C. Decision

I conclude that Washington's application for program revision meets all of the statutory and regulatory requirements established by RCRA. Accordingly, Washington is granted final authorization to operate its hazardous waste program as revised. Washington has responsibility for permitting treatment, storage, and disposal facilities within its borders and carrying out other aspects of the RCRA program, subject to the limitation of its revised program application and previously approved authorities. Washington also has primary enforcement responsibilities, although EPA retains the right to conduct inspections under section 3007 of RCRA and to take enforcement actions under section 3008, 3013 and 7003 of RCRA.

Compliance With Executive Order 12291

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

Certification Under the Regulatory Flexibility Act

Pursuant to the provisions of 4 U.S.C. 605(b), I hereby certify that this authorization will not have a significant economic impact on a substantial number of small entities. This authorization effectively suspends the applicability of certain Federal regulations in favor of Washington's program, thereby eliminating duplicative requirements for handlers of hazardous waste in the State. It does not impose any new burdens on small entities. This rule, therefore, does not require a regulatory flexibility analysis.

List of Subjects in 40 CFR Part 271

Administrative practice and procedure, Confidential business information, Hazardous materials transportation, Hazardous waste, Indian lands, Intergovernmental relations, Penalties, Reporting and recordkeeping requirements, Water pollution control, Water supply.

Authority: This notice is issued under the authority of sections 2002(a), 3006 and 7004(b) of the Solid Waste Disposal Act as amended 42 U.S.C. 6912(a), 6926, 6974(b).

Thomas P. Dunne,

Acting Regional Administrator.

[FR Doc. 90-19419 Filed 8-16-90; 8:45 am]

BILLING CODE 6560-50-M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Part 413

[BPD-601-F]

RIN 0938-AD76

Medicare Program; Payment for Outpatient Surgery at Eye Specialty Hosptials and Eye and Ear Specialty Hospitals

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

ACTION: Final rule.

SUMMARY: In accordance with section 4068(a) of the Omnibus Budget Reconciliation Act of 1987, this final rule revises the payment provisions concerning outpatient hospital services furnished in connection with ambulatory surgical procedures for certain qualified eye specialty hospitals and eye and ear specialty hospitals. It establishes that, for cost reporting periods beginning on or after October 1, 1988 and before October 1, 1990, the blended payment amount applicable to these hospitals remains at 75 percent of the hospital-specific amount and 25 percent of the ambulatory surgical center amount.

EFFECTIVE DATE: This final rule is effective September 17, 1990.

FOR FURTHER INFORMATION CONTACT: Linda McKenna, (301) 966-4530.

SUPPLEMENTARY INFORMATION:

I. Background

Section 9343(a) of the Omnibus Budget Reconciliation Act of 1986 (Pub. L. 99-509), enacted on October 21, 1986, set forth a new methodology to be used in determining Medicare payment for facility services furnished in a hospital on an outpatient basis in connection with covered ambulatory surgical center (ASC) procedures that are specified by the Secretary in accordance with section 1833(i)(1)(A) of the Social Security Act (the Act) and 42 CFR 416.65. Section 9343(a) of Public Law 99-509 amended section 1833(a)(4) of the Act and added a new section 1833(i)(3) to the Act to provide that, for hospital cost reporting periods beginning on or after October 1, 1987, payment for outpatient facility services in the aggregate shall be based on a comparison between two amounts. The payment is the lesser of the following:

- The amount for the services that would be paid to the hospital under section 1833(a)(2)(B) of the Act (that is, the lower of the hospital's reasonable costs or customary charges for the services, reduced by the applicable deductible and coinsurance amounts).
- An amount based on a blend of—

—The amount that would be paid to the hospital for the services under section 1833(a)(2)(B) of the Act (referred to below as the hospital-specific amount); and

—The amount that would be paid to a freestanding ASC for the same procedure in the same geographic area, in accordance with section 1833(i)(2)(A) of the Act, which is equal to 80 percent of the standard overhead amount reduced by the applicable deductible amount (referred to below as the ASC payment amount).

Section 1833(i)(3)(B) of the Act, as added by section 9343(a) of Public Law 99-509, provided that for cost reporting periods beginning on or after October 1, 1987 but before October 1, 1988, the blended amount is based on 75 percent of the hospital-specific amount and 25 percent of the ASC payment amount attributable to the procedure. For cost reporting periods beginning on or after October 1, 1988, the blended payment amount is based on 50 percent of the hospital-specific amount and 50 percent of the ASC payment amount.

We published a final rule in the Federal Register on October 1, 1987 (52 FR 36765) to implement the revised payment methodology for hospital outpatient ASC procedures which is set forth at 42 CFR 413.118.

II. New Legislation

Section 4068(a) of the Omnibus Budget Reconciliation Act of 1987 (Pub. L. 100-203), enacted on December 22, 1987, amended section 1833(i)(3)(B)(ii) of the Act to provide certain hospitals a 2-year extension of the blended payment amount applicable for cost reporting periods beginning in Federal fiscal year (FY) 1988. The extension of that blended payment amount (that is, 75 percent of the hospital-specific amount and 25 percent of the ASC payment amount) applies to eye specialty hospitals and eye and ear specialty hospitals that meet certain criteria discussed below and is effective for cost reporting periods beginning on or after October 1, 1988 and before October 1, 1990.

Section 4068(a)(2) of Public Law 100-203 amended section 1833(i)(3)(B)(ii) of the Act to provide that a hospital may make an application to the Secretary for an extension of the blended payment amount (75 percent of the hospital-specific amount and 25 percent of the ASC payment amount) if it demonstrates that it—

• Specializes in eye services, or eye and ear services, as determined by the Secretary;

• Receives more than 30 percent of its total revenues from outpatient services; and

• Was an eye specialty hospital or eye and ear specialty hospital on October 1, 1987.

On January 26, 1989, we published a proposed rule to implement the provisions of section 4068(a) of Public Law 100–203.

III. Provisions of the Proposed Rule

As set forth in the proposed rule, to qualify as an eye specialty hospital or an eye and ear specialty hospital under section 4068(a) of Public Law 100–203, a hospital, in addition to making an application as discussed below, would have to meet certain qualifying criteria set forth in section 1833(i)(3)(B)(ii) of the Act.

One of the criteria that a hospital would have to meet to qualify for the extension of the FY 1988 blended payment amount (that is, a blended amount based on 75 percent of the hospital-specific amount and 25 percent of the ASC payment amount) is that it would have to specialize in eye services or eye and ear services.

We proposed that a hospital that has more than 60 percent of its Medicare discharges classified into the diagnosis-related groups (DRGs) relating to diseases and disorders of the eye (that is, DRGs 36 through 48), or ear, nose, and throat (that is, DRGs 49 through 74), clearly specializes in eye procedures or eye and ear procedures and thus could qualify as an eye specialty hospital or an eye and ear specialty hospital for purposes of section 1833(i)(3)(B)(ii) of the Act.

