service of providing secondary transmissions; and

"Form 3" systems: $292,000 or more in semiannual gross receipts from the basic service of providing secondary transmissions

The Cable Representatives and Copyright Owners further agree that the semiannual royalty fee payment for Form 1 cable systems shall be $28.00, commencing with the first semiannual accounting period of 1985 and continuing for each accounting period thereafter.

Article V

(A) Cable Representatives and Copyright Owners agree not to seek in the 1985 Inflation Adjustment Proceeding any adjustment to rates currently prescribed in § 308.2(c) of the Tribunal's rules, relating to rates for distant signals in excess of the former FCC distant signal rules, or in § 308.2(d) of the Tribunal's rules, relating to rates for elimination of syndicated exclusivity protection.

(B) This Settlement Agreement does not preclude and is without prejudice to the Cable Representatives and Copyright Owners seeking adjustments in the rates specified in paragraph (A) above in any proceeding to change rates in accordance with sections 801(b)(2) (B) and (C) and 804(b) of the Act or in any inflation adjustment proceeding other than the 1985 Inflation Adjustment Proceeding.

Article VI

(A) The Cable Representatives and Copyright Owners will use their best efforts to persuade the Tribunal and all parties participating in the 1985 Inflation Adjustment Proceeding to adopt the terms of this Settlement Agreement and to have the Tribunal amend its regulations in accordance with this Settlement Agreement.

(B) Each of the Cable Representatives and Copyright Owners states that it has the authority to enter into this Settlement Agreement as an industry representative and is presently unaware of any other person or entity which would oppose this Settlement Agreement.

Article VII

(A) This Settlement Agreement is made upon the express understanding that it constitutes a negotiated settlement of the 1985 Inflation Adjustment Proceeding. No person shall be deemed to have accepted as precedent, or approved, accepted, agreed to, or consented to any principle underlying, or which may be asserted to underlie, it nor to any principle advanced by Copyright Owners or Cable Representatives as to any of the matters at issue in said proceeding.

(B) This Settlement Agreement is without prejudice to any position, contention, or argument which Copyright Owners or Cable Representatives may take in any proceeding or litigation other than the 1985 Inflation Adjustment Proceeding.

Article VIII

The Cable Representatives and Copyright Owners agree that the various provisions of this Settlement Agreement are not severable. The parties further agree that, except as may be necessary in connection with jointly seeking approval of this Settlement Agreement before the Tribunal or before a court on judicial review of a Tribunal order approving this Settlement Agreement, it shall be privileged and not admissible in evidence or in any way described or discussed in the 1985 Inflation Adjustment Proceeding or in any other proceeding.

Article IX

This Agreement may be executed in any number of counterparts, all of which taken together shall constitute one Agreement, and a party may execute this Settlement Agreement by signing any such counterpart.

In Witness Whereof, the parties to this Settlement Agreement have caused it to be executed by their authorized representatives as of the day and year first above written.

National Cable Television Association, Inc.
By /s/ Robert St. John Roper, Robert St. John Roper, LeBoeuf, Lamb, Liby & MacRae, 1333 New Hampshire Ave., N.W., Washington, D.C. 20036

Major League Baseball
By /s/ Robert Alan Garrett, Robert Alan Garrett, Arnold & Porter, 1200 New Hampshire Ave., N.W., Washington, D.C. 20036

National Basketball Association and North American Soccer League
By /s/ Philip R. Hochberg, Philip R. Hochberg, Baraff, Koerner, Olender & Hochberg, 2033 M Street, N.W., Washington, D.C. 20036

National Collegiate Athletic Association
By /s/ Michael Scott, Michael Scott, Squire, Sanders & Dempsey, 1201 Pennsylvania Ave., N.W., Washington, D.C. 20004

Community Antenna Television Association
By /s/ Stephen R. Effros, Stephen R. Effros, Community Antenna Television Association, 3977 Chain Bridge Road, Fairfax, Virginia 22030

Motion Picture Association of America, Inc.
By /s/ Dennis Lane, Dennis Lane, Wilner & Scheiner, 1200 New Hampshire Ave., N.W., Washington, D.C. 20036

National Hockey League
By /s/ Robert W. Coll, Robert W. Coll, McKenna, Wilkinson & Kittner, 1150 Seventeenth Street, N.W., Washington, D.C. 20036

