Competitive Equality Banking Act of 1987, thereby avoiding disruption of current procedures and preserving the benefits and rights provided to claimants under existing statutes and regulations beyond February 10, 1988, Treasury finds good cause to make the extension of the effective date of the legislation operative immediately on publication. Current regulations will remain in effect until new regulations implementing the legislation are issued.

(Competitive Equality Banking Act of 1987, Pub. L. No. 100-86, sec. 1006, 101 Stat. 552, 659-660.)

William E. Douglas,

Commissioner.

[FR Doc. 88-2623 Filed 2-5-88; 8:45 am]

BILLING CODE 4810-35-M

POSTAL SERVICE

39 CFR Part 111

Carrier Route Presort Information Mandatory Updates

AGENCY: Postal Service.

ACTION: Final rule.

SUMMARY: This rulemaking changes the frequency of required updating of addressing information for mailing at carrier route presort rates from two times a year to four times a year. This change is implemented to lessen the use of outdated Carrier Route Information System (CRIS) data which results in costly extra handling of the mail.

EFFECTIVE DATES: April 15, 1988. Use of the April 15, 1988, quarterly update is valid until September 30, 1988. As a transition measure, for this year only, use of the February 15, 1988, update is also valid until September 30, 1988.

FOR FURTHER INFORMATION CONTACT: Paul Bakshi, (202) 268-3520.

SUPPLEMENTARY INFORMATION: On November 9, 1987, the Postal Service published in the **Federal Register** (52 FR 43089) a proposal to change the frequency of use for mandatory CRIS updates from two times a year to four times a year.

The Postal Service received comments from eight organizations. Four endorsed the proposal; three were not in favor; and one stated a preference that mandatory updates remain at two times a year. However, if the Postal Service does change to four times a year, this organization stated it will start using CRIS monthly change information regularly. Currently, this organization is using CRIS monthly change information on a limited basis.

One commenter not in favor of the proposal assumed that the CRIS quarterly update process would begin on January 1, 1988. This commenter concluded that a January 1 implementation date would not provide sufficient time to adjust and develop new procedures to comply with quarterly update requirements. This commenter requested an extension until January 1, 1989 to comply with the quarterly update requirements.

As stated in the effective dates above, for this year only, use of the February 15, 1988 CRIS mandatory update, provided to current subscribers under the present semiannual (February 15 and July 15) schedule, is valid until September 30, 1988. Use of the April 15, 1988 mandatory update produced under the new quarterly update schedule is optional for mailers who have updated their files with the February 15 update. The next quarterly update (after April 15) is July 15. Use of the July 15 mandatory update is valid until December 31, 1988. Therefore, current CRIS subscribers, for this year, can use the February 15 and July 15 updates (same as under two times a year update schedule) and be in compliance with the Postal Service CRIS mandatory quarterly update requirements until December 31, 1988. Thus, the adoption of this rule as scheduled provides sufficient time to this commenter and others to adjust and develop new procedures for CRIS quarterly updates.

Another commenter argued that the problems experienced by the Postal Service from mailers using outdated CRIS information have arisen primarily from carrier route presorted third-class mail, not from First-Class Mail. Therefore, the commenter requested that quarterly update requirements should only be imposed on third-class carrier route presort mail.

The Postal Service believes that unless mailers use the monthly change information, regardless of whether the mailer is sending carrier route third-class or First-Class presort mailings, they do not reflect the most up-to-date carrier route information on their mailings. Currently, only a small number of mailers subscribe to monthly change information. The longer the gap between the mandatory updates, the more severe the problem associated with the rehandling of the incorrectly prepared mailings. The Postal Service has concluded that the existing period covered by each mandatory update is too long—the February 15 issuance covers 7½ months and the July 15 issuance covers 10½ months. Thus, mailers (both First- and third-class) are using outdated information for long periods. This use is a major contributor to the incorrectly prepared carrier route presort volume. Incorrectly prepared mail pieces require rehandling, which results in additional operating costs to the Postal Service. This cost is not included in the current carrier route presort rate. Therefore, increasing the frequency of CRIS mandatory updates is expected to sharply decrease the costs associated with processing incorrectly prepared mail pieces.

Another commenter opposed to this proposal expressed concern that the proposed increase in CRIS mandatory update frequency would place an undue cost burden on mailers. This mailer maintains a residential address list in carrier route delivery sequence. This list is used in preparing carrier route delivery (walk sequence) mailings and is updated by using the Postal Service address card sequencing service. See Domestic Mail Manual (DMM) Section 946.

According to DMM section 946.81, the customers (mailers) presenting the carrier route walk sequenced mailings to the Postal Service must ensure that mailings are prepared in the correct carrier route delivery sequence and resequence cards whenever necessary. Therefore, increasing the CRIS mandatory update frequency should not add an extra cost burden to the requirement for sequencing the cards.

After careful consideration of all the comments and for the above reasons, the Postal Service has decided to adopt its proposal and hereby amends the Domestic Mail Manual, which is incorporated by reference in the Code of Federal Regulations (see 39 CFR 111.1), as follows:

PART 111—[AMENDED]

1. The authority citation in 39 CFR Part 111 continues to read as follows:

Authority: 5 U.S.C. 552(a); 39 U.S.C. 101, 401, 403, 404, 3001-3011, 3201-3219, 3403-3406, 3621, 5001.

PART 323—PRESORTED FIRST-CLASS MAIL

2. In 323.2, revise the sixth sentence to read as follows: "Mailers must incorporate CRIS changes in their mailings within 75 days of the effective date (January 15, April 15, July 15 and October 15) of the quarterly updates."

PART 468—SPECIAL PREPARATION REQUIREMENTS OR OPTIONS FOR RESORT-LEVEL DISCOUNT-RATED PIECES (LEVELS B, C, H, I AND K)

3. In 468.2, revise the first two sentences of b(1) to read as follows: "Mailers are responsible for makeup of mail to carrier routes according to the latest quarterly Postal Service scheme. Mailers must incorporate Carrier Route Information System (CRIS) changes in their mailings within 75 days of the effective date (January 15, April 15, July 15 and October 15) of the quarterly updates."

PART 622—THIRD-CLASS BULK MAIL

4. In 622.11e(1), revise the first two sentences to read as follows: "Mailers are responsible for the proper makeup of mail to carrier routes according to the latest quarterly Postal Service scheme. Mailers must incorporate Carrier Route Information System (CRIS) changes in their mailings within 75 days of the effective date (January 15, April 15, July 15 and October 15) of the quarterly updates."

5. In 622.11e(2)(b), in the heading change the word "Semiannual" to "Quarterly"; in the last sentence change the word "semiannual" to "quarterly"; and revise the second sentence to read as follows: "Hard Copy form is not availble from the Postal Service on a regional, state or national basis."

6. In 622.11e(2)(c), in the heading change the word "Semiannual" to "Quarterly"; and in the last sentence change the word "semiannual" to "quarterly".

7. Revise 622.11e(2)(d) to read as follows:

(d) *CRIS Quarterly Updates and Monthly Scheme Tape Changes.* CRIS scheme information in machine-sensible form on magnetic tapes is available for one or more states or for the entire United States. There are also monthly updates available on tape.

8. In 622.11e(2)(e), delete the words "except July".

9. In the Note following 622.112e(2)(e), revise the introductory sentence to read as follows: "*Note:* In any CRIS scheme tape request, the mailer must specify which of the following magnetic tape characteristics are required: ", and delete the characteristic in the Note labeled "(iv)".

PART 763—CARRIER ROUTE BOUND PRINTED MATTER

10. Revise 763.2 to read as follows:

763.2 Current Scheme.

.21 Proper Makeup. See 622.11e(1).

.22 Obtaining Schemes. See 662.11e(2).

A transmittal letter making these changes in the pages of the Domestic Mail Manual will be published and will be transmitted to subscribers automatically. Notice of issuance of the transmittal letter will be published in the **Federal Register** as provided in 39 CFR 111.3.

Fred Eggleston,

Assistant General Counsel, Legislation Division.

[FR Doc. 88-2536 Filed 2-5-88; 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-F]

Medicaid Program Payments to Institutions

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

ACTION: Final rule.

SUMMARY: This final rule (1) provides greater flexibility to States by amending regulations that specify how much of an institutionalized individual's income must be applied to the cost of care in the facility; and (2) requires that States electing to use the special income eligibility standard for institutionalized individuals apply that standard beginning with the first day of a period of not less than thirty consecutive days of institutionalization.

These final rules are designed to clarify regulations, delete unnecessary or burdensome requirements, and provide maximum flexibility to States while maintaining patient health and safety.

DATES: These regulations are effective April 8, 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 the State submits the necessary preprint plan material by that date.

