instead of exempting the categorically needy totally from all cost sharing the law permitted States to impose copayments on all optional services. Copayments on required services and enrollment fees for the categorically needy continued to be prohibited. The 1972 amendments also made imposition of enrollment fees on medically needy mandatory but this requirement was repealed by section 9(a) of Pub. L. 93–368, effective January 1, 1973 without being implemented. Thus, all services to the medically needy could be subject to either type of cost sharing at the State's option. The only direction in the law regarding cost sharing amounts was that they must be in accordance with the Secretary's standards of what is nominal for copayment charges, and, in the case of enrollment fees, must be related to income.

B. Program Experience

In 1973, we published regulations implementing the 1972 amendments on cost sharing. (These regulations are set forth at 42 CFR 447.50–447.59.) These regulations established the basic requirements that apply if a State's medical assistance plan includes cost sharing, and set forth the scope of the State's options. Additionally, the regulations implemented the statutory requirements that copayments be nominal, by setting maximum deductible, coinsurance, and copayment amounts, and that premiums or enrollment fees be income-related, by setting out both minimum and maximum dollar amounts for monthly enrollment fees. These amounts have remained unchanged since 1973. Additionally, the regulations specify that copayment charges imposed may be related to income as long as they do not exceed the maximum amounts set forth in 42 CFR 447.54.

Because these rules prohibited imposition of both types of cost sharing on the majority of Medicaid recipients (approximately 74 percent of Medicaid recipients are categorically needy), States have often identified the cost sharing regulations as one of the most troublesome barriers to efficient program administration. In addition, since a large portion of services furnished were excluded, cost sharing could not be used as an effective means of utilization control.

C. 1982 Legislation

On September 3, 1982, the Tax Equity and Fiscal Responsibility Act of 1982 (Pub. L. 97–248) was enacted. Section 131 of the Act amended the Medicaid law by removing the previous restrictions on imposition of copayments on required services for categorically needy eligibles. Instead, section 131 added a new section 1916 to Title XIX entitled "Use of Enrollment Fees, Premiums, Deductions, Cost Sharing, and Similar Charges".

Under section 131 States may now impose deductibles, coinsurance, copayments, or similar cost sharing charges on most services furnished to categorically needy, as well as medically needy individuals. However, the restriction against the use of cost sharing in the form of enrollment fees and premiums was retained for categorically needy individuals.

The legislation prohibits imposition of deductions, cost sharing or similar charges on certain recipients, whether categorically or medically needy, i.e., individuals under 18 and those institutionalized individuals who are required to spend all of their income (except for a minimal personal needs allowance) for medical care costs. Additionally, cost sharing is precluded for certain types of services, such as those related to pregnancy, emergency services, and family planning services. Finally, services provided by a health maintenance organization (HMO) to categorically needy individuals enrolled in the HMO are also excluded from cost sharing. States may further exclude cost copayments for HMO services furnished to medically needy enrollees, if they desire. They may also exclude individuals under 21, 20 or 19 (rather than just 18) from cost sharing, or exclude from cost sharing all services to pregnant women.

The amendent further requires that copayments be nominal, and that no provider participating under Medicaid deny medical care to an individual because of his inability to pay the assessed cost sharing amount. (The right of access to medical care does not extinguish, however, the recipient's liability for the cost sharing payment.)

1. *Nominal Charges.*—Section 1916 provides that any copayment imposed by the State must be nominal in amount. (However, the amendment provides for waiver of this requirement for nonemergency services furnished in hospital emergency rooms, as discussed in item 2. below.) The legislation references the current maximum cost sharing charges that are contained in current regulations, 42 CFR 447.54. Further, the amendment specifies that if the current definition of nominal is changed, the new definition must take into account the level of cash assistance provided by the State.

We are not making any revisions to the current nominal amounts at this time. However, since the current nominal amounts were established in 1973, we plan to consider revisions to the definition of nominal and invite public comment on this issue. We will issue any proposed revisions as a Notice of Proposed Rulemaking for specific public comment if we decide to revise the definition at a later date.

