from a cost recovery settlement with responsible parties for the Site.

E. Five-Year Review

EPA finalized the first Five-Year Review for the A.L. Taylor Site in June 1992, in which groundwater, surface water, leachate, sediment and gas samples were collected. The review concluded that the remedy was still protective of the human health and environment.

F. State Concurrence to Delete A.L. Taylor Site

EPA, with concurrence of the Commonwealth of Kentucky, believes that the following criterion for deletion have been met: (1) EPA has implemented all appropriate response actions required; and (2) All appropriate response under CERCLA has been implemented. Consequently, EPA is proposing deletion of A.L. Taylor Site from the NPL. Documents supporting this action are available from the docket.

Dated: February 20, 1996.

Phyllis P. Harris,

Acting Regional Administrator, U.S. EPA Region 4.

[FR Doc. 96–5531 Filed 3–7–96; 8:45 am]

BILLING CODE 6560–50–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Part 440

[MB–071–P]

RIN 0938–AG36

Medicaid Program; Coverage of Personal Care Services

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

ACTION: Proposed rule.

SUMMARY: In accordance with the provisions of section 13601(a)(5) of the Omnibus Budget Reconciliation Act of 1993, which added section 1905(a)(24) to the Social Security Act, this proposed rule would specify the revised requirements for Medicaid coverage of personal care services furnished in a home or other location as an optional benefit, effective for services furnished on or after October 1, 1994. In particular, this proposed rule would specify that personal care services may be furnished in a home or other location by any individual who is qualified to do so. Additionally, we are proposing two minor changes to the Medicaid regulations concerning home health services.

DATES: Comments will be considered if we receive them at the appropriate address, as provided below, no later than 5 p.m. on May 7, 1996.

ADDRESSES: Mail written comments (one original and three copies) to the following address: Health Care Financing Administration, Department of Health and Human Services, Attention: MB–071–P, P.O. Box 7517–0517, Baltimore, MD 21207.

If you prefer, you may deliver your written comments (one original and three copies) to one of the following addresses: Room 309–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201, or Room No. C5–11–17, 7500 Security Boulevard, Baltimore, MD 21244–1850.

Because of staffing and resource limitations, we cannot accept comments by facsimile (FAX) transmission. In commenting, please refer to file code MB–071–P. Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a 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 p.m. (phone: (202) 690–7890).

FOR FURTHER INFORMATION CONTACT: Terese Klitenic (410) 786–5942.

SUPPLEMENTARY INFORMATION:

I. Background

Title XIX of the Social Security Act (the Act) authorizes grants to States for medical assistance (Medicaid) to certain individuals whose income and resources are insufficient to meet the cost of necessary medical care. The Medicaid program is jointly financed by the Federal and State governments and administered by the States. Within Federal rules, each State chooses eligible groups, types and ranges of services, payment levels for most services, and administrative and operating procedures. The nature and scope of a State's Medicaid program is described in the State plan that the State submits to HCFA for approval. The plan is amended whenever necessary to reflect changes in Federal or State law, changes in policy, or court decisions.

Under section 1902(a)(10) of the Act, States must provide certain basic services. Section 1905(a) of the Act defines the services States may provide as medical assistance. Personal care services historically have been permitted under the Secretary's discretionary authority under current section 1905(a)(25) of the Act until the enactment of legislation, described below. Currently, regulations concerning personal care services are located at 42 CFR 440.170(f).

II. Legislation Concerning Personal Care Services

Before the enactment of the legislation discussed below, a State had the option to elect to cover personal care services under its Medicaid State plan. Although not specifically mentioned in section 1905(a) of the Act, personal care services could be covered under section 1905(a)(22) of the Act (redesignated as section 1905(a)(25) of the Act on November 5, 1990), under which a State may furnish any additional services specified by the Secretary and recognized under State law. In § 440.170(f), the Secretary specified that personal care services may be covered.

Section 4721 of the Omnibus Budget Reconciliation Act of 1990 (OBRA '90) (Pub. L. 101–508, enacted on November 5, 1990) amended section 1905(a)(7) of the Act to include personal care services as part of the home health services benefit and to impose certain conditions on the provision of personal care services, effective for services furnished on or after October 1, 1994. This amendment would have had a significant effect since, under section 1902(a)(10)(D) of the Act, home health services are a mandatory benefit for all Medicaid recipients eligible for nursing facility services under the State plan. Thus, had section 1905(a)(7) of the Act not been further amended (as discussed below) before the effective date of section 4721 of OBRA '90, personal care services would have become a mandatory benefit for all recipients eligible for nursing facility services, effective October 1, 1994.

