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Friday
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Contents

Federal Register

Vol. 64, No. 146

Friday, July 30, 1999

Agriculture Department
See Animal and Plant Health Inspection Service
See Federal Crop Insurance Corporation
See Natural Resources Conservation Service

Alcohol, Tobacco and Firearms Bureau
NOTICES
Explosives detection canines; odor recognition proficiency standard, 41487

Animal and Plant Health Inspection Service
RULES
Exportation and importation of animals and animal products:
Ports of entry—
New Jersey and New York; ports designated for exportation of horses, 41266
Interstate transportation of animals and animal products (quarantine):
Texas (splenetic) fever in cattle; incorporation by reference, 41265–41266

Blind or Severely Disabled, Committee for Purchase From People Who Are
See Committee for Purchase From People Who Are Blind or Severely Disabled

Centers for Disease Control and Prevention
NOTICES
Inventions, Government-owned; availability for licensing, 41432
Meetings:
Diabetes Prevention and Control Programs Translation Advisory Committee, 41433
Vessel sanitation program:
Cruise ship inspections; fees, 41433–41434

Children and Families Administration
NOTICES
Grants and cooperative agreements; availability, etc.:
Low Income Home Energy Assistance Program; 1998 FY funds reallotment, 41435
Meetings:
Medical Child Support Working Group, 41434–41435

Commerce Department
See Foreign-Trade Zones Board
See International Trade Administration
See Minority Business Development Agency
See National Oceanic and Atmospheric Administration
See Patent and Trademark Office

Committee for Purchase From People Who Are Blind or Severely Disabled
NOTICES
Procurement list; additions and deletions, 41373–41374
Correction, 41374

Committee for the Implementation of Textile Agreements
NOTICES
Textile and apparel categories:
Illegal transshipment; entry denial, 41395
Macau; list of companies denied entry of products for illegal transshipment, 41395–41396

Commodity Futures Trading Commission
NOTICES
Contract market proposals:
Dual trading prohibition; exemption petitions—
New York Mercantile Exchange, 41396–41397

Consumer Product Safety Commission
NOTICES
Agency information collection activities:
Submission for OMB review; comment request, 41397–41398

Copyright Office, Library of Congress
RULES
Copyright office and procedures:
Digital phonorecord deliveries; notice and recordkeeping requirements, 41286–41289
NOTICES
Cable royalty funds:
Secondary transmission by cable systems (1997); Phase I or Phase II controversy ascertainment; comment request, 41473

Defense Department
See Defense Logistics Agency
See Navy Department
NOTICES
Agency information collection activities:
Proposed collection; comment request, 41398–41399
Meetings:
Kosovo C31SR Operations and Lessons Learned Task Force, 41399

Defense Logistics Agency
NOTICES
Privacy Act:
Systems of records, 41399–41401

Education Department
PROPOSED RULES
Postsecondary education:
Student assistance general provisions, 41751–41763
NOTICES
Agency information collection activities:
Proposed collection; comment request, 41403–41404
Grants and cooperative agreements; availability, etc.:
Postsecondary education—
Federal Pell Grant Program, 41703–41708
Postsecondary education:
William D. Ford Federal Direct Student Loan Program; correction, 41404

Employment and Training Administration
NOTICES
Adjustment assistance:
Acordis Cellulosic Fibers, Inc., 41466
Cliff's Drilling, 41466
Cobre Mining Co., 41467
F.W.A.-J.S.M. Drilling Co., 41467

Fairfield Industries Inc., 41467
Fort James Corp., 41467
Inspector's Corp. et al., 41467–41468
International Mill Service, 41468
Johnson & Johnson Medical, Inc., 41468–41469
Martin Marietta Magnesia Specialties Inc., 41469
Morris Button Co., 41469
O.S. Kelly Co., 41469
Perfection Pad Co., Inc., 41470
Trans Texas Corp., 41470
Watlow Controls, 41470
Whisper Knits, Inc./Jahmpasa USA, Inc., 41470
Agency information collection activities:
Proposed collection; comment request, 41470–41471
NAFTA transitional adjustment assistance:
Bend Wood Products, Inc., 41465
Jahmpasa USA, Inc., 41471
Johnson & Johnson Medical, Inc., 41465–41466
Seagull Energy Corp., 41466
Whisper Knits, Inc./Jahmpasa USA, Inc., 41466

Employment Standards Administration
NOTICES
Minimum wages for Federal and federally-assisted construction; general wage determination decisions, 41471–41473

Energy Department
See Energy Information Administration
See Federal Energy Regulatory Commission
NOTICES
Environmental statements; availability, etc.:
Argonne National Laboratory-West, ID, et al.; sodium-bonded spent nuclear fuel treatment and management, 41404–41405

Energy Information Administration
NOTICES
Agency information collection activities:
Submission for OMB review; comment request, 41405–41406

Environmental Protection Agency
RULES
Air programs; approval and promulgation; State plans for designated facilities and pollutants:
Washington, 41291–41294
Pesticides; tolerances in food, animal feeds, and raw agricultural commodities:
Diuron, 41297–41305
Propiconazole, 41294–41297
PROPOSED RULES
Air programs; approval and promulgation; State plans for designated facilities and pollutants:
Washington, 41364–41365
NOTICES
Agency information collection activities:
Submission for OMB review; comment request, 41415–41417
Air pollution control; new motor vehicles and engines:
Urban buses (1993 and earlier model years); retrofit/rebuild requirements; equipment certification—
Engelhard Corp., 41417–41419
Committees; establishment, renewal, termination, etc.:
Environmental Laboratory Advisory Board, 41420
Environmental statements; availability, etc.:
Agency statements—
Comment availability, 41420–41421
Weekly receipts, 41420
Meetings:
Methyl parathion; revised organophosphate pesticide risk assessment, 41423–41425
Toxic and hazardous substances control:
Lead-based paint activities in target housing and child-occupied facilities; State and Indian Tribe authorization applications—
Rhode Island and New Hampshire, 41421–41423

Federal Aviation Administration
RULES
Airworthiness directives:
Pratt & Whitney, 41273–41274
IFR altitudes, 41274–41281
Standard instrument approach procedures, 41281–41286
PROPOSED RULES
Class E airspace, 41360–41364
NOTICES
Agency information collection activities:
Proposed collection; comment request, 41482–41483

Federal Communications Commission
RULES
Common carriers:
Streamlined contributor reporting requirements; biennial regulatory review, 41320–41333
NOTICES
Agency information collection activities:
Proposed collection; comment request, 41425
Submission for OMB review; comment request, 41425–41428

Federal Crop Insurance Corporation
PROPOSED RULES
Crop insurance regulations:
Potato crop; certified seed endorsement, 41336–41338

Federal Deposit Insurance Corporation
NOTICES
Meetings; Sunshine Act, 41428

Federal Election Commission
RULES
Contribution and expenditure limitations and prohibitions:
Corporate and labor organizations—
Membership association member; definition, 41266–41273

Federal Emergency Management Agency
RULES
Flood elevation determinations:
Various States, 41306–41320
Flood insurance program:
Group flood insurance policy, 41305–41306
PROPOSED RULES
Flood elevation determinations:
Various States, 41365–41372

Federal Energy Regulatory Commission
NOTICES
Electric rate and corporate regulation filings:
Foote Creek III L.L.C. et al., 41408–41410
Niagara Mohawk Power Corp. et al., 41410–41413
Hydroelectric applications, 41413–41415
Applications, hearings, determinations, etc.:
Koch Gateway Pipeline Co., 41406
Southern Co. Services, Inc., et al., 41407
Texas Eastern Transmission Corp. et al., 41407–41408

Federal Highway Administration
NOTICES
Environmental statements; notice of intent:
Lawrence County, OH and Greenup County, KY, 41483
Motor carrier safety standards:
Hours of service of drivers—
Hulcher Services, Inc.; exemption application, 41483–41486

Federal Reserve System
NOTICES
Banks and bank holding companies:
Change in bank control, 41428–41429
Formations, acquisitions, and mergers, 41429

Federal Retirement Thrift Investment Board
NOTICES
Meetings; Sunshine Act, 41429

Federal Trade Commission
NOTICES
Prohibited trade practices:
Fleet Finance Inc. et al., 41429–41432

Financial Management Service
See Fiscal Service

Fiscal Service
PROPOSED RULES
Treasury tax and loan depositaries:
Federal taxes payment and Treasury Tax and Loan Program; change to interest rate on note balances, 41747–41749

Food and Drug Administration
PROPOSED RULES
Medical devices
Surgeon's and patient examination gloves; reclassification, 41709–41743
NOTICES
Medical devices:
Obstetrics and gynecology devices—
Home uterine activity monitor; reclassification, 41435–41440
Reports and guidance documents; availability, etc.:
Computer-Controlled Potentially High Risk Medical Devices; List of Device Types, 41440–41441
Electronic records; electronic signatures; compliance policy guide; republication, 41442–41443
Home uterine activity monitors, 41443–41444
Medical Glove Guidance Manual, 41744–41745

Foreign-Trade Zones Board
NOTICES
Applications, hearings, determinations, etc.:
California, 41374–41375
Indiana
SMC Pneumatics, Inc.; pneumatic automation products manufacturing and warehousing facilities, 41375

Health and Human Services Department
See Centers for Disease Control and Prevention
See Children and Families Administration
See Food and Drug Administration
See Health Care Financing Administration
See National Institutes of Health

Health Care Financing Administration
RULES
Medicare:
Hospital inpatient prospective payment systems and 2000 FY rates, 41489–41641
Skilled nursing facilities; prospective payment system and consolidated billing, 41643–41683
NOTICES
Agency information collection activities:
Proposed collection; comment request, 41444
Submission for OMB review; comment request, 41444–41445
Medicare:
Skilled nursing facilities; prospective payment system and consolidated billing; update; report to Congress, 41684–41701

Housing and Urban Development Department
NOTICES
Agency information collection activities:
Submission for OMB review; comment request, 41452–41456
Grants and cooperative agreements; availability, etc.:
Facilities to assist homeless—
Excess and surplus Federal property, 41456

Immigration and Naturalization Service
NOTICES
Temporary protected status program designations:
Liberia, 41463–41464

Interior Department
See Land Management Bureau
NOTICES
Environmental statements; availability, etc.:
Central Arizona Project—
Water supply allocation and expected long-term contract execution, 41456–41457

International Trade Administration
NOTICES
Antidumping:
Creatine monohydrate from—
China, 41375–41380
Polyethylene terephthalate film, sheet, and strip from—
Korea, 41380–41382
Welded stainless steel pipe from—
Taiwan, 41382

International Trade Commission
NOTICES
Import investigations:
Cold-rolled steel products from—
Various countries, 41458–41459
Polychloroprene rubber from—
Japan, 41458

Justice Department
See Immigration and Naturalization Service
See Prisons Bureau
NOTICES
Grants and cooperative agreements; availability, etc.:
Community oriented policing services (COPS)—
School-Based Partnerships Program, 41459–41463

Labor Department
See Employment and Training Administration
See Employment Standards Administration

NOTICES
Committees; establishment, renewal, termination, etc.:
Employee Welfare and Pension Benefit Plans Advisory Council, 41465

Land Management Bureau
NOTICES
Closure of public lands:
California, 41457
Meetings:
Resource Advisory Councils—
Front Range, 41457–41458

Library of Congress
See Copyright Office, Library of Congress

Minority Business Development Agency
NOTICES
Grants and cooperative agreements; availability, etc.:
Client service-delivery programs, 41382–41383

National Council on Disability
NOTICES
Meetings; Sunshine Act, 41473–41474

National Institutes of Health
NOTICES
Agency information collection activities:
Proposed collection; comment request, 41445–41446
Meetings:
National Cancer Institute, 41446–41447
National Institute of Allergy and Infectious Diseases, 41448
National Institute of General Medical Sciences, 41449
National Institute of Mental Health, 41447 , 41448
National Institute of Neurological Disorders and Stroke, 41449
National Institute on Drug Abuse, 41447–41448
Scientific Review Center, 41449–41451
Warren Grant Magnuson Clinical Center Board of Governors, 41451–41452
Patent licenses; non-exclusive, exclusive, or partially exclusive:
Immune Complex Corp., 41452

National Oceanic and Atmospheric Administration
NOTICES
Marine mammals:
Incidental taking; authorization letters, etc.—
Western Geophysical/Western Atlas International; Beaufort Sea; offshore seismic activities, 41384–41391

Natural Resources Conservation Service
NOTICES
Field office technical guides; changes:
Indiana, 41373

Navy Department
NOTICES
Privacy Act:
Systems of records, 41401–41402

Nuclear Regulatory Commission
PROPOSED RULES
Special nuclear material; domestic licensing:
Critical mass possession; public health and environmental safety measures, 41338–41357
NOTICES
Reports and guidance documents; availability, etc.:
Nuclear power plants—
Year 2000 transition; enforcement discretion for Y2K noncompliance, 41474–41476

Patent and Trademark Office
NOTICES
Patents:
Patent application examination; supplemental guidelines, 41392–41394

Personnel Management Office
PROPOSED RULES
Employment:
Senior Executive Service; career and limited appointments; Qualifications Review Board certification, 41334–41336

Postal Service
RULES
Organization, functions, and authority delegations:
Information release and records management, 41289–41291
NOTICES
Privacy Act:
Systems of records, 41476–41477

Prisons Bureau
NOTICES
Environmental statements; notice of intent:
South Carolina; high security or medium security federal correctional facilities development, 41464–41465

Public Debt Bureau
See Fiscal Service

Public Health Service
See Centers for Disease Control and Prevention
See Food and Drug Administration
See National Institutes of Health

Securities and Exchange Commission
NOTICES
Self-regulatory organizations; proposed rule changes:
Chicago Board Options Exchange, Inc., 41477–41478
National Association of Securities Dealers, Inc., 41478–41480
Philadelphia Stock Exchange, Inc., 41480–41482

Small Business Administration
NOTICES
Agency information collection activities:
Submission for OMB review; comment request, 41482

State Department
NOTICES
Organization, functions, and authority delegations:
Arms Control and Disarmament Agency; responsibilities redelegated to Secretary of State, 41482

Surface Transportation Board
NOTICES
Railroad operation, acquisition, construction, etc.:
Penn Virginia Corp., 41486
Winifrede Railroad Co., 41486

Textile Agreements Implementation Committee
See Committee for the Implementation of Textile Agreements

Transportation Department
See Federal Aviation Administration
See Federal Highway Administration
See Surface Transportation Board

Treasury Department
See Alcohol, Tobacco and Firearms Bureau
See Fiscal Service
NOTICES
Senior Executive Service:
Legal Division Performance Review Board; membership, 41486–41487

United States Information Agency
NOTICES
Art objects; importation for exhibition:
Golden Age of Chinese Archaeology Celebrated Discoveries from the People's Republic of China, 41487–41488
Unseen Treasures: Imperial Russia and the New World, 41488

Separate Parts In This Issue

Part II
Department of Health and Human Services, Health Care Financing Administration, 41489–41641

Part III
Health and Human Services, Health Care Financing Administration, 41643–41701

Part IV
Department of Education, 41703–41708

Part V
Department of Health and Human Services, Food and Drug Administration, 41709–41745

Part VI
Department of the Treasury, Fiscal Service, 41747–41749

Part VII
Department of Education, 41751–41763

Reader Aids
Consult the Reader Aids section at the end of this issue for phone numbers, online resources, finding aids, reminders, and notice of recently enacted public laws.

CFR PARTS AFFECTED IN THIS ISSUE

A cumulative list of the parts affected this month can be found in the Reader Aids section at the end of this issue.

5 CFR

Proposed Rules:
317 41334

7 CFR

Proposed Rules:
457 41336

9 CFR
72 41268
91 41269

10 CFR

Proposed Rules:
70 41338

11 CFR
100 41266
114 41266

14 CFR
39 41273
95 41273
97 (3 documents) 41281, 41283, 41284

Proposed Rules:
71 (6 documents) 41357, 41358, 41359 41360, 41362, 41363

21 CFR

Proposed Rules:
801 41710
878 41710
880 41710

31 CFR

Proposed Rules:
203 41748

34 CFR

Proposed Rules:
668 41752

37 CFR
201 41286

39 CFR
261 41289
262 41289
263 41289
264 41289
265 41289
266 41289
267 41289

40 CFR
62 41291
180 (2 documents) 41294, 41297

Proposed Rules:
62 41364

42 CFR
409 41644
411 41644
412 41490
413 (2 documents) 41490, 41644
483 41490
485 41490
489 41644

44 CFR
61 41305
65 (3 documents) 41306, 41309, 41312
67 (2 documents) 41315, 41317

Proposed Rules:
67 (2 documents) 41365, 41368

47 CFR
1 41320
52 41320
54 41320
64 41320

Rules and Regulations

Federal Register
Vol. 64, No. 146
Friday, July 30, 1999

This section of the FEDERAL REGISTER contains regulatory documents having general applicability and legal effect, most of which are keyed to and codified in the Code of Federal Regulations, which is published under 50 titles pursuant to 44 U.S.C. 1510.

The Code of Federal Regulations is sold by the Superintendent of Documents. Prices of new books are listed in the first FEDERAL REGISTER issue of each week.

DEPARTMENT OF AGRICULTURE

Animal and Plant Health Inspection Service

9 CFR Part 72

[Docket No. 96–067–2]

Texas (Splenetic) Fever in Cattle; Incorporation by Reference

AGENCY: Animal and Plant Health Inspection Service, USDA.

ACTION: Final rule.

SUMMARY: We are amending the Texas (splenetic) fever in cattle regulations by removing the section that describes the area of Texas quarantined because of ticks and replacing it with an incorporation by reference of the Texas Animal Health Commission's regulations that describe the same area. Because the quarantined area in Texas is defined and established by the Texas Animal Health Commission and an up-to-date description of the quarantined area is provided in the commission's regulations in the Texas Administrative Code, we do not believe that it is necessary to reproduce that description in our regulations. This change in the regulations will eliminate the need for us to maintain a description of the Texas quarantined area in our regulations, which will reduce the volume of material included in those regulations while continuing to provide for the treatment and inspection of cattle moved from the area of Texas quarantined for ticks.

EFFECTIVE DATE: August 30, 1999. The incorporation by reference provided for by this rule is approved by the Director of the Federal Register as of August 30, 1999.

FOR FURTHER INFORMATION CONTACT: Dr. Dave Wilson, Senior Staff Veterinarian, Emergency Programs, VS, APHIS, 4700 River Road Unit 41, Riverdale, MD 20737–1231; (301) 734–8073; or e-mail: Dave.D.Wilson@usda.gov.

SUPPLEMENTARY INFORMATION:

Background

The regulations in 9 CFR part 72, ''Texas (Splenetic) Fever in Cattle'' (referred to below as the regulations), restrict the interstate movement of cattle from areas quarantined because of the presence of ticks that are vectors of bovine babesiosis. This disease is referred to in the regulations as splenetic or tick fever. Splenetic or tick fever is a contagious, infectious, and communicable disease of cattle that causes cattle to become weak and dehydrated and can cause death. The areas quarantined because of ticks include all of Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands, as well as portions of Texas. These quarantined areas are described in §§ 72.3 and 72.5 of the regulations.

On April 12, 1999, we published in the **Federal Register** (64 FR 17573–17574, Docket No. 96–067–1) a proposed rule to amend the regulations by removing the description of the quarantined area in Texas from § 72.5 and replacing it with an incorporation by reference of the Texas Animal Health Commission's (TAHC's) regulations in title 4 of the Texas Administrative Code that describe the same area.

We solicited comments concerning our proposed rule for 60 days ending on June 11, 1999. We did not receive any comments. Therefore, for the reasons given in the proposed rule, we are adopting the proposed rule as a final rule, without change.

Executive Order 12866 and Regulatory Flexibility Act

This rule has been reviewed under Executive Order 12866. For this action, the Office of Management and Budget has waived its review under Executive Order 12866.

This rule amends the Texas (splenetic) fever in cattle regulations to incorporate by reference the description of fever tick eradication areas contained in the Texas Administrative Code. Incorporating the TAHC's description of fever tick eradication areas by reference rather than continuing to reproduce the description in our regulations eliminates the need for the Animal and Plant Health Inspection Service (APHIS) to maintain an up-to-date description of the quarantined area in Texas and reduces the volume of material included in our regulations while continuing to provide for the treatment and inspection of cattle moved from the tick eradication area in Texas.

Our incorporation by reference of the Texas Administrative Code's description of fever tick eradication areas in Texas is not expected to have an economic impact on any entities, large or small, because it is the TAHC that defines and establishes the boundaries of the tick eradication areas in Texas; that description has merely been reproduced in APHIS' regulations in part 72. There will be no change in the quarantined area in Texas as a result of its description being removed from part 72, so no livestock or property owners in Texas will be affected by this rule.

Under these circumstances, the Administrator of the Animal and Plant Health Inspection Service has determined that this action will not have a significant economic impact on a substantial number of small entities.

Executive Order 12372

This program/activity is listed in the Catalog of Federal Domestic Assistance under No. 10.025 and is subject to Executive Order 12372, which requires intergovernmental consultation with State and local officials. (See 7 CFR part 3015, subpart V.)

Executive Order 12988

This rule has been reviewed under Executive Order 12988, Civil Justice Reform. This rule: (1) Preempts all State and local laws and regulations that are in conflict with this rule; (2) has no retroactive effect; and (3) does not require administrative proceedings before parties may file suit in court challenging this rule.

Paperwork Reduction Act

This rule contains no new information collection or recordkeeping requirements under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*).

Regulatory Reform

This action is part of the President's Regulatory Reform Initiative, which, among other things, directs agencies to remove obsolete and unnecessary

regulations and to find less burdensome ways to achieve regulatory goals.

List of Subjects in 9 CFR Part 72

Animal diseases, Cattle, Incorporation by reference, Quarantine, Transportation.

Accordingly, we are amending 9 CFR part 72 as follows:

PART 72—TEXAS (SPLENETIC) FEVER IN CATTLE

1. The authority citation for part 72 continues to read as follows:

Authority: 21 U.S.C. 111–113, 115, 117, 120, 121, 123–126, 134b, and 134f; 7 CFR 2.22, 2.80, and 371.2(d).

2. Section 72.5 is revised to read as follows:

§ 72.5 Area quarantined in Texas.

The area quarantined in Texas is the permanent quarantined area described in the regulations of the Texas Animal Health Commission (TAHC) contained in § 41.2 of title 4, part II, of the Texas Administrative Code (4 TAC 41.2), effective July 22, 1994, which is incorporated by reference. This incorporation by reference was approved by the Director of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. Copies of 4 TAC 41.2 may be obtained from the TAHC at 2105 Kramer Lane, Austin, TX 78758, and from area offices of the TAHC, which are listed in local Texas telephone directories. The TAHC also maintains a copy of its regulations on its Internet homepage at http://www.tahc.state.tx.us/. Copies may be inspected at the Animal and Plant Health Inspection Service, Veterinary Services, Emergency Programs, Suite 3B08, 4700 River Road, Riverdale, MD, or at the Office of the Federal Register, 800 North Capitol Street, NW., suite 700, Washington, DC.

Done in Washington, DC, this 23rd day of July 1999.

Alfonso Torres,

Acting Administrator, Animal and Plant Health Inspection Service.

[FR Doc. 99–19421 Filed 7–29–99; 8:45 am]

BILLING CODE 3410–34–P

DEPARTMENT OF AGRICULTURE

Animal and Plant Health Inspection Service

9 CFR Part 91

[Docket No. 98–078–2]

Ports Designated for Exportation of Horses; New Jersey and New York

AGENCY: Animal and Plant Health Inspection Service, USDA.

ACTION: Direct final rule; confirmation of effective date.

SUMMARY: On June 4, 1999, the Animal and Plant Health Inspection Service published a direct final rule. (See 64 FR 29947–29949, Docket No. 98–078–1.) The direct final rule notified the public of our intention to amend the ''Inspection and Handling of Livestock for Exportation'' regulations by changing the lists of approved ports of embarkation and export inspection facilities for horses in New Jersey and New York. In New Jersey, we are removing Deep Hollow Farm in Woodstown, NJ, as the export inspection facility for horses exported from the ocean port of Salem, NJ, and adding Mannington Meadows Farm in Woodstown, NJ, in its place. We are adding Elizabeth and Newark International Airport, NJ, as ports of embarkation, and Tolleshunt Horse Farm in Whitehouse, NJ, and the U.S. Equestrian Team's headquarters in Gladstone, NJ, as export inspection facilities for horses for those ports. We are also adding Tolleshunt Horse Farm and the U.S. Equestrian Team's headquarters as export inspection facilities for horses for the currently approved port of New York, NY. These actions update the regulations by adding two ports of embarkation and three export inspection facilities through which horses may be processed for export. We did not receive any written adverse comments or written notice of intent to submit adverse comments in response to the direct final rule.

EFFECTIVE DATE: The effective date of the direct final rule is confirmed as: August 3, 1999.

FOR FURTHER INFORMATION CONTACT: Dr. Michael David, Senior Staff Veterinarian, Animals Program, National Center for Import and Export, VS, APHIS, 4700 River Road, Unit 39, Riverdale, MD 20737–1231; (301) 734–8354.

Authority: 21 U.S.C. 105, 112, 113, 114a, 120, 121, 134b, 134f, 136, 136a, 612, 613, 614, and 618; 46 U.S.C. 466a and 466b; 49 U.S.C. 1509(d); 7 CFR 2.22, 2.80, and 371.2(d).

Done in Washington, DC, this 26th day of July 1999.

Bobby R. Acord,

Acting Administrator, Animal and Plant Health Inspection Service.

[FR Doc. 99–19563 Filed 7–29–99; 8:45 am]

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FEDERAL ELECTION COMMISSION

11 CFR Parts 100 and 114

[Notice 1999–12]

Definition of ''Member'' of a Membership Organization

AGENCY: Federal Election Commission.

ACTION: Final rules and transmittal of regulations to Congress.

SUMMARY: The Commission has revised its rules governing who qualifies as a ''member'' of a membership organization. An incorporated membership organization or labor organization can solicit contributions from its members to a separate segregated fund (''SSF'') established by the organization, and can include express electoral advocacy in communications to its members. Unincorporated membership organizations can similarly make internal communications to their members but cannot establish SSF's. The revisions largely address the internal characteristics of an organization that, when coupled with certain financial or organizational attachments, are sufficient to confer membership status.

DATES: Further action, including the publication of a document in the **Federal Register** announcing an effective date, will be taken after these regulations have been before Congress for 30 legislative days pursuant to 2 U.S.C. 438(d).

FOR FURTHER INFORMATION CONTACT: Ms. Rosemary C. Smith, Acting Assistant General Counsel, or Ms. Rita A. Reimer, Attorney, 999 E Street N.W., Washington, DC 20463, (202) 694–1650 or (800) 424–9530.

SUPPLEMENTARY INFORMATION: Although the Federal Election Campaign Act of 1971 as amended (''FECA'' or ''Act''), 2 U.S.C. 431 *et seq.*, prohibits direct corporate contributions in connection with federal campaigns, 2 U.S.C. 441b(a), it permits corporations, including incorporated membership organizations, to solicit contributions from their restricted class to a separate segregated fund. In the case of incorporated membership organizations, the restricted class consists of the

members of each association, their executive and administrative personnel, and their families. These contributions can be used for federal political purposes. The Act also allows membership organizations to communicate with their members on any subject, including communications that include express electoral advocacy. 2 U.S.C. 441b(b)(2)(A), 441b(b)(4)(C). The Commission's implementing regulations defining who is a ''member'' of a membership organization are found at 11 CFR 100.8(b)(4)(iv) and 11 CFR 114.1(e).

The Commission's original ''member'' rules, which had been adopted in 1977, were the subject of a 1982 United States Supreme Court decision, *FEC* v. *National Right to Work Committee* (''*NRWC*''), 459 U.S. 196 (1982). In 1993, following a series of advisory opinions in this area, the Commission revised the text of the rules to reflect that decision. 58 FR 45770 (Aug. 30, 1993), effective Nov. 10, 1993. 58 FR 59640. The revised rules were held to be unduly restrictive by the United States Court of Appeals for the District of Columbia Circuit in *Chamber of Commerce of the United States (''Chamber'')* v. *FEC*, 69 F.3d 600 (D.C. Cir. 1995), *amended on denial of rehearing*, 76 F.3d 1234 (D.C. Cir. 1996). This rulemaking followed.