2. *Waiver of Nominal Amounts for Nonemergency Services Furnished in Hospital Emergency Rooms.*—Under section 1916(a)(3) and (b)(3), States may impose a copayment amount up to twice the current maximum for services furnished in hospital emergency rooms that do not meet the definition of emergency services. In imposing higher copayment amounts in this circumstance, States must assure that individuals have actually available and accessible to them alternative sources of nonemergency, outpatient services. For example, alternative sources of outpatient services would include physicians or clinics participating in the

Medicaid program that are located within reasonable travel distance of the recipient.

II. Revised Regulations

A. Deductibles, Coinsurance, Copayment, or Similar Cost-Sharing Charges (Copayments)

As described in section I.C. of this preamble, section 131 of Pub. L. 97-248 made extensive changes in the requirements for copayment charges. Therefore, we are deleting the material currently in 42 CFR 447.53 (a) and (b) and replacing it with the requirements contained in the amended statute as described below.

1. *Services Furnished to Individuals under 18.*—States must not impose a deductible or other copayment on any services furnished to individuals under 18. If a State provides Medicaid to reasonable categories of individuals between 18 and 21 years of age, the State may also exclude copayments for these individuals.

2. *Institutionalized Individuals.*—Medicaid regulations require that State payments to institutions for care furnished to Medicaid eligible individuals be reduced by the recipients' income (42 CFR 435.725, 435.733, 435.832, and 436.832). The regulations permit institutionalized individuals to retain a personal needs allowance for personal and certain other maintenance needs. All other income must be applied to the cost of medical care of the institutionalized individual. Current regulations require that, although the personal needs allowance is protected for use by the recipient, the individual must, if necessary, use it to pay for any cost-sharing charges the State imposes under Medicaid.

Section 1916 provides that States may no longer impose cost-sharing on institutionalized individuals who are required to spend for their health care all (minus certain deductions) of their income, except for a personal needs allowance. Since current regulations state that institutionalized individuals must, if necessary, use their personal needs allowance to pay for any cost-sharing charges the State imposes, we are revising 42 CFR 435.725(c)(1)(iii), 435.733(c)(1)(iii), 435.832(c)(1)(iii), and 436.832(c)(1) to remove this requirement.

3. *Services Related to Pregnancy.*—Section 1916 precludes the imposition of copayments on services furnished to pregnant women, if these services relate to pregnancy or to other medical conditions that may complicate the pregnancy. We are specifying that these services include routine prenatal care, labor and delivery, routine post-partum care, and complications of pregnancy or delivery likely to affect the pregnancy, such as hypertension, diabetes, and urinary tract infection. Moreover, section 1916 permits States to exclude from copayments all services furnished to pregnant women if they desire.

The Senate Finance Committee, in considering this provision, recognized that it may not be operationally feasible for States to ascertain in all cases whether recipients for whom claims are submitted were pregnant. Consequently, the report specifies the committee's intent that copayments not be imposed with respect to pregnancy-related services (or all services, if the State has decided to exclude all services) when it can be determined from the claim submitted that the recipient was pregnant (S. Rept. No. 97-494, vol. 1, 97th Cong., 2nd Sess. (1982), page 36). In keeping with the congressional intent, we are adopting the policy that this copayment exclusion need be applied only where it can be determined from the claim submitted that the recipient was pregnant.

4. *Emergency Services.*—Section 1916 excludes emergency services, as defined by the Secretary, from copayment obligations. Medicaid regulations already contain a definition for emergency services at 42 CFR 440.170(e). Emergency hospital services are defined as services that are necessary to prevent the death or serious impairment of the health of a recipient, and because of the threat to the life or health of the recipient, necessitate the use of the most accessible hospital available that is equipped to furnish the services. Under the definition, the exclusion from copayments for emergency services applies regardless of whether the emergency services are furnished on an inpatient or outpatient basis and whether the hospital otherwise participates in the Medicaid program or not. Since the present definition was developed for coverage purposes, we particularly solicit comments on whether we should revise it in the future in light of the purpose of the new cost sharing provisions.

