Commanding Officer, Naval Submarine Base Bangor. The certificate of exemption shall be maintained on board the exempted vessel so long as such vessel is operating in the security zone.

(2) Any vessel authorized to enter or remain in the security zone may anchor in the security zone anchorage.

(3) Other vessels desiring access to this zone shall secure permission from the Captain of the Port through the Security Office of the Naval Submarine Base Bangor. The request shall be forwarded in a timely manner to the Captain of the Port by the appropriate Navy official.

(d) *Enforcement.* The U.S. Coast Guard may be assisted in the patrol and monitoring of this security zone by the U.S. Navy.

Dated: December 1, 1987.

T.J. Wojnar,

Rear Admiral, U.S. Coast Guard, Commander, Thirteenth Coast Guard District.

[FR Doc. 87-28986 Filed 12-16-87; 8:45 am]

BILLING CODE 491-14-M

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 52

[A-1-FRL-3300-8]

Approval and Promulgation of Air Quality Implementation Plans; Connecticut; Reasonably Available Control Technology for Belding Corticelli Thread Co.

AGENCY: Environmental Protection Agency (EPA).

ACTION: Final rule.

SUMMARY: EPA is approving a State Implementation Plan (SIP) revision submitted by the State of Connecticut. This revision establishes and requires the use of reasonably available control technology (RACT) to control volatile organic compounds (VOC) emissions from the Belding Corticelli Thread Company (Belding) in Putnam, Connecticut. The intended effect of this action is to approve a source-specific RACT determination made by the State in accordance with commitments made in its Ozone Attainment Plan which was approved by EPA on March 21, 1984 (49 FR 10542). This action is being taken in accordance with section 110 of the Clean Air Act.

EFFECTIVE DATE: This rule will become effective January 19, 1988.

ADDRESSES: Copies of the documents relevant to this action are available for public inspection during normal business hours at the Air Management Division, U.S. Environmental Protection Agency, Region I, JFK Federal Building, Room 2313, Boston, MA 02203; Public Information Reference Unit, EPA Library, 401 M Street SW., Washington, DC 20460; and the Air Compliance Unit, Department of Environmental Protection, State Office Building, 165 Capitol Avenue, Hartford, CT 06106.

FOR FURTHER INFORMATION CONTACT: David B. Conroy, (617) 565-3252; FTS 835-3252.

SUPPLEMENTARY INFORMATION: On March 25, 1987 (57 FR 9502), EPA published a Notice of Proposed Rulemaking (NPR) for the State of Connecticut. The NPR proposed approval of State Order No. 8007 as a revision to the Connecticut SIP. The provisions of the Connecticut Department of Environmental Protection's (DEP's) State Order define and impose RACT on Belding as required by subsection 22a-174-20(ee), "Reasonably Available Control Technology for Large Sources," of Connecticut's Regulations for the Abatement of Air Pollution.

Under subsection 22a-174-20(ee), the Connecticut DEP determines and imposes RACT on all stationary sources with the potential to emit one hundred tons per year or more of VOC that are not already subject to RACT under Connecticut's regulations developed pursuant to the control techniques guidelines (CTG) documents. EPA approved this regulation on March 21, 1984 (49 FR 10542) as part of Connecticut's 1982 Ozone Attainment Plan. That approval was granted with the agreement that all source-specific RACT determinations made by the DEP would be submitted to EPA as source-specific SIP revisions.

EPA has reviewed State Order No. 8007 and has determined that the level of control required by this Order represents RACT for Belding. The application of RACT by Belding, which consists of installing pollution control equipment by December 31, 1987 on each of its thread coating machines that will be in operation after December 31, 1987, will reduce Belding's actual emissions from approximately 100 tons per year to less than 37 tons per year. The requirements of the State Order and the rationale for EPA's proposed action are explained in the NPR and will not be restated here. No public comments were received on the NPR.

Since submission of the formal SIP revision by the State of Connecticut, Belding has indicated to the Connecticut DEP that it may choose to shut down all of its thread coating machines by December 31, 1987 in order to achieve compliance with the State Order. This compliance strategy is consistent with the requirements of the State Order. Therefore, the requirements of the State Order regarding the pollution control equipment will only apply to Belding if Belding chooses to operate any of its thread coating machines after December 31, 1987.

Final Action

EPA is approving Connecticut State Order No. 8007 as a revision to the Connecticut SIP. The provisions of State Order No. 8007 define and impose RACT on the Belding Corticelli Thread Company to control VOC emissions as required by subsection 22a-174-20(ee) of Connecticut's regulations.

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

Under section 307(b)(1) of the Clean Air Act, petitions for judicial review of this action must be filed in the United States Court of Appeals for the appropriate circuit by February 16, 1988. This action may not be challenged later in proceedings to enforce its requirements. (See section 307(b)(2).)

List of Subjects in 40 CFR Part 52

Air pollution control, Hydrocarbons, Incorporation by reference, Intergovernmental relations, Ozone, Reporting and recordkeeping requirements.

Note: Incorporation by reference of the State Implementation Plan for the State of Connecticut was approved by the Director of the Federal Register on July 1, 1982.

Date: December 7, 1987.

Lee M. Thomas,

Administrator.

Subpart H, Part 52 of Chapter I, Title 40 of the Code of Federal Regulations is amended as follows:

PART 52—[AMENDED]

Subpart H—Connecticut

1. The authority citation for Part 52 continues to read as follows:

Authority: 42 U.S.C. 7401-7642.

2. Section 52.370 is amended by adding paragraph (c)(39) to read as follows:

§ 52.370 Identification of plan

* * * * *

(c) * * *

(39) Revisions to the State Implementation Plan submitted by the Connecticut Department of

Environmental Protection on August 24, 1987.

(i) Incorporation by reference.

(A) Letter from the Connecticut Department of Environmental Protection dated August 24, 1987 submitting a revision to the Connecticut State Implementation Plan.

(B) State Order No. 8007 for Belding Corticelli Thread Company dated July 13, 1987.

[FR Doc. 87-28505 Filed 12-16-87; 8:45 am]

BILLING CODE 6560-50-M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 431, 435, 440, and 441

[BERC-513-F]

Medicaid Program; Relations With Other Agencies, Miscellaneous Medicaid Definitions, Third Party Liability Quality Control, and Limitations on Federal Funds for Abortions

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

ACTION: Final rule.

SUMMARY: These final regulations (1) revise Medicaid rules to reflect current policy on State payment of cost sharing amounts under Medicare Part B "buy-in" agreements; (2) revise and clarify certain Medicaid definitions; (3) remove the requirement that State plans include third party liability quality control reviews as part of the State's Medicaid quality control system; and (4) provide for limitations on the use of Federal funds for abortion.

These final regulations allow States with Medicare Part B buy-in agreements the option of paying cost sharing amounts for Medicaid beneficiaries for those Medicare services that States do not cover in their Medicaid plans. States may pay cost sharing amounts under Medicare Part B buy-in agreements on all, some or none of the Part B Medicare services that are covered in the Medicaid plan.

We are revising definitions and clarifying ambiguities in several existing Medicaid regulations. The revisions are to the definitions of private duty nursing services, inpatient and outpatient, inpatient and outpatient hospital services, and other laboratory and x-ray services.

We are removing the requirement in our quality assurance regulations that States monitor third party liability errors as a part of their quality control system. Instead, we plan to issue regulations which encourage improved third party liability (TPL) operations by making them an integral component of State Medicaid Management Information System subject to periodic evaluation through systems performance reviews.

We are revising the Medicaid regulations to provide for limitations on the use of Federal funds for abortion, in accordance with previously enacted laws.