History of the Rulemaking

On February 24, 1997, the Commission received a Petition for Rulemaking from James Bopp, Jr., on behalf of the National Right to Life Committee, Inc. The Petition urged the Commission to revise its member rules to reflect the *Chamber* decision. The Commission published a Notice of Availability (''NOA'') in the **Federal Register** on March 29, 1997, 62 F.R. 13355, and received two comments in response.

On July 31, 1997, the Commission published in the **Federal Register** an Advance Notice of Proposed Rulemaking (''ANPRM'') addressing these rules. 62 FR 40982. Because the *Chamber* decision, the petition for rulemaking, and the comments received in response to the NOA provided few specific suggestions as to how the rules should be amended to comport with the decision, the Commission did not propose specific amendments to the rules. Rather, it sought general guidance on the factors to be considered in determining the existence of this relationship. The Commission received 14 comments in response to the ANPRM.

On December 22, 1997, the Commission published a Notice of Proposed Rulemaking (''NPRM'') on this matter, 62 FR 66832, and received 22 comments in response. On April 29, 1998, the Commission held a public hearing on this rulemaking at which 10 witnesses testified.

The 1997 NPRM sought comments on three alternative proposals, referenced as Alternatives A, B, and C. None of the alternatives proposed any changes to the three preliminary requirements, or to the provisions in the current rules that recognize as members persons who have a stronger financial interest in an organization than the payment of annual dues, such as those who own or lease seats on stock exchanges or boards of trade. 11 CFR 100.8(b)(4)(iv)(B)(1), 114.1(e)(2)(i), AO 1997–5.

Under Alternative A, all persons who paid $50 in annual dues or met specified organizational attachments would be considered members. The NPRM suggested such attachments as the voting rights contained in the current rules; the right to serve on policy-making boards of the organization; eligibility to be elected to the governing positions in the organization; and the possibility of disciplinary action against the member by the organization. A lesser dues obligation coupled with weaker organizational attachments would also be sufficient for this purpose.

Alternative B distinguished between the types of organizations addressed by the *Chamber* decision, i.e., those formed to further business or economic interests or to implement a system of self-discipline or self-regulation within a line of commerce; and ideological, social welfare, and political organizations. Persons paying any amount of annual dues would be considered members of the first category of organizations, while annual dues of $200 or more would be required for membership in the second category, unless the purported members had the same voting rights required by the current rule.

Under Alternative C, an organization that qualified as a membership organization by meeting the three preliminary requirements could consider as members all persons who paid the amount of annual dues set by the organization, regardless of amount.

The 1997 NPRM also proposed that direct membership in any level of a multi-tiered organization be construed as membership in all tiers of the organization for purposes of these rules.

As was the case with the ANPRM, the comments and testimony received in response to the NPRM expressed a wide range of views—there was no consensus on how best to address this situation. After further consideration, the Commission sought comments on a slightly different approach, one that would address more fully the attributes of membership organizations, in addition to members' required financial or organizational attachments. The Commission accordingly published a second NPRM that focused primarily on characteristics of membership organizations. 63 F.R. 69224 (Dec. 16, 1998).

The Commission received 25 comments in response to the second NPRM. Commenters included the Alliance for Justice; the American Federation of Labor and Congress of Industrial Organizations (''AFL–CIO''); the American Federation of State, County and Municipal Employees (''AFSCME''); the American Hotel and Motel Association (''AH&MA''); the American Medical Association; the Americans Back in Charge Foundation; the American Society of Association Executives (''ASAE''); Peter A. Bagatelos; Camille Bradford; the Hon. Thomas M. Davis; the Free Speech Coalition; Harmon, Curran, Spielberg & Eisenberg; the Internal Revenue Service; the James Madison Center for Free Speech; the National Association of Business Political Action Committees (''NABPAC''); the National Association of Realtors; the National Citizens Legal Network (''NCLN''); the National Education Association (''NEA''); the National Lumber and Building Material Dealers Association (''NLBMDA''); the National Right to Work Committee; the National Rural Electric Cooperative Association; the National Telephone Cooperative Association; Vigo G. Nielsen, Jr.; Daniel M. Schember; and the United States Chamber of Commerce.

The Commission held a hearing on this NPRM on March 17, 1999, at which 13 witnesses testified. Witnesses included representatives of the Alliance for Justice; the AFL–CIO; AFSCME; AH&MA; the Americans Back in Charge Foundation; ASAE; the Free Speech Coalition; the James Madison Center for Free Speech; NABPAC; NCLN; NEA; Ms. Bradford; and Mr. Schember.

Explanation and Justification

Background

In its *NRWC* decision, the Supreme Court rejected an argument by a nonprofit, noncapital stock corporation, whose articles of incorporation stated that it had no members, that it should be able to treat as members individuals who had at one time responded, not necessarily financially, to an NRWC advertisement, mailing, or personal contact. The Supreme Court rejected

this definition of ''member,'' saying that to accept it ''would virtually excise from the statute the restriction of solicitation to 'members.' '' 459 U.S. at 203. The Court determined that ''members'' of nonstock corporations should be defined, at least in part, by analogy to stockholders of business corporations and members of labor unions. Viewing the question from this perspective meant that ''some relatively enduring and independently significant financial or organizational attachment is required to be a 'member' '' for these purposes. *Id.* at 204. The NRWC's asserted members did not qualify under this standard because they played no part in the operation or administration of the corporation, elected no corporate officials, attended no membership meetings, and exercised no control over the expenditure of their contributions. *Id.* at 206. The 1993 revisions to the Commission's rules were intended to incorporate this standard.

The Current Rules

The current rules require an organization to meet three preliminary requirements before it can qualify as a membership organization. These requirements are that it (1) expressly provide for ''members'' in its articles and by-laws; (2) expressly solicit members; and (3) expressly acknowledge the acceptance of membership, such as by sending a membership card or including the member on a membership newsletter list. 11 C.F.R. 100.8(b)(4)(iv)(A), 114.1(e)(1). If these preliminary requirements are met, a person may qualify as a member either by having a significant financial attachment to the membership organization (not merely the payment of dues), or the right to vote directly for all members of the organization's highest governing body. However, in most instances a combination of regularly-assessed dues and the right to vote directly or indirectly for at least one member of the organization's highest governing body is required. The term ''membership organization'' includes membership organizations, trade organizations, cooperatives, corporations without capital stock, and local, national and international labor organizations that meet the requirements set forth in these rules.

The Chamber of Commerce Decision

The United States District Court for the District of Columbia held that the current rules were not arbitrary, capricious or manifestly contrary to the statutory language, and therefore deferred to what the court found to be a valid exercise of the Commission's regulatory authority. *Chamber of Commerce of the United States* v. *FEC*, Civil Action No. 94–2184 (D.D.C. Oct. 28, 1994) (1994 WL 615786). However, the Court of Appeals for the D.C. Circuit reversed this ruling.

The case was jointly brought by the Chamber of Commerce and the American Medical Association (''AMA''), two organizations that do not provide their asserted ''members'' with the voting rights necessary to confer this status under the current rules. The appellate court held that the ties between these members and the Chamber and the AMA are nonetheless sufficient to comply with the Supreme Court's *NRWC* criteria, and therefore concluded that the Commission's rules are invalid because they define the term ''member'' in an unduly restrictive fashion. 69 F.3d at 604.

The Chamber is a nonprofit corporation whose members include 3,000 state and local chambers of commerce, 1,250 trade and professional groups, and 215,000 ''direct business members.'' The members pay annual dues ranging from $65 to $100,000 and may participate on any of 59 policy committees that determine the Chamber's position on various issues. However, the Chamber's Board of Directors is self perpetuating (that is, Board members elect their successors); so no member entities have either direct or indirect voting rights for any members of the Board.

The AMA challenged the exclusion from the definition of member 44,500 ''direct'' members, those who do not belong to a state medical association. Direct members pay annual dues ranging from $20 to $420; receive various AMA publications; and participate in professional programs put on by the AMA. They are also bound by and subject to discipline under the AMA's Principles of Medical Ethics. However, since state medical associations elect members of the AMA's House of Delegates, that organization's highest governing body, direct members do not satisfy the voting criteria set forth in the current rules.

The *Chamber* court, in an Addendum to the original decision, noted that the Commission ''still has a good deal of latitude in interpreting'' the term ''member.'' 76 F.3d at 1235. However, in its original decision, the court held the rules to be arbitrary and capricious as applied to the Chamber, since under the current rules even those paying $100,000 in annual dues cannot qualify as members. As for the AMA, the rule excludes members who pay up to $420 in annual dues and, among other organizational attachments, are subject to sanctions under the Principles of Medical Ethics. The court explained that this latter attachment ''might be thought, [] for a professional, [to be] the *most* significant organizational attachment.'' 69 F.3d at 605 (emphasis in original).

Section 100.8(b)(4) Membership Organizations

First, the Commission has replaced the term ''membership association'' wherever it appears in this section with the term ''membership organization.'' The Commission believes it is appropriate to refer to the covered entities as ''membership organizations'' because that is the term used in the Act. *See*, 2 U.S.C. 431(9)(B)(iii) and 441b(b)(4)(C). ''Membership organization'' is also referred to in 11 CFR 100.8(b)(4), which describes the entities entitled to the ''internal communication'' exception to the Act's definition of expenditure.

The NPRM proposed adding unincorporated associations to the definition of membership organizations, for purposes of 11 CFR 100.8 only. The comments on this proposal were mixed. Some supported the idea, while others argued against it, saying that it might exceed the Commission's authority by blurring the statutory distinction between corporations and other entities contained in the FECA.

The Commission is expanding the definition of membership organization to include unincorporated associations because it believes this is consistent with congressional intent. It is clear from the placement of the exception at 2 U.S.C. 431(9)(B)(iii), i.e., in the Act's ''definition'' section, that Congress intended to allow noncorporate and non-labor union organizations to avail themselves of the internal membership communication exception. By including the internal communications exception in the definition of ''expenditure,'' the statute allows noncorporate and non-union membership organizations to communicate with their members without subjecting them to the normal prohibitions and reporting requirements.

Paragraph (b)(4) lists the types of entities entitled to the expenditure exemption and the types of communications (i.e., express advocacy) that an exempted organization may engage in without those communications being classified as an expenditure. It currently states that entities ''organized primarily for the purpose of influencing the nomination for election, or election, of any individual to Federal office'' are not

entitled to the membership communications exemption.

The Commission has decided to move this language to new paragraph 11 CFR 100.8(b)(4)(iv)(A)(*6*), the provision in 11 CFR 100.8 that explicitly defines a ''membership organization.'' This change insures that organizations primarily organized to influence a Federal election cannot, by definition, be classified as membership organizations under the Act.

The NPRM proposed further revising this section to include only communications ''subject to the direction and control of [the membership organization] and not any other person.'' Several commenters expressed concern that this provision could infringe on constitutionally protected free speech rights, and lead to unwarranted Commission intrusion into an organization's internal workings. The Commission is not including this language in the final rule because it has determined that the current language, which encompasses ''[a]ny cost incurred for any communication by a membership organization to its members,'' sufficiently addresses its concern that an organization not be used as a conduit by a candidate or other outside entity seeking to influence unlawfully a Federal election.

Section 100.8(b)(4)(iv)(A) Attributes of Membership Organizations

Paragraph (b)(4)(iv)(A) of this section addresses the attributes of membership organizations. Since the purpose of the Act's ''membership communications'' exception is to allow *bona fide* membership organizations to engage in political communications with their members, these rules are intended to prevent individuals from establishing ''sham'' membership organizations in an effort to circumvent the Act's contribution and expenditure limits. For this reason, the Commission believes it is appropriate to focus on the structure of the membership organization as well as on who qualifies as a member.

Accordingly, revised paragraph (A)(1) states that a membership organization shall be composed of members vested with the power and authority to operate or administer the organization pursuant to the organization's articles, bylaws, constitution or other formal organizational documents. The Commission believes it is axiomatic that membership organizations should be composed of members, and that members should have the power to operate or administer the organization. This language is a combination of that contained in proposed paragraphs (A)(*1*) and (A)(*3*) of the December, 1998 NPRM (63 F.R. 69224). Proposed paragraph (A)(*3*) of the December, 1998 NPRM required that the organization ''be self governing, such that the power and authority to direct and control the organization is vested in some of all members.'' The phrases ''self-governing'' and ''direct and control'' were removed in favor of the revised language noted above. The Commission notes that organizations would be able to delegate administrative and related responsibilities to smaller committees or other groups of members; the new rule does not require that all members approve all organization actions. Additionally, membership organizations with self-perpetuating boards of directors will be considered to have met this requirement if all members of the board are themselves members of the organization, as long as the organization has chosen this structure and it meets all other requirements of these regulations.

With regard to the requirement in paragraph (A)(*2*) that the qualifications and requirements for membership be expressly stated, the Commission notes that this provision would not preclude the organizational documents from delegating the responsibility to set specific requirements, such as the amount of dues or other qualifications or requirements, to the board of directors or other committees or groups of members.

The term ''constitution'' was also added to paragraphs (A)(1), (A)(2) and (A)(3) as a ''formal organizational document'' in response to several comments noting that many membership organizations considered constitutions to be their primary organizing document.

One commenter asked the Commission to drop the requirement that membership organizations ''shall be composed of members,'' arguing that some membership organizations include non-members and might find it difficult to distinguish between the two. Since the FECA specifically refers to ''members,'' and limits communications and solicitations to members, the Commission believes it is appropriate to include this requirement in the rules. Please note, this does not mean that organizations that permit non-members to participate in certain aspects of their operations will lose their status as a membership organization pursuant to the FECA, although they cannot solicit from or send express advocacy communications to such non members.

Some commenters pointed out that covered organizations may have to amend their bylaws to comply with these new requirements; and that this can be a lengthy process for those organizations which, for example, must approve the proposed changes at consecutive annual meetings. The Commission may consider such organizations to be in compliance with these rules while steps are underway, in accordance with the organization's rules, to come into compliance, assuming that the other requirements of the rules are met, as long as necessary changes are made at the first opportunity available under the organization's rules.

Revised paragraph (A)(*3*) states that membership organizations shall make their articles, bylaws or other formal organizational documents available to their members. As noted above, the Supreme Court's language in the *NRWC* decision, 459 U.S. at 204, pointed to the need for members of membership organizations to have ''relatively enduring and independently significant financial or organizational attachments'' to the organization. Those attachments can hardly be meaningful if the members are unaware of their rights and obligations. This requirement is therefore a corollary to that found at revised paragraph (A)(*1*), that members constitute the organization.

The NPRM proposed that such documents be made ''freely'' available to members, a term some commenters thought implied that the documents would have to be provided free of charge. They argued that this could prove costly for small organizations with lengthy organizational documents.

The Commission did not intend by its use of the word ''freely'' to indicate that the documents would have to be made available ''free of charge.'' Rather, organizations may impose reasonable copying and delivery fees for this service. They may also make these documents available at their headquarters or other offices, where members choosing to do so may consult and copy them.

Labor organizations also asserted that the Commission has no authority to impose requirements in addition to those contained in the Labor-Management Reporting and Disclosure Act of 1959 (''LMRDA'') and other Federal labor laws. The Commission believes that the revised rules largely comport with the LMRDA's requirements. However, the FECA and the Federal labor laws were enacted for different purposes, and the Commission cannot be bound by other statutes that would limit its authority in enforcing and interpreting the FECA.

New paragraphs (A)(*4*) and (*5*) contain the two preliminary requirements that formerly appeared in paragraphs (A)(*2*)

and (*3*). These paragraphs state that membership organizations shall expressly solicit members, and expressly acknowledge the acceptance of membership, such as by sending a membership card or including the member on a membership newsletter list. New paragraph (A)(4) has been revised slightly to clarify that an organization must expressly solicit persons to become members of the organization.

New paragraph (A)(*6*) contains the language moved from the introductory text of 11 CFR 100.8(b)(4), *supra*. It states that organizations primarily organized for the purpose of influencing the nomination for election, or election, of any individual for Federal office cannot qualify as membership organizations for purposes of these rules.

Section 100.8(b)(4)(iv)(B) Definition of ''member'' of a membership organization

The Commission interprets the Supreme Court's requirement in the *NRWC* decision that members of membership organizations have a ''relatively enduring and independently significant financial or organizational'' attachment, *supra*, to mean that members must have a long term and continuous bond with the organization itself. The new rules define this as either a meaningful ownership or investment stake; the payment of dues on a regular basis; or direct participatory rights in the governance of the organization.

The introductory language of paragraph (b)(4)(iv)(B), which states that members must satisfy the requirements for membership in a membership organization and affirmatively accept the organization's invitation to become a member, has not been changed. Nor has paragraph (B)(*1*), which confers membership on those having some significant financial attachment to the organization, such as a significant investment or ownership stake.

One commenter objected to this provision, saying that it would allow wealthy individuals and other entities to purchase memberships, and that the payment of dues should be sufficient for this purpose. However, this provision addresses the situation where a member may pay several hundred thousand dollars to purchase a seat on a stock exchange, for example, but does not pay dues.

Paragraph (B)(*2*) requires members to pay membership dues at least annually, of a specific amount predetermined by the organization. Commenters largely agreed with the Commission's proposal not to set any minimum amount of dues, because this varies so widely from organization to organization. The term ''at least'' has been added to the language proposed in the NPRM to address situations where dues are paid more frequently, i.e., bi-weekly or monthly, as is true of most labor organizations.

Several commenters expressed concern over the annual dues requirement, noting that, despite an organization's best efforts, not all members renew their memberships within a twelve-month period. These commenters raised the question of whether the annual dues standard would require organizations to exclude, for FECA purposes, any members who are late in paying dues. As long as organizations maintain and enforce an annual (or more frequent) dues requirement, payments within a flexible window or subject to a reasonable grace period would meet this requirement.

Paragraph (B)(*3*) defines significant organizational attachment to include (i) the affirmation of membership on at least an annual basis, and (ii) direct participatory rights in the governance of the organization. The regulation cites as examples of such rights the right to vote directly or indirectly for at least one individual on the membership organization's highest governing board; the right to vote on policy questions where the highest governing body of the membership organization is obligated to abide by the results; the right to approve the organization's annual budget; or the right to participate directly in similar aspects of the organization's governance.

The Commission notes that these requirements apply only to those members who do not pay annual dues, or whose financial attachment to the organization is not a significant investment or ownership stake. This allays the concern of some commenters that, as the proposal was originally drafted, members might be required to annually affirm their membership in addition to paying annual dues.

As with the annual dues requirement, the Commission intends to give organizations some flexibility in interpreting the phrase ''annual affirmation.'' For example, such activities as attending and signing in at a membership meeting or responding to a membership questionnaire would satisfy this requirement. The organization would not have to send out a mailing form for this purpose unless a member did not pay dues and had no other significant contact with the organization over the period in question.

Several commenters objected to the annual affirmation requirement proposed in the NPRM, and the Commission has substantially loosened this in an effort to address their concerns. It has not eliminated it entirely, however, because the Commission is bound by the Supreme Court's requirement that there be a significant or relatively enduring attachment between the member and the organization.

Section 100.8(b)(4)(iv)(C) Case-by-case Determinations

The Commission is revising paragraph (b)(4)(iv)(C) of this section, which provides for case-by-case determinations of membership status through the advisory opinion (''AO'') process for those who do not precisely meet the requirements set forth in paragraph (B), to specifically state that it applies to retired members, in addition to the student and lifetime members addressed in the former version.

The NPRM proposed adding new paragraph (b)(4)(iv)(D) to address the status of retired union members who had paid dues for a period of at least ten years. Some unions commented that they could not easily determine which retired members met this criterion. Other commenters urged the Commission to treat all retired members the same, regardless of whether they had retired from a union or from some other organization.

It is apparent from these comments that membership organizations have a wide range of relationships with their retired members. For this reason the Commission has decided that it is best to address this situation through the advisory opinion process, as is true of student, lifetime, honorary and similar member categories. In addition, please note that the Commission has addressed the question of retired members in AOs 1995–14, 1995–13, and 1987–5, which continue to provide guidance to similarly-situated organizations.

For instance, the most permissive advisory opinion, AO 1987–5, approved a life membership policy including members who had paid dues for ten years and reached age 65. That opinion also involved the retention of voting rights, which would not be essential under the new rules. These new rules include separate annual dues and organizational attachment tests as alternatives. Members who possess the requisite voting rights and affirm membership at least annually would qualify as members regardless of whether they ever paid dues.

Section 100.8(b)(4)(iv)(D) Labor Organizations

This provision, which has not been revised, states that, notwithstanding the requirements of paragraphs (b)(4)(iv)(B)(*1*) through (*3*) of this section, members of a local union are considered to be members of any national or international union of which the local union is a part and of any federation with which the local, national, or international union is affiliated.

The NPRM proposed deleting this language and replacing it with the provision relating to retired union members that has now been incorporated into the case-by-case determination process. At the time the NPRM was published, the Commission believed that unions with several organized levels would fall within the provisions relating to multi-tiered organizations contained in new paragraph 100.8(b)(4)(iv)(E) of this section, *infra*. However, some of the labor organizations that commented pointed out that their particular organizational structure did not precisely fit this model. The Commission is therefore retaining the current language to insure that unions continue to be treated as Congress intended in drafting this portion of the FECA. *See FEC* v. *Sailors' Union of the Pacific Political Fund*, 824 F. Supp. 492, 495 (N.D. Cal. 1986), *aff'd* 828 F.2d 502 (9th Cir. 1987).

Section 100.8(b)(4)(iv)(E) Multi-tiered Organizations

This provision, which was originally proposed in the 1997 NPRM, states that, in the case of a membership organization which has a national federation structure or has several levels, including, for example, national, state and/or local affiliates, a person who qualifies as a member of any entity within the federation or of any affiliate by meeting the requirements of paragraphs (b)(4)(iv)(B) (*1*), (*2*), (*3*), or (*4*) of this section, shall also qualify as a member of all affiliates for purposes of these rules. It further states that the factors set forth in the Commission's affiliation rules at 11 CFR 100.5(g)(2), (3) and (4) shall be used to determine whether entities are affiliated for purposes of this paragraph.

The commenter who first recommended this approach noted that a person who joins one tier of a multi-tiered organization clearly demonstrates an intention to associate with the entire organization. This new approach will also make enforcement easier and prevent what could otherwise be a large number of requests for advisory opinions from multi-tiered organizations. No comments were received opposing this change.

Section 100.8(b)(4)(iv)(F) Inapplicability of State Law

Paragraph (b)(4)(iv)(F) provides that, for purposes of these rules, the status of a membership organization shall be determined pursuant to paragraph (b)(4)(iv) of this section and not by provisions of State law governing unincorporated associations, trade associations, cooperatives, corporations without capital stock or labor organizations. Several commenters objected to this proposal, arguing that the Commission should defer to State law in this area.

Where an organization does not have ''members'' under that definition of state law, the right to vote for directors, and to exercise other rights normally given to members, is typically vested in the directors themselves. The board of directors thus elects its own successors, and in that sense is a self-perpetuating, autonomous board.

State law, however, also typically gives an organization that elects not to have ''members'' as defined by state law the right to have other persons affiliated with the organization under such terms and conditions as the organizational documents or directors provide, and to call those persons ''members'' if the organization wishes to do so. In that circumstance, if the terms and conditions of membership satisfied these regulations, those persons would be ''members'' for purposes of the FECA, even if they were not ''members'' as defined under state law.

The Commission does not believe that the vagaries of state law should determine whether or not an organization has members for purposes of the FECA. Therefore, the regulations make it clear that the determination of whether an organization has members for purposes of the FECA will be determined under these regulations, and not by the definitions of state law that may either include or exclude persons as members of an organization for reasons unrelated to the FECA.

Section 114.1(e) Definition of Membership Organization for Purposes of Corporate and Labor Organization Activity

Revised section 114.1(e) is identical to revised section 100.8(b)(4)(iv). Please note, however, that the reference to unincorporated associations which appears in revised 11 CFR 100.8(b)(4) applies only to Part 100 and not to Part 114, since part 114 addresses only activities by corporations and labor organizations.

Section 114.8(g) Federations of Trade Associations

As was the case with rural cooperatives, the 1998 NPRM proposed the repeal of 11 CFR 114.8(g), relating to federations of trade associations, because it believed these provisions would be encompassed by the proposed multi-tier language. While no commenter addressed this change, the Commission notes that parts of this section address additional issues that are beyond the scope of the present rulemaking. For example, there is a difference in the trade association context between the groups that can be solicited for contributions to the trade association's SSF and those who can get other election-influencing messages that are not SSF solicitations. For this reason, the Commission is retaining the current language without revision.

Other Issues

Rural Cooperatives

The Commission's rules at 11 CFR 114.7(k) allow certain rural cooperatives to, *inter alia*, solicit from and make express advocacy electoral communications to not only their own members, but the members of the cooperative's regional, state or local affiliates. The 1998 NPRM proposed repealing this provision and addressing this situation through 11 CFR 100.8(b)(4)(iv)(E), the general multi-tiered organization provision discussed above. However, one of the rural electric cooperatives that commented stated that the structure of most rural cooperatives does not readily correspond to the multi-tiered model envisioned in that section. The Commission is therefore retaining 11 CFR 114.7(k), to insure continued coverage of rural cooperatives under these rules.

Advisory Opinions Superseded

AO 1991–24 addressed the efforts of the Credit Union National Association, Inc. (''CUNA'') and the Wisconsin Credit Union League to make partisan communications across multiple tiers of the organization. While the Commission approved the proposed procedures, these rules increase the options available to these and comparably situated multi tiered organizations. In AO 1993–24, the Commission determined that certain persons were not members of the National Rifle Association for purposes of the former rules because they did not have the required voting rights. The new rules supersede that portion of the AO that

requires voting rights to establish membership.

The Regulatory Flexibility Act

One commenter disputed the Commission's certification under the Regulatory Flexibility Act, 5 U.S.C. 605(b), in the NPRM that the proposed rule would not have a significant economic impact on a substantial number of small entities. While the Commission does not concur with that assessment, it nevertheless has taken steps to allay this commenter's concerns by clarifying that (1) organizations may charge reasonable copying and mailing fees for making their organizational documents available to their members; and (2) organizations may follow their usual procedures in revising their bylaws or other documents, if these rules require this action.

Certification of no Effect Pursuant to 5 U.S.C. 605(b) [Regulatory Flexibility Act]

These rules do not have a significant economic impact on a substantial number of small entities. The basis for this certification is that the rules would broaden the current definition of who qualifies as a member of a membership association, thus expanding the opportunity for such associations to send electoral advocacy communications and solicit contributions to their separate segregated funds. The increased costs of such activity, if any, do not qualify as ''significant'' for purposes of this requirement.

List of Subjects

11 CFR Part 100

Elections.

11 CFR Part 114

Business and industry, Elections, Labor.

For the reasons set out in the preamble, Subchapter A, Chapter I of Title 11 of the Code of Federal Regulations is amended as follows:

PART 100—SCOPE AND DEFINITIONS (2 U.S.C. 431)

1. The authority citation for Part 100 continues to read as follows:

Authority: 2 U.S.C. 431, 438(a)(8).

2. Section 100.8 is amended by revising paragraphs (b)(4) introductory text and (b)(4)(iv) to read as follows:

§ 100.8 Expenditure (2 U.S.C. 431(9)).

* * * * *

(b) * *

(4) Any cost incurred for any communication by a membership organization, including a labor organization, to its members, or any cost incurred for any communication by a corporation to its stockholders or executive or administrative personnel, is not an expenditure, except that the costs directly attributable to such a communication that expressly advocates the election or defeat of a clearly identified candidate (other than a communication primarily devoted to subjects other than the express advocacy of the election or defeat of a clearly identified candidate) shall, if those costs exceed $2,000 per election, be reported to the Commission on FEC Form 7 in accordance with 11 CFR 104.6.