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

SUPPLEMENTARY INFORMATION:

I. Background

When an individual in an institution is determined to be eligible for Medicaid, his or her income, except for a small amount for personal needs, must be used to partially pay for the cost of institutional care. The Medicaid program pays the remaining amount at the Medicaid reimbursement rate. Existing regulations require that States deduct from a recipient's income bills for medical expenses that are not covered in the State Medicaid plan. States may, however, place reasonable limits on these deductions. The existing regulations were published under the authority of section 1902(a)(17) of the Social Security Act (the Act), which gives the Secretary broad authority to set standards for the reasonable treatment of an individual's income.

States have complained that the existing regulations require them to deduct the cost of medical services that States have decided not to cover in their Medicaid plans. Some of these noncovered medical deductions are considered by States to be nonessential medical services, or services that duplicate covered services. The result is that less of an individual's income is available to contribute to the cost of institutional care, and the State pays more for care. In addition, States have reported that it is difficult for them to make monthly payment adjustments to an institution when a recipient's income is reduced by irregular medical deductions. States suggested that it would be easier for them to pay institutions if they are allowed the flexibility to estimate and project monthly recipient income and medical deductions, based on their experience in a preceding period.

On March 19, 1985, we published in the **Federal Register**, at 50 FR 10992, a Notice of Proposed Rulemaking (NPRM) to solicit comments on proposed changes to the regulations that specify how much of an institutionalized individual's income must be applied to the cost of care in the facility.

In an effort to reduce administrative problems for States, we proposed in the NPRM to permit States the flexibility to use either actual monthly income received or to project anticipated income using the average amount of monthly income received by an individual over the preceding 6 month period. Second, we proposed that a State may deduct from an individual's income none, some or all of the cost of medical expenses that are not covered under the State's Medicaid plan, subject to reasonable limits. Further, we proposed that a State must deduct from an individual's income any medical expenses that are covered in the State's plan, even though they exceed limits set by the State on amount, duration or scope, subject to reasonable limits set

by a State. Third, although not included as a proposed rule change, we solicited comments on the feasibility of permitting States the additional option of projecting deductions of an individual's medical expenses, based on an average of those expenses in previous months. On this last proposal our intent was to permit such an option if we received sufficient public support for the proposal.

These regulations do not reflect the provisions of Pub. L. 99–643, which became effective on July 1, 1987. This law amends section 1611(e)(1) of the Act, to provide an additional 2 months Supplemental Security Income (SSI) payment for certain institutionalized individuals. The additional 2 months of SSI payment is intended for the individual's use in meeting expenses outside the institution. Pub. L. 99–643 also amends section 1902 of the Act to provide that this income must be disregarded under the Medicaid program when determining the individual's required contribution to the cost of care in a medical institution. We are developing instructions and revisions to the regulations to implement the provisions of Pub. L. 99–643.

II. Response to Public Comments

In response to our request for public comments on the March 19, 1985 publication, we received 37 letters, of which 24 were from State Medicaid agencies.

A. Permit States to Project Anticipated Income Based on the Average Monthly Income Received in the Previous 6 Month Period

We proposed that, in determining an individual's monthly income to be applied to the cost of care, each State may continue to use monthly income received or it may project anticipated income using the average amount of monthly income received by an individual over the preceding 6 month period. If a State chooses to project income, we proposed that the State must periodically reconcile actual income with estimated income.

1. *Comment:* Three commenters questioned whether the proposal applies not only to income that is irregularly received or that fluctuates in amount, but also to income that is regularly received in fixed amounts, such as Social Security benefits. One commenter suggested using different methods of projection for various types of income. For example:

- For income that is received seasonally or yearly, a State would base the projection on the corresponding period of the year.
- For regularly received income, a State would base the projection on the current amount of income.
- For income that is irregularly received or that fluctuates in amount, a State would base the projection on the average amount received in the preceding 6 month period.

Response: Our intent was that the provision to project income apply to all types of income mentioned by the commenters. As the commenters pointed out, a State may be able to anticipate income that is received by an individual seasonally or yearly, and want to include that income in the projection. We believe that this is reasonable, and compatible with the intent of the projection method. Therefore, we are clarifying in the final regulations, §§ 435.725(e)(2), 435.733(e)(2), 435.832(e)(2), and 436.832(e)(2), that the agency's estimate of income must include anticipated income.

2. *Comment:* Several commenters had difficulty understanding the variety of terms we used with regard to income. They asked that we define the terms "income," "total income," "actual income," and "available income."

Response: In the proposed rule, we used "total income" to mean gross income from all sources, before any deductions are taken. The other terms listed were synonymous with total income. We distinguish total income from "countable income," which is used in Medicaid eligibility determinations to mean income remaining after certain deductions are taken. We agree that the terms used in the proposed rule were confusing, and as a result, in the final regulations we are consistently using the term "total income."

3. *Comment:* Three commenters recommended that we disregard infrequently received income when it is less than $20.00 per month, and small amounts of income (less than $10.00) from interest and dividends because they are difficult for States to verify. Another commenter suggested that States be permitted to allow small amounts of income from interest or dividends, for example, that are received infrequently to accrue as a resource, and then adjust monthly income periodically to reflect amounts exceeding allowable resource limits.

Response: We do not consider interest and dividends to be resources. We define them as income when received. Therefore, interest and dividends must be taken into account in the eligibility process. The post-eligibility process is based on a consideration of all income considered in the eligibility process. Since interest and dividends are taken into account in the eligibility step, we do not believe it is reasonable to make an exception for this type of income in the post-eligibility step. Once the State knows the amount of interest and dividends for the eligibility step, that income, no matter how small, can be calculated into the projection of total income.

4. *Comment:* Five commenters were concerned that the projections of income should be based not only on past experience, but also on reliable information concerning future changes.

Response: We agree, and are revising the regulations to require that States consider significant changes in income as they occur, and take future or past changes in circumstances into consideration when projecting income. This provision is contained in revised paragraph (e)(3) of §§ 435.725, 435.733, 435.832, and 436.832. While we are requiring that States make adjustments as soon as significant changes in circumstances are known, in the interest of State flexibility, we leave it to each State to define "significant change."

5. *Comment:* Commenters had many concerns about the requirement that States periodically reconcile the income projection with income actually received. Four commenters saw reconciliation as duplicative of the regular budgeting process, and unnecessarily burdensome. One commenter complained that requiring periodic reconciliation reduces the flexibility States had wanted.

Response: We believe that it is essential that States reconcile differences between projected and actual income to assure that the recipient's actual liability, rather than an estimate, is determined. The projection method was intended to reduce budgeting problems for States when income is irregularly received or fluctuates in amount. It was not meant to take the place of actual income in determining a recipient's contribution to the cost of care and the amount of the State's payment.

6. *Comment:* One commenter recommended that we use a retrospective budgeting procedure instead of reconciliation.

Response: Retrospective budgeting methods do not use current income as the basis for projection, but income previously received. In the retrospective budgeting used in some State cash assistance programs, future income is estimated solely on the basis of the income that was actually received in a prior period. There is no consideration of anticipated changes in income. For income such as pension checks, that are usually constant in amount, the result

under both methods will be the same. When income is irregularly received or differs in amount from time to time, retrospective budgeting may understate or overstate recipient liability, with no mechanism for adjustment. Therefore, we believe that the use of retrospective budgeting is not appropriate in the post eligibility period, and is not sufficient to protect the interests of recipients and States.

7. *Comment:* Three commenters were concerned that when projections of income are lower than actual income received, at the time of readjustment a recipient may suddenly owe the facility a large amount of money, and may have already spent that money for other things. They asked if this increased liability could be applied in future determinations.

One commenter suggested that we require that States notify a recipient at the beginning of a 6 month period that the recipient's liability is based on an estimate of income to be received in future months, and that adjustments will be required if the estimated income is different from actual income received.

Response: If a projection is too low, the additional funds received by a recipient would be adjusted in the month of reconciliation. As discussed in the response to comment A.4 States must make an immediate adjustment when there is any significant change in income. We believe that this will reduce adjustments at reconciliation to a minimal level. Moreover, this situation should occur infrequently when States work with recipients and, when appropriate, their representatives.

We do not agree with the suggestion that States should be required to notify recipients at the beginning of a period that their liability for future months is based on an estimate. Existing regulations at 42 CFR 431.206 and 431.210 require that an agency notify an applicant or recipient of any action affecting his or her claim for Medicaid benefits, and explain the reasons for the action. We believe that it is reasonable to require that agencies notify a recipient only when reconciliation results in an adjustment in the recipient's liability. Agencies may, however, provide advance notice to recipients in addition to the required notice.

8. *Comment:* Some commenters were concerned about the frequency of reconciliations between projected and actual income. One commenter thought that the requirement that States "periodically" reconcile projected income with actual income was too general, and suggested that the term, "periodically," be replaced by "at the close of each 6 month period." Two commenters recommended that reconciliation be required when a recipient dies or leaves the facility, rather than at a predetermined date.