Before the provisions of OBRA '90 became effective, the Omnibus Budget Reconciliation Act of 1993 (OBRA '93) (Pub. L. 103–66) was enacted on August 10, 1993. Section 13601(a)(1) of OBRA '93 amended section 1905(a)(7) of the Act to remove personal care services from the definition of home health services. Additionally, section 13601(a)(5) of OBRA '93 added a new paragraph (24) to section 1905(a) of the Act, to include payment for personal care services under the definition of medical assistance. Under section 1905(a)(24) of the Act, personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease is an optional benefit for which States may provide medical assistance payments.

The statute specifies that personal care services must be: (1) Authorized for an individual by a physician in accordance with a plan of treatment or (at the option of the State) otherwise authorized for the individual in accordance with a service plan approved by the State; (2) provided by an individual who is qualified to provide such services and who is not a member of the individual's family; and (3) furnished in a home or other location. This amendment is effective October 1, 1994. Therefore, as a result of the legislative changes made by OBRA '93, personal care services continue to be an optional State plan benefit, and are now authorized under section 1905(a)(24) of the Act, effective for services furnished on or after October 1, 1994.

III. Provisions of the Proposed Regulations

A. Personal Care Services in a Home or Other Location (§ 440.167)

As historically used in the Medicaid program, personal care services means services related to a patient's physical requirements, such as assistance with eating, bathing, dressing, personal hygiene, activities of daily living, bladder and bowel requirements, and taking medications. These services primarily involve ''hands on'' assistance by a personal care attendant with a recipient's physical dependency needs (as opposed to purely housekeeping services). These tasks are similar to those that would normally be performed by a nurse's aide if the recipient were in a hospital or nursing facility. Although personal care services may be similar to or overlap some services furnished by home health aides, skilled services that may be performed only by a health professional are not considered personal care services. Alternatively, services that require a lower level of skill such as personal care services may also be provided by home health aides in the home under the home health benefit.

The above description of personal care services is based on the definition of personal care services originally set forth in Part 5, Section 140, of the Medical Assistance Manual (the precursor of the State Medicaid Manual) and reflects States' experiences in providing these services. We plan to publish a definition of personal care services in the State Medicaid Manual in the near future. Until that time, States should use the above description of personal care services as a guide in setting parameters for this optional benefit. To provide States with maximum flexibility in providing personal care services, we are providing guidelines for this benefit in a manual issuance, rather than codifying it in the regulations.

Currently, provisions regarding personal care services in a recipient's home are set forth at § 440.170. This section of the regulations defines the additional services that States may furnish as any other medical care or remedial care recognized under State law and specified by the Secretary. Under § 440.170(f), personal care services in a recipient's home means services prescribed by a physician in accordance with the recipient's plan of treatment, and furnished by an individual who is (1) qualified to provide the services, (2) supervised by a registered nurse, and (3) not a member of the recipient's family. The existing regulations do not provide for personal care services furnished in settings other than the recipient's home.

To conform the regulations to the provisions of section 1905(a)(24) of the Act (as added by section 13601(a)(5) of OBRA '93), we propose to add a new § 440.167, ''Personal care services in a home or other location.'' We would specify that personal care services are services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease, that are: (1) authorized for the individual by a physician in accordance with a plan of treatment or (at the option of the State) otherwise authorized for the individual in accordance with a service plan approved by the State; (2) provided by an individual who is qualified to provide such services and who is not a member of the individual's family; and (3) furnished in a home, and if the State chooses, in another location.

