(37) Income received by American Indian beneficiaries from Trust or Restricted lands (Pub. L. 103–66)	Excluded	Excluded	Excluded	Excluded	3.262(v)

3. In § 3.262, paragraph (v) and its authority citation are added to read as follows:

§ 3.262 Evaluation of income.

* * * * *

(v) *Income received by American Indian beneficiaries from trust or restricted lands.* There shall be excluded from income computation payments of up to $2,000 per calendar year to an individual Indian from trust lands or restricted lands as defined in 25 CFR 151.2. (January 1, 1994) (Authority: Sec. 13736, Pub. L. 103–66; 107 Stat. 663)

4. In § 3.272, paragraph (r) and its authority citation are added to read as follows:

§ 3.272 Exclusions from income.

* * * * *

(r) *Income received by American Indian beneficiaries from trust or restricted lands.* Income of up to $2,000 per calendar year to an individual Indian from trust lands or restricted lands as defined in 25 CFR 151.2. (January 1, 1994) (Authority: Sec. 13736, Pub. L. 103–66; 107 Stat. 633)

[FR Doc. 94–18004 Filed 7–22–94; 8:45 am]
BILLING CODE 8320–01–M

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 52

[WV 5–1–6307; FRL–4888–7]

Approval and Promulgation of Air Quality Implementation Plans; West Virginia: Limited Approval and Disapproval of PM–10 Implementation Plan for the Follansbee Area

AGENCY: Environmental Protection Agency (EPA).

ACTION: Final rule.

SUMMARY: EPA is taking simultaneous limited approval and limited disapproval action on a State Implementation Plan (SIP) revision submitted by the State of West Virginia. West Virginia submitted the plan revisions in order to achieve the national ambient air quality standards (NAAQS) for particulate matter with an aerodynamic diameter less than or equal to a nominal 10 micrometers (PM–10) and to fulfill other Clean Air Act (Act) requirements for the Follansbee, West Virginia area. The limited approval makes bilateral consent orders between the West Virginia Office of Air Quality and six companies federally enforceable and fulfills some of the requirements of the Act applicable to the Follansbee area. The limited disapproval disapproves West Virginia's submittal for the purpose of fulfilling its requirements under sections 172 and 189 of the Act to demonstrate that the SIP will provide for the attainment of the NAAQS. These actions are being taken under section 110 of the Act in light of EPA's authority pursuant to section 301(a) to adopt regulations necessary to further air quality improvement by strengthening the SIP.

EFFECTIVE DATE: This rule will become effective on August 24, 1994.

ADDRESSES: Copies of the documents relevant to this action are available for public inspection during normal business hours at the Air, Radiation, and Toxics Division, U.S. Environmental Protection Agency, Region III, 841 Chestnut Building, Philadelphia, Pennsylvania 19107; Air and Radiation Docket and Information Center, U.S. Environmental Protection Agency, 401 M Street SW, Washington, DC 20460; and West Virginia Department of Environmental Protection, Office of Air Quality, 1558 Washington Street, East, Charleston, West Virginia, 25311.

FOR FURTHER INFORMATION CONTACT: Thomas A. Casey, (215) 597–2746.

SUPPLEMENTARY INFORMATION: The air quality planning requirements for PM–10 nonattainment areas, such as the Follansbee area, are set out in subparts 1 and 4 of Title I of the Act. Among other requirements, the Act requires that SIPs provide for reasonably available control measures (RACM) including reasonably available control technology (RACT), emissions inventories, and demonstrations (including air quality modeling) that the SIP will provide for attainment of the NAAQS by the statutory attainment date.

On January 7, 1994 (59 FR 988), EPA published a Notice of Proposed Rulemaking (NPR) that proposed limited approval and limited disapproval West Virginia's November 15, 1991 PM–10 SIP submittal for the Follansbee, West Virginia PM–10 nonattainment area. The submittal is not fully approvable because it does not demonstrate attainment of NAAQS, and, therefore, does not satisfy the requirements of section 189(a)(1)(B) of the Clean Air Act. Specifically, the modeling is unapprovable as a demonstration of attainment because of deficiencies in estimating emissions from coke oven batteries and other sources, the lack of an approvable analysis of intermediate terrain, and the nonguideline use of the Gaussian Plume Multiple Source Air Quality Algorithm (RAM) dispersion model in a meteorologically rural area.

While the submittal does not meet specific provisions of Part D, it does contain some provisions (enforceable consent orders) which advance the NAAQS-related air quality protection goals of the Act. Therefore, EPA is approving the submittal for the limited purpose of approving the consent agreements and making them part of the SIP. EPA has evaluated the consent agreements for consistency with the Act and EPA regulations and has found that they provide State and federally enforceable provisions to decrease PM–10 emissions in the nonattainment area.

While approving the consent orders for incorporation by reference into the SIP, EPA is taking no action at this time on the contingency measures contained therein with respect to the requirements of section 172(c)(9) of the Act. The General Preamble to Title I of the Clean Air Act Amendments established a November 15, 1993 deadline for state submittal of contingency plans (57 FR 13498).

In addition to the limited approval and limited disapproval, EPA proposed to determine that PM–10 precursors, such as sulfur dioxide, nitrogen oxides, and volatile organic compounds, do not contribute significantly to PM–10 concentrations in the Follansbee area. (See section 189(e).) EPA based this proposal an air quality data presented by West Virginia in its submittal.

The rationale for today's action is presented in more detail in the NPR and in the Technical Support Document

(TSD) which is available at the addresses indicated above.

Summary of Public Comments

EPA received two letters of comment; comments were submitted by the West Virginia Department of Environmental Protection and by the Wheeling-Pittsburgh Steel Corporation (WPS).

1. In correspondence dated February 4, 1994, West Virginia described its "planned action" to correct the deficiencies in its submittal. West Virginia stated its intent to correct PM–10 emission rates, perform an analysis of intermediate terrain, and replace RAM with an approvable technique for modeling certain area sources under rural meteorological conditions. Additionally, West Virginia also related its intent to alter the characterizations of certain buoyant volume sources.

EPA Response West Virginia did not comment on EPA's proposed action or its underlying rationale, so no response is necessary. EPA intends to provide technical guidance to West Virginia to assist in the submittal of a fully approvable SIP revision.

2. EPA received comments from WPS dated February 4, 1994. WPS commented on and disputed deficiencies identified by EPA in the NPR. WPS also provided its own air quality analysis. WPS's comments are summarized and responses are provided below.

a. Coke Oven Emissions

WPS Comment. WPS agrees that the coke oven emissions estimations are in error and provided revised estimates attributed to the West Virginia Office of Air Quality.

EPA Response. As described above, EPA intends to provide technical guidance to West Virginia to assist in the submittal of a fully approvable SIP revision.

b. Intermediate Terrain [1]

WPS Comment. WPS comments that at the time of the West Virginia SIP submittal, there was no single, EPA-approved model applicable to intermediate terrain; that its consultant had developed a post-processor to combine the results of simple and complex terrain models; and that EPA had approved the use of this post-processor in two permit applications in West Virginia in 1988. WPS continues to comment that its submittals to West Virginia and Ohio were consistent with EPA's intermediate terrain policy, including, in 1991, an analysis employing a model that integrates simple and complex terrain models. Finally, WPS comments that the deficiency relating to intermediate terrain is not identified in EPA's August 3, 1993 notice of proposed rulemaking for the Ohio PM–10 SIP (58 FR 41218).

EPA Response. West Virginia's attainment demonstration did not address intermediate terrain as required by the Guideline on Air Quality Models as revised in 1986 (EPA–450/2–78–027R) [2] and clarified in 1989.[3] WPS's comments do not dispute this fact. The consultant's post-processor and integrated model were two of several approaches available at the time to implement EPA's intermediate terrain policy. (See, for example, EPA's widely available post-processor, POSTIT). The development of these techniques by WPS or its consultant does not alter the fact that no such analysis was included in the West Virginia SIP submittal. Therefore, this comment does not affect today's action or its underlying rationale.

As matter of clarification, EPA's August 3, 1993 notice for Ohio affected the regulation of PM–10 emissions statewide.[4] Today's action applies only to the West Virginia SIP. Because of the broader scope of that notice, some issues that were presented in the NPR for the Follansbee, West Virginia nonattainment area were relegated to the technical support document [5] in EPA's rulemaking on the Ohio SIP. The NPR for the Ohio SIP clearly referred interested readers to the TSD for further information regarding EPA's underlying rationale for that notice, generally, and the deficiencies in Ohio's attainment demonstration, specifically. That TSD clearly articulated EPA's concern over Ohio's lack of an intermediate terrain analysis and other deficiencies in Ohio's November 4, 1991 and January 8, 1992 SIP submittals.

c. The Use of RAM

WPS Comment. WPS commented that the use of RAM was discussed with the Ohio Environmental Protection Agency (OEPA) before the West Virginia SIP was submitted. WPS also comments that this deficiency was not articulated in EPA's NPR for the Ohio PM–10 SIP referenced above (58 FR 41218).

EPA Response. Conversations between WPS and OEPA do not exempt or ameliorate the deficiencies in West Virginia submittal or invalidate today's action or its underlying rationale. As noted above, EPA's notice regarding the Ohio SIP addressed this deficiency through its technical support document.

d. WPS's Air Quality Analysis

WPS Comment. WPS supplied an alternative air quality analysis that concluded, "Controls resulting in the PM–10 emissions in Attachment 2 are shown to meet the NAAQS for PM–10 when naturally occurring buoyancy of several process fugitives is included in the dispersion modeling." Attachment 2 lists the PM–10 emissions rates for model input.

EPA Response. Setting aside the problem that this analysis was not submitted by the State of West Virginia and, therefore, does not satisfy the requirement of section 189(a)(2), this analysis is not approvable as an attainment demonstration for at least two reasons.

First, the emissions estimations used as model input are flawed. While an attempt was made to correct the unapprovable aspects of emissions from coke ovens, estimates of emissions from WPS's basic oxygen furnaces (BOF) in Mingo Junction, Ohio remain profoundly underestimated. Deficiencies in BOF emissions estimation were outlined in the TSD and described in more detail in EPA's notice and TSD regarding the Ohio SIP

Second, the buoyancy of emissions from certain large volume sources (coke oven battery fugitives, the BOF, and blast furnace cast houses) was only incorporated in the estimation of impacts at receptors (locations) where a more conventional methodology failed to show attainment. This approach is unapprovable because incorporation of buoyancy effects, by design, will disturb the spatial distribution of estimated PM–10 impacts. Therefore, it is necessary to model using a more extensive array of receptors than was employed in the WPS analysis.

For these reasons, WPS's air quality analysis does not effect today's action or its underlying rationale.

Final Action

EPA is approving West Virginia's submittal for the limited purpose of incorporating the enforceable provisions into the SIP and disapproving the submittal for the purpose of fulfilling the attainment demonstration requirements of Part D of Title I of the

[1] "Intermediate terrain" is a term used to describe terrain with an elevation between stack height and plume height. It is a subset of complex terrain and is defined separately for each stack.

[2] This document has subsequently been revised (Supplement B) and incorporated into federal regulations at 40 CFR part 51 appendix W.

[3] June 8, 1989 memorandum from Joseph Tikvart to Alan Cimorelli.

[4] West Virginia and Ohio collaborated on parts of the attainment demonstration, but each submittal stands alone.

[5] Memorandum from John Summerhays and Randall Robinson to "Files" dated November 17, 1992.

Act. EPA is also formally finding that PM–10 precursors do not contribute significantly to PM–10 concentrations exceeding the NAAQS in the Follansbee area (see section 189(e)).[6]

This limited disapproval constitutes a disapproval under section 179(a)(2) of the Act (see generally 57 FR 13566–67). As provided under section 179(a) of the Act, the State of West Virginia has up to 18 months after a final SIP disapproval to correct the deficiencies that are the subject of the disapproval before EPA is required to impose either the highway funding sanction or the requirement to provide two-to-one new source review offsets. If the State has not corrected its deficiency within 6 months thereafter, EPA must impose the second sanction. Any sanction EPA imposes must remain in place until EPA determines that the State has come into compliance. Note also that any final disapproval would trigger the requirement for EPA to impose a federal implementation plan within 24 months as provided under section 110(c)(1) of the Act.

Nothing in this action should be construed as permitting or allowing or establishing a precedent for any future request for revision to any state implementation plan. Each request for revision to the state implementation plan shall be considered separately in light of specific technical, economic, and environmental factors and in relation to relevant statutory and regulatory requirements.

This action has been classified as a Table 2 action for signature by the Acting Regional Administrator under the procedures published in the Federal Register on January 19, 1989 (54 FR 2214–2225), as revised by an October 4, 1993 memorandum from Michael H. Shapiro, Acting Assistant Administrator for Air and Radiation. A future notice will inform the general public of these tables. On January 6, 1989, the Office of Management and Budget (OMB) waived Table 2 and Table 3 SIP revisions (54 FR 2222) from the requirements of Section 3 of Executive Order 12291 for a period of two years. The U.S. EPA has submitted a request for a permanent waiver for Table 2 and 3 SIP revisions. The OMB has agreed to continue the temporary waiver until such time as it rules on U.S. EPA's request. This request continues in effect under Executive Order 12866, which superseded Executive Order 12291 on September 30, 1993.

Under section 307(b)(1) of the Clean Air Act, petitions for judicial review of this action must be filed in the United States Court of Appeals for the appropriate circuit by September 23, 1994. Filing a petition for reconsideration by the Administrator of the Follansbee, West Virginia PM–10 final rule does not affect the finality of this rule for the purposes of judicial review nor does it extend the time within which a petition for judicial review may be filed, and shall not postpone the effectiveness of such rule or action. This action may not be challenged later in proceedings to enforce its requirements. (See section 307(b)(2).)

[6] Note that while EPA is making a general finding for this area, today's finding is based on the current character of the area including, for example, the existing mix of sources in the area. It is possible, therefore, that future growth could change the significance of precursors in the area. EPA intends to issue future guidance addressing such potential differences in the significance of precursor emissions in PM–10 nonattainment areas.

List of Subjects in 40 CFR Part 52

Environmental protection, Air pollution control, Hydrocarbons, Incorporation by reference, Intergovernmental relations, Nitrogen dioxide, Particulate matter, Reporting and recordkeeping requirements, Sulfur oxides.

Editorial Note: This document was received by the Office of the Federal Register on July 19, 1994.

Dated: March 30, 1994.

Stanley L. Laskowski,

Acting Regional Administrator, EPA Region III.

40 CFR part 52, subpart XX of chapter I, title 40 is amended as follows:

PART 52—[AMENDED]

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

Authority: 42 U.S.C. 7401–7642.

Subpart XX—West Virginia

2. Section 52.2520 is amended by adding paragraph (c)(26) to read as follows:

§ 52.2520 Identification of plan.

* * * * *

(c) * * *

(26) Bilateral consent orders between the West Virginia Air Pollution Control Commission and six companies to limit emissions of particulate matter. The effective date of the consent order with Koppers is November 15, 1991; the effective date of the five other orders cited in paragraph (i)(B), below, is November 14, 1991.

(i) Incorporation by reference.

(A) Letter dated November 12, 1991 from the West Virginia Department of Commerce, Labor, and Environmental Resources transmitting six consent orders.

(B) Consent orders with the following companies (West Virginia order number and effective date in parentheses): Follansbee Steel Corporation (CO-SIP–91–31, November 14, 1991); International Mill Service, Incorporated (CO-SIP–91–33, November 14, 1991); Koppers Industries, Incorporated (CO-SIP–91–32, November 15, 1991); Standard Lafarge (CO-SIP–91–29, November 14, 1991); Starvaggi Industries, Incorporated (CO-SIP–91–34, November 14, 1991); and Wheeling-Pittsburgh Steel Corporation (CO-SIP–91–29, November 14, 1991).

3. Section 52.2522 of chapter I, title 40 is amended by adding paragraph (f) to read as follows as follows:

§ 52.2522 Approval Status.

* * * * *

(f) The Administrator approves West Virginia's November 15, 1991 SIP submittal for fulfilling all PM–10-specific requirements of part D of the Clean Air Act applicable to the Follansbee, West Virginia PM–10 nonattainment area, except for the section 189(a)(1)(B) requirement for a demonstration that the plan is sufficient to attain the PM–10 NAAQS, which the Administrator is disapproving, and the section 172(c)(9) requirement for contingency measures, which the Administrator has yet to act upon.

[FR Doc. 94–17935 Filed 7–22–94; 8:45 am]

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40 CFR Part 52

[CO33–1–6406; and CO5–1–6686; FRL–5003–7]

Clean Air Act Approval and Promulgation of PM_{10} Implementation Plan and Oxygenated Gasoline Program for Colorado

AGENCY: Environmental Protection Agency (EPA).

ACTION: Final rule.

SUMMARY: In this action, EPA is finalizing two separate proposed actions: EPA is finalizing the limited approval of the control measures which were contained in the State Implementation Plan (SIP) revisions submitted by the State of Colorado to achieve attainment of the national ambient air quality standards (NAAQS) for particulate matter with an aerodynamic diameter less than or equal to a nominal 10 micrometers (PM_{10}). EPA is approving these control measures for the limited purpose of strengthening the federally approved

SIP for Colorado. (At this time, EPA is not approving the control measures limiting the emissions from Purina Mills and Electron Corporation. EPA will act on these measures at a later date.) The SIP revisions were submitted by Colorado to satisfy certain federal requirements for an approvable moderate nonattainment area PM_{10} SIP for Denver. Approval of these measures makes them federally enforceable. The EPA will take separate action, as appropriate, on the revisions as a whole at a later date. EPA is also approving revisions to Regulation No. 13 (oxygenated gasoline program) submitted on August 6, 1990, and November 27, 1992, implementing and amending oxygenated gasoline programs in the Fort Collins-Loveland, Colorado Springs, and Boulder-Denver Metropolitan Statistical Areas (MSA) as required by Section 211(m) of the Clean Air Act, as amended by the Clean Air Act Amendments of 1990 (the Act). This action is being taken under Section 110 of the Clean Air Act.