* * * * *

(iv) (A) For purposes of paragraph (b)(4) of this section *membership organization* means an unincorporated association, trade association, cooperative, corporation without capital stock, or a local, national, or international labor organization that:

(*1*) Is composed of members, some or all of whom are vested with the power and authority to operate or administer the organization, pursuant to the organization's articles, bylaws, constitution or other formal organizational documents;

(*2*) Expressly states the qualifications and requirements for membership in its articles, bylaws, constitution or other formal organizational documents;

(*3*) Makes its articles, bylaws, constitution or other formal organizational documents available to its members;

(*4*) Expressly solicits persons to become members;

(*5*) Expressly acknowledges the acceptance of membership, such as by sending a membership card or including the member's name on a membership newsletter list; and

(*6*) Is not organized primarily for the purpose of influencing the nomination for election, or election, of any individual for Federal office.

(B) For purposes of paragraph (b)(4) of this section, the term *members* includes all persons who are currently satisfying the requirements for membership in a membership organization, affirmatively accept the membership organization's invitation to become a member, and either:

(*1*) Have some significant financial attachment to the membership organization, such as a significant investment or ownership stake; or

(*2*) Pay membership dues at least annually, of a specific amount predetermined by the organization; or

(*3*) Have a significant organizational attachment to the membership organization which includes: affirmation of membership on at least an annual basis and direct participatory rights in the governance of the organization. For example, such rights could include the right to vote directly or indirectly for at least one individual on the membership organization's highest governing board; the right to vote on policy questions where the highest governing body of the membership organization is obligated to abide by the results; the right to approve the organization's annual budget; or the right to participate directly in similar aspects of the organization's governance.

(C) Notwithstanding the requirements of paragraph (b)(4)(iv)(B) of this section, the Commission may determine, on a case-by-case basis, that persons who do not precisely meet the requirements of the general rule, but have a relatively enduring and independently significant financial or organizational attachment to the organization, may be considered members for purposes of this section. For example, student members who pay a lower amount of dues while in school, long term dues paying members who qualify for lifetime membership status with little or no dues obligation, and retired members may be considered members of the organization.

(D) Notwithstanding the requirements of paragraphs (b)(4)(iv)(B)(*1*) through (*3*) of this section, members of a local union are considered to be members of any national or international union of which the local union is a part and of any federation with which the local, national, or international union is affiliated.

(E) In the case of a membership organization which has a national federation structure or has several levels, including, for example, national, state, regional and/or local affiliates, a person who qualifies as a member of any entity within the federation or of any affiliate by meeting the requirements of paragraphs (b)(4)(iv)(B)(*1*), (*2*), or (*3*) of this section shall also qualify as a member of all affiliates for purposes of paragraph (b)(4)(iv) of this section. The factors set forth at 11 CFR 100.5(g)(2), (3) and (4) shall be used to determine whether entities are affiliated for purposes of this paragraph.

(F) The status of a membership organization, and of members, for purposes of paragraph (b)(4) of this section, shall be determined pursuant to paragraph (b)(4)(iv) of this section and not by provisions of state law governing unincorporated associations, trade associations, cooperatives, corporations

without capital stock, or labor organizations.

* * * * *

PART 114—CORPORATE AND LABOR ORGANIZATION ACTIVITY

3. The authority citation for Part 114 continues to read as follows:

Authority: 2 U.S.C. 431(8)(B), 431(9)(B), 432, 437d(a)(8), 438(a)(8), and 441b.

4. Section 114.1 is amended by revising paragraph (e) to read as follows:

§ 114.1 Definitions.

* * * * *

(e)(1) For purposes of this part *membership organization* means a trade association, cooperative, corporation without capital stock, or a local, national, or international labor organization that:

(i) Is composed of members, some or all of whom are vested with the power and authority to operate or administer the organization, pursuant to the organization's articles, bylaws, constitution or other formal organizational documents;

(ii) Expressly states the qualifications and requirements for membership in its articles, bylaws, constitution or other formal organizational documents;

(iii) Makes its articles, bylaws, constitution, or other formal organizational documents available to its members upon request;

(iv) Expressly solicits persons to become members;

(v) Expressly acknowledges the acceptance of membership, such as by sending a membership card or including the member's name on a membership newsletter list; and

(vi) Is not organized primarily for the purpose of influencing the nomination for election, or election, of any individual to Federal office.

(2) For purposes of this part, the term *members* includes all persons who are currently satisfying the requirements for membership in a membership organization, affirmatively accept the membership organization's invitation to become a member, and either:

(i)Have some significant financial attachment to the membership organization, such as a significant investment or ownership stake; or

(ii) Pay membership dues at least annually, of a specific amount predetermined by the organization; or

(iii) Have a significant organizational attachment to the membership organization which includes: affirmation of membership on at least an annual basis; and direct participatory rights in the governance of the organization. For example, such rights could include the right to vote directly or indirectly for at least one individual on the membership organization's highest governing board; the right to vote directly for organization officers; the right to vote on policy questions where the highest governing body of the membership organization is obligated to abide by the results; the right to approve the organization's annual budget; or the right to participate directly in similar aspects of the organization's governance.

(3) Notwithstanding the requirements of paragraph (e)(2) of this section, the Commission may determine, on a case-by-case basis, that persons who do not precisely meet the requirements on the general rule, but have a relatively enduring and independently significant financial or organizational attachment to the organization, may be considered members for purposes of this section. For example, student members who pay a lower amount of dues while in school, long term dues paying members who qualify for lifetime membership status with little or no dues obligation, and retired members of the organization may be considered members for purposes of these rules.

(4) Notwithstanding the requirements of paragraphs (e)(2)(i) through (iii) of this section, members of a local union are considered to be members of any national or international union of which the local union is a part and of any federation with which the local, national, or international union is affiliated.

(5) In the case of a membership organization which has a national federation structure or has several levels, including, for example, national, state, regional and/or local affiliates, a person who qualifies as a member of any entity within the federation or of any affiliate by meeting the requirements of paragraphs (e)(2)(i), (ii), or (iii) of this section shall also qualify as a member of all affiliates for purposes of this part. The factors set forth at 11 CFR 100.5 (g)(2), (3) and (4) shall be used to determine whether entities are affiliated for purposes of this paragraph.

(6) The status of a membership organization, and of members, for purposes of this part, shall be determined pursuant to paragraph (e)(1) of this section and not by provisions of state law governing trade associations, cooperatives, corporations without capital stock, or labor organizations.

* * * * *

Dated: July 27, 1999.

Scott E. Thomas,

Chairman, Federal Election Commission.

[FR Doc. 99–19515 Filed 7–29–99; 8:45 am]

BILLING CODE 6715–01–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. 98–ANE–21–AD; Amendment 39–11233; AD 98–23–07 R1]

Airworthiness Directives; Pratt & Whitney JT9D Series Turbofan Engines

AGENCY: Federal Aviation Administration, DOT.

ACTION: Final rule; rescission; request for comments.

SUMMARY: This amendment rescinds Airworthiness Directive (AD) 98–23–07, which is applicable to certain Pratt & Whitney (PW) JT9D series turbofan engines. That AD requires a one-time acid etch inspection of the turbine exhaust case (TEC) wall between and on either side of the ''3R'' and ''S'' rails in the engine mount lug area (top quadrant of the case) for the presence of weld material, and if weld material is detected, removal from service and replacement with serviceable parts. The requirements of that AD were intended to prevent TEC structural failure under abnormal operating conditions, which could result in reduced main mount load capability, engine separation from the wing and subsequent loss of control of the airplane. Since the issuance of that AD, the FAA received reports from the manufacturer that describe a new safety analysis that determines the acid etch inspection for weld material is unnecessary.

DATES: Effective July 30, 1999.

Comments for inclusion in the Rules Docket must be received on or before September 28, 1999.

ADDRESSES: Submit comments in triplicate to the Federal Aviation Administration (FAA), New England Region, Office of the Regional Counsel, Attention: Rules Docket No. 98–ANE–21–AD, 12 New England Executive Park, Burlington, MA 01803–5299. Comments may also be sent via the Internet using the following address: ''9–ane–adcomment@faa.gov''. Comments sent via the Internet must contain the docket number in the subject line.

FOR FURTHER INFORMATION CONTACT: Tara Goodman, Aerospace Engineer, Engine Certification Office, FAA, Engine and Propeller Directorate, 12 New England

Executive Park, Burlington, MA 01803–5299; telephone (781) 238–7130, fax (781) 238–7199.

SUPPLEMENTARY INFORMATION: On November 5, 1998, the Federal Aviation Administration (FAA) issued Airworthiness Directive (AD) 98–23–07, amendment 39–10872 (63 FR 63393, November 13, 1998), applicable to certain Pratt & Whitney (PW) Models JT9D–7, –7A, –7H, –7AH, –7F, –7J, –20, –20J, –7Q, –7Q3, –59A, –70A, and –7R4D turbofan engines. That AD requires a one-time acid etch inspection of the turbine exhaust case (TEC) wall between and on either side of the ''R'' and ''S'' rails in the engine mount lug area (top quadrant of the case) for the presence of weld material, and if weld material is detected, removal from service and replacement with serviceable parts. That action was prompted by reports of weld rework performed in the outer case wall of the TEC, in the mount lug fillet area, during original production to address local under minimum wall thickness conditions which at the time was considered to have left the TEC's structural capability compromised. That condition, if not corrected, was considered to have the potential to result in TEC structural failure under abnormal operating conditions, which could result in reduced main mount load capability, engine separation from the wing and subsequent loss of control of the airplane.

Since the issuance of that AD, the FAA has reviewed detailed analyses for PW JT9D engine installations (excluding the JT9D–7R4 bulged low pressure turbine/TEC configurations). The analyses show that sufficient margin exists for TECs installed in JT9D–3A, –7, –7A, –7H, –7AH, –7F, –7J, –20, –20J, –7Q, –7Q3, –59A, –70A, and –7R4D engine configurations under abnormal operating conditions. The results also show that there are no flight safety issues resulting from weld rework in the outer case wall of the TEC in the mount lug fillet area.

Welding in the mount lug area of the TEC was performed on several PW JT9D series TECs during original manufacture in order to address case wall thickness that was below the minimum. Since original type certification and at present, cracking and welding are prohibited in the mount lug area in accordance with the Engine Manual, because of concern for structural integrity during abnormal operating conditions. The results of the analyses show that the area where welding is prohibited in the Engine Maintenance Manual can be redefined, such that welding would only be prohibited on the mount pads.

The FAA has reviewed the analytical results and has determined that welding in the fillets at the base of the ''R'' and ''S'' rails and the shell wall does not compromise the structural integrity of the TEC. Therefore, the FAA has determined that it is necessary to rescind AD 98–23–07 in order to prevent operators from performing an unnecessary action. The current AD requires a one-time inspection of the TEC to be performed at the next shop visit. Operators are currently facing the requirement to perform this unnecessary inspection; therefore, it is impractical to provide prior notice and opportunity for public comment before rescinding the current AD.

In addition, since this action rescinds a requirement to perform an unnecessary action, it has no adverse economic impact and imposes no additional burden on any person. Therefore, notice and public procedures hereon are impractical and the rescission may be made effective upon publication in the **Federal Register**.

Comments Invited

Although this action is in the form of a final rule that involves requirements affecting flight safety and, thus, was not preceded by notice and an opportunity for public comment, comments are invited on this rule. Interested persons are invited to comment on this rule by submitting such written data, views, or arguments as they may desire. Communications should identify the Rules Docket number and be submitted in triplicate to the address specified under the caption **ADDRESSES**. All communications received on or before the closing date for comments will be considered, and this rule may be amended in light of the comments received. Factual information that supports the commenter's ideas and suggestions is extremely helpful in evaluating the effectiveness of the AD action and determining whether additional rulemaking action would be needed.

Comments are specifically invited on the overall regulatory, economic, environmental, and energy aspects of the rule that might suggest a need to modify the rule. All comments submitted will be available, both before and after the closing date for comments, in the Rules Docket for examination by interested persons. A report that summarizes each FAA-public contact concerned with the substance of this AD will be filed in the Rules Docket.

Commenters wishing the FAA to acknowledge receipt of their comments submitted in response to this notice must submit a self-addressed, stamped postcard on which the following statement is made: ''Comments to Docket Number 98–ANE–21–AD.'' The postcard will be date stamped and returned to the commenter.

The Rescission

Accordingly, pursuant to the authority delegated to me by the Administrator, the Federal Aviation Administration amends part 39 of the Federal Aviation Regulations (14 CFR part 39) as follows:

PART 39—AIRWORTHINESS DIRECTIVES

1. The authority citation for part 39 continues to read as follows:

Authority: 49 U.S.C. 106(g), 40113, 44701.

§ 39.13 [Amended]

2. Section 39.13 is amended by removing amendment 39–10872 and adding 98–23–07 R1 to read as follows:

98–23–07 R1: Amendment 39–11233. Docket No. 98–ANE–21–AD. Rescinds AD 98–23–07, Amendment 39–10872.

Applicability: Pratt & Whitney (PW) Models JT9D–7, –7A, –7H, –7AH, –7F, –7J, –20, –20J, –7Q, –7Q3, –59A, –70A, and –7R4D turbofan engines. These engines are installed on but not limited to Boeing 747 and 767 series, McDonnell Douglas DC–10 series, and Airbus Industrie A300 and A310 series airplanes.

This rescission is effective July 30, 1999.

Issued in Burlington, Massachusetts, on July 15, 1999.

Mark C. Fulmer,

Acting Manager, Engine and Propeller Directorate, Engine Certification Office.

[FR Doc. 99–19296 Filed 7–29–99; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 95

[Docket No. 29678; Amdt. No. 417]

IFR Altitudes; Miscellaneous Amendments

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Final rule.

SUMMARY: This amendment adopts miscellaneous amendments to the required IFR (instrument flight rules) altitudes and changeover points for certain Federal airways, jet routes, or direct routes for which a minimum or maximum en route authorized IFR altitude is prescribed. This regulatory

action is needed because of changes occurring in the National Airspace System. These changes are designed to provide for the safe and efficient use of the navigable airspace under instrument conditions in the affected areas.

EFFECTIVE DATE: 0901 UTC, September 9, 1999.

FOR FURTHER INFORMATION CONTACT: Donald P. Pate, Flight Procedure Standards Branch (AMCAFS–420), Flight Technologies and Programs Division, Flight Standards Service, Federal Aviation Administration, Mike Monroney Aeronautical Center, 6500 South Macarthur Blvd. Oklahoma City, OK 73169 (Mail Address: P.O. Box 25082 Oklahoma City, OK 73125) telephone: (405) 954–4164.

SUPPLEMENTARY INFORMATION: This amendment to part 95 of the Federal Aviation Regulations (14 CFR part 95) amends, suspends, or revokes IFR altitudes governing the operation of all aircraft in flight over a specified route or any portion of the route, as well as the changeover points (COPs) for Federal airways, jet routes, or direct routes as prescribed in part 95.

The Rule

The specified IFR altitudes, when used in conjuction with the prescribed changeover points for those routes, ensure navigation aid coverage that is adequate for safe flight operations and free of frequency interference. The reasons and circumstances that create the need for this amendment involve matters of flight safety and operational efficiency in the National Airspace System, are related to published aeronautical charts that are essential to the user, and provide for the safe and efficient use of the navigable airspace. In addition, those various reasons or circumstances require making this amendment effective before the next scheduled charting and publication date of the flight information to assure its timely availability to the user. The effective date of this amendment reflects those considerations. In view of the close and immediate relationship between these regulatory changes and safety in air commerce, I find that notice and public procedure before adopting this amendment are impracticable and contrary to the public interest and that good cause exists for making the amendment effective in less than 30 days.

Conclusion

The FAA has determined that this regulation only involves an established body of technical regulations for which frequent and routine amendments are necessary to keep them operationally current. It, therefore—(1) is not a ''significant regulatory action'' under Executive Order 12866; (2) is not a ''significant rule'' under DOT Regulatory Policies and Procedures (44 FR 11034; February 26, 1979); and (3) does not warrant preparation of a regulatory evaluation as the anticipated impact is so minimal. For the same reason, the FAA certifies that this amendment will not have a significant economic impact on a substantial number of small entities under the criteria of the Regulatory Flexibility Act.

List of Subjects in 14 CFR Part 95

Airspace, Navigation (air).

Issued in Washington, D.C. on July 23, 1999.

L. Nicholas Lacey,

Director, Flight Standards Service.

Adoption of the Amendment

Accordingly, pursuant to the authority delegated to me by the Administrator, part 95 of the Federal Aviation Regulations (14 CFR part 95) is amended as follows effective at 0901 UTC, September 9, 1999.

1. The authority citation for part 95 continues to read as follows:

Authority: 49 U.S.C. 106(g), 40103, 40106, 401113, 40114, 40120, 44502, 44514, 44719, 44721.

2. Part 95 is amended to read as follows:

PART 95—[AMENDED]

Revisions to IFR Altitudes & Changeover Points

[Amendment 417 effective date, September 9, 1999]

From	To	MEA
§ 95.6004 VOR Federal Airway 4 Is Amended to Read in Part		
Topeka, KS VORTAC	Kansas City, MO VORTAC	2700
Kansas City, MO VORTAC	Hallsville, MO VORTAC	2500
§ 95.6010 VOR Federal Airway 10 Is Amended to Read in Part		
Emporia, KS VORTAC	Johnson County, MO VOR/DME	2700
Johnson County, KS VOR/DME	Napoleon, MO VORTAC	3000
§ 95.6012 VOR Federal Airway 12 Is Amended to Read in Part		
Emporia, KS VORTAC	Johnson County, KS VOR/DME	2700
Johnson County, KS VOR/DME	Napoleon, MO VORTAC	3000
§ 95.6013 VOR Federal Airway 13 Is Amended to Read in Part		
Napoleon, MO VORTAC	Lamoni, IA VORTAC	2600
§ 95.6014 VOR Federal Airway 14 Is Amended to Read in Part		
Buffalo, NY VOR/DME	Geneseo, NY VOR/DME	*6000
*4000—MOCA		
§ 95.6017 VOR Federal Airway 17 Is Amended To Read In Parts		
Milet, TX Fix	Somer, TX Fix	*4000
*2200—MOCA		
Somer, TX FIX	San Antonio, TX VORTAC	*3500
*2400—MOCA		

Revisions to IFR Altitudes & Changeover Points—Continued

[Amendment 417 effective date, September 9, 1999]

From	To	MEA
San Antonio, TX VORTAC	Centex, TX VORTAC	3500
§ 95.6029 VOR Federal Airway 29 Is Amended To Read in Part		
Pager, NY FIX	Watertown, NY VORTAC	*2600
*2000—MOCA		
Watertown, NY VORTAC	*Letus, NY FIX	*3000
*4000—MRA		
*1800—MOCA		
Letus, NY FIX	Massena, NY VORTAC	*3000
§ 95.6044 VOR Federal Airway 44 Is Amended to Read in Part		
Pawling, NY VOR/DME	Group, NY FIX	3000
Group, NY FIX	Albany, NY VORTAC	*2800
§ 95.6061 VOR Federal Airway 61 Is Amended to Read in Part		
Pawnee City, NE VORTAC	Robinson, KS VOR/DME	2800
Robinson, KS VOR/DME	Bowler, KS FIX	2600
§ 95.6061 VOR Federal Airway 61 Is Amended to Delete		
Bowler, KS FIX	Goldn, MO FIX	*4500
*2500—MOCA		
§ 95.6065 VOR Federal Airway 65 Is Amended to Delete		
Lamoni, IA VORTAC	Goldn, MO FIX	2900
§ 95.6070 VOR Federal Airway 70 Is Amended to Read in Part		
Lafayette, LA VORTAC	*Rosey, LA FIX	2000
*5000—MRA		
Rosey, LA FIX	Baton Rouge, LA VORTAC	2000
§ 95.6071 VOR Federal Airway 71 Is Amended to Read in Part		
Hot Springs, AR VOR/DME	Ollas, AR FIX	*3600
*3100—MOCA		
Ollas, AR FIX	Haawk, AR FIX	*4500
*2400—MOCA		
Haawk, AR FIX	Harrison, AR VOR/DME	*4500
§ 95.6084 VOR Federal Airway 84 Is Amended to Read in Part		
Buffalo, NY VOR/DME	Geneseo, NY VOR/DME	*6000
§ 95.6099 VOR Federal Airway 99 Is Amended to Read in Part		
LaGuardia, NY VOR/DME	Outte, CT FIX	4000
Outte, CT FIX	Sorry, CT FIX	10000
§ 95.6116 VOR Federal Airway 116 Is Amended to Read in Part		
Excel, MO FIX	Macon, MO VOR/DME	*3000
*2300—MOCA		
§ 95.6123 VOR Federal Airway 123 Is Amended to Read in Part		
Robbinsville, NJ VORTAC	Minks, NJ FIX	2000
Minks, NJ FIX	La Guardia, NY, VOR/DME	5000
La Guardia, NY VOR/DME	Famma, NY FIX	2000
Famma, NY FIX	Haarp, NY FIX	3000
Haarp, NY FIX	*Rymes, NY FIX	**5000
*5000—MRA.		
**2000—MOCA		
Rymes, NY FIX	Carmel, NY VOR/DME	2500
Carmel, NY VOR/DME	*Wigan, NY FIX	3000
*4500—MRA		
Wigan, NY FIX	Group, NY FIX	3000
Group, NY FIX	Albany, NY VORTAC	*2800
*2300—MOCA		

Revisions to IFR Altitudes & Changeover Points—Continued

[Amendment 417 effective date, September 9, 1999]

From	To	MEA
Albany, NY VORTAC *4500—MCA Cambridge VOR/DME N BND **3000—MOCA #ALB R–067 Unusable, Use CAM R–248.	*Cambridge, NY VOR/DME	#**4000
Cambridge, NY VOR/DME	Glens Falls, NY VORTAC	4500
§ 95.6157 VOR Federal Airway 157 Is Amended to Read in Part		
Robbinsville, NJ VORTAC	Minks, NJ FIX	2000
Minks, NJ FIX	La Guardia, NY VOR/DME	5000
La Guardia, NY VOR/DME	Famma, NY FIX	2000
Famma, NY FIX	Haarp, NY FIX	3000
Haarp, NY FIX *2700—MOCA	Kingston, NY VOR/DME	*4000
Kingston, NY VOR/DME *4500—MRA	*Wigan, NY FIX	3000
Wigan, NY FIX	Group, NY FIX	3000
Group, NY, FIX *2300—MOCA	Albany, NY VORTAC	*2800
§ 95.6159 VOR Federal Airway 159 Is Amended to Read in Part		
Napoleon, MO VORTAC	Lasso	2600
Lasso	St Joseph, MO VORTAC	2500
§ 95.6161 VOR Federal Airway 161 Is Amended to Read in Part		
Napoleon, MO VORTAC	Lamoni, IA VORTAC	2600
§ 95.6165 VOR Federal Airway 165 Is Amended to Read in Part		
Olympia, WA VORTAC *1900—MOCA	Carro, WA FIX	*4000
Carro, WA FIX *5200—MOCA	Arpee, WA FIX	*6000
§ 95.6165 VOR Federal Airway 165 Is Amended by Adding		
Arpee, WA FIX *2700—MOCA	Diggn, WA FIX	*5000
Diggn, WA FIX *2100—MOCA	Penn Cove, WA VOR/DME	*5000
Penn Cove, WA VOR/DME *1500—MOCA	Islnd, WA FIX	*5000
Islnd, WA FIX *2800—MOCA	Candl, WA FIX	*5000
Candl, WA FIX *1900—MOCA	Bellingham, WA VORTAC	*4000
§ 95.6194 VOR Federal Airway 194 Is Amended to Read in Part		
Lafayette, LA VORTAC *5000—MRA	*Rosey, LA FIX	2000
Rosey, LA FIX	Baton Rouge, LA VORTAC	2000
Liberty, NC VORTAC	Raleigh/Durham, NC VORTAC	3000
§ 95.6205 VOR Federal Airway 205 is Amended to Read in Part		
Bradley, CT VORTAC	Putnam, CT VOR/DME	3000
§ 95.6267 VOR Federal Airway 267 is Amended to Read in Part		
Craig, FL VORTAC *3000—MRA	*Baxley, GA FIX	3000
§ 95.6287 VOR Federal Airway 287 is Amended to Read in Part		
Olympia, WA Vortac *1900—MOCA	Carro, WA Fix	*4000
Carro, WA FIX *4700—MCA Arpee FIX S Bnd **5200—MOCA	*Arpee, WA FIX	**6000

Revisions to IFR Altitudes & Changeover Points—Continued

[Amendment 417 effective date, September 9, 1999]

From	To	MEA
§ 95.6287 VOR Federal Airway 287 is Amended to Read in Part		
Arpee, WA FIX	Lofal, WA FIX	4000
Lofal, WA FIX	Paine, WA VOR/DME	*3000
*1800—MOCA		
Paine, WA VOR/DME	Penn Cove, WA VOR/DME	*3000
*1800—MOCA		
§ 95.6323 VOR Federal Airway 323 is Amended to Read in Part		
Montgomery, AL VORTAC	Peech, AL FIX	2400
§ 95.6409 VOR Federal Airway 409 is Amended to Read in Part		
Liberty, NC VORTAC	Raleigh/Durham, NC VORTAC	3000
§ 95.6423 VOR Federal Airway 423 is Amended to Read in Part		
Pager, NY FIX	Watertown, NY VORTAC	*2600
*2000—MOCA.		
§ 95.6441 VOR Federal Airway 441 is Amended to Read in Part		
Monia, FL FIX	Brunswick, GA VORTAC	3000
§ 95.6451 VOR Federal Airway 451 is Amended to Read in Part		
Nessi, CT FIX	Keyed, NY FIX	2500
Keyed, NY FIX	Cream, NY FIX	2000
Cream, NY FIX	Groton, CT VOR/DME	6000
§ 95.6483 VOR Federal Airway 483 is Amended to Read in Part		
Rymes, NY FIX	Carmel, NY VOR/DME	2500
§ 95.6502 VOR Federal Airway 502 is Amended to Read in Part		
Emporia, KS VORTAC	Kansas City, MO VORTAC	3100
Kansas City, MO VORTAC	Braymer, MO VOR/DME	2600
Braymer, MO VOR/DME	Kirskville, MO VOTAC	2900
§ 95.6508 VOR Federal Airway 508 Is Amended to Read in Part		
Topeka, KS VORTAC	Rugbb, KS FIX	2800
Rugbb, KS FIX	Johnson County, KS VOR/DME	2600
§ 95.6534 VOR Federal Airway 534 is Amended to Read in Part		
Little Rock, AR VORTAC	Bibbs, AR FIX	3500
Bibbs, AR FIX	Haawk, AR FIX	*4500
*2500—MOCA		
Haawk, AR FIX	*Scran, AR FIX	**4500
*3300—MRA		
**3100—MOCA		
SCRAN, AR FIX	*Drano, AR FIX	**3500
*3000—MRA		
**3000—MOCA		
DRANO, AR FIX	Fort Smith, AR VORTAC	*2600
*2100—MOCA		
§ 95.6401 1 Hawaii VOR Federal Airway is Amended to Read in Part		
Rowin, HI FIX	Jessi, HI FIX	*7000
*1200—MOCA		
Jessi, HI FIX	*Lavas, HI FIX	**7000
*7000—MRA		
**1200—MOCA	Maken, HI FIX	*7000
Lavas, HI FIX.		
*5000—MOCA		
Maken ,HI FIX	Harpo, HI FIX	5000
Harpo, HI FIX	Maui, HI VORTAC	6000
§ 95.6402 2 Hawaii VOR Federal Airway is Amended to Read in Part		
Lanai, HI VORTAC	Keiki, HI FIX	5000
Keiki, HI FIX	Camps, HI FIX	*5000
*1200—MOCA		
Camps, HI FIX	Harpo, HI FIX	*5000

Revisions to IFR Altitudes & Changeover Points—Continued

[Amendment 417 effective date, September 9, 1999]