Since section 1905(a)(24) of the Act does not require that the services be supervised by a registered nurse, we would not require such supervision in proposed § 440.167. While section 13601(a)(1) of OBRA '93 eliminated the statutory requirement for supervision by a registered nurse, the versions of the bill passed by both the House and Senate (H.R. 2264) contained this requirement. The nurse supervision requirement was apparently dropped while the bill was in conference; however, the conference report does not specifically refer to this change (H. Conf. Rept. No. 2133, 103rd Cong., 1st sess., page 833, (1993)). We believe our proposal reflects statutory intent to eliminate the requirement for such supervision. Moreover, since extensive medical knowledge or technical skill is not required to provide personal care services, we believe that supervision by a registered nurse is not necessary in most cases. However, we are soliciting public comments concerning the need to retain the requirement that personal care services be provided under the supervision of a registered nurse or another supervisory individual, such as a medical social worker.

Under our proposal, States that elect to offer the personal care services benefit must cover personal care services provided in the home but may also choose to cover personal care services provided in other locations. We believe that this proposal is consistent with the intent of the statute to expand the possible settings where personal care services may be covered under the Medicaid program. We note that coverage of personal care services outside the home is not optional with respect to those individuals who require personal care services that are medically necessary to correct or ameliorate conditions discovered as a result of a screen performed under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program.

We also considered two other options for implementing the provision of OBRA '93 that allows States to cover personal care services furnished outside the home. One option was to require States that elect to offer the personal care services benefit to cover such services in both the home *and* other locations. However, section 1905(a)(24)(C) of the Act refers to services ''furnished in a home *or* other location,'' and we believe that this option would unnecessarily limit States' flexibility in implementing the personal care services benefit. Moreover, it could work against the best interests of recipients if States choose not to offer the personal care services benefit at all because of the expense involved in covering the services both inside and outside the home.

We also considered allowing States electing to offer this benefit to cover the services either in the home or in other locations. Since many States historically have covered these services when furnished in the recipient's home, we do not believe that it would be consistent with statutory intent to allow States to choose to cover personal care services only in locations other than the home. That is, States that have previously covered personal care services furnished in the home should not be allowed to eliminate this location and opt to cover the services only when provided outside of the home. Again, we believe that the purpose of section 1905(a)(24) of the Act is to add to the possible settings where

States may provide personal care services, not to decrease the amount of services currently being offered. Thus, we believe that our proposed policy is the most appropriate interpretation of the statute, is in the best interest of recipients, and gives States the discretion necessary to operate their programs in an efficient manner.

We propose to leave to the State's option the decision of whether personal care services are to be authorized by a physician in accordance with a plan of treatment, or otherwise authorized in accordance with a service plan approved by the State. Similarly, we would permit States to determine, through development of provider qualifications, which individuals are qualified to provide personal care services (other than family members). Again, we believe that these proposed provisions would allow States to maintain a high level of flexibility in providing and defining optional personal care services. We note that home health aides employed by home health agencies may sometimes provide personal care services. Home health aides that provide only personal care services under Medicaid need only meet the qualifications set forth at § 484.36(e) (and not the other qualifications for home health aide services).

Section 1905(a)(24)(B) of the Act specifies that, for Medicaid purposes, personal care services may not be furnished by a member of the individual's family. To date, we have not defined ''family member'' for purposes of the personal care services benefit. Thus, each State that offers this benefit makes its own determination as to who is considered a family member for purposes of personal care services. To provide for more clarity and consistency in this regard, we propose to define family members under new § 440.167(b) as spouses of recipients and parents (or step-parents) of minor recipients. This definition is essentially identical to the one that applies to personal care services provided under a home and community-based waiver (see section 4442.3.B.1. of the State Medicaid Manual). We believe that spouses and parents are inherently responsible for meeting the personal care needs of their family members, and, therefore, it would not be appropriate to allow Medicaid reimbursement for such services. States would continue to have the flexibility to expand upon the definition of family members at § 440.167. That is, States could further restrict which family members can qualify as providers by extending the definition to apply to family members other than spouses and parents.

We note that our proposed definition of family member would only apply for purposes of the personal care services benefit in § 440.167 and not for other Medicaid benefits that allow reimbursement for family members. Because we recognize that States have developed their own definitions of ''family members'' for purposes of the personal care services benefit, we welcome comments on our proposed definition.

Since personal care services are now an optional benefit under section 1905(a)(24) of the Act, we would remove current § 440.170(f), which provides for coverage of personal care services in a recipient's home as part of any other medical care or remedial care recognized under State law and specified by the Secretary.