The second criterion that a hospital would have to meet to qualify for the extension of the FY 1988 blended payment amount is that it receives more than 30 percent of its total revenues from outpatient services. For purposes of these provisions, the proposed rule stated that we would consider revenues to be a hospital's gross charges as defined for the purpose of Medicare reimbursement. That is, gross charges are the regular rates established by a provider for services furnished to beneficiaries and other charge-paying patients. Each charge should be related to the cost of the service and applied uniformly to all patients, that is, both inpatients and outpatients.

The third criterion is that a hospital must have been an eye specialty hospital or an eye and ear specialty hospital on October 1, 1987. Therefore, as proposed, the data available for a hospital's cost reporting period beginning on or after October 1, 1986, and before October 1, 1987, would be used to determine if the hospital meets the necessary criteria. Whereas the statute is silent with respect to the period during which the hospital's outpatient revenues must represent 30 percent of its total revenues, section 1833(i)(3)(B)(ii) of the Act requires that a hospital demonstrate it was an eye specialty hospital or an eye and ear specialty hospital on October 1, 1987. Thus, we believe it is fully consistent and appropriate to apply the outpatient revenue test during the cost reporting period when the hospital's specialty is determined.

The proposed rule stated that a hospital seeking to qualify for the 2-year extension of the FY 1988 blended payment rate under the criteria described above would be required to submit its request in writing to its fiscal intermediary by March 27, 1989 (that is 60 days from from the date of publication) or by the start of the hospital's cost reporting period beginning on or after October 1, 1988, whichever is later. As discussed above, in determining whether a hospital qualifies for an extension, the intermediary would use data available from cost reporting periods beginning on or after October 1, 1986, and before October 1, 1987. Upon completion of its determination, the intermediary would notify the hospital and the appropriate HCFA regional office of its determination.

As proposed, a hospital that meets the three criteria and has its application approved would be eligible for an extension of the FY 1988 blended payment amount under § 413.118 for cost reporting periods beginning on or after October 1, 1988, and before October 1, 1990. We proposed that each hospital that qualifies for the extension would have the extension granted retroactive to its first cost reporting period beginning on or after October 1, 1988. The blended payment amount would be equal to the sum of 75 percent of the hospital-specific amount and 25 percent of the ASC payment amount. For cost reporting periods beginning on or after October 1, 1990, the blended payment amount for eye specialty hospitals and eye and ear specialty hospitals would be equal to the sum of 50 percent of the hospital-specific amount and 50 percent of the ASC payment amount (which is the blended payment amount applicable to all hospitals not eligible for the extension effective with cost reporting periods beginning on or after October 1, 1988). We noted in the proposed rule that hospitals that qualify for the extension would continue to be subject to the payment principle in § 413.118(c) that provides that the aggregate amount of payments for facility services that are related to ASC procedures furnished by a hospital on an outpatient basis is equal to the lesser of—

• The hospital's reasonable costs or customary charges; or

• The blended payment amount.

We proposed to amend § 413.118(d) to implement the special payment provisions for eye specialty hospitals and eye and ear specialty hospitals required by section 4068(a) of Public Law 100–203. We also proposed to revise an incorrect statutory citation in § 413.118(a) so that paragraph (a) correctly states that § 413.118 implements sections 1833 (a)(4) and (i)(3) of the Act.

In August of 1988, before publication of the proposed rule, we issued instructions implementing section 4068(a) of Public Law 100–203 in new § 2830.8 of the Provider Reimbursement Manual (PRM). We indicated in that new section that the requirements would be subject to change based on notice and comment rulemaking. In the new § 2830.8 of the PRM, we stated that to quality as an eye specialty hospital or an eye and ear specialty hospital more than 50 percent of a hospital's Medicare discharges would have to be classified into DRGs that relate to diseases and disorders of the eye or ear (DRGs 36 through 74). However, we later proposed that more than 60 percent of a hospital's Medicare discharges would have to be classified into eye or ear DRGs for a hospital to be considered an eye specialty hospital or an eye and ear specialty hospital. Under this final rule, we are adopting the requirements as stated in the proposed rule.

To take into account the requirement of this final rule that differs from the program instruction, we will apply the following procedures:

• A hospital that is in its first year of the extension based on meeting the criterion in § 2830.8 of the PRM, (that is, that has more than 50 percent of its Medicare discharges classified into eye and ear DRGs), but which will no longer qualify for the extension because more than 60 percent of the Medicare discharges are not classified into eye and ear DRGs, will receive a blended payment amount based on 50 percent of the hospital-specific amount and 50 percent of the ASC payment amount effective 30 days after publication of this final rule in the **Federal Register**.

• A hospital that is in its second year of the extension and would otherwise

not continue to qualify for the extension will continue to receive the blended payment amount based on 75 percent of the hospital-specific amount and 25 percent of the ASC payment amount for the remainder of its second year.

Section 2830.8 of the PRM will be corrected to reflect this new provision.

IV. Discussion of Comments

We received only one comment on the provisions of the proposed rule as follows:

Comment: The commenter requested that the application of the selection criteria should focus on a hospital "operating entity" rather than Medicare provider number. The commenter believes that the proposed qualification process penalizes single Medicare providers that operate multihospital medical centers that provide a full range of services. The commenter suggested that in applying the criteria for selection as a qualified eye or eye and ear specialty hospital, the regulations should acknowledge that major medical centers that use one provider number for cost reporting purposes often consist of many specialized hospitals. Therefore, the provider should be allowed to submit a request for one of its component hospitals and use only the data from that hospital to meet the selection criteria.

Response: A multihospital medical center is comprised of several hospitals that have chosen to be treated as a single provider of services. A multihospital medical center is certified as a single hospital, and all hospitals within the medical center have agreed to be paid as though they were one hospital. Therefore, we believe it would be inconsistent to treat the various hospitals of the medical center as one hospital for certification purposes and for purposes of calculating payment for all other services and as individual hospitals for purposes of receiving the extension of the blended payment amount for ASC procedures. The multihospital medical center must be considered as a single entity (or hospital) in determining whether it meets the qualifying criteria to receive an extension of the blended payment amount. Since we believe this application of the qualifying criteria to be both reasonable and equitable, no changes have been made in the final regulations.

V. Regulatory Impact Statement

A. Executive Order 12291

Executive Order 12291 (E.O. 12291) requires us to prepare and publish a final regulatory impact analysis for any final rule that meets one of the E.O. criteria for a "major rule"; that is, that will be likely to result in—

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

This final rule does not meet the $100 million criterion nor do we believe that it meets the other E.O. 12291 criteria. Therefore, this final rule is not a major rule under E.O. 12291, and a regulatory impact analysis is not required.