EFFECTIVE DATE: This rule will become effective on August 24, 1994.

ADDRESSES: Copies of the State's submittal and other information are available for inspection during normal business hours at the following locations: Environmental Protection Agency, Region VIII, Air Programs Branch, 999 18th Street, Suite 500, Denver, Colorado 80202–2405; Colorado Air Pollution Control Division, 4300 Cherry Creek Dr. South, Denver, Colorado 80222–1530, and Air and Radiation Docket and Information Center, Environmental Protection Agency, 401 M Street SW., Washington, DC, 20460.

FOR FURTHER INFORMATION CONTACT: Final limited approval—Callie Videtich, Air Programs Branch, U.S. Environmental Protection Agency, Region VIII, Denver, Colorado 80202–2466, (303) 293–1754. Regulation No. 13 final approval—Scott P. Lee, Air Programs Branch, U.S. Environmental Protection Agency, Region VIII, Denver, Colorado 80202–2466, (303) 293–1887.

Denver PM10

SUPPLEMENTARY INFORMATION:

I. Background

The Denver, Colorado area was designated nonattainment for PM_{10} and classified as moderate under sections 107(d)(4)(B) and 188(a) of the Clean Air Act, upon enactment of the Clean Air Act Amendments of 1990.[1] See 56 FR 56694 (Nov. 6, 1991); 40 CFR 81.306 (specifying PM_{10} nonattainment designation for the Denver metropolitan area). The air quality planning requirements for moderate PM_{10} nonattainment areas are set out in subparts 1 and 4 of part D, title I of the Act[2].

The EPA has issued a "General Preamble" describing EPA's preliminary views on how EPA intends to review SIPs and SIP revisions submitted under title I of the Act, including those State submittals containing moderate PM_{10} nonattainment area SIP requirements (see generally 57 FR 13498 (April 16, 1992) and 57 FR 18070 (April 28, 1992)). Because EPA is describing it's interpretations here only in broad terms, the reader should refer to the General Preamble for a more detailed discussion of the interpretations of title I advanced in this final action and the supporting rationale.

Those States containing initial moderate PM_{10} nonattainment areas (*i.e.*, those areas designated nonattainment for PM10 under section 107(d)(4)(B) of the Act) were required to submit, among other things, the following provisions by November 15, 1991:

(1) Provisions to assure that reasonably available control measures (RACM), (including such reductions in emissions from existing sources in the area as may be obtained through the adoption, at a minimum, of reasonably available control technology (RACT)) shall be implemented no later than December 10, 1993;

(2) Either a demonstration (including air quality modeling) that the plan will provide for attainment as expeditiously as practicable but no later than December 31, 1994, or a demonstration that attainment by that date is impracticable;

(3) Quantitative milestones which are to be achieved every 3 years and which demonstrate reasonable further progress (RFP) toward attainment by December 31, 1994; and

(4) Provisions to assure that the control requirements applicable to major stationary sources of PM_{10} also apply to major stationary sources of PM_{10} precursors except where the Administrator determines that such sources do not contribute significantly to PM_{10} levels which exceed the NAAQS in the area. See sections 172(c), 188, and 189 of the Act. Some provisions are due at a later date. States with initial moderate PM_{10} nonattainment areas were required to submit a permit program for the construction and operation of new and modified major stationary sources of PM_{10} by June 30, 1992 (see section 189(a)). Such States also must submit contingency measures by November 15, 1993 that become effective without further action by the State or EPA, upon a determination by EPA that the area has failed to achieve RFP or to attain the PM_{10} NAAQS by the applicable statutory deadline. See section 172(c)(9) and 57 FR 13543–13544.

On December 20, 1993 (at 58 FR 66326), EPA announced its intention to take two separate actions with two independent public comment periods on the SIP revisions submitted by the State of Colorado to satisfy the moderate PM_{10} nonattainment area SIP requirements due November 15, 1991 for the Denver PM_{10} nonattainment area. One proposed action was to grant conditional approval of the SIP revisions due to the State's need to fulfill a final commitment to revise permit limitations at two stationary sources (Purina Mills, and Electron Corporation) prior to December 1, 1993. EPA will take action on the conditional approval at a later date. The second proposed action was to limitedly approve the control measures, excluding the permit limits for Purina Mills and Electron Corporation, contained in the SIP revisions for the limited purpose of strengthening the federally enforceable SIP for Colorado. In the proposed rulemaking actions and related Technical Support Document (TSD), EPA described in detail its interpretations of the Act and its rationale for proposing to approve the control measures for their limited purpose in strengthening the federally approved implementation plan for Denver, taking into consideration the specific factual issues presented.

EPA requested public comments on all aspects of the proposal related to the limited approval (please reference 58 FR 66326). EPA received no comments during the public comment period regarding the proposed limited approval. This final action on the limited approval of the control measures in the Denver moderate nonattainment area PM_{10} SIP revisions is unchanged

[1] The 1990 Amendments to the Clean Air Act made significant changes to the air quality planning requirements for areas that do not meet (or that significantly contribute to ambient air quality in a nearby area that does not meet) the PM_{10} National Ambient Air Quality Standards (see Public Law No. 101–549, 104 Stat. 2399). References herein are to the Clean Air Act, as amended (the Act), 42 U.S.C. 7401, *et seq.*

[2] Subpart 1 contains provisions applicable to nonattainment areas generally, and subpart 4 contains provisions specifically applicable to PM_{10} nonattainment areas. At times, subpart 1 and subpart 4 overlap or conflict. EPA has attempted to clarify the relationship among these provisions in the "General Preamble" and, as appropriate, in today's notice and supporting information.

from the December 20, 1993, proposed approval action.

The discussion herein provides only a broad overview of the proposed action EPA is now finalizing. The public is referred to the December 20, 1993, proposed rule for a more in-depth discussion of the action now being finalized.

II. Response to Comments

EPA did not receive any public comments regarding its December 20, 1993, proposed limited approval of the Denver moderate nonattainment area PM_{10} SIP control measures. (58 FR 66326–66334).

III. This Action

Section 110(k) of the Act sets out provisions governing EPA's review of SIP submittals (see 57 FR 13565–13566). The Governor of Colorado submitted the Denver PM_{10} SIP revision in a letter dated June 7, 1993. That submittal and subsequent submittals made on September 3, 1993, and October 20, 1993, fulfilled commitments made on June 7, 1993, were intended to satisfy those moderate PM_{10} SIP requirements due for Denver on November 15, 1991. As described in EPA's proposed action on this SIP (58 FR 66326–66334, December 20, 1993), the Denver June 7, 1993, moderate nonattainment area PM_{10} plan and subsequent submittals include control measures. EPA may grant a "limited" approval of SIP requirements under section 110(k)(3) of the Act in light of the general authority delegated to EPA under section 301(a) of the Act which allows EPA to take actions necessary to carry out the purposes of the Act. EPA is granting a final limited approval of the referenced PM_{10} control measures for Denver because they strengthen the SIP by advancing the PM_{10} air quality protection goal of the Act. Federal approval of the control measures makes them federally-enforceable. However, this limited approval is not approving those measures as satisfying the RACM requirement or any other specific requirement of the Act, nor does it constitute full approval of the SIP pursuant to section 110(k)(3). Please refer to EPA's notice of proposed rulemaking (58 FR 66326) and the TSD for that action for a more detailed discussion on control measures contained in the Denver plan.

In this notice of final rulemaking action, EPA is announcing its approval of the control measures, excluding the permit limits for Purina Mills and Electron Corporation, contained in the June 7, 1993 Denver PM_{10} SIP and subsequent submittals noted above for their limited purpose in strengthening the SIP.

Four sources/source categories were identified as contributing to the PM_{10} nonattainment problem in Denver and, therefore, were targeted for control in the SIP revisions. Control measures were developed for the following area sources: residential wood combustion, street sanding and sweeping of paved streets, and mobile sources. In addition, controls reducing emissions from stationary sources were also developed.

EPA views the following measures as reasonable, enforceable, and responsible for PM_{10} emissions reductions in the Denver PM_{10} nonattainment area: (1) Colorado Regulation No. 4 which regulates residential wood burning; (2) Colorado Regulation No. 16 which sets sanding and sweeping requirements; (3) the federal tailpipe standards, which provide an ongoing benefit due to fleet turnover and Colorado Regulations 12 and 13 which were developed independently from the PM_{10} SIP but are included because of their particulate emission reduction benefit; and (4) Colorado Regulation No. 1, which provides stationary source emission control regulations for particulates, smokes, carbon monoxide and sulfur oxides.

A more detailed discussion of the individual source contributions and their associated control measures (including available control technology) can be found in the TSD accompanying EPA's proposed approval of the Denver moderate PM_{10} nonattainment area SIP (58 FR 66326). EPA has reviewed the State's documentation and concluded that the control measures on which EPA is taking final action on today serve to strengthen the existing SIP by advancing the PM_{10} air quality protection goal of the Act.

As noted, EPA is finalizing the control measures contained in Colorado's June 7, 1993 SIP submittal and subsequent SIP submittals for the Denver PM_{10} nonattainment area, excluding the permit limits for Purina Mills and Electron Corporation which will be acted on at a later date. This action is explained in the notice of proposed rulemaking (58 FR 66326–66334) and associated TSD.

IV. Final Action—Limited Approval

This document announces EPA's final action on the limited approval rulemaking proposed at 58 FR 66326. As noted elsewhere in this action, EPA received no adverse public comments on the proposed action to approve the control measures for their limited purpose in strengthening the existing SIP. As a direct result, the Regional Administrator has reclassified this action from Table 1 to Table 3 under the processing procedures established at 54 FR 2214, January 19, 1989.

Nothing in this action should be construed as permitting or allowing or establishing a precedent for any future request for revision to any SIP. Each request for a revision to the SIP shall be considered separately in light of specific technical, economic, and environmental factors, and in relation to relevant statutory and regulatory requirements.

Regulation No. 13

SUPPLEMENTARY INFORMATION: On January 11, 1994 (59 FR 1513–1515), EPA published a notice of proposed rulemaking for the State of Colorado. The notice proposed approval of an oxygenated gasoline program.

The formal SIP revisions were submitted by the State of Colorado on August 6, 1990 and November 27, 1992. (The November 27, 1992 revision supersedes the August 6, 1990 submission. EPA mentions the August 6, 1990 submittal as historical information. EPA is taking action on only the November 27, 1992 revision.) The revisions included amended versions of Colorado's Regulation 13. These regulatory changes were adopted by the Colorado Air Quality Control Commission. A more detailed analysis of the state submittal was prepared as part of the proposed action and is contained in a TSD dated September 25, 1993, which is available from the Region VIII office listed in the Addresses section of this document. Other specific requirements of the oxygenated gasoline program and the rationale for EPA's proposed action are explained in the proposed rulemaking and will not be restated here. No public comments were received on the proposal.

I. Final Action—Regulation No. 13

EPA is approving Colorado's Regulation No. 13: Oxygenated Gasoline Program as adopted September 17, 1992 by the Colorado Air Quality Control Commission as part of the Air Quality Implementation Plan for State of Colorado. This Regulation was submitted on November 27, 1992.

Nothing in this action should be construed as permitting or allowing or establishing a precedent for any future request for revision to any SIP. Each request for revision to the SIP shall be considered separately in light of specific technical, economic, and environmental factors and in relation to relevant statutory and regulatory requirements.

Under section 307(b)(1) of the Clean Air Act, petitions for judicial review of

this action must be filed in the United States Court of Appeals for the appropriate circuit by September 23, 1994. Filing a petition for reconsideration by the Administrator of this final rule does not affect the finality of this rule for the purposes of judicial review nor does it extend the time within which a petition for judicial review may be filed, and shall not postpone the effectiveness of such rule or action. This action may not be challenged later in proceedings to enforce its requirements. (See section 307(b)(2)).

Executive Order (EO) 12866

This action has been classified as a Table 3 action by the Regional Administrator under the procedures published in the **Federal Register** on January 19, 1989 (54 FR 2214–2225), as revised by an October 4, 1993, memorandum from Michael H. Shapiro, Acting Assistant Administrator for Air and Radiation. A future notice will inform the general public of these tables. On January 6, 1989, the Office of Management and Budget (OMB) waived Table 2 and Table 3 SIP revisions (54 FR 2222) from the requirements of Section 3 of Executive Order 12291 for 2 years. The EPA has submitted a request for a permanent waiver for Table 2 and Table 3 SIP revisions. The OMB has agreed to continue the temporary waiver until such time as it rules on EPA's request. This request continues in effect under Executive Order 12866 which superseded Executive Order 12291 on September 30, 1993. OMB has exempted this regulatory action from E.O. 12866 review.

List of Subjects in 40 CFR Part 52

Environmental protection, Air pollution control, Carbon monoxide, Hydrocarbons, Incorporation by reference, Intergovernmental relations, Nitrogen dioxide, Ozone, Particulate matter, Reporting and recordkeeping requirements, Sulfur oxides, and Volatile organic compounds.

Dated: June 1, 1994.

Nela Y. Cooke,

Acting Regional Administrator.

40 CFR, part 52, Subpart G, is amended as follows:

Subpart G—Colorado

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

Authority: 42 U.S.C. 7401–7642.

2. Section 52.320 is amended by adding paragraphs (c)(61) and (c)(67) to read as follows:

§ 52.320 Identification of plan.

* * * * *

(c) * * *

(61) The Governor of Colorado submitted a portion of the requirements for the moderate nonattainment area PM_{10} State Implementation Plan (SIP) for Denver, Colorado with a letter dated June 7, 1993, and subsequent submittals dated September 3, 1993, and October 20, 1993, fulfilling most of the commitments made in the June 7, 1993, letter. The submittals were made to satisfy those moderate PM_{10} nonattainment area SIP requirements due for the Denver PM_{10} nonattainment area on November 15, 1991. EPA is approving, for the limited purpose of strengthening the SIP, the control measures contained in the SIP revisions identified above. (EPA is not approving, at this time, the control measures limiting the emissions from Purina Mills and Electron Corporation.)

(i) Incorporation by reference.

(A) Revisions to Regulation No. 4, "Regulation on the Sale of New Woodstoves and the Use of Certain Woodburning Appliances During High Pollution Days," as adopted by the Air Quality Control Commission on June 24, 1993, effective August 30, 1993, as follows: insert new Section VIII and recodification of References Section. This revision pertains to local jurisdiction implementation and enforcement of ordinances and resolutions restricting wood burning on high pollution days.

(B) Regulation No. 16, "Concerning Material Specifications for, Use of, and Clean-up of Street Sanding Material," as adopted by the Air Quality Control Commission on June 24, 1993, effective August 30, 1993, as follows: recodification of Regulation and addition of Sections II and III, which regulate emissions from street sanding and sweeping in the Denver PM_{10} nonattainment area.

(C) Revisions to Regulation No. 1, "Emission Control Regulations for Particulates, Smokes, Carbon Monoxide, and Sulfur Oxides for the State of Colorado," as adopted by the Air Quality Control Commission on August 19, 1993, effective October 30, 1993, as follows: insert new Sections VII and VIII and recodification of the two following Sections, "Emission Regulations Concerning Areas Which are Nonattainment for Carbon Monoxide—Refinery Fluid Bed Catalytic Cracking Units", and "Statements of Basis and Purpose" Sections. The revisions pertain to restrictions on the use of oil as a back-up fuel for certain sources and set new emission limits at the following Public Service Company Power Plants: Cherokee, Arapahoe, and Valmont.

(D) Coors Glass Plant allowable emission limitations on three furnaces.

1. Permit 92JE129–1, effective date January 19, 1993, regulating emissions at the KTG glass melting furnace #1.

2. Permit 92JE129–2, effective date January 19, 1993, regulating emissions at the KTG glass melting furnace #2.

3. Permit 92JE129–3, effective date January 19, 1993, regulating emissions at the KTG glass melting furnace #3.

(E) Conoco Refinery allowable emission limitations from the refinery.

1. Permit 90AD524, effective date March 20, 1991, regulating a Tulsa natural gas fired 20MMbtu/hour heater equipped with low-Nox burners.

2. Permit 90AD053, effective date March 20, 1991, regulating process heaters H–10, H–11 and H–27 and process boilers B4, B6, and B8 all burning fuel gas only.

3. Permit 91AD180–3, effective December 28, 1992, regulating the three stage Claus sulfur recovery unit with tail gas recovery unit.

(ii) Additional material.

(A) Regional Air Quality Council, "Guidelines for Reducing Air Pollution from Street Sanding" sets voluntary guidelines for public works departments to follow to reduce the amount of street sand applied, and includes recommendations for increasing the effectiveness of street cleaning operations.

(B) Adolph Coors Company Brewery permit emission limitations on five boilers. Permits: C–12386–1&2, C–12386–3, C–10660, C–11199, and C–11305.

(67) On November 27, 1992, the Governor of Colorado, submitted a revision to the Colorado SIP. This revision replaces previous versions of Regulation No. 13 with the amended Regulation No. 13 (oxygenated gasoline program) adopted September 17, 1992. Regulation No. 13 requires the oxygenated gasoline programs to be implemented in the Fort Collins-Loveland, Colorado Springs, and Boulder-Denver Metropolitan Statistical Areas (MSA) as required by Section 211(m) of the Clean Air Act Amendments of 1990.

(i) Incorporation by reference.

(A) Revision to Regulation No. 13, "Oxygenated Gasoline Program," as adopted by the Colorado Air Quality Control Commission on September 17, 1992, effective October 10, 1992, as follows: entire Regulation revision. This regulation supersedes and replaces all

previous revisions to Regulation No. 13, (40 CFR, 52.320(46)(2)).