B. Proposed Changes Concerning Home Health Services (§ 440.70)

We are proposing several changes to the regulations concerning home health services. Currently, § 440.70(a)(2) provides that home health services must be furnished to a recipient on his or her physician's orders as part of a written plan of care that the physician reviews every 60 days. Section 440.70(b) lists the services that constitute home health services and thus are subject to the plan of care requirements. Section 440.70(b)(3) specifies that these services include medical supplies, equipment, and appliances suitable for use in the home. We have found that in many cases, once a recipient's need for medical supplies, equipment, and appliances is indicated by a physician, that need is unlikely to change within 60 days. Thus, absent changes in a recipient's condition, we do not believe that a recipient's need for medical equipment necessitates routine inclusion in a plan of care reviewed every 60 days by a physician.

Modification of the plan of care and physician review requirements for medical equipment would decrease physicians' paperwork burden as well as the time and costs involved with these requirements. Accordingly, we would revise § 440.70(b)(3) to provide that physician review of a recipient's need for medical supplies, equipment, and appliances suitable for use in the home under the home health benefit would be required annually. We believe that the requirement for annual review of medical supplies and equipment would allow States flexibility in furnishing home health services while providing an appropriate level of oversight. Frequency of further review of a recipient's continuing need for the equipment on other than an annual basis would be determined on a case-by-case basis depending on the nature of the item prescribed. A recipient's need for supplies or pieces of equipment that generally tend to be used on a long-term basis would not be reviewed as frequently as equipment that is usually used only temporarily. For example, review of the need for a wheelchair need not be as frequent as review of the need for an oxygen concentrator. In all cases, a physician's order for the equipment would be required initially.

Additionally, § 440.70(d) now defines a home health agency for purposes of Medicaid reimbursement as a public or private agency or organization, or part of an agency or organization, that meets requirements for participation in Medicare. We propose to revise this definition to indicate that in order to participate in Medicaid, the agency must meet Medicare requirements for participation as well as any additional standards the State may wish to apply that are not in conflict with Federal requirements. This proposed change reflects the long standing principle in the Medicaid program that affords States flexibility in establishing Medicaid program requirements tailored to their own specific needs. Under this proposal a State would have the option of imposing additional standards on home health agencies for participation in Medicaid beyond the Medicare conditions of participation.

Finally, we are making a technical change to § 440.70(c) to remove an obsolete reference to subparts F and G of part 442.

IV. Impact Statement

A. Background

For proposed rules such as this, we generally prepare a regulatory flexibility analysis that is consistent with the Regulatory Flexibility Act (RFA) (5 U.S.C. 601 through 612), unless we certify that a proposed rule will not have a significant economic impact on a substantial number of small entities. For purposes of a RFA, States and individuals are not considered small entities. However, providers are considered small entities.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis for any proposed rule that may have a significant impact on the operation 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 that is located outside of a Metropolitan

Statistical Area and has fewer than 50 beds.

We are not preparing a rural impact statement since we have determined, and we certify, that this proposed rule would not have a significant impact on the operations of a substantial number of small rural hospitals.

In accordance with the provisions of section 1905(a)(24) of the Act, this proposed regulation would revise the regulations to incorporate the new statutory requirements concerning personal care services. In accordance with the statute, we are proposing that the services must be: (1) Authorized for the individual by a physician in accordance with a plan of treatment or (at the option of the State) otherwise authorized for the individual in accordance with a service plan approved by the State; (2) provided by an individual who is qualified to provide such services and who is not a member of the individual's family; and (3) furnished in a home or other location.

In general, the provisions of this proposed rule are prescribed by section 1905(a)(24) of the Act, as added by section 13601(a)(5) of OBRA '93. The most significant change required under the statute is that, as of October 1, 1994, the settings in which States may elect to cover personal care services have been expanded to include locations outside the home. We believe that this statutory provision will increase Medicaid program expenditures independently of the promulgation of this rule. The primary discretionary aspect of this rule is our proposal that States electing to offer the personal care services benefit must cover the services in the home and may choose to cover them in any other location. As discussed in section III.A of this preamble, we considered requiring States that elect to offer the personal care services benefit to cover such services in both the home and other locations. We also considered allowing States to cover the services either in the home or in other locations. However, we believe that our proposed policy is the most appropriate interpretation of the statute and gives States the discretion necessary to operate their programs in an efficient manner and in the best interest of their recipients.