C. Regulatory Flexibility Act

We generally prepare a final regulatory flexibility analysis that is consistent with the Regulatory Flexibility Act (RFA) (5 U.S.C. 601 through 612) unless the Secretary certifies that a final rule will not have a significant economic impact on a substantial number of small entities. For purposes of the RFA, all hospitals are treated as small entities.

Section 1102(b) of the Act requires the Secretary to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. Such as analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital with fewer than 50 beds located outside of a Metropolitan Statistical Area.

Based on the definition of specialty hospital set forth in this final rule, we have identified 15 hospitals that would qualify as either eye specialty hospitals or eye and ear specialty hospitals. Although the effects of the statute and this final rule may have a significant effect on those hospitals that qualify as specialty hospitals, we believe that the number of hospitals that will qualify represents a small fraction of all small rural hospitals and of all hospitals. Thus, because affected hospitals do not represent a substantial number either of all small rural hospitals or of all hospitals, the Secretary certifies that a regulatory flexibility analysis and an analysis of the effects of this final rule on small rural hospitals is not required.

V. Other Required Information

Paperwork Reduction Act

This final rule contains no information collection requirements; therefore, it need not be reviewed by the Office of Management and Budget under the provisions of the Paperwork Reduction Act of 1980 (44 U.S.C. 3501 through 3511).

List of Subjects in 42 CFR Part 413

Health facilities, Kidney diseases, Medicare, Reporting and recordkeeping requirements.

42 CFR part 413 is amended as set forth below:

PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICE

1. The authority citation for part 413 is revised to read as follows:

Authority: Secs. 1102, 1122, 1814(b), 1815, 1833(a) and (i), 1861(v), 1881, and 1886 of the Social Security Act as amended (42 U.S.C. 1302, 1320a–1, 1395f(b), 1395g, 1395l(a) and (i), 1395x(v), 1395hh, 1395rr, and 1395ww).

2. In § 413.118, paragraph (a) is revised; the spelling of the word "date" in paragraph (c)(2) is corrected to read "data"; the word "reasonble" in paragraph (d)(1)(i) is corrected to read "reasonable"; paragraph (d)(2)(is revised; and a new paragraph (d)(3) is added to read as follows:

§ 413.118 Payment for facility services related to covered ASC surgical performed in hospitals on an outpatient basis.

(b) *Basis and scope.* This section implements sections 1833 (a)(4) and (i)(3) of the Act and establishes the method for determining Medicare payments for services related to covered ambulatory surgical center (ASC) procedures performed in a hospital on an outpatient basis. It does not apply to services furnished by an ASC operated by a hospital that has an agreement with HCFA to be paid in accordance with § 416.30 of this chapter. [For regulations governing ASCs see part 416 of this chapter.]

* * * * *

(d) *Blended payment amount.* * * *

(2) Except as provided in paragraph (d)(3) of this section, for cost reporting periods beginning on or after October 1, 1988, the blended payment amount is equal to 50 percent of the hospital-specific amount and 50 percent of the ASC payment amount.

(3) For cost reporting periods beginning on or after October 1, 1988

and before October 1, 1990, the blended payment amount is equal to the sum of 75 percent of the hospital-specific amount and 25 percent of the ASC payment amount for a hospital that makes an application to its fiscal intermediary and meets the following requirements:

(i) More than 60 percent of the hospital's inpatient hospital discharges, as described in § 412.60 of this chapter, occurring during its cost reporting period beginning on or after October 1, 1986 and before October 1, 1987, are classified in diagnosis-related groups 36 through 74.

(ii) During its cost reporting period begining on or after October 1, 1986 and before October 1, 1987, more than 30 percent of the hospital's total revenues is derived from outpatient services.

* * * * *

(Catalog of Domestic Assistance Programs No. 13.773, Medicare-Hospital Insurance; and No. 13.774, Medicare-Supplementary Medical Insurance)

Dated: April 25, 1990.

Gail R. Wilensky,

Administrator, Health Care Financing Administration.

Approved: June 11, 1990.

Louis W. Sullivan,

Secretary.

[FR Doc. 90-19410 Filed 8-16-90; 8:45 am]

BILLING CODE 4120-01-M

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42 CFR Part 435

[MB-016-FC]

RIN 0938-AC82

Medicaid Program; Eligibility of Qualified Severely Impaired Individuals Who Work

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

ACTION: Final rule with comment period.

SUMMARY: This rule amends the Medicaid regulations to specify, for Medicaid coverage, a permanent eligibility group of qualified individuals who, although severely impaired, work and demonstrate ability to perform substantial gainful activity and who are considered to be Supplemental Security Income (SSI) recipients. It also specifies how SSI payments made to certain institutionalized individuals are to be disregarded as income under Medicaid for a limited period. The amendments conform the regulations to provisions of the Omnibus Budget Reconciliation Act of 1986 and the Employment Opportunities for Disabled Americans Act.

DATES: The effective date of these regulations is November 15, 1990. Comments will be considered if we receive them at the appropriate address, as provided below, no later than 5 p.m. on October 16, 1990.

ADDRESSES: Mail comments to the following address: Health Care Financing Administration, Department of Health and Human Services, Attention: MB-016-FC, P.O. Box 26676, Baltimore, Maryland 21207.

If you prefer, you may deliver your comments to one of the following addresses:

Room 309-G, Hubert H. Humphrey Building, 200 Independence Ave., SW., Washington, DC,

or

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

Due to staffing and resource limitations, we cannot accept facsimile (FAX) copies of comments.

In commenting, please refer to file code MB-016-FC. Comments received timely will be available for public inspection as they are received, beginning approximately three weeks after publication of this document, in Room 309-G of the Department's offices at 200 Independence Ave., SW., Washington, DC, on Monday through Friday of each week from 8:30 a.m. to 5 p.m. (phone: 202-245-7890).

FOR FURTHER INFORMATION CONTACT: Marinos Svolos, (301) 966-6529.

SUPPLEMENTARY INFORMATION:

Background

Under section 1902(a)(10)(A)(i)(II) of the Social Security Act (the Act), recipients of Supplementary Security Income (SSI) under title XVI of the Act are automatically entitled to Medicaid coverage as cash assistance recipients in States with Medicaid programs unless the State chooses to apply more restrictive eligibility requirements under the provisions of section 1902(f) of the Act. Under section 1902(f) of the Act, a State may apply more restrictive eligibility requirements than SSI to aged, blind, or disabled individuals, provided these requirements are no more restrictive than those applied under its approved Medicaid plan as of January 1, 1972. In States that elect to use more restrictive criteria, individuals receiving SSI are not automatically entitled to Medicaid by virtue of their eligibility for SSI benefits. These individuals must apply for and be determined eligible for Medicaid under the State's more restrictive requirements as discussed in detail later in this preamble.