[FR Doc. 94–17692 Filed 7–22–94; 8:45 am]
BILLING CODE 6560–50–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 435, 440, and 441

[MB–008–FC]

RIN 0938–AC55

Medicaid Program; Home and Community-Based Services and Respiratory Care for Ventilator-Dependent Individuals

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

ACTION: Final rule with comment period.

SUMMARY: This final rule with comment period expands coverage of Medicaid home and community-based services under the waiver provisions of section 1915(c) of the Social Security Act. This final rule also adds coverage of respiratory care services as an optional benefit under State Medicaid plans.

These revisions and additions incorporate changes made by the Consolidated Omnibus Budget Reconciliation Act of 1985 and the Omnibus Budget Reconciliation Act of 1986 and respond to the public comments that we received as a result of the June 1, 1988, publication of a proposed rule. This final rule with comment period also incorporates self-implementing provisions of the Omnibus Budget Reconciliation Act of 1987, the Medicare Catastrophic Coverage Act of 1988, the Technical and Miscellaneous Revenue Act of 1988, and the Omnibus Budget Reconciliation Act of 1990 concerning home and community-based services, and makes other technical changes not specifically related to these statutes.

DATES: Effective Date: This final rule with comment period is effective on August 24, 1994.

Comment Date: Written comments will be accepted on changes as noted in sections II.C.2., II.G.2.b., II.G.3.b., II.G.4.b., II.G.5.b., II.G.6.b., and II.I.2. The comments will be considered if we receive them at the appropriate address, as provided below, no later than 5:00 p.m. on September 23, 1994.

ADDRESSES: Mail written comments (original and two copies) to the following address: Health Care Financing Administration, Department of Health and Human Services, Attention: MB–008–FC, P.O. Box 7518, Baltimore, Maryland 21207.

If you prefer, you may deliver your written comments (original and two copies) to one of the following addresses:

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

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

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

If comments concern information collection or recordkeeping requirements, please address a copy of comments to: Office of Management and Budget, Office of Information and Regulatory Affairs, Room 10235, New Executive Office Building, Washington, DC 20503, Attention: Laura Oliven.

In commenting, please refer to file code MB–008–FC. Comments 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 Avenue, SW., Washington DC on Monday through Friday of each week from 8:30 a.m. to 5:00 p.m. (phone (690) 245–7890).

FOR FURTHER INFORMATION CONTACT: Robert C. Wardwell, (410) 966–5659, for Payment and Coverage Policy.

Marinos T. Svolos, (410) 966–4451, for Post-Eligibility Treatment of Income and Resources.

SUPPLEMENTARY INFORMATION:

I. General Background

This final rule with comment period contains final regulations for the provision of Medicaid home and community-based services under waivers granted under section 1915(c) of the Social Security Act (the Act), and for the provision of respiratory care services as an optional benefit under the Medicaid program.

Home and community-based services are those medical assistance services provided under a State waiver that are not otherwise available under a State's Medicaid plan. These services: (1) must be furnished in accordance with an individually written plan of care that is subject to approval by the State Medicaid agency; and (2) may be furnished only to persons who, but for the provision of such services, would otherwise require the level of care provided in a hospital, nursing facility (NF) (formerly referred to as a skilled nursing facility (SNF) or intermediate care facility (ICF)), or intermediate care facility for the mentally retarded (ICF/MR). (Under section 4211(a)(3) of the Omnibus Budget Reconciliation Act of 1987 (OBRA '87), Public Law 100–203, the distinction between SNFs and ICFs under the Medicaid program ended, effective October 1, 1990. Both of these facilities are now categorized as NFs, as defined in section 1919(a) of the Act, effective October 1, 1990. We generally use the acronym "NF" throughout this rule unless we are quoting directly from a statute or providing an historical reference. Medicaid recognizes two types of long-term care facilities—NFs and ICFs/MR.)

Respiratory care services as medical assistance may be provided as an option under the Medicaid program, as authorized and described in sections 1902(e)(9) and 1905(a)(20) of the Act.

On June 1, 1988, we published a proposed rule in the Federal Register (53 FR 19950) proposing to revise the Medicaid regulations governing the provision of home and community-based services under waivers and respiratory care services. This rule proposed to codify in regulations section 9502 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Public Law 99–272, enacted on April 7, 1986, and sections 9408, 9411, and 9435(a) of the Omnibus Budget Reconciliation Act of 1986 (OBRA '86), Public Law 99–509, enacted on October 21, 1986.

Four additional public laws have been passed that contain provisions that impact on the proposed rule. These laws were enacted either immediately preceding or subsequent to the publication of the proposed rule. The public laws are:

- The Omnibus Budget Reconciliation Act of 1987 (OBRA '87), Public Law 100–203, enacted on December 22, 1987 (sections 4102 (b) and (c), 4118, and 4211);
- The Medicare Catastrophic Coverage Act of 1988 (MCCA), Public Law 100–360, enacted on July 1, 1988 (sections 411(k)(10)(A) and 411(k)(10)(H));
- The Technical and Miscellaneous Revenue Act of 1988 (TMRA), Public Law 100–647, enacted on November 10, 1988 (section 8437); and
- The Omnibus Budget Reconciliation Act of 1990 (OBRA '90), Public Law 101–508, enacted on November 5, 1990 (sections 4741 and 4742).

In this final rule with comment period, we are incorporating provisions of these public laws that relate to many of the regulatory provisions in the June 1, 1988, proposed rule. We are inviting public comments on the revisions that

we have made to this proposed rule in response to these legislative changes.

We have also revised the proposed regulations in response to public comments. We received, on a timely basis, 16 letters from individuals, associations, State agencies, and providers of services (primarily home health agencies). While most commenters supported the provisions in the proposed rule, the majority also expressed interest in expanding the waiver program. Some commenters correctly noted that the proposed rule did not include statutory changes made by OBRA '87, MCCA, and TMRA.

Because we have made a substantial number of revisions to the proposed rule in response to legislative changes, we have organized our discussion in this preamble by specific subject areas. We are using this organization to group all of the additions and revisions to each subject in one place. We are presenting the legislative basis for the proposed rule and any subsequent legislative provisions that changed or added to the provisions of the proposed rule. We are following the legislative foundation with a discussion of the proposed regulations for that area, any public comments we received, and our responses to the public comments. We conclude each topic with a description of the applicable provisions contained in this final rule.

II. Home and Community-Based Services Waivers

Section 1915(c) of the Social Security Act authorizes the Secretary to waive certain Medicaid statutory requirements to enable a State to cover a broad array of home and community-based services. Coverage of these services enables elderly, disabled, and chronically ill persons, who would otherwise be institutionalized, to live in the community. Section 1915(c) specifies the services that may be covered, the conditions for granting waivers, and the provisions governing the scope of services under waivers. Section 1915(c) was added to title XIX of the Act by the Omnibus Budget Reconciliation Act of 1981 (OBRA '81), Public Law 97–35, to encourage the provision of services to Medicaid recipients in noninstitutional settings. Prior to the enactment of OBRA '81, the Medicaid program provided limited coverage for long-term care services in noninstitutional settings.

A State may request approval by HCFA of waivers under section 1915(c) to provide home and community-based services that are not otherwise available to certain recipients under the State's Medicaid plan. These services must be furnished in accordance with an individual written plan of care subject to approval by the State's Medicaid agency and may be furnished only if the individual would otherwise require the level of care provided in a hospital, NF, or ICF/MR and if the costs are reimbursable under the State's plan. (The original statute specified SNF or ICF. OBRA '87 struck out SNF or ICF and substituted NF or ICF/MR.)

Existing regulations governing home and community based services under waivers under section 1915(c) appear in various sections of 42 CFR parts 435, 440, and 441. This final rule with comment period contains regulations which amend each of these three parts.

A. Expanded Habilitation Services

1. Background

Prior to the enactment of COBRA, a waiver granted under section 1915(c) of the Act allowed a State to receive Federal financial participation (FFP) for the following services as home and community-based services: case management services, homemaker/home health aide services, personal care services, adult day health services, habilitation services, respite care, and "other" services as requested by the State and approved by the Secretary. Section 9502(a) of COBRA revised section 1915(c) of the Act to explicitly include certain prevocational, supported employment, and educational services as habilitation services under home and community-based services.

Habilitation services are authorized by section 1915(b)(4) of the Act and defined in section 1915(c)(5)(A) of the Act, as amended by section 9502 of COBRA, as services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings. Section 9502(a) of COBRA also added new sections 1915(c)(5) (B) and (C) to the Act that allow a State to request HCFA's approval to include certain additional services previously excluded from coverage in its definition of "habilitation services" for individuals who receive waiver services after discharge from a NF or ICF/MR. Sections 1915(c)(5) (B) and (C) provide that habilitation services include prevocational, educational, and supported employment services, but do not include—

- Special education and related services, as defined in section 602 (16) and (17) of the 1975 Amendments to the Education of the Handicapped Act (Public Law 94–142, now located at 20 U.S.C. 1401 (16) and (17)), that are otherwise available to the individual through a local educational agency; and
- Vocational rehabilitation services that are otherwise available to the individual through a program funded under section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

Section 9502(j)(1) of COBRA provides that section 9502(a) is effective for services furnished on or after April 7, 1986. Section 4118(j) of OBRA '87 amended section 9502(j)(1) of COBRA to provide that eligibility of previously institutionalized individuals for the expanded habilitation services under a section 1915(c) waiver is determined without regard to whether the individuals were receiving institutional services before their eligibility under the waiver. Section 1915(c)(5) as added by section 9502(a) of COBRA refers to habilitation services, "* * * with respect to individuals who receive such services after discharge from a nursing facility or intermediate care facility for the mentally retarded * * *". In our proposed rule, we interpreted "after discharge" as meaning that an individual is discharged directly into a home and community-based services waiver. (Individuals who have never been institutionalized, however, are not eligible for the expanded habilitation services.) This provision was effective as if it were included in the enactment of section 9502(j)(1) of COBRA. As indicated in the Report of the Committee on the Budget to accompany H.R. 3545 (OBRA '87) (H. Rept. No. 391, 100th Cong., 1st Sess. 537 (1987)), the Congress included this amendment to section 9502(j) because it believed HCFA had misread COBRA in the proposed rule by stating that expanded habilitation services would be provided only to recipients discharged directly from a NF or ICF/MR into a home and community-based services waiver program.

In the proposed rule, we included in regulations the provisions of section 9502(a) by—

- Revising § 440.180 to provide for the expanded definition of habilitation services under paragraphs (b)(6) and (c);
- Adding §§ 440.180(c)(2) and (3) to provide for the inclusion of prevocational, educational, and supported employment services under a home and community-based waiver and for the exclusion of certain services; and adding § 441.302(i) and § 441.303(h) to require documentation to support State health and welfare assurances for the provision of these expanded services.
- Revising § 441.310(a)(3) to provide for limits on FFP for prevocational, educational, and supported employment services.

We received the following comments on this proposal:

Comment: Five commenters raised issues concerning the expanded definition of habilitation to include educational, prevocational, and supported employment services. Some commenters suggested that HCFA was imposing an age minimum of 22 for the expanded habilitation services. Others stated that our definition of prevocational services was too strict and should be more consistent with section 4442.3(B)(3)(a) of the State Medicaid Manual, which distinguishes prevocational services from noncovered vocational services. (This definition was added in HCFA Transmittal No. 37, issued in September 1988.)

Response: We are not imposing a minimum age for the expanded habilitation services. Our discussion of this subject in the preamble of the proposed rule pertained only to the fact that most educational and prevocational services for individuals under 22 years of age ordinarily would be provided under State and Federal programs other than Medicaid. We agree with the commenters concerning the need for more consistency between the regulations defining prevocational services and the related HCFA instructions, and have revised § 440.180(c)(2)(i) of the proposed regulations to make the policy consistent.

2. Provisions of the Final Rule

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

- We have revised § 440.180(c)(1) to provide that a State may provide expanded habilitation services under a new or amended waiver to recipients who have been discharged from a Medicaid-certified NF or ICF/MR, regardless of when the discharge occurred. We have made a conforming change to § 441.302(i)(2).
- We have revised § 440.180(c)(2)(i) to incorporate a provision to distinguish covered prevocational services from noncovered vocational services.
- We have revised § 441.310(a)(3)(iii) to clarify that FFP is not available for prevocational, educational, or supported employment services, or any combination of these services, as part of habilitation services provided to recipients who were never institutionalized in Medicaid-certified NFs or ICFs/MR.

B. Services to Patients with Chronic Mental Illness

1. Background

Section 9411(d) of OBRA '86 amended section 1915(c)(4)(B) of the Act by adding day treatment or other partial hospitalization services, psychosocial rehabilitation services, and clinic services (whether or not furnished in a facility) for individuals with chronic mental illness to the list of services specifically enumerated as home and community-based services. Therefore, effective October 21, 1986 (the date OBRA '86 was enacted), States may request that any of the above services be provided under a waiver or renewal of a waiver for persons diagnosed as chronically mentally ill.

In the proposed rule, we—

- Revised § 440.180 to add a new paragraph (b)(8) to provide for the inclusion of day treatment or other partial hospitalization services, psychosocial rehabilitation services, and clinic services for individuals with chronic mental illness as home and community-based waiver services;
- Added new §§ 441.302(i) and 441.303(i) to specify requirements for written State health and welfare assurances for the provision of these services and for supporting documentation of these assurances;
- Added a new § 441.310(a)(4) to specify limits on FFP for the provision of these services.

We received the following public comment on these proposed regulations:

Comment: One commenter noted that States may provide the specified services to the mentally retarded as well as to the chronically mentally ill.

Response: Section 1915(c)(4)(B) of the Act authorizes the provision of day treatment or other partial hospitalization services, psychosocial rehabilitation services, and clinic services (whether or not furnished in a facility) for individuals with chronic mental illness. Neither the statute nor the conference committee report mentions individuals diagnosed as mentally retarded. However, States may request the authority to provide these services to the mentally retarded under the broader waiver authority of section 1915(c)(4)(B) of the Act as "other" services. The "other" services category has been in existence since the home and community-based services waiver program was established, and HCFA has approved a variety of services under this category that States establish as cost-effective and necessary to avoid institutionalization.

2. Provisions of the Final Rule

We are adopting the proposed provisions, with minor editorial changes, as final rules. We have also redesignated § 441.302(i) as § 441.302(j) to accommodate other revisions.

C. Scope of Respite Care

1. Background

Under section 1915(c)(4)(B) of the Act, a State may provide respite care under its home and community-based waiver services program. Respite care may be provided in institutional and noninstitutional settings. However, under existing regulations at § 441.310, FFP is not available for the cost of room and board, except when provided as part of respite care in a State-approved facility that is not a private residence. Because respite care generally should be a short-term service, we have required States to fully document the need for more than 30 days of care.

In the proposed § 440.180(b)(7), in accordance with section 1915(c)(4) of the Act, we imposed a 30-day limitation on the duration of institutional respite care services provided during a waiver year to any individual under a waiver program. We indicated in the proposed rule that we were not placing a limit on noninstitutional respite care but that we would closely review all waiver applications that requested noninstitutional respite care in excess of 30 days per waiver year.

(Note: We have traditionally used the term "waiver year" for any 12-month period for which a waiver applies. While we recognize that the statute uses the term "fiscal year", we have not had a problem with our use of "waiver year" for "fiscal year". Since the term "waiver year" is generally understood and accepted by those involved in the waiver process, we are continuing to use it in the Medicaid regulations. We believe that a switch from the term "waiver year" to "fiscal year" would cause unnecessary confusion.)

Subsequent to the publication of the proposed rule, section 4742(d)(1) of OBRA '90 amended section 1915(c)(4) of the Act to eliminate restrictions on the number of hours or days of respite care that a State may provide in any period under a waiver as long as the State continues to show cost-neutrality in its waiver program. ("Cost-neutrality" means that the average per capita expenditures for individuals under waivers does not exceed what the average per capita expenditures for these individuals would have been if the waiver had not been granted.) Section 4742(d)(2) of OBRA '90 specifies that the changes under section 4742(d)(1) apply as if included under OBRA '81, the original legislation for

the waiver program, enacted August 13, 1981.

We received the following public comments on this proposal:

Comment: Six commenters expressed concerns about the proposed 30-day limit on institutional respite care. Two commenters indicated that room and board should be included under noninstitutional respite care. Three commenters indicated that the 30-day limit is too strict; two recommended a 60-day limit and one a 90-day limit. One of the commenters who recommended a 60-day limit also recommended a 2-week limit on consecutive weeks of institutional respite care.

Response: Section 1915(c)(4) of the Act prohibits the Secretary from placing durational limits on respite care as long as the waiver retains cost-neutrality as required under section 1915(c)(2)(D). The issues raised by the commenters regarding our formerly proposed limits on institutional respite care are now moot.

Section 1915(c)(1) of the Act specifically excludes room and board as a covered waiver service. However, an exception with regard to respite care was included under regulations based on the text of section 1915(c)(4)(B) of the Act, the legislative history of OBRA '81 that amended the Act to include the home and community-based waiver program, and the fundamental nature of respite care services. In discussing the services that could be included under section 1915(c) waiver programs, the Congress explained in H. Rept. No. 208, 97th Cong., 1st Sess. 966 (1981) that respite care services were provided on a short-term basis to individuals unable to care for themselves and designed to fill-in for the absence of care or the "need for relief for those persons normally providing such care." The Congress indicated that such services can be offered in "the home of an individual or an approved facility such as a hospital, nursing home, foster home, or community-residential facility."

Because of the Congress' discussion of certain institutional facilities as locations for the provision of respite care, and the fact that room and board costs are a core aspect of the costs of respite care services offered in these facilities, we believe that the Congress intended to allow for payment of room and board costs as part of the costs of respite care services. Based in part on the cited language from the Conference Report, we have decided to limit institutional respite care to States which limit the facilities authorized to provide such care to (1) Medicaid-certified hospitals and nursing homes, and (2) foster homes and community-residential facilities that meet State standards as specified in an approved waiver. Payment for room and board costs as part of the costs of respite care services can be authorized only for care provided in these facilities.