National Association of Broadcasters
By /s/ John I. Stewart, John I. Stewart, Crowell & Moring, 1100 Connecticut Ave., N.W., Washington, D.C. 20036

American Society of Composers, Authors and Publishers
By /s/ Bernard Korman, Bernard Korman, ASCAP, One Lincoln Plaza, New York, New York 10023

Sesac, Inc.
By /s/ Nicholas Arcomano, Nicholas Arcomano, Vice President and Counsel, SESAC, 10 Columbus Circle, New York, New York 10019

Broadcast Music, Inc.
By /s/ Charles T. Duncan, Charles T. Duncan, Reid & Priest, 1111—19th Street, N.W., Suite 1100, Washington, D.C. 20036

[FR Doc. 85-6444 Filed 3-18-85; 8:45 am]
BILLING CODE 1410-08-M

POSTAL SERVICE

39 CFR Part 111

Correct ZIP Codes for Mailings

AGENCY: Postal Service.

ACTION: Proposed rule.

SUMMARY: This proposed rule would amend the Domestic Mail Manual to require mailers of certain categories of mail and those who desire to participate in certain presort discount mailings to include the correct five-digit ZIP Code in the address of each piece. With certain exceptions, current postal regulations do not explicitly require mailers to use correct ZIP Codes. When mailers fail to use correct ZIP Codes, the Postal Service incurs additional handling expense. This nullifies the savings the Postal Service would otherwise receive when mailers presort their mail.

DATE: Comments must be received on or before April 18, 1985.

ADDRESS: Written comments should be mailed or delivered to the Director, Office of Address Information and Management Control Systems, U.S. Postal Service Headquarters, 475 L'Enfant Plaza West, S.W., Washington, D.C. 20260–7230.

Copies of all written comments will be available for inspection and photocopying between 9:00 a.m. and 4:00 p.m., Monday through Friday in Room 7427 at the above address.

FOR FURTHER INFORMATION CONTACT: William Price, (202) 245–5784.

SUPPLEMENTARY INFORMATION: Most bulk rate mailings of First-, second-, third-, and fourth-class mail are required to be presorted by mailers to specific ZIP Code and other destinations. The addresses on bulk rate mailings and certain other mail are required to contain either a ZIP+4 code or a five-digit ZIP Code. Except for mailers of bulk second-class and ZIP+4 First-Class Mail, current postal regulations do not explicitly require mailers to use correct ZIP code in addressing their mail. When incorrect ZIP Codes are used, mail must be forwarded at additional expense in order to effect delivery. In particular, this additional handling expense reduces or nullifies the cost savings that justify the rate discounts that mailers receive for presorting their mail.

This proposed rule would amend postal regulations to require all bulk rate mailers to include correct five-digit ZIP Codes on their mail. The proposed rule would also amend postal regulations to

provide that the correct ZIP Code be used when a ZIP Code is required in the address. This would eliminate the additional handlings and expense associated with the use of incorrect ZIP Codes. Mailers would satisfy the requirement by using the ZIP Codes in the version of Publication 65, *National Five-Digit ZIP Code and Post Office Directory* (issued annually in January) that is current at the time of mailing or in the version of the "ZIP-A-LIST" computer tapes (issued quarterly) that are current at the time of mailing. Mailers will be allowed until March 15 of each year to update their mailing lists with current ZIP Codes.

This proposed change does not replace, supplement, or otherwise affect the existing regulations which require that the correct ZIP+4 code appear on each piece of ZIP+4 mail.

Although exempt from the notice and comment requirements of the Administrative Procedure Act (5 U.S.C. 553(b)(c)) regarding proposed rulemaking by 39 U.S.C. 410(a), the Postal Service invites comment on the following proposed revision of the Domestic Mail Manual, incorporated by reference in the Code of Federal Regulations. *See* 39 CFR 111.1.

List of Subjects in 39 CFR Part 111

Postal service.

PART 111—[AMENDED]

1. In 122.6, revise 122.634 and .635 to read as follows:

122.6 ZIP Code System.

* * * * *

.63 Assignment of ZIP Codes.

* * * * *

.634 Presorting by ZIP Code. Presort rate mailings of First-, Second-, Third-, and Fourth-Class mail must be presorted by the mailer to specific ZIP Code and other destinations. The correct five-digit ZIP Code must be included in the address of each piece. See 122.635 for correct ZIP Codes. Lists for use by bulk rate mailers in sorting to optional multi-ZIP Code cities, unique three-digit ZIP Code prefix cities, sectional center facilities (SCF's), area distribution centers (ADC's), state distribution centers (SDC's), states, and bulk mail centers (BMC's) are in Exhibits 122.63 a through 1.