Under section 1619 of the Act, certain blind and severely impaired disabled individuals who work and who otherwise would be ineligible under SSI because of their earnings are given special title XVI benefits and retain SSI status for purposes of Medicaid eligibility. Specifically, under section 1619(a) of the Act, disabled individuals who otherwise would lose SSI because they work and demonstrate the ability to perform substantial gainful activity in spite of severe medical impairments may continue to receive special SSI benefits if they continue to meet the eligibility requirements for SSI benefits. Under section 1619(b), disabled individuals whose income exceeds the amount allowed to retain financial eligibility for regular SSI payments or the special SSI benefit under section 1619(a) (and/or Federally administered State supplementary payments, where applicable) and blind individuals who lose regular SSI payments (and/or Federal administered State supplementary payments) may continue to retain special SSI status for purposes of Medicaid eligibility under certain specified conditions. We refer to these individuals as being "in section 1619(b) status."

For purposes of Medicaid, disabled individuals receiving cash benefits under section 1619(a) of the Act and blind and disabled individuals determined to be in section 1619(b) status are considered to be SSI recipients. Thus, individuals in a State that covers individuals receiving SSI payments (all those except States using the more restrictive criteria of section 1902(f)) and has an agreement under section 1634 of the Act to have the Social Security Administration (SSA) determine Medicaid eligibility are not required to file a separate application with the Medicaid agency—their SSI eligibility automatically confers Medicaid eligibility. Individuals in a State that covers SSI recipients but does not have a section 1634 agreement with SSA must file applications with the Medicaid agency and be found eligible by the agency in order to receive Medicaid benefits. Individuals in States using more restrictive eligibility requirements than those under SSI under the authority of section 1902(f) (i.e., where an individual's SSI recipient status under section 1619 does not automatically confer Medicaid eligibility) must file a separate application for Medicaid with the Medicaid agency and be determined eligible under the State's eligibility criteria, some, if not all, of which are more restrictive than those under SSI.

Legislative Amendments

Congress, in the Omnibus Budget Reconciliation Act of 1986 (OBRA'86), Public Law 99–509, enacted on October 21, 1986, established a mandatory categorically needy Medicaid eligibility group of qualified severely impaired individuals who meet the section 1619 eligibility criteria to ensure continued Medicaid for these individuals. Section 9404 of OBRA'86 amended section 1902(a)(10)(A)(i)(II) of the Act to provide that, in addition to individuals receiving SSI already provided for under that section, States must provide Medicaid eligibility for individuals who are qualified severely impaired individuals as defined in a new section 1905(q) of the Act. The new section 1905(q) defines a qualified severely impaired individual as an individual under age 65—

(1) Who, for the month preceding the first month in which section 1905(q) applies to the individual—

• Received an SSI payment under section 1611(b) on the basis of blindness or disability; a supplementary payment under section 1616 of the Act or under section 212 of Public Law 93–66 on the basis of blindness or disability; a payment of monthly benefits under section 1619(a); or a supplementary payment under section 1616(c)(3); and

• Was eligible for medical assistance under the State approved Medicaid plan; and

(2) With respect to whom the Secretary determines that—

• The individual continues to be blind or continues to have a disabling physical or mental impairment on the basis of which he was found to be under a disability and, except for his earnings, continues to meet all nondisability-related requirements for eligibility for SSI benefits;

• The income of the individual would not, except for his earnings, be equal to or in excess of the amount that would cause him to be ineligible for payments under section 1611(b) (if he were otherwise eligible for such payments);

• The lack of eligibility for Medicaid benefits would seriously inhibit his ability to continue or obtain employment; and

• The individual's earnings are not sufficient to allow him to provide for himself a reasonable equivalent of the benefits under title XVI (including any federally administered State supplementary payments), Medicaid, and publicly funded attendant care services (including personal care assistance) that would be available to him in the absence of such earnings.

The statutory language of OBRA '86 used to describe qualified severely impaired individuals in section 1905(q) of the Act is virtually identical to the language describing individuals under the provisions of section 1619(b) of the Act. (The latter authority was to have expired on June 30, 1987.) The new section 1905(q) also provides that an individual who is eligible for medical assistance under section 1619(b) in June 1987 is also considered a qualified severely impaired individual for as long as the individual meets the requirements of section 1905(q)(2) of the Act. Shortly after OBRA '86 was enacted, Congress passed the Employment Opportunities for Disabled Americans Act (EODAA), Public Law 99–643, on November 10, 1986. Section 2 of EODAA made section 1619 permanent. Thus, individuals who were eligible or who became eligible under section 1619 for SSI benefits and thus were entitled to Medicaid continued to be eligible for these benefits after June 20, 1987. EODAA also made some conforming and technical amendments to sections 1619 (a) and (b) of the Act to reflect the permanent nature of this special benefits program.

In addition, section 7 of EODAA revised section 1619(b) and section 1902(f) of the Act. Under these revisions, States using more restrictive Medicaid eligibility requirements than SSI under the authority of section 1902(f) of the Act must provide mandatory categorically needy Medicaid coverage to certain disabled and blind individuals covered under section 1619 of the Act. These are individuals who either: (1) Qualify for cash benefits under section 1619(a) of the Act, or (2) are determined by SSA to be in section 1619(b)(1) status and were eligible for Medicaid under the State's approved Medicaid plan in the month immediately preceding the first month in which they qualified for benefits under section 1619(a) or went into section 1619(b)(1) status.

Sections 2 and 7 of EODAA and section 9404 of OBRA '86 were effective on July 1, 1987, except in two instances. If the Secretary determined that State legislation (other than legislation appropriating funds) was required in order for the State's Medicaid plan to meet these legislative requirements, the State Medicaid plan was not to be considered as failing to comply with the requirements of title XIX solely on the basis of its failure to meet the legislative requirements until 60 days after the close of the first regular session of the State legislature that began after November 10, 1986 with respect to section 7 of EODAA, and until the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that began after October 21, 1986, with respect to section 9404 of OBRA '86.

Proposed Implementation of Legislative Changes

On May 4, 1988, we published a proposed rule to implement these legislative amendments (53 FR 15857). Below is a discussion of how we proposed to implement them.

In States covering SSI recipients, Medicaid eligibility is granted on the basis of an individual's SSI recipient Status. We considered the group of "qualified severely impaired individuals" created by section 9404 of OBRA '86 to be equivalent to the group of individuals who are in section 1619(b) status and, therefore, are treated for Medicaid purposes in the same way as SSI recipients. Thus, in States covering SSI recipients, we proposed to continue to apply the policy in existence before the legislative revisions that provided automatic Medicaid coverage to individuals in section 1619 status who were considered to be SSI recipients.