Section 1915(c)(2)(D) of the Act requires that a State maintain the overall cost-neutrality of its waiver program. Significant increases in respite care, particularly institutional respite care because it is generally costly, could jeopardize the cost-neutrality of a waiver program. A State that wishes to revise its limit on the number of hours or days of respite care in a previously approved waiver program must submit an amendment to its currently operating waiver. The amendment must specify the revised limits and revise the cost-neutrality formula to allow for the increased costs attributable to the revised respite care limits.

2. Provisions of the Final Rule

We are not including in these final regulations any limits on the duration of respite care. However, the State must continue to show cost-neutrality in its waiver program. Because of the changes in the law, the proposed revision to § 440.180(b)(7) that contained limits on respite care has been deleted. We will consider timely comments on this deletion.

D. Permitting Hospital Level of Care for Certain Ventilator-Dependent Recipients

1. Background

Section 9502(b) of COBRA amended sections 1915(c)(1) and (c)(2)(C) of the Act. These amendments allowed States to provide home and community-based services to individuals who are ventilator-dependent and who, but for the provision of home and community-based services, would continue to receive inpatient hospital, NF, or ICF/MR services under a State's Medicaid plan. (The original statute specified SNF or ICF. OBRA '87 struck out "SNF" or "ICF" and substituted "NF" or "ICF/MR".) Thus, sections 1915(c)(1) and (c)(2) of the Act authorized waiver payments for individuals who require an inpatient hospital level of care, if they enter the waiver program directly from a hospital and are ventilator-dependent. Prior to this legislation, only persons requiring NF or ICF/MR levels of care could be covered under a home and community-based waiver program.

Section 9411(a)(1) of OBRA '86 subsequently amended section 1915(c)(1) of the Act to remove the amendments made by section 9502(b) of COBRA and added a broader authority to permit States to extend home and community-based services to individuals who, but for the provision of these services, would require the inpatient hospital level of care. Section 9411(a)(2) of COBRA amended section 1915(c)(2)(B) of the Act to also require the State to provide for an evaluation of the individual's need for inpatient hospital services prior to permitting the use of home and community-based services as an alternative to inpatient hospital services.

In the proposed rule, we revised or added provisions under §§ 441.301(a)(3)(i), (b)(1)(ii), and (b)(1)(iii)(A), §§ 441.302(c)(1), (c)(2)(i), (e), and (f), and §§ 441.303(f)(1), (3), and (5), to incorporate the provisions of section 1915(c)(2). These provisions extended home and community-based services coverage to individuals who would otherwise need inpatient hospital care and required States to provide for an evaluation of the need for inpatient hospital services. In addition, we included a proposed expansion of § 441.303(c)(2) to require States that use a level of care evaluation form other than that used for nursing home placements to assure us that the outcome of that evaluation form is reliable, valid, and fully comparable to the form used for nursing home placement.

2. Provisions of the Final Rule

We did not receive any comments on these provisions. We have, however, made the following clarifying changes in the final rule:

- We substituted "NF" or "ICF/MR" for "SNF" or "ICF" to conform the regulations to OBRA '87.
- We have revised § 441.303(c)(2) by substituting "hospital, nursing facility, or ICF/MR" for "nursing home." Level of care evaluation forms from any of these facilities will not need State assurances for reliability and validity.

E. Bundling of Services

1. Background

We proposed to revise § 441.301(b)(4) to require States to describe the services to be furnished under home and community-based services waivers under section 1915(c) so that each service is separately defined. Multiple services that are generally considered to be separate services cannot be consolidated under a single definition. Commonly accepted terms must be used to describe the service and definitions may not be open-ended in scope.

We received the following comments on the proposed rule:

Comment: Two commenters recommended that States be allowed to combine (bundle) certain services under a single definition under home and community based services waivers under section 1915(c) for ease of reporting.

Response: We believe that services enumerated in the statute (section 1915(c)(4)(B)), such as personal care or adult day health services, must stand alone and not be included in a bundled service. In addition, bundling of these services would not ease the waiver process because the cost of each component of the combined service would need to be computed separately to show how the single service cost was derived. The bundling of several waiver services into a single service definition may also unnecessarily restrict an individual's freedom of choice of providers (section 1902(a)(23) of the Act) by limiting the pool of qualified providers. Bundling would limit the pool of providers able to furnish the bundled service because fewer providers would be capable of furnishing the broader array of services that result when various services are combined into bundles. Under a bundling arrangement, a provider must be able to furnish all of the component services in a bundle to qualify for a provider agreement. We will consider a combined service definition if the State establishes that the bundling of services will permit more efficient delivery of services and not compromise either the availability of services or an individual's free choice of providers. If HCFA authorizes the bundling of services, however, States must continue to compute separately the costs of the component services to support the final cost of the bundled waiver service for the cost-neutrality formula.

2. Provisions of the Final Rule

We have adopted the proposed regulations as final rules with two modifications:

- We have revised proposed § 441.301(b)(4) to specify that HCFA will approve combined service definitions (bundling) if the definitions will permit more efficient delivery of services and not compromise an individual's access to or free choice of providers.

- We have added a new paragraph § 441.303(f)(10) to require States to continue to compute separately the costs and utilization of the component services that compose a HCFA-approved bundled service.

F. Waiver of Comparability Requirement and Certain Income and Resource Eligibility Requirements

1. Waiver of Comparability Requirement

Section 9411(c) of OBRA '86 amended section 1915(c)(3) of the Act to limit the Medicaid State plan requirements under section 1902(a)(10) of the Act that may be waived under section 1915(c) to "comparability" of covered services under section 1902(a)(10)(B); that is, that covered services be equal in amount, duration, and scope for certain Medicaid recipients. Previously, all of section 1902(a)(10) of the Act could be waived by the Secretary if requested by States. By indicating that only section 1902(a)(10)(B) of the Act may be waived, the Congress narrowed the scope of this particular waiver option. Specifically, section 1902(a)(10)(B) of the Act requires that the medical assistance made available to any eligible categorically needy individual may not be less in amount, duration, or scope than the medical assistance made available to any other categorically needy individual, and may not be less in amount, duration, or scope than the medical assistance made available to medically needy individuals. Consequently, a waiver of comparability affords the State an opportunity to target waivers to certain specific groups without providing those services to other groups. The amendment made by section 9411(c) is effective for waivers and renewals of waivers approved on or after October 21, 1986.

Regulations implementing section 1902(a)(10)(B) are located at § 440.240.

In the proposed rule, we revised § 441.301(a)(2) to provide that, when applicable, a request for waiver of Medicaid requirements could include a waiver of sections 1902(a)(1) and (a)(10)(B) of the Act which concern "statewide" application of Medicaid and "comparability of services." Prior to enactment of section 9411 of OBRA '86, a State could request and receive waivers of section 1902(a)(1) and 1902(a)(10) of the Act. A waiver of 1902(a)(10) included waiver of comparability as well as all other subsections in that section of the statute. Section 9411(c) of OBRA '86 limited the waiver authority to section 1902(a)(10)(B) or "comparability of services". Because of this limitation, a State could no longer apply rules for deeming of income and resources for institutionalized medically needy recipients to determine Medicaid eligibility of the waiver population.

2. Medicaid Eligibility Rules

Section 4118(a)(1) of OBRA '87 amended section 1915(c)(3) of the Act to allow States to waive section 1902(a)(10)(C)(i)(III) which contains rules for determining income and resource eligibility for the medically needy. This option allows States to use income and resource methods and standards, other than those that would ordinarily be used for medically needy individuals living in the community, provided that such rules do not conflict with other provisions of the Medicaid statute which States may not waive. That is, the option permits waiver of rules, such as deeming of income and resources, that are applied differently in the community than in an institution and are barriers to participation in a waiver program.

When this provision was enacted, deeming was the primary barrier. Over time, this has changed. There are now other eligibility policies applied in an institutional setting that a State may wish to use instead of policies that would normally be used in the community. For example, under its waiver, a State may wish to apply to a home and community-based waiver recipient living with a spouse, the spousal impoverishment protection rules of section 1924 of the Act which would have applied to this recipient had the recipient been living in a medical institution. As a second example, for its home and community-based recipients, a State might use more liberal income or resource methods that the State has approved under section 1902(r)(2) of the Act for institutionalized individuals who are eligible under a special income level under § 435.231.

If a State elects to use more liberal income rules under this waiver authority, it is still subject to the FFP limits on Medicaid expenditures for the medically needy under section 1903(f) of the Act, as interpreted under § 435.1007. These limits may not be waived. The FFP limit for the medically needy is 133 and 1/3 percent of the highest State's Aid to Families with Dependent Children (AFDC) money payment for a family of the same size which has no income or resources. Because the legislative history explicitly states that the Congress intended that this waiver option permit States to use institutional deeming rules, we are interpreting the FFP limits at § 435.1007 to mean that the income used for purposes of determining if the FFP limits are met is income that would be used in the institutional setting. That is, only the waiver recipient's income

would be used in calculating the FFP limits since spousal and parental income is not deemed to be available in an institution. This interpretation will be reflected in a revision to § 435.1007 in a separate rule.

Prior to this amendment to section 1915(c)(3) and the amendment under section 9411(c) of OBRA '86 limiting waivers under section 1902(a)(10) to "comparability" of covered services under section 1902(a)(10)(B), States had been permitted to waive eligibility requirements for the categorically needy, but not the medically needy. Generally, States used the waiver authority to use institutional income and resource deeming rules. The result of these two amendments to section 1915(c) is that this waiver authority no longer extends to the categorically needy, but extends only to the medically needy. However, a State may continue to use the institutional eligibility rules for categorically needy waiver recipients, if the individuals are members of an eligibility group that the State may elect to cover under section 1902(a)(10)(A)(ii)(VI) of the Act and § 435.217.

3. Post-Eligibility Treatment of Income

In the proposed rule, we revised the post-eligibility rules at § 435.726(c)(1) and § 435.735(c)(1) to include the provisions of section 9502(e) of COBRA and section 9435(a) of OBRA '86. Post-eligibility calculations for individuals who are found eligible under § 435.217 determine how much of eligible waiver recipients' income is applied to the cost of home and community-based waiver services. One of the deductions from waiver recipients' income included in these calculations is a deduction for the maintenance needs of the waiver recipient.

Section 9502(e) of COBRA amended section 1915(c) of the Act to reflect a change in the amount States may protect for the maintenance needs of waiver recipients in the post-eligibility calculations. The amendment in COBRA specifically allows States to use a higher maintenance needs standard for home and community-based recipients than permitted under §§ 435.726 and 435.735(c)(1) for waivers approved or renewed on or after April 7, 1986. The amendment in OBRA '86 further amended section 1915(c) to also permit use of the higher maintenance need standards for waivers approved or renewed before April 7, 1986. In the proposed rule, we provided that the maintenance amount be based on a reasonable assessment of need and that States set an upper limit which cannot be exceeded for any one individual. Should a State choose to use maintenance need standards that vary by individual, it must assure that all individuals in like circumstances are treated comparably.

The proposed rule did not address how the rules used to determine income in the post-eligibility income and resource process for an institutionalized individual who has a spouse who lives in the community would affect home and community-based waiver recipients whose eligibility is based on section 1924 of the Act. We are addressing this issue in a separate rule that will propose further revisions to the post-eligibility regulations. These revisions will address application of the section 1924 rules and other matters. They will include our interpretation of "institutionalized spouse" at section 1924(h)(1) as allowing, on a waiver-by-waiver basis, use of the post-eligibility rules at section 1924(d) to determine Medicaid benefits payable for individuals who are eligible for home and community-based waiver services under § 435.217. That is, an individual would be subject to the section 1924 post-eligibility rules if (1) the individual's State elected the section 1924(h)(1) post-eligibility option, (2) the individual meets the criteria of § 435.217, and (3) the individual has a spouse who is neither institutionalized in a medical institution or nursing facility nor receiving home and community-based waiver services.

We caution States to carefully evaluate how section 1924(d) post-eligibility rules will affect the waiver population. Generally, the election of the section 1924(d) post-eligibility rules would not adversely affect the waiver recipient. However, there is at least one exception with respect to individuals who *are not living* with their community spouses. If the section 1924(d) post-eligibility rules are used for such individuals, the waiver recipient is not likely to have enough protected income to pay for his or her maintenance needs. This situation can occur because only the personal needs allowance for institutionalized individuals is protected in the section 1924 post-eligibility calculation. Income above the personal needs allowance would go either to the community spouse in the form of a monthly income allowance, or for medical and remedial care expenses (including waiver services). Thus, the waiver recipient is not likely to have income to pay for his or her food, clothing, and shelter in the community.

4. Provisions of the Final Rule

We are adopting the proposed § 441.301(a)(2) to allow a State to request a waiver of section 1902(a)(1) or section 1902(a)(10)(B) as final. We are also adding a provision to that section to allow for waiver of the requirements of section 1902(a)(10)(C)(i)(III) of the Act concerning income and resource rules applicable to institutionalized individuals with spouses living in the community, as added by section 4118(a)(1) of OBRA '87.

We are adopting the proposed revisions to § 435.726(c)(l) and § 435.735(c)(l) as final, without further modification.

G. Expenditure for Waiver Services

1. Prohibition on Imposition of Certain Regulatory Limits on Expenditures

a. *Background.* Section 9502(c) of COBRA amended section 1915(c)(2)(D) of the Act and added a new section 1915(c)(6). Section 9502(c)(1) of COBRA clarified section 1915(c)(2)(D) to specify that, under a home and community-based services waiver, a State's estimated average per capita expenditure for individuals under the waiver must not exceed the estimated average per capita expenditure for services without the waiver. We refer to this as "a cost-neutrality test for section 1915(c) waivers." (We have always interpreted section 1915(c)(2)(D) of the Act in this manner and previously implemented the applicable standards accordingly.) The cost estimate formula is located in regulations at § 441.303(f)(l).

Section 1915(c)(6) of the Act, as enacted by section 9502(c)(2) of COBRA, directs the Secretary to abolish the regulatory limitation concerning home and community-based services waiver expenditures. This expenditure limitation appears in existing regulations at §§ 441.302(e)(2) and 441.310(a)(2) and requires a State to provide satisfactory assurance that actual total expenditures for home and community-based services and the State's claim for FFP for the services will not exceed the State's approved estimates for waiver services. Under the existing regulations, expenditures that exceed the State's approved estimates would not have been eligible for FFP.

In the proposed rule, we revised § 441.302 (e) and (f) that deal with a State's assurances on the cost-neutrality of its waiver programs. Section 441.302(e) deals with a State's estimates as contained in its waiver proposals and § 441.302(f) deals with a State's actual expenditures as reported on the State's annual expenditure reports as required

under section 1915(c)(2)(E) of the Act. We inserted "100 percent" in each section to clearly indicate the intention of section 9502(c) of COBRA that a waiver be cost-neutral (formerly referred to as "cost-effective"). The Congress intended that expenditures made under a State waiver not exceed 100 percent of the average per capita expenditure that the State reasonably estimates would have been made if the waiver had not been granted.

We also proposed revisions to § 441.304(d) to indicate that we will review all estimates very closely to determine if they are reasonable and based on statistically supportable assumptions. For waivers that are approved and operational, we will compare the data the State must furnish annually on its actual experience (HCFA form 372) with the approved expenditures the State estimated would occur absent the waiver. If we find that actual expenditures exceed the State's approved estimates for expenditures absent the waiver, we will require the State to amend its estimates for the subsequent waiver year(s). We will compare the revised estimates with the State's actual experience to determine if these estimates are reasonable. We may terminate a waiver if we find that, based on the revised estimates in the amendment request, the waiver is not cost-neutral or that the revised estimates are unreasonable. For waiver renewal requests, we will compare the estimated expenditures for the renewal period against the State's actual experience as shown in its annual reports. Based on this comparison, we will not approve a waiver renewal request if we find that the renewal request is not cost-neutral or that the estimates are not reasonable based on the annual reports.

These revisions were required by section 9502(c)(2) of COBRA.

We received the following public comments on these proposed provisions.

Comment: A State agency suggested that a single recipient's cost not be used to determine the waiver's cost effectiveness.

Response: In virtually all cases, we determine the cost-neutrality of a waiver request by comparing the average costs for all recipients under the waiver to the estimated average costs absent the waiver. The only time we would review a single recipient's cost under a home and community-based services waiver would be when a waiver serves only one person. If the recipient's costs exceeded the appropriate institutional costs, the waiver would not be cost-neutral. However, section 1915(c)(4)(A) of the Act authorizes a State, at its option, to limit home and community-based services waivers to those recipients for whom the State has a reasonable expectation that the cost of medical assistance under the waiver for those individuals will not exceed the cost of medical assistance for those same recipients absent the waiver. Thus, this section of the Act permits States to include (1) only recipients whose costs under a waiver are reasonably expected to be less than or the same as the appropriate institutional costs under medical assistance and (2) individual recipients whose waiver costs are reasonably expected to exceed institutional costs under medical assistance (if the waiver did not apply), as long as the estimated average per capita cost with the waiver does not exceed the estimated average per capita cost absent the waiver.

Comment: Two commenters asserted that a State should not be required to submit an amendment to its waiver proposal if the State exceeds its approved cost and utilization estimates.

Response: Section 1915(c)(2)(D) of the Act requires that we assess the reasonableness of a State's estimates of the cost-neutrality of its program. The amendment must be submitted prior to the expiration of the waiver year in question and must include cost and utilization changes for the current waiver year and all waiver years that follow through the term of the approved waiver request. If a State anticipates substantive changes in its cost and utilization estimates, we believe that the State should be required to submit amendments to explain the basis and extent of the changes. The State's recomputed cost-effectiveness formula, based on the revised cost and utilization, must substantiate continued cost-neutrality.