.635 Correct ZIP Codes. Correct five-digit ZIP Code information is contained in the most current Publication 65, *National Five-Digit ZIP Code and Post Office Directory*, or in the latest "ZIP-A-LIST" computer tapes. The directory is available for purchase at all post offices, classified stations and branches, and from the Government Printing Office. ZIP-A-LIST computer tapes are available from the Postal Service at no charge and can be obtained by submitting a completed Form 5602, *ZIP-A-LIST/DOPO Tapes Order Form*, to the address indicated on the form. Form 5602, *ZIP-A-LIST/DOPO Tapes Order Form*, can be obtained from the local postmaster. Use of each calendar year's *National Five-Digit ZIP Code and Post Office Directory* for including the current five-digit ZIP Code on each piece of a bulk rate mailing is mandatory after March 15 of each year. Use of the more current ZIP-A-LIST data is permitted and encouraged.

2. In 361, revise 361.3 to read as follows:

361 Addressing.

* * * * *

361.3 Presort First-Class Mail and Carrier Route First-Class Mail.

The address of each piece of Presort First-Class Mail and Carrier Route First-Class Mail must include either the correct ZIP+4 code or the correct five-digit ZIP Code. The address of each piece of carrier route First-Class Mail must also contain the correct carrier route code.

3. In 661, revise 661.2 to read as follows:

661 Addressing.

* * * * *

661.2 ZIP Code.

Each piece including the top copy of a firm package (see 667.121a) must bear the name and address of the addressee. The address must include either the correct ZIP+4 code or the correct five-digit code ZIP Code. *Exception:* A ZIP Code may be omitted from pieces bearing a simplified address in accordance with 122.41 and from pieces mailed at the rates in 611.11 and 611.4.

4. In 761, revise 761.11 to read as follows:

761 General Requirements.

761.1 Addressing.

.11 The address on all fourth-class matter mailed at bulk parcel post, bound printed matter, library and special fourth-class rates must contain either the correct ZIP+4 code or the correct five-digit ZIP Code.

An appropriate amendment to 39 CFR 111.3 to reflect this change will be published if the proposal is adopted.

(39 U.S.C. 401, 403(b))

Fred Eggleston,

Assistant General Counsel, Legislative Division.

[FR Doc. 85-6523 Filed 3-18-85; 8:45 am]

BILLING CODE 7710-12-M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 435 and 436

[BERC-514-P]

Medicaid Program; Payments to Institutions

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

ACTION: Proposed rule.

SUMMARY: This proposal would provide greater flexibility to States by amending the Medicaid regulations that govern post-eligibility determinations for institutionalized individuals.

The proposed rules are part of the Department's regulation reform efforts that are designed to clarify regulations, delete unnecessary or burdensome requirements, and provide maximum flexibility to States while maintaining patient health and safety.

DATE: To assure consideration comments should be submitted by May 20, 1985.

ADDRESS: Address comments in writing to: Health Care Financing Administration, U.S. Department of Health and Human Services, Attention: BERC-514-P, P.O. Box 26676, Baltimore, Maryland 21207.

In commenting, please refer to file code BERC-514-P.

If you prefer, you may deliver your comments to Room 309-G Hubert H. Humphrey Building, 200 Independence Ave., SW., Washington, D.C., or to room 132 East High Rise, 6325 Security Boulevard, Baltimore, Md.

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

FOR FURTHER INFORMATION CONTACT: Marinos Svolos, (301) 594-9050.

SUPPLEMENTARY INFORMATION:

I. Background

The Medicaid program (title XIX of the Social Security Act (the Act, U.S.C. 1396 et seq.)) is a Federally supported and State administered assistance program providing medical care and services to certain low income individuals and families. Eligible individuals may include certain aged, blind or disabled individuals who are institutionalized in health care facilities (i.e., hospitals, skilled nursing facilities and intermediate care facilities). Eligibility for Medicaid for persons in these institutions is determined by the monthly application of a combination of State and Federal criteria concerning income levels.