In States that use more restrictive eligibility criteria than SSI under section 1902(f) of the Act, an individual's SSI recipient status does not confer Medicaid eligibility. Before the legislative revisions, section 1902(f) States were not required to provide automatic Medicaid eligibility to SSI recipients or individuals considered to be SSI recipients, such as under section 1619 of the Act. Section 7 of the EODAA amended section 1619(b) and section 1902(f) of the Act to provide that, in section 1902(f) States, an individual who qualified for benefits under section 1619(a) of the Act or meets the requirements of section 1619(b)(1) of the Act, as determined by SSA, and who was eligible for Medicaid under the State's more restrictive Medicaid eligibility criteria in the State approved Medicaid plan in the month immediately preceding the first month in which the individual meets the conditions for section 1619 (a) or (b)(1) status and who continues in section 1619 (a) or (b)(1) status must be covered as mandatory categorically needy under Medicaid. In this context, we proposed to interpret the provision in section 1619(b)(3)(B) that the individual was eligible for medical assistance under the State plan approved under title XIX (in the reference month for purposes of Medicaid eligibility) to mean that the State must verify that the individual actually had been determined eligibile for Medicaid as either categorically or medically needy in the (reference) month immediately preceding the first month of section 1619 (a) or (b)(1) status

without having to satisfy any additional conditions. We did not propose to interpret this to mean that the individual must have actually used Medicaid services during the reference month. Generally, an individual is considered eligible during the reference month if a Medicaid card was issued to him for that month.

In order for an individual to remain eligible for Medicaid in section 1902(f) States under the amendments made by section 7 of EODAA, the individual must continue to be eligible under section 1619 (a) or (b)(1) as determined by the Social Security Administration. Thus, if the individual loses section 1619 (a) or (b)(1) status or, if there is a break in this status, he would not be eligible for Medicaid under section 1619(b)(3) of the Act for the months when he was not eligible under section 1619 (a) or (b)(1). An individual who is not protected by section 1619(b)(3) may still become eligible for Medicaid on some other basis, such as under a State's medically needy program. If the individual is considered for eligibility on some other basis, he needs to satisfy the State's more restrictive eligibility requirements imposed under section 1902(f).) If the individual returns to section 1619 (a) or (b)(1) status, continued Medicaid coverage would be determined by the eligibility test for the initial month of section 1619 eligibility.

It is not clear from the statute or the legislative history of EODAA whether, in the phrase "month immediately preceding the first month in which the individual qualified for a benefit under such subsection or met such requirements" in section 1619(b)(3), the term "first month" means the first month in an individual's life in which he qualified for section 1619 (a) benefits or (b)(1) status or the first month of the individual's current continuous section 1619 (a) or (b)(1) eligibility. Therefore, we proposed to allow States maximum flexibility in providing Medicaid coverage to these severely impaired individuals. We proposed to provide States with two options in determining the first month of section 1619 (a) or (b)(1) eligibility (the reference month) in cases where an individual has more than one period of eligibility under section 1619 (a) or (b)(1). This occurs in situations where there are breaks in section 1619 (a) or (b)(1) status, such as when an individual returns to regular SSI status under section 1611, becomes ineligible for section 1619(a) benefits or section 1619(b)(1) status altogether.

The option that the State chooses would have to be applied to all individuals. Under the first option, the first month of section 1619 (a) or (b)(1) status would be the first month of the first period the individual went into this status—that is, there were no periods of section 1619 (a) or (b)(1) status occurring before this period. Under the second option, the first month of section 1619 (a) or (b)(1) status would be the first month the individual went into this status in the most recent period of eligibility under section 1619. We gave examples to illustrate the application of these options.

Under section 1616 of the Act, States may make supplementary payments to individuals in addition to the regular Federal SSI payment. Section 1616(c)(3) of the Act also provides States the option of making supplementary payments to individuals eligibile under section 1619 of the Act. These optional State supplementary payments are administered either by SSA or the State making the payment. Under the changes made by EODAA to section 1619 of the Act, federally administered payments (that is, regular Federal SSI benefits and federally administered State supplementary payments) are considered by SSA in determining eligibility under section 1619(a). SSA also considers State-administered optional State supplementary payments in determining whether an individual is eligible under section 1619(a). Specific regulations governing eligibility requirements as determined by SSA under section 1619 (a) and (b)(1) are located in 20 CFR part 416, subpart B.

In States that have agreements with SSA under section 1634 of the Act to determine Medicaid eligibility of SSI recipients, individuals determined to be in section 1619 (a) or (b)(1) status would be automatically determined eligible for Medicaid without the need to apply to the Medicaid State agency for Medicaid benefits. In States that cover individuals receiving SSI but do not have section 1634 agreements with SSA, individuals in section 1619 (a) or (b)(1) status, as do individuals receiving regular SSI benefits, must file a separate application with the State Medicaid agency in order to obtain Medicaid benefits. In these cases, the Social Security Administration notifies these individuals of their potential eligibility for Medicaid and their need to file an application with the State Medicaid agency in order to receive Medicaid.

In States that apply more restrictive criteria than SSI requirements under section 1902(f), individuals who have been determined by SSA to be eligible under section 1619(a) or in section 1619(b)(1) status also would have to apply to the State Medicaid agency for Medicaid benefits. If SSA determines that an individual is in section 1619 (a) or (b)(1) status, the State agency in 1902(f) States then would determine if these individuals are eligible for Medicaid as mandatory categorically needy under the more restrictive requirements of the State's approved Medicaid plan in accordance with the provisions of section 1619(b)(3) as added by section 7 of EODAA as discussed previously.

States would need to ascertain only an individual's section 1619 (a) or (b)(1) status as determined by SSA through, for example, the use of the SSI State Data Exchange (SDX) System. For section 1902(f) States and those States that do not have section 1634 agreements, we have issued instructions that specify how to determine an individual's status under section 1619 through use of the SDX system and how to determine the first month that an individual went into such status, since the system does not indicate the first month of section 1619 status.

With respect to individuals in section 1619 (a) or (b)(1) status who do not meet the Medicaid eligibility requirements as mandatory categorically needy under the provisions of section 1619(b)(3), section 1902(f) States also have the option of treating these individuals under the State's more restrictive criteria in the same manner in which they treat other SSI recipients. These States may, at their option, disregard some or all of the income that individuals in section 1619(b)(1) status have that is in excess of the SSI income eligibility level. Depending on whether the State applies an income level that is the same as or lower than the SSI categorically needy income level, this could result in these individuals obtaining eligibility for Medicaid without the need for any spenddown or after meeting a reduced spenddown. (If a section 1902(f) State uses a more restrictive definition of disability than SSI's, this optional treatment of income does not result in providing Medicaid for an individual who does not meet the more restrictive definition of disability. For purposes of section 1619(b)(3) of the Act, if an individual does not meet the State's more restrictive disability criteria, he or she will not qualify for protection under that provision, unless he or she met those criteria or was eligible for Medicaid on another basis during the reference month.)