As noted above, the major provisions of this proposed rule are required by the statute. Thus, costs associated with these proposed regulations are the result of legislation. However, to the extent that a legislative provision being implemented through rulemaking may have a significant effect on recipients or providers or may be viewed as controversial, we believe that we should address any potential concerns. In this instance, we believe it is desirable to inform the public of our estimate of the substantial budgetary effect of these statutory changes. The statutorily driven costs have been included in the Medicaid budget baseline. In addition, we anticipate that a large number of Medicaid recipients and providers, particularly home health agencies, will be affected. Thus, the expansion of settings where personal care services may be furnished represents an expansion of Medicaid benefits that, if exercised by States, would likely have significant effects, particularly on Medicaid recipients.

B. Impact of New Personal Care Services Provision

1. Overview

This analysis addresses a wide range of costs and benefits of this rule. Whenever possible, we express impact quantitatively. In cases where quantitative approaches are not feasible, we present our best examination of determinable costs, benefits and associated issues.

It is difficult to predict the economic impact of expanding the settings where personal care services may be covered under Medicaid to locations outside the home. We do not know the exact number and type of personal care services furnished by individual States or how much these services currently cost. Currently, approximately 32 States offer coverage for personal care services, and we do not have cost data from all of those States. States also differ in their definitions of personal care services and rules concerning who may furnish them. Since we do not have a full picture of the scope or cost of the different services, it is difficult for us to quantify the impact these changes will have. Other unknown factors regarding the future provision of personal care services include which States now offering the personal care services benefit will choose to cover services furnished outside the home, how many additional States will opt to offer coverage, how many Medicaid recipients will elect to utilize these services in States in which the services have not been covered, and the type and costs of these specific services. We believe that the majority of those individuals who qualify for these services will elect to utilize this benefit. Thus, although costs to States will rise as they begin to pay for the additional services, there would be substantial benefits to some providers and to Medicaid recipients as described in detail below.

2. Effects Upon Medicaid Recipients

Permitting States that elect to offer the personal care services benefit the option of covering these services in locations outside the home will have a positive effect on recipients. In States where coverage has been provided only for personal care services in the home, this proposed rule may expand the types of personal care services available and/or the settings where recipients may receive these services. Expansion of personal care services or settings could help improve the quality of life for these recipients as well as for recipients who have not been receiving personal care services. It also would save money for some Medicaid recipients or their families since they would no longer have to pay for these services. No data are available on the number of recipients or family members who are currently paying for these services. However, since only 32 States currently pay for personal care services, we believe that a substantial number of recipients who receive these services are paying for them out of pocket.

3. Effects on Providers

By expanding the range of settings in which Medicaid will cover personal care services, we anticipate that this proposed rule will increase the demand for such services. We believe this effect will be viewed as beneficial to providers of personal care services. If the increase in demand for such services is sufficient, the number of providers of personal care services may increase.

4. Effects on Medicaid Program Expenditures

This proposed rule would implement the provisions of section 1905(a)(24) of the Act by specifying that personal care services are an optional State plan benefit under the Medicaid program. The proposed rule would allow States the option to cover personal care services furnished in a home or other location, effective for services furnished on or after October 1, 1994. Table 1 below provides an estimate of the anticipated additional Medicaid program expenditures associated with furnishing these services outside the home, beginning on October 1, 1994. This estimate was made using various assumptions about increases in utilization by current recipients, adjusted for age, as well as assumptions about the induced utilization that would result from the availability of these services. We have assumed a utilization increase of 5 percent for the aged and 10 percent for the non-aged, and an overall induction factor of 10 percent. We have

also assumed that the option of providing personal care services outside the home would affect only those States that represent 33 percent of Medicaid personal care spending. Given these assumptions, our estimate based on Federal budget projections is shown in Table 1, which also provides a breakdown of these costs. The first row of figures shows the costs of providing this optional State plan benefit. The second row shows the administrative costs associated with furnishing these services. We estimate the following costs to the Medicaid program:

TABLE 1.—PERSONAL CARE SERVICES OUTSIDE THE HOME

	Federal medicaid cost estimate (in millions)*			
	FY 1996	FY 1997	FY 1998	FY 1999
Services	$230	$280	$350	$430
Administration costs	10	10	15	15
Total	$240	$290	$365	$445

*Figures are rounded to the nearest $5 million. We note that the costs associated with these proposed regulations are the result of legislation and due to the interpretation of statutory changes already in effect. Therefore, these costs have been included in the Medicaid budget estimates.