Section 1902(a)(17) of the Act (42 U.S.C. 1396a(a)(17)) gives the Secretary broad authority to set standards for the reasonable treatment of an individual's income. Current regulations (42 CFR 435.725, 435.733 and 435.832 for the various Medicaid States, District of Columbia and Northern Mariana Islands, and 42 CFR 436.832 for Guam, Puerto Rico, and the Virgin Islands) provide that, after these criteria are applied and eligibility for Medicaid is established, the State's payment to the institution must be reduced by the amount of the institutionalized individual's income less certain allowable deductions. (Such allowable deductions must include any incurred medical expenses for services which are not covered in a State's Medicaid plan.) These provisions reflect Congressional intent to have an individual with income defray the cost of institutional care to the extent possible.

States have found current regulations regarding post-eligibility treatment of income and resources of institutionalized individuals to be inflexible and administratively burdensome. States have advised us that they have experienced problems in making the individual calculations and adjusting payments to institutions because the income and expenses of an individual patient can fluctuate widely from month to month. Additionally, States point out that the regulations require them, when calculating an individual's cost of care liability, to deduct the costs of medical services which the States have decided not to cover in their State plans. Costs which the States are not required to cover in their State plans should also not be required to be deducted in calculating the individual's liability, they maintain. Instead, States have asked for greater flexibility in deciding how these post-eligibility determinations will be made.

II. Provisions of the Regulations

To allow States more flexibility in administering their programs, we are proposing to make several changes to the current regulations. First, we would revise 42 CFR 435.725, 435.733, 435.832 and 436.832 to allow States greater flexibility in administering provisions relating to making the computations and applying patient income to the cost of care in institutions. We would amend the regulations to provide that, in determining income for institutionalized individuals, each State may, at its option, either continue to use total available income in the computation, or it may project anticipated income using the average available amount of monthly income received by the individual over the prior 6 month period. By projecting the individual's available income over a 6 month period a State can make a reliable and consistent prediction of the individual's income. This would eliminate the need for monthly recalculations of eligibility to account, for example, for interest and dividend payments which can vary from month to month. However, States that project income over a 6 month period would be required to reconcile actual income against projected income for that period, and apply the difference to future post-eligibility determinations, in accordance with procedures specified by the State.

Second, we would amend the regulations to allow States greater flexibility in determining allowable medical deductions from the patient's income when establishing his or her contribution to the cost of care. When considering the individual's allowable medical expenses, there are two types which would fit the general category of "noncovered" medical expenses, i.e., medical expenses incurred by the recipient for which title XIX will not be making any payment. These are:

(1) Medical expenses for services which are recognized under State law, but not covered at all under the State plan; and

(2) Medical expenses for services which exceed State plan limitations on amount, duration or scope.

For example, assume a State's plan does not cover dentures, but will pay for up to two dental services per month. An institutionalized individual with income to be considered towards cost of care sees the dentist several times one month which results in charges for five dental services in that month. In the same month, the individual incurs a charge for dentures.

Under this proposal, States *may* deduct none, some, or all of the cost of the dentures from this individual's income. However, the State *must* deduct some amount for the three dental services which exceed its State plan limit on those services. The proposal would permit the State to set a reasonable limit on the amounts to be deducted for these additional dental services. States would not, however, be permitted to set an aggregate amount on these services. For example, the State may not set an overall fixed amount of $150 on noncovered medical expenses when setting reasonable limits but must, rather, set reasonable limits on each type of service.

We are particularly interested in receiving public comments on whether States should have the added option of projecting deductions of individuals' medical or remedial expenses, based on an average of expenses in previous months. We believe that this option would give States increased administrative flexibility by eliminating the need to do monthly budgeting for those individuals who have recurring medical expenses, such as insulin injections.

III. Impact Analysis

A. Executive Order 12291

Executive Order 12291 requires us to prepare and publish a regulatory impact analysis for any regulations that are likely to have an annual effect on the economy of $100 million or more, cause a major increase in costs or prices, or meet other threshold criteria that are specified in that Order. Such analysis must show, when published, that the agency issuing the regulations has examined alternatives that might minimize unnecessary burden or otherwise ensure the regulations to be cost-effective. We have determined that the proposal to amend the Medicaid regulations that govern post-eligibility determinations for institutionalized individuals would not result in an annual economic effect of $100 million or meet the other thresholds in section 1(b) of the Order.