5. *Family Planning Services.*—Section 1916 prohibits the imposition of copayments on family planning services and supplies as defined in section 1905(a)(4)(C) of the Act. These are services and supplies furnished (directly or under arrangements with others) to individuals of child-bearing age who desire family planning services and supplies.

6. *HMO Enrollees.*—Services furnished by a health maintenance organization (HMO) to categorically needy recipients enrolled in the HMO plan are excluded from both types of cost sharing under section 1916 of the Medicaid law. States may also exclude from cost sharing all HMO services furnished medically needy recipients, if they desire, without violating the comparability requirements of section 1902(a)(10) of the Act.

7. *Comparability.*—Prior to the Tax Equity and Fiscal Responsibility Act of 1982, section 1902(a)(10) of the Social Security Act provided that medical assistance made available to any categorically needy eligible shall not be less in amount, duration, or scope than that made available to any other such individual and shall not be less in amount, scope, or duration than the medical assistance made available to any medically needy recipient. Under this requirement, imposition of a copayment on one category of Medicaid recipients for a particular service necessitated imposition of copayments for an equivalent service for all recipients in that category. However, section 131(b) of the Tax Equity and Fiscal Responsibility Act of 1982 (Pub. L. 97-248) amends this comparability provision by adding an exception in a new clause (IV) to section 1902(a)(10)(D) of the Act. This provision states that imposition of copayments on an individual who is not exempted by one of the conditions in section 1916 (a)(2) or (b)(2) shall not require the imposition of copayments on an individual who is eligible for such exemption. We are revising 42 CFR 440.250, which sets forth the limitation on comparability of services, to add this new exception. States have the option whether to impose copayments on both the categorically and medically needy. If the State decides to impose copayments, it must exclude those individuals and services outlined above. (The State also may exclude from copayments services to medically needy HMO recipients, services to individuals 18 or older but under 21, and all services furnished to pregnant women.) However, because of comparability requirements, States are precluded from exempting additional groups of individuals or services from a copayment which is imposed by the State.

B. Clarification of Maximum Copayment Charges for Noninstitutional Services

Although we are not implementing the statutory amendment concerning revision of nominality at this time, we are including a minor clarification that is not related to the changes made by section 131 in this rule. This clarification is necessary to eliminate gaps in the

current regulations that have created confusion for the States. We believe it is more convenient for the readers to include this clarification in this revision implementing the statutory changes, even though they are unrelated, than to issue this clarification in a separate rule.

Medicaid regulations at 42 CFR 447.54(a)(3) specify maximum allowable copayment charges for noninstitutional services. The regulations currently permit copayments up to $.50 when the State's payment for the service is $10 or less; up to $1 maximum copayment when the State's payment for the service is $11 to $25, etc. These regulations fail to provide guidance for maximum copayments when the State's payment for services is between whole dollar amounts for each maximum charge such as between $10 and $11, $25 and $26, and $50 and $51.

We are, therefore, revising 42 CFR 447.54(a)(3) to clarify that the maximum copayment for services is $1 where State payment is $10.01 through $25.00, is $2 where the State's payment is $25.01 through $50, and is $3 where the State's payment is $50.01 and more. Since the regulations prescribe maximum copayments, there never has been a rule to prohibit States from charging a $1 copayment as long as the State's payment for the service was over $10, as the current rule specifies a $.50 maximum where States' payment is "$10 or less". Consequently this revision is a clarification of existing policy rather than a change in the maximum nominal amounts. (As such, it does not fall within the purview of section 1916 which requires that changes in the current definition of nominal take into account the level of cash assistance in the State.)