Additional Related Legislative Change

Before EODAA, under section 1611(e)(1)(A) of the Act, when an SSI recipient entered a hospital, extended

care facility, skilled nursing facility, or intermediate care facility in which a substantial portion of the cost of care (that is, over 50 percent) was paid by Medicaid, the individual's monthly Federal SSI benefit was limited to a maximum of $25 (which was later raised to $30), beginning with the first full calendar month the individual was in the institution. Individuals whose countable income exceeded $25/$30 were not eligible for a Federal SSI payment.

Section 3 of EODAA amended section 1611(e)(1) of the Act by adding a new section 1611(e)(1)(E) to provide that individuals eligible under section 1619 (a) or (b) in the month preceding the first full month of institutionalization in a hospital, extended care facility, skilled nursing facility, intermediate care facility, or public medical or psychiatric facility remain eligible for SSI based on the full Federal SSI benefit rate under section 1611(b) of the Act for the first full month of institutionalization and, if they remain institutionalized, for the subsequent month. This additional receipt of SSI payments is intended for the individual's use in meeting expenses outside the institution (e.g., maintaining his place of residence). Section 1611(e)(1)(E)(iii) of the Act, as amended by EODAA, indicates that any individual who "under an agreement of the public institution or the hospital, extended care facility, nursing home, or intermediate care facility is permitted to retain" the increased SSI benefit for one month (or two months, as appropriate) will be considered an eligible individual or spouse for purposes of SSI. We proposed to consider that an institution that has a Medicaid provider agreement with the State will have satisfied the requirement under section 1611(e)(1)(E)(iii) of the Act for the "agreement" and no further agreement is necessary to meet this condition.

Section 3 of EODAA also amended section 1902 of the Act to add a Medicaid State plan requirement to provide that any SSI benefits paid under the new section 1611(e)(1)(E) of the Act to an individual who is eligible for Medicaid and who is in a hospital, skilled nursing facility, or intermediate care facility must be disregarded for purposes of determining the amount of any post-eligibility contribution by the individual to the cost of the care and services provided by the hospital, skilled nursing facility, or intermediate care facility. This provision was effective on July 1, 1987.

Provisions of the Proposed Regulations

In the May 4, 1988, proposed rule we proposed to amend § 435.120 of the Medicaid regulations to incorporate as a permanent eligibility group the new qualified severely impaired group of individuals for mandatory Medicaid coverage as individuals who are considered to be receiving SSI under section 1619 of the Act by removing the June 30, 1987 expiration date. We also proposed to amend § 435.121 (relating to coverage of individuals in States using more restrictive eligibility criteria than SSI) to provide for the mandatory coverage of individuals who are eligible under section 1619 (a) or (b)(1) and who met the State's more restrictive Medicaid eligibility requirements in the month before the month they became eligible under section 1619 (a) or (b)(1). The proposed revised § 435.121 also specified the option of the section 1902(f) State to consider individuals who are recipients under section 1619(a) or who have section 1619(b)(1) status to have income equal to, but not less than, the SSI Federal benefit rate.

We proposed to amend §§ 435.725 and 435.733 to provide for the disregard of the SSI benefit paid under section 1611(e)(1)(E) in determining the amount of any post-eligibility contribution by the individual to the cost of services provided by the hospital, skilled nursing facility, or intermediate care facility.

In addition, we proposed to make a technical change to § 435.120. Section 2 of Public Law 97-123 repealed section 1622 of the Act. Section 1622 of the Act provided entitlement to minimum benefits under SSI for certain individuals who lost eligibility for minimum social security benefits but excluded these individuals from being considered as SSI recipients for purposes of other provisions of the Act, including eligibility for Medicaid. This exclusion from being eligible on the basis of receipt of SSI is reflected in the existing regulations under § 435.120(b). We proposed to delete this paragraph (b) to conform the regulations to repeal of section 1622 of the Act.

Comments and Responses

We received six comments on the proposed revisions. Four of the comments were positive and supportive; the remaining two expressed concern over certain aspects of implementation. We discuss these below.

1. *Comment:* One of the commenters recommends that the SDX system (described earlier) be changed to include dates of section 1619 changes. The commenter would like there to be more information on the SDX or would like the State to be held harmless for section 1619-related quality control errors that are the result of procedural errors.

Response: Acceptance of the commenter's suggestion does not require revision to the proposed rule. We discussed with SSA the possibility of that agency adding the necessary information. SSA suggested the commenter either switch from "option 2" that his State now uses to another option with room for expansion or to determine dates for 1619 cases by looking at the record processing date; a record is sent to his State each time there is a change in 1619 status. We are also considering the hold-harmless suggestion. If changes are made they will be included in program instructions.

2. *Comment:* The other commenter suggested that we collect data concerning the implementation of the option that allows the State to choose its reference month and its impact on individuals over time.

Response: Of the 13 States that have the option of choosing which reference month to use, none currently chose the month before the first month of eligibility, rather than the month before the current period of eligibility. (At the time the proposed rule was published, one State did choose the month before the first month of eligibility.) We have decided to eliminate the option that no State is using (see discussion below in "Final rule") and will therefore do no monitoring.

Final rule

We are adopting the proposed rules as final rules, with the following exceptions:

a. In §§ 435.725(c)(5) and 435.733(c)(5), we are moving the word "paid". This is a technical change only, to clarify that the description of facilities flows from section 1902(o) of the Act rather than section 1611(e)(1)(E).

b. We would also like to point out that section 4211 of the Omnibus Budget Reconciliation Act of 1987 generally replaces the terms "skilled nursing facility" and "intermediate care facility" with "nursing facility" effective October 1, 1990. Therefore, effective October 1, 1990, we expect the provisions of §§ 435.725(c)(5) and 435.733(e)(5) to apply to individuals in nursing facilities.

c. In § 435.121(b)(2) we are defining the reference month for determining Medicaid eligibility for individuals in 1902(f) States under section 1619 of the Act to be the month immediately preceding the first month of the most recent period of eligibility under section 1619(a) or 1619(b)(1). This eliminates the option for States to use the first month of 1619(a) or 1619(b)(1) status in an individual's lifetime as the reference month in cases where an individual has

had more than one period of 1619 status. We are making this change to conform the rule to the actual procedure currently used by all 1902(f) States and to reduce the potential administrative burden of determining eligibility in these cases.

All 1902(f) States are currently interpreting the statutory language at 1619(b)(3)(B), "the month immediately preceding the first month in which the individual qualified for a benefit under such subsection or met such requirements" as meaning the month immediately preceding the first month of the most recent period of eligibility under section 1619.

This interpretation facilitates eligibility determinations by avoiding the need to go back in time to determine if the individual would have qualifed under State Medicaid requirements at some earlier date.