We estimate that this proposal would result in some Medicaid savings, but we cannot give an exact estimate because we do not know which options within the proposal the States will select. Although we have little data on which to base an estimate, we have developed a rough estimate based on the Medicaid population in the areas most likely to be affected and an approximation of the level of savings per eligible individual associated with the proposed change in the post-eligibility determination process. On that basis, we estimate that

the FY 1984 savings could range from 0–$28 million.

Also, we believe that this proposal would ease some of the States' administrative burden associated with the current regulations. We believe that it would be cost effective to give the States the right to eliminate unnecessary administrative expenses. However, we estimate that there would be only a savings to the States' Medicaid program and that the savings would be negligible.

B. Regulatory Flexibility Act

The Regulatory Flexibility Act (Pub. L. 96–354) requires us to prepare and publish a regulatory flexibility analysis in regulations unless the Secretary certifies that the regulations will not have a significant impact on a substantial number of small entities. Such analyses must, when prepared, show that the agency issuing the regulations has examined alternatives that might minimize unnecessary burden or otherwise ensure the regulations to be cost-effective.

As defined by the Regulatory Flexibility Act, the term "small entity" includes the term "small governmental jurisdiction", which means governments of cities, counties, towns, townships, villages, school districts, or special districts with a population of less than fifty thousand. No State meets this definition, and since this proposal primarily affects States and individuals, an analysis is not required for these affected States and individuals. However, with respect to the effect of the post-eligibility provision on institutions, we believe that some institutions could be affected by a reduction in State payments as a result of a State choosing to set a reasonable limit on the amount of the expenses to be deducted. Setting reasonable limits would probably reduce State payment as payment in full to institutions as required by § 447.15. However, since we do not know which States would establish reasonable limits or what amount of an institution's expenses would exceed the limit and not be reimbursed, we cannot predict the fiscal impact of this provision.

Therefore, the Secretary certifies, under Section 5 U.S.C. 605(b), enacted by the Regulatory Flexibility Act of 1980 (Pub. L. 96–354), that the proposed regulations would not have a significant impact on a substantial number of small entities.

IV. Response to Comments

Because of the large number of comments we receive, we cannot acknowledge or respond to them individually. However, in preparing the final rule, we would consider all comments and respond to them in the preamble to that rule.

V. List of Subjects

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 Parts 435 and 436 would be amended as set forth below:

A. Part 435 would be amended as follows:

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.

1. Section 435.725 is amended by revising paragraph (a), the introductory language of paragraph (c), redesignating paragraph (c)(4)(ii) as (d)(1), and revising paragraphs (c)(4) and (d) 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.

(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) of this section, from the individual's income or projected income that is based on the individual's average available income for the preceding 6 months. States that elect to project income must periodically reconcile projected income with actual income for the 6 month period, and apply any difference between the two amounts to future post eligibility determinations in accordance with procedures specified by the State.

* * * * *

(c) In reducing its payment to the institution, the agency must deduct the following amounts, in the following order, from the individual's total or projected income, as determined under paragraph (a) of this section. Using either method, income that was disregarded in determining eligibility must be considered in this process.

* * * * *

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

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

(ii) Necessary medical or remedial services included in the State's Medicaid plan, even when they exceed limitations on amount, duration or scope imposed by the agency, subject to reasonable limits the agency may establish on amounts of these expenses.

(d) In determining the amount of the individual's income to be used to reduce the agency's payment to the institution, the agency may deduct the following amounts from the individual's income as determined under paragraph (a) of this section:

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

(2) For single individuals, an amount (in addition to the personal needs allowance) for maintenance of the individual's home if—

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

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

3. Section 435.733 is amended by revising paragraph (a), the introductory language of paragraph (c), redesignating paragraph (c)(4)(ii) as (d)(1), and revising paragraphs (c)(4) and (d) to read as follows:

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

(a) The agency must reduce its payment to an institution, for services provided to an individual specified in paragraph (b) of this section, by the amount that remains after deducting the amounts specified in paragraph (c) of this section, from the individual's income or projected income that is based on the individual's average available income for the preceding 6 months. States that elect to project

income must periodically reconcile projected income with actual income for the 6 month period, and apply any differences between the two amounts to future post eligibility determinations in accordance with procedures specified by the State.

* * * * *

(c) The agency must deduct the following amounts, in the following order, from the individual's total or projected income, as determined under paragraph (a) of this section. Using either method, income that was disregarded in determining eligibility must be considered in this process.