C. Provider Requirements

Section 1916(c) includes a provision that specifies that no provider participating under Medicaid may deny care or services to an individual because of his or her inability to pay the required cost sharing charges. The law provides that this requirement on the provider does not extinguish the liability of the individual receiving the services from payment of the copayment charged. Instead, the intent of this provision is to assure that availability of services is not diminished because of the additional authority allowed in the law to impose copayments on the Medicaid population.

We are, therefore, revising the regulation at 42 CFR 447.15 to specify that providers participating in the Medicaid program must accept State payment and recipient copayment amounts as payment in full for services and that providers may not deny services to recipients because of their inability to pay the copayment charge assessed.

States are required in accordance with CFR 435.905 to notify recipients of changes in their rights and responsibilities with regard to the Medicaid program. Thus, States that impose copayment obligations on recipients must take the appropriate action to notify recipients of the exclusions set forth in this regulation and the prohibition on denial of services on providers.

D. Waiver of Nominal Amounts for Nonemergency Services Furnished in Hospital Emergency Rooms

We are amending the regulations at 42 CFR 431.55 and 447.54 to provide for waiver of nominal copayment amounts for nonemergency outpatient services furnished in a hospital emergency room, as permitted in section 1916 (a)(3) and (b)(3). States may impose a copayment amount up to twice the current maximum for services that do not meet the definition of emergency services, as specified in 42 CFR 440.170(e), which are furnished in hospital emergency rooms. In imposing higher copayment amounts in this circumstance, States must establish, to the satisfaction of HCFA, that individuals have actually available and accessible to them alternative sources of nonemergency, outpatient services. Alternative sources of outpatient services would include physicians or clinics participating in the Medicaid program that are located within reasonable travel distance of the recipient. HCFA may request additional information from the State, such as quantitative estimates of the availability of alternative sources of outpatient services, if it is not clear from the State's waiver request that these alternative sources adequately exist.

Neither section 131 of Pub. L. 97-248 nor the legislative history of this provision provides any direction regarding implementation of this provision, such as duration of the waiver or monitoring of the effects of the waiver. However, section 1915 of the Act provides for similar waivers of other provisions of the Medicaid law. Subsection (d) of section 1915 specifies that all waivers under that section (other than waivers allowing States to provide home and community-based services), are to be granted for a two year period and may be continued at the State's written request if HCFA approves.

Subsection (e)(1) of section 1915 authorizes HCFA to monitor the implementation of waivers granted under section 1915.

In the absence of congressional direction as to the implementation of the waiver authority granted in section 1916 of the law, we believe it is appropriate to apply the same general requirements applicable to other types of program waivers. Therefore, we are limiting the duration of granted waivers to 2 years, unless the State agency requests a continuation. Further, HCFA will monitor the implementation of waivers and where this monitoring shows evidence that the agency is not in compliance with the requirements of the waiver, HCFA may terminate the waiver granted, after a hearing in accordance with 42 CFR 431.55(b)(3).

Although waivers of the requirement that copayments be nominal for nonemergency services furnished in hospital emergency rooms will generally be granted for a two-year period, we are specifying that approved waivers will be re-evaluated if the State increases its current nominal amounts. Since HCFA's approval of a waiver request is based in part on the State's assurance of the accessibility of alternative sources of care and changes in copayment amounts could affect individuals' access to these sources of care, we believe re-evaluation of the waiver approval in the light of these changes is appropriate.

Even though these general procedures were published for public comment on October 1, 1981, and were mandated by statute (section 2175 of Pub. L. 97-35), they were designed specifically to implement waiver provisions of the Medicaid law other than those contained in section 1916. We are applying these procedures to section 1916 waivers and publishing these regulations as final rules with comment period at this time in view of the statutory effective date for implementation. However, we particularly welcome public comment as to the applicability of the already established procedures for other waiver of title XIX requirements to waiver for nonemergency services furnished in hospital emergency rooms.