Given the purpose of 1619 benefits in minimizing disincentives associated with potential loss of SSI and Medicaid benefits for disabled individuals who are able to work and earn income, it is sensible to use the month preceding the most recent period of 1619 eligibility as a reference month. Otherwise, the possibility exists that a disabled individual now in transition from SSI and Medicaid eligibility in a 1902(f) State to 1619(a) or 1619(b)(1) could lose Medicaid eligibility because he or she did not meet State Medicaid eligibility criteria in an earlier reference period in his or her lifetime. Since the individual's degree of disability or financial status may change significantly over his or her lifetime, it is desirable to use the most recent possible reference month. We are defining as eligible for Medicaid those individuals who were issued Medicaid cards for the reference month. We request comments on this provision.

Impact Statement

Executive Order 12291 and Regulatory Flexibility Act of 1980 (Pub. L. 96–354).

Executive Order (E.O.) 12291 requires us to prepare and publish a regulatory impact analysis for any regulation that meets one of the E.O. criteria for a major rule; that is, that would be likely to result in: an annual effect on the economy of $100 million or more; a major increase in costs or prices for consumers, individual industries, Federal, State, or local government agencies, or geographic regions; or significant adverse effects on competition, employment, investment, productivity, innovation, or on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic or export markets. In addition, we generally prepare a regulatory flexibility analysis that is consistent with the Regulatory Flexibility Act (RFA) (5 U.S.C. 601 through 612), unless the Secretary certifies that a regulation does not have a significant impact on a substantial number of small entities. For purposes of the RFA, State Medicaid agencies and individuals who will be affected by this rule are not considered as small entities.

Implementation of these provisions is expected to increase Medicaid program expenditures by approximately five million dollars each year. We have, therefore, determined that a regulatory impact analysis is not required because this regulation does not meet the major rule threshold criteria of E.O. 12291. Further, we have determined, and the Secretary certifies, that this rule does not have a significant economic impact on a substantial number of small entities, and, therefore, we have not prepared a regulatory flexibility analysis.

Also, section 1102(b) of the Social Security Act requires the Secretary to prepare a regulatory impact analysis for any rule that may have a significant impact on the operations of a substantial number of small rural hospitals. Such an analysis must conform to the provisions of section 603 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital with fewer than 50 beds located outside a metropolitan statistical area. We have determined, and the Secretary certifies, that this rule does not have a significant impact on the operations of a substantial number of small rural hospitals.

Paperwork Reduction Act of 1980 (Pub. L. 96–511)

These regulations do not impose information collection or reporting requirements that are subject to review by the Office of Management and Budget under the authority of the Paperwork Reduction Act (44 U.S.C. chapter 35).

Response to Comments

Because of the large number of items of correspondence we normally receive on a final rule with comment period, we are not able to acknowledge or respond to them individually. However, if we prepare a final rule following this final rule with comment period, we will consider all comments that we receive by the date and time specified in the "DATES" section of this preamble and we will respond to the comments in the preamble of that rule.

Waiver of Proposed Rulemaking

The Administrative Procedure Act (5 U.S.C. 553) requires us 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 time, place and nature of rulemaking proceedings, reference to the legal authority under which the rule is proposed, and the terms or substance of the proposed rule or a description of the subjects and issues involved. However, this requirement does not apply when the agency finds 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.

We have in this final rule with comment removed the option presented in the proposed rule that allowed a State to choose the month preceding the first month of 1619(a) or (b)(1) status in an individual's lifetime as the reference month of eligibility. We are requesting comments on this provision but do not believe it is necessary or in the public interest to publish a proposed rule to obtain public comment.

It is not necessary to publish a proposed rule because although 1902(f) States have had two options concerning which reference month to use, all of them are using the same option. The one State that did use the option we are removing has abandoned its status as a section 1902(f) State.

The change we are making also benefits the public and the States. The remaining option is administratively simpler to administer, as it is not necessary to determine the eligibility rules at some point in the past; the State need only keep track of current and very recent eligibility rules. In addition, some recipients might lose Medicaid eligibility if they do not meet State Medicaid eligibility in an earlier reference period.

Because it is unnecessary and to the public benefit we find good cause to waive proposed rulemaking.

List of Subjects in 42 CFR Part 435

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

Accordingly, 42 CFR part 435 is amended as follows:

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

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

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

2. Section 435.120 is revised to read as follows:

§ 435.120 Individuals receiving SSI.

Except as allowed under § 435.121, the agency must provide Medicaid to aged, blind, and disabled individuals or couples who are receiving or are deemed to be receiving SSI. This includes individuals who are—

(a) Receiving SSI pending a final determination of blindness or disability;

(b) Receiving SSI under an agreement with the Social Security Administration to dispose of resources that exceed the SSI dollar limits on resources; or

(c) Receiving benefits under section 1619(a) of the Act or in section 1619(b) status (blind individuals or those with disabling impairments whose income equals or exceeds a specific Supplemental Security Income limit). (Regulations at 20 CFR 416.260 through 416.269 contain requirements governing determinations of eligibility under this provision.) For purposes of this paragraph (c), this mandatory categorically needy group of individuals includes those qualified severely impaired individuals defined in section 1905(q) of the Act.

3. Section 435.121 is revised to read as follows:

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

(a) *Option for use of more restrictive eligibility criteria.* The agency may use Medicaid eligibility requirements for the aged, blind, or disabled that are more restrictive than the eligibility requirements for SSI. The agency may be more restrictive in defining blindness or disability, more restrictive in setting financial requirements for income or resources, or both. The requirements may apply to the aged or the blind or the disabled, or to any combination. For example, the agency may use a more restrictive definition of disability for those applying for Medicaid as disabled and a more restrictive income requirement for those who apply as aged, but provide Medicaid to all individuals receiving SSI on the basis of blindness.

(b) *Mandatory coverage of severely impaired individuals who work.* If the agency uses more restrictive eligibility requirements for aged, blind, and disabled individuals than SSI, it must provide Medicaid to individuals who—

(1) Qualify for benefits under section 1619(a) or are in eligibility status under section 1619(b)(1) of the Act as determined by SSA; and

(2) Were eligible for Medicaid under the more restrictive criteria in the State's approved Medicaid plan in the reference month—the month immediately preceding the first month in which they became eligible under section 1619 (a) or (b)(1). "Were eligible for Medicaid" means that individuals were issued Medicaid cards by the State for the reference month. Under this provision, the reference month for determining Medicaid eligibility for all individuals under section 1619 of the Act is the month immediately preceding the first month of the most recent period of eligibility under section 1619.

(c) *Special requirements.* If an agency uses more restrictive requirements under this section—

(1) Each requirement may be no more restrictive than that in effect under the State's Medicaid plan on January 1, 1972, and no more liberal than that applied under SSI or an optional State supplement program that meets the conditions of § 435.230;

(2) In determining financial eligibility of an individual in the category to which the more restrictive requirements apply, the agency must deduct, from the individual's income, his SSI payment, any optional State supplement, and incurred medical expenses as specified in § 435.732; and

(3) For purposes of counting income, with respect to individuals who are receiving benefits under section 1619(a) of the Act or are in section 1619(b)(1) status but who do not meet the requirements of paragraph (b)(2) of this section, the agency may disregard some or all of the amount of the individual's income that is in excess of the SSI Federal benefit rate under section 1611(b) of the Act.