From	To	MEA
*1200 MOCA		
Harpo, HI FIX	Maken, HI FIX	5000
Maken, HI FIX	Upolu Point, HI vortac	5000
§ 95.6403 3 Hawaii VOR Federal Airway is Amended to Read in Part		
Mynah, HI FIX	*Jason, HI FX	
*4700—MCA Jason FIX NE BND	3500.	
Jason, HI FIX	Kamuela, VOR/DME	6500
§ 95.6405 5 Hawaii VOR Federal Airway is Amended to Read in Part		
Kona HI VORTAC	*Mynah, HI FIX	5000
*3500—MCA Mynah FIX SE BND		2000
Mynah, HI FIX	Hefti, HI FIX	2000
Hefti, I FIX	Maken, HI FIX	
NW BND		*8000
SE BND		*7000
*5500—MOCA		
§ 95.6406 6 Hawaii VOR Federal Airway is Amended to Read in Part		
Blush, HI FIX	Plumb, HI FIX	*5000
*1200—MOCA		
Plumb, HI FIX	Maui, HI VOTAC	5000
§ 95.6408 8 Hawaii VOR Federal Airway is Amended to Read in Part		
Molokai, HI Vortac	Blush, HI FIX	5000
Blush, HI FIX	Fishe, HI FIX	*4000
*1200—MOCA		
§ 95.6411 11 Hawaii VOR Federal Airway is Amended to Read in Part		
Reefs, HI FIX	Mynah, HI FIX	2000
Mynah, HI FIX	*Flitt, HI FIX	2000
*4500—MCA FLITT N BND		
Barby, HI FIX	Sweep, HI FIX	*5000
*3000—MOCA		
Sweep, HI FIX	Opana, HI FIX	*5000
*3000—MOCA		
Opana, HI FIX	Maui, HI VORTAC	5000
§ 95.6415 15 Hawaii VOR Federal Airway is Amended to Read in Part		
*Molokai, HI VORTAC	Loret, HI FIX	7000
*5000—MCA MOLOKAI VORTAC E BND		
*Loret, HI FIX	**Maui, HI VORTAC	8000
*7800—MCA LORET FIX E BND		
**6800—MCA Maui, VORTAC W BND		
Maui, HI FIX	Barby, HI FIX	7000
Barby, HI FIX	*Rabat, HI FIX	**10000
*1000—MRA		
*1200—MOCA		
§ 95.6416 16 Hawaii VOR Federal Airway is Amended to Read in Part		
Lanai, HI.		
*7000—MRA VORTAC	*Lavas, HI FIX	4300
§ 95.6417 17 Hawaii VOR Federal Airway is Amended to Read in Part		
Harpo, HI FIX	Maui, HI VORTAC	6000
Stait, HI FIX	Fredi, HI FIX	*17000
*1200—MOCA		
Fredi, HI FIX	Rexie, HI FIX	*28000
*1200—MOCA		
§ 95.6420 20 Hawaii VOR Federal Airway is Amended to Read in Part		
Typho, HI FIX	Andes, HI FIX	*3000
*1200—MOCA		
Andes, HI FIX	*Robyn, HI FIX	3000

Revisions to IFR Altitudes & Changeover Points—Continued

[Amendment 417 effective date, September 9, 1999]

From	To	MEA
*3800—MCA ROBYIN FIX SE BND		
§ 95.6421 21 Hawaii VOR Federal Airway is Amended to Read in Part		
Lana1, HI VORTAC	Keiki, HI FIX	5000
Keiki, HI FIX	Camps, HI FIX	*5000
*1200—MOCA		
Camps, HI FIX	*Harpo, HI FIX	**5000
*8100—MCA HARPO FIX E BND		
**1200—MOCA		
Harpo, HI FIX	Funki, HI FIX	*10000
*9000—MOCA		
Funki, HI FIX	*Pumic, HI FIX	10000
*10000—MRA		
§ 95.6422 22 Hawaii VOR Federal Airway is Amended to Read in Part		
*Molokai, HI VORTAC	Plumb, HI FIX	7000
*5000—MCA Molokai VORTAC E BND		
Plumb, HI FIX	Maui, HI FIX	5000
Maui, HI VORTAC	*Barby, HI FIX	7000
*10500—MCA Barby FIX SE BND		
§ 95.6423 23 Hawaii VOR Federal Airway is Amended to Read in Part		
Upolu Point, HI VORTAC	Jessi, HI FIX	*6000
*5000—MOCA		
Jessi, HI FIX	Fires, HI FIX	6000
§ 95.6424 24 Hawaii VOR Federal Airway is Amended to Read in Part		
*Lanai, HI VORTAC	**Maui, HI VORTAC	***9000
*5100—MCA Lanai VORTAC NE BND		
**6700—MCA Maui VORTAC SW BND		
***7800—MOCA		
§ 95.6425 25 Hawaii VOR Federal Airway is Amended to Read in Part		
Coddy, HI FIX	Arrow, HI FIX	26000
Arrow, HI FIX	Cluts, HI FIX	*26000
**1200—MOCA		

From	To	MEA	MAA
§ 95.7078 Jet Route No. 78 Is Amended to Read in Part			
Farmington, MO VORTAC	Pocket City, IN VORTAC	18000	45000
Pocket City, IN VORTAC	Louisville, KY VORTAC	18000	45000
§ 95.7112 Jet Route No. 112 Is Amended to Read in Part			
Farmington, MO VORTAC	Pocket City, IN VORTAC	18000	45000
Pocket City, IN VORTAC	Louisville, KY VORTAC	18000	45000

From	To	Changeover points	
		distance	from
§ 95.8003 VOR Federal Airway Changeover Points Airway Segment			
V–12 Is Amended to Add Changeover Point			
Emporia, KS VORTAC	Johnson County, MO VOR/DME.	49	Emporia
V–13 Is Amended to Add Changeover Point			
Napoleon, MO VORTAC	LaMonia, IA VORTAC	40	Napoleon
V–123 Is Amended to Add Changeover Point			
Woodstown, NJ VORTAC	Robbinsville, NJ VORTAC	19	Woodstown
V–157 Is Amended to Add Changeover Point			
Woodstown, NJ VORTAC	Robbinsville, NJ VORTAC	19	Woodstown
V–161 Is Amended to Add Changeover Point			
Napoleon, MO VORTAC	Lamoni, IA VORTAC	40	Napoleon
V–534 Is Amended to Add Changeover Point			
Little Rock, AR VORTAC	Fort Smith, AR VORTAC	58	Little Rock

[FR Doc. 99–19619 Filed 7–29–99; 8:45 am]
BILLING CODE 4910–13–M

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 97

[Docket No. 29666; Amdt. No. 1942]

Standard Instrument Approach Procedures; Miscellaneous Amendments

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Final rule.

SUMMARY: This amendment establishes, amends, suspends, or revokes Standard Instrument Approach Procedures (SIAPs) for operations at certain airports. These regulatory actions are needed because of changes occurring in the National Airspace System, such as the commissioning of new navigational facilities, addition of new obstacles, or changes in air traffic requirements. These changes are designed to provide safe and efficient use of the navigable airspace and to promote safe flight operations under instrument flight rules at the affected airports.

DATES: An effective date for each SIAP is specified in the amendatory provisions.

Incorporation by reference-approved by the Director of the Federal Register on December 31, 1980, and reapproved as of January 1, 1982.

ADDRESSES: Availabilitiy of matter incorporated by reference in the amendment is as follows:

For Examination—

1. FAA Rules Docket, FAA Rules Docket, FAA Headquarters Building, 800 Independence Avenue, SW., Washington, DC 20591;

2. The FAA Regional Office of the region in which affected airport is located; or

3. The Flight Inspection Area Office which originated the SIAP.

For Purchase—Individual SIAP copies may be obtained from:

1. FAA Public Inquiry Center (APA–200), FAA Headquarters Building, 800 Independence Avenue, SW., Washington, DC 20591; or

2. The FAA Regional Office of the region in which the affected airport is located.

By Subscription—Copies of all SIAPs, mailed once every 2 weeks, are for sale by the Superintendent of Documents, US Government Printing Office, Washington, DC 20402.

FOR FURTHER INFORMATION CONTACT: Donald P. Pate, Flight Procedure Standards Branch (AMCAFS–420), Flight Technologies and Programs Division, Flight Standards Service, Federal Aviation Administration, Mike Monroney Aeronautical Center, 6500 South MacArthur Blvd. Oklahoma City, OK. 73169 (Mail Address: P.O. Box 25082, Oklahoma City, OK. 73125) telephone: (405) 954–4164.

SUPPLEMENTARY INFORMATION: This amendment to part 97 of the Federal Aviation Regulations (14 CFR part 97) establishes, amends, suspends, or revokes Standard Instrument Approach Procedures (SIAPs). The complete regulatory description on each SIAP is contained in the appropriate FAA Form 8260 and the National Flight Data Center (FDC)/Permanent (P) Notices to Airmen (NOTAM) which are incorporated by reference in the amendment under 5 U.S.C. 552(a), 1 CFR part 51, and § 97.20 of the Federal Aviation's Regulations (FAR). Materials incorporated by reference are available for examination or purchase as stated above.

The large number of SIAPs, their complex nature, and the need for a special format make their verbatim publication in the **Federal Register** expensive and impractical. Further, airmen do not use the regulatory text of the SIAPs, but refer to their graphic depiction of charts printed by publishers of aeronautical materials. Thus, the advantages of incorporation by reference are realized and publication of the complete description of each SIAP contained in FAA form documents is unnecessary. The provisions of this amendment state the affected CFR (and FAR) sections, with the types and effective dates of the SIAPs. This amendment also identifies the airport, its location, the procedure identification and the amendment number.

The Rule

This amendment to part 97 of the Federal Aviation Regulations (14 CFR part 97) establishes, amends, suspends, or revokes SIAPs. For safety and timeliness of change considerations, this amendment incorporates only specific changes contained in the content of the following FDC/P NOTAMs for each SIAP. The SIAP information in some previously designated FDC/Temporary (FDC/T) NOTAMs is of such duration as to be permanent. With conversion to FDC/P NOTAMs, the respective FDC/T NOTAMs have been canceled.

The FDC/P NOTAMs for the SIAPs contained in this amendment are based on the criteria contained in the U.S. Standard for Terminal Instrument Procedures (TERPS). In developing these chart changes to SIAPs by FDC/P NOTAMs, the TERPS criteria were applied to only these specific conditions existing at the affected airports. All SIAP amendments in this rule have been previously issued by the FAA in a National Flight Data Center (FDC) Notice to Airmen (NOTAM) as an emergency action of immediate flight safety relating directly to published aeronautical charts. The circumstances which created the need for all these SIAP amendments requires making them effective in less than 30 days.

Further, the SIAPs contained in this amendment are based on the criteria contained in the TERPS. Because of the close and immediate relationship between these SIAPs and safety in air commerce, I find that notice and public procedure before adopting these SIAPs are impracticable and contrary to the public interest and, where applicable, that good cause exists for making these SIAPs effective in less than 30 days.

Conclusion

The FAA has determined that this regulation only involves an established body of technical regulations for which frequent and routine amendments are necessary to keep them operationally current. It, therefore—(1) Is not a ''significant regulatory action'' under Executive Order 12866; (2) is not a ''significant rule'' under DOT Regulatory Policies and Procedures (44 FR 11034; February 26, 1979); and (3) does not warrant preparation of a regulatory evaluation as the anticipated impact is so minimal. For the same reason, the FAA certifies that this amendment will not have a significant economic impact on a substantial number of small entities under the criteria of the Regulatory Flexibility Act.

List of subjects in 14 CFR Part 97

Air traffic control, Airports, Navigation (air).

Issued in Washington, DC on July 23, 1999.

L. Nicholas Lacey,

Director, Flight Standards Service.

Adoption of the Amendment

Accordingly, pursuant to the authority delegated to me, part 97 of the Federal Aviation Regulations (14 CFR part 97) is amended by establishing, amending, suspending, or revoking Standard Instrument Approach Procedures, effective at 0901 UTC on the dates specified, as follows:

PART 97—STANDARD INSTRUMENT APPROACH PROCEDURES

1. The authority citation for part 97 is revised to read as follows:

Authority: 49 U.S.C. 40103, 40113, 40120, 44701; 49 U.S.C. 106(g); and 14 CFR 11.49(b)(2).

2. Part 97 is amended to read as follows:

By amending: § 97.23 VOR, VOR/DME, VOR or TACAN, and VOR/DME or TACAN; § 97.25 LOC, LOC/DME, LDA, LDA/DME, SDF, SDF/DME; § 97.27 NDB, NDB/DME; § 97.29 ILS, ILS/DME, ISMLS, MLS, MLS/DME, MLS/RNAV; § 97.31 RADAR SIAPs; § 97.33 RNAV SIAPs; § 97.35 COPTER SIAPs, identified as follows:

* * * *Effective Upon Publication*

Date	State	City	Airport	FDC No.	SIAP
7/07/99	MT	Great Falls	Great Falls Intl	9/4734	VOR or GPS Rwy 3, amdt 16...
7/07/99	MT	Great Falls	Great Falls Intl	9/4735	ILS Rwy 3, Amdt 2...
7/08/99	MT	Great Falls	Great Falls Intl	9/4776	HI–VOR/DME or TACAN Rwy 3, Amdt 2...
7/08/99	MT	Great Falls	Great Falls Intl	9/4777	HI–ILS Rwy 3, Orig...
7/08/99	NE	Crete	Crete Muni	9/4797	VOR/DME Rwy 35, Amdt 3...
7/09/99	CT	Chester	Chester	9/4823	VOR/DME RNAV or GPS Rwy 35 Amdt 1...
7/09/99	MA	Provincetown	Provincetown Muni	9/4824	ILS Rwy 7 Amdt 7...
7/09/99	VA	South Boston	William M. Tuck	9/4817	VOR or GPS–A Amdt 7...
7/09/99	VA	South Boston	William M. Tuck	9/4818	GPS Rwy 36 Orig...
7/12/99	TN	Memphis	Memphis Intl	9/4875	ILS Rwy 36L (CAT I, II, III), Amdt 13A...
7/13/99	AL	Birmingham	Birmingham Intl	9/4910	ILS Rwy 23, Orig...
7/13/99	AL	Birmingham	Birmingham Intl	9/4911	NDB Rwy 23, Amdt 16...
7/13/99	AL	Birmingham	Birmingham Intl	9/4912	ILS Rwy 5, Amdt 41A...
7/13/99	AL	Birmingham	Birmingham Intl	9/4913	GPS Rwy 23, Orig...
7/13/99	AL	Birmingham	Birmingham Intl	9/4914	HI–ILS Rwy 5, Amdt 6...
7/13/99	AL	Birmingham	Birmingham Intl	9/4915	NDB or GPS Rwy 5, Amdt 30...
7/13/99	AL	Birmingham	Birmingham Intl	9/4916	Radar-1, Amdt 19A...
7/13/99	NV	Reno	Reno/Tahoe Intl	9/4896	GPS Rwy 16R Orig...
7/13/99	PA	Monongahela	Rostraver	9/4922	GPS Rwy 25 Orig-A...
7/13/99	VA	Hot Springs	Ingalls Field	9/4918	ILS Rwy 24 Amdt 2B...
7/14/99	MS	Columbus-West Point-Starkville.	Golden Triangle Regional	9/4954	GPS Rwy 18, Orig...
7/14/99	OH	Columbus	Port Columbus Intl	9/4942	ILS Rwy 28L, Amdt 27...
7/15/99	CO	Fort Collins/Loveland	Fort Collins-Loveland Muni	9/4999	VOR/DME or GPS–B, Amdt 1...
7/15/99	CO	Fort Collins/Loveland	Fort Collins-Loveland Muni	9/5000	ILS Rwy 33, Amdt 5A...
7/15/99	GA	Toccoa	Toccoa RG Letour-Neau Field	9/5037	VOR/DME Rwy 2, Orig-A...
7/15/99	NJ	Teterboro	Teterboro	9/5012	ILS Rwy 6 Amdt 29...
7/15/99	NJ	Teterboro	Teterboro	9/5013	COPTER ILS Rwy 6 Amdt 1...
7/15/99	NJ	Teterboro	Teterboro	9/5014	FMS/ILS Rwy 6 Orig-A...
7/15/99	SC	Greer	Greenville-Spartanburg	9/4991	ILS Rwy 22, Amdt 3...
7/15/99	WA	Ellensburg	Bowers Field	9/5032	GPS Rwy 25, Orig...
7/15/99	WA	Ellensburg	Bowers Field	9/5033	VOR or GPS–B, Amdt 1...
7/15/99	WA	Ellensburg	Bowers Field	9/5034	VOR or GPS–A, Amdt 2...
7/15/99	WV	Point Pleasant	Mason County	9/5031	GPS Rwy 25 Orig...
7/16/99	CA	Salinas	Salinas Muni	9/5090	VOR Rwy 13 Amdt 11
7/16/99	CA	Salinas	Salinas Muni	9/5091	ILS Rwy 31 Amdt 5...
7/16/99	CA	Salinas	Salinas Muni	9/5172	LOC/DME Rwy 31 Amdt 4...
7/16/99	KY	Louisville	Bowman Field	9/5079	NDB or GPS Rwy 32 Amdt 15...
7/16/99	KY	Louisville	Bowman Field	9/5080	VOR Rwy 32 Amdt 14...
7/16/99	KY	Louisville	Bowman Field	9/5081	VOR Rwy 24 Amdt 7...
7/16/99	KY	Louisville	Bowman Field	9/5082	VOR or GPS Rwy 14 Amdt 9...
7/16/99	KY	Louisville	Bowman Field	9/5083	GPS Rwy 24 Orig-A...
7/16/99	MD	Cumberland	Greater Cumberland Regional	9/5084	NDB–A Amdt 8...
7/16/99	MO	St Louis	Lambert-St Louis Intl	9/5055	TACAN Rwy 30L, Orig...
7/16/99	MO	St Louis	Lambert-St Louis Intl	9/5056	TACAN Rwy 12 R, Orig...
7/16/99	NJ	Caldwell	Essex County	9/5062	NDB or GPS Rwy 22 Amdt 5...
7/16/99	NJ	Caldwell	Essex County	9/5076	LOC Rwy 22 Amdt 1B...
7/16/99	NJ	Caldwell	Essex County	9/5077	NDB or GPS–A Amdt 5A...
7/16/99	RI	Westerly	Westerly State	9/5050	LOC Rwy 7 Amdt 5...
7/16/99	TN	Jacksboro	Campbell County	9/5067	GPS Rwy 23 Orig...
7/16/99	TN	Smyrna	Smyrna	9/5069	NDB Rwy 32 Amdt 8A...
7/19/99	FL	Tallahasse	Tallahasse Regional	9/5165	ILS Rwy 27 Amdt 6 (CAT I and II)...
7/19/99	NV	Reno	Reno/Tahoe Intl	9/5152	LOC–2 Rwy 16R Amdt 6A...
7/21/99	CA	Hayward	Hayward Air Terminal	9/5254	VOR/DME or GPS–B Amdt. 1A
7/21/99	CA	Hayward	Hayward Air Terminal	9/5255	GPS Rwy 28L Orig...
7/21/99	CA	Hayward	Hayward Air Terminal	9/5256	LOC/DME Rwy 28L Amdt 1...
7/21/99	CA	Hayward	Hayward Air Terminal	9/5257	VOR or GPS–A Amdt 6A...

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DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 97

[Docket No. 29667; Amdt. No. 1943]

Standard Instrument Approach Procedures; Miscellaneous Amendments

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Final rule.

SUMMARY: This amendment establishes, amends, suspends, or revokes Standard instrument Approach Procedures (SIAP's) for operations at certain airports. These regulatory actions are needed because of the adoption of new or revised criteria, or because of changes occurring in the National Airspace System, such as the commissioning of new navigational facilities, addition of the new obstacles, or changes in air traffic requirements. These changes are designed to provide safe and efficient use of the navigable airspace and to promote safe flight operations under instrument flight rules at the affected airports.

DATES: An effective date for each SIAP is specified in the amendatory provisions.

Incorporation by reference-approved by the Director of the Federal Register on December 31, 1980, and reapproved as of January 1, 1982.

ADDRESSES: Availability of matters incorporated by reference in the amendment in the amendment is as follows:

For Examination—

1. FAA Rules Docket, FAA Headquarters Building, 800 Independence Avenue, SW., Washington, DC 20591;
2. The FAA Regional Office of the region in which the affected airport is located; or
3. The Flight Inspection Area Office which originated the SIAP.

For Purchase—Individual SIAP copies may be obtained from:

1. FAA Public Inquiry Center (APA–200), FAA Headquarters Building, 800 Independence Avenue, SW, Washington, DC 20591; or
2. The FAA Regional Office of the region in which the affected airport is located.

By Subscription—Copies of all SIAP's, mailed once every 2 weeks, are for sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402.

FOR FURTHER INFORMATION CONTACT: Donald P. Pate, Flight Procedure Standards Branch (AMCAFS–420), Flight Technologies and Programs Division, Flight Standards Service, Federal Aviation Administration, Mike Monroney Aeronautical Center, 6500 South MacArthur Blvd. Oklahoma City, OK. 73169 (Mail Address: P.O. Box 25082 Oklahoma City, OK. 73125) telephone: (405) 954–4164.

SUPPLEMENTARY INFORMATION: This amendment to part 97 of the Federal Aviation Regulations (14 CFR part 97) establishes, amends, suspends, or revokes SIAP's. The complete regulatory description of each SIAP is contained in official FAA form documents which are incorporated by reference in this amendment under 5 U.S.C. 552(a), 1 CFR part 51, and 14 CFR 97.20 of the Federal Aviation Regulations (FAR). The applicable FAA Forms are identified as FAA Form 8260–5. Materials incorporated by reference are available for examination or purchase as stated above.

The large number of SIAP's, their complex nature, and the need for a special format make their verbatim publication in the **Federal Register** expensive and impractical. Further, airmen do not use the regulatory text of the SIAPs, but refer to their graphic depiction on charts printed by publishers of aeronautical materials. Thus, the advantages of incorporation by reference are realized and publication of the complete description of each SIAP contained in FAA form documents is unnecessary. The provisions of this amendment state the affected CFR sections, with the types and effective dates of the SIAPs. This amendment also identifies the airport, its location, the procedure identification and the amendment number.

The Rule

This amendment to part 97 is effective upon publication of each separate SIAP as contained in the transmittal. The SIAP's contained in this amendment are based on the criteria contained in the United States Standard for Terminal Instrument Procedures (TERPS). In developing these SIAPs, the TERPS criteria were applied to the conditions existing or anticipated at the affected airports.

The FAA has determined through testing that current non-localizer type, non-precision instrument approaches developed using the TERPS criteria can be flown by aircraft equipped with a Global Positioning System (GPS) and or Flight Management System (FMS) equipment. In consideration of the above, the applicable SIAP's will be altered to include ''or GPS or FMS'' in the title without otherwise reviewing or modifying the procedure. (Once a stand alone GPS or FMS procedure is developed, the procedure title will be altered to remove ''or GPS or FMS'' from these non-localizer, non-precision instrument approach procedure titles.)

The FAA has determined through extensive analysis that current SIAP's intended for use by Area Navigation (RNAV) equipped aircraft can be flown by aircraft utilizing various other types of navigational equipment. In consideration of the above, those SIAP's currently designated as ''RNAV'' will be redesignated as ''VOR/DME RNAV'' without otherwise reviewing or modifying the SIAP's.

Because of the close and immediate relationship between these SIAP's and safety in air commerce, I find that notice and public procedure before adopting these SIAPs are, impracticable and contrary to the public interest and, where applicable, that good cause exists for making some SIAPs effective in less than 30 days.

Conclusion

The FAA has determined that this regulation only involves an established body of technical regulations for which frequent and routine amendments are necessary to keep them operationally current. It, therefore—(1) Is not a ''significant regulatory action'' under Executive Order 12866; (2) is not a ''significant rule'' under DOT Regulatory Policies and Procedures (44 FR 11034; February 26, 1979); and (3) does not warrant preparation of a regulatory evaluation as the anticipated impact is so minimal. For the same reason, the FAA certifies that this amendment will not have a significant economic impact on a substantial number of small entities under the criteria of the Regulatory Flexibility Act.

List of Subjects in 14 CFR Part 97

Air traffic control, Airports, Navigation (air).

Issued in Washington, DC on July 23, 1999.

L. Nicholas Lacey,

Director, Flight Standards Service.

Adoption of the Amendment

Accordingly, pursuant to the authority delegated to me, part 97 of the Federal Aviation Regulations (14 CFR part 97) is amended as follows:

PART 97—STANDARD INSTRUMENT APPROACH PROCEDURES

1. The authority citation for part 97 continues to read:

Authority: 49 U.S.C. 106(g), 40103, 40106, 40113–40114, 40120, 44502, 44514, 44701, 44719, 44721–44722.

2. Amend 97.23, 97.27, 97.33 and 97.35, as appropriate, by adding, revising, or removing the following SIAP's effective at 0901 UTC on the dates specified:

** * * Effective September 9, 1999*

Fort Yukon, AK, Fort Yukon, VOR/DME or TACAN or GPS Rwy 3, Amdt 1A, Canceled
Fort Yukon, AK, Fort Yukon, VOR/DME or TACAN Rwy 3, Amdt 1A
Fort Yukon, AK, Fort Yukon, VOR/DME or TACAN or GPS Rwy 21, Amdt 1A, Canceled
Fort Yukon, AK, Fort Yukon, VOR/DME or TACAN Rwy 21, Amdt 1A
Redding, CA, Redding Muni, VOR or GPS Rwy 34, Amdt 10C, Canceled
Redding, CA, Redding Muni, VOR Rwy 34, Amdt 10C
Akron, CO, Akron-Washington County, VOR or GPS Rwy 29 Orig, Canceled
Akron, CO, Akron-Washington County, VOR Rwy 29 Orig
Fort Myers, FL, Southwest Florida Intl, NDB or GPS Rwy 6, Amdt 4A, Canceled
Fort Myers, FL, Southwest Florida Intl, NDB Rwy 6, Amdt 4A
Fort Myers, FL, Southwest Florida Intl, VOR/DME or TACAN or GPS Rwy 24, Amdt 1, Canceled
Fort Myers, FL, Southwest Florida Intl, VOR/DME or TACAN Rwy 24, Amdt 1
St. Petersburg-Clearwater, FL, St. Petersburg-Clearwater Intl, VOR or GPS Rwy 17L, Amdt 11B, Canceled
St. Petersburg-Clearwater, FL, St. Petersburg-Clearwater Intl, VOR Rwy 17L, Amdt 11B
Paducah, KY West Kentucky Airpark, VOR or GPS Rwy 4, Amdt 16A, Canceled
Paducah, KY, West Kentucky Airpark, VOR Rwy 4, Amdt 16A
Paducah, KY, West Kentucky Airpark, NDB or GPS Rwy 22 Amdt 2, Canceled
Paducah, KY, West Kentucky Airpark NDB Rwy 22, Amdt 2
Van Wert, Van Wert County, NBD or GPS Rwy 9, Amdt 1, Canceled
Van Wert, OH, Van Wert County, NBD Rwy 9, Amdt 1
Van Wert, OH, Van Wert County, NBD or GPS Rwy 27, Orig, Canceled
Van Wert, OH, Van Wert County, NBD Rwy 27, Orig
Norman, OK, University of Oklahoma Westheimer, VOR/DME or RNAV or GPS Rwy 3, Orig-C, Canceled
Norman, OK, University of Oklahoma Westheimer, VOR/DME or RNAV Rwy 3, Orig-C
Tahlequah, OK, Tahlequah Muni, NDB or GPS Rwy 17, Amdt 1, Canceled
Tahlequah, OK, Tahlequah Muni, NDB Rwy 17, Amdt 1
Jackson, TN, McKeller-Sipes Regional, NDB or GPS Rwy 2, Amdt 6, Canceled
Jackson, TN, McKeller-Sipes Regional, NDB Rwy 2, Amdt 6

[FR Doc. 99–19622 Filed 7–29–99; 8:45 am]

BILLING CODE 4910–13–M

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 97

[Docket No. 29665; Amdt. No. 1941]

Standard Instrument Approach Procedures; Miscellaneous Amendments

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Final rule.