EFFECTIVE DATE: These regulations are effective January 19, 1988. State agencies have until 90 days after receipt of a revised State plan preprint to submit their plan amendments and required attachments. We will not hold a State to be out of compliance with the requirements of these final regulations if they submit the necessary preprint plan material by the date.

FOR FURTHER INFORMATION CONTACT:

Bill Lasowski, Relations with Other Agencies, (301) 597-1301

Thomas Hoyer, Miscellaneous Medicaid Definitions, (301) 594-9446

Lester Belsky, Third Party Liability, (301) 594-6710

Luisa Iglesias, Limitations on FFP for Abortions, (202) 245-0383.

I Background

On March 11, 1983, we published in the **Federal Register** at 48 FR 10378, a proposed rule (NPRM) to solicit comments on proposed changes to the regulations on Part B buy-in and Medicaid definitions. The revisions were intended to simplify and clarify regulations, delete requirements that are unnecessary or burdensome to States as well as to the public, and provide maximum flexibility to States while promoting patient health and safety.

The existing Medicare Part B buy-in provisions of the regulations have been cited as burdensome by States. States with buy-in agreements, under section 1843 of the Social Security Act (the Act), have been required to pay, in addition to the Part B premium, the Part B coinsurance and deductible amounts (cost sharing amounts) for all services provided to beneficiaries under Part B of Medicare, even if those same services were not covered in the Medicaid State plan. Some States objected to the payment of Medicare cost sharing amounts for services they had chosen to exclude from coverage under their Medicaid plans. In addition, the court, in *Fob James, et al.* v. *Richard Morris, et al.*, (U.S.D.C. M.D. Ala., N. Div., Civil Action No. 80-172-N), held that our interpretation of the policy set forth at 42 CFR 431.625 was not supported by the statute. (This case was incorrectly cited as *James* v. *Harris* in the NPRM. Copies of this opinion are available from HCFA upon request.)

We also included in the March 11, 1983 NPRM, revised Medicaid definitions of inpatient outpatient, inpatient and outpatient hospital services, private duty nursing services, inpatient psychiatric services and reserved beds. Our intent in proposing these revised definitions was to remove unintentional inconsistencies and avoid misinterpretation between definitions that appear in Parts 440 and 441 of these regulations.

On August 9, 1983, we published in the **Federal Register**, at 48 FR 36151, an NPRM to solicit comments on proposed changes to the Medicaid quality control claims processing and third party liability (TPL) requirements. In those proposed regulations, we included a proposal to remove the quality control systems requirement applicable to performing TPL reviews because those reviews were time consuming for States, and produced questionable data. In addition, past reviews have shown that TPL error rates, as calculated in accordance with existing procedures, have remained consistently low.

II. Response to Public Comments

In response to our request for comments on the March 11, 1983 publication, we received a total of 29 comments from physicians and physician associations, medical equipment suppliers, client advocacy groups, State agencies, a university, a State governor, and a member of the U.S. House of Representatives. In response to our request for comments on the August 9, 1983 publication, we received a total of six comments from States on the elimination of TPL quality control requirements.

A. Comments on the Buy-in Provisions

1. *Comment:* Some commenters argued that the revisions to 42 CFR 431.625 violate the requirements of section 1902(a)(15) of the Act. This section requires that when a State pays only a portion of the Medicare copayments and deductibles for those individuals who are entitled to both Medicare and Medicaid, that portion must be related to the beneficiary's income and resources. One commenter contends that this rule directly contradicts the statutory provision because it would allow States to reduce payment of Medicare coinsurance and deductibles for dually entitled individuals without any established justification based on either the income

or resources of the beneficiaries affected.

Response: Although there is no statutory basis to require States to pay the Part B cost sharing amounts on those Part B services that are not covered under the State Medicaid plan, if a State does choose to pay a portion of the cost sharing on noncovered services, it must be done in accordance with section 1902(a)(15) of the Act. We agree with the commenters that section 1902(a)(15) of the Act imposes an income related test to determine the amount that a recipient is required to pay. The district court, in *James v. Morris* concluded that this income related test does not apply when services are not covered in the State plan, unless a State elects to pay a part of the cost sharing for those noncovered services.

Therefore, we are revising § 431.625(c) to remove any ambiguity that if a State elects to pay a portion of the Medicare cost sharing amount for a noncovered service, the amount paid by a State must be reasonably related to an individual's income and resources. A State must define the term reasonably related in its State plan.

2. *Comment:* Two commenters believed that the proposal could be interpreted to permit States to terminate payment of all Medicare Part B cost sharing amounts. Another commenter questioned whether the proposed change could be interpreted to limit dually entitled individuals (persons entitled to both Medicare and Medicaid) to benefits provided under the State Medicaid plan and, thus, deprive them of the full Medicare benefits legally mandated for all Medicare beneficiaries. Two of these commenters recommended that we clarify our intent and publish a new NPRM accordingly.

Response: In the summary paragraph to the NPRM, we stated that the proposed regulations would "allow States the option of paying cost sharing amounts for Medicaid beneficiaries who are covered under Medicaid Part B buy-in agreements." It was not our intention that States could terminate payment on all Medicare Part B cost sharing amounts, as the summary may have inadvertently suggested. We believe that the subsequent discussion in the preamble and the regulation text made this clear. Rather, a State may choose to make cost sharing payments on all, some, or none of those Medicare Part B benefits that the State does not cover in its Medicaid State plan. When the amount paid by third parties is less than the State's Medicaid payment amount, we will continue to require that a State pay cost sharing amounts on those Medicare Part B Benefits that the State covers in its Medicaid plan.

Under this rule, when a State Medicaid agency elects not to pay the cost sharing charges for dually entitled individuals for services not covered in its State plan, such dually entitled individuals would remain entitled to the full, uniformly mandated range of Medicare benefits available for all Medicare beneficiaries, subject only to the requirements relating to deductibles and coinsurance which are uniformly applicable to all Medicare beneficiaries.

Morever, while commenters both agreed and disagreed with the proposed rule, virtually all commenters clearly understood the thrust of the rule. For this reason, it would be unnecessary for us to republish this rule in proposed form. However, we are revising § 431.625(c) to clarify that a State has the option of paying the deductible and coinsurance amounts "for those Medicare Part B services" not covered under the Medicaid State plan. We believe that this language is more precise than "on a full range of Medicare Part B services" which was used in the proposed regulation.

3. *Comment:* Some commenters contend that under the revised regulations, as State will be able to select the Part B services on which it will pay cost sharing amounts for dually entitled individuals. They conclude that this will establish a class distinction between Medicare beneficiaries with income to pay part B premiums and cost sharing amounts and those without income, and that benefits will vary widely from State to State. Several commenters were concerned that if States do not pay Part B cost sharing amounts on certain services, individuals eligible for both Medicare and Medicaid would be responsible for those payments, and that those individuals can least afford to pay Medicare cost sharing amounts. A commenter predicted that providers may refuse treatment, and individuals may be denied necessary health care.