5. Effects on States

As stated above, the coverage of personal care services is optional except when such services are medically necessary to correct or ameliorate medical problems found as a result of a screen under the EPSDT program. Many States currently do not cover optional personal care services. In those States that do offer the personal care services benefit, services furnished outside the home previously could not be covered. Therefore, there may be a substantial economic impact on States that decide to provide coverage for personal care services furnished outside the home. The varying State definitions of personal care services, and rules concerning who may furnish them, make it difficult to estimate accurately the potential increases in expenditures for those States that choose to expand coverage of personal care services to include services furnished outside the home. However, Table 2, which is based upon the same data and assumptions used to formulate the Federal expenditures shown in Table 1, estimates the cost to States.

TABLE 2.—PERSONAL CARE SERVICES OUTSIDE THE HOME

	State cost estimate (in millions)*			
	FY 1996	FY 1997	FY 1998	FY 1999
Services	$175	$210	$265	$325
Administration costs	5	10	10	10
Total	180	220	275	335

*Figures are rounded to the nearest $5 million.

C. Conclusion

The provisions of this proposed rule are required by section 1905(a)(24) of the Act. We believe that the provisions of this rule adding personal care services as an optional State plan benefit and expanding the possible settings for covering personal care services to locations outside the home will benefit providers, recipients and their families.

As shown above in Tables 1 and 2, the costs to the Federal government and States associated with paying for personal care services furnished outside the home are substantial. There may be some minor off setting of costs if the number of admissions to nursing facilities decreases as a result of these provisions, but we have no data to determine the potential savings, if any. Regardless of any possible savings, the economic impact of these provisions is attributable to the statutory changes mandated by OBRA '93.

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

V. Collection of Information Requirements

This document does not impose information collection and recordkeeping requirements. Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995.

VI. Response to Comments

Because of the large number of items of correspondence we normally receive on a proposed rule, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, if we proceed with a final rule, we will respond to the comments in the preamble to that document.

List of Subjects in 42 CFR Part 440

Grant programs-health, Medicaid.

42 CFR part 440 is proposed to be amended as set forth below:

PART 440—SERVICES: GENERAL PROVISIONS

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

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

Subpart A—Definitions

2. In § 440.70, the introductory text of paragraph (a) and the first sentence of the introductory text of paragraph (b) are republished and paragraphs (a)(2), (b)(3), (c) and (d) are revised to read as follows:

§ 440.70 Home health services.

(a) ''Home health services'' means the services in paragraph (b) of this section that are provided to a recipient—

* * * * *

(2) On his or her physician's orders as part of a written plan of care that the physician reviews every 60 days, except

as specified in paragraphs (b)(3) (i) and (ii) of this section.

(b) Home health services include the following services and items. * * *

* * * * *

(3) Medical supplies, equipment, and appliances suitable for use in the home.

(i) A recipient's need for medical supplies, equipment, and appliances must be reviewed by a physician annually.

(ii) Frequency of further physician review of a recipient's continuing need for the items is determined on a case-by-case basis, based on the nature of the item prescribed;

* * * * *

(c) A recipient's place of residence, for home health services, does not include a hospital, nursing facility, or intermediate care facility for persons with mental retardation.

(d) ''Home health agency'' means a public or private agency or organization, or part of an agency or organization that meets requirements for participation in Medicare and any additional standards legally promulgated by the State that are not in conflict with Federal requirements.

* * * * *

3. A new § 440.167 is added to read as follows:

§ 440.167 Personal care services

(a) *Personal care services* means services that are furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for persons with mental retardation, or institution for mental disease that are—

(1) Authorized for the individual by a physician in accordance with a plan of treatment or (at the option of the State) otherwise authorized for the individual in accordance with a service plan approved by the State;

(2) Provided by an individual who is qualified to provide such services and who is not a member of the individual's family; and

(3) Furnished in a home, and at the State's option, in another location.