SUMMARY: This amendment establishes, amends, suspends, or revokes Standard Instrument Approach Procedures (SIAPs) for operations at certain airports. These regulatory actions are needed because of the adoption of new or revised criteria, or because of changes occurring in the National Airspace System, such as the commissioning of new navigational facilities, addition of new obstacles, or changes in air traffic requirements. These changes are designed to provide safe and efficient use of the navigable airspace and to promote safe flight operations under instrument flight rules at the affected airports.

DATES: An effective date for each SIAP is specified in the amendatory provisions.

Incorporatioin by reference-approved by the Director of the Federal Register on December 31, 1980, and reapproved as of January 1, 1982.

ADDRESSES: Availability of matters incorporated by reference in the amendment is as follows:

For Examination—

1. FAA Rules Docket, FAA Headquarters Building, 800 Independence Avenue, SW., Washington, DC 20591;

2. The FAA Regional Office of the region in which the affected airport is located; or

3. The Flight Inspection Area Office which originated the SIAP.

For Purchase—

Individual SIAP copies may be obtained from:

1. FAA Public Inquiry Center (APA–200), FAA Headquarters Building, 800 Independence Avenue, SW., Washington, DC 20591; or

2. The FAA Regional Office of the region in which the affected airport is located.

By Subscription—

Copies of all SIAPs, mailed once every 2 weeks, are for sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402.

FOR FURTHER INFORMATION CONTACT: Donald P. Pate, Flight Procedure Standards Branch (AMCAFS–420), Flight Technologies and Programs Division, Flight Standards Service, Federal Aviation Administration, Mike Monroney Aeronautical Center, 6500 South MacArthur Blvd. Oklahoma City, OK. 73169 (Mail Address: P.O. Box 25082 Oklahoma City, OK. 73125) telephone: (405) 954–4164.

SUPPLEMENTARY INFORMATION: This amendment to part 97 of the Federal Aviation Regulations (14 CFR part 97) establishes, amends, suspends, or revokes Standard Instrument Approach Procedures (SIAPs). The complete regulatory description of each SIAP is contained in official FAA form documents which are incorporated by reference in this amendment under 5 U.S.C. 552(a), 1 CFR part 51, and § 97.20 of the Federal Aviation Regulations (FAR). The applicable FAA Forms are identified as FAA Forms 8260–3, 8260–4, and 8260–5. Materials incorporated by reference are available for examination or purchase as stated above.

The large number of SIAPs, their complex nature, and the need for a special format make their verbatim publication in the **Federal Register** expensive and impractical. Further, airmen do not use the regulatory text of the SIAPs, but refer to their graphic depiction on charts printed by publishers of aeronautical materials. Thus, the advantages of incorporation by reference are realized and publication of the complete description of each SIAP contained in FAA form Documents is unnecessary. The provisions of this amendment state the affected CFR (and FAR) sections, with the types and effective dates of the SIAPs. This amendment also identifies the airport, its location, the procedure

identification and the amendment number.

The Rule

This amendment to part 97 is effective upon publication of each separate SIAP as contained in the transmittal. Some SIAP amendments may have been previously issued by the FAA in a National Flight Data Center (NFDC) Notice to Airmen (NOTAM) as an emergency action of immediate flight safety relating directly to published aeronautical charts. The circumstances which created the need for some SIAP amendments may require making them effective in less than 30 days. For the remaining SIAPs, an effective date at least 30 days after publication is provided.

Further, the SIAPs contained in this amendment are based on the criteria contained in the U.S. Standard for Terminal Instrument Procedures (TERPS). In developing these SIAPs, the TERPS criteria were applied to the conditions existing or anticipated at the affected airports. Because of the close and immediate relationship between these SIAPs and safety in air commerce, I find that notice and public procedure before adopting these SIAPs are impracticable and contrary to the public interest and, where applicable, that good cause exists for making some SIAPs effective in less than 30 days.

Conclusion

The FAA has determined that this regulation only involves an established body of technical regulations for which frequent and routine amendments are necessary to keep them operationally current. It, therefore—(1) Is not a ''significant regulatory action'' under Executive Order 12866; (2) is not a ''significant rule'' under DOT Regulatory Policies and Procedures (44 FR 11034; February 26, 1979); and (3) does not warrant preparation of a regulatory evaluation as the anticipated impact is so minimal. For the same reason, the FAA certifies that this amendment will not have a significant economic impact on a substantial number of small entities under the criteria of the Regulatory Flexibility Act.

List of Subjects in 14 CFR Part 97

Air traffic control, Airports, Navigation (Air).

Issued in Washington, DC on July 23, 1999.

L. Nicholas Lacey,

Director, Flight Standards Service.

Adoption of the Amendment

Accordingly, pursuant to the authority delegated to me, part 97 of the Federal Aviation Regulations (14 CFR part 97) is amended by establishing, amending, suspending, or revoking Standard Instrument Approach Procedures, effective at 0901 UTC on the dates specified, as follows:

PART 97—STANDARD INSTRUMENT APPROACH PROCEDURES

1. The authority citation for part 97 is revised to read as follows:

Authority: 49 U.S.C. 106(g), 40103, 40113, 40120, 44701; and 14 CFR 11.49(b)(2).

2. Part 97 is amended to read as follows:

§§ 97.23, 97.25, 97.27, 97.29, 97.31, 97.33, 97.35 [Amended]

By amending: § 97.23 VOR, VOR/DME, VOR or TACAN, and VOR/DME or TACAN; § 97.25 LOC, LOC/DME, LDA, LDA/DME, SDF, SDF/DME; § 97.27 NDB, NDB/DME; § 97.29 ILS, ILS/DME, ISMLS, MLS, MLS/DME, MLS/RNAV; § 97.31 RADAR SIAPs; § 97.33 RNAV SIAPs; and § 97.35 COPTER SIAPs, identified as follows:

** * * Effective August 12, 1999*

Escanaba, MI, Delta County, ILS/DME RWY 9, Amdt 4A, CANCELLED
Escanaba, MI, Delta County, ILS RWY 9, Orig
Iron Mountain/Kingsford, MI, Ford, VOR OR GPS RWY 31, Amdt 15
Iron Mountain/Kingsford, MI, Ford, LOC/DME BC RWY 19, Amdt 12
Iron Mountain/Kingsford, MI, Ford, NDB RWY 1, Orig
Iron Mountain/Kingsford, MI, Ford, ILS RWY 1, Amdt 11
Newark, NJ, Newark Intl, ILS RWY 22R, Amdt 2
Memphis, TN, Memphis International, ILS RWY 9, Amdt 26
Nashville, TN, John C. Tune, LOC/DME RWY 19, Amdt 2A, CANCELLED
Nashville, TN, John C. Tune, ILS/DME RWY 19, Orig

** * * Effective September 9, 1999*

Atqasuk, AK, Atqasuk Edward Burnell Sr. Memorial NDB RWY 6, Orig
Atqasuk, AK, Atqasuk Edward Burnell Sr. Memorial NDB RWY 24, Orig
Cold Bay, AK, Cold Bay, VOR/DME OR TACAN–A, Amdt 2
Cold Bay, AK, Cold Bay, MLS RWY 32, Amdt 1
Palmer, AK, Palmer Muni, GPS–A, Orig
Arcata-Eureka, CA, Arcata, GPS RWY 2, Orig
Arcata-Eureka, CA, Arcata, GPS RWY 14, Orig
Arcata-Eureka, CA, Arcata, GPS RWY 32, Orig
Colusa, CA, Colusa County, GPS RWY 13, Orig
Colusa, CA, Colusa County, GPS RWY 31, Orig
Washington, DC, Ronald Reagan Washington National, VOR RWY 1, Amdt 12
Washington, DC, Ronald Reagan Washington National, VOR/DME OR GPS RWY 19, Amdt 9
Washington, DC, Ronald Reagan Washington National, LDA/DME RWY 19, Amdt 2
Washington, DC, Ronald Reagan Washington National, ROSSLYN LDA RWY 19, Amdt 15
Washington, DC, Ronald Reagan Washington National, NDB OR GPS RWY 1, Amdt 11
Washington, DC, Ronald Reagan Washington National, ILS RWY 1, Amdt 40
Emporia, KS, Emporia Muni, VOR OR GPS–A, Amdt 13
Emporia, KS, Emporia Muni, VOR/DME RNAV RWY 19, Amdt 8
Emporia, KS, Emporia Muni, GPS RWY 19, Orig
Fort Leavenworth, KS, Sherman AAF, VOR/DME–A, Orig
Somerset, KY, Somerset-Pulaski County-J.T. Wilson Field, GPS RWY 4, Orig
Shreveport LA, Shreveport Regional, NDB OR GPS RWY 14, Amdt 20
Shreveport LA, Shreveport Regional, ILS RWY 14, Amdt 22
Augusta, ME, Augusta State, GPS RWY 8, Orig
Augusta, ME, Augusta State, GPS RWY 17, Orig
Augusta, ME, Augusta State, GPS RWY 35, Orig
Frederick, MD, Frederick Muni, VOR OR GPS–A, Amdt 2
Frederick, MD, Frederick Muni, ILS RWY 23, Amdt 4
Frederick, MD, Frederick Muni, GPS RWY 5, Amdt 1
Palmer, MA, Metropolitan, GPS RWY 4, Orig
Glencoe, MN, Glencoe Muni, NDB RWY 31, Orig
Rushford MN, Rushford Muni, GPS RWY 34, Orig
Silver Bay, MN, Silver Bay Muni, GPS RWY 25, Amdt 1
Butler, MO, Butler Memorial, VOR–A, Amdt 4
Kansas City, MO, Kansas City Intl, VOR OR GPS RWY 27, Amdt 14, CANCELLED
Kansas City, MO, Kansas City Intl, VOR/DME OR TACAN RWY IL, Orig
Kansas City, MO, Kansas City Intl, VOR/DME OR TACAN RWY 19R, Orig
Kansas City, MO, Kansas City Intl, VOR/DME OR TACAN RWY 27, Orig
Kansas City, MO, Kansas City Intl, GPS RWY 1R, Orig
Kansas City, MO, Kansas City Intl, GPS RWY 9, Orig
Kansas City, MO, Kansas City Intl, GPS RWY 19R, Orig
Kansas City, MO, Kansas City Intl, GPS RWY 27, Orig
Minden, NV, Minden-Tahoe, GPS–A, Orig
Minden, NV, Minden-Tahoe, GPS–B, Orig
Waverly, OH, Pike County, GPS RWY 7, Orig
Waverly, OH, Pike County, GPS RWY 25, Orig
Grants Pass, OR, Grants Pass, GPS–A, Amdt 1
Allendale, SC, Allendale County, GPS RWY 17, Orig
Allendale, SC, Allendale County, GPS RWY 35, Orig
Britton, SD, Britton Muni, NDB OR GPS RWY 13, Amdt 1
Britton, SD, Britton Muni, GPS RWY 31, Amdt 1
Alice, TX, Alice Intl, VOR–A, Amdt 1

Alice, TX, Alice Intl, VOR RWY 31, Amdt 12
Alice, TX, Alice Intl, LOC RWY 31, Amdt 6
Alice, TX, Alice Intl, GPS RWY 13, Orig
Alice, TX, Alice Intl, GPS RWY 31, Amdt 1
Bremerton, WA, Bremerton National, NDB RWY 1, Amdt 1
Bremerton, WA, Bremerton National, ILS RWY 19, Amdt 13
Bremerton, WA, Bremerton National, GPS RWY 1, Amdt 1
Burlington/Mount Vernon, WA, Skagit Regional NDB RWY 10, Amdt 3
Burlington/Mount Vernon, WA, Skagit Regional GPS RWY 10, Amdt 1
Friday Harbor, WA, Friday Harbor, NDB RWY 34, Amdt 1
Friday Harbor, WA, Friday Harbor, GPS RWY 34, Amdt 1
Shelton, WA, Sanderson Field, NDB OR GPS–A, Amdt 2
Shelton, WA, Sanderson Field, GPS RWY 5, Amdt 1
Shelton, WA, Sanderson Field, GPS RWY 23, Amdt 1
Tacoma, WA, Tacoma Narrows, NDB RWY 35, Amdt 7
Tacoma, WA, Tacoma Narrows, GPS RWY 17, Orig
Tacoma, WA, Tacoma Narrows, GPS RWY 35, Orig

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LIBRARY OF CONGRESS

Copyright Office

37 CFR Part 201

[Docket No. RM 98–7C]

Notice and Recordkeeping for Making and Distributing Phonorecords

AGENCY: Copyright Office, Library of Congress.

ACTION: Interim regulations.

SUMMARY: The Copyright Office is announcing interim regulations which specify notice and recordkeeping requirements associated with the making of digital phonorecord deliveries. The Digital Performance Right in Sound Recordings Act of 1995 requires the Librarian of Congress to establish these regulations to insure proper payment to copyright owners for the use of their works.

EFFECTIVE DATE: The interim regulations shall become effective on August 30, 1999.

FOR FURTHER INFORMATION CONTACT: David O. Carson, General Counsel, or Tanya M. Sandros, Attorney Advisor, Copyright Arbitration Royalty Panel (''CARP''), P.O. Box 70977, Southwest Station, Washington, D.C. 20024. Telephone: (202) 707–8380. Telefax: (202) 252–3423.

SUPPLEMENTARY INFORMATION:

Background

On November 1, 1995, Congress enacted the Digital Performance Right in Sound Recordings Act of 1995 (''DPRA''), Pub. L. 104–39 (1995). Among other things, this law clarifies that the compulsory license for making and distributing phonorecords includes the distribution of a phonorecord of a nondramatic musical work by means of a digital phonorecord delivery. 17 U.S.C. 115(c)(3).

The DPRA requires the Librarian of Congress to ''establish requirements by which copyright owners may receive reasonable notice of the use of their works under this section, and under which records of such use shall be kept and made available by persons making digital phonorecord deliveries.'' 17 U.S.C. 115(c)(3)(D).

The Copyright Office initiated the process to promulgate regulations on the subject of the notice and recordkeeping requirements on September 4, 1998, with the publication of a Notice of Inquiry. 63 FR 47215 (September 4, 1998). The notice sought comment on whether the existing regulations, 37 CFR 201.18 and 201.19, governing the administration of the section 115 compulsory license, could be amended to accommodate the additional notice and recordkeeping requirements. Comments were due on October 19, 1998, and reply comments were due on November 18, 1998.

On October 19, 1998, the Recording Industry Association of America (''RIAA'') and the National Music Publishers' Association of America, Inc. (''NMPA'') filed a joint petition with the Copyright Office. The petition requested a six-month extension of the filing period in order to allow these parties additional time to work out a joint proposal that would address the complex technical and business issues involved in the making of digital phonorecord deliveries (''DPDs''). In response to the parties' concerns expressed in the petition and a second request for additional time, the Copyright Office reopened the comment period twice. 63 FR 65567 (November 27, 1998); 63 FR 69251 (December 16, 1998).

The Commenters

The Copyright Office received five comments from six parties: NMPA and the Songwriters Guild of America (''SGA''), jointly; RIAA; Digital Media Association (''DiMA''); Broadcast Music, Inc. (''BMI''), and the American Society of Composers, Authors, and Publishers (''ASCAP'').

The Scope of This Proceeding

BMI and ASCAP filed comments to underscore their understanding that the DPRA does not in any way diminish the right of public performance and that the current rulemaking does not involve the right of public performance, but rather is limited to the right of reproduction and the right of distribution. BMI's and ASCAP's assessment as to the scope of this proceeding is correct. It implicates only the rights of reproduction and distribution in the making and distribution of phonorecords, and not the right of public performance.

A Request for Interim Regulations

NMPA/SGA, RIAA, and DiMA indicate a strong preference for delaying the adoption of final regulations on notice and recordkeeping because the industry is in its infancy and business models to handle the transactions involved in making DPDs are still evolving. These commenters encourage the Office to adopt interim regulations for a period of between six months to two years in order to allow continued negotiations among industry representatives. BMI and ASCAP also have no objections to adopting interim regulations so long as such amendments do not apply to the right of public performance. The Copyright Office agrees with the commenters and is adopting interim regulations for a period of two years; however, a party with a substantial interest in notice and recordkeeping requirements for DPDs may petition the Office to reopen the rulemaking for good cause before the expiration of this period. The interim regulations are promulgated without prejudice to the parties who, at the appropriate time, may propose final regulations that may differ significantly from the interim rules based upon the developing business trends in the industry.

Proposed Amendments to 37 CFR 201.18 and 201.19

Section 115(b)(1) of the Copyright Act, title 17 of the United States Code, requires ''[a]ny person who wishes to obtain a compulsory license under this section . . . [to] serve notice of intention to do so on the copyright owner.'' This section also requires the Copyright Office to prescribe regulations specifying the form, content, and manner of service of the notice of intention. Section 201.18 of title 37 of the Code of Federal Regulations meets this requirement. Similarly, the regulations in § 201.19 address the requirement that each compulsory licensee file monthly and annual

statements of account for each section 115 compulsory license in accordance with 17 U.S.C. 115(c)(5).

NMPA/SGA, RIAA, and DiMA proposed amendments to §§ 201.18 and 201.19 that would adapt these rules to digital phonorecord deliveries at least for purposes of filing notices of intention to use the license and statements of account. However, NMPA and SGA do not believe that amending the current regulations will be sufficient to address the requirements of section 115(c)(3)(D), of title 17 of the United States Code, relating to notice and recordkeeping. They contend that the requirements of section 115(c)(3)(D) are separate and distinct from the requirements to file a notice of intention to use the license and statements of account specified in sections 115(b)(1) and (c)(5), respectively, but acknowledge that the requirements share some common ground. On the other hand, RIAA states that it believes the proposed amendments would fulfill the notice and recordkeeping requirements set out in 17 U.S.C. 115(c)(3)(D), in addition to the traditional requirements for filing a notice of intention to use the license and statements of account set out in 17 U.S.C. 115(b)(1) and (c)(5). Reply comments of RIAA at 5 n.1.

While acknowledging the potential need to draft additional amendments, for purposes of the interim regulations the Copyright Office accepts RIAA's analysis on this point. The interim regulations will require those users who avail themselves of the section 115 license for the purpose of making DPDs to file a notice of intention to use the license and statements of account with the copyright owner in those cases where the public records of the Copyright Office identify the owner. Certainly, direct notice to the copyright owner fulfills the section 115(c)(3)(D) requirement for notice, and the detailed statements of account filed with the copyright owner should provide sufficient information to document the use of the copyrighted works to meet the recordkeeping requirement. Nevertheless, the Office supports NMPA/SGA's suggestion for further discussion on these issues, especially as to whether the current regulations, as amended herein, go far enough to prescribe how ''records of such use shall be kept and made available by persons making digital phonorecord deliveries.'' 17 U.S.C. 115(c)(3)(D).

As to the actual amendments proposed, we note that each party proposed modest changes to the existing rules that would allow a user to take advantage of the compulsory license, but that the commenters differed in their view on whether the traditional concepts of ''relinquished from possession,'' ''phonorecord reserves,'' or ''returns'' applied to DPDs. NMPA/SGA contend that the terms, ''voluntarily distributed,'' ''reserves,'' and ''returns'' do not properly apply to DPDs as used in the current regulations. ''NMPA and SGA are not aware of any 'returns' of DPDs or even how such returns could technically be accomplished. Accordingly, we see no basis to provide for 'reserves' with respect to such 'returns' of DPDs.'' Further comments of NMPA and SGA at 4 n.3.

RIAA and DiMA, however, have less trouble applying these same concepts to DPDs. Citing the possibility of a failed transmission or an incomplete reproduction, RIAA and DiMA foresee a need to be able to offer DPD recipients credits or replacements. RIAA argues that ''(w)hen the relevant commercial arrangements provide for a credit or replacement and generally accepted accounting principles require such treatment, RIAA believes that a maker of DPDs should have the opportunity to make mechanical royalty payments reflecting such credits or replacements and any corresponding reserve.'' Reply comments of RIAA at 4; *see also* DiMA at 3. Similarly, DiMA foresees a business model that allows a distributor to prepay for a preset number of DPDs in conjunction with the right to return the unsold portion for a credit or as an offset. Both approaches incorporate the concepts of ''reserves'' and ''returns,'' and require that the rules define the term ''voluntarily distributed'' as it relates to a DPD. Under either model, the user must be able to account for and receive credit for the ''returns'' and the ''reserves.''

The Copyright Office has weighed the arguments of the commenting parties and agrees with RIAA that a distributor should be allowed to provide a replacement DPD in order to rectify a problem on the receiving end of the transmission, or to account for a failed transmission or an incomplete reproduction. However, the Office has found no basis for adopting the concept of ''reserves'' to DPDs. Therefore, the interim regulations require accounting for all DPDs, both attempted and completed, but at the same time, provide a mechanism whereby a distributor may adjust for failed transmissions and replacement DPDs made for the purpose of delivering a complete and usable DPD to an intended recipient. We also adopt DiMA's suggestion to add the term, ''digital phonorecord delivery,'' to the list of phonorecord configurations in §§ 201.18(c)(1)(vi) and 201.19(e)(3)(ii)(D).

To effect the proposed scheme, it is necessary to ascertain when a DPD is made, manufactured, or distributed for purposes of the section 115 license such that the obligation to pay the royalty fee attaches. RIAA and NMPA/SGA define the point as the ''date the digital delivery is completed,'' but neither commenter offered any insight on how to ascertain the date of completion. The answer to this question is of critical import, because royalties will be paid only for those DPDs which are completed. In anticipation of this problem, DiMA suggests amending § 201.19(a)(5) to define the concept of ''voluntarily and permanently part(ing) with,'' a DPD as ''the time when the delivery and making of the digital phonorecord can be confirmed as completed.'' DiMA at 3. According to DiMA, the transmitting entity could confirm ''that the transmission arrived intact,'' DiMA at 3, but it need not do so. Instead, DiMA proposes a presumption in favor of a successful transmission in the absence of a notification from the intended recipient that the transmission or reproduction failed.

The Copyright Office finds that DiMA's approach sets the mark too far down the line when determining the point at which delivery is complete because it leaves the resolution of when the DPD actually occurs in the hands of the intended recipient. This approach fails to account for a misdirected DPD or for a successful transmission to a recipient who, for whatever reason, cannot access and utilize the phonorecord. Therefore, for purposes of the interim regulations, the Office will start with a rebuttable presumption that a DPD is complete on the date the transmission is made. However, the Office recognizes that if a transmission fails or results in an incomplete reproduction, as determined by means within the sole control of the distributor, no delivery has occurred and no copyright liability accrues. In such cases, the distributor may overcome the presumption by explaining when and why the transmission failed and deduct one unit DPD from the monthly total. A distributor may also deduct a unit DPD from the monthly tally for a retransmission of a sound recording to an intended recipient in the case where although the initial transmission to the intended recipient resulted in a specifically identifiable reproduction of that sound recording, for some reason it remained inaccessible to the intended recipient.

This interpretation comports with the statutory definition of a digital phonorecord delivery. Section 115(d)(1) defines a digital phonorecord delivery as ''each individual delivery of a phonorecord by digital transmission of a sound recording which results in a specifically identifiable reproduction by or for any transmission recipient.'' The statutory definition requires only that transmission of an identifiable reproduction of a sound recording be successfully completed. It does not require that the intended recipient actually receive and verify receipt of a usable reproduction. The key factor is the delivery of a specifically identifiable reproduction of a sound recording and not verification by an intended recipient. Consequently, receipt of an identifiable, but unusable reproduction still will require payment of an initial copyright royalty fee. Under such circumstances, the distributor may retransmit a phonorecord of the same sound recording and treat the retransmission as a replacement for the initial phonorecord.

The Office takes this approach because it accounts for every transaction without imposing additional liability on the distributor in those cases where replacements need to be supplied to a customer. While it is arguable that each transmission constitutes a separate DPD, the Office has determined that it is unreasonable to impose additional costs for replacements on a distributor, since retransmissions are not likely to increase the risk of further copying at the expense of the copyright owner. A recipient who wishes to make further copies can do so easily from a single reproduction of the sound recording. Such is the nature of the digital environment. Therefore, the Copyright Office can see no reason to prevent a distributor from making multiple transmissions to the same recipient for the sole purpose of completing the DPD of a particular sound recording, nor can it see any reason why a customer would request a second transmission once he or she has received a complete and usable file. Consequently, the interim regulations will allow a maker of DPDs to adjust the total monthly count of DPDs to account for subsequent transmissions of a sound recording made to an intended recipient in an attempt to complete delivery of the initial request. However, this does not mean that the distributor can avoid payment on an initial transmission which results in a specifically identifiable reproduction, or extend a credit to a customer for a different sound recording because the customer was unable to make use of the initial DPD.

The Office rejects RIAA's proposal to adopt a regulatory scheme that would allow a distributor of DPDs to offer credits to a consumer in the event of a purported faulty or incomplete transmission, because the potential for abuse is too high. This is true because there is no apparent means to verify whether a request for a credit is legitimate. Nothing would prevent a customer from claiming a credit upon the mere assertion that the DPD was incomplete, even though the initial DPD was properly made. The intended recipient could then use the credit to order a different DPD, ultimately receiving two DPDs for the price of one. Such a result is contrary to the purpose of the compulsory license and must be avoided. For purposes of the compulsory license, the royalty obligation accrues upon the initial transmission of the phonorecord. Corrections for defective transmissions or for replacement DPDs are made as adjustments to the total number of transmissions. Such offsets benefit the distributor only, and may not be extended to the consumer directly under the auspices of the statutory license. Of course, a distributor may decide to grant a credit to a consumer who does not receive a complete reproduction or cannot access a file, but that decision does not alter how the distributor meets his obligations under the statutory license.

The Copyright Office also rejects DiMA's concept of reserves. Under its model, a distributor would prepay for the right to deliver a preset number of DPDs, and consequently, would have need of a system that allowed the distributor to receive a credit or offset for the authorized DPDs that never occurred. Yet, under section 115, the distributor incurs no copyright liability until the DPD is completed. For this reason, the Office can see no rationale for prepaying a copyright owner for DPDs which may not occur, when all that is needed is an accurate accounting mechanism for registering those that do. Of course, a distributor may enter into a contractual relationship with a copyright owner which calls for prepayment. In such cases, the parties could provide for additional credits or offsets.

In addition, the Office has not adopted the suggested language that would require the recipient to delete or destroy an original DPD before a second transmission is made, since such actions cannot be verified nor do they seem calculated to alleviate any identifiable problem. However, if the technology develops to the point where such actions prove useful in controlling the distribution of sound recordings by means of a digital transmission, an interested party may petition for reconsideration of the regulations on this point.

We adopt these amendments on an interim basis in order to adapt the existing regulatory framework to the immediate needs of the compulsory licensee who wishes to make DPDs in today's marketplace. Nevertheless, we acknowledge that the developing technologies associated with making DPDs may require a different system for notice and recordkeeping and will consider any new proposals, suggestions, or adjustments when we revisit the issue before finalizing regulations governing the notice and recordkeeping requirements associated with making DPDs.

Regulatory Flexibility Act

Although the Copyright Office, as a department of the Library of Congress and part of the legislative branch, is not an ''agency'' subject to the Regulatory Flexibility Act, 5 U.S.C. 601–612, the Register of Copyrights has considered the effect of these interim regulations on small businesses. The Register has determined that the regulations would not have a significant economic impact on a substantial number of small entities that would require provision of special relief for small entities in the regulations. The interim regulations are designed to minimize any significant economic impact on small entities.

List of Subjects in 37 CFR Part 201

Copyright.

Interim Regulations

For the reasons set forth in the preamble, part 201 of title 37 of the Code of Federal Regulations is amended as follows:

PART 201—GENERAL PROVISIONS

1. The authority citation for part 201 continues to read as follows:

Authority: 17 U.S.C. 702.

2. Section 201.18 is amended as follows:

(a) By adding a new paragraph (a)(4); and

(b) In paragraph (c)(1)(vi), by adding the phrase ''a digital phonorecord delivery,'' in the parenthetical clause before the words ''or a combination of them''.