Response: Congress has given the States discretion in selecting services to be covered under their Medicaid programs. We believe that a regulation requiring States to pay for services not covered under their plans improperly interferes with the flexibility intended by Congress. Moreover, the majority of Medicare Part B services are also covered Medicaid services under most State plans. The only Part B services not mandatorily covered under Medicaid are speech and physical therapy, services of podiatrists and chiropractors, and the rental of certain medical equipment. These services may be furnished under coverage options selected by the State under its State plan or may be covered in connection with one of the mandatory services (medical equipment, and speech and physical therapy may be covered as home health services). Further, individuals who cannot afford the Part B cost sharing amounts for uncovered services are no worse off than similarly situated individuals in States that do not have a buy-in agreement. If an individual paid the Part B premium, instead of the State, the individual would still be obligated to meet the cost sharing requirements of the Medicare program. We believe that an individual's inability to meet the cost sharing requirements of the Medicaid or Medicare programs does not result in unlawful class distinction because those individuals who are covered by a buy-in agreement, but who cannot afford the Part B cost sharing amounts are already in a more favorable position than other Medicaid recipient who are entitled to services covered by Medicare. There is an exemption from the "comparability of services" requirement to permit this result. The exemption to the comparability requirement, however, does not specify that States must pay the Medicare cost sharing amounts for recipients covered under a buy-in program. Nor does the exemption impose an additional comparability requirement with respect to the amounts of the Medicare cost sharing that a State pays for recipients under a buy-in program. Moreover, the buy-in program confers upon the individual eligible for both Medicare and Medicaid an additional benefit, which is beyond the scope of services that a State provides to other Medicaid recipients. When viewed as an additional benefit, rather than as part of the Medicaid services package, the recipient is hardly disadvantaged because the State elects not to cover any of the cost sharing obligations for Part B services that it does not cover for its Medicaid eligibles.

The effect on benefits will vary from State to State depending on how comprehensive the State plan is on coverage of services. All dually entitled individuals will remain entitled to the full scope of Medicare benefits subject to deductible and coinsurance requirements applicable to all Medicare beneficiaries.

Therefore, we believe that it is reasonable to require that individuals pay cost sharing amounts on Medicare Part B services that a State does not cover in its Medicaid plan. We also believe that if a State decides that it will

be cost effective to pay certain cost sharing amounts for services not otherwise covered under the Medicaid State plan, then the State will continue to make those payments.

Finally, if providers refuse treatment, this result would be no different than would be the case if the State did not buy-in for Medicare Part B and the individual had only Medicaid covered services to rely on, or if the individual were not Medicaid eligible and could not afford the Part B cost sharing amounts. Furthermore, a State, by selecting what services it will cover under its Medicaid program has made a determination which services it believes are necessary for its Medicaid population. This regulation removes ambiguity by making it clear that the State is not obligated to pay the cost sharing amounts with respect to services that are covered by Medicare Part B, but not covered by Medicaid.

4. *Comment:* Three commenters expressed the view that our proposed revisions to the buy-in provision in 42 CFR 431.625 conflict with the intent of the buy-in agreement. The commenters believe that the buy-in agreement is intended to assure that individuals eligible for both Medicare and Medicaid receive the full scope of Medicare benefits even if they lack the income to pay Part B cost sharing amounts.

Response: We disagree with the commenters' view of the purpose of the buy-in provision and the buy-in agreement. We believe that the buy-in was enacted to permit States to take advantage (at a cost saving to the Medicaid program) of the coverage of services which is available under Medicare Part B to individuals who would qualify for Part B coverage if they paid their Part B premiums. We have not found any support in the legislative history of the buy-in for the proposition that States must pay the Medicare cost sharing amounts for any uncovered services by virtue of their electing to participate in a buy-in agreement. This view is supported by the *James* v. *Morris* decision. Under these final regulations, a State must continue to pay cost sharing amounts on Medicare Part B benefits that are covered in its State Medicaid plan (subject to State limits on reimbursement and amount, duration and scope of services as explained in the response to comment 8). We do not believe that this provision is contrary to the intent of buy-in agreements.

5. *Comment:* Two medical equipment suppliers believe that since Medicare is the primary payer under a buy-in agreement, the States should not control what are "covered" services and the resulting payments.

Response: The Medicare and Medicaid programs are designed with different coverage of services. While Medicare operates under uniform regulations that are applicable nationwide, the statutory framework of Medicaid gives States substantial leeway to offer different ranges of coverage, especially among optional services. Section 1902(a)(10)(A) establishes the services that are mandatory under Medicaid and gives States the option of covering certain additional services specified in section 1905(a). One purpose of this rule is to clarify each State's authority to establish what is or is not a covered optional benefit under its Medicaid program. The rule will remove a barrier if a State wishes to prevent situations where its program would give greater benefits to one Medicaid recipient than to another Medicaid recipient who is not entitled to Medicare coverage.

6. *Comment:* One State agency asked whether States would also have the option of not paying cost sharing amounts on Medicare services not covered under the State's Medicaid plan when a Medicaid recipient pays his own Part B premium.

Response: This comment is beyond the scope of these regulations. Under State buy-in agreements, States pay the Part B premium for those individuals included in their coverage groups. These groups include all individuals entitled to Medicare Part B who are receiving or are eligible for a category of assistance under Medicaid as specified in the State's buy-in agreement. Inclusion in one of the State coverage groups is the basis for buy-in coverage, and not whether the individual can actually pay his own premiums. Individuals who do not qualify for inclusion in one of these coverage groups are responsible for paying their own Medicare Part B premium. States are not required to pay cost sharing amounts for those individuals who pay their own Part B premiums in the case of services not covered under the Medicaid plan.

7. *Comment:* Three medical equipment suppliers predicted that the regulations will be difficult for home care and durable medical equipment suppliers to administer when billing and administering the collection of payments for services that are not covered under a State Medicaid plan, and that the increased administrative costs would be passed on to all customers. It will be particularly complex for companies doing business in multiple States.

Response: The burden of knowing what services are covered by Medicaid in the various States serviced rests upon each Medicaid provider. Under the buy-in agreement, the billing and collection practices imposed for services covered by Medicare but not covered under the State plan will work on the same principle as they do for Medicare-only beneficiaries. We recognize that these regulations might result in some administrative problems and increased costs for suppliers. However, we believe that suppliers already have administrative procedures in place for billing and collection of Medicare-only claims that can accommodate these changes and lessen the impact of administrative burden. In any event, we believe that the language in the Act and interpretation by the court in *James* v. *Morris* justify these changes.

8. *Comment:* One State agency asked whether States have the option to limit payment of Part B cost sharing amounts in accordance with State limitations imposed on Medicaid services covered under the State plan.

Response: Yes, if a State limits the amount, duration or scope of Medicaid services covered in the State plan, then the State may similarly limit payment of Medicare Part B cost sharing amounts on those same services in accordance with its Medicaid service limitations. For example, if a State plan provides that a State pays for a maximum of five home health visits per year, then the State must pay the copayments on each of those five visits, but is not required to do so on visits exceeding the fifth. Additional examples are in Part 7373 of the State Medicaid Manual.

9. *Comment:* One commenter asked how individuals eligible for both Medicare and Medicaid will be advised of the difference between the State's contribution and their own contribution if the individuals need Part B services which the State excludes under its Medicaid plan.

Response: Under 42 CFR 435.905, the State has the responsibility at the time Medicaid eligibility is established to inform individuals which services are covered under Medicaid. Should the State Medicaid benefit package change after eligibility is established, the State is required, under 42 CFR Subpart E, 431.200, 431.221, and 431.230, to mail a notice to individuals receiving Medicaid benefits at least 10 days before the State reduces services. Individuals thus should be aware of the services for which the State will pay.

10. *Comment:* One commenter asked who will determine the cost sharing amounts for Medicare services the State has chosen not to cover under its Medicaid plan.

Response: Records on cost sharing amounts are maintained by the

Medicare carrier (the organization under contract to the Federal government to process Medicare Part B claims). Individuals needing information on cost sharing amounts can contact either the State Medicaid agency, or the appropriate Medicare carrier.