Comment: One commenter requested that we simplify the waiver application process which includes estimations of expenditures based on an equation specified in the regulations.

Response: We agree with the commenter's request. We are making a significant change in the formula values proposed at § 441.303(f)(1) to simplify the waiver cost-neutrality formula and thus reduce the overall complexity of the waiver application procedure. We are reducing the formula by retaining only those formula values which are critical in assessing the cost-neutrality of the program: D, D', G, and G'.

Section 1915(c)(2)(D) requires that States make assurances, satisfactory to the Secretary, that waiver programs will be cost-neutral to the Medicaid program. Cost-neutrality is defined in terms which require that the average per capita annual Medicaid expenditure with the waiver in place not exceed the average per capita annual Medicaid expenditure without the waiver. The waiver formula is intended to provide a uniform method of providing data to the Secretary, sufficient to allow a determination of whether the State's estimate of per capita cost-neutrality is reasonable. We believe that, based on many years of program experience, the formula can be simplified to its key elements. Specifically, we would retain the two factors which represent average per-capita costs for waiver and other Medicaid services under the waiver (D and D'). These would be compared to the average per capita cost for alternative institutional care and other related Medicaid expenditures without the waiver (G and G'). To ensure these factors are inclusive of all relevant Medicaid expenditures, we have redefined D' and G' to include all other medical assistance expenditures and expanded services not under a State plan for early and periodic screening, diagnostic and treatment (EPSDT) services recipients. The meanings of D and G remain unchanged, but the definitions have been revised for clarity. We are also deleting the requirement at proposed § 441.303(f)(3) that States must submit data on the estimated number of beneficiaries and expenditures for those who would receive hospital, NF, or ICF/MR services. With our simplification and redefinition of formula values, there is no longer a need for these data. We are renumbering the remaining paragraphs in section (f) accordingly.

The following are our new definitions:

D = the estimated annual average per capita Medicaid cost for home and community-based services for individuals in the waiver program.

D' = the estimated annual average per capita Medicaid cost for all other services provided to individuals in the waiver program.

G = the estimated annual average per capita Medicaid cost for hospital, NF, or ICF/MR care that would be incurred for individuals served in the waiver, were the waiver not granted.

G' = the estimated annual average per capita Medicaid costs for all services other than those included in factor G for individuals served in the waiver, were the waiver not granted.

Even though we have eliminated the "C" value (number of unduplicated waiver individuals a State intends to serve for each year of the waiver) from the equation, we will continue to require each State to report this information to us as part of a waiver

request. This number may be revised when a State determines that it needs to increase or decrease the number of individuals it estimates it would serve under the waiver. We will include this number in our approval notices.

b. *Provisions of the final rule.* We are revising § 441.303(f) to include the changes noted above. We are simplifying the formula at § 441.303(f)(1). We are providing in § 441.303(f)(2) that, for purposes of the formula, the prime factors include the average per capita cost for all services provided under the State plan that are not accounted for in other formula values and include expanded EPSDT services.

To further simplify the waiver application process, we are also revising § 441.304 by deleting paragraph (a)(2), renumbering paragraphs (a)(1)(i) and (a)(1)(ii) as paragraphs (a)(1) and (a)(2), and revising paragraph (b). Section 441.304(b) will now read: HCFA will determine whether a request for extension of an existing waiver is actually an extension request or a request for a new waiver. If a State submits an extension request that would add a new group to the existing group of recipients covered under the waiver (as defined under § 441.301(b)(6)), HCFA will consider it to be two requests: one as an extension request for the existing group, and the other as a new waiver request for the new group. Waivers may be extended for additional 5-year periods.

2. Computation of Estimated Expenditures Under Waivers for Individuals With a Particular Illness or Condition

a. *Background.* Section 9502(d) of COBRA added a new section 1915(c)(7) of the Act that authorized States that have established or wish to establish separate waivers for institutionalized, physically disabled individuals to estimate the average per capita expenditure for such individuals separately from the expenditures for all other individuals in NFs and ICFs/MR. Section 9411(a)(3) of OBRA '86 subsequently changed section 1915(c)(7) to allow such separate demonstrations of cost-neutrality to be applied in any waiver targeted to inpatients with particular illnesses or conditions. In both cases, the specific group of eligible individuals must have been inpatients in hospitals, NFs, or ICFs/MR prior to being deinstitutionalized into the waiver program. Prior to the enactment of COBRA, States were not authorized to compute expenditures differently for a specific group of individuals by comparing costs to those in that group only, rather than total inpatient populations.

Section 9411(a)(3) of OBRA '86 amended section 1915(c)(7) of the Act to allow States the option of using an alternative method for estimating costs under section 1915(c)(2)(D) of the Act. This alternative method applies to waivers for individuals with a particular illness or condition, who are inpatients in hospitals, NFs, or ICFs/MR. The State may determine the average per capita expenditure that would have been made in a fiscal year for those individuals under the State plan separately from the expenditures for other individuals who are inpatients of those respective facilities. Alternatively, States may continue to use the usual method of estimating average per capita expenditures; that is, include the utilization and cost of all Medicaid recipients otherwise using a hospital, NF, or ICF/MR.

In the Conference Committee report for OBRA '86 (H. Rept. No. 1012, 99th Cong., 2d Sess. 400 (1986)), the Congress indicated its intention by stating that "illness or diagnosis" meant, for example, acquired immune deficiency syndrome (AIDS), or AIDS-related condition (ARC) and that "condition" meant, for example, chronic mental illness or ventilator dependency. Thus, for waivers directed to any specified group, States may make expenditure estimates specific to that group of patients who are inpatients of hospitals, NFs, or ICFs/MR, distinguished by illness or condition.

As with all home and community-based waivers, States must furnish reasonable and verifiable cost estimates for waivers dealing with individuals with a specific illness or condition.

The provisions of section 1915(c)(7) of the Act, as amended by OBRA '86, apply to applications for waivers (or renewals) approved on or after October 21, 1986.

Section 8437(a) of TMRA made a further amendment to section 1915(c)(7)(A) of the Act to extend the principle of specific illness or condition cost estimates to individuals "who would require the level of care provided in hospitals, NFs or ICFs/MR." As amended by TMRA, section 1915(c)(7)(A) specifies that, for a home and community-based services waiver that applies to individuals with a particular illness or condition, who are inpatients in, or who would require the level of care provided in, hospitals, NFs, or ICFs/MR, the Secretary must allow the State to determine the average per capita expenditure that would have been made in a fiscal year for those individuals under the State plan separately from the expenditures for other individuals who are inpatients in, or who would require the level of care provided in, those respective facilities. This provision applies to eligible individuals whether or not those individuals are institutionalized prior to entering the waiver.

Section 8437(b) of TMRA made the amendments to section 1915(c)(7)(A) effective for waiver applications submitted before, on, or after November 10, 1988, the date TMRA was enacted.

In the proposed rule, we revised § 441.303(f)(3) to provide that, for waivers that apply only to individuals with a particular illness or condition (formerly referred to as physically disabled in section 9502(d) of COBRA) who are inpatients in hospitals, NFs, or ICFs/MR, the State may determine the average per capita expenditures that would have been made in each waiver year for those individuals under the State plan separately from the expenditures for other inpatients of the respective certified facilities.

We did not receive public comments on this specific provision.

b. *Provisions of the final rule.* We are adopting this proposed provision as final with the change described below. We will consider timely comments submitted on this change.

We have revised proposed § 441.303(f)(4) (and renumbered it as § 441.303(f)(3) to accommodate other revisions) to include reference to individuals who would require the level of care provided in hospitals, NFs, or ICFs/MR. In addition, we have revised this section to allow an agency to (1) exclude expenditures for other individuals in the affected hospitals, NFs, or ICFs/MR when estimating average per capita expenditures for a waiver for individuals with a particular illness or condition who would otherwise require hospital, NF, or ICF/MR level of care, as provided for in section 8437(a) of TMRA; and (2) support the accompanying data with documentation to verify that the cost-effectiveness estimates for these illness or condition specific waivers are reasonable as required under section 1915(c)(2)(D) of the Act.

3. Computation of Estimated Expenditures Under Waiver for Institutionalized Developmentally Disabled Individuals

a. *Background.* Section 4118(k) of OBRA '87 added a new paragraph (B) to section 1915(c)(7) of the Act concerning computation of the average per capita expenditure estimates made by a State under section 1915(c)(2)(B) of the Act for a waiver that applies only to

individuals with developmental disabilities who are inpatients in a nursing facility. (The original wording of the statute specified SNFs and ICFs.) The new provision states that, if the State has determined, on the basis of an evaluation under section 1915(c)(2)(B) of the Act, that individuals need the level of care provided in an ICF/MR, the State may determine the average per capita expenditures that would have been made in a fiscal year for those individuals under the State plan based on the average per capita expenditures under the State plan for services to individuals who are inpatients of ICFs/MR (rather than NFs).

We have determined that the evaluation required under section 1915(c)(2)(B) of the Act should be completed as part of the preadmission screening annual resident review (PASARR) required under section 1919(e)(7)(B) of the Act entitled "State Requirements for Annual Resident Review." Section 1919(e)(7)(B)(ii) requires that, as of April 1, 1990, in the case of each resident of a nursing facility who is mentally retarded, the State mental retardation or developmental disability authority must review and determine—

(1) Whether or not the resident, because of the resident's physical and mental condition, requires the level of services of an intermediate care facility described under section 1905(d) (ICF/MR); and

(2) Whether or not the resident requires specialized services for mental retardation.

We assume that the evaluation of need noted above would be accomplished during the annual resident review. (The requirement that the States use the PASARR process in conducting these evaluations was established by HCFA and is not contained in section 1915(c)(2)(B) of the Act.)

Section 411(k)(10)(H) of MCCA amended section 1915(c)(7)(B) of the Act to clarify that, in making estimates as to cost-neutrality in a waiver that applies exclusively to developmentally disabled individuals under section 1915(c)(7)(B) of the Act, who have been identified as inappropriately placed in NFs, yet requiring the level of services provided by an ICF/MR, the State may estimate utilization without regard to the availability of ICF/MR beds for such inpatients. Therefore, section 1915(c)(7)(B) exempts States from the requirement to demonstrate ICF/MR bed capacity for recipients served by waivers proposed under section 1915(c)(7)(B) of the Act.

b. *Provisions of the final rule.* We have added a new § 441.303(f)(4) to provide that, in making estimates for a separate waiver program that applies only to individuals (1) who are developmentally disabled, (2) who are inpatients of a NF, and (3) who have been determined by the State through the PASARR process (section 1919(e)(7)(B) of the Act) to require the level of care provided in an ICF/MR, the State may determine the average per capita expenditures that would have been made in a fiscal year for those individuals based on the average per capita expenditures for inpatients in an ICF/MR. When submitting estimates of institutional costs without the waiver, the State may use the average per capita costs of ICF/MR care even though the deinstitutionalized developmentally disabled individuals were inpatients of NFs. We will consider timely comments submitted on this addition.

4. Computation of Expenditure Estimates for Persons With Mental Retardation or a Related Condition in a Decertified Facility

a. *Background.* Section 4742(c)(1) of OBRA '90 added a new section 1915(c)(7)(C) to the Act relating to waivers for individuals with mental retardation or a related condition who are residents in an ICF/MR that has had its participation under the State's Medicaid plan terminated. This added provision allows a State, when making estimates under section 1915(c)(2)(D) of the Act, to determine the average per capita expenditures under a waiver that would have been made in a fiscal year for those individuals without regard to the termination and as if Medicaid institutional payment continued. Termination of an ICF/MR's participation under a State plan does not affect estimates made under section 1915(c)(2)(D).

Section 4742(c)(2) provides that this provision applies as if included in the enactment of OBRA '81, but only applies to facilities terminated on or after November 5, 1990, the enactment date of OBRA '90.

b. *Provisions of the final rule.* We are adding a new § 441.303(f)(7) to state that in making estimates for waivers that apply to persons with mental retardation or related conditions, States may include costs and utilization of Medicaid residents in ICFs/MR that have been terminated on or after November 5, 1990, when determining the average per capita expenditure that would have been made in a waiver year. We will consider timely comments submitted on this addition.

5. Adjustments in Estimates To Include Preadmission Screening Requirements

a. *Background.* Section 4742(e) of OBRA '90 provides that, under section 1915(c) of the Act, a State may adjust its waiver estimates, submitted under section 1915(c)(2)(D) of the Act, of average per capita expenditures for individuals with mental retardation or a related condition to include expenditures made on or after January 1, 1989, that result from the preadmission screening program required under section 1919(e)(7)(B) of the Act. The State may include increases in expenditures for, or utilization of, ICFs/MR resulting from its preadmission screening program for making determinations for individuals with mental retardation admitted to NFs on or after January 1, 1989.

b. *Provisions of the final rule.* We are adding a new section 441.303(f)(9) to incorporate the provisions of section 4742(e) of OBRA '90. We will consider timely comments submitted on this addition.

6. Treatment of Room and Board in Submitting Estimates of Expenditures for Personal Caregivers

a. *Background.* Section 1915(c)(1) of the Act provides for payment, as medical assistance, of part or all of the cost of home and community-based services under an approved waiver (other than room and board). Except for respite care furnished in a State-approved facility that is not a private residence, FFP is not available for room and board as part of a home and community-based service.

Section 4741(a)(1) of OBRA '90 amended section 1915(c)(1) to specify that, for purposes of this section of the Act, "the term 'room and board' shall not include an amount established under a method determined by the State to reflect the portion of costs of rent and food attributable to an unrelated personal caregiver who is residing in the same household with an individual who, but for the assistance of such caregiver, would require admission to a hospital, nursing facility, or intermediate care facility for the mentally retarded."

b. *Provisions of the final rule.* We are adding a new § 441.303(f)(8) to provide that, in submitting estimates for waivers that include personal caregivers as a waiver service, the State may include a portion of the rent and food attributed to the unrelated personal caregiver who resides in the waiver recipient's home or residence. The method of apportioning the costs of rent and food is determined by the State, subject to

review and approval by HCFA. The method used must be explained fully to receive HCFA's approval. A personal caregiver provides a waiver service to meet the recipient's physical, social, or emotional needs (as opposed to services not directly related to the care of the recipient; that is, housekeeping or chore services). FFP for live-in caregivers is not available if the recipient lives in the caregiver's home or in a residence that is owned or leased by the caregiver. We have interpreted language in the statute that rent and food costs attributable to the live-in caregiver may now be included in the State's estimates of cost-neutrality to include situations in which the live-in caregiver resides in the recipient's home and the recipient would incur additional costs for such a caregiver. When the recipient lives with the caregiver, the caregiver incurs the additional costs for the recipient. We believe the payment to the caregiver for the recipient's rent and food would violate the room and board exclusion under section 1915(c)(1) of the Act. We will consider timely comments on this addition.

H. Coordinated Services Between Maternal and Child Health Programs and Home and Community-Based Service Programs

1. Background

Section 9502(h) of COBRA added a new section 1915(c)(8) to the Act. This section allows the State agency that administers the Medicaid plan to make cooperative arrangements, whenever appropriate, with the State agency that administers the program for children with special health care needs under the Maternal and Child Health Program (Title V of the Act), to improve access to coordinated services to meet the children's needs. The amendment made by section 9502(h) was effective April 7, 1986.

In the proposed rule, we redesignated the existing § 441.306 as § 441.308 and added a new § 441.306 to incorporate the provisions of section 1915(c)(8) of the Act, as added by section 9502(h) of COBRA.

We did not receive any public comments on this provision.

2. Provisions of the Final Rule

We are adopting the proposed regulations, without modification, as final rules.

I. Limitation on Participants in Waiver Programs

1. Background

Section 9502(i) of COBRA added a new section 1915(c)(9) to the Act. This addition provides that when a waiver contains a limit on the number of individuals who can receive home and community-based services, the State may substitute additional individuals to replace any recipients who die or become ineligible for Medicaid services under the State plan. This provision was effective on April 7, 1986.

In the proposed rule, we redesignated existing § 441.305 as § 441.307 and added a new § 441.305 to provide that a State may substitute additional individuals to replace those under a home and community-based services waiver who die or become ineligible for waiver services, when the waiver contains a federally imposed limit on the number of individuals receiving waiver services, as specified in section 1915(c)(9) of the Act, as added by section 9502(i) of COBRA.

Section 4118(b) (entitled "Increase in Number of Individuals Who May Be Served Under Model Home and Community-Based Services Waiver) of OBRA '87 amended section 1915(c) of the Act by adding a new paragraph (10) that states that "No waiver under this subsection shall limit by an amount less than 200 the number of individuals in the State who may receive home and community-based services under such waiver." We interpreted this provision as restricting the Secretary's ability to limit the number of recipients a State could serve in a model waiver program. That is, the Secretary may not place a limit below 200 on the number of persons a State may serve. While the provision could, arguably, be read to limit the actual number of individuals who may receive model waiver services to no less than 200, based on the legislative history, and the history of the section 1915(c) program, we believe that this reading is unsupportable. First, model waiver programs have historically had a Federally established limit of 50 individuals who could receive services. Second, the limited size of the program is specifically noted in the OBRA '87 Conference Report (H. Rept. No. 495, 100th Cong., 1st Sess. 755 (1987)), in the section describing the current state of the law. Finally, section 4118 of MCCA is entitled "Increase in Number of Individuals Who May Be Served Under Model Home and Community-Based Services Waiver." On these bases, we believe that the Congress intended to enable States to serve a greater number of persons while maintaining the Secretary's authority to impose a limit on programs which she believes are of excessive size.