Response: We agree with the comment that the term, "periodically" is vague. In response to the comment, we are revising paragraph (e)(3) of §§ 435.725, 435.733, 435.832, and 436.832 of the regulations to specify that States must reconcile estimated income with income received and adjust estimates at the end of a prospective period not to exceed 6 months.

In regard to the second suggestion, that States should reconcile income when a recipient dies or leaves an institution, we believe the changes discussed in the response to comment A.4 would apply. That is, paragraph (e)(3) of §§ 435.725, 435.733, 435.832, and 436.832 of the regulations now requires that States adjust their calculations when a recipient's income or circumstances change significantly.

9. *Comment:* One commenter noted that the proposal seemed to permit States to continue averaging of income.

Response: Contrary to the commenter's belief, we have never permitted averaging of income when computing recipient cost of care liability in an institution. As we understand the term, income averaging means that income received over a number of months is totaled and then divided by the number of months to obtain an average. This average income is then applied to the cost of care without any readjustment for actual amounts received. The final rule provides that projected income must be reconciled at least once every 6 months.

10. *Comment:* One commenter suggested that we include guidelines in the final rule to assist States in making reasonable income projections.

Response: We will issue guidelines to States in the form of instructions. We believe that detailed guidelines are more appropriately placed in instructions than in the final regulations.

B. Permit States to Deduct None, Some or all of Medical Expenses not Covered in the State Medicaid Plan, Subject to Reasonable Limits

We proposed that a State may deduct from an individual's income none, some or all of the cost of medical expenses that are recognized under State law, but not covered in the State's Medicaid plan, subject to reasonable limits set by a State. Further, we proposed that a State must deduct any medical expenses that are included in the State's plan, but limited by the State in amount, duration or scope, subject to reasonable limits set by the State.

On the basis of numerous comments against the proposal to require States to deduct from an individual's income medical expenses that are covered in the State plan, but beyond amount, duration and scope limits, we are revising our position on this issue. Several States said that our proposal requires them to subsidize indirectly services for which they have chosen not to pay. They believe that it also increases Medicaid program costs because recipient income that is used for noncovered medical expenses is not applied to the cost of institutional care. The result is higher payments by the State Medicaid program to a facility to compensate for smaller amounts of income from recipients. Some commenters also stated their belief that this provision is contrary to their authority under the Act to establish limits on amount, duration and scope of services covered in their State plan. Other commenters objected to it because they believe that it will be burdensome and difficult to implement, or have inequitable results, and gave illustrations.

After careful consideration of the numerous comments on this issue, we have come to the conclusion that requiring States to deduct medical expenses for services included in the State plan, but which exceed State plan limits, would be inconsistent with our intent to provide States with greater flexibility. Moreover, the comments convince us that these services fall into the same category as services not covered under the plan, in that no payment is made for them. We believe that it is reasonable to treat these services in the same way as services not covered under the State plan. Consequently, we are not requiring that States deduct these services, but are making these deductions optional. In §§ 435.725(d)(1), 435.733(d)(1), 435.832(d)(1), and 436.832(d)(1) of this final rule, we provide that a State may deduct any medical expenses included in the State's plan, which exceed that State's limits on amount, duration or scope of services for the group under which the individual is eligible, subject to reasonable limits set by the State. In §§ 435.725(d)(2), 435.733(d)(2), 435.832(d)(2), and 436.832(d)(2), we provide that a State may deduct medical expenses recognized under State law, but not included in the State's Medicaid plan.

Other specific comments follow.

1. *Comment:* One commenter requested clarification on how the

provision to deduct none, some, or all expenses not covered in the State plan would be implemented for State plan covered services requiring prior approval, and for covered services furnished by non-enrolled providers. The commenter also suggested that we revise the regulations to specify that a recipient may not deduct an institution's daily rate.

Response: We regard any service included in the State plan that is subject to prior approval, and which has been disapproved or for which the request has not been acted upon by the State in a timely manner, as a service that exceeds amount, duration and scope limits. Under these final regulations, States may deduct none, some or all of the expenses for these services from the individual's income, subject to reasonable limits set by the State. A service included in the State plan that is furnished by a nonenrolled provider may be deducted from a recipient's income. States may also choose to deduct none, some or all of an individual's expenses for services not covered under the State plan.

Since the daily or per diem rate paid by the Medicaid program to a facility that is enrolled in the program is an expense covered under the State plan, it is not an expense that is deducted from an institutionalized person's income that is applied to the cost of care.

2. *Comment:* One commenter suggested that we require that States provide recipients with a "notice of noncovered allowance". The allowance should be made only when the recipient requests it and when he or she provides verification of medical expenses.

Response: States may take this approach if they choose, but we are not making it a requirement for all States. We think it most appropriate for States to decide how to implement these provisions.

3. *Comment:* Several commenters suggested that we revise the regulations to place limits on medical deductions for expenses incurred during a period of ineligibility. One of these commenters argued that deductions should be permitted only for services furnished within a budget period. Otherwise, a State is subsidizing medical expenses for a period during which an individual was ineligible. The second commenter asked if States may limit the amount of deductions for institutional expenses during periods of ineligibility to no more than the Medicaid reimbursement rate. A third commenter asked for specific examples of limits or parameters in guidelines.

Response: Services furnished to an individual during a period of ineligibility are services not covered under the State plan. Therefore, the State is not required to deduct medical expenses for services furnished during a period of ineligibility, and may limit deductions to services within the budget period. If the State chooses to allow deductions for medical expenses furnished during a period of ineligibility, it may place reasonable limits on these deductions. This includes institutional expenses incurred during a period of ineligibility and expenses for other covered services. States have the option to deduct institutional expenses at the private rate or at the Medicaid reimbursement rate, subject to reasonable limits imposed by the State.

We will provide guidance to any State requesting it, and will consider issuing State Medicaid Manual guidelines that contain examples.

4. *Comment:* Two commenters suggested that the regulations include a definition of "reasonable limits." One of the commenters was concerned that a State may establish limits that underestimate actual medical costs, resulting in the disadvantage of recipients. The commenter suggested that we define "reasonable" to mean "reasonably reflecting actual costs incurred." The commenter suggested that States should also be required to describe how they determine that an expense is reasonable.

Response: A fixed definition of the term, "reasonable limits," would limit the flexibility we intended. Therefore, we are not defining it in these final regulations. However, as noted in the response to comment 3, we will consider issuing guidelines on this subject. Because each State has the discretion to decide what optional services will be covered under its Medicaid program and how much it will pay for the service, we believe it is inappropriate to define what constitutes "reasonable limits" in these final regulations. States have always been required to describe any limits they place on these expenses, subject to our review, and these regulations do not change this requirement.

We note that in the preamble to the proposed rule, we cited aggregate limits as an example of limits we would consider to be unreasonable. We said that it would be unreasonable for States to set a monthly dollar (aggregate) limit on all noncovered medical expenses to be deducted by an individual, but that it would be reasonable for States to set limits on each type of service not covered in the plan. In reviewing the comments, we have come to the conclusion that restricting States from imposing aggregate limits would limit flexibility in a manner inconsistent with our intent in revising this policy.

5. *Comment:* One commenter was concerned that requiring States to deduct expenses for covered services exceeding State plan limits would increase the quality control (QC) error rate.

Response: In these final regulations we are not requiring that States deduct expenses for covered services exceeding State plan limits. Quality control reviews are done in accordance with individual State plan provisions. We see no reason for increased error rates if reasonable limits are clearly described in the State plan.

6. *Comment:* Five commenters believe that the provision giving States the option to permit deductions only for services covered in the State plan will result in higher Medicaid costs. The commenters expect that significant numbers of recipients will go without needed medical care or preventive services, which will lead to recipients who need more expensive services in the future.

Response: We do not believe that this provision will result in significantly higher Medicaid costs. We have no evidence that the anticipated shift in the pattern of care will occur. Each individual in an institution is under a plan of care that must meet strict standards, and most of an individual's medical needs are met by the institution. Further, we believe that States will be careful to assure that a recipient's medical needs are met and that a neglected condition does not result in a higher cost at a later date.

7. *Comment:* Thirteen commenters argued against implementing the proposal because it will adversely affect institutional patients by denying them access to necessary medical care by preventing them from using their income for this purpose. They cite as a possible consequence that providers will refuse services. The personal needs allowance, at a minimum of $25.00 per month, is insufficient to cover the cost of noncovered care.

Response: We agree that when a particular service is not covered in a State's Medicaid plan there may be no way for a recipient to obtain that service without financial help. We believe that, because most necessary medical services for institutionalized individuals are included in services paid for by Medicaid, there is no strong evidence that individuals will not receive essential medical services that are available to a State's Medicaid population.

8. *Comment:* Three commenters contend that the proposal is inconsistent with a provision of the Act which

requires that States take into account costs for incurred medical care.