11. *Comment:* One State agency suggested that we add title IV–E recipients to the list in 42 CFR 431.625(d) of Medicaid recipients receiving cash payments for whom Federal financial participation (FFP) is available in State expenditures for Medicare Part B premiums, as such recipients may be eligible for Medicare Part B services.

Responses: Individuals receiving foster care and adoption assistance payments under title IV–E of the Act are eligible for Medicaid on the same basis as title IV–A recipients (Aid to Families with Dependent Children, AFDC). Sections 472(h) and 473(b) of title IV–E of the Act specify that individuals receiving foster care maintenance payments and adoption assistance payments, respectively, are deemed to be recipients of AFDC under title IV–A of the Act. These same individuals may also be eligible for Medicare Parts A and B if they receive Social Security disability insurance benefits under section 223 of the Act, or child's insurance benefits based on disability under section 202(d) of the Act. In response to this comment, we reexamined the list in § 431.625(d) and found that several other groups were missing. We have expanded the list to include not only the title IV–E recipients, but six other groups for whom State-paid Medicare Part B premiums FFP is currently available. Members of these groups are by statute considered to be recipients of Federal Supplemental Security Income (SSI) benefits, qualifying State Supplementary Payments or title IV–A benefits (AFDC). Therefore, they are encompassed within the authority of section 1903(a)(1) of the Act to provide for FFP in State expenditures for their Part B premiums.

12. *Comment:* Two commenters were opposed to our reference to the district court opinion of *James v. Morris.* Their objections were based on the fact that this is an unreported judicial decision that was not appealed to a higher court and has no precedential value.

Response: We are authorized to make changes to regulations in the interest of removing unnecessary requirements and constraints so that States have greater flexibility in administering the Medicaid program. We must ensure that regulations are clearly within the authority delegated by law and consistent with Congressional intent.

Although we have made reference to this court decision, the decision is not the sole basis for revising the regulations. As stated in the proposed rule, several States have objected to our current ambiguous rules. The court decision supports the need for revising the regulations. It was not intended that the court decision be understood as compelling these changes, but that it might help the public to better understand the changes. Moreover, it has binding effect in Alabama, and may be considered to be persuasive authority in other jurisdictions, especially since it is the only court decision on the issue it addresses.

B. Comments on Medicaid Definition Changes

1. *Comment:* We received a comment from a client advocacy group which objected to our revision, in the absence of specific new or revised legislative intent, of the definition of private duty nursing services, which describes the settings in which private duty nursing services can be furnished.

Response: In the original Medicaid legislation (the 1965 amendments to the Social Security Act), Congress listed private duty nursing services among the services that could be covered under the program, without defining them. By not defining the term "private duty nursing services" in the legislation or accompanying committee reports, Congress left the responsibility to us for developing a reasonable interpretation of this term. We are making this revision because the existing regulations have been misinterpreted to mean that a State providing private duty nursing services must provide those services in all three settings: The recipient's home, a hospital, or a skilled nursing facility. This was not our original intent. Our revision merely clarifies our original intent that States have flexibility, and may limit the provision of these services to any one or more of the three cited locations. We believe that our revision is a reasonable interpretation of the law and gives States maximum flexibility in covering this benefit. The private duty nursing benefit is an optional one, and States generally have considerable latitude in defining the scope of optional services. This flexibility serves as an incentive for States to elect coverage of these services, by allowing States to tailor optional services to the specific needs of their populations.

2. *Comment:* A State agency asked whether the revisions to the regulations at 42 CFR 440.160 and 441.151 specifying requirements for Medicaid coverage of inpatient psychiatric services affect coverage of psychiatric services furnished in general (nonpsychiatric) hospitals. One client advocacy group objected to the revised language in §§ 440.160 and 441.151, which requires that inpatient psychiatric services for individuals under age 21 be provided "in a psychiatric facility or an inpatient program in a psychiatric facility." Section 440.160 previously stated that those services be provided "in a facility or program," and § 441.151 specified that services be provided "by a psychiatric facility or an inpatient program in a psychiatric facility." The commenter contends that our revised language inappropriately excludes coverage of services under an accredited inpatient program when those services are not furnished "in" the psychiatric facility itself. Examples are day treatment in community settings for institutionalized children, and services to assist in the transition from institutional to community living.

Response: We are not making the proposed revisions to §§ 440.160 and 441.151 dealing with inpatient psychiatric services for individuals under age 21 because amendments to the Act made by Pub. L. 99–272 in regard to this benefit require that we reassess our policy before we revise the regulations.

3. *Comment:* We received comments from the two State agencies on our proposed revision to the inpatient hospital services definition in 42 CFR 440.10. One commenter suggested that the regulations be revised to require actual participation in Medicare by a hospital, rather than merely specify that the hospital meet the requirements for such participation. Another commenter expressed concern that, by specifying that hospitals must meet the Medicare requirements for participation as a hospital, rather than as a skilled nursing facility (SNF), the regulations might be interpreted as excluding coverage for services in hospital units that provide less than acute care, yet are not certified or operated as SNFs.

Response: Regarding the first issue, Medicaid regulations at 42 CFR 440.10(a)(3)(iii), in defining inpatient hospital services, have always required that hospitals meet the requirements for participation in Medicare, as opposed to actually requiring them to participate in Medicare. Our purpose in having a hospital meet the requirements for participation in Medicare is to ensure that the hospital staff and facilities meet certain standards of quality, without the reduction in State and provider flexibility that would occur if we made actual participation in Medicare a prerequisite for participation in

Medicaid. However, States may make participation in Medicare a condition for Medicaid participation if they so choose. Regarding the second concern, our intent is simply to specify the conditions of participation that define a facility as a hospital under Medicaid. We believe the commenter mistook the change we proposed as intended to preclude the existence of distinct part SNFs or ICFs in hospital buildings. The revision would not have this effect.

3. *Comment:* We received comments from two State agencies, one university, two provider associations and one client advocacy group on our proposed revisions to the outpatient hospital services definition in 42 CFR 440.20(a). The comments all pertained to the provision that would allow a State to exclude from the definition those items and services that are not generally furnished by most hospitals in the State. The State agencies expressed support for any changes that would give them greater flexibility in this area. Several commenters were concerned that this revision would allow a State to exclude highly specialized outpatient hospital services that are not generally furnished by most hospitals in the State, yet are essential to meet the health needs of specific patient populations. These services might not be otherwise available, or might be available only in the more costly inpatient hospital setting. Additionally, one commenter expressed concern that in predominately rural States, a broad range of outpatient services might be concentrated in a small minority of larger, urban hospitals. These States could, under the definition proposed in the NPRM, exclude all of these services, since they are not "generally furnished by most hospitals in the State."

Response: We believe that our changes would not produce the results that the commenters anticipate. It was our intent that § 440.20(a)(4) permit States to exclude from the definition of "outpatient hospital services" only those broad generic categories of services (for example, dental services) that are not generally furnished by most hospitals in the State. Outpatient hospital services, as specified in § 440.20(a)(1), continue to include preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished to outpatients. Thus, States must continue to cover those generic services that are generally furnished by most hospitals, such as physicians' services, nursing services, and diagnostic tests. The commenters expressed concerns that mainly related to the treatment of specific illnesses (for example, cancer in children, sickle cell anemia, spina bifida), rather than generic service categories. The commenters apparently were concerned that the proposed revision would permit States to exclude individual items and services within a generally furnished category when they are associated with the treatment of specific medical conditions. We believe that this regulation would not have that effect. Under 42 CFR 440.230(c), a State may not arbitrarily deny or reduce the amount, duration or scope of a required service solely because of the recipient's diagnosis, type of illness, or condition. However, in view of the comments, we are clarifying in § 440.20(a)(4) that a State may exclude "types of items and services" rather than "items and services."