Section 411(k)(10)(A) of MCCA further amended section 1915(c)(10) of the Act in an attempt to clarify the language in section 4118(b) of OBRA '87, and confirmed our interpretation of the Congress' intent in enacting that provision. This amendment restricts the Secretary's power to limit the number of persons who can receive home and community-based waivers to no lower than 200. Again, in light of the history of the waiver program and the legislative history of this provision, we interpret this amendment to restrict the Secretary's power to limit the number of participants in the model waiver program only. Historically, there has been no limit on the number of participants in the regular home and community-based waiver programs, whereas there has been a 50-person Federally imposed limit on the number of persons who can participate in a model waiver. Also, section 411(k)(10)(A) was specifically enacted to remedy the ambiguity in section 4118(b), which itself was aimed only at model waivers. We believe, therefore, that this provision enables the Secretary to limit the number of participants in a model home and community-based program to 200 persons, or any amount above 200. Through these regulations, the Secretary has opted to impose a maximum limit of 200 persons for any State waiver program. On an individual State basis, an approved State plan may contain a maximum limit that is lower than 200. Thus, no State may serve any more than 200 persons, but any State may be limited to a lower number as approved in its waiver program. There is no comparable limit on regular waiver programs. Thus, the 200-person limit represents the maximum number of individuals that a State may serve under a "model" home and community-based services waiver at any one time.

A State may, in accordance with section 1915(c)(9) of the Act, replace individuals who die or lose Medicaid eligibility for State plan services. However, the State is still limited to serving no more than the number approved in its model waiver request, or 200 individuals, at any time.

Section 411(k)(10)(A) is effective as if included in the enactment of OBRA '87, that is, December 22, 1987. Thus, States may continue to serve less than 200 recipients under approved model waivers and renew these requests by any number of recipients up to the new 200-person limit. States with model waivers approved prior to December 21, 1987, may submit an amendment to obtain approval to serve clients in excess of those originally approved, up to the new 200-person limit.

We received the following comments on the proposed rule:

Comment: Two commenters recommended that States be allowed to substitute recipients in a home and community-based services waiver program under section 1915(c) of the Act, as is permitted under a model waiver program.

Response: The model waiver program derives its legal base from the same statutory authority as the section 1915(c) waiver program but administratively it has been limited in the total number of recipients that could be served. The original limit was 50 individuals. As we stated above, the amendment made by section 4118(b) of OBRA '87 increased the limit on model waivers to 200 individuals and the amendment made by section 9502(i) of COBRA authorized substitution for recipients who die or lose Medicaid eligibility. Although States may replace recipients, there is no authorization for exceeding (at any point in time) the 200-person limit on the model waiver request.

In contrast, HCFA has never prohibited the substitution of recipients under the section 1915(c) waiver program. In fact, we require that the utilization estimates submitted prior to approval must be based on unduplicated recipient counts, not "slots" or full-time equivalents. "Unduplicated" means that once a recipient is counted in a particular setting (in a NF, for example), that recipient cannot be recounted in that setting if readmitted during the reporting period (waiver year). This is the same reporting principle used in HCFA Forms 64 and 2082. State waiver utilization estimates must include an adjustment for Medicaid recipients who die, lose eligibility, or leave the program for any reason (institutionalization, for example). Therefore, substitutions are expected, and all persons replaced should already be incorporated into the waiver utilization estimates approved for each year of every waiver program. Because the unduplicated recipient count includes reasonable estimates of substitution and the statute requires reasonableness of estimates and cost-neutrality, we are requiring waiver amendments if the State expects to exceed its approved cost and utilization estimates, regardless of the reason for the change.

Comment: Two commenters stated that HCFA is narrowing the legislative intent by requiring institutional bed capacity to offset increases in waiver recipients, especially since section 9502(c)(2) of COBRA eliminated HCFA's proposed cap on total waiver costs as established under § 441.304(d)(1). The proposed cap was the product of the State's estimate of waiver participants times the estimated average per capita cost.

Response: We agree. The regulatory cap on total waiver costs has already been eliminated by legislative action (section 1915(c)(6) of the Act). Moreover, we believe the requirement that States establish that there would be sufficient institutional bed capacity for their waiver population in the event there was no waiver should be rescinded. While this requirement served a sound analytical purpose as part of the cost-neutrality test in the early days of the program, our experience over the last several years has shown it to be of diminishing value. The requirement placed an unreasonable burden on States by requiring them to project the estimated development of additional institutional capacity. That additional burden was never the requirement's intent and its development was contrary to the interests of the States and the Federal Government. Moreover, States have generally been successful in documenting additional bed capacity sufficient to allow the expansion of their waiver programs. Because the bed capacity test has become an unnecessary and nonproductive exercise, we are deleting this requirement. In lieu of this test, and in the absence of information to the contrary, we will accept a State's assurance that, absent the waiver, recipients in the waiver would receive the appropriate level of Medicaid funded institutional care. Also, because the elimination of the bed capacity test recognizes that data regarding program utilization will no longer be relevant to the waiver application process, we have simplified the waiver formula to eliminate those formula values that relate to utilization. Instead, the formula now deals exclusively with program costs, with and without the waiver. As noted above, we will continue to require States to submit estimates of the number of unduplicated waiver recipients it will serve in each year of the waiver term. This figure will be indicated as "C" value and may be revised as a State deems necessary.

2. Provisions of the Final Rule

We have adopted, as final, the revised § 441.303(f) and the proposed new § 441.305 that incorporated the provision of section 1915(c)(9) of the Act as added by section 9502(i) of COBRA, with one change: We have revised paragraph § 441.305(b) to specify that there is a 200-person limit (instead of 50) for model waivers under section 1915(c)(10) as amended by section 411(k)(10)(A) of MCCA. The revised § 441.303(f) reads, "An explanation with supporting documentation satisfactory to HCFA of how the agency estimated the average per capita expenditures for services." We will consider timely comments on these revisions.

We are also redesignating proposed § 441.302(g) as (h) and adding a new § 441.302(g) to require that a State provide assurance that, absent a waiver, recipients in the waiver would receive the appropriate type of Medicaid-funded institutional care (hospital, NF, or ICF/MR) that they require. We will consider timely comments on this addition.

J. Waiver Extensions and Renewals

1. Background

Initially, section 1915(c) of the Act provided that approved home and community-based services waivers could be granted for an initial term of 3 years and could be extended for additional 3-year periods if a State requests an extension. The Secretary could approve a request for a waiver extension if the extension request met the waiver requirements for the extended period and HCFA determined that the State met all of the required assurances for the term of the initial waiver.

Section 9502(f) of COBRA provided that the Secretary, upon a State's request, may extend any home and community-based services waiver that expired on or after September 30, 1985, and before September 30, 1986, subject to the State's meeting all requirements for the waiver. The extension granted must be for a period of not less than 1 year and no more than 5 years.

Section 9502(g) of COBRA amended section 1915(c)(3) of the Act to revise the periods of time for which a waiver may be renewed from additional 3-year periods to additional 5-year periods under section 9502(j)(6) of COBRA. This amendment is effective for waiver renewals approved on or after September 30, 1986.

In our proposed rule, we revised § 441.304(a) to change waiver extension or renewal periods to reflect the statutory requirements. We did not receive any public comments on this provision.

Section 4102(c) of OBRA '87 provided that the Secretary extend approval of a State's section 1915(c) waiver for the elderly on the same terms and conditions through September 30, 1988, when (1) the State as of December 1, 1987, had a waiver approved for elderly individuals under section 1915(c) of the Act; (2) the waiver was scheduled to

expire before July 1, 1988; and (3) the State notified the Secretary of its intention to file an application for a waiver under section 1915(d) of the Act.

2. Provisions of the Final Rule

We have adopted, as a final rule, the proposed § 441.304(a) to change the waiver extension and renewal periods to conform to section 1915(c)(3), as amended by section 9502(g) of COBRA. We have not included in the final rule changes to paragraph (a)(2) that were included in the proposed rule because those changes are no longer necessary.

K. Technical/Administrative Changes

1. Terminology Change

We have revised proposed § 440.185 and amended § 441.301 through § 441.304 and § 441.310 by changing references to "SNF" and "ICF" to "NF" to conform them to nomenclature changes made to section 1915(c) by section 4211(a)(3) of OBRA '87.

2. Independent Assessment

Although not specifically addressed in the proposed rule, a State agency asserted that our requirement in § 441.303(g) for an independent assessment of a State's waiver program that evaluates the quality of care, the access to care, and the cost effectiveness is costly and duplicates HCFA's regional office (RO) reviews.

Since the publication of this requirement (50 FR 10028, March 13, 1985), various State agencies have asserted that the requirement is costly, unproductive, and duplicative of RO assessments. We agree with the commenter and are making the independent assessment voluntary. If a State determines it will contract for an independent assessment, FFP is available for the costs attributable to the assessment. The results should be forwarded to HCFA by the 90th day prior to expiration of the approved waiver and cover at least the first 24 or 48 months of the waiver.

3. Provision of Final Rule

We are revising 441.303(g) to read as follows: "The agency, at it option, may provide for an independent assessment of its waiver that evaluates the quality of care provided, access to care, and the cost-neutrality. The results of the assessment should be submitted to HCFA at least 90 days prior to the expiration of the waiver and cover the first 24 or 48 months of the waiver. If a State chooses to provide for an independent assessment, FFP is available for the costs attributable to the independent assessment."

III. Respiratory Care Services

A. Background

Until the enactment of OBRA '86, the Medicaid statute did not permit payment for respiratory therapy services in a patient's home as a separate and distinct State plan service. Previously, such services could only be provided as a component of other State plan services or as a home and community-based service under a section 1915(c) waiver. For example, certain types of respiratory therapy services in the home were available when provided as a medically necessary component of covered home health nursing services. States also had the option of providing respiratory therapy services as an element of three other optional Medicaid benefits: medical or remedial care provided by a licensed practitioner, private duty nursing, and rehabilitative services. Thus, when respiratory care was available previously under the Medicaid State plan, it was provided as a part of a broader coverage authority. Because these authorities did not allow respiratory care services to be directed only to a specific population but required that such services be available to all recipients, very few States provided coverage for respiratory care services. Moreover, while respiratory care services could be provided to a specific population under a home and community-based services waiver, States' use of this waiver process to provide coverage was limited.

Section 9408(a) of OBRA '86 amended section 1902(e) of the Act to provide, under paragraph (9), that, at the option of the State, a State Medicaid plan may be amended to include respiratory care services as medical assistance for an individual who:

- Is medically dependent on a ventilator for life support at least 6 hours per day;
- Has been so dependent on ventilator support for at least 30 consecutive days as an inpatient (or the maximum number of days of inpatient care authorized under the State plan, if less than 30 days) as demonstrated by a continuous stay in one or more hospitals, NFs, or ICFs/MR;
- But for the availability of respiratory care services, would require respiratory care as an inpatient in a hospital, NF, or ICF/MR and would be eligible to have payment made for inpatient care under the State plan;
- Has adequate social support services to be cared for at home; and
- Wishes to be cared for at home.

Under this provision, respiratory care services are services provided on a part-time basis in the home of the individual by a respiratory therapist or other health care professional who is trained in respiratory therapy (as determined by the State). The services under this benefit may not be included within other items and services furnished to these individuals as medical assistance under the State Medicaid plan.

Section 9408(b) of OBRA '86 amended section 1902(a)(10) of the Act by adding item (IX) in the matter following section 1902(a)(10)(E), to provide that a State is not required to make respiratory care services (as defined in section 1902(e)(9)(C) of the Act) available, or available in the same amount, duration, and scope, to individuals who do not meet the criteria in section 1902(e)(9)(A) of the Act. However, if the State provides this benefit, it is required to make respiratory care services available in the same amount, duration, and scope to all Medicaid recipients who do meet the criteria in section 1902(e)(9)(A) of the Act.

Section 9408(c) of OBRA '86 includes respiratory care services under the definition of medical assistance in section 1905(a)(20) of the Act and makes technical conforming amendments to sections 1902(a)(10)(C)(iv) and 1902(j) of the Act.

In our proposed rule, we added—

- A new § 440.185 to allow a State the option to amend State Medicaid plan coverage of respiratory therapy services for ventilator-dependent individuals under the specific conditions of coverage that were enumerated by section 9408(a) of OBRA '86;
- A new § 440.250(o) to the list of exceptions to the comparability of service requirement. In following the statutory language in section 9408(a) of OBRA '86, we also indicated that respiratory care services for ventilator-dependent individuals are exempt from the general comparability requirement that services be provided in equal amount, duration, and scope to any eligible group under the State plan. We have, however, required comparability of services among those Medicaid-eligible persons under the State plan satisfying the explicit conditions of coverage for these services.

Six entities submitted comments concerning respiratory care services as a new optional Medicaid benefit.

Comment: One commenter asked whether respiratory care equipment, particularly ventilators, would be covered as equipment under the new benefit.

Response: Ventilators will not be covered under this benefit. Section 1902(e)(9) of the Act, as added by section 9408 of OBRA '86, provides for respiratory therapy services, not

equipment, to be provided to ventilator-dependent individuals as an optional service. The statute and accompanying conference committee report (H. Rept. No. 1012, 99th Cong., 2d Sess. 413–414 (1986)) do not suggest that equipment required in the home (such as ventilators, needed to sustain the recipient's health and welfare) would be included. Such equipment is supplied by the State as a home health benefit under § 440.70(b)(3), that mandates the provision of medical supplies, equipment, and appliances suitable for use in the home. In addition, States that pay for the optional prosthetic devices benefit may cover ventilators as a prosthetic device that supports a weak or deformed portion of the body under § 440.120(c)(3).

Comment: Another commenter asked us to define a recipient's home.

Response: A recipient's home is a place of residence other than a hospital, NF, ICF/MR, or other institution as defined at § 435.1009. We have revised § 440.185 to specify that a recipient's home does not include these facilities.

Comment: Two commenters suggested that more medical direction be required in decisions regarding the provision of respiratory therapy at home. One commenter proposed the use of medically sound criteria to determine eligibility and the other commenter recommended that more physician oversight and involvement in the direction of care be required.

Response: We agree with the commenters concerning the need for greater medical direction for individuals in need of respiratory care services. We have added § 440.185(a)(6) to require the direction of a physician who is familiar with the technical and medical components of home ventilator support and who has determined that in-home care is safe and feasible.

Comment: One commenter stated that the regulations implementing the option to provide respiratory care services are too restrictive and limited as a Medicaid State plan option because respiratory care services would be limited to individuals who (1) need at least 6 hours of ventilator support for life support, (2) depend on ventilator support for at least 30 consecutive days and (3) require respiratory care as an inpatient.

Response: Our proposed regulations closely followed the statutory language and the only restrictions we imposed were those contained in the statute. In response to comments, we are now adding the requirement that a recipient receive respiratory care services under the direction of a physician who is familiar with the technical and medical components of home ventilator support and who has determined that in-home care is safe and feasible.

Comment: One commenter was concerned that the payment rate for in-home respiratory therapy would not be adequate.

Response: Under the Medicaid program, the State establishes the payment rate within broad Federal guidelines. We believe it would be inappropriate to dictate a special payment procedure for this service.

Comment: One commenter requested that HCFA specifically refer to "respiratory therapy technician" as approved provider of respiratory care services to effectively recognize another level of skilled respiratory care practitioner.

Response: Section 9408(a) of OBRA '86 does not anticipate or require that we specify which practitioners or technicians are accepted by the States as providers. In the proposed rule (53 FR 19957 and 19960), we designated a broad and inclusive category "other health care professional trained in respiratory therapy (as determined by the State)" in the preamble and in § 440.185 of the regulation text. This "other" category could include the respiratory therapy technician as well as other types of skilled practitioners to the degree that they are recognized under State law.

B. Provisions of the Final Rule

We are adopting the proposed regulations under § 440.185 and § 440.250(o) as final rules with the following modifications:

- We have added § 440.185(a)(6) to require that (1) an individual who receives home respiratory care must receive these services under the care of a physician who is familiar with the technical and medical components of home ventilator support, and (2) that this physician must determine medically that in-home care is safe and feasible for the recipient.
- We have revised § 440.185(b) to specify the facilities that are not considered to be a recipient's home.

IV. Regulatory Impact Analysis

A. Introduction

Any impact of this final rule with comment period upon providers will be the result of individual State decisions as developed in waiver requests and including coverage of respiratory care for ventilator-dependent individuals. Due to the positive reception of the home and community-based waiver program, we believe that this rule will be well-received by those concerned with such programs. This rule generally benefits States and providers. The revisions to regulations covering home and community-based waivers offer broader service coverage than current rules and may result in new waiver applications and expansion of existing waivers. Thus, there may be more funds flowing through waivers. Because of the appeal of the program to States, the proportion of Medicaid expenditures flowing through home and community-based waivers is growing. The broader coverage made possible under this final rule with comment period is one factor that offers opportunity for further growth. Waivers would also be approved for longer periods, which may increase the aggregate magnitude of granted waivers.

Thus, although this final rule with comment period should contribute to the growth of expenditures under waivers, we are unable to isolate the effects of this final rule from other factors affecting the growth of waivers.

If this final rule with comment period results in a substantial increase in the growth of waivers, it could affect small entities. Most entities would benefit—contingent upon State decisions that cannot be predicted. Although the changes being implemented in this final rule will facilitate the approval of an increased volume of waivers, we do not expect the rule in itself to increase waivers to the extent that a demonstrable significant economic impact would result. With the exception of the revision to § 441.303(f)(1) that eliminates the bed capacity (also called the "cold bed test") factor from the annual average per capita expenditures estimate, regulations establishing terms or conditions of Federal grants, contracts, or financial assistance call for a different form of regulatory analysis than do other types of regulations. In some instances, an extensive benefit-cost analysis may be appropriate to inform the Congress and the President more fully about the desirability of the program, but this would not ordinarily be required in a regulatory impact analysis. The primary function of an RIA for this type of regulation should be to verify that the terms and conditions are the minimum necessary to achieve the purpose for which the funds were appropriated. Beyond controls to prevent abuse and to ensure that funds appropriated to achieve a specific purpose are channeled efficiently toward that end, maximum discretion should be allowed in the use of Federal funds particularly when the recipient is a State or local government.