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

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

(2) Section 435.330, medically needy coverage.

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

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

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

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

4. In § 435.725, paragraph (c) introductory text is republished and a new paragraph (c)(5) is added to read as follows:

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

* * * * *

(c) *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 the process.

* * * * *

(5) SSI benefits under section 1611(e)(1)(E) of the Act paid to individuals who receive care in a hospital, skilled nursing facility, or intermediate care facility.

* * * * *

5. In § 435.733, paragraph (c) introductory text is republished and a new paragraph (c)(5) is added to read as follows:

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

* * * * *

(c) *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.

* * * * *

(5) SSI benefits under section 1611(e)(1)(E) of the Act paid to individuals who receive care in a hospital, skilled nursing facility, or intermediate care facility.

* * * * *

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

Dated: July 21, 1990.

Gail R. Wilensky,

Administrator, Health Care Financing Administration.

Approved: August 9, 1990.

Louis W. Sullivan,

Secretary.

[FR Doc. 90-19168 Filed 8-16-90; 8:45 am]

BILLING CODE 4120-01-M

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 73

[MM Docket No. 89-450; RM-6806]

Radio Broadcasting Services; Rogers, AR

AGENCY: Federal Communications Commission.

ACTION: Final rule.

SUMMARY: This document substitutes Channel 232C3 for Channel 232A at Rogers, Arkansas, and modifies the Class A license issued to R & R Broadcasting, Inc. for Station KAMO-FM, as requested, to specify operation on the higher powered channel, thereby providing that community with its first expanded coverage FM service. See 54 FR 43088, October 20, 1989. Coordinates for Channel 232C3 at Rogers are 36-24-00 and 94-04-00. With this action, the proceeding is terminated.

EFFECTIVE DATE: September 27, 1990.

FOR FURTHER INFORMATION CONTACT: Nancy Joyner, Mass Media Bureau, (202) 634-6530.

SUPPLEMENTARY INFORMATION: This is a synopsis of the Commission's Report and Order, MM Docket No. 89-450, adopted July 31, 1990, and released August 14, 1990. The full text of this Commission decision is available for inspection and copying during normal business hours in the FCC Dockets Branch (room 230), 1919 M Street NW., Washington, DC. The complete text of this decision may also be purchased from the Commission's copy contractors, International Transcription Service, (202) 857-3800, 2100 M Street NW., suite 140, Washington, DC 20037.

List of Subjects in 47 CFR Part 73

Radio broadcasting.

PART 73—[AMENDED]

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

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

§ 73.202 [Amended]

2. Section 73.202(b), the Table of FM Allotments for Arkansas, is amended by amending the entry for Rogers, by removing Channel 232A and adding Channel 232C3.

Federal Communications Commission.

Kathleen B. Levitz,

Deputy Chief, Policy and Rules Division, Mass Media Bureau.

[FR Doc. 90-19434 Filed 8-16-90; 8:45 am]

BILLING CODE 6712-01-M

47 CFR Part 73

[MM Docket No. 89-410; RM-6828]

Radio Broadcasting Services; Ferriday, LA

AGENCY: Federal Communications Commission.

ACTION: Final rule.

SUMMARY: This document substitutes Channel 296C3 for Channel 296A at Ferriday, Louisiana, and modifies the license of Station KFNV-FM to specify operation on the higher powered channel, at the request of Tom Gay d/b/a The Radio Group. *See* 54 FR 40419, October 2, 1989. Action taken here provides Ferriday with its first expanded FM service. A site restriction of 12.4 kilometers (7.7 miles) east of the city is required. The coordinates are 31-40-00 and 91-26-00. With this action, this proceeding is terminated.

EFFECTIVE DATE: September 27, 1990.

FOR FURTHER INFORMATION CONTACT: Leslie K. Shapiro, (202) 634-6530.

SUPPLEMENTARY INFORMATION: This is a synopsis of the Commission's Report and Order, MM Docket No. 89-410, adopted July 26, 1990, and released August 14, 1990. The full text of this Commission decision is available for inspection and copying during normal business hours in the FCC Dockets Branch (Room 230), 1919 M Street NW., Washington, DC. The complete text of this decision may also be purchased from the Commission's copy contractors, International Transcription Service, (202) 857-3800, 2100 M Street NW., Suite 140, Washington, DC 20037.

List of Subjects in 47 CFR Part 73

Radio broadcasting.

PART 73—[AMENDED]

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

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

§ 73.202 [Amended]

2. Section 73.202(b), the Table of FM Allotments is amended, under Louisiana, by removing Channel 296A and adding Channel 296C3 at Ferriday.

Federal Communications Commission.

Kathleen B. Levitz,

Deputy Chief, Policy and Rules Division, Mass Media Bureau.

[FR Doc. 90-19438 Filed 8-16-90; 8:45 am]

BILLING CODE 6712-01-M

47 CFR Part 73

[MM Docket No. 89-431; RM-6817]

Radio Broadcasting Services; Alamo, TN

AGENCY: Federal Communications Commission.

ACTION: Final rule.

SUMMARY: This document substitutes Channel 226C3 for Channel 226A at Alamo, Tennessee, and modifies the license of Station WNBE-FM to specify operation on the higher class co-channel, at the request of Charles C. Allen. *See* 54 FR 41466, October 10, 1989. The coordinates for Channel 226C3 at Alamo are 35-43-31 and 89-03-25. With this action, this proceeding is terminated.

EFFECTIVE DATE: September 27, 1990.

FOR FURTHER INFORMATION CONTACT: Leslie K. Shapiro, (202) 634-6530.

SUPPLEMENTARY INFORMATION: This is a synopsis of the Commission's Report and Order, MM Docket No. 89-431, adopted July 26, 1990, and released August 14, 1990. The full text of this Commission decision is available for inspection and copying during normal business hours in the FCC Dockets Branch (Room 230), 1919 M Street NW., Washington, DC. The complete text of this decision may also be purchased from the Commission's copy contractors, International Transcription Service, (202) 857-3800, 2100 M Street NW., Suite 140, Washington, DC 20037.

List of Subjects in 47 CFR Part 73

Radio broadcasting.

PART 73—[AMENDED]

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

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

§ 73.202 [Amended]

2. Section 73.202(b), the Table of FM Allotments, is amended under Tennessee by removing Channel 226A and adding Channel 226C3 at Alamo.

Federal Communications Commission.

Kathleen B. Levitz,

Deputy Chief, Policy and Rules Division, Mass Media Bureau.

[FR Doc. 90-19437 Filed 8-16-90; 8:45 am]

BILLING CODE 6712-01-M