Response: While section 1902(a)(17) of the Act requires that States take into account some costs of incurred medical expenses, it does not require that all incurred expenses be considered. The Act gives the Secretary a great deal of discretion in setting standards to determine the extent of medical assistance. Moreover, the provision in section 1902(a)(17) regarding consideration of incurred medical expenses is the basis of the spend down process by which eligibility is determined for the medically needy. The statutory basis for the post-eligibility process is found elsewhere in section 1902(a)(17) in the language that authorizes States to determine the extent of medical assistance.

9. *Comment:* One provider association predicted that providers will lose Medicaid revenue under this proposal, or they will restrict services to institutional patients. The commenter also thought that the proposal would jeopardize the ability of institutions to provide quality care.

Response: The commenter seems to suggest that an institution will determine whether a recipient's income will be used for institutional care or be used for care that is beyond State plan limits. The physician, in consultation with the recipient, usually determines the need for care not provided in the institution, and the extent to which it needs to be provided. We do not believe that providers participating in a State's Medicaid program will lose Medicaid revenues since these regulations do not change the way non-institutional providers are reimbursed, and States are required to reimburse facilities the difference between patient contributions to care and the Medicaid reimbursement rate.

10. *Comment:* One client advocacy group contends that the provision discriminates against individuals in States with very limited Medicaid programs. Another commenter argued that this proposal creates an incentive for States to restrict their Medicaid coverage.

Response: Section 1902(a)(10) of the Act requires that States provide a basic level of medical coverage for Medicaid recipients. States must provide certain basic services, but have the option to expand the range of services. We believe that this provision is consistent with this basic Medicaid program principle. The potential impact of permitting States the option to exclude deduction of noncovered services, however, may be greater in States with very few covered services, which decide not to deduct uncovered medical expenses since the recipient's income after required deductions would be applied to the cost of institutional care.

There are many criteria upon which a State bases its coverage and limitations of coverage. We believe that it is unlikely that a State will substantially alter the extent of covered services in response to this provision.

11. *Comment:* One client advocacy group believes that the proposal would require an individual to use his or her personal needs allowance for noncovered care. The commenter reported that in the Tax Equity and Fiscal Responsibility Act of 1982 (Pub. L. 97–248), Congress declared that nursing home residents are not required to use their personal needs allowances for copayments for Medicaid services.

Response: We did not propose that nursing home residents use their personal needs allowances for medical services. We are defining how income remaining after deduction of the personal needs allowance and other specific deductions is used for medical services not paid for by a State.

12. *Comment:* One commenter noted that since the proposed regulations do not use the phrase, "recognized under State law," this would permit States to treat medical services in different ways, depending on whether the service is covered in the State Medical plan.

Response: The phrase, "recognized under State law," remains in § 435.725(d)(2), 435.733(d)(2), 435.832(d)(2), and 436.832(d)(2), and is used only in reference to services that are not covered in a State's Medicaid plan. We omitted that reference in regard to covered services because it is unlikely that a service would be covered in a State plan and not be recognized under State law.

13. *Comment:* One commenter believes that we need to encourage States to more carefully evaluate whether a noncovered medical service is medically necessary and whether the cost is reasonable. Also, the commenter suggested that we place greater emphasis on preventing unscrupulous providers from taking unfair advantage of institutionalized recipients by furnishing unnecessary or duplicative services.

Response: We agree with the commenter that institutionalized recipients may be coerced into obtaining unneeded or expensive services. We are continuing to encourage States to work with the provider community to ensure that this problem is minimized.

C. Permit States to Project Medical Deductions for Services not Paid for by a State, Based on an Average of Expenses in Previous Months

Although not included as a proposed rule change, we indicated in the preamble to the March 19, 1985 proposal that we were particularly interested in reviewing public comments on whether States should have the additional option to project deductions of an individual's medical expenses based on an average of expenses in previous months. This proposed option was intended to eliminate the need for States to do monthly budgeting.

1. *Comment:* Nineteen commenters support the idea of permitting States to project medical expenses. Six commenters added that without permitting projection of medical expenses, projection of income alone would not make monthly budgeting any easier for States. One commenter pointed out that, because existing regulations at 42 CFR 435.725, 435.733, 435.832 and 436.832 do not require that deductions for noncovered medical expenses be made on a monthly basis, we could interpret the existing regulations to permit projection of medical expenses.

Response: The overwhelming number of commenters favored permitting States to project medical expenses. While we agree that the existing regulations can be interpreted to permit projection of medical expenses, we believe it best to explicitly provide for projection of medical expenses in the regulations and to clarify the policy. In response to the comments, we are revising the regulations to permit States to project anticipated medical expenses for a period not to exceed 6 months. This estimate is to be based on the average monthly medical expenses incurred by a recipient during the preceding 6 month period. As with income projection, we will require that States consider future changes in a recipient's expenses when making the projection, and to reassess the projection if unpredicted changes occur within the 6 month period. To ensure that the projection estimate is in line with actual deductions, we will require that States reconcile estimated expenses with actual expenses at the end of each 6 month period.

2. *Comment:* Two commenters asked how quality control reviews will be performed when medical expenses are projected.

Response: Quality control reviews will determine whether a State paid the correct amount to an institution based on actual recipient income received and

medical expenses deducted. If a State chooses to estimate and project income and medical expenses, QC will determine whether a State correctly followed requirements in the regulations and procedures specified in the State's Medicaid plan. The QC reviewers will determine if the estimates of income and medical expenses are correct in view of previously received income and incurred medical expenses, whether significant changes were considered timely, and whether a reconciliation was properly done.

3. *Comment:* Commenters had different views on what time period should be used as a basis for projections of medical expense deductions and what prospective period should be used. Two commenters recommended basing the projection on the previous 6 month period, while one commenter suggested using a shorter period of no more than 3 months. Three commenters believe a prospective period of 6 months should be used to be consistent with projection of income.

Response: We agree with the majority of the commenters that a 6 month prospective period is the longest period that should be used in the interest of avoiding errors and making adjustments easier. This period is also consistent with the period used for projection of income. We are revising the regulations (paragraphs (f)(1) and (2) of §§ 435.725, 435.733, 435.832 and 436.832) to provide that States may project medical expense deductions for a prospective period not to exceed 6 months. States may base the projection on a preceding period, not to exceed 6 months.

4. *Comment:* Seven commenters agreed that, as with income projections, some kind of adjustment will be needed to reconcile estimated medical deductions with actual deductions. A variety of recommendations were made on how we should modify the regulations to ensure prompt and accurate adjustments. One commenter suggested that we permit States to set aggregate allowances for medical deductions with a reconciliation at the end of 6 months. Another commenter recommended a flexible system allowing States to recalculate expenses whenever significant changes occur. A third commenter advocated requiring that if actual costs exceed average projected costs by more than $50, a State must recalculate the projection.

Response: In considering the comments, we believe that two issues are important: (1) Flexibility for States to devise their own procedures, and (2) consistency with the policy on projection of income so that expenses and income are considered together. Consequently, we are revising the regulations (paragraph (f) of §§ 435.725, 435.733, 435.832, and 436.832) to parallel the provisions on income projection, to require that adjustments to estimates of monthly medical deductions must be made at the end of the prospective period, not to exceed 6 months, or when any significant change occurs. In the interest of flexibility, States are free to define "significant change." We believe that if States readjust calculations when medical expenses change significantly, then a recipient's monthly liability can be adjusted accordingly. To further increase flexibility, as we noted in the response to comment B.4, we are permitting States to set aggregate limits on monthly medical deductions.

D. General Comments Relating to All the Proposals

1. *Comment:* Two commenters suggested that we revise the regulations governing the quality control system and Federal financial participation (FFP) disallowances based on error rates. The commenters contend that the quality control system is unfair because FFP disallowances are taken only on errors that result in overpayment by the Medicaid program. Underpayment should also be penalized. The commenters are concerned that estimating and projecting income and medical deductions under these regulations may result in a recipient paying too much income to a facility, and the Medicaid program making too small a payment.

Response: If procedures on reconciliation of income and expenses are correctly followed by States, we anticipate few errors. We think that it is unlikely that States would deliberately underpay when they have the flexibility to design a system which promotes both accuracy and ease of administration in the post eligibility process.

2. *Comment:* One commenter recommended that these provisions be exempt from the quality control review process saying that it is too difficult to account for expenses prospectively when they are not fixed expenses.

Response: Revisions to the quality control review process are beyond the scope of these regulations.

3. *Comment:* Two commenters suggested that we must also amend 42 CFR 435.831(c)(1) (which concerns deduction of incurred medical expenses for purposes of establishing Medicaid eligibility of medically needy individuals).

Response: On September 2, 1983, we published a proposed rule (48 FR 39959) and requested public comments on revisions to regulations at 42 CFR 435.732, 435.831, and 436.831. That rule proposed changes to the eligibility process commonly known as spenddown, in which incurred medical expenses are deducted from income in determining eligibility for Medicaid. The proposed spenddown procedures are similar to those contained in this final rule, but apply only to medical deductions before an individual qualifies for Medicaid. Any revision to section 435.831 will be accomplished after public comments are considered and when the final rule is published.