The new paragraph (a)(4) reads as follows:

§ 201.18 Notice of intention to obtain a compulsory license for making and distributing phonorecords of nondramatic musical works.

(a) * * *

(4) For the purposes of this section, a digital phonorecord delivery shall be treated as a type of phonorecord configuration, and a digital phonorecord delivery shall be treated as a phonorecord manufactured, made, and distributed on the date the phonorecord is digitally transmitted.

* * * * *

3. Section 201.19 is amended as follows:

(a) By redesignating paragraphs (a)(5), (a)(6) and (a)(7) as (a)(6), (a)(8) and (a)(9) respectively;

(b) By adding a new paragraph (a)(5);

(c) By revising the first sentence of newly designated paragraph (a)(6);

(d) By adding new paragraphs (a)(7), (a)(10), and (a)(11);

(e) In paragraph (e)(3)(i)(A), by adding the phrase ‘‘, including digital phonorecord deliveries,’’ after the phrase ‘‘The number of phonorecords’’;

(f) In paragraph (e)(3)(i)(B), by removing the word ‘‘or’’ after the fourth undesignated clause ‘‘Returned to the compulsory licensee for credit or exchange;’’ and adding two new clauses to the end of the section;

(g) By revising paragraph (e)(3)(ii)(D);

(h) By adding a new paragraph (e)(3)(ii)(E); and

(i) In paragraph (e)(4)(ii), by adding paragraphs (d) and (e) to Step 4.

The additions and revisions to § 201.19 read as follows:

§ 201.19 Royalties and statements of account under compulsory license for making and distributing phonorecords of nondramatic musical works.

(a) * * *

(5) For the purposes of this section, a digital phonorecord delivery shall be treated as a type of phonorecord configuration, and a digital phonorecord delivery shall be treated as a phonorecord, with the following clarifications:

(i) A digital phonorecord delivery shall be treated as a phonorecord made and distributed on the date the phonorecord is digitally transmitted; and

(ii) A digital phonorecord delivery shall be treated as having been *voluntarily distributed* and *relinquished from possession*, and a compulsory licensee shall be treated as having *permanently parted with possession* of a digital phonorecord delivery, on the date that the phonorecord is digitally transmitted.

(6) Except as provided in paragraph (a)(5), a phonorecord is considered *voluntarily distributed* if the compulsory licensee has voluntarily and permanently parted with possession of the phonorecord.

* * * * *

(7) To the extent that the terms *reserve, credit* and *return* appear in this section, such provisions shall not apply to digital phonorecord deliveries.

* * * * *

(10) An *incomplete transmission* is any digital transmission of a sound recording which, as determined by means within the sole control of the distributor, does not result in a specifically identifiable reproduction of the entire sound recording by or for any transmission recipient.

(11) A *retransmission* is a subsequent digital transmission of the same sound recording initially transmitted to an identified recipient for the purpose of completing the delivery of a complete and usable reproduction of that sound recording to that recipient.

* * * * *

(e) * * *

(3) * * *

(i) * * *

(B) * * *

Never delivered due to a failed transmission; or

Digitally retransmitted in order to complete a digital phonorecord delivery.

* * * * *

(ii) * * *

(D) Each phonorecord configuration involved (for example: single disk, long-playing disk, cartridge, cassette, reel-to-reel, digital phonorecord delivery, or a combination of them).

(E) The date of and a reason for each incomplete transmission.

* * * * *

(4) * * *

(ii) * * *

Step 4: * * *

(d) Incomplete transmissions. If, in the month covered by the Monthly Statement, there are any digital transmissions of a sound recording which do not result in specifically identifiable reproductions of the entire sound recording by or for any transmission recipient, as determined by means within the sole control of the distributor, the number of such phonorecords is subtracted from the Step 3 subtotal.

(e) Retransmitted digital phonorecords. If, in the month covered by the Monthly Statement, there are retransmissions of a digital phonorecord to a recipient who did not receive a complete and usable phonorecord during an initial transmission, and such transmissions are made for the sole purpose of delivering a complete and usable reproduction of the initially requested sound recording to that recipient, the number of such retransmitted digital phonorecords is subtracted from the Step 3 subtotal.

* * * * *

Dated: July 15, 1999.

Marybeth Peters,

Register of Copyrights.

James H. Billington,

The Librarian of Congress.

[FR Doc. 99–19458 Filed 7–29–99; 8:45 am]

BILLING CODE 1410–30–P

POSTAL SERVICE

39 CFR Parts 261, 262, 263, 264, 265, 266, and 267

Release of Information and Records Management

AGENCY: Postal Service.

ACTION: Final rule.

SUMMARY: This rule revises organizational names and titles contained in Postal Service regulations relating to policies for the release of information and records management. These names and titles changed as a result of agency restructuring. The revisions reflect to whom the public should address issues relating to the release of information and records management.

This rule also updates composition of the Postal Service’s Data Integrity Board which oversees agency computer matching.

EFFECTIVE DATE: August 30, 1999.

FOR FURTHER INFORMATION CONTACT: Susie Travers, Administration and FOIA, (202) 268–3362.

SUPPLEMENTARY INFORMATION: As a result of an agency restructuring, Postal Service regulations governing the release of information and records management contain outdated organizational names and titles. This rule revises those names and titles to show the current organization and officials responsible for release of information and records management functions.

List of Subjects

39 CFR Parts 261, 262, 263, and 264

Archives and records.

39 CFR Part 265

Freedom of information.

39 CFR Part 266

Privacy.

39 CFR Part 267

Archives and records, Classified information.

For the reasons set out in the preamble, 39 CFR parts 261 through 267 are amended as set forth below.

PART 261—RECORDS AND INFORMATION MANAGEMENT

1. The authority citation for part 261 continues to read as follows:

Authority: 39 U.S.C. 401.

2. Section 261.4 is revised to read as follows:

§ 261.4 Responsibility.

(a) The manager, Administration and FOIA, under the Chief Financial Officer and Senior Vice President, administers the Postal Service release of information and privacy of information programs with the assistance of FOIA coordinators in the finance function of area and district offices.

(b) The manager, Corporate Accounting, under the Vice President, Finance, Controller, administers the Postal Service records maintenance and disposition program.

(c) Postal Service managers are responsible for administering records and information management policies and for complying with all handbooks, directives, and instructions in support of this policy.

PART 262—RECORDS AND INFORMATION MANAGEMENT DEFINITIONS

3. The authority citation for part 262 continues to read as follows:

Authority: 39 U.S.C. 401; 5 U.S.C. 552, 552a.

4. In § 262.2 paragraph (b) is revised and paragraph (d) is added to read as follows:

§ 262.2 Officials.

* * * * *

(b) *Manager, Administration and FOIA.* The official responsible for the issuance of policy on the protection of privacy and the release of Postal Service records with the power to authorize the disclosure of such records and to delegate or take appropriate action if that policy is not adhered to or if questions of interpretation or procedure arise.

* * * * *

(d) *Manager, Corporate Accounting.* The official responsible for the issuance of policy on the maintenance and disposition of Postal Service records and information, and to delegate or take appropriate action if such policy is not adhered to or if questions of interpretation or procedure arise.

§ 262.4 [Amended]

5. In Section 262.4 paragraph (a) is amended by removing the words ''USPS Records Office'' and adding, in their place, the words ''office of Corporate Accounting'' and paragraph (b) is amended by removing the words ''Records Office'' and adding ''office of Corporate Accounting'' in their place.

§ 262.5 [Amended]

6. Section 262.5(d)(2) is amended by removing the words ''Records Office'' and adding, in their place, the words ''office of Administration and FOIA.''

PART 263—RECORDS RETENTION AND DISPOSITION

7. The authority citation for part 263 continues to read as follows:

Authority: 39 U.S.C. 401.

§ 263.3 [Amended]

8. Section 263.3(a) is amended by removing the words ''Records Office'' and adding, in their place, the words ''office of Corporate Accounting.''

8a. Section 263.4 is removed and section 263.5 is redesignated as § 263.4.

§ 263.4 [Amended]

9. Newly redesignated § 263.4 is amended by removing the words ''the Records Office'' and adding, in their place, the words ''Corporate Accounting.''

10. Section 263.6 is redesignated as § 263.5 and revised to read as follows:

§ 263.5 Inquiries.

Inquiries regarding records maintenance and disposition should be directed to the Manager, Corporate Accounting, United States Postal Service, 475 L'Enfant Plaza, SW, Washington, DC 20260–5240, or, by telephone, to the Records Specialist, (202) 268–4869.

PART 264—VITAL RECORDS

11. The authority citation for part 264 continues to read as follows:

Authority: 39 U.S.C. 401.

12. In § 264.3 paragraphs (a) and (b) are revised to read as follows:

§ 264.3 Responsibility.

(a) *Manager, Corporate Accounting.* The Manager, Corporate Accounting, is responsible for categorizing records as vital, and in conjunction with the Chief Postal Inspector/Emergency Coordinator shall establish and maintain the vital records program, and ensure compliance with supportive procedures.

(b) Chief Postal Inspector. As the Postal Service's Emergency Coordinator, the Chief Postal Inspector shall establish and maintain a program to ensure that vital records are available at predesignated off-site locations for use during a national emergency.

* * * * *

§ 264.4 [Amended]

13. Section 264.4 is amended by removing the words ''USPS Records Office'' and adding, in their place, the words ''office of Corporate Accounting.''

PART 265—RELEASE OF INFORMATION:

14. The authority citation for part 265 continues to read as follows:

Authority: 5 U.S.C. 552; 39 U.S.C. 401, 403, 410, 1001, 2601; 5 U.S.C. App. 3.

15. In § 265.3 paragraph (b) is revised to read as follows:

§ 265.3 Responsibility.

* * * * *

(b) *Freedom of Information/Privacy Acts Officer.* The USPS Freedom of Information/Privacy Acts Officer, under the Manager, Administration and FOIA, is responsible for the overall administration of this part, including the issuance of detailed instructions to custodians.

* * * * *

§ 265.4 [Amended]

16. Section 265.4 is amended by removing the words ''Washington, DC 20260–5243, telephone (202) 268–2608'' and adding, in their place, ''Washington, DC 20260–5202, telephone (202) 268–2608.''

§ § 265.6 and 265.9 [Amended]

17. In the following places, remove the words ''Records Office'' or ''USPS Records Office'' and add, in their place, the words ''office of Administration and FOIA:''

(a) Section 265.6(b) introductory text;

(b) Section 265.9(b)(2)(ii); and

(c) Section 265.9(g)(4).

§ 265.7 [Amended]

18. Section 265.7(a)(2) is amended as follows:

(a) By removing the words ''USPS Records Officer, USPS Freedom of Information/Privacy Acts Officer, U.S. Postal Service, 475 L'Enfant Plaza, SW., Washington, DC 20260–5243, telephone (202) 268–2608'' and adding, in their place, the words ''USPS Freedom of Information/Privacy Acts Officer, U.S. Postal Service, 475 L'Enfant Plaza, SW., Washington, DC 20260–5202, telephone (202) 268–2608;'' and

(b) By removing the words ''USPS Records Office is deemed'' and adding, in their place, the words ''office of Administration and FOIA is deemed.''

§ 265.12 [Amended]

19. Section 265.12(b)(7) is amended by removing the words ''Records Office, U.S. Postal Service, 475 L'Enfant Plaza, SW., Washington, DC 20260–5243, telephone (202) 268–2608'' and adding, in their place, the words ''Freedom of Information/Privacy Acts Officer, U.S. Postal Service, 475 L'Enfant Plaza, SW., Washington, DC 20260–5202, telephone (202) 268–2608.''

PART 266—PRIVACY OF INFORMATION

20. The authority citation for part 266 continues to read as follows:

Authority: 39 U.S.C. 401; 5 U.S.C. 552a.

21. In Section 266.3 paragraphs (a), (c), and (d)(2) are revised to read as follows:

§ 266.3 Responsibility.

(a) *Freedom of Information/Privacy Acts Officer.* The USPS Freedom of Information/Privacy Acts Officer, under the Manager, Administration and FOIA, will ensure Postal Service-wide compliance with this policy.

* * * * *

(c) Information System Executive. These managers are responsible for reporting to the office of Administration and FOIA the existence or proposed development of Privacy Act systems of records. They also must report any change that would alter the systems description as published in the **Federal Register**. They establish the relevancy of the information within those systems.

* * * * *

(d) * * *

(2) *Composition.* The Privacy Act requires that the senior official responsible for implementation of agency Privacy Act policy and the Inspector General serve on the Board. The Manager, Administration and FOIA, as administrator of Postal Service Privacy Act policy, serves as Secretary of the Board and performs the administrative functions of the Board. The Board is composed of these and other members designated by the Postmaster General, as follows:

(i) Chief Financial Officer and Senior Vice President (Chairman).

(ii) Chief Postal Inspector.

(iii) Inspector General.

(iv) Vice President, Human Resources.

(v) Senior Vice President, General Counsel.

(vi) Manager, Administration and FOIA.

§ 266.4 [Amended]

22. In Section 266.4 paragraph (b)(6)(i) is amended by removing the words ''USPS Records Officer'' and adding, in their place, the words ''Freedom of Information/Privacy Acts Officer,'' and paragraphs (b)(6)(iii) and (iv) are amended by removing ''Records Officer'' and adding ''Freedom of Information/Privacy Acts Officer'' in their place.

§ 266.5 [Amended]

23. Section 266.5(d) is amended by removing the words ''Records Office'' and adding, in their place, the words ''office of Administration and FOIA.''

§ 266.6 [Amended]

24. Section 266.6(a)(1) is amended by removing the words ''Washington, DC 20260–5243, telephone (202) 268–2608'' and adding, in their place, the words ''Washington, DC 20260–5202, telephone (202) 268–2608.''

§ 266.7 [Amended]

25. Section 266.7 is amended by removing, in paragraph (a)(4), the words ''Records Office'' and adding, in their place, the words ''office of Administration and FOIA.''

§ 266.10 [Amended]

26. Section 266.10(b) is amended by removing the words ''Washington, DC 20260–5243'' and adding, in their place, the words ''Washington, DC 20260–5202.''

PART 267—PROTECTION OF INFORMATION

27. The authority citation for part 267 continues to read as follows:

Authority: 39 U.S.C. 401; Pub. L. 93–579, 88 Stat. 1896.

§ 267.5 [Amended]

28. Section 267.5(e)(3)(i) is amended by removing the words ''Manager, Payroll Accounting and Records, U.S. Postal Service, 475 L'Enfant Plaza, SW., Washington, DC 20260–5243'' and adding, in their place, the words ''Manager, Administration and FOIA, U.S. Postal Service, 475 L'Enfant Plaza, SW., Washington, DC 20260–5202.''

Stanley F. Mires,

Chief Counsel, Legislative.

[FR Doc. 99–19465 Filed 7–29–99; 8:45 am]

BILLING CODE 7710–12–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 62

[Docket# WA–1–0001; FRL–6408–6]

Approval and Promulgation of State Plans for Designated Facilities and Pollutants: Washington

AGENCY: Environmental Protection Agency.

ACTION: Direct final rule.

SUMMARY: The United States Environmental Protection Agency (EPA) approves the sections 111(d)/129 State Plan submitted by the State of Washington, Department of Ecology (WADOE) on January 4, 1999, for implementing and enforcing the Emissions Guidelines (EG) applicable to existing large Municipal Waste Combustors (MWCs) with capacity to combust more than 250 tons/day of municipal solid waste (MSW). *See* 40 CFR part 60, subpart Cb.

DATES: This action is effective on September 28,1999 unless significant, material, and adverse comments are received by August 30, 1999. If significant, material, and adverse comments are received by the above date, this direct final rule will be withdrawn, and timely notice will be published in the **Federal Register**.

ADDRESSES: Written comments should be addressed to: Catherine Woo, Office of Air Quality (OAQ–107), EPA, 1200 Sixth Avenue, Seattle, Washington 98101.

Documents which are incorporated by reference are available for public inspection at the Air and Radiation Docket and Information Center, Environmental Protection Agency, 401 M Street, SW, Washington, DC 20460. Copies of materials related to this action may be examined during normal business hours. The interested persons wanting to examine these documents should make an appointment with the appropriate office at least 24 hours before the day of the visit. These documents can be viewed at: EPA, Region 10, Office of Air Quality, 1200 Sixth Avenue (OAQ–107), Seattle, Washington 98101, and at Washington State Department of Ecology, P.O. Box 47600, Olympia, Washington 98504–7600.

FOR FURTHER INFORMATION CONTACT: Catherine Woo, Office of Air Quality (OAQ–107), EPA, Seattle, Washington 98101,(206) 553–1814.

SUPPLEMENTARY INFORMATION:

I. What action is being taken by EPA today?

II. Why do we need to regulate MWCs emissions?
III. What is a State Plan?
IV. What does the Washington State Plan contain?
V. Is my MWC subject to these regulations?
VI. What steps do I need to take?
VII. Administrative Requirements.

I. What Action Is Being Taken by the EPA Today?

We are approving the Washington State Plan, as submitted on January 4, 1999, for the control of air emissions from large MWC's, except for those large MWCs located in Indian Country. When we developed our New Source Performance Standards (NSPS) for large MWC's, we also developed an EG to control air emissions from older, existing MWC's. See 60 FR 65387 (December 19, 1995), and as subsequently amended, 62 FR 45116 and 45124 (August 25, 1997). The WDOE developed a State Plan, as required by sections 111(d)/129 of the Clean Air Act (the Act), 42 U.S.C. 4211(d)/ 4229, to adopt the EG into their body of regulations, and we are acting today to approve it.

This approval action will supercede the requirements of the EPA's Federal Plan, developed for sources in States which did not have an approved State Plan by December 19, 1996. In the review of the State of Washington's Plan, EPA determined that the requirements were at least as protective as the emission guidelines as well as the requirements promulgated into 40 CFR part 60, subpart FFF, which is the Federal Plan for Large Municipal Waste Combustors. As of the effective date of this action, September 28, 1999, the Federal Plan will no longer apply to the sources in the State of Washington. Sources must comply with the requirements found within this State Plan.

We are publishing this action without prior proposal because we view this as a noncontroversial approval and anticipate no adverse comments. However, in a separate document in this **Federal Register** publication, we are proposing to approve the revision, should significant, material and adverse comments be filed. This action is effective September 28, 1999, unless we received any significant, material or adverse comments by August 30, 1999. If we receive such comments, this action will be withdrawn before the effective date by publishing a subsequent document that will withdraw the final action. All public comments received will be addressed in a subsequent final rule based on the proposed rule. We will not institute a second comment period on this action. Any parties interested in commenting on this action should do so at this time.

II. Why Do We Need To Regulate MWC Emissions?

When burned, municipal waste emits various air pollutants, including dioxin/furan, sulfur dioxide, hydrogen chloride and toxic metals (lead, cadmium and mercury.) Mercury is highly hazardous and is of particular concern because it persists in the environment and bioaccumulates through our food sources. Serious developmental effects in humans, primarily damage to the nervous system, have been associated with exposures to mercury.

Exposure to particulate matter has been linked with adverse health effects, including aggravation of existing respiratory and cardiovascular disease and increased risk of premature death. Hydrochloric acid is a clear colorless gas. Chronic exposure to hydrochloric acid has been reported to cause gastritis, chronic bronchitis, dermatitis, and photosensitization.

Exposure to dioxin and furan can cause skin disorders, cancer, and reproductive effects such as endometriosis. These pollutants can also affect the immune system.

For a more detailed background related to the hazards of exposure to the air emissions from large MWC's, contact the EPA's Office of Air Quality Planning and Standards, Research Triangle Park, North Carolina, 27711.

III. What Is a State Plan?

Sections 111(d)/129 of the Act require that pollutants controlled under the NSPS must also be controlled at older, existing sources in the same source categories. Section 129 of the Act provides additional requirements for incineration sources. Once an NSPS is promulgated for a specific source category, we then publish an EG applicable to the control of the same pollutants from the existing (designated) facilities. States with designated facilities must then develop a State Plan to adopt the EG into their body of regulations. States must also include in this State Plan other elements, such as emission inventories, legal authority, and public participation documentation, and demonstration of the ability to enforce the State Plan.

IV. What Does the Washington State Plan Contain?

The WADOE submitted regulations, as promulgated by the Spokane County Air Pollution Control Agency (SCAPCA) and adopted into State regulations on June 4, 1999. The WADOE adopted and submitted local regulations, because there is only one identified existing source for this specific category. This designated source, located in Spokane, Washington, is directly regulated by the local authority, SCAPCA. When the State adopted the local regulation, these requirements also became State-enforceable. Any additional existing designated sources identified at a later date must also comply with the requirements of the SCAPCA rule, as adopted by the State, unless the State revises its regulation and resubmits its revised State Plan to the EPA for approval. The Washington State Plan contains:

1. A demonstration of the State's legal authority to implement the section 111(d) State Plan;
2. SCAPCA rule, Regulation I, section 6.17 (Amending WSR 98–01–037), as adopted by reference by WADOE;
3. An inventory of the known, designated facility, along with estimates of their toxic air emissions;
4. Emission limits that are as protective as the EG;
5. A compliance date 1 year from the date of SCAPCA's rule effective date;
6. Testing, monitoring, reporting and recordkeeping requirements for the designated facility;
7. Records from the public hearing; and
8. Provisions for progress report to EPA.

The Washington State Plan was reviewed for approval against the following criteria: 40 CFR 60.23 through 60.26, *subpart B—Adoption and Submittal of State Plans for Designated Facilities*; and, 40 CFR 60.30b through 60.39b, *subpart Cb—Emission Guidelines and Compliance Times for Municipal Waste Combustors.* Based upon our review of the submission, EPA has determined that the Washington State Plan for existing large MWC's satisfies all the requirements for section 111(d) of the Clean Air Act approval. Accordingly, we are approving this State Plan. A detailed discussion of our evaluation of the Washington State Plan is included in our technical support document, located in the official file for this action.

V. Is My MWC Subject to These Regulations?

The EG for existing MWCs affect any MWC built on or before September 20, 1994 and which combust at least 250 tons of municipal solid waste a day. If your facility meets this criterion, you are subject to these regulations.

VI. What Steps Do I Need To Take?

If you are a designated source, as defined under 40 CFR part 60, subpart

Cb, you must comply with the all the requirements as adopted under SCAPCA regulations, section 6.17. In general, you must comply with all the requirements of regulations listed within the State Plan within one year from the date we approve it; however, there are provisions to extend your compliance date. See 40 CFR 60.39b.

VII. Administrative Requirements

A. Executive Order 12866

This action has been classified as a Table 3 action for signature by the Regional Administrator under the procedures published in the **Federal Register** on January 19, 1989 (54 FR 2214–2225), as revised by a July 10, 1995, memorandum from Mary Nichols, Assistant Administrator for Air and Radiation. The Office of Management and Budget (OMB) has exempted this regulatory action from E.O. 12866 review.

B. Executive Order 12875

Under E.O. 12875, EPA may not issue a regulation that is not required by statute and that creates a mandate upon a State, local or tribal government, unless the Federal government provides the funds necessary to pay the direct compliance costs incurred by those governments, or EPA consults with those governments. If EPA complies by consulting, E.O. 12875 requires EPA to provide to the OMB a description of the extent of EPA's prior consultation with representatives of affected State, local and tribal governments, the nature of their concerns, copies of any written communications from the governments, and a statement supporting the need to issue the regulation. In addition, E.O. 12875 requires EPA to develop an effective process permitting elected officials and other representatives of State, local and tribal governments ''to provide meaningful and timely input in the development of regulatory proposals containing significant unfunded mandates.''

Today's rule does not create a mandate on State, local, or tribal governments. The rule does not impose any enforceable rules on any of these entities. This action does not create any new requirements but simply approves requirements that the State is already imposing. Accordingly, the requirements of section 1(a) of E.O. 12875 do not apply to this rule.

C. Executive Order 13045

Executive Order 13045, entitled ''Protection of Children from Environmental Health Risks and Safety Risks'' (62 FR 19885, April 23, 1997), applies to any rule that: (1) Is determined to be ''economically significant'' as defined under E.O. 12866, and (2) concerns an environmental health or safety risk that EPA has reason to believe may have a disproportionate effect on children. If the regulatory action meets both criteria, the Agency must evaluate the environmental health or safety effects of the planned rule on children, and explain why the planned regulation is preferable to other potentially effective and reasonably feasible alternatives considered by the Agency.

The EPA interprets E.O. 13045 as applying only to those regulatory actions that are based on health or safety risks, such that the analysis required under section 5–501 of the Order has the potential to influence the regulation. This final rule is not subject to E.O. 13045 because it approves a State program.

D. Executive Order 13084

Under E.O. 13084, EPA may not issue a regulation that is not required by statute, that significantly or uniquely affects the communities of Indian tribal governments, and that imposes substantial direct compliance costs on those communities, unless the Federal government provides the funds necessary to pay the direct compliance costs incurred by the tribal governments, or EPA consults with those governments. If EPA complies by consulting, E.O. 13084 requires EPA to provide to the OMB, in a separately identified section of the preamble to the rule, a description of the extent of EPA's prior consultation with representatives of affected tribal governments, a summary of the nature of their concerns, and a statement supporting the need to issue the regulation. In addition, E.O. 13084 requires EPA to develop an effective process permitting elected officials and other representatives of Indian tribal governments ''to provide meaningful and timely input in the development of regulatory policies on matters that significantly or uniquely affect their communities.''

Today's rule does not significantly or uniquely affect the communities of Indian tribal governments. This action does not involve or impose any requirements that affect Indian tribes. Accordingly, the requirements of section 3(b) of E.O. 13084 do not apply to this rule.

E. Regulatory Flexibility Act

Under the Regulatory Flexibility Act, 5 U.S.C. 600 *et seq.*, EPA must prepare a regulatory flexibility analysis assessing the impact of any proposed or final rule on small entities. 5 U.S.C. 603 and 604. Alternatively, EPA may certify that the rule will not have a significant impact on a substantial number of small entities. Small entities include small businesses, small not-for-profit enterprises, and government entities with jurisdiction over populations of less than 50,000.

Pursuant to section 605(b) of the Regulatory Flexibility Act, I certify that this rule will not have a significant economic impact on a substantial number of small entities. This Federal action approves pre-existing requirements under federal, State or local law, and imposes no new requirements on any entity affected by this rule, including small entities. Therefore, these amendments will not have a significant impact on a substantial number of small entities.

F. Unfunded Mandates

Under section 202 of the Unfunded Mandates Reform Act of 1995 (''Unfunded Mandates Act''), signed into law on March 22, 1995, EPA must prepare a budgetary impact statement to accompany any proposed or final rule that includes a Federal mandate that may result in estimated costs to State, local, or tribal governments in the aggregate, or to the private sector, of $100 million or more. Under section 205, EPA must select the most cost-effective and least burdensome alternative that achieves the objectives of the rule and is consistent with statutory requirements. Section 203 requires EPA to establish a plan for informing and advising any small governments that may be significantly or uniquely impacted on by the rule.

EPA has determined that the approval action promulgated does not include a Federal mandate that may result in estimated costs of $100 million or more to either State, local, or tribal governments in the aggregate, or to the private sector. This Federal action approves pre-existing requirements under State or local law, and imposes no new requirements. Accordingly, no additional costs to State, local, or tribal governments, or to the private sector, result from this action.

G. Submission to Congress and the Comptroller General

The Congressional Review Act, 5 U.S.C. 801 *et seq.*, as added by the Small Business Regulatory Enforcement Fairness Act of 1996, generally provides that before a rule may take effect, the agency promulgating the rule must submit a rule report, which includes a copy of the rule, to each House of the Congress and to the Comptroller General

of the United States. The EPA will submit a report containing this rule and other required information to the U.S. Senate, the U.S. House of Representatives, and the Comptroller General of the United States prior to publication of the rule in the **Federal Register**. A major rule cannot take effect until 60 days after it is published in the **Federal Register**. This action is not a ''major'' rule as defined by 5 U.S.C. 804(2). This rule will be effective September 28, 1999.