E. Effective Date

Section 131 of the Pub. L. 97-248 specifies that these provisions are effective October 1, 1982. However, if implementation of these regulations requires State legislation, section 131 also specifies that a State plan will not be out of compliance with these new requirements unless it has not been amended by the first day of the first calendar quarter beginning after the close of the first regular session of the

State legislature that begins after September 3, 1982. However, the State plan must be amended immediately to implement any provisions of this regulation which do not require State legislation.

Regulations governing effective dates of State Medicaid plans at 45 CFR 201.3(g) specify that plans may be effective the first day of the calendar quarter in which an approvable plan is submitted. We have already instructed State Medicaid agencies to amend their plans to bring them into conformity with section 131 of Pub. L. 97–248 effective October 1, 1982.

III. Impact Analysis

A. Executive Order 12291

Executive Order 12291 requires that a regulatory impact analysis be performed for any "major rule". We do not believe that this final rule will not have an annual effect on the national economy of $100 million, or otherwise meet the threshold criteria to be considered a major rule.

These regulations do not require States to make any changes in their current copayment practices, except where the State is currently imposing cost sharing charges on services or categories of recipients which are prohibited under the new law. However, we expect many States will revise their State plans to add copayment charges as permitted by section 131 of Pub. L. 97–248. Our actuaries have estimated the economic impact will be Federal program savings of $78 million in FY 1983, $90 million for FY 1984, and $103 million in FY 1985.

However, even if we were to determine that there was an impact of $100 million or more, we would not classify this regulation as a major rule for purposes of the Executive Order. This is because we have determined that section 131 of Pub. L. 97–248, the Tax Equity and Fiscal Responsibility Act of 1982, and State actions arising from this legislation have occasioned this impact, and not these regulations which merely implement the statutory provision. Therefore, a regulatory impact analysis is not required.

B. Regulatory Flexibility Analysis

The Secretary certifies under 5 U.S.C. 605(b), enacted by the Regulatory Flexibility Act of 1980 (Pub. L. 96–345), that these regulations will not have a significant impact on a substantial number of small businesses, nonprofit entities or small local governments. However, even if there were a significant effect on a substantial number of small entities, we have determined that this effect is the result of the statutory provision and State behavior in exercising the options permitted under this legislation, not these regulations, which merely implement the recent amendment.

IV. Waiver of Proposed Rulemaking

The amendments contained in this regulation merely revise existing regulations to the extent that they are in conflict with the statute as amended, or to restate those provisions of the statute that are self-executing. These regulations implement section 131 of Pub. L. 97–248, which became effective on October 1, 1982. Since the statute does not permit the Secretary discretion to change the classes of individuals or categories of services on which cost sharing charges may be imposed, we believe that publication of a notice of proposed rulemaking is unnecessary for implementation of those cost sharing provisions. Since the statute clearly specifies that the amendments made by it will be effective on October 1, 1982, States are required to amend their State plans, where necessary, effective that date. Our failure to have regulations in effect, as close to October 1 as possible, which provide guidance on implementing these statutory changes and reflect the new statutory requirements, might create confusion and unnecessary delay in implementation of those requirements. We are particularly concerned to avoid any confusion with respect to those services for which the statute now prohibits copayments. We, therefore, believe that any delay in permitting the States to introduce the new provisions Congress intended to become effective by October 1, 1982 would be contrary to the public interest. We are, however, not including in this regulation any provisions that are not required by October 1, particularly those dealing with revision of the definition of "nominal" amounts.