4. *Comment:* A commenter suggested that the deduction for maintenance of a home, specified in 42 CFR 435.725(d), should be permitted not only for an individual, but also for an institutionalized couple.

Response: We agree that, in order to maintain the home in cases in which both members of a couple are institutionalized temporarily, States should be permitted to deduct an amount from their joint income for maintenance of their home. In response to this comment, we are revising §§ 435.725(d), 435.733(d), 435.832(d) and 436.832(d) to permit States to deduct an amount for maintenance of the home when both spouses are institutionalized temporarily.

5. *Comment:* One commenter suggested that we revise the regulations to permit deductions in cases in which a support obligation is court-ordered due to separation or divorce, and the amount exceeds allowable limits.

Response: The existing regulations, 42 CFR 435.725(c)(3), 435.733(c)(3), 435.832(c)(3), and 436.832(c)(3), require that a State deduct an amount from an institutionalized recipient's income for maintenance needs of a family at home. In applying the criteria on amounts to be deducted, we do not make a distinction between individuals with court ordered obligations exceeding the limits and individuals with other financial obligations above the limits. The same limits apply to deductions in both cases.

6. *Comment:* Three commenters suggested that we extend these revisions to regulations at §§ 435.726 and 435.735 on post eligibility treatment of income and resources of individuals receiving home and community based services. One commenter suggested that we should set a higher level of protected income for housing and maintenance for individuals receiving home and community based services, define "medical and remedial deductions," waive a percentage of insurance payments to individuals for medical expenses, and develop a system for validating medical expenses that does

not not require collection of receipts from recipients and families.

Response: We will examine the regulations concerning home and community based services to see if revisions are desirable, and consider issuing a proposed rule. Our consideration will involve changes to home and community based services made by Pub. L. 99–272, the Consolidated Omnibus Budget Reconciliation Act of 1985, enacted April 7, 1986.

7. *Comment:* One commenter argued that we failed to comply with the Administrative Procedure Act (APA) and solicit comments before we published the existing final rules in October, 1978.

Response: The regulations published in October, 1978 were recodifications of existing rules. Since those regulations were not revised policy, we were not required to publish a proposed rule and request public comments under the APA.

III. Application of the Special Income Standard in the First 30 Days of Institutionalization

We are revising our regulations to conform them to the Medicaid statute as amended by section 9510 of the Consolidated Omnibus Reconciliation Act, Pub. L. 99–272, enacted April 7, 1986. We believe that it is unnecessary to publish these revisions in a proposed rule because section 9510 contains clear language that leaves us no discretion in implementing the policy. (See section V.—Waiver of Proposed Rulemaking.) Following is a discussion of legislative changes and background concerning State use of the optional special income standard for institutionalized individuals.

Sections 1902(a)(10) and 1903(f)(4) of the Act (42 U.S.C. 1396a(a)(10) and 1396b(f)(4)) permit States to provide Medicaid coverage to certain institutionalized aged, blind, or disabled individuals whose income exceeds the payment standards for Supplemental Security Income (SSI) benefits or State supplements to SSI benefits as established by title XVI of the Act (42 U.S.C. 1381 et seq. and 42 U.S.C. 1382e). Under this optional provision, a State determines financial eligibility for Medicaid by comparing an individual's income to a special income standard for institutionalized individuals. This higher institutional income standard reflects the higher cost of institutional care compared to the cost of residential living in the community. Individuals often have adequate income, according to cash assistance standards, to pay living expenses in a home or apartment, but inadequate income to pay for the cost of care in an institution. For example, an individual with $800 per month income in the community may be ineligible for Medicaid based on cash assistance standards. Another individual with the same monthly income in an institution costing $1,000 per month may be eligible for Medicaid if a State uses a special income standard for institutionalized individuals.

Existing regulations at 42 CFR 435.722(c) provide that this special income standard must be applied beginning with the first full month of institutionalization. We have interpreted "full month" to mean that an individual must have been in an institution from the first day of a calendar month through the last day of that month. Thus, individuals entering an institution after the first day of a month, under existing policy, are not eligible for Medicaid under the special income standard until the following month. Thus, under existing regulations and interpretations, an individual's days in an institution prior to the first day of the calendar month would be disregarded in applying the special income standard. This interpretation parallels a requirement under the Supplemental Security Income (SSI) program that an individual's SSI benefit is reduced if he or she has been in a medical institution throughout a full calendar month.

The existing full calendar month policy has been criticized as rigid and unfair, and can have inequitable results for recipients who have been in an institution for the same length of time as other recipients, but not a full calendar month.

Recent legislation has made significant changes to the application of the special income standard. Section 9510 of Pub. L. 99–272, enacted April 7, 1986, amends section 1902(a)(10)(A)(ii)(V) of the Act, and requires that eligibility under the special institutional income standard begin with the first day of a period of not less than 30 consecutive days of institutionalization. This provision is effective with respect to payment for services furnished on or after October 1, 1985. We are revising 42 CFR 435.722(c) to add this new provision.

IV. Revisions to the Regulations

We are adopting as final the proposed rule published on March 19, 1985 at 50 FR 10992 with the following modifications:

1. In §§ 435.725, 435.733, 435.832, and 436.832, we are adding headings for paragraphs, for ease of reference.

2. In §§ 435.725(a), 435.733(a) and 435.832(a) and 436.832(a), we are inserting the term "total income," at the end of the first sentence. We are also moving provisions of the option for agencies to project income to a new paragraph (e) in each section listed above.

3. In paragraph (c) of §§ 435.725, 435.733, 435.832, and 436.832, the cross reference in the introductory language is changed to refer to paragraph (e).

4. In paragraph (d) of §§ 435.725, 435.733, 435.832, and 436.832, language is changed to refer to paragraph (e). In paragraph (d)(1) of the same sections, we are clarifying that the agency may deduct expenses for necessary medical and remedial services included in the State plan (for the categorically needy in §§ 435.725 and 435.733, and for the medically needy in §§ 435.832 and 436.832) that exceed agency limitations on amount, duration, or scope of services. In paragraph (d)(2) of these same sections, we are specifying that agencies may deduct from couples' income in addition to single individuals, an amount for maintenance of the home.

5. We are revising 42 CFR 435.725, 435.733, 435.832, and 436.832 by adding a new paragraph (e) to each section. In (e)(1), we clarify that State agencies may project income over a period not to exceed 6 months; in (e)(2), we require that States base estimates of projected income on income received in the preceding period, not to exceed 6 months and on income expected to be received; and in (e)(3) we require agencies to readjust estimates of projected income whenever significant changes occur in a recipient's income.

6. We are revising 42 CFR 435.725, 435.733, 435.832, and 436.832 by adding a new paragraph (f) to each section. In (f)(1), we specify that, in determining the amount of medical expenses to be deducted from an individual's income, an agency may deduct either incurred medical expenses, or estimate and project medical expenses for a prospective period not to exceed 6 months; In (f)(2), we require that an agency base the prospective monthly estimate of incurred medical expenses on expenses incurred in the preceding period, not to exceed 6 months and medical expenses expected to be incurred; and in (f)(3) we require that agencies adjust estimates of monthly medical expenses at the end of the prospective period, or when any significant change occurs.

7. Finally, we are revising 42 CFR 435.722(c) to require that States apply the special income standard for institutionalized individuals effective with a period of not less than 30 consecutive days of institutionalization.

This revision is in accordance with the requirements of section 9510 of Pub. L. 99-272, enacted April 7, 1986. This change was not a part of the March 19, 1985 proposed rule.

V. Waiver of Proposed Rulemaking

It is our practice to publish general notice of proposed rulemaking in the **Federal Register**, and afford prior public comment on proposed rules. Such notice includes a statement of the nature of rulemaking proceedings, reference to the legal authority under which a rule is proposed, and the terms or substance of the proposed rule or a description of the subjects and issues involved. However, we do not provide a public comment period 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 rules issued.

The revisions we are making to § 435.722(c) bring it in conformance with the requirements of section 9510 of Pub. L. 99-272. The requirements of this section of the law are very clear and not subject to interpretation.

Consequently, we believe it is unnecessary to publish a proposed rule, and find good cause to waive proposed rulemaking.

VI. Regulatory Impact Analysis

A. Introduction

Executive Order 12291 requires us to prepare and publish a regulatory impact analysis for any regulation that is likely to:

- Have an annual effect on the economy of $100 million or more;
- Cause a major increase in cost or prices for consumers, individual industries, Federal, State, or local governments, agencies, or any geographic regions; or
- Have significant adverse effect on competition, employment, investment, productivity, innovation or on the ability of the United States based enterprises to compete with foreign based enterprises in domestic or export markets.