H. Petitions for Judicial Review

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 28, 1999. 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), 42 U.S.C. 7607(b)(2)).

List of Subjects in 40 CFR Part 62

Environmental protection, Administrative practice and procedure, Air pollution control, Intergovernmental relations, Municipal Waste Combustors, Reporting and recordkeeping requirements.

Dated: July 19, 1999.

Randall F. Smith,

Acting Regional Administrator, Region 10.

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

40 CFR Part 62 of the Code of Federal Regulations is amended as follows:

1. The authority citation for Part 62 continues to read as follows:

Authority: 42 U.S.C. 7401–7642.

Subpart WW—Washington

2. Sections 62.11860 and 62.11870 are added, along with undesignated centerheads, to subpart WW, reading as follows:

Plans for the Control of Designated Pollutants From Existing Facilities (Section 111(d) Plan)

§ 62.11860 Identification of Plan.

(a) *Identification of Plan.* Washington State Designated Facility Plan (Section 111(d) Plan).

(b) The plan was officially submitted as follows:

(1) Control of metals, acid gases, organic compounds and nitrogen oxide emissions from existing municipal waste combustors was submitted by State of Washington Department of Ecology on January 4, 1999.

(2) RESERVED.

(c) *Designated Facilities.* The plan applies to existing facilities in the following category of sources:

(1) Existing municipal waste combustors.

(2) [RESERVED]

Metals, Acid Gases, Organic Compounds and Nitrogen Oxide Emissions From Existing Municipal Waste Combustors With the Capacity to Combust Greater Than 250 Tons Per Day of Municipal Solid Waste

§ 62.11870 Identification of sources.

The plan applies to existing facilities at the following municipal waste combustor sites:

(1) Spokane Regional Solid Waste System, Spokane, WA.

(2) [RESERVED]

[FR Doc. 99–19431 Filed 7–29–99; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 180

[OPP–300899; FRL–6093–3]

RIN 2070–AB78

Propiconazole; Extension of Tolerances for Emergency Exemptions

AGENCY: Environmental Protection Agency (EPA).

ACTION: Final rule.

SUMMARY: This regulation extends time-limited tolerances for combined residues of the fungicide propiconazole and its metabolites in or on blueberries, cranberries and raspberries at 1.0 part per million (ppm) for an additional 1–year period. The tolerance for cranberries will expire and is revoked on July 31, 2000; the tolerances for blueberries and raspberries will expire and are revoked on December 31, 2000. This action is in response to EPA's granting of emergency exemptions under section 18 of the Federal Insecticide, Fungicide, and Rodenticide Act (FIFRA) authorizing use of the pesticide on blueberries, cranberries and raspberries. Section 408(l)(6) of the Federal Food, Drug, and Cosmetic Act requires EPA to establish a time-limited tolerance or exemption from the requirement for a tolerance for pesticide chemical residues in food that will result from the use of a pesticide under an emergency exemption granted by EPA under FIFRA section 18.

DATES: This regulation becomes effective July 30, 1999. Objections and requests for hearings must be received by EPA, on or before September 28, 1999.

ADDRESSES: Written objections and hearing requests, identified by the docket control number [OPP–300899], must be submitted to: Hearing Clerk (1900), Environmental Protection Agency, Rm. M3708, 401 M St., SW., Washington, DC 20460. Fees accompanying objections and hearing requests shall be labeled ''Tolerance Petition Fees'' and forwarded to: EPA Headquarters Accounting Operations Branch, OPP (Tolerance Fees), P.O. Box 360277M, Pittsburgh, PA 15251. A copy of any objections and hearing requests filed with the Hearing Clerk identified by the docket control number, [OPP–300899], must also be submitted to: Public Information and Records Integrity Branch, Information Resources and Services Division (7502C), Office of Pesticide Programs, Environmental Protection Agency, 401 M St., SW., Washington, DC 20460. In person, bring a copy of objections and hearing requests to Rm. 119, Crystal Mall 2 (CM #2), 1921 Jefferson Davis Hwy., Arlington, VA.

A copy of objections and hearing requests filed with the Hearing Clerk may also be submitted electronically by sending electronic mail (e-mail) to: opp-docket@epa.gov. Copies of electronic objections and hearing requests must be submitted as an ASCII file avoiding the use of special characters and any form of encryption. Copies of objections and hearing requests will also be accepted on disks in WordPerfect 5.1/6.1 or ASCII file format. All copies of electronic objections and hearing requests must be identified by the docket control number [OPP–300899]. No Confidential Business Information (CBI) should be submitted through e-mail. Copies of electronic objections and hearing requests on this rule may be filed online at many Federal Depository Libraries.

FOR FURTHER INFORMATION CONTACT: By mail: Stephen Schaible, Registration Division (7505C), Office of Pesticide Programs, Environmental Protection Agency, 401 M St., SW., Washington, DC 20460. Office location, telephone number, and e-mail address: Rm. 271, CM #2, 1921 Jefferson Davis Hwy., Arlington, VA, (703) 308–9362, schaible.stephen@epa.gov.

SUPPLEMENTARY INFORMATION: EPA issued a final rule, published in the **Federal Register** of April 11, 1997 (62 FR 17710) (FRL–5600–5), which announced that on its own initiative under section 408 of the Federal Food, Drug, and Cosmetic Act (FFDCA), 21 U.S.C. 346a, as amended by the Food Quality Protection Act of 1996 (FQPA) (Public Law 104–170) it established a time-limited tolerance for the combined residues of propiconazole and its metabolites in or on cranberries at 41.0 ppm, with an expiration date of July 31, 1998. The tolerance level was corrected to be 1.0 ppm in the **Federal Register** of May 2, 1997 (62 FR 24045) (FRL–5714–5). EPA extended the expiration date of this tolerance to July 31, 1999, in a **Federal Register** notice published April 20, 1998 (63 FR 19408) (FRL–5783–5). EPA also issued a final rule, published in the **Federal Register** of January 20, 1999 (64 FR 2995) (FRL–6049–8), which announced that on its own initiative under section 408 of the FFDCA, 21 U.S.C. 346a, as amended by the FQPA (Public Law 104–170) it established time-limited tolerances for the combined residues of propiconazole and its metabolites in or on blueberries and raspberries at 1.0 ppm, with an expiration date of December 31, 1999. EPA established these tolerances because section 408(l)(6) of the FFDCA requires EPA to establish a time-limited tolerance or exemption from the requirement for a tolerance for pesticide chemical residues in food that will result from the use of a pesticide under an emergency exemption granted by EPA under FIFRA section 18. Such tolerances can be established without providing notice or period for public comment.

EPA received requests to extend the use of propiconazole on blueberries and cranberries for this year's growing season due to the continued emergency situation facing blueberry and cranberry growers due to the cancellation of the fungicide triforine, which was the only product registered to control cottonball disease in cranberries or mummy berry disease in blueberries. Raspberry growers in Oregon and Washington requested the use of propiconazole be extended due to the continued unfavorable weather conditions which result in severe disease pressure from yellow rust. After having reviewed the submissions, EPA concurs that emergency conditions exist. EPA has authorized under FIFRA section 18 the uses of propiconazole on blueberries for control of mummy berry disease, on cranberries for control of cottonball disease, and on raspberries for control of yellow rust.

EPA assessed the potential risks presented by residues of propiconazole in or on blueberries, cranberries and raspberries. In doing so, EPA considered the safety standard in FFDCA section 408(b)(2), and decided that the necessary tolerances under FFDCA section 408(l)(6) would be consistent with the safety standard and with FIFRA section 18. The data and other relevant material have been evaluated and discussed in the final rules of April 11, 1997 (62 FR 17710), and January 20, 1999 (64 FR 2995). Based on that data and information considered, the Agency reaffirms that extension of the time-limited tolerances will continue to meet the requirements of section 408(l)(6). Therefore, the time-limited tolerances are extended for an additional 1–year period. EPA will publish a document in the **Federal Register** to remove the revoked tolerances from the Code of Federal Regulations (CFR). Although the tolerance on cranberries will expire and is revoked on July 31, 2000, and the tolerances on blueberries and raspberries will expire and are revoked on December 31, 1999, under FFDCA section 408(l)(5), residues of the pesticide not in excess of the amounts specified in the tolerances remaining in or on blueberries, cranberries and raspberries after that date will not be unlawful, provided the pesticide is applied in a manner that was lawful under FIFRA and the application occurred prior to the revocation of the tolerance. EPA will take action to revoke these tolerances earlier if any experience with, scientific data on, or other relevant information on this pesticide indicate that the residues are not safe.

I. Objections and Hearing Requests

The new FFDCA section 408(g) provides essentially the same process for persons to ''object'' to a tolerance regulation as was provided in the old section 408 and in section 409. However, the period for filing objections is 60 days, rather than 30 days. EPA currently has procedural regulations which govern the submission of objections and hearing requests. These regulations will require some modification to reflect the new law. However, until those modifications can be made, EPA will continue to use those procedural regulations with appropriate adjustments to reflect the new law.

Any person may, by September 28, 1999, file written objections to any aspect of this regulation and may also request a hearing on those objections. Objections and hearing requests must be filed with the Hearing Clerk, at the address given under the ''ADDRESSES'' section (40 CFR 178.20). A copy of the objections and/or hearing requests filed with the Hearing Clerk should be submitted to the OPP docket for this rulemaking. The objections submitted must specify the provisions of the regulation deemed objectionable and the grounds for the objections (40 CFR 178.25). Each objection must be accompanied by the fee prescribed by 40 CFR 180.33(i). EPA is authorized to waive any fee requirement ''when in the judgement of the Administrator such a waiver or refund is equitable and not contrary to the purpose of this subsection.'' For additional information regarding tolerance objection fee waivers, contact James Tompkins, Registration Division (7505C), Office of Pesticide Programs, Environmental Protection Agency, 401 M St., SW., Washington, DC 20460. Office location, telephone number, and e-mail address: Rm. 239, CM #2, 1921 Jefferson Davis Hwy., Arlington, VA, (703) 305–5697, tompkins.jim@epa.gov. Requests for waiver of tolerance objection fees should be sent to James Hollins, Information Resources and Services Division (7502C), Office of Pesticide Programs, Environmental Protection Agency, 401 M St., SW., Washington, DC 20460.

If a hearing is requested, the objections must include a statement of the factual issues on which a hearing is requested, the requestor's contentions on such issues, and a summary of any evidence relied upon by the requestor (40 CFR 178.27). A request for a hearing will be granted if the Administrator determines that the material submitted shows the following: There is genuine and substantial issue of fact; there is a reasonable possibility that available evidence identified by the requestor would, if established, resolve one or more of such issues in favor of the requestor, taking into account uncontested claims or facts to the contrary; and resolution of the factual issues in the manner sought by the requestor would be adequate to justify the action requested (40 CFR 178.32). Information submitted in connection with an objection or hearing request may be claimed confidential by marking any part or all of that information as CBI. Information so marked will not be disclosed except in accordance with procedures set forth in 40 CFR part 2. A copy of the information that does not contain CBI must be submitted for inclusion in the public record. Information not marked confidential

may be disclosed publicly by EPA without prior notice.

II. Public Record and Electronic Submissions

EPA has established a record for this regulation under docket control number [OPP–300899] (including any comments and data submitted electronically). A public version of this record, including printed, paper versions of electronic comments, which does not include any information claimed as CBI, is available for inspection from 8:30 a.m. to 4 p.m., Monday through Friday, excluding legal holidays. The public record is located in Rm. 119 of the Public Information and Records Integrity Branch, Information Resources and Services Division (7502C), Office of Pesticide Programs, Environmental Protection Agency, CM #2, 1921 Jefferson Davis Hwy., Arlington, VA.

Objections and hearing requests may be sent by e-mail directly to EPA at:

opp-docket@epa.gov

E-mailed objections and hearing requests must be submitted as an ASCII file avoiding the use of special characters and any form of encryption.

The official record for this regulation, as well as the public version, as described in this unit will be kept in paper form. Accordingly, EPA will transfer any copies of objections and hearing requests received electronically into printed, paper form as they are received and will place the paper copies in the official record which will also include all comments submitted directly in writing. The official record is the paper record maintained at the Virginia address in ''ADDRESSES'' at the beginning of this document.

III. Regulatory Assessment Requirements

A. Certain Acts and Executive Orders

This final rule establishes a tolerance under section 408 of the FFDCA. The Office of Management and Budget (OMB) has exempted these types of actions from review under Executive Order 12866, entitled *Regulatory Planning and Review* (58 FR 51735, October 4, 1993). This final rule does not contain any information collections subject to OMB approval under the Paperwork Reduction Act (PRA), 44 U.S.C. 3501 *et seq.*, or impose any enforceable duty or contain any unfunded mandate as described under Title II of the Unfunded Mandates Reform Act of 1995 (UMRA) (Public Law 104–4). Nor does it require any special considerations as required by Executive Order 12898, entitled *Federal Actions to Address Environmental Justice in Minority Populations and Low-Income Populations* (59 FR 7629, February 16, 1994), or require OMB review in accordance with Executive Order 13045, entitled *Protection of Children from Environmental Health Risks and Safety Risks* (62 FR 19885, April 23, 1997).

In addition, since tolerances and exemptions that are established under section 408(l)(6) of FFDCA, such as the tolerance in this final rule, do not require the issuance of a proposed rule, the requirements of the Regulatory Flexibility Act (RFA) (5 U.S.C. 601 *et seq.*) do not apply. Nevertheless, the Agency previously assessed whether establishing tolerances, exemptions from tolerances, raising tolerance levels or expanding exemptions might adversely impact small entities and concluded, as a generic matter, that there is no adverse economic impact. The factual basis for the Agency's generic certification for tolerance actions published on May 4, 1981 (46 FR 24950), and was provided to the Chief Counsel for Advocacy of the Small Business Administration.

B. Executive Order 12875

Under Executive Order 12875, entitled *Enhancing the Intergovernmental Partnership* (58 FR 58093, October 28, 1993), EPA may not issue a regulation that is not required by statute and that creates a mandate upon a State, local or tribal government, unless the Federal government provides the funds necessary to pay the direct compliance costs incurred by those governments. If the mandate is unfunded, EPA must provide to OMB a description of the extent of EPA's prior consultation with representatives of affected State, local, and tribal governments, the nature of their concerns, copies of any written communications from the governments, and a statement supporting the need to issue the regulation. In addition, Executive Order 12875 requires EPA to develop an effective process permitting elected officials and other representatives of State, local, and tribal governments ''to provide meaningful and timely input in the development of regulatory proposals containing significant unfunded mandates.''

Today's rule does not create an unfunded Federal mandate on State, local, or tribal governments. The rule does not impose any enforceable duties on these entities. Accordingly, the requirements of section 1(a) of Executive Order 12875 do not apply to this rule.

C. Executive Order 13084

Under Executive Order 13084, entitled *Consultation and Coordination with Indian Tribal Governments* (63 FR 27655, May 19, 1998), EPA may not issue a regulation that is not required by statute, that significantly or uniquely affects the communities of Indian tribal governments, and that imposes substantial direct compliance costs on those communities, unless the Federal government provides the funds necessary to pay the direct compliance costs incurred by the tribal governments. If the mandate is unfunded, EPA must provide OMB, in a separately identified section of the preamble to the rule, a description of the extent of EPA's prior consultation with representatives of affected tribal governments, a summary of the nature of their concerns, and a statement supporting the need to issue the regulation. In addition, Executive Order 13084 requires EPA to develop an effective process permitting elected officials and other representatives of Indian tribal governments ''to provide meaningful and timely input in the development of regulatory policies on matters that significantly or uniquely affect their communities.''

Today's rule does not significantly or uniquely affect the communities of Indian tribal governments. This action does not involve or impose any requirements that affect Indian tribes. Accordingly, the requirements of section 3(b) of Executive Order 13084 do not apply to this rule.

IV. Submission to Congress and the Comptroller General

The Congressional Review Act, 5 U.S.C. 801 *et seq.*, as added by the Small Business Regulatory Enforcement Fairness Act of 1996, generally provides that before a rule may take effect, the Agency promulgating the rule must submit a rule report, which includes a copy of the rule, to each House of the Congress and the Comptroller General of the United States. EPA will submit a report containing this rule and other required information to the U.S. Senate, the U.S. House of Representatives and the Comptroller General of the United States prior to publication of the rule in the **Federal Register**. This rule is not a ''major rule'' as defined by 5 U.S.C. 804(2).

List of Subjects in 40 CFR Part 180

Environmental protection, Administrative practice and procedure, Agricultural commodities, Pesticides and pests, Reporting and recordkeeping requirements.

Dated: July 20, 1999.

James Jones,

Director, Registration Division, Office of Pesticide Programs.

Therefore, 40 CFR chapter I is amended as follows:

PART 180—[AMENDED]

1. The authority citation for part 180 continues to read as follows:

Authority: 21 U.S.C. 321(q), 346a and 371.

§ 180.434 [Amended]

2. In § 180.434, by amending the table in paragraph (b) by revising the date for ''Cranberries'' from ''7/31/99'' to read ''7/31/00'' and by revising the date for ''Blueberries'' and ''Raspberries'' from ''12/31/99'' to read ''12/31/00''.

[FR Doc. 99–19596 Filed 7–29–99; 8:45 am]

BILLING CODE 6560–50–F

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 180

[OPP–300881; FRL 6087–2]

RIN 2070–AB78

Diuron; Pesticide Tolerances for Emergency Exemptions

AGENCY: Environmental Protection Agency (EPA).

ACTION: Final rule.

SUMMARY: This regulation establishes a time-limited tolerance for combined residues of diuron in or on catfish. This action is in response to EPA's granting of an emergency exemption under section 18 of the Federal Insecticide, Fungicide, and Rodenticide Act authorizing use of the pesticide in catfish ponds. This regulation establishes a maximum permissible level for residues of diuron in this food commodity pursuant to section 408(l)(6) of the Federal Food, Drug, and Cosmetic Act, as amended by the Food Quality Protection Act of 1996. The tolerance will expire and is revoked on June 30, 2001.

DATES: This regulation is effective July 30, 1999. Objections and requests for hearings must be received by EPA on or before September 28, 1999.

ADDRESSES: Written objections and hearing requests, identified by the docket control number [OPP–300881], must be submitted to: Hearing Clerk (1900), Environmental Protection Agency, Rm. M3708, 401 M St., SW., Washington, DC 20460. Fees accompanying objections and hearing requests shall be labeled ''Tolerance Petition Fees'' and forwarded to: EPA Headquarters Accounting Operations Branch, OPP (Tolerance Fees), P.O. Box 360277M, Pittsburgh, PA 15251. A copy of any objections and hearing requests filed with the Hearing Clerk identified by the docket control number, [OPP–300881], must also be submitted to: Public Information and Records Integrity Branch, Information Resources and Services Division (7502C), Office of Pesticide Programs, Environmental Protection Agency, 401 M St., SW., Washington, DC 20460. In person, bring a copy of objections and hearing requests to Rm. 119, Crystal Mall #2, 1921 Jefferson Davis Hwy., Arlington, VA.

A copy of objections and hearing requests filed with the Hearing Clerk may also be submitted electronically by sending electronic mail (e-mail) to: opp-docket@epa.gov. Copies of electronic objections and hearing requests must be submitted as an ASCII file avoiding the use of special characters and any form of encryption. Copies of objections and hearing requests will also be accepted on disks in WordPerfect 5.1/6.1 or ASCII file format. All copies of electronic objections and hearing requests must be identified by the docket control number [OPP–300881]. No Confidential Business Information (CBI) should be submitted through e-mail. Copies of electronic objections and hearing requests on this rule may be filed online at many Federal Depository Libraries.

FOR FURTHER INFORMATION CONTACT: By mail: David Deegan, Registration Division (7505C), Office of Pesticide Programs, Environmental Protection Agency, 401 M St., SW., Washington, DC 20460. Office location, telephone number, and e-mail address: Rm. 286, Crystal Mall #2, 1921 Jefferson Davis Hwy., Arlington, VA, 703–308–9358; e-mail: deegan.dave@epa.gov.

SUPPLEMENTARY INFORMATION: EPA, on its own initiative, pursuant to sections 408(l)(6) of the Federal Food, Drug, and Cosmetic Act (FFDCA), 21 U.S.C. 346a, is establishing a tolerance for combined residues of the herbicide diuron and its metabolites, convertible to 3,4-dichloroaniline in or on catfish at 2.0 parts per million (ppm). This tolerance will expire and is revoked on June 30, 2001. EPA will publish a document in the **Federal Register** to remove the revoked tolerance from the Code of Federal Regulations.

I. Background and Statutory Findings

The Food Quality Protection Act of 1996 (FQPA)(Public Law 104–170) was signed into law August 3, 1996. FQPA amends both the Federal Food, Drug, and Cosmetic Act (FFDCA), 21 U.S.C. 301 *et seq.*, and the Federal Insecticide, Fungicide, and Rodenticide Act (FIFRA), 7 U.S.C. 136 *et seq.* The FQPA amendments went into effect immediately. Among other things, FQPA amends FFDCA to bring all EPA pesticide tolerance-setting activities under a new section 408 with a new safety standard and new procedures. These activities are described in this preamble and discussed in greater detail in the final rule establishing the time-limited tolerance associated with the emergency exemption for use of propiconazole on sorghum (61 FR 58135, November 13, 1996) (FRL–5572–9).

New section 408(b)(2)(A)(i) of the FFDCA allows EPA to establish a tolerance (the legal limit for a pesticide chemical residue in or on a food) only if EPA determines that the tolerance is ''safe.'' Section 408(b)(2)(A)(ii) defines ''safe'' to mean that ''there is a reasonable certainty that no harm will result from aggregate exposure to the pesticide chemical residue, including all anticipated dietary exposures and all other exposures for which there is reliable information.'' This includes exposure through drinking water and in residential settings, but does not include occupational exposure. Section 408(b)(2)(C) requires EPA to give special consideration to exposure of infants and children to the pesticide chemical residue in establishing a tolerance and to ''ensure that there is a reasonable certainty that no harm will result to infants and children from aggregate exposure to the pesticide chemical residue. . . .''

Section 18 of FIFRA authorizes EPA to exempt any Federal or State agency from any provision of FIFRA, if EPA determines that ''emergency conditions exist which require such exemption.'' This provision was not amended by FQPA. EPA has established regulations governing such emergency exemptions in 40 CFR part 166.

Section 408(l)(6) of the FFDCA requires EPA to establish a time-limited tolerance or exemption from the requirement for a tolerance for pesticide chemical residues in food that will result from the use of a pesticide under an emergency exemption granted by EPA under section 18 of FIFRA. Such tolerances can be established without providing notice or period for public comment.

Because decisions on section 18-related tolerances must proceed before EPA reaches closure on several policy issues relating to interpretation and implementation of the FQPA, EPA does not intend for its actions on such tolerances to set binding precedents for the application of section 408 and the new safety standard to other tolerances and exemptions.

II. Emergency Exemption for Diuron on Catfish and FFDCA Tolerances

EPA has authorized, under FIFRA section 18, the use of diuron in and on catfish ponds for control of algae in Mississippi, Louisiana, and Arkansas. After having reviewed the submissions, EPA concurs that emergency conditions exist in these States. The three applicants requested use of diuron in catfish ponds to control unwanted growth of blue-green algae. The rapid spread of the blue-green algae makes it a secondary food source—albeit undesirable—for the catfish. If algae is present in the ponds, the catfish consume large quantities of it, resulting in an undesirable flavor in the catfish fillet, when the fish are harvested and eaten. Fish with this off flavor are less marketable for producers.

As part of its assessment of this emergency exemption, EPA assessed the potential risks presented by residues of diuron in or on catfish. In doing so, EPA considered the safety standard in FFDCA section 408(b)(2), and EPA decided that the necessary tolerance under FFDCA section 408(l)(6) would be consistent with the safety standard and with FIFRA section 18. Consistent with the need to move quickly on the emergency exemption in order to address an urgent non-routine situation and to ensure that the resulting food is safe and lawful, EPA is issuing this tolerance without notice and opportunity for public comment under section 408(e), as provided in section 408(l)(6). Although this tolerance will expire and is revoked on June 30, 2001, under FFDCA section 408(l)(5), residues of the pesticide not in excess of the amounts specified in the tolerance remaining in or on catfish after that date will not be unlawful, provided the pesticide is applied in a manner that was lawful under FIFRA, and the residues do not exceed a level that was authorized by this tolerance at the time of that application. EPA will take action to revoke this tolerance earlier if any experience with, scientific data on, or other relevant information on this pesticide indicate that the residues are not safe.

Because this tolerance is being approved under emergency conditions, EPA has not made any decisions about whether diuron meets EPA's registration requirements for use on catfish or whether a permanent tolerance for this use would be appropriate. Under these circumstances, EPA does not believe that this tolerance serves as a basis for registration of diuron by a State for special local needs under FIFRA section 24(c). Nor does this tolerance serve as the basis for any State other than Mississippi, Louisiana, and Arkansas to use this pesticide on this crop under section 18 of FIFRA without following all provisions of EPA's regulations implementing section 18 as identified in 40 CFR part 166. For additional information regarding the emergency exemption for diuron, contact the Agency's Registration Division at the address provided under the ''ADDRESSES'' section.

III. Aggregate Risk Assessment and Determination of Safety

EPA performs a number of analyses to determine the risks from aggregate exposure to pesticide residues. For further discussion of the regulatory requirements of section 408 and a complete description of the risk assessment process, see the final rule on Bifenthrin Pesticide Tolerances (62 FR 62961, November 26, 1997) (FRL–5754–7).

Consistent with section 408(b)(2)(D), EPA has reviewed the available scientific data and other relevant information in support of this action. EPA has sufficient data to assess the hazards of diuron and to make a determination on aggregate exposure, consistent with section 408(b)(2), for a time-limited tolerance for combined residues of diuron on catfish at 2.0 ppm. EPA's assessment of the dietary exposures and risks associated with establishing the tolerance follows.

A. Toxicological Profile

EPA has evaluated the available toxicity data and considered its validity, completeness, and reliability as well as the relationship of the results of the studies to human risk. EPA has also considered available information concerning the variability of the sensitivities of major identifiable subgroups of consumers, including infants and children. The nature of the toxic effects caused by diuron are discussed in this unit.

B. Toxicological Endpoint

1. *Acute toxicity*. Acute reference dose (RfD) 0.16 milligram/kilogram/day (mg/kg/day). For acute dietary risk assessment, EPA has identified the no observed adverse effect level (NOAEL) of 16.0 mg/kg/day, based on decreased body weight (beginning at gestation day 9) and food consumption (during gestation days 6–10) at the lowest observed adverse effect level (LOAEL) of 80 mg/kg/day, from the developmental study in the rat. EPA's risk assessment has evaluated acute dietary risk to all population subgroups.

2. *Chronic toxicity*. EPA has established the RfD for diuron at 0.003 mg/kg/day. This RfD is based on a 2–year chronic feeding/oncogenicity study in the rat with a LOAEL of 1.02 mg/kg/day and an uncertainty factor (UF) of 300 (additional UF of 3 for the use of a LOAEL) based on decreased erythrocyte count in females, increased hemosiderin in the spleen, increased spleen weight, bone marrow activation, increased hematopoietic marrow, decreased fat marrow (% surface area of fat marrow in bone marrow) and thickened urinary bladder wall in males.

3. *Carcinogenicity*. Diuron has been classified as a ''known/likely'' human carcinogen by all routes, based on urinary bladder carcinomas in both sexes of the Wistar rat, kidney carcinomas in the male rat (a rare tumor), and mammary gland carcinomas in the female NMRI mouse. A Q_1*(mg/kg/day)$^{-1}$ of 1.91 x 10^{-2} in human equivalents has been calculated based on the male rat urinary bladder carcinomas.