Further, the statute authorizes the Secretary to begin to grant waivers of the requirement that copayment charges be nominal for nonemergency services furnished in hospital emergency rooms on October 1, 1982. The Secretary wishes to effectuate the will of Congress by considering waiver requests as soon as possible after October 1. To avoid confusion and promote consistency in waiver determinations, it is important that these regulations be issued as quickly as possible so that States will receive guidance concerning the standards we will apply in approving and disapproving waiver requests. In order to have these regulations in place as close as possible to the effective date in the law, we must publish these regulations in final form. We believe that a prior public comment period is unnecessary, impractical and contrary to public interest. Therefore, we find good cause to waive publication of a notice of proposed rulemaking on this issue. For the same reasons, we also find good cause to waive the usual 30-day delay in effective date. We will, however, consider any comments on this rule that are mailed by the date specified in the "DATES" section and make any further changes that may be necessary.

V. Other Required Information

A. Public Comments

Because of the large number of comments we receive, we cannot acknowledge or respond to them individually. However, we will consider all comments and will respond to them in the preamble to a revised final rule, if we find it is necessary.

B. List of Subjects

42 CFR Part 431

Administrative practice and procedure, Contracts (Agreements), Fair hearings, Federal financial participation, Grant-in-Aid program—health, Health facilities, Health maintenance organizations (HMO), Indians, Information (Disclosure), Medicaid, Mental health centers, Prepaid health plans, Privacy, Quality control, Reporting requirement.

42 CFR Part 435

Aid to Families with Dependent Children, Aliens, Categorically needy, Contracts (Agreements—State Plan), Eligibility, Grant-in-Aid program—health, Health facilities, Medicaid, Medically needy, Reporting requirements, Spend-down, Supplemental security income (SSI).

42 CFR Part 436

Aid to Families with Dependent Children, Aliens, Contracts (Agreements), Eligibility, Grant-in-Aid program—health, Guam, Health facilities, Medicaid, Puerto Rico, Supplemental security income (SSI), Virgin Islands.

42 CFR Part 440

Clinics, Dental health, Drugs, Grant-in-Aid program—health, Health care, Health facilities, Health professions, Hearing disorders, Home health services, Inpatients, Laboratories, Language disorders, Lung diseases, Medicaid, Mental health centers, Occupational therapy, Personal care

services, Physical therapy, Prosthetic devices, Outpatients, Ophthalmic goals and services, Rural areas, Speech disorders, X-rays.

42 CFR Part 447

Accounting, Clinics, Contracts (Agreements), Copayments, Drugs, Grant-in-Aid program—health, Health facilities, Health professions, Hospitals, Medicaid, Nursing homes, Payments for services—general, Payments—timely claims, Reimbursement, Rural areas.

PART 431—STATE ORGANIZATION AND GENERAL ADMINISTRATION

The authority citation for Part 431 reads as follows:

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

42 CFR 431.55 is amended by revising paragraph (a) and adding paragraph (g) as set forth below:

§ 431.55 Waiver of other Medicaid requirements.

(a) *Basis and purpose.* This section implements section 1915(b) of the Act, which authorizes the Secretary to waive the requirements of sections 1902 and 1903(m) of the Act to the extent he or she finds proposed improvements in the provision of services under Medicaid to be cost-effective, efficient, and consistent with the objectives of the Medicaid program. This section also implements sections 1915 (d), (e), and (f) of the Act, which govern how such waivers are to be approved, continued, monitored, and terminated. Additionally, paragraph (g) of this section implements section 1916 (a)(3) and (b)(3) of the Act, which authorizes the Secretary to waive the requirement in those sections that cost-sharing amounts be nominal.

* * * * *

(g) *Cost sharing requirement.* Beginning October 1, 1982, under sections 1916 (a)(3) and (b)(3), the Secretary may permit by waiver, copayments of up to double the nominal amount, as described in section 447.54, to be imposed on nonemergency services furnished in a hospital emergency room.

(1) Nonemergency services are those services that do not meet the definition of emergency services at section 447.53(b)(4).

(2) In order for a waiver to be approved under this provision, the State must establish to the satisfaction of HCFA, that alternative sources of nonemergency, outpatient services are available and accessible to eligible individuals.