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

For purposes of the RFA, we treat all institutional providers as small entities. Institutional providers in any State that chooses to deduct some or all of a recipient's income spent on noncovered medical services will be directly affected. We also consider providers of noninstitutional services, such as physicians, dentists, and pharmacists, to be small entities. Although this rule may not directly affect the latter entities, it may affect the amount of income institutionalized recipients have available for the purchase of medically necessary services not covered by the Medicaid State plan, which may, in turn, have an economic effect on providers of the noncovered medical services. Thus, it is clear that this final rule will affect a substantial number of small entities.

In the proposed rule, we stated that the regulations would have a savings effect of between 0 and $28 million, thus not requiring us to treat this as a "major rule". In view of this relatively small effect on total Medicaid expenditures, we also determined that the proposed rule would not have a significant economic impact on small entities as defined under the RFA.

Comment: We received two comments questioning the estimated savings amount to be gained from the proposed rule. They claimed that our estimated savings figures were too low and the actual impact will be in excess of $100 million. On this basis, the commenters argued that we had not provided necessary analyses.

Response: In order to verify our initial estimates of the savings impact these regulations will have on State and Federal expenditures, we reexamined the assumptions and the data upon which our initial estimate was based. As a result of our reexamination, we have determined that the effect of these regulations could be in excess of $100 million a year within the five year period from the date these regulations become effective. Therefore, we have decided to treat this rule as a major rule and to conduct an impact analysis. Also, because the impact on small entities may be significant, we are conducting a regulatory flexibility analysis.

B. Objectives of the Regulations

As explained in section I of this preamble, section 1902(a)(17) of the Act gives the Secretary broad authority to define income for purposes of determining continued Medicaid eligiblity. Under current regulations, once an institutionalized person is determined to be eligible, and continues to meet the income requirements, a State must deduct the cost of all noncovered medical expenses from the recipient's income. Some States have argued that this requirement forces them to subsidize medical services they have elected not to cover under their State plan. By excluding the cost of such noncovered services from a recipient's income, the State is indirectly paying for the services even though the State has chosen not to provide certain services, or to limit services with respect to amount, duration, or scope.

In addition, by reducing the amount of a recipient's available income, a State must pay a larger share of the recipient's institutional care costs than it would otherwise have to pay, if it could include, as income, the amounts paid by recipients for noncovered services. Permitting a State to include amounts currently paid for noncovered medical services as income enables the State to shift more of the financial responsibility for the cost of nursing home care to the recipient, thereby permitting the State to reduce its reimbursement to the institution for institutional care. It also allows the State to eliminate the indirect subsidy for noncovered services.

These regulations will permit States to include, as income, any amounts a recipient spends for services that are not covered under the State's Medicaid plan. This provision also may be applied to those services upon which the State has set limits with respect to amount, duration, or scope. In either instance, a State has discretion over when, how, and to what extent it will consider a recipient's expenses for noncovered or covered medical services that exceed a State's limits on amount, duration, or scope. For example, a State may elect to exclude (that is, not count as available income) a recipient's expenses for certain noncovered services, and not others. Another possible approach is for a State to establish reasonable limits on the amount, duration or scope of covered or noncovered services for which it will exclude expenses from a recipient's income, Thus, States have several alternatives, which may be employed in various combinations of approaches, in excluding or including amounts expended by recipients for noncovered medical expenses as income.

The most likely approach we believe States will take under these regulations is to restrict the income deductions for those services that the State believes have marginal or questionable therapeutic value. By limiting the amount of income a recipient spends on such questionable services (either with respect to the entire service, or limited to the scope or amount), the State can discourage the recipient from using his or her income to purchase medical services of dubious value.

C. Projected Impact

Since the revisions we are implementing give States the option to

consider as income money a recipient spends on noncovered services (or services which exceed a State's limits), but does not require them to do so, it is difficult to predict precisely the impact of this rule on States, recipients and providers. Many factors will influence the course of action individual States adopt with respect to these revisions. In deciding how best to implement these revised rules, States will examine the needs of their institutionalized recipients, their current policies on noncovered services, the average income of institutionalized recipients residing in the respective States, budget constraints and other local issues specific to each State.

In keeping with the uncertainty over how States will react to the added flexibility in determining recipients income granted under these regulations, we have examined the sensitivity of estimates of Federal and State Medicaid program savings to two key assumptions: the number of recipients affected (which is dependent on the number of States that elect to exercise the flexibility authorized under this rule), and the average monthly savings per recipient realized by the States as a whole (which is dependent on both the available income of recipients currently spent on noncovered services, and the amount of that income that States elect to include).

It is impossible to predict exactly which States would include this income. However, we assume that enough States would do so to affect at least 20 percent of all institutionalized Medicaid recipients, and it is possible that as many as 50 percent of recipients could be affected. It is conceivable that less than 20 percent or more than 50 percent of recipients would be affected, but we view it as unlikely.[1] In a similar manner, we have assumed that the average monthly savings per recipient (which would be shared by the States and the Federal government) would probably fall between $50 and $75 a month. In particular States, annual per recipient savings could be higher or lower.

Based on these variables, and assuming a May 1, 1988 implementation date, we have developed a low estimate (assuming that only 20 percent of recipients would be affected and that monthly savings per recipients would average $50) and a high estimate (assuming that 50 percent of recipients would be affected and that monthly savings per recipient would average $75), as follows:

FISCAL YEAR (FY) SAVINGS (ROUNDED TO NEAREST $5 MILLION)

Assumptions used	1988			1989			1990		
	Federal	State	Total	Federal	State	Total	Federal	State	Total
Low	$5,000,000	0	$5,000,000	$25,000,000	$20,000,000	$45,000,000	$45,000,000	$40,000,000	$85,000,000
High	10,000,000	10,000,000	20,000,000	100,000,000	80,000,000	180,000,000	170,000,000	140,000,000	310,000,000

The assumptions concerning the amount of money recipients currently spend on noncovered services, which underlie our assumptions on average annual savings per recipient, deserve some discussion. Typically, an institutionalized recipient is female, over 85 years old, and receives some form of income. The most common source of income is Social Security survivors benefits. Almost all institutionalized recipients would be eligible for SSI benefits but for the fact that they are in a Medicaid certified institution. Also, because almost all of the recipients are over 65, they are eligible to receive Medicare Part A benefits as well as Medicaid. In addition, most States "buy-in" to the part B program by paying the premium, deductible, and copayments for their dually eligible recipients, thereby enabling them to receive additional inpatient and outpatient services that may not be covered under Medicaid.

While we do not have exact information on the average institutionalized recipient's income level, we estimate the median income for a nursing home patient receiving Medicaid benefits is approximately $583 per month, and may range as high as $853 per month. These estimates are based on Bureau of the Census data and maximum allowable income levels for Medicaid institutionalized recipients. Based on the available data, we estimate that institutionalized recipients in States that provide a more complete range of optional services ("generous" States) may deduct from patient income up to $300 per month for noncovered services. We believe that, ultimately, such "generous" States will not choose to deduct all such expenses from income, but will reduce the amount protected for noncovered services by $50 to $75 per month. States that are less generous in allowing expenses for noncovered services, naturally, also may seek to cut the protected amount. However, States with fewer covered services and more restrictive income criteria also generally are States with the poorest populations. Thus, recipients in these States have very little extra income to spend on noncovered services. As a result, we believe that the "poorer" States, also, will only be able to save from $50 to $75 per month institutionalized recipient.

D. Impact on Small Entities

These regulations could save from $160 to $615 million (combined Federal and State savings) for fiscal years 1987 through 1989 through transferring a portion of the cost of institutional care from the State to the recipient. However, while a State will be permitted to count more of recipients' income as available for paying for their institutional care, under current regulations, States may not force recipients to apply their income toward their nursing home care. We expect some States, as a result of exercising the flexibility available under these rules, will reduce the total amount they pay to SNFs, ICFs, and in some cases to ICFs/MR for the care of recipients.

To protect themselves from financial harm, SNFs, ICFs, and affected ICFs/MR will probably seek to adopt strategies to ensure that recipients will compensate them for the reduction in State payments. Because the institution is generally in a position to deny admission to Medicaid recipients without suffering financially, it seems likely that some will persuade newly admitted recipients to apply their available income toward their institutional care rather than for the noncovered services. However, we doubt that abuses will occur in this area because of the likelihood of adverse publicity to the institution concerned as

[1] Based on an unduplicated count of recipients in skilled nursing facilities (SNFs) intermediate care facilities (ICFs) and intermediate care facilities for the mentally retarded (ICFs/MR), the total number of institutionalized recipients reported for fiscal year (FY) 1984 was 1.488 million.

well as possible local restrictions on the actions of nursing institutions in such matters. Also, we believe that in most cases, recipients voluntarily will assume the additional cost of paying for their institutional care and forego some of the noncovered services. In many cases, these noncovered services are of marginal value, and when faced with the choice of either contributing a larger share of their income toward their maintenance and care in the nursing home or paying for medical services whose benefits are questionable, we believe that most recipients will elect the former option of paying for their institutional care.