5. *Comment:* We received comments from two State agencies and one provider organization regarding our proposed definitions of the terms inpatient and outpatient in 42 CFR 435.1009, and 440.2(a). We proposed that inpatient satus be determined by a patient's stay of at least 24 hours or by the medical institution's decision to admit an individual as an inpatient with the expectation that he or she will receive room, board and professional services in the institution for a 24-hour period or longer, even if this expectation is not realized. Two commenters were concerned that certain outpatient visits might be inappropriately classified as inpatient stays under this provision. One noted that a hospital might routinely allege an "expectation" of an inpatient stay in all instances. The other commenter suggested that an individual who stays for less than 24 hours be recognized as an inpatient only when items or services typical of an inpatient stay are used. A third commenter expressed the opposite concern—that some inpatient stays might be classified inappropriately as outpatient visits. This commenter described a situation in which an individual is admitted as an outpatient, but subsequently develops a need for care that is far more intensive than originally anticipated, and dies or is discharged before 24 hours elapse.

Response: Regarding the first concern (outpatient visits inappropriately classified as inpatient stays), if a hospital attempts to bill inappropriately for an outpatient visit as if it were an inpatient stay, the hospital risks having the entire claim rejected. We believe that in the claims review process, States should be able to detect hospitals that have patterns of inappropriate classification of outpatient visits as inpatient stays. Some factors they might consider, for example, in evaluating these patterns are the nature of the conditions for which admission is made or the provision of items and services that they regard as typical of an inpatient stay. Due to the changing nature of inpatient and outpatient services, however, we believe that it would be difficult to develop a definitive, nationwide set of criteria identifying services that are "typically" inpatient.

Regarding the second concern (inpatient stays inappropriately classified as outpatient visits), under the new inpatient definition, as under the previous definition, the decision on whether or not to admit an individual as an inpatient remains with the provider. This gives the provider flexibility in dealing with individual cases. Thus, if a hospital outpatient's condition should suddenly deteriorate, the hospital could decide at that point to admit the individual as an inpatient.

C. Comments on Elimination of Third Party Liability (TPL) Quality Control Requirements

Comment: Three commenters were opposed to our removal of third party liability monitoring activities from State plan quality control review requirements in § 431.800. These commenters indicated that information from those reviews led to the identification of liable third parties and substantial recoveries, resulting in direct savings to State Medicaid programs. Even though States have the option to continue TPL reviews, one State contended that those reviews would be funded entirely by the State, and continued reviews, therefore, would be unlikely because of fiscal limitations. One State commented that technical assistance from Federal staff, proposed as an alternative to required reviews, had not been useful in the past.

Response: We are eliminating the requirement that States do TPL-QC reviews for several reasons. These reviews were a burden on State resources, and the reliability and utility of the data from the reviews, as they have been conducted, have been questionable. Moreover, because TPL quality control error rates, as currently calculated, have remained consistently low, we believe that continuing nationwide TPL quality control activities in the same manner as other quality control monitoring activities is not warranted.

Our interest in TPL has not diminished, however. We are merely changing the focus of Medicaid TPL oversight. We intend to continue with aggressive operational improvements and regulation changes to specify

effective procedures for TPL identification, data matching and use of TPL information. TPL operations will become an integral component in State Medicaid Management Information Systems, subject to periodic evaluation through the System Performance review. In addition, we plan to notify States of model TPL practices that we have identified, focusing on the potential for substantial Medicaid savings and suggesting opportunities for States to establish cost effective TPL practices. States may, if they choose, continue their TPL quality control program or another case review system, and the administrative expenditures for such programs will be eligible for FFP in accordance with 42 CFR 433.15. We will no longer require the activities, however, as a part of State plan requirements relating to quality control systems.

D. Additional Technical Changes

Subpart E of Part 441 of the existing Medicaid rules specifies that FFP is available in State expenditures for abortions only if continuation of the pregnancy would endanger the mother's life, or the pregnancy is the result of rape or incest. Section 402 of Pub. L. 97–12 and later laws that appropriate funds for the Medicaid program, including section 204 of Pub. L. 98–619, prohibit the use of Federal funds to pay for abortions except when continuation of the pregnancy would endanger the mother's life. This provision is more restrictive than the provisions that were in effect when the regulations on abortions were last published.

We have revised Part 441 of the Medicaid regulations to reflect the limitation imposed by Pub. L. 97–12, and extended by later legislative documents that provide funds for the Medicaid program. The provision of FFP in State payments in cases of rape or incest is removed.

This is merely a conforming change. The provisions of Pub. L. 97–12 and the later legislative documents have been implemented as early as 1981 through instructions to the States and Regional Offices.

In addition to the revisions noted above, we are making a minor and technical revision to 42 CFR 440.30(c). Existing paragraph (c) requires that an independent laboratory participating in Medicaid must meet the requirements for participation in Medicare. We believe that, when the regulation was drafted, the intention was to refer to the Medicare requirements for independent laboratories. Consequently, we are revising § 440.30(c) by rephrasing it to clarify that "other laboratory and x-ray services" means services furnished by a laboratory that meets the Medicare conditions for coverage of services for independent laboratories under Part 405, Subpart M. We are rephrasing paragraph (c) to make it clear that 42 CFR 440.30 does not apply to any services furnished by a laboratory that is part of a hospital, skilled nursing facility or rural health clinic participating in the Medicare program. The conditions that apply to these laboratories are in 42 CFR Part 405, Subparts J, K and X, respectively.

In the March 11, 1983 NPRM, we proposed to clarify an ambiguity in existing Medicaid regulations at 42 CFR 447.40 concerning Medicaid payment for reserved beds. The clarification proposed in the March 11, 1983 publication has been accomplished by final regulations published on July 3, 1986 (51 FR 24484).

III. Revisions To The Regulations

A. We are adopting the proposed rule published on March 11, 1983 (48 FR 10378) as final with minor editorial corrections and the following revisions to the proposed regulations:

1. To the basis and purpose in § 431.625(a), we are adding a new paragraph (5) to reference section 1902(a)(15) of the Act.

2. In § 431.625, we are breaking paragraph (c) into two subparagraphs. In paragraph (c)(1), we are clarifying that a State has the option of paying the deductible and coinsurance amounts "for those Medicare Part B services" not covered under the State plan. This is more precise than "on a full range of Medicare Part B services" which appeared in the proposed regulation. In new paragraph (c)(2), we specify that when a State pays a portion of Medicare Part B cost sharing amounts, the amount paid must be reasonably related to a recipient's income and resources.

3. In § 431.625, we are breaking paragraph (d)(1) into two subparagraphs, revising the wording for clarity, and adding seven groups inadvertently omitted from the previous listing. Subparagraph (d)(1) is revised to set forth the basic rule regarding availability of FFP for payment of Medicare Part B premiums, and a new paragraph (d)(2) is added to indicate the exceptions to that rule. To new paragraph (d)(2), we are adding the following groups of individuals to the list of Medicaid recipients receiving cash payments for whom FFP is available in State expenditures for Medicare Part B premiums, since these recipients may also be eligible for Medicare benefits:

(a) Individuals receiving foster care maintenance payments and adoption assistance payments who, under title IV–E of the Act, are considered as receiving AFDC payments.

(b) Individuals required to be covered under 42 CFR 435.120, that is, blind or disabled individuals who, under section 1619(b) of the Act, are considered to be receiving SSI.

(c) Individuals who, in accordance with 42 CFR 435.115 and 436.114 are, for purposes of Medicaid eligibility, considered to be receiving AFDC. These are participants in a work supplementation program, or individuals denied AFDC because the payment would be less than $10.