* * * * *

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

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

(ii) Necessary medical or remedial services included in the State's Medicaid plan, even when they exceed limitations on amount, duration or scope imposed by the agency, subject to reasonable limits the agency may establish on amounts of these expenses.

(d) In determining the amount of the individual's income to be used to reduce the agency's payment to the institution, the agency may deduct the following amounts from the individual's income as determined under paragraph (a) of this section:

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

(2) For single individuals, an amount (in addition to the personal needs allowance) for maintenance of the individual's home if—

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

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

4. Section 435.832 is amended by revising paragraph (a), the introductory language of paragraph (c), redesignating paragraph (c)(4)(ii) as (d)(1), and revising paragraphs (c)(4) and (d) to read as follows:

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

(a) The agency must reduce its payment to an institution, for services provided to an individual specified in paragraph (b) of this section, by the amount that remains after deducting the amounts specified in paragagraph (c) of this section, from the individual's income or projected income that is based on the individual's average available income for the preceding 6 months. States that elect to project income must periodically reconcile projected income with actual income for the 6 month period, and apply any difference between the two amounts to future post eligibility determinations in accordance with procedures specified by the State.

* * * * *

(c) The agency must deduct the following amounts, in the following order, from the individual's total or projected income, as determined under paragraph (a) of this section. Using either method, income that was disregarded in determining eligibility must be considered in this process.

* * * * *

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

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

(ii) Necessary medical or remedial services included in the State's Medicaid plan, even when they exceed limitations on amount, duration or scope imposed by the agency, subject to reasonable limits the agency may establish on amounts of these expenses.

(d) In determining the amount of the individual's income to be used to reduce the agency's payment to the institution, the agency may deduct the following amounts from the individual's income as determined under paragraph (a) of this section:

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

(2) For single individuals, an amount (in addition to the personal needs allowance) for maintenance of the individual's home if—

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

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

B. Part 436 would be amended as follows:

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.

1. Section 436.832 is amended by revising paragraph (a), the introductory language of paragraph (c), redesignating paragraph (c)(4)(ii) as (d)(1), and revising paragraphs (c)(4) and (d) to read as follows:

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

(a) The agency must reduce its payment to an institution, for services provided to an individual specified in paragraph (b) of this section, by the amount that remains after deducting the amounts specified in paragraph (c) from the individual's income or a projected income that is based on the individual's average available income for the preceding 6 months. States that elect to project income must periodically reconcile projected income with actual income for the 6 month period, and apply any difference between the two amounts to future post eligibility determinations in accordance with procedures specified by the State.

* * * * *

(c) The agency must deduct the following amounts, in the following order, from the individual's total or projected income as determined under paragrpah (a) of this section. Using either method, income that was disregarded in determining eligibility must be considered in this process.

* * * * *

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

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

(ii) Necessary medical or remedial services included in the State's Medicaid plan, even when they exceed limitations on amount, duration or scope imposed by the agency, subejct to reasonable limits the agency may establish on amounts of these expenses; and

(d) In determining the amount of the individual's income to be used to reduce the agency's payment to the institution, the agency may deduct the following amounts from the individual's income as determined under paragraph (a) of this section:

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

(2) For single individuals, an amount (in addition to the personal needs allowance) for maintenance of the individual's home if—

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

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

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

Dated: December 12, 1983.

Carolyne K. Davis,

Administrator, Health Care Financing Administration.

Approved: October 2, 1984.

Margaret M. Heckler,

Secretary.

[FR Doc. 85-6532 Filed 3-18-85; 8:45 am]

BILLING CODE 4120-01-M

DEPARTMENT OF THE INTERIOR

Office of the Secretary

43 CFR Part 4

Department Hearings and Appeals Procedures

AGENCY: Office of Hearings and Appeals, Office of the Secretary, Interior.

ACTION: Proposed rule.

SUMMARY: The Office of Hearings and Appeals (OHA) is proposing to revise its procedural rules at 43 CFR 4.5 and 4.27 to clarify that the Secretary does not have power to exercise jurisdiction over matters before the Interior Board of Contract Appeals (IBCA), to establish procedures relating to the exercise of the Secretary's reserved powers over OHA proceedings and to broaden and strengthen the general prohibition against *ex parte* communications in OHA proceedings. OHA is also proposing to remove duplicative provisions regarding *ex parte* communications from the procedures for particular OHA proceedings.

DATE: Written comments on the proposed amendments must be received by April 18, 1985.