(b) For purposes of this section, *family member* means a parent (or step parent) of a minor recipient or a recipient's spouse.

4. In § 440.170, paragraph (f) is removed and reserved.

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

Dated: October 6, 1995.

Bruce C. Vladeck,

Administrator, Health Care Financing Administration.

[FR Doc. 96–5511 Filed 3–7–96; 8:45 am]

BILLING CODE 4120–01–P

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 73

Radio Broadcasting Services; Esperanza, PR, Christiansted, VI

AGENCY: Federal Communications Commission.

ACTION: Proposed rule; dismissal of petition.

SUMMARY: The Commission denies the petition for reconsideration filed by Esperanza Broadcasters which requests the allotment of Channel 258B to Esperanza, Puerto Rico, as the community's first local aural broadcast service. To accommodate the allotment at Esperanza, petitioner also requests the substitution of Channel 293B for Channel 258B at Christiansted, Virgin Islands, and the modification of Station WVIQ(FM)'s license accordingly. The Commission found that the petition was prematurely filed since it is contingent upon the outcome of the on-going proceeding in MM Docket 91–259 and that the petitioner failed to comply with the provisions of Section 1.401(d) which require that a copy of the petition be served on all affected licensees, in this case, the licensee of Station WVIQ(FM).

FOR FURTHER INFORMATION CONTACT: Leslie K. Shapiro, Mass Media Bureau, (202) 418–2180.

SUPPLEMENTARY INFORMATION: This is a synopsis of the Commission's *Memorandum Opinion and Order,* adopted February 20, 1996, and released March 4, 1996. The full text of this Commission decision is available for inspection and copying during normal business hours in the FCC Reference Center (Room 239), 1919 M Street, NW., Washington, DC. The complete text of this decision may also be purchased from the Commission's copy contractor, International Transcription Services, Inc., (202) 857–3800, 2100 M Street, NW., Suite 140, Washington, DC 20037.

Federal Communications Commission.

Douglas W. Webbink,

Chief, Policy and Rules Division, Mass Media Bureau.

[FR Doc. 96–5436 Filed 3–8–96; 8:45 am]

BILLING CODE 6712–01–F

47 CFR Part 73

[MM Docket No. 96–27; RM–8750]

Radio Broadcasting Services; Pullman, WA

AGENCY: Federal Communications Commission.

ACTION: Proposed rule.

SUMMARY: The Commission requests comments on a petition filed by Keith E. Lamonica proposing the allotment of Channel 249A at Pullman, Washington, as the community's third local commercial FM transmission service. Channel 249A can be allotted to Pullman in compliance with the Commission's minimum distance separation requirements with a site restriction of 8. 8 kilometers(5.5 miles) east to avoid a short-spacing to the construction permit site for Station WLKY(FM),Channel 250C1, Milton-Freewater, Oregon. The coordinates for Channel 249A at Pullman are North Latitude 46–44–37 and West Longitude 117–03–34. Since Pullman is located within 320 kilometers (200 miles) of the U.S.-Canadian border, concurrence of the Canadian government has been requested.

DATES: Comments must be filed on or before April 25, 1996 and reply comments on or before May 10, 1996.

ADDRESSES: Federal Communications Commission, Washington, DC 20554. In addition to filing comments with the FCC, interested parties should serve the petitioner, or its counsel or consultant, as follows: Keith E. Lamonica, 760 SE. Carolstar, Pullman, Washington 99163 (Petitioner).

FOR FURTHER INFORMATION CONTACT: Sharon P. McDonald, Mass Media Bureau, (202) 418–2180.

SUPPLEMENTARY INFORMATION: This is a synopsis of the Commission's *Notice of Proposed Rule Making,* MM Docket No. 96–27, adopted February 20, 1996, and released March 4, 1996. The full text of this Commission decision is available for inspection and copying during normal business hours in the FCC Reference Center (Room 239), 1919 M Street, NW., Washington, DC. The complete text of this decision may also be purchased from the Commission's copy contractor, International Transcription Service, Inc., (202) 857–3800, 2100 M Street, NW., Suite 140, Washington, DC 20037.

Provisions of the Regulatory Flexibility Act of 1980 do not apply to this proceeding.

Members of the public should note that from the time a Notice of Proposed Rule Making is issued until the matter