(d) Recipients of Veterans Administration pensions who, under section 310(b) of Pub. L. 97–272, are considered to be eligible for SSI, mandatory State supplements, or AFDC.

(e) Disabled children living at home to whom the State provides Medicaid under section 1902(e)(3) of the Act.

(f) Individuals who, in accordance with section 406(h) of the Act, become ineligible for AFDC because of the collection or increased collection of child or spousal support, but remain eligible for Medicaid for four more months.

(g) Individuals who, in accordance with section 402(a)(37) of the Act, become ineligible for AFDC because they are no longer eligible for the disregard of earnings of $30 or of $30 plus one third of the remainder, but are considered as receiving AFDC for an additional period of time.

4. We are revising § 440.20(a)(4) to clarify that a Medicaid agency may exclude from the definition of outpatient hospital services those types of items and services that are not generally furnished by most hospitals in the State.

B. We are adopting the portions of the proposed rule dealing with third party liability, published on August 9, 1983 (48 FR 36151) as final. In 42 CFR 431.800, we are removing requirements for States to conduct third party liability quality control reviews in paragraphs (a), (b), (d) and (g).

C. We are making a technical revision to § 440.30(c) to clarify that "other laboratory and x-ray services" means services furnished by a laboratory that meets the Medicare conditions for coverage of services for independent laboratories, (42 CFR Part 405, Subpart M). Without the clarification, there could be confusion over whether the section referred to requirements for participation under Subpart M or the conditions in Subparts J, K, and X.

respectively. This revision does not alter either coverage or billing provisions.

D. We are revising Subpart E of Part 441 by removing § 441.204 [Reserved] and § 441.205, Rape and Incest, and by making conforming changes to § 441.202, 441.206 and 441.208 to eliminate references to deleted § 441.205.

IV. Waiver of Proposed Rulemaking

We ordinarily publish notices of proposed rulemaking in the **Federal Register**, and offer the public an opportunity to comment on proposed rules. Such notices include a statement of the nature of the rulemaking proceeding, reference to the legal authority under which the rule is proposed, and the terms or substance of the proposed rule or a description of the subjects and issues involved. However, this requirement can be waived when we find good cause that such a notice and comment procedure is impracticable, unnecessary, or contrary to the public interest, and incorporates a statement of the finding and its reasons in the rule issued.

The revisions to Part 441, Subpart E relating to limitations on the use of Federal funds for abortions are merely those necessary to conform the regulation text to statutory provisions and appropriations documents that have been implemented as early as 1981 through instructions to States and the Regional Offices. Accordingly, we have concluded that issuance of these legislative changes for notice and comment would be unnecessary and contrary to the public interest. Therefore, we find good cause to waive the proposed rulemaking procedure.

With regard to the revisions to regulations at 42 CFR 440.30(c), we believe that, since these technical revisions are merely clarifications of our original intent, and in no way affect any existing practices in any State, it is unnecessary to publish them in proposed form. We further believe that no purpose would be served and it would not be in the public interest to delay publication of these revisions. Therefore, we find good cause to waive proposed rulemaking for the regulatory provisions in § 440.30(c).

V. Regulatory Impact Statement

Executive Order 12291 requires us to prepare and publish a regulatory impact analysis for any regulations that are likely to result in:

- An annual effect on the economy of $100 million or more;
- A major increase in costs or prices, for consumers, individual industries, Federal, State, or local government agencies, or geographic regions; or
- Significant adverse effects on competition, employment investment, productivity, innovation, or on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic or export markets.

In addition, consistent with the Regulatory Flexibility Act (5 U.S.C. 601–612), we prepare and publish a regulatory flexibility analysis for regulations unless the Secretary certifies that the regulations will not have significant economic impact on a substantial number of small entities.

In the NPRM published on March 11, 1983 (48 FR 10378), we stated on assumption that about two-thirds of States with Medicare Part B buy-in agreements would elect not to pay cost sharing amounts for Medicaid recipients for those Medicare services that States do not cover in their Medicaid plans. We estimated that Federal savings resulting from this possible outcome would be $5 million in FY 1984 and $6 million FY 1985.

Comment: Two client advocacy groups disagreed with our estimate of the economic impact of these regulations. They believe that the impact will exceed $100 million, which would require us to prepare and publish a regulatory impact analysis under Executive Order 12291. Several commenters argued that the regulations would not result in State or Federal savings and might increase costs because some individuals, unable to pay Part B cost sharing amounts, may seek Part B services in a different setting where the service is covered under the Medicaid plan. If the Medicare service is covered under the State Medicaid plan, the State would be required to pay the cost sharing amounts.

Response: We believe that these comments reflect a misinterpretation of the intent of these regulations. Our estimate was based upon the assumption that States may choose to pay cost sharing amounts under Medicare Part B buy in agreements on all, some, or none of the Part B benefits that are not covered in the States' Medicaid plan. We believe that the commenters have included in their estimates cost sharing amounts for Part B benefits that are covered in the States' Medicaid plan.

For the final regulation, we are updating the assumptions and methodology involved with the previous estimate. We still contend that the major assumption affecting potential savings is the number of States that elect to exercise this option.

Updating the estimate involved surveying the twelve States that pay the highest amounts of premiums for Medicare buy-ins to determine their expected programmatic changes in response to this option. The survey indicates that some States would elect the option of not paying the coinsurance amounts, while several others expressed uncertainty about any potential changes. Thus, we are not able to conclude how States will respond to the change to current buy-in agreements. Absent this information it is not possible to develop a quantified estimate of FFP savings resulting from these changes to our current regulations. However, given current amounts of FFP paid as the Federal cost-sharing for these Part B services, and, furthermore, assuming that States' responses will range between not paying the cost-sharing amounts to paying the full cost-sharing amount for non-Medicaid-covered Part B services, potential Federal savings could range from $0 to 10 million annually. A State's savings would be 80 percent of actual Federal savings related to FFP paid to that State in any one year.

We expect a small impact of providers currently furnishing noncovered services for which States are paying copayment under Medicare. If States choose to discontinue paying copayment, there may be an effect on some providers, such as home health agencies. In view of the difficulty in predicting the response of States, it is not feasible to analyze this impact.

As noted in section II. A of the preamble, we are adding to the regulation seven groups of Medicaid recipients receiving cash payments to the list of Medicaid recipients for whom FFP is available to States for expenditures for Medicare Part B premiums. This change merely conforms the regulation to the statutory requirement and to what has already been implemented.

As noted in the NPRM, the revision to the definition of outpatient hospital services provides that the States may, at their discretion, exclude services not generally furnished as outpatient hospital services by most hospitals in a State. Data are not currently available to determine the extent to which States are now paying for these services or the extent to which they will choose to exercise this option. However, although it is not possible to estimate the budgetary impact of these provisions, based on our programmatic experience we believe that the economic effect is not significant.

By removing the requirement that States perform TPL quality control reviews, we believe that the accompanying Federal burden on States

will be reduced and the States will have greater flexibility. It is not possible to estimate the economic impact this will have on State operations.

In view of the preceding discussion, this regulation does not require an analysis under either Executive Order 12291 or the Regulatory Flexibility Act. We have determined, and the Secretary certifies, that these final regulations will not have a significant economic impact on a substantial number of small entities.

VI. Reporting Requirements

This regulation does not contain information collection requirements under the Paperwork Reduction Act. Therefore, we have not submitted a copy of this rule to OMB for its review under the Paperwork Reduction Act.

List of Subjects

42 CFR Part 431

Grant programs-health, Health facilities, Medicaid, Privacy, Reporting and recordkeeping requirements.