ADDRESSES: Written comments are to be mailed or hand-delivered to the Director, Office of Hearings and Appeals, Department of the Interior, 4015 Wilson Boulevard, Arlington, Virginia 22203.

FOR FURTHER INFORMATION CONTACT: John H. Kelly, Deputy Director, OHA, (703) 235-3810; Deborah S. Ryan, Attorney-Advisor, Office of the Solicitor, (202) 343-5216.

SUPPLEMENTARY INFORMATION: OHA is the body within the Department of the Interior that has been delegated the authority of the Secretary to hear, consider, and determine matters within the jurisdiction of the Department involving hearings, appeals, and other review functions of the Secretary. OHA's general rules relating to procedures and practice are contained in 43 CFR Part 4, Subpart B. Other subparts in 43 CFR Part 4 contain procedural rules applicable to particular types of hearings, for example, land appeals.

OHA's general rules relating to procedures and practice clearly state that the Secretary has the authority to take jurisdiction at any stage of any case pending before OHA and render the final decision after holding such hearing as may be required by law, to review any OHA decision, and to direct reconsideration of any decision. 43 CFR 4.5(a). The rules also state that the Director of OHA, pursuant to his delegated authority from the Secretary, may assume jurisdiction of or review any case before an appeals board or direct reconsideration of any decision by an appeals board. 43 CFR 4.5(b). The existing rules say nothing about what procedures are to be followed once the Secretary or Director elects to assume jurisdiction of a case or review an OHA decision. The proposed subsection would provide that when the Secretary or Director becomes personally involved in the decisionmaking process by taking jurisdiction of a pending case or reviewing a decision already issued, the parties and appropriate Departmental personnel—which would include the board or administrative law judge handling the case—will be notified, the administrative record will be requested, and a written decision will be issued. We believe that these are appropriate procedural safeguards which enhance the adminstrative process. The proposed policy would not modify existing policy with repect to the finality of OHA decisions for the purpose of exhaustion of adminstrative remedies or create an opportunity for appeal to the Secretary or Director. The proposed subsection would merely clarify procedures relating to the exercise of the Secretary's reserved power and establish adminstrative records for Secretarial review of OHA proceedings.

The existing rules fail to recognize that IBCA, unlike the other OHA boards, is a creature of statute, namely the Contract Disputes Act of 1978, Pub. L. No. 95-563, 41 U.S.C. 601-613 (1982), and that its decisions are final for the Department. We propose changes to 43 CFR 4.5 which would acknowledge the distinct status of IBCA by expressly excepting it from the provisions relating to the exercise of reserved power by the Secretary or Director.

OHA's general rules relating to procedures and practice also contain a two-sentence provision on *ex parte* communications that is applicable to all OHA proceedings. The first sentence of the provision prohibits communications between any party and a member of OHA concerning the merits of a proceeding or an appeal unless the communication is furnished in writing to other parties or made orally in the presence of the other parties or their representatives. The second sentence of the provision states that an OHA appeals board is to refuse to receive, except as part of the appeal record, any information having a substantial bearing on an appeal from persons who are not representatives or parties but who have an interest in the decision to be rendered. 43 CFR 4.27(b). Other prohibitions against *ex parte* communications are contained in the procedures for the Board of Contract Appeals, 43 CFR 4.100(f), the Board of Indian Appeals, 43 CFR 4.317(b), and proceedings concerning nondiscrimination in Federally assisted programs, 43 CFR 4.832(a).

OHA is proposing revisions of the general prohibition against *ex parte* communications in 43 CFR 4.27(b) that would change the provision's scope, applicability, and enforceability. The first proposed change would broaden the scope of the prohibited *ex parte* communications from communications on the merits of a proceeding or an appeal, as currently provided, to communications concerning the merits of a case or any related action pending before OHA, including a rulemaking that would affect a pending case. The second proposed change would increase the number of people who may not have *ex parte* communications from any party and a member of OHA, as currently provided, to any party, person who has an interest in the decision to be rendered, or representative of a party or interested person and a member of OHA involved or likely to become involved in the decisionmaking process of a given proceeding. The term "interested person" is intended to be a wide, inclusive term covering any individual or other person with an interest in the proceeding. The interest need not be monetary, nor need a person be a party to, or intervenor in, the proceeding to come under this section. The term includes, but is not limited to, parties, competitors, public officials, and