(3) Although, in accordance with paragraph (b)(2) of this section, a waiver will generally be granted for a 2 year duration, HCFA will re-evaluate approved waivers if the State increases the nominal copayment amounts in effect when the waiver was approved.

PART 435—ELIGIBILITY IN THE STATES, DISTRICT OF COLUMBIA AND THE NORTHERN MARIANA ISLANDS

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.

42 CFR Part 435 is amended as set forth below:

1. Section 435.725(c)(1)(iii) is revised to read as follows:

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

* * * * *

(c) * * *

(1) * * *

(iii) For other individuals, a reasonable amount set by the agency, based on a reasonable difference in their personal needs from those of the aged, blind, and disabled.

* * * * *

2. Section 435.733(c)(1)(iii) is revised to read as follows:

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

* * * * *

(c) * * *

(1) * * *

(iii) For other individuals, a reasonable amount set by the agency, based on a reasonable difference in their personal needs from those of the aged, blind, and disabled.

* * * * *

3. Section 435.832(c)(1)(iii) is revised to read as follows:

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

* * * * *

(c) * * *

(1) * * *

(iii) For other individuals, a reasonable amount set by the agency, based on a reasonable difference in their personal needs from those of the aged, blind, and disabled.

* * * * *

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

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 CFR Part 436.832(c)(1) is revised as set forth below:

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

* * * * *

(c) * * *

(1) A personal needs allowance that is reasonable in amount for clothing and other personal needs of the individual while in the institution.

* * * * *

PART 440—SERVICES: GENERAL PROVISIONS

The authority citation for Part 440 reads as follows:

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

42 CFR 440.250 is amended by adding a new paragraph (l) as set forth below:

§ 440.250 Limits on comparability of services.

* * * * *

(l) If the agency imposes cost sharing on recipients in accordance with 447.53, the imposition of cost sharing on an individual who is not exempted by one of the conditions in section 447.53(b) shall not require the State to impose copayments on an individual who is eligible for such exemption.

PART 447—PAYMENT FOR SERVICES

The authority citation for Part 447 reads as follows:

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

42 CFR Part 447 is amended as set forth below:

1. Section 447.15 is revised to read as follows:

§ 447.15 Acceptance of State payment as payment in full.

A State plan must provide that the Medicaid agency must limit participation in the Medicaid program to providers who accept, as payment in full, the amounts paid by the agency plus any deductible, coinsurance or copayment required by the plan to be paid by the individual. However, the provider may not deny services to any eligible individual on account of the

individual's inability to pay the cost sharing amount imposed by the plan in accordance with § 447.53.

(Sec. 1916(c) of the Act)

2. Section 447.53 (a), (b) and (c) are revised to read as follows:

Deductible, Coinsurance, Co-payment or Similar Cost-Sharing Charge

§ 447.53 Applicability; specification; multiple charges.

(a) *Basic requirements.* Except as specified in paragraph (b) of this section, the plan may impose a nominal deductible, coinsurance, copayment, or similar charge upon categorically and medically needy individuals for any service under the plan.

(b) *Exclusions from cost sharing.* Effective October 1, 1982, the plan may not provide for imposition of a deductible, coinsurance, copayment, or similar charge upon categorically or medically needy individuals (except as specified in paragraph (b)(6) of this section) for the following:

(1) *Children.* Services furnished to individuals under 18 years of age (and, at the option of the State, individuals under 21, 20, or 19 years of age, or any reasonable category of individuals 18 years of age or over but under 21) are excluded from cost sharing.

(2) *Pregnant women.* Services furnished to pregnant women (when it can be determined from the claim submitted that the recipient was pregnant), if such services relate to the pregnancy, or to any other medical condition which may complicate the pregnancy are excluded from cost sharing obligations. These services include routine prenatal care, labor and delivery, routine post-partum care, and complications of pregnancy or delivery likely to affect the pregnancy, such as hypertension, diabetes, and urinary tract infection. States may further exclude from cost sharing all services furnished to pregnant woman if they desire.