Based on this assessment of the impact of the change in the rules for post eligibility income determination, it appears highly likely that the major impact of this regulation will fall on providers of noninstitutional services such as physicians, dentists, and physical and occupational therapists. Since each State imposes its own set of restrictions on the various types of services available in the State, it is impossible to know how the effects of these rules will be distributed.

E. Application of the Special Income Standard

We have determined that the revision to the regulations that establishes Medicaid eligibility from the first day of a stay of at least 30 days in a medical institution will not result in an annual economic effect of $100 million or meet the other thresholds in section 1(b) of the Order. Our actuaries estimate that this proposal would result in total annual costs of $9 million beginning in FY 1988 ($5 million Federal costs and $4 million State costs). Even though these costs depend on the number of States that choose to apply the special income standard as described, we have better data on which to base a cost estimate because we know that there are 17 States that use the special income standard and can project the extent to which the Medicaid institutionalized population could be affected.

Establishing Medicaid eligibility from the first day of a stay of at least 30 days will benefit those who, to date, have paid the cost of care for those days prior to the first full month of institutionalization. We believe that this change will primarily benefit recipients and family members who are paying these costs for institutional care.

VII. Paperwork Reduction Act

These changes do not impose information collection requirements; consequently, they need not be reviewed by the Executive Office of Management and Budget under the authority of the Paperwork Reduction Act of 1980 (44 U.S.C. 3501 et seq.).

List of Subjects

42 CFR Part 435

Aid to families with dependent children, Grant programs-health, Medicaid, Supplemental Security Income (SSI).

42 CFR Part 436

Aid to families with dependent children, Grant programs-health, Guam, Medicaid, Puerto Rico, Supplemental Security Income (SSI), Virgin Islands.

42 CFR Part 435 and 436 are amended as set forth below: Part 435 is amended as follows:

PART 435—ELIGIBILITY IN THE STATES, 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), unless otherwise noted.

Subpart H—Financial Requirements for the Categorically Needy

Financial Eligibility Requirements Applicable to Optional Groups: The Aged, Blind, and Disabled in States Covering Individuals Receiving SSI

2. Section 435.722 is amended by revising paragraph (c) to read as follows:

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

* * * * *

(c) The agency must apply the income standards established under this section effective with the first day of a period of not less than 30 consecutive days of institutionalization.

3. In Subpart H, section 435.725 is amended by revising paragraph (a), the introductory language of paragraph (b) and paragraph (c), revising paragraphs (c)(4) and (d), and adding new paragraphs (e) and (f) 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) *Application of patient income.* 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 paragraphs (c) and (d) of this section, from the individual's total income, as determined in paragraph (e) of this section.

(b) *Applicability.* This section applies to the following individuals in med'cal institutions and intermediate care facilities.

* * * * *

(c) *Required deductions.* In reducing its payment to the institution, the agency must deduct the following amounts, in the following order, from the individual's total income, as determined under paragraph (e) of this section. Income that was disregarded in determining eligibility must be considered in this process.

* * * * *

(4) Amounts for Medicare and other health insurance premiums, deductibles, or coinsurance charges that are not subject to payment by a third party.

(d) *Optional deductions.* 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 total income as determined under paragraph (e) of this section:

(1) Necessary medical or remedial services included in the State's Medicaid plan for the categorically needy, which exceed limitations on amount, duration or scope imposed by the agency, subject to reasonable limit the agency may establish on amounts of these expenses;

(2) 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

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

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

(ii) A physician has certified that either of the individuals is likely to return to the home within that period.

(e) *Determination of income*—(1) *Option.* In determining the amount of an individual's income to be used to reduce the agency's payment to the institution, the agency may use total income received, or it may project monthly income for a prospective period not to exceed 6 months.

(2) *Basis for projection.* The agency must base the projection on income received in the preceding period, not to exceed 6 months, and on income expected to be received.

(3) *Adjustments.* At the end of the prospective period specified in

paragraph (e)(1) of this section, or when any significant change occurs, the agency must reconcile estimates with income received.

(f) *Determination of medical expenses*—(1) *Option.* In determining the amount of medical expenses to be deducted from an individual's income, the agency may deduct incurred medical expenses, or it may project medical expenses for a prospective period not to exceed 6 months.

(2) *Basis for projection.* The agency must base the estimate on medical expenses incurred in the preceding period, not to exceed 6 months, and on medical expenses expected to be incurred.

(3) *Adjustments.* At the end of the prospective period specified in paragraph (f)(1) of this section, or when any significant change occurs, the agency must reconcile estimates with incurred medical expenses.

(4) In Subpart H, section 435.733 is amended by revising paragraph (a), the introductory language of paragraph (b) and revising paragraphs (c)(4) and (d), and adding new paragraphs (e) and (f) to read as follows:

Financial Eligibility for the Aged, Blind, and Disabled in States Using More Restrictive Requirements Than SSI

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

(a) *Application of patient income.* 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 paragraphs (c) and (d) of this section from the individual's total income, as determined in paragraph (e) of this section.

(b) *Applicability.* This section applies to the following individuals in medical institutions and intermediate care facilities:

* * * * *

(c) *Required deductions.* The agency must deduct the following amounts, in the following order, from the individual's total income, as determined under paragraph (e) of this section. Income that was disregarded in determining eligibility must be considered in this process.

* * * * *

(4) Amounts for Medicare and other health insurance premiums, deductibles, or coinsurance charges that are not subject to payment by a third party.

(d) *Optional deductions.* 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 total income as determined under paragraph (e) of this section:

(1) Necessary medical or remedial services included in the State's Medicaid plan for the categorically needy, which exceed limitations on amount, duration or scope imposed by the agency, subject to reasonable limits the agency may establish on amounts of these expenses;

(2) 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

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

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

(ii) A physician has certified that either of the individuals is likely to return to the home within that period.

(e) *Determination of income*—(1) *Option.* In determining the amount of an individual's income to be used to reduce the agency's payment to the institution, the agency may use total income received, or it may project total monthly income for a prospective period not to exceed 6 months.

(2) *Basis for projection.* The agency must base the projection on income received in the preceding period, not to exceed 6 months, and on income expected to be received.

(3) *Adjustments.* At the end of the prospective period specified in paragraph (e)(1) of this section, or when any significant change occurs, the agency must reconcile estimates with income received.

(f) *Determination of medical expenses*—(1) *Option.* In determining the amount of medical expenses that may be deducted from an individual's income, the agency may deduct incurred medical expenses, or it may project medical expenses for a prospective period not to exceed 6 months.

(2) *Basis for projection.* The agency must base the estimate on medical expenses incurred in the preceding period, not to exceed 6 months, and medical expenses expected to be incurred.

(3) *Adjustments.* At the end of the prospective period specified in paragraph (f)(1) of this section, or when any significant change occurs, the agency must reconcile estimates with incurred medical expenses.

Subpart I—Financial Requirements for the Medically Needy

5. In Subpart I, section 435.832 is amended by revising paragraph (a), the introductory language of paragraph (b) and paragraph (c), revising paragraphs (c)(4) and (d), and adding new paragraphs (e) and (f) to read as follows:

Medically Needy Income Eligibility

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

(a) *Application of patient income.* 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 paragraphs (c) and (d) of this section, from the individual's total income, as determined in paragraph (e) of this section.

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

(c) *Required deductions.* The agency must deduct the following amounts, in the following order, from the individual's total income, as determined under paragraph (e) of this section. Income that was disregarded in determining eligibility must be considered in this process.

* * * * *

(4) Amounts for Medicare and other health insurance premiums, deductibles, or coinsurance charges that are not subject to payment by a third party.

(d) *Optional deductions.* 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 total income as determined under paragraph (e) of this section:

(1) Necessary medical or remedial services included in the State's Medicaid plan for the medically needy, which exceed limitations on amount, duration or scope imposed by the agency, subject to reasonable limits the agency may establish on amounts of these expenses;

(2) 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

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

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

(ii) A physician has certified that either of the individuals is likely to return to the home within that period.

(e) *Determination of income*—(1) *Option.* In determining the amount of an individual's income to be used to reduce the agency's payment to the institution, the agency may use total income received or it may project total monthly income for a prospective period not to exceed 6 months.

(2) *Basis for projection.* The agency must base the projection on income received in the preceding period, not to exceed 6 months, and on income expected to be received.

(3) *Adjustments.* At the end of the prospective period specified in paragraph (e)(1) of this section, or when any significant change occurs, the agency must reconcile estimates with income received.

(f) *Determination of medical expenses*—(1) *Option.* In determining the amount of medical expenses to be deducted from an individual's income, the agency may deduct incurred medical expenses, or it may project medical expenses for a prospective period not to exceed 6 months.