42 CFR Part 435

Aid to Families with Dependent Children, Grant programs-health, Medicaid, Reporting and recordkeeping requirements, Supplemental Security Income (SSI), Wages.

42 CFR Part 440

Grant programs-health, Medicaid.

42 CFR Part 441

Family planning, Grant programs-health, Infants and children, Medicaid, Penalties, Prescription drugs, Reporting and recordkeeping requirements.

42 CFR Chapter IV is amended as set forth below:

PART 431—STATE ORGANIZATION AND GENERAL ADMINISTRATION

1. The authority citation for Part 431 continues to read as follows:

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

Subpart M—Relations With Other Agencies

2. Section 431.625 is amended by revising paragraph (a), by revising and redesignating paragraph (c) as paragraph (d) and by adding a new paragraph (c) to read as follows:

§ 431.625 Coordination of Medicaid with Medicare part B.

(a) *Basis and purpose.* (1) Section 1843(a) of the Act requests the Secretary to have entered into an agreement with any State that requested that agreement before January 1, 1970, or during calendar year 1981, under which the State could enroll certain Medicare-eligible recipients under Medicare part B and agree to pay their premiums.

(2) Section 1902(a)(10) of the Act (in clause (II) following subparagraph (D)), allows the State to pay the premium, deductibles, cost sharing, and other charges for recipients enrolled under Medicare part B without obligating itself to provide the range of part B benefits to other recipients; and

(3) Section 1903 (a)(1) and (b) of the Act authorizes FFP for State payment of Medicare part B premiums for certain recipients.

(4) This section—

(i) Specifies the exception, relating to part B coverage, from the requirement to provide comparable services to all recipients; and

(ii) Prescribes FFP rules concerning State payment for Medicare premiums and for services that could have been covered under Medicare.

(5) Section 1902(a)(15) of the Act requires that if a State chooses to pay only a portion of deductibles, cost sharing or other charges for recipients enrolled under Medicare Part B, the portion that is to be paid by a Medicaid recipient must be reasonably related to the recipient's income and resources.

* * * * *

(c) *Effect of payment of premiums on State liability for cost sharing.* (1) State payment of Part B premiums on behalf of a Medicaid recipient does not obligate it to pay on the recipient's behalf the Part B deductible and coinsurance amounts for those Medicare Part B services not covered in the Medicaid State plan.

(2) If a State pays on a recipient's behalf any portion of the deductible or cost sharing amounts under Medicare Part B, the portion paid by a State must be reasonably related to the recipient's income and resources.

(d) *Federal financial participation: Medicare Part B premiums*—(1) *Basic rule.* Except as provided in paragraph (d)(2) of this section, FFP is not available in State expenditures for Medicare Part B premiums for Medicaid recipients unless the recipients receive money payments under title I, IV–A, X, XIV, XVI (AABD or SSI) of the Act, or State supplements as permitted under section 1616(a) of the Act, or as required by section 212 of Pub. L. 93–66.

(2) *Exception.* FFP is available in expenditures for Medicare Part B premiums for the following groups:

(i) AFDC families required to be covered under §§ 435.112 and 436.116 of this subchapter, those eligible for continued Medicaid coverage despite increased income from employment;

(ii) Recipients required to be covered under §§ 435.114, 435.134, and 436.112 of this subchapter, those eligible for continued Medicaid coverage despite increased income from monthly insurance benefits under title II of the Act;

(iii) Recipients required to be covered under § 435.135 of this subchapter, those eligible for continued Medicaid coverage despite increased income from cost-of-living increases under title II of the Act;

(iv) Recipients of foster care maintenance payments or adoption assistance payments who, under Part E of title IV of the Act are considered as receiving AFDC;

(v) Individuals required to be covered under § 435.120 of this chapter, that is, blind or disabled individuals who, under section 1619(b) of the Act, are considered to be receiving SSI;

(vi) Individuals who, in accordance with §§ 435.115 and 436.114 of this chapter are, for purposes of Medicaid eligibility, considered to be receiving AFDC. These are participants in a work supplementation program, or individuals denied AFDC because the payment would be less than $10;

(vii) Certain recipients of Veterans Administration pensions during the limited time they are, under section 310(b) of Pub. L. 96–272, considered as receiving SSI, mandatory State supplements, or AFDC;

(viii) Disabled children living at home to whom the State provides Medicaid under section 1902(e)(3) of the Act;

(ix) Individuals who become ineligible for AFDC because of the collection or increased collection of child or spousal support, but, in accordance with section 406(h) of the Act, remain eligible for Medicaid for four more months; and

(x) Individuals who become ineligible for AFDC because they are no longer eligible for the disregard of earnings of $30 or of $30 plus one-third of the remainder, but, in accordance with section 402(a)(37) of the Act, are considered as receiving AFDC for a period of 9 to 15 months.

(3) No FFP is available in State Medicaid expenditures that could have been paid for under Medicare part B but were not because the person was not enrolled in part B. This limit applies to all recipients eligible for enrollment under part B, whether individually or through an agreement under section 1843(a) of the Act. However, FFP is available in expenditures required by §§ 435.914 and 436.901 of this subchapter for retroactive coverage of recipients.

Subpart P—Quality Control

3. Section 431.800 is amended by removing the definition of "Third-party

liability error" from paragraph (b), and revising paragraphs (a), (d)(4), and (i)(1) to read as follows:

§ 431.800 Medicaid quality control (MQC) system.

(a) *Basis and purpose*—(1) *Basis.* This subpart implements the following sections of the Act, which establish requirements for State plans and for payment of Federal financial participation (FFP) to States:

1902(a)(4) Administrative methods for proper and efficient operation of the State plan.

1903(u) Limitation of FFP for erroneous medical assistance expenditures.

(2) *Purpose.* This section establishes State plan requirements for a Medicaid quality control system designed to reduce erroneous expenditures by monitoring eligibility determinations, and claims processing.

* * * * *

(d) *Basic elements of an MQC eligibility system.* The agency—

* * * * *

(4) Must review any claims pertaining to each active case to identify erroneous payments resulting from—

(i) Ineligibility; and

(ii) Recipient understated or overstated liability.

* * * * *

(i) *Corrective action.* The agency must—

(1) Take action to correct any eligibility, or negative case action errors found in the sample cases;

* * * * *

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

1. The authority citation for Part 435 continues to read as follows:

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

2. Section 435.1009 is amended by revising the definition of "inpatient" and by adding in alphabetical order the definition of "outpatient".

§ 435.1009 Definitions relating to institutional status.

* * * * *

"Inpatient" means a patient who has been admitted to a medical institution as an inpatient on recommendation of a physical or dentist and who—

(1) Receives room, board and professional services in the institution for a 24 hour period or longer, or

(2) Is expected by the institution to receive room, board and professional services in the insitution for a 24 hour period or longer even though it later develops that the patient dies, is discharged or is transferred to another facility and does not actually stay in the institution for 24 hours.

* * * * *

"Outpatient" means a patient of an organized medical facility or distinct part of that facility who is expected by the facility to receive, and who does receive, professional services for less than a 24-hour period regardless of the hour of admission, whether or not a bed is used or whether or not the patient remains in the facility past midnight.

* * * * *

PART 440—SERVICES: GENERAL PROVISIONS

1. The authority citation for Part 440 continues to read as follows:

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

2. Section 440.2(a) is amended by revising the definition of "Outpatient" and by adding in alphabetical order the definition of "Inpatient".

§ 440.2 Specific definitions; definitions of services for FFP purposes.