(3) *Institutionalized individuals.* Services furnished to any individual who is an inpatient in a hospital, long-term care facility, or other medical institution if the individual is required (pursuant to §§ 435.733, 435.832, or 436.832), as a condition of receiving services in the institution, to spend all, but a minimal amount of his income required for personal needs, for medical care costs are excluded from cost sharing.

(4) *Emergency services.* Inpatient or outpatient services are considered emergency services (in accordance with § 440.170 (e)) under this exclusion if:

(i) The services are necessary to prevent the death or serious impairment of the health of the individual; and

(ii) Because of the threat to life or health of the individual, the services are furnished in the most accessible hospital available that is equipped to furnish the required care even if the facility does not meet the conditions for participation under Medicare or meet the definitions of inpatient or outpatient services under §§ 440.10 and 440.20.

(5) *Family planning.* Family planning services and supplies furnished to individuals of child-bearing age are excluded from cost sharing.

(6) *HMO Enrollees.* Services furnished by a health maintenance organization (HMO) to categorically needy individuals enrolled in the HMO are excluded from cost sharing. States may further exclude copayment charges for HMO services furnished to medically needy individuals.

(c) *Prohibition against multiple charges.* For any service, the plan may not impose more than one type of charge referred to in paragraph (a) of this section.

* * * * *

5. Section 447.54(a) is revised, paragraphs (b) and (c) are redesignated as paragraphs (c) and (d), respectively, and a new paragraph (b) is added to read as follows:

§ 447.54 Maximum allowable charges.

(a) *Non-institutional services.* Except as specified in paragraph (b), for non-institutional services, the plan must provide that—

(1) Any deductible it imposes does not exceed $2.00 per month per family for each period of Medicaid eligibility. For example, if Medicaid eligibility is certified for a 3-month period, the maximum deductible which may be imposed on a family for that period of eligibility is $6.00;

(2) Any coinsurance rate it imposes does not exceed 5 percent of the payment the agency makes for the services; and

(3) Any co-payments it imposes do not exceed the amounts shown in the following table:

States payment for the service	Maximum copayment chargeable to recipient
$10 or less	$.50
$10.01 to $25	1.00
$25.01 to $50	2.00
$50.01 or more	3.00

(b) *Waiver of the requirement that cost sharing amounts be nominal.* Upon approval from HCFA, the requirement that cost sharing charges must be nominal may be waived, in accordance with section 431.55(g) for nonemergency services furnished in a hospital emergency room.

(c) *Institutional services.* For institutional services, the plan must provide that the maximum deductible, coinsurance or co-payment charge for each admission does not exceed 50 percent of the payment the agency makes for the first day of care in the institution.

(d) *Cumulative maximum.* The plan may provide for a cumulative maximum amount for all deductible, coinsurance or co-payment charges that it imposes on any family during a specified period of time.

4. Section 447.58 is revised to read as follows:

§ 447.58 Payments to prepaid capitation organizations.

Except for HMO services subject to the co-payment exclusion in § 447.53(b)(6), if the agency contracts with a prepaid capitation organization that does not impose the agency's deductibles, coinsurance, co-payments or similar charges on its recipient members, the plan must provide that the agency calculates its payments to the organization as if those cost sharing charges were collected.

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

Dated: November 22, 1982.

Carolyne K. Davis,

Administrator, Health Care Financing Administration.

Approved: January 18, 1983.

Richard S. Schweiker,

Secretary.

[FR Doc. 83-3250 Filed 2-7-83; 8:45 am]

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DEPARTMENT OF THE INTERIOR

Office of the Secretary

43 CFR Part 20

Employee Responsibilities and Conduct

AGENCY: Interior Department.

ACTION: Notice of availability—Appendices C, D, E, F, and G to 43 CFR Part 20.

SUMMARY: This notice announces the availability of Appendices C, D, E, F,