(2) *Basis for projection.* The agency must base the estimate on medical expenses incurred in the preceding period, not to exceed 6 months, and medical expenses expected to be incurred.

(3) *Adjustments.* At the end of the prospective period specified in paragraph (f)(1) of this section, or when any significant change occurs, the agency must reconcile estimates with incurred medical expenses.

B. Part 436 is amended as follows:

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

5. The authority citation for Part 436 continues to read as follows:

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

6. Section 436.832 is amended by revising paragraph (a), the introductory language of paragraph (b) and paragraph (c), revising paragraphs (c)(4) and (d), and adding new paragraphs (e) and (f) 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) *Application of patient income.* 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 paragraphs (c) and (d) from the individual's total income, as determined in paragraph (e) of this section.

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

(c) *Required deductions.* The agency must deduct the following amounts, in the following order, from the individual's total income as determined under paragraph (e) of this section. Income that was disregarded in determining eligibility must be considered in this process.

* * * * *

(4) Amounts for Medicare and other health insurance premiums, deductibles, or coinsurance charges that are not subject to payment by a third party.

(d) *Optional deductions.* 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 total income as determined under paragraph (e) of this section:

(1) Necessary medical or remedial services included in the State's Medicaid plan for the medically needy, which exceed limitations on amount, duration or scope imposed by the agency, subject to reasonable limits the agency may establish on amounts of these expenses;

(2) 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

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

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

(ii) A physician has certified that either of the individuals is likely to return to the home within that period.

(e) *Determination of income*—(1) *Option.* In determining the amount of an individual's income to be used to reduce the agency's payment to the institution, the agency may use total income received or it may project total monthly income for a prospective period not to exceed 6 months.

(2) *Basis for projection.* The agency must base the projection on income received in the preceding period, not to exceed 6 months, and on income expected to be received.

(3) *Adjustments.* At the end of the prospective period specified in paragraph (e)(1) of this section, or when any significant change occurs, the agency must reconcile estimates with income received.

(f) *Determination of medical expenses*—(1) *Option.* In determining the amount of medical expenses to be deducted from an individual's income, the agency may deduct incurred medical expenses, or it may project medical expenses for a prospective period not to exceed 6 months.

(2) *Basis for projection.* The agency must base the estimate on medical expenses incurred in the preceding period, not to exceed 6 months, and medical expenses expected to be incurred.

(3) *Adjustments.* At the end of the prospective period specified in paragraph (f)(1) of this section, or when any significant change occurs, the agency must reconcile estimates with incurred medical expenses.

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

Dated: August 7, 1987.

William L. Roper,

Administrator, Health Care Financing Administration.

Approved: November 4, 1987.

Otis R. Bowen,

Secretary.

[FR Doc. 88-2480 Filed 2-5-88; 8:45 am]

BILLING CODE 4120-01-M

FEDERAL EMERGENCY MANAGEMENT AGENCY

44 CFR Part 205

Individual and Family Grant Program Provisions

AGENCY: Federal Emergency Management Agency.

ACTION: Final rule.

SUMMARY: On Friday, October 9, 1987, FEMA published a proposed rule in the Federal Register on the Individual and Family Grant (IFG) program. This program operates under authority of the Disaster Relief Act of 1974, Pub. L. 93-288. The comment period has ended, and FEMA is now publishing the proposal as a final rule.

Comments were requested by December 9, 1987, but accepted until December 22, 1987. Four comments were received—from the Illinois Department of Transportation, the Maryland Department of Human Resources, the New Jersey Department of Law and Public Safety (Office of Emergency

Management), and from the Alabama Department of Human Resources. All four commenters were supportive of the proposals, which dealt with the IFG flood insurance requirements and with acceptance of late IFG applications. Individual letters acknowledging receipt of the comment are being sent separately to the four commenters.

Illinois also submitted an unsolicited comment regarding another IFG matter; we will consider it separately in upcoming changes to the IFG regulations, and have notified Illinois accordingly.

The final rule makes two changes to the IFG program regulations. First, it changes the flood insurance requirement language to provide that a recipient of previous IFG assistance who was under a different flood insurance requirement retention period will be assumed to have met that requirement if he/she maintained the policy in force for three years from the grant award date. This change makes the flood insurance maintenance requirements for prior recipients equal to that of current recipients—a change to promote uniformity and consistency. States will not have to keep records back any further than three years from any current disaster declaration date to determine who should still be required to be maintaining their IFG-required policy for three years. If the State determines, through checking with the National Flood Insurance Program, that a prior grant recipient canceled a required policy within three years from the date of his/her grant, and if that cancellation occurred within three years before the current declaration, then he/she would be ineligible for assistance under the IFG program for insurable housing and personal property items.

The second change deals with acceptance of late IFG applications. It applies only when an application reaches the IFG agency late as a result of having been processed late by the Small Business Administration's (SBA) disaster loan program. (NOTE: Filing for an SBA disaster loan is a prerequisite for obtaining IFG assistance.) The rule now provides that SBA will refer cases, even if beyond the normal 60- plus 30-day application period, to the IFG program if they find that the application was filed late by the applicant because of "substantial causes beyond the control of the applicant," and that these referred cases will be considered timely filed. SBA will not refer late cases of IFG if the reason for late filing at SBA did not meet the "substantial causes" test. The State may then determine, using its own criteria, whether to continue processing these late-referred cases through to an IFG eligibility determination.

EFFECTIVE DATE: March 9, 1988.

FOR FURTHER INFORMATION CONTACT: Agnes C. Mravcak, Office of Disaster Assistance Programs, Federal Emergency Management Agency, 500 C Street SW., Room 710, Washington, DC 20472, Phone: 202–646–3660.

SUPPLEMENTARY INFORMATION:

Content of the Rule

This rule implements section 408 of the Disaster Relief Act of 1974, 42 U.S.C. 5178. It provides FEMA policy and national eligibility criteria for use by States implementing the Individual and Family Grant program.

List of Subjects in 44 CFR Part 205

Community facilities, Disaster assistance, Grant programs, Housing and community development.

PART 205—FEDERAL DISASTER ASSISTANCE (PUB. L. 93–288)

Accordingly, 44 CFR Part 205 is amended.

1. The authority citation for Part 205 continues to read as follows:

Authority: 42 U.S.C. 5001; Reorg. Plan No. 3 of 1978; E.O. 12148.

2. Section 205.54 is amended by revising paragraph (d)(1)(iii)(C)(*1*) as follows:

§ 205.54 Individual and Family Grant Programs.

(d) * * *

(1) * * *

(iii) * * *

(C)(*1*) The State may not make a grant for acquisition or construction purposes in a designated flood hazard area in which the sale of flood insurance is available under the NFIP unless the individual or family agrees to purchase adequate flood insurance and to maintain such insurance for 3 years, or as long as they live in the residence to which the grant assistance relates, whichever is less. Any previous grant recipient who may have been required to maintain a policy for a longer period of time (under previous regulations) but who kept it for at least three years, is deemed to have satisfied this requirement. This provision need be applied only during the 3-year period prior to a new disaster declaration. Adequate flood insurance, for IFG purposes, means a policy which covers $5,000 building and $2,000 contents (homeowners) or $5,000 contents (renters). If the grant recipient fails to obtain the required flood insurance, he/she must return to the State the amount of the grant received for acquisition and construction of insurable real and personal property, and the flood insurance premium. If a grant recipient cancels a required policy within the 3-year period, he/she is ineligible for subsequent IFG assistance for insurable real and personal property for the remainder of the 3-year period, up to the amount which should have been covered by flood insurance. The cost of the first year's policy is a necessary expense for those required under this section to buy flood insurance.

3. Section 205.54 is amended by revising paragraph (j)(1)(ii) as follows:

* * * * *

(j)(1) * * *

(ii) Applications shall be accepted from individuals or families for a period of 60 days following the declaration, and for no longer than 30 days thereafter when the State determines that extenuating circumstances beyond the applicants' control (such as, but not limited to, hospitalization, illness, or inaccessibility to application centers) prevented them from applying in a timely way. *Exception:* If applicants exercising their responsibility to first apply to the Small Business Administration do so after SBA's deadline, and SBA accepts their case for processing because of "substantial causes essentially beyond the control of the applicant," and provides a formal decline or insufficient loan based on lack of repayment ability, unsatisfactory credit, or unsatisfactory experience with prior loans (i.e., the reasons a loan denial client would normally be eligible for IFG assistance), then such an application referred to the State by the SBA is considered as meeting the IFG filing deadline. The State may then apply its own criteria in determining whether to process the case for grant assistance. The State automatically has an extension of time to complete the processing, eligibility, and disbursement functions. However, the State must still complete all administrative activity within the 270-day period described in this section.

Grant C. Peterson,

Associate Director, State and Local Programs and Support.

[FR Doc. 88–2561 Filed 2–5–88; 8:45 am]

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