B. Regulatory Flexibility Act

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 final rule does not have a significant economic impact on a substantial number of small entities. For purposes of the RFA, we consider all providers to be small entities. Thus, both those providers that lose patients deinstitutionalized into the home or community and the home and community-based providers of services that receive these patients/recipients are small entities. This final rule will also affect States and Medicaid recipients, but they are not considered small entities under the RFA.

C. Effect on Medicaid Program Costs

We anticipate that the discretionary provision to eliminate the bed capacity test may result in the following costs:

MEDICAID COSTS

[In millions rounded to the nearest $5 million]

Fiscal year	Federal costs	State costs
1994	$85	$65
1995	110	85
1996	135	100
1997	160	120
1998	190	145
1999	225	170

These cost increases are due to the expectation that more individuals will be eligible for home and community-based waiver services under Medicaid as a result of the elimination of the bed capacity test. However, it should be noted that the State costs reflected in the above chart may include costs that are currently being, or will be in the future, spent by States to provide medical assistance under programs other than Medicaid. Additionally, we believe that costs for waiver growth may be limited as a result of the fiscal capacities of the States.

Under section 1915(c)(2)(D) of the Act, the estimated average per capita expenditure under a home and community-based waiver may not exceed 100 percent of the estimated average per capita expenditure that the State reasonably estimates would have been made if the waiver had not been granted. All States have assured HCFA of this as a condition of waiver approval. Thus, under the law, this final rule is expected to be technically budget neutral with the exception of the costs associated with the elimination of the bed capacity test. However, section 9502 of COBRA and sections 9408 and 9411 of OBRA '86 have negligible costs associated with them overall. It is difficult to determine and may be impossible to assess precisely whether these changes would substantially affect the rate of growth in Medicaid expenditures.

We expect coverage of home respiratory care for ventilator-dependent individuals to have a similar impact. This new program also allows home care as an alternative to institutionalization. New programs may be added as alternatives to institutionalization as a result of this final rule with comment period.

We do not expect that the adoption of this final rule with comment period will result in a major increase in costs or prices for consumers, individual industries, or local government agencies in any geographic region. Employment in institutional care is more capital intensive; home and community services are more labor intensive. Increased costs or revenue losses may be experienced by providers (both their owners and employees) that formerly served institutionalized recipients. Although an institutional provider of services may be adversely affected by the existence of a waiver in its area, it may choose to provide services covered under a home and community-based waiver, and the adverse impact probably will be offset by increased business.

In conclusion, home and community-based waivers and respiratory care for ventilator-dependent individuals generally may result in services being furnished in different settings, often by different providers, with possibly some losses in revenue by some providers offset by increases to other providers. We do not consider this redistributive effect to be significant. We do expect recipients to benefit from a deinstitutionalized life and from the services that may be provided under these provisions.

D. Rural Hospital Impact Statement

Section 1102(b) of the Social Security Act (the Act) requires the Secretary to prepare a regulatory impact analysis for any final 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 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 a metropolitan statistical area. We have determined and the Secretary certifies that this final rule with comment period will not have a significant impact on the operations of a substantial number of small rural hospitals.

E. Executive Order 12866

In accordance with the provisions of Executive Order 12866, this notice was reviewed by the Office of Management and Budget.

V. Recordkeeping and Reporting Requirements

Sections 440.180, 441.301 and 441.303 of this final rule with comment period contain information collection requirements that are subject to Office of Management and Budget (OMB) approval under the Paperwork Reduction Act of 1980. The public is not required to comply with the information collection requirements until OMB approves these requirements under section 3507 of the Paperwork Reduction Act (44 U.S.C. 3507). A notice will be published in the Federal Register when approval is obtained.

List of Subjects

42 CFR Part 435

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

42 CFR Part 440

Grant programs-health, Medicaid.

42 CFR Part 441

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

42 CFR chapter IV, subchapter C is amended as set forth below:

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

A. Part 435 is amended as follows:

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. In § 435.726, the section heading is revised; the introductory text of paragraph (c) is republished; and paragraph (c)(1) is revised to read as follows:

§ 435.726 Post-eligibility treatment of income of individuals receiving home and community-based services furnished under a waiver: Application of patient income to the cost of care.

* * * * *

(c) In reducing its payment for home and community-based services, the agency must deduct the following

amounts, in the following order, from the individual's total income (including amounts disregarded in determining eligibility):

(1) An amount for the maintenance needs of the individual that the State may set at any level, as long as the following conditions are met:

(i) The deduction amount is based on a reasonable assessment of need.

(ii) The State establishes a maximum deduction amount that will not be exceeded for any individual under the waiver.

* * * * *

3. In § 435.735, the introductory text of paragraph (c) is republished; and paragraph (c)(1) is revised to read as follows:

§ 435.735 Post-eligibility treatment of income and resources of individuals receiving home and community-based services furnished under a waiver: Application of patient income to the cost of care.

* * * * *

(c) In reducing its payment for home and community-based services, the agency must deduct the following amounts, in the following order, from the individual's total income (including amounts disregarded in determining eligibility):

(1) An amount for the maintenance needs of the individual that the State may set at any level, as long as the following conditions are met:

(i) The deduction amount is based on a reasonable assessment of need.

(ii) The State establishes a maximum deduction amount that will not be exceeded for any individual under the waiver.

* * * * *

PART 440—SERVICES: GENERAL PROVISIONS

B. Part 440 is amended as follows:

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

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

2. Section 440.180 is revised to read as follows:

§ 440.180 Home or community-based services.

(a) *Description and requirements for services.* "Home or community-based services" means services, not otherwise furnished under the State's Medicaid plan, that are furnished under a waiver granted under the provisions of Part 441, subpart G of this chapter.

(1) These services may consist of any or all of the services listed in paragraph (b) of this section, as those services are defined by the agency and approved by HCFA.

(2) The services must meet the standards specified in § 441.302(a) of this chapter concerning health and welfare assurances.

(3) The services are subject to the limits on FFP described in § 441.310 of this chapter.

(b) *Included services.* Home or community-based services may include the following services, as they are defined by the agency and approved by HCFA:

(1) Case management services.

(2) Homemaker services.

(3) Home health aide services.

(4) Personal care services.

(5) Adult day health services.

(6) Habilitation services.

(7) Respite care services.

(8) Day treatment or other partial hospitalization services, psychosocial rehabilitation services and clinic services (whether or not furnished in a facility) for individuals with chronic mental illness, subject to the conditions specified in paragraph (d) of this section.

(9) Other services requested by the agency and approved by HCFA as cost effective and necessary to avoid institutionalization.

(c) *Expanded habilitation services, effective April 7, 1986*—(1) *General rule.* Expanded habilitation services are those services specified in paragraph (c)(2) of this section, that are provided to recipients who have been discharged from a Medicaid-certified NF or ICF/MR, regardless of when the discharge occurred.

(2) *Services included.* The agency may include as expanded habilitation services the following services:

(i) Prevocational services, which means services that prepare an individual for paid or unpaid employment and that are not job-task oriented but are, instead, aimed at a generalized result. These services may include, for example, teaching an individual such concepts as compliance, attendance, task completion, problem solving and safety. Prevocational services are distinguishable from noncovered vocational services by the following criteria:

(A) The services are provided to persons who are not expected to be able to join the general work force or participate in a transitional sheltered workshop within one year (excluding supported employment programs).

(B) If the recipients are compensated, they are compensated at less than 50 percent of the minimum wage;

(C) The services include activities which are not primarily directed at teaching specific job skills but at underlying habilitative goals (for example, attention span, motor skills); and

(D) The services are reflected in a plan of care directed to habilitative rather than explicit employment objectives.

(ii) Educational services, which means special education and related services (as defined in sections 602(16) and (17) of the Education of the Handicapped Act) (20 U.S.C. 1401 (16 and 17)) to the extent they are not prohibited under paragraph (c)(3)(i) of this section.

(iii) Supported employment services, which facilitate paid employment, that are—

(A) Provided to persons for whom competitive employment at or above the minimum wage is unlikely and who, because of their disabilities, need intensive ongoing support to perform in a work setting;

(B) Conducted in a variety of settings, particularly worksites in which persons without disabilities are employed; and

(C) Defined as any combination of special supervisory services, training, transportation, and adaptive equipment that the State demonstrates are essential for persons to engage in paid employment and that are not normally required for nondisabled persons engaged in competitive employment.

(3) *Services not included.* The following services may not be included as habilitation services:

(i) Special education and related services (as defined in sections 602(16) and (17) of the Education of the Handicapped Act) (20 U.S.C. 1401 (16) and (17)) that are otherwise available to the individual through a local educational agency.

(ii) Vocational rehabilitation services that are otherwise available to the individual through a program funded under section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

(d) *Services for the chronically mentally ill*—(1) *Services included.* Services listed in paragraph (b)(8) of this section include those provided to individuals who have been diagnosed as being chronically mentally ill, for which the agency has requested approval as part of either a new waiver request or a renewal and which have been approved by HCFA on or after October 21, 1986.

(2) *Services not included.* Any home and community-based service, including those indicated in paragraph (b)(8) of this section, may not be included in home and community-based service waivers for the following individuals:

(i) For individuals aged 22 through 64 who, absent the waiver, would be

institutionalized in an institution for mental diseases (IMD); and, therefore, subject to the limitation on IMDs specified in § 435.1008(a)(2) of this subchapter.

(ii) For individuals, not meeting the age requirements described in paragraph (d)(2)(i) of this section, who, absent the waiver, would be placed in an IMD in those States that have not opted to include the benefits defined in § 440.140 or § 440.160.

3. Section 440.185 is added to read as follows:

§ 440.185 Respiratory care for ventilator-dependent individuals.

(a) "Respiratory care for ventilator-dependent individuals" means services that are not otherwise available under the State's Medicaid plan, provided on a part-time basis in the recipient's home by a respiratory therapist or other health care professional trained in respiratory therapy (as determined by the State) to an individual who—

(1) Is medically dependent on a ventilator for life support at least 6 hours per day;

(2) Has been so dependent for at least 30 consecutive days (or the maximum number of days authorized under the State plan, whichever is less) as an inpatient in one or more hospitals, NFs, or ICFs/MR;

(3) Except for the availability of respiratory care services, would require respiratory care as an inpatient in a hospital, NF, or ICF/MR and would be eligible to have payment made for inpatient care under the State plan;

(4) Has adequate social support services to be cared for at home;

(5) Wishes to be cared for at home; and

(6) Receives services under the direction of a physician who is familiar with the technical and medical components of home ventilator support, and who has medically determined that in-home care is safe and feasible for the individual.

(b) For purposes of paragraphs (a)(4) and (5) of this section, a recipient's home does not include a hospital, NF, ICF/MR or other institution as defined in § 435.1009.

4. In § 440.250, a new paragraph (o) is added to read as follows:

§ 440.250 Limits on comparability of services.

* * * * *

(o) If the agency makes respiratory care services available under § 440.185, the services need not be made available in equal amount, duration, and scope to any individual not eligible for coverage under that section. However, the services must be made available in equal amount, duration, and scope to all individuals eligible for coverage under that section.

* * * * *

C. Part 441 is amended as follows:

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

1. The authority citation for Part 441 continues to read as follows:

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

2. In § 441.301, paragraph (a) is revised; the introductory text of paragraph (b) is revised; the introductory text of paragraph (b)(1) is republished; paragraph (b)(1)(ii) is revised; a new paragraph (b)(1)(iii) is added; and paragraph (b)(4) is revised to read as follows:

§ 441.301 Contents of request for a waiver.

(a) A request for a waiver under this section must consist of the following:

(1) The assurances required by § 441.302 and the supporting documentation required by § 441.303.

(2) When applicable, requests for waivers of the requirements of section 1902(a)(1), section 1902(a)(10)(B), or section 1902(a)(10)(C)(i)(III) of the Act, which concern respectively, statewide application of Medicaid, comparability of services, and income and resource rules applicable to individuals with spouses living in the community.

(3) A statement explaining whether the agency will refuse to offer home or community-based services to any recipient if the agency can reasonably expect that the cost of the services would exceed the cost of an equivalent level of care provided in—

(i) A hospital (as defined in § 440.10 of this chapter);

(ii) A NF (as defined in section 1919(a) of the Act); or

(iii) An ICF/MR (as defined in § 440.150 of this chapter), if applicable.

(b) If the agency furnishes home and community-based services, as defined in § 440.180 of this subchapter, under a waiver granted under this subpart, the waiver request must—

(1) Provide that the services are furnished—

* * * * *

(ii) Only to recipients who are not inpatients of a hospital, NF, or ICF/MR; and

(iii) Only to recipients who the agency determines would, in the absence of these services, require the Medicaid covered level of care provided in—

(A) A hospital (as defined in § 440.10 of this chapter);

(B) A NF (as defined in section 1919(a) of the Act); or

(C) An ICF/MR (as defined in § 440.150 of this chapter);

* * * * *

(4) Describe the services to be furnished so that each service is separately defined. Multiple services that are generally considered to be separate services may not be consolidated under a single definition. Commonly accepted terms must be used to describe the service and definitions may not be open ended in scope. HCFA will, however, allow combined service definitions (bundling) when this will permit more efficient delivery of services and not compromise either a recipient's access to or free choice of providers.

* * * * *

3. In § 441.302, the introductory paragraph is revised; paragraphs (c) and (e) are revised; paragraph (f) is redesignated as paragraph (h) and republished; and new paragraphs (f), (g), (i), and (j) are added to read as follows:

§ 441.302 State assurances.

Unless the Medicaid agency provides the following satisfactory assurances to HCFA, HCFA will not grant a waiver under this subpart and may terminate a waiver already granted:

* * * * *

(c) *Evaluation of need.*—Assurance that the agency will provide for the following:

(1) *Initial evaluation.*—An evaluation of the need for the level of care provided in a hospital, a NF, or an ICF/MR when there is a reasonable indication that a recipient might need the services in the near future (that is, a month or less) unless he or she receives home or community-based services. For purposes of this section, "evaluation" means a review of an individual recipient's condition to determine—

(i) If the recipient requires the level of care provided in a hospital as defined in § 440.40 of this subchapter, a NF as defined in section 1919(a) of the Act, or an ICF/MR as defined by § 440.150 of this subchapter; and

(ii) That the recipient, but for the provision of waiver services, would otherwise be institutionalized in such a facility.

(2) *Periodic reevaluations.*—Reevaluations, at least annually, of each recipient receiving home or community-based services to determine if the recipient continues to need the level of care provided and would, but for the provision of waiver services, otherwise be institutionalized in one of the following institutions:

(i) A hospital;
(ii) A NF; or
(iii) An ICF/MR.
* * * * *

(e) *Average per capita expenditures.*—Assurance that the average per capita fiscal year expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made in the fiscal year for the level of care provided in a hospital, NF, or ICF/MR under the State plan had the waiver not been granted.

(1) These expenditures must be reasonably estimated and documented by the agency.

(2) The estimate must be on an annual basis and must cover each year of the waiver period.

(f) *Actual total expenditures.*—Assurance that the agency's actual total expenditures for home and community-based and other Medicaid services under the waiver and its claim for FFP in expenditures for the services provided to recipients under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred by the State's Medicaid program for these individuals, absent the waiver, in—

(1) A hospital;
(2) A NF; or
(3) An ICF/MR.

(g) *Institutionalization absent waiver.*—Assurance that, absent the waiver, recipients in the waiver would receive the appropriate type of Medicaid-funded institutional care (hospital, NF, or ICF/MR) that they require.

(h) *Reporting.*—Assurance that annually, the agency will provide HCFA with information on the waiver's impact. That information must be consistent with a data collection plan designed by HCFA and must address the waiver's impact on—

(1) The type, amount, and cost of services provided under the State plan; and

(2) The health and welfare of recipients.

(i) *Habilitation services.*—Assurance that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver, are—

(1) Not otherwise available to the individual through a local educational agency under section 602 (16) and (17) of the Education of the Handicapped Act (20 U.S.C. 1401 (16 and 17)) or as services under section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730); and

(2) Furnished only to individuals who have been deinstitutionalized, regardless of discharge date from a Medicaid-certified NF or ICF/MR.

(3) Furnished as part of expanded habilitation services on or after April 7, 1986, if the State has requested and received HCFA's approval under a waiver or an amendment to a waiver.

(j) *Day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services for individuals with chronic mental illness.* Assurance that FFP will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are—

(1) Age 22 to 64;

(2) Age 65 and older and the State has not included the optional Medicaid benefit cited in § 440.140; or

(3) Age 21 and under and the State has not included the optional Medicaid benefit cited in § 440.160.

4. In § 441.303, the introductory paragraph is revised; the introductory text of paragraph (c) is republished; paragraph (c)(2) is revised; the introductory text of paragraph (f) is revised; paragraphs (f)(1) and (f)(2) are revised; (f)(3) is removed; paragraph (f)(4) is redesignated as paragraph (f)(3) and revised; new paragraphs (f)(4), (5), (6), (7), (8), (9), and (10) are added; paragraph (g) is revised; and new paragraphs (h) and (i) are added to read as follows:

§ 441.303 Supporting documentation required.

The agency must furnish HCFA with sufficient information to support the assurances required by § 441.302. Except as HCFA may otherwise specify for particular waivers, the information must consist of the following:
* * * * *

(c) A description of the agency's plan for the evaluation and reevaluation of recipients, including—
* * * * *

(2) A copy of the evaluation form to be used; and if it differs from the form used in placing recipients in hospitals, NFs, or ICFs/MR, a description of how and why it differs and an assurance that the outcome of the new evaluation form is reliable, valid, and fully comparable to the form used for hospital, NF, or ICF/MR placement;
* * * * *

(f) An explanation with supporting documentation satisfactory to HCFA of how the agency estimated the average per capita expenditures for services.