(a) *Specific definitions.*

"Inpatient" means a patient who has been admitted to a medical institution as an inpatient on recommendation of a physician or dentist and who—

(1) Receives room, board and professional services in the institution for a 24 hour period or longer, or

(2) Is expected by the institution to receive room, board and professional services in the institution for a 24 hour period or longer even though it later develops that the patient dies, is discharged or is transferred to another facility and does not actually stay in the institution for 24 hours.

"Outpatient" means a patient of an organized medical facility, or distinct part of that facility who is expected by the facility to receive and who does receive professional services for less than a 24-hour period regardless of the hour of admission, whether or not a bed is used, or whether or not the patient remains in the facility past midnight.

* * * * *

3. Section 440.10 is amended by revising paragraph (a)(3)(iii) to read as follows. The introductory texts of paragraphs (a) and (a)(3) are republished.

§ 440.10 Inpatient hospital services, other than services in an institution for mental diseases.

(a) "Inpatient hospital services means services that—

* * * * *

(3) Are furnished in an institution that—

* * * * *

(iii) Except in the case of medical supervision of nurse-mid wife services, as specified in § 440.165, meets the requirements for participation in Medicare as a hospital; and

* * * * *

4. Section 440.20 is amended by revising paragraph (a)(3)(ii) and adding paragraph (a)(4) to read as follows. The introductory text of paragraphs (a) and (a)(3) are republished.

§ 440.20 Outpatient hospital services and rural health clinic services.

(a) "*Outpatient hospital services*" means preventive, diagnostic, therapeutic, rehabilitative, or palliative services that—

* * * * *

(3) Are furnished by an institution that—

* * * * *

(ii) Except in the case of medical supervision of nurse-midwife services, as specified in § 440.165, meets the requirements for participation in Medicare as a hospital; and

(4) May be limited by a Medicaid agency in the following manner: A Medicaid agency may exclude from the definition of "outpatient hospital services" those types of items and services that are not generally furnished by most hospitals in the State.

* * * * *

5. Section 440.30 is amended by reprinting the introductory text and revising paragraph (c) as follows:

§ 440.30 Other laboratory and X-ray services.

"Other laboratory and X-ray services" means professional and technical laboratory and radiological services—

* * * * *

(c) Furnished by a laboratory that meets the Medicare conditions for coverage of services for independent laboratories.

6. Section 440.80 is revised to read as follows:

§ 440.80 Private duty nursing services.

"Private duty nursing services" means nursing services for recipients who require more individual and continuous care than is available from a visiting nurse or routinely provided by the

nursing staff of the hospital or skilled nursing facility. These services are provided—

(a) By a registered nurse or a licensed practical nurse;

(b) Under the direction of the recipient's physician; and

(c) To a recipient in one or more of the following locations at the option of the State—

(1) His or her own home;

(2) A hospital; or

(3) A skilled nursing facility.

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

1. The authority citation continues to read as follows:

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

2. Section 441.200 is revised to read as follows:

§ 441.200 Basis and purpose.

This subpart implements section 402 of Pub. L. 97–12, and subsequent laws that appropriate funds for the Medicaid program, including section 204 of Pub. L. 98–619. All of these laws prohibit the use of Federal funds to pay for abortions except when continuation of the pregnancy would endanger the mother's life.

3. Section 441.201 is revised to read as follows:

§ 441.201 Definition.

As used in this subpart, "physician" means a doctor of medicine or osteopathy who is licensed to practice in the State.

4. Section 441.202 is revised to read as follows:

§ 441.202 General rule.

FFP is not available in expenditures for an abortion unless the conditions specified in §§ 441.203 and 441.206 are met.

§ 441.205 [Removed]

5. Section 441.205 is removed.

6. Section 441.206 is revised to read as follows:

§ 441.206 Documentation needed by the Medicaid agency.

FFP is not available in any expenditures for abortions or other medical procedures otherwise provided for under § 441.203 if the Medicaid agency has paid without first having received the certifications and documentation specified in that section.

7. Section 441.208 is revised to read as follows:

§ 441.208 Recordkeeping requirements.

Medicaid agencies must maintain copies of the certifications and documentation specified in § 441.203 for 3 years under the recordkeeping requirements at 45 CFR 74.20.

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

Dated: June 26, 1987.

William L. Roper,

Administrator, Health Care Financing Administration.

Approved: September 25, 1987.

Otis R. Bowen,

Secretary.

[FR Doc. 87–28903 Filed 12–16–87; 8:45 am]

BILLING CODE 4120–01–M

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 73

[MM Docket No. 86–455; RM–5088, RM–5337, RM–5766]

Radio Broadcasting Services; Andalusia, Brantley, and Georgiana, AL; and Crestview, FL

AGENCY: Federal Communications Commission.

ACTION: Final rule.

SUMMARY: This document allots Channel 282A to Brantley, Alabama (in lieu of Channel 262A as proposed by the *Notice*) in response to the petition of Stewart Marsh and Virgil Leon Strickland for first FM service at Brantley. At the request of Crestview Broadcasting Company, licensee of Station WAAZ–FM, Crestview, Florida, Channel 284C2 is substituted for Channel 285A and its license modified to specify the Class C2 Channel. In addition, Channel 279A is substituted for Channel 284A at Andalusia, Alabama, and the construction permit for Station WAAO–FM, modified accordingly, in order to accommodate the Brantley and Crestview allotments. The counterproposal of Mac Carter requesting the allotment of Channel 262A to Georgiana, Alabama, has been dismissed at Carter's request in order to consider allotting Channel 262C2 to Georgiana, as a conflicting proposal in Docket 86–470. With this action, this proceeding is terminated.

DATES: Effective January 22, 1988. The window period for filing applications for Channel 282A at Brantley, Alabama, will open on January 25, 1988, and close on February 24, 1988.

FOR FURTHER INFORMATION CONTACT: Montrose H. Tyree, Media Bureau, (202) 634–6530.

SUPPLEMENTARY INFORMATION: This is a summary of the Commission's Report and Order, MM Docket No. 86–455, adopted November 23, 1987, and released December 10, 1987. The full text of this Commission decision is available for inspection and copying during normal business hours in the FCC Dockets Branch (Room 230), 1919 M Street NW., Washington, DC. The complete text of this decision may also be purchased form the Commission's copy contractors, International Transcription Service, (202) 857–3800, 2100 M Street NW., Suite 140, Washington, DC 20037.

List of Subjects in 47 CFR Part 73

Radio broadcasting.

PART 73—[AMENDED]

1. The authority citation for Part 73 continues to read as follows:

Authority: 47 U.S.C. 154, 303.

§ 73.202 [Amended]

2. Section 73.202(b), the Table of FM Allotments is amended for Andalusia, Alabama, by removing Channel 284A and adding Channel 279A; Brantley, Alabama, Channel 282A is added; and for Crestview, Florida, by removing Channel 285A and adding Channel 284C2.

Federal Communications Commission.

Mark N. Lipp,

Chief, Allocations Branch, Policy and Rules Division, Mass Media Bureau.

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NATIONAL AERONAUTICS AND SPACE ADMINISTRATION

48 CFR Part 1852

[NASA FAR Supplement Directive 85–9]

Miscellaneous Amendments to NASA FAR Supplement; Correction

AGENCY: Office of Procurement, Procurement Policy Division, NASA.

ACTION: Final rule, Correction.

SUMMARY: This document, published Thursday, December 10, 1987, beginning on page 46765, published amendments to the NASA Federal Acquisition Regulation Supplement (NFS), but inadvertently failed to remove sections which are no longer applicable.

FOR FURTHER INFORMATION CONTACT: W.A. Greene, Procurement Policy