(1) The annual average per capita expenditure estimate of the cost of home and community-based and other Medicaid services under the waiver must not exceed the estimated annual average per capita expenditures of the cost of services in the absence of a waiver. The estimates are to be based on the following equation:
$D+D' \leq G+G'$.

The symbol "≤" means that the result of the left side of the equation must be less than or *equal* to the result of the right side of the equation.
D = the estimated annual average per capita Medicaid cost for home and community-based services for individuals in the waiver program.
D′ = the estimated annual average per capita Medicaid cost for all other services provided to individuals in the waiver program.
G = the estimated annual average per capita Medicaid cost for hospital, NF, or ICF/MR care that would be incurred for individuals served in the waiver, were the waiver not granted.
G′ = the estimated annual average per capita Medicaid costs for all services other than those included in factor G for individuals served in the waiver, were the waiver not granted.

(2) For purposes of the equation, the prime factors include the average per capita cost for all State plan services and expanded EPSDT services provided that are not accounted for in other formula values.

(3) In making estimates of average per capita expenditures for a waiver that applies only to individuals with a particular illness (for example, acquired immune deficiency syndrome) or condition (for example, chronic mental illness) who are inpatients in or who would require the level of care provided in hospitals as defined by § 440.10, NFs as defined in section 1919(a) of the Act, or ICFs/MR, the agency may determine the average per capita expenditures for these individuals absent the waiver without including expenditures for other individuals in the affected hospitals, NFs, or ICFs/MR.

(4) In making estimates of average per capita expenditures for a separate waiver program that applies only to individuals identified through the preadmission screening annual resident review (PASARR) process who are developmentally disabled, inpatients of a NF, and require the level of care provided in an ICF/MR as determined by the State on the basis of an evaluation under § 441.303(c), the agency may determine the average per capita expenditures that would have been made in a fiscal year for those

individuals based on the average per capita expenditures for inpatients in an ICF/MR. When submitting estimates of institutional costs without the waiver, the agency may use the average per capita costs of ICF/MR care even though the deinstitutionalized developmentally disabled were inpatients of NFs.

(5) For persons diverted rather than deinstitutionalized, the State's evaluation process required by § 441.303(c) must provide for a more detailed description of their evaluation and screening procedures for recipients to ensure that waiver services will be limited to persons who would otherwise receive the level of care provided in a hospital, NF, or ICF/MR, as applicable.

(6) The State must indicate the number of unduplicated beneficiaries to which it intends to provide waiver services in each year of its program. This number will constitute a limit on the size of the waiver program unless the State requests and the Secretary approves a greater number of waiver participants in a waiver amendment.

(7) In determining the average per capita expenditures that would have been made in a waiver year, for waiver estimates that apply to persons with mental retardation or related conditions, the agency may include costs of Medicaid residents in ICFs/MR that have been terminated on or after November 5, 1990.

(8) In submitting estimates for waivers that include personal caregivers as a waiver service, the agency may include a portion of the rent and food attributed to the unrelated personal caregiver who resides in the home or residence of the recipient covered under the waiver. The agency must submit to HCFA for review and approval the method it uses to apportion the costs of rent and food. The method must be explained fully to HCFA. A personal caregiver provides a waiver service to meet the recipient's physical, social, or emotional needs (as opposed to services not directly related to the care of the recipient; that is, housekeeping or chore services). FFP for live-in caregivers is not available if the recipient lives in the caregiver's home or in a residence that is owned or leased by the caregiver.

(9) In submitting estimates for waivers that apply to individuals with mental retardation or a related condition, the agency may adjust its estimate of average per capita expenditures to include increases in expenditures for ICF/MR care resulting from implementation of a PASARR program for making determinations for individuals with mental retardation or related conditions on or after January 1, 1989.

(10) For a State that has HCFA approval to bundle waiver services, the State must continue to compute separately the costs and utilization of the component services that make up the bundled service to support the final cost and utilization of the bundled service that will be used in the cost-neutrality formula.

(g) The State, at its option, may provide for an independent assessment of its waiver that evaluates the quality of care provided, access to care, and cost-neutrality. The results of the assessment should be submitted to HCFA at least 90 days prior to the expiration date of the approved waiver-period and cover the first 24 or 48 months of the waiver. If a State chooses to provide for an independent assessment, FFP is available for the costs attributable to the independent assessment.

(h) For States offering habilitation services that include prevocational, educational, or supported employment services, or a combination of these services, consistent with the provisions of § 440.180(c) of this chapter, an explanation of why these services are not available as special education and related services under sections 602 (16) and (17) of the Education of the Handicapped Act (20 U.S.C. 1401 (16, and 17)) or as services under section 110 of the Rehabilitation Act of 1973 (29 U.S.C. section 730);

(i) For States offering home and community-based services for individuals diagnosed as chronically mentally ill, an explanation of why these individuals would not be placed in an institution for mental diseases (IMD) absent the waiver, and the age group of these individuals.

5. In § 441.304, paragraphs (a), (b), and (d) are revised to read as follows:

§ 441.304 Duration of a waiver.

(a) The effective date for a new waiver of Medicaid requirements to provide home and community-based services approved under this subpart is established by HCFA prospectively on or after the date of approval and after consultation with the State agency. The initial approved waiver continues for a 3-year period from the effective date. If the agency requests it, the waiver may be extended for additional periods unless—

(1) HCFA's review of the prior waiver period shows that the assurances required by § 441.302 were not met; and

(2) HCFA is not satisfied with the assurances and documentation provided by the State in regard to the extension period.

(b) HCFA will determine whether a request for extension of an existing waiver is actually an extension request or a request for a new waiver. If a State submits an extension request that would add a new group to the existing group of recipients covered under the waiver (as defined under § 441.301(b)(6)), HCFA will consider it to be two requests: One as an extension request for the existing group, and the other as a new waiver request for the new group. Waivers may be extended for additional 5-year periods.

* * * * *

(d) If HCFA finds that an agency is not meeting one or more of the requirements for a waiver contained in this subpart, the agency is given a notice of HCFA's findings and an opportunity for a hearing to rebut the findings. If HCFA determines that the agency is not in compliance with this subpart after the notice and any hearing, HCFA may terminate the waiver. For example, a State submits to HCFA a waiver request for home and community-based services that includes an estimate of the expenditures that would be incurred if the services were provided to the covered individuals in a hospital, NF, or ICF/MR in the absence of the waiver. HCFA approves the waiver. At the end of the waiver year, the State submits to HCFA a report of its actual expenditures under the waiver. HCFA finds that the actual expenditures under the waiver exceed 100 percent of the State's approved estimate of expenditures for these individuals in a hospital, NF, or ICF/MR in the absence of the waiver. HCFA next requires the State to amend its estimates for subsequent waiver year(s). HCFA then compares the revised estimates with the State's actual experience to determine if the revised estimates are reasonable. HCFA may terminate the waiver if the revised estimates indicate that the waiver is not cost-neutral or that the revised estimates are unreasonable.

§ 441.305 [Redesignated as § 441.307]

6. Section 441.305 is redesignated as § 441.307.

7. A new § 441.305 is added to read as follows:

§ 441.305 Replacement of recipients in approved waiver programs.

(a) *Regular waivers.* A State's estimate of the number of individuals who may receive home and community-based services must include those who will replace recipients who leave the program for any reason. A State may replace recipients who leave the program due to death or loss of eligibility under the State plan without

regard to any federally-imposed limit on utilization, but must maintain a record of recipients replaced on this basis.

(b) *Model waivers.*

(1) The number of individuals who may receive home and community-based services under a model waiver may not exceed 200 recipients at any one time.

(2) The agency may replace any individuals who die or become ineligible for State plan services to maintain a count up to the number specified by the State and approved by HCFA within the 200-maximum limit.

§ 441.306 [Redesignated as § 441.308]

8. Section 441.306 is redesignated as § 441.308.

9. A new § 441.306 is added to read as follows:

§ 441.306 Cooperative arrangements with the Maternal and Child Health program.

Whenever appropriate, the State agency administering the plan under Medicaid may enter into cooperative arrangements with the State agency responsible for administering a program for children with special health care needs under the Maternal and Child Health program (Title V of the Act) in order to ensure improved access to coordinated services to meet the children's needs.

10. Section 441.310 is revised to read as follows:

§ 441.310 Limits on Federal financial participation (FFP).

(a) FFP for home and community-based services listed in § 440.180 of this chapter is not available in expenditures for the following:

(1) Services provided in a facility subject to the health and welfare requirements described in § 441.302(a) during any period in which the facility is found not to be in compliance with the applicable State standards described in that section.

(2) The cost of room and board except when provided as—

(i) Part of respite care services in a facility approved by the State that is not a private residence; or

(ii) For waivers that allow personal caregivers as providers of approved waiver services, a portion of the rent and food that may be reasonably attributed to the unrelated caregiver who resides in the same household with the waiver recipient. FFP for a live-in caregiver is not available if the recipient lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services (the caregiver). For purposes of this provision, "board" means 3 meals a day or any other full nutritional regimen and does not include meals provided as part of a program of adult day health services as long as the meals provided do not constitute a "full" nutritional regimen.

(3) Prevocational, educational, or supported employment services, or any combination of these services, as part of habilitation services that are—

(i) Provided prior to April 7, 1986;

(ii) Provided in approved waivers that include a definition of "habilitation services" but which have not included prevocational, educational and supported employment services in that definition;

(iii) Provided to recipients who were never institutionalized in a Medicaid certified NF or ICF/MR; or

(iv) Otherwise available to the recipient under either special education and related services as defined in section 602(16) and (17) of the Education of the Handicapped Act (20 U.S.C. 1401 (16) and (17)) or vocational rehabilitation services available to the individual through a program funded under section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

(4) For waiver applications and renewals approved on or after October 21, 1986, home and community-based services provided to individuals aged 22 through 64 diagnosed as chronically mentally ill who would be placed in an institution for mental diseases. FFP is also not available for such services provided to individuals aged 65 and over and 21 and under as an alternative to institutionalization in an IMD if the State does not include the appropriate optional Medicaid benefits specified at §§ 440.140 and 440.160 of this chapter in its State plan.

(b) FFP is available for expenditures for expanded habilitation services, as described in § 440.180, if the services are included under a waiver or waiver amendment approved by HCFA on or after April 7, 1986.

(Catalog of Federal Assistance Program No. 93.778, Medical Assistance Program)

Dated: May 11, 1994.

Bruce C. Vladeck,

Administrator, Health Care Financing Administration.

Dated: June 21, 1994.

Donna E. Shalala,

Secretary.

[FR Doc. 94–17816 Filed 7–22–94; 8:45 am]

BILLING CODE 4120–01–P

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 1

[FCC 94–181]

Document Specifications

AGENCY: Federal Communications Commission.

ACTION: Final rule.

SUMMARY: The Commission grants petitions for reconsideration of previous order amending the Commission's rules regarding document specifications. The rule is amended to eliminate the character per inch requirement for Commission filings. Instead, the amended rule requires that Commission filings must utilize type of at least 12-point in height, must be double spaced, and must be filed on A4 or 8.5 × 11 inch (21.6 cm. × 27.9 cm.) paper with the printed material not exceeding 6.5 × 9.5 inches (16.5 cm. × 24.1 cm.).

EFFECTIVE DATE: July 25, 1994.

FOR FURTHER INFORMATION CONTACT: S. Lee Martin, Office of General Counsel (202) 418–1758.

SUPPLEMENTARY INFORMATION: This is a summary of the Commission's memorandum opinion and order, adopted on July 7, 1994, and released on July 20, 1994. The full text of the memorandum opinion and order is available for inspection and copying during normal business hours in the FCC Reference Center (Room 239), 1919 M Street NW., Washington, D.C. The complete text may also be purchased from the Commission's copy contractor, International Transcription Service, Inc., Suite 140, 2100 M Street NW., Washington, DC 20037.

Summary of Memorandum Opinion and Order

1. By its order the Commission granted reconsideration of a previous order, Amendment of Section 1.49 of the Commission's Rules, 58 FR 63087 (Nov. 30, 1993), that was intended to ensure against the circumvention of the page limitations by the use of printing reduction processes. To achieve this goal more effectively, the Commission determined on reconsideration that it would eliminate the character per inch requirement, but that it would amend § 1.49(a) to specify with greater precision the acceptable format for Commission filings. These changes are designed to ensure that all parties filing a particular pleading have an equal opportunity to make a substantive presentation to the Commission without regard to whether they have access to

sophisticated word processing equipment.

2. Section 1.49(a) continues to require that all Commission filings be double spaced, but the rule is amended to specify a distance of at least 7/32 of an inch (0.158 cm.) between the lines. Although footnotes and quoted material may be single spaced, parties are cautioned against abusing the page limitations with filings that contain excessive single spaced material. The permissible paper size is unchanged but the rule is amended to specify that the margins must be set so that the printed material does not exceed 6.5 × 6.9 inches (16.5 × 24.1 cm.).

3. The Commission has adopted the suggestion that pleadings must utilize 12-point or larger type, but it has deleted the character per inch requirement. Such requirement was deemed unnecessary in light specifications as to point size, margins, and the minimum distance between each line of text.

4. The Commission also amended 47 CFR 1.50 to reflect that briefs should be typewritten or mechanically produced unless the Commission specifically requests printed briefs, and that typewritten or mechanically produced briefs must meet all the general format specifications that are set forth in section 1.49(a) of the rules.

List of Subjects for 47 CFR Part 1

Administrative practice and procedure, Pleadings, Briefs, and other papers.

Federal Communications Commission.

William F. Caton,

Acting Secretary.

Rule Changes

Part 1 of Chapter I of Title 47 of the Code of Federal Regulations is amended as follows:

PART 1—[AMENDED]

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

Authority: Secs. 4, 303, 48 Stat. 1066, 1082, as amended; 47 U.S.C. 154, 303; Implement, 5 U.S.C. 552 and 21 U.S.C. 853a, unless otherwise noted.

2. Section 1.49 is amended by revising paragraph (a) to read as follows:

§ 1.49 Specifications as to pleadings and documents.

(a) All pleadings and documents filed in any Commission proceeding shall be typewritten or prepared by mechanical processing methods, and shall be filed on A4 (21 cm. × 29.7 cm.) or on 8½ × 11 inch (21.6 cm. × 27.9 cm.) paper with the margins set so that the printed material does not exceed 6½ × 9½ inches (16.5 cm. × 24.1 cm.). The printed material may be in any typeface of at least 12-point (0.42333 cm. or 12/72") in height. The body of the text must be double spaced with a minimum distance of 7/32 of an inch (0.5556 cm.) between each line of text. Footnotes and long, indented quotations may be single spaced, but must be in type that is 12-point or larger in height, with at least 1/16 of an inch (0.158 cm.) between each line of text. Counsel are cautioned against employing extended single spaced passages or excessive footnotes to evade prescribed pleading lengths. If single-spaced passages or footnotes are used in this manner the pleading will, at the discretion of the Commission, either be rejected as unacceptable for filing or dismissed with leave to be refiled in proper form. Pleadings may be printed on both sides of the paper. Pleadings that use only one side of the paper shall be stapled, or otherwise bound, in the upper left-hand corner; those using both sides of the paper shall be stapled twice, or otherwise bound, along the left-hand margin so that it opens like a book. The foregoing shall not apply to printed briefs specifically requested by the Commission, official publications, charted or maps, original documents (or admissible copies thereof) offered as exhibits, specially prepared exhibits, or if otherwise specifically provided. All copies shall be clearly legible.

* * * * *

3. Section 1.50 is revised to read as follows:

§ 1.50 Specifications as to briefs.

The Commission's preference is for briefs that are typewritten or prepared by mechanical processing methods. Printed briefs will be accepted only if specifically requested by the Commission. Typewritten or mechanically produced briefs must conform to all of the specifications for pleadings and documents set forth in § 1.49.

[FR Doc. 94–17991 Filed 7–22–94; 8:45 am]

BILLING CODE 6712–01–M

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 301

[Docket No. 931235–4107; I.D. 071594H]

Pacific Halibut Fisheries

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Notice of inseason action.

SUMMARY: The Assistant Administrator for Fisheries, NOAA, on behalf of the International Pacific Halibut Commission (IPHC), publishes notice of this inseason action pursuant to IPHC regulations approved by the U.S. Government to govern the Pacific halibut fishery. This action is intended to enhance the conservation of Pacific halibut stocks in order to help sustain them at an adequate level in the northern Pacific Ocean and Bering Sea.

EFFECTIVE DATE: July 12, 1994, through October 31, 1994.

FOR FURTHER INFORMATION CONTACT: Steven Pennoyer, telephone 907–586–7221; Gary Smith, telephone 206–526–6140; or Donald McCaughran, telephone 206–634–1838.

SUPPLEMENTARY INFORMATION: The IPHC, under the Convention between the United States of America and Canada for the Preservation of the Halibut Fishery of the Northern Pacific Ocean and Bering Sea (signed at Ottawa, Ontario, on March 2, 1953), as amended by a Protocol Amending the Convention (signed at Washington, DC, on March 29, 1979), has issued this inseason action pursuant to IPHC regulations governing the Pacific halibut fishery. The regulations have been approved by the Secretary of State (59 FR 22522, May 2, 1994). On behalf of the IPHC, this inseason action is published in the **Federal Register** to provide additional notice of its effectiveness, and to inform persons subject to the inseason action of the restrictions and requirements established therein.

Inseason Action

1994 Halibut Landing Report No. 11, Area 2A to Reopen on July 19

The July 6 fishing period in Area 2A (Washington, Oregon, and California) resulted in a catch of 125,000 lb (56.7 mt), leaving nearly 54,000 lb (24.5 mt) yet to be caught from the 178,750 lb (81 mt) catch limit. Area 2A will reopen on July 19 for 10 hours from 8:00 a.m. to 6:00 p.m. local time. Fishing period limits as indicated in the following table will be in effect for this opening. Note that the fishing period limits for the three smallest vessel classes have all been set at the same level.