C. Exposures and Risks

1. *From food and feed uses*. Tolerances have been established (40 CFR 180.106) for the combined residues of diuron (3-(3,4-dichlorophenyl)-1,1-dimethylurea), in or on a variety of raw agricultural commodities at levels ranging from 0.1 ppm in nuts and peaches to 7 ppm in bermuda grass. The residues of concern for diuron in plant commodities are the parent compound and all metabolites convertible to 3,4-dichloroaniline (DCA). Although the Code of Federal Regulations (CFR) only mentions diuron in the tolerance expression, the analytical methods determine all metabolites convertible to 3,4-dichloroaniline. The parent compound usually comprises only a small portion of the total residue or of the DCA-containing residues. For both the acute and chronic dietary risk assessments it was assumed that total residues of the closely related herbicides, linuron and propanil will contribute to the toxicological effects of concern (with the acute dietary analysis, there were two exceptions: residues of linuron on potatoes and soybeans where metabolism studies were examined to determine which metabolites are common to those from diuron). It was

also assumed that the tolerances for linuron and propanil represent total residues convertible to 3,4-dichloroaniline, although petition files and residue data were not examined for linuron to confirm this. The propanil residue studies which were reviewed for chronic anticipated residues did involve determination of total base-released 3,4-dichloroaniline. Risk assessments were conducted by EPA to assess dietary exposures and risks from diuron as follows:

i. *Acute exposure and risk*. Acute dietary risk assessments are performed for a food-use pesticide if a toxicological study has indicated the possibility of an effect of concern occurring as a result of a 1–day or single exposure. For this risk assessment of the section 18 requests to use diuron, EPA has identified an acute RfD of 0.16 mg/kg/day. In conducting this acute dietary risk analysis, EPA used partially refined, i.e., percent crop treated data. In those cases where data indicated <1% crop treated, a value of 1% was used for the analysis. For those crops where information was not available to EPA, a default value of 100% crop treated was used for this risk assessment, EPA assumed that 100% of catfish would contain residues of diuron. At the time the anticipated residues (ARs) were developed for the acute dietary risk assessment, percent crop treated data were not available for linuron and propanil; therefore, it was assumed that 100% of the crop was treated for commodities having tolerances for those herbicides. The Novigen DEEM (Dietary Exposure Evaluation Model) system was used for the acute dietary exposure analysis, utilizing mixtures of tolerances/anticipated residues and percent crop treated data for diuron, linuron and propanil. With respect to fruit juices, the default concentration factors in the DEEM run were used except for grape juice and pineapple juice.

The population subgroup with the highest acute dietary exposure (food only) is non-nursing infants. With a high-end anticipated residue contribution (ARC) exposure estimate of 0.03810 mg/kg/day, it was estimated that only 24% of the acute RfD population adjusted dose (PAD) would be utilized for this population subgroup. This acute dietary risk estimate (food only) should be viewed as a partially refined risk estimate (the diuron assessment was highly refined); further refinement using additional anticipated residue values and percent crop treated data for linuron and propanil in conjunction with another Monte Carlo analysis would result in a lower acute dietary exposure estimate. To arrive at this conclusion, EPA determined that for this tolerance action only, the FQPA Safety Factor be removed (1x) in assessing the risk posed by diuron (see aggregate risk section for infants and children). Therefore, the acute RfD is identical to the acute PAD.

ii. *Chronic exposure and risk*. For this risk assessment, EPA has identified a chronic RfD of 0.003 mg/kg/day. For this risk assessment, EPA has utilized the Novigen DEEM system for the chronic dietary exposure analysis. In conducting the chronic dietary risk analysis, EPA used highly refined data. As stated previously, EPA included percent crop treated data for diuron (see acute risk section, above). Percent crop treated data for linuron uses were taken from the dietary risk evaluation system (DRES) run conducted in 1995 and propanil uses (1995–98) were also utilized by EPA in this risk assessment. For those crops where EPA did not have information, a default value of 100% crop treated was used. Anticipated residues of diuron have been developed previously for numerous commodities. These anticipated residues were used with the following additions: 0.03 ppm for alfalfa sprouts (1% crop treated) and 0.92 ppm for fish-finfish/freshwater (76% crop treated). For the purposes of the present section 18 use, an updated analysis of linuron residues in food was not conducted; therefore, the most recent percent crop treated data for linuron (1995–97) was not used. Chronic exposures from linuron for various populations were taken from the DRES analysis conducted in 1995 in support of the increase in the asparagus tolerance. That analysis used anticipated residues (mean field trial values) and percent crop treated available at that time for numerous crops. For propanil, the chronic anticipated residues and percent crop treated have also been calculated by EPA. The chronic dietary risk analysis includes monitoring data for residues in drinking water. Therefore, in this document EPA summarizes risk of exposure for both food and water in the aggregate risk section.

Section 408(b)(2)(E) authorizes EPA to use available data and information on the anticipated residue levels of pesticide residues in food and the actual levels of pesticide chemicals that have been measured in food. If EPA relies on such information, EPA must require that data be provided 5 years after the tolerance is established, modified, or left in effect, demonstrating that the levels in food are not above the levels anticipated. Following the initial data submission, EPA is authorized to require similar data on a time frame it deems appropriate. As required by section 408(b)(2)(E), EPA will issue a data call-in for information relating to anticipated residues to be submitted no later than 5 years from the date of issuance of this tolerance.

Section 408(b)(2)(F) states that the Agency may use data on the actual percent of crop treated (PCT) for assessing chronic dietary risk only if the Agency can make the following findings: That the data used are reliable and provide a valid basis to show what percentage of the food derived from such crop is likely to contain such pesticide residue; that the exposure estimate does not underestimate exposure for any significant subpopulation group; and if data are available on pesticide use and food consumption in a particular area, the exposure estimate does not understate exposure for the population in such area. In addition, the Agency must provide for periodic evaluation of any estimates used. To provide for the periodic evaluation of the estimate of PCT as required by the section 408(b)(2)(F), EPA may require registrants to submit data on PCT.

The Agency used PCT information as follows:

As detailed above, in conducting both the acute and chronic dietary risk analyses, EPA used PCT data. In order to conduct such a refined analysis, EPA utilized the Novigen DEEM system for the dietary exposure analysis, with which EPA calculated mixtures of tolerances/anticipated residues and percent crop treated data for diuron, linuron uses taken from the DRES run conducted in 1995, and propanil uses (1995–98). With respect to fruit juices, the default concentration factors in the DEEM run were used except for grape juice and pineapple juice. Processing studies indicated that residues did not concentrate in the latter two juices. In those cases where data indicated <1% crop treated, a value of 1% was used for the analysis. For those crops where information was not available to EPA, a default value of 100% crop treated was used. At the time the anticipated residues were developed for the acute dietary risk assessment, percent crop treated data were not available for linuron and propanil; therefore, it was assumed that 100% of the crop was treated for commodities having tolerances for those herbicides.

Anticipated residues of diuron have been developed previously for numerous commodities. These anticipated residues were used with the following additions: 0.03 ppm for alfalfa sprouts (1% crop treated) and 0.92 ppm for fish-finfish/freshwater (76% crop

treated). For the purposes of the present action, an updated analysis of linuron residues in food was not conducted; therefore, the most recent percent crop treated data for linuron (1995–97) was not used. Chronic exposures from linuron for various populations were taken from EPA's Dietary Risk Evaluation System (DRES) analysis conducted in 1995 in support of the increase in the asparagus tolerance. That analysis used anticipated residues (mean field trial values) and percent crop treated available at that time for numerous crops. For propanil, the chronic anticipated residues and percent crop treated have also been calculated by EPA. The chronic dietary risk analysis includes monitoring data for residues in drinking water.

The Agency believes that the three conditions, discussed in section 408(2)(F) in this unit concerning the Agency's responsibilities in assessing chronic dietary risk findings, have been met. The PCT estimates are derived from Federal and private market survey data, which are reliable and have a valid basis. Typically, a range of estimates are supplied and the upper end of this range is assumed for the exposure assessment. By using this upper end estimate of the PCT, the Agency is reasonably certain that the percentage of the food treated is not likely to be underestimated. The regional consumption information and consumption information for significant subpopulations is taken into account through EPA's computer-based model for evaluating the exposure of significant subpopulations including several regional groups. Use of this consumption information in EPA's risk assessment process ensures that EPA's exposure estimate does not understate exposure for any significant subpopulation group and allows the Agency to be reasonably certain that no regional population is exposed to residue levels higher than those estimated by the Agency. Other than the data available through national food consumption surveys, EPA does not have available information on the regional consumption of food to which diuron may be applied in a particular area.

2. *From drinking water*. EPA conducted an analysis of the contribution of residues of diuron from drinking water based upon monitoring data for water with emphasis on the US Geological Survey (USGS) National Water Quality Assessment Program (NAWQA) surface water sampling in central California. The NAWQA program analyzed 3,417 samples of surface water for diuron throughout the United States. Approximately 13% of the samples (429) contained detectable diuron residues (only parent compound analyzed) ranging from 0.001 to 14 parts per billion (ppb). The average value for the detectable samples was 0.8 ppb. The 95th percentile value for the surface water samples was 0.2 ppb. For ground water there were 2,726 samples analyzed and about 2% (51) contained diuron residues with values ranging from 0.002 to 2 ppb.

However, EPA's analysis has concluded that the above data may underestimate or under represent concentrations of diuron to be expected in surface water, due to low recovery rates and incomplete sampling in some areas. Furthermore, estimates for diuron degradates in drinking water could not be provided due to the small amount of data and the data not being representative of drinking water. In light of these factors, EPA has concluded that the highest value of 14 ppb of all surface water samples having detectable residues should be used for acute risk assessment and that the average value of 0.8 ppb of all the surface water samples having detectable residues should be used for chronic risk assessment. By using these upper end values of diuron parent in surface water as the estimates, at least some compensation can be made for the poor recoveries of the analytical method and the lack of sufficient data to predict levels of diuron degradates, many of which are likely to be formed by linuron and propanil as well. For the acute dietary aggregate risk analysis, 14 ppb was used as a value for comparison in calculating a drinking water level of comparison (DWLOC). When the acute DEEM run was conducted, it was determined at that point that the percentage of the acute RfD (PAD) taken up by residue exposure in food only was sufficiently low such that a DWLOC could be calculated in lieu of conducting a probabilistic analysis with inclusion of water. However, for the chronic dietary aggregate risk analysis, 0.8 ppb was incorporated into the DEEM assessment as a value taken from monitoring data.

The above risk assessment is sufficient for the purposes of the related section 18 emergency exemption authorized by the Agency. However, EPA expects that for it to take action on a registration and establishment of a permanent tolerance for the catfish pond use, a more thorough analysis would be undertaken to determine which degradates of diuron, linuron and propanil would be included in drinking water residue estimates.

3. *From non-dietary exposure*. Diuron is currently not registered for use on any residential sites.

4. *Cumulative exposure to substances with a common mechanism of toxicity*. Diuron is a member of the phenylurea class of pesticides. Other members of this class include fluometuron, fenuron-TCA, linuron, siduron and tebuthiuron. Section 408(b)(2)(D)(v) requires that, when considering whether to establish, modify, or revoke a tolerance, the Agency consider ''available information'' concerning the cumulative effects of a particular pesticide's residues and ''other substances that have a common mechanism of toxicity.''

The Agency believes that ''available information'' in this context might include not only toxicity, chemistry, and exposure data, but also scientific policies and methodologies for understanding common mechanisms of toxicity and conducting cumulative risk assessments. For most pesticides, although the Agency has some information in its files that may turn out to be helpful in eventually determining whether a pesticide shares a common mechanism of toxicity with any other substances, EPA does not at this time have the methodologies to resolve the complex scientific issues concerning common mechanism of toxicity in a meaningful way. EPA has begun a pilot process to study this issue further through the examination of particular classes of pesticides. The Agency hopes that the results of this pilot process will increase the Agency's scientific understanding of this question such that EPA will be able to develop and apply scientific principles for better determining which chemicals have a common mechanism of toxicity and evaluating the cumulative effects of such chemicals. The Agency anticipates, however, that even as its understanding of the science of common mechanisms increases, decisions on specific classes of chemicals will be heavily dependent on chemical-specific data, much of which may not be presently available.

Although at present the Agency does not know how to apply the information in its files concerning common mechanism issues to most risk assessments, there are pesticides as to which the common mechanism issues can be resolved. These pesticides include those that are toxicologically dissimilar to existing chemical substances (in which case the Agency can conclude that it is unlikely that a pesticide shares a common mechanism of activity with other substances) and pesticides that produce a common toxic metabolite (in which case common mechanism of activity will be assumed).

Diuron shares a common metabolite with linuron and propanil. The non-cancer dietary risk assessments take this into consideration. For the purposes of this section 18, residues from linuron and propanil were not taken into consideration for the carcinogenicity risk assessment because the target organs (i.e., the tumors) for diuron versus linuron and propanil are of different origins and because metabolism and mechanistic data indicate that the mechanism of action for tumor induction are different for diuron when compared to linuron and propanil.

The residues of concern for diuron are the parent compound and all metabolites convertible to 3,4-dichloroaniline (DCA). There are two closely related herbicides which are also metabolized to DCA and/or other residues convertible to DCA (linuron and propanil). Therefore, it was assumed that residues from the use of these two pesticides will contribute to the toxicological effects of concern for the dietary risk analyses (for further explantion, see exposure discussion in section III. C. below). The toxicological data bases for these two pesticides were examined to see if there are similar target organs. For the acute dietary risk analysis, the toxicological endpoint, decreased bodyweight and food consumption, is not specific enough for comparison. Nevertheless, it was still assumed that residues from all three herbicides will contribute to the same acute effects. For chronic exposure, these three pesticides share a similar toxicological endpoint: hematological effects, particularly methemoglobinemia. These effects were observed in chronic feeding studies, in either the rat, dog or mouse. The target organs for carcinogenicity may be similar for linuron and propanil, but not for diuron. Diuron induces urinary bladder carcinomas in rats (both sexes) and mammary gland carcinomas in female mice. In addition, an increase in the incidence of a rare kidney tumor was observed in male rats. Linuron induces testicular interstitial cell adenomas in rats and hepatocellular adenomas in mice. Available mechanistic and metabolism data indicate that linuron and diuron may be inducing tumors through different mechanisms of action. Propanil has not been reviewed by the Office of Pesticide Programs Cancer Assessment Review Committee (CARC). However, two new studies have been received which indicate that it may induce malignant lymphomas of the spleen in female mice, testicular interstitial cell tumors in male rats and hepatocellular adenomas in female rats, the latter at a dose level which probably exceeds the maximum tolerated dose. Therefore, since the target organs for tumor induction for diuron are different than those for linuron and propanil, and data are available which indicate that the mechanism of action may be different for diuron, for the purpose of this tolerance action, the estimated dietary carcinogenic risk will not include residues from linuron and propanil. However, for any future permanent tolerance requests, a detailed analysis of any potential contribution of residues from linuron and propanil to the dietary carcinogenic risk will be conducted, including examination of available toxicological and mechanistic data.

EPA does not have, at this time, available data to determine whether diuron has a common mechanism of toxicity with any other substances or how to include this pesticide in a cumulative risk assessment. For the purposes of this tolerance action, therefore, EPA has not assumed that diuron has a common mechanism of toxicity with substances other than linuron and propanil. For more information regarding EPA's efforts to determine which chemicals have a common mechanism of toxicity and to evaluate the cumulative effects of such chemicals, see the final rule for Bifenthrin Pesticide Tolerances (62 FR 62961, November 26, 1997).

D. Aggregate Risks and Determination of Safety for U.S. Population

1. *Acute risk*. The acute dietary risk analysis estimated that the acute dietary exposure (food only) for the U.S. Population will utilize 17% of the acute RfD, which, because there is no FQPA 10x Safety Factor added to this risk assessment, is identical to the acute population adjusted dose (PAD). All other adult population subgroups have acute risk estimates (food only) below that of the U.S. population. As stated previously, the acute dietary risk analysis used partially refined ARC exposure estimates and percent crop treated values. The analysis included total residues convertible to the diuron metabolite, DCA from food. Residue contributions from diuron, linuron and propanil uses were taken into account. For DCA-convertible residues from diuron, linuron and propanil, it was determined that an acute dietary exposure (food plus water) of 100% or less of the acute RfD (PAD) is acceptable to protect the safety of all population subgroups. The estimated exposures at the 99.9th percentile for all population subgroups utilize less than 100% of the acute RfD (PAD).

Monitoring data were available for drinking water for the acute aggregate risk estimate. However, since the percentage of the acute RfD (PAD) taken up by exposure to DCA residues from food only was sufficiently low, it was decided that a DWLOC would be calculated. Therefore, for this tolerance, the estimated maximum concentration of 14 ppb from the monitoring data was used for comparison to the back calculated human health DWLOC for the acute endpoint. The DWLOCs for the specific population subgroups are calculated as follows:

The maximum water exposure (acute) (mg/kg/day) = acute PAD - food exposure (mg/kg/day) from acute DEEM run.

The DWLOC (μg/L) = max. water exposure (mg/kg/day) x body wt (kg) ÷ (10^{-3} mg/μg) x water consumption (L/day).

EPA used the following default body weights in these calculations: General U.S. population, 70 kg; males (13+ years old), 70 kg; females (13+ years old), 60 kg; and other adult populations, 70 kg.

EPA's default daily drinking rates are 2L/day for adults.

The DWLOCs are between 4,300 and 5,000 ppb for acute dietary risk. Based on a comparison of the calculated DWLOCs and the estimated exposure to diuron in drinking water (14 ppb), EPA does not expect the aggregate exposure to exceed 100% of the Acute RfD for any of the U.S. population. The DWLOCs are at least 100 times higher than the maximum value observed in monitoring studies. Therefore, EPA concludes that there is a reasonable certainty that no harm will result to the U.S. population from acute aggregate exposure to diuron residues.

2. *Chronic risk*. EPA determined that for this tolerance, the FQPA Safety Factor can be removed (1x) in assessing the risk posed by diuron. Therefore, because there is not a FQPA 10x Safety Factor added to this risk assessment, the chronic RfD is identical to the chronic PAD. EPA has calculated that chronic dietary exposure to diuron alone from food and water will utilize 4.7% of the chronic RfD (PAD) for the U.S. population. When residues from linuron and propanil are included, the dietary exposure to residues convertible to the metabolite (DCA) from food and water will utilize 12% of the chronic RfD (PAD) for the U.S. population and 15% of the chronic RfD (PAD) for the non-hispanic, non-white, non-black U.S. population.

As stated previously, the chronic dietary risk analysis used highly refined

ARC exposure estimates and percent crop treated values. EPA generally has no concern for exposures below 100% of the chronic RfD (PAD) because the chronic RfD (PAD) represents the level at or below which daily aggregate dietary exposure over a lifetime will not pose appreciable risks to human health. There are no registered residential uses for diuron. Therefore, EPA concludes that there is a reasonable certainty that no harm to adults will result from chronic aggregate exposure to DCA-convertible residues from diuron, linuron and propanil.

3. *Short- and intermediate-term risk*. Short- and intermediate-term aggregate exposure takes into account chronic dietary food and water (considered to be a background exposure level) plus non-dietary, non-occupational exposures. Since there are no registered uses of diuron that would result in such exposures, short- and intermediate-term aggregate risk estimates were not conducted.

4. *Aggregate cancer risk for U.S. population*. The dietary cancer risk for the U.S. population is calculated by multiplying the Q_1* by the dietary exposure value. The Q_1*(mg/kg/day)$^{-1}$ for diuron is 1.91 x 10^{-2}. The dietary exposure value for registered food crops for the U.S. population is 0.000092 mg/kg/day. This highly refined value does not include either the drinking water exposure value or the catfish exposure that was included in the exposure values described above in the discussion on chronic aggregate risk. Multiplying the Q_1* by the dietary exposure value for the U.S. population, the cancer risk for the U.S. population is 1.76 x 10^{-6} for all registered foods. Adding in calculated risks from catfish and the average monitoring value of 0.8 ppb diuron parent in all drinking water, the total estimation of cancer risk for the U.S. population is 2.71 x 10^{-6}. This value does not include contributions from linuron and propanil metabolites because, as explained in the toxicological endpoints section, the tumor target organs are different for diuron when compared to linuron and propanil and because mechanistic and metabolism data indicate that diuron may be inducing tumors through a different mechanism of action. Metabolites in water are also not included; however, EFED's upper end value of diuron parent in surface water partially compensates for not including metabolites in water.

5. *Determination of safety*. Based on these risk assessments, EPA concludes that there is a reasonable certainty that no harm will result from aggregate exposure to diuron residues.

E. Aggregate Risks and Determination of Safety for Infants and Children

1. *Safety factor for infants and children*— i. *In general*. In assessing the potential for additional sensitivity of infants and children to residues of diuron, EPA considered data from developmental toxicity studies in the rat and rabbit and a 2–generation reproduction study in the rat. The developmental toxicity studies are designed to evaluate adverse effects on the developing organism resulting from maternal pesticide exposure during gestation. Reproduction studies provide information relating to effects from exposure to the pesticide on the reproductive capability of mating animals and data on systemic toxicity.

FFDCA section 408 provides that EPA shall apply an additional tenfold margin of safety for infants and children in the case of threshold effects to account for pre- and postnatal toxicity and the completeness of the data base unless EPA determines that a different margin of safety will be safe for infants and children. Margins of safety are incorporated into EPA risk assessments either directly through use of a margin of exposure (MOE) analysis or through using uncertainty (safety) factors in calculating a dose level that poses no appreciable risk to humans. EPA believes that reliable data support using the standard MOE and uncertainty factor (usually 100 for combined inter- and intra-species variability) and not the additional tenfold MOE/uncertainty factor when EPA has a complete data base under existing guidelines and when the severity of the effect in infants or children or the potency or unusual toxic properties of a compound do not raise concerns regarding the adequacy of the standard MOE/safety factor.

ii. *Developmental toxicity studies—Rats*. In the developmental study in rats, the maternal (systemic) NOAEL was 16 mg/kg/day, based on reduction in body weight and food consumption at the LOAEL of 80 mg/kg/day. The developmental (fetal) NOAEL was 80 mg/kg/day, based on increases in delayed ossification of vertebrae and sternebrae as well as decreased fetal weights at the LOAEL of 400 mg/kg/day.

Rabbits. In the developmental toxicity study in rabbits, the maternal (systemic) NOAEL was 10 mg/kg/day, based on decreased body weight and food comsumption at the LOAEL of 50 mg/kg/day. The developmental (pup) NOAEL was 50 mg/kg/day, the highest dose tested. There were no developmental effects.

iii. *Reproductive toxicity study—Rats*. In the 2–generation reproductive toxicity study in rats, the parental (systemic) NOAEL was 16.9 (males) and 20.3 (females) mg/kg/day, based on decreased body weight, body weight gain and food consumption in both sexes at the LOAEL of 120 (males) and 144 (females) mg/kg/day. The developmental (pup) NOAEL was 20.3 mg/kg/day, based on decreased pup body weight during the lactation period for both sexes and generations at the LOAEL of 144 mg/kg/day. The reproductive NOAEL was 120 (males) and 144 (females) mg/kg/day, the highest dose tested. There were no reproductive effects.

iv. *Pre- and postnatal sensitivity*. The toxicological data base for evaluating pre- and postnatal toxicity for diuron is complete with respect to current data requirements. Based on the developmental and reproductive toxicity studies discussed above for diuron, there does not appear to be an extra sensitivity for pre- or postnatal effects. EPA has concluded that the FQPA Safety Factor can be removed (1x) in assessing the risk posed by this chemical. The decision applies only to this tolerance action.

v. *Conclusion*. There is a complete toxicity data base for diuron and exposure data are complete or are estimated based on data that reasonably accounts for potential exposures.

2. *Acute risk*. The acute dietary risk analysis using partially refined data estimated that the acute dietary exposure (food only) for the population subgroup, non-nursing infants will utilize 24% of the acute RfD (PAD). All other infant and children population subgroups have acute risk estimates (food only) below that of non-nursing infants (see discussion on residue contributions in the Acute Aggregate Risk section for the U.S. population). For DCA-convertible residues from diuron, linuron and propanil, it was determined that an acute dietary exposure (food plus water) of 100% or less of the acute RfD (PAD) is acceptable to protect the safety of all infant and children population subgroups. The estimated exposures at the 99.9th percentile for all infant and children population subgroups utilize less than 100% of the Acute RfD, which, because there is no FQPA 10x Safety Factor, is identical to the acute PAD.

As stated in the aggregate risk section for the U.S. population, for purposes of risk assessment, the estimated maximum concentration of 14 ppb from the monitoring data will be used for comparison to the back-calculated human health DWLOC for the acute endpoint. For the DWLOC calculations, the EPA default body weights are:

Females (13+ years old), 60 kg and all infants/children, 10 kg.

EPA has used daily drinking rates of 2L/day for adults and 1L/day for children.

The DWLOCs are between 1,200 and 4,300 ppb for acute dietary risk. Based on a comparison of the calculated DWLOCs and the estimated exposure to diuron in drinking water (14 ppb), EPA does not expect the aggregate exposure to exceed 100% of the Acute RfD for either infants or children. The DWLOCs are approximately 100 times higher than the maximum value observed in monitoring studies. Therefore, EPA concludes that there is a reasonable certainty that no harm will result to either infants or children from acute aggregate exposure to diuron residues.

3. *Chronic risk*. Using the exposure assumptions described in this unit, EPA has concluded that aggregate exposure to diuron from food will utilize 28% of the chronic RfD for non-nursing infants, which is the highest exposed population subgroup. All other infant and children population subgroups have lower chronic dietary exposure. EPA generally has no concern for exposures below 100% of the chronic RfD (PAD) because the chronic RfD (PAD) represents the level at or below which daily aggregate dietary exposure over a lifetime will not pose appreciable risks to human health. There are no registered residential uses for diuron. EPA concludes that there is a reasonable certainty that no harm will result to infants and children from chronic aggregate exposure to DCA residues from diuron, linuron and propanil. Despite the potential for exposure to diuron in drinking water and from non-dietary, non-occupational exposure, EPA does not expect the aggregate exposure to exceed 100% of the RfD/PAD.

4. *Short- or intermediate-term risk*. Short- and intermediate-term aggregate exposure takes into account chronic dietary food and water (considered to be a background exposure level) plus non-dietary, non-occupational exposures. Since there are no registered uses of diuron which would result in such exposures, short- and intermediate- term aggregate risk estimates were not conducted.

5. *Determination of safety*. Based on these risk assessments, EPA concludes that there is a reasonable certainty that no harm will result to infants and children from aggregate exposure to diuron residues.

IV. Other Considerations

A. Metabolism in Plants and Animals

The nature of the residue in plants is adequately understood. The parent compound usually comprises only a small portion of the total residue. Significant residues formed by demethylation include dichlorophenylmethylurea (DCPMU) and dichlorophenylurea (DCPU). Although tolerances in 40 CFR 180.106 are expressed simply as ''residues of the herbicide diuron,'' as part of the reregistration process EPA has noted that the residue to be regulated in plants is diuron and its related compounds convertible to 3,4-dichloroaniline as determined by the enforcement and data collection methods. The tolerance expression should be revised in this manner when reregistration eligibility decisions are made for diuron. For the purposes of the current action, the tolerance will be based on the combined residues of diuron and its metabolites convertible to 3,4-dichloroaniline.

EPA addressed the residues of concern in livestock commodities. While DCPMU and DCPU are also formed in livestock, five hydroxylated metabolites are found that are not observed in plants. EPA concluded these residues are not of concern in livestock tissues and eggs as the DCA method determined 80% or more of the total radioactive residue in these commodities. In milk the DCA method recovered only 10% of the TRR and EPA concluded that while the remaining 90% of the residue need not be quantified using a different method, the diuron residues observed in milk (by conversion to DCA) in the feeding study will be multiplied by 10 for purposes of risk assessment. Although livestock are not directly involved in this tolerance action, a tolerance is being established for residues in catfish. For the purposes of this tolerance, the residue of concern in catfish will be considered the same as in plants and livestock tissues (i.e., diuron and it metabolites convertible to DCA).

B. Analytical Enforcement Methodology

Adequate enforcement methodology (example - gas chromotography) is available to enforce the tolerance expression. The method may be requested from: Calvin Furlow, PIRIB, IRSD (7502C), Office of Pesticide Programs, Environmental Protection Agency, 401 M St., SW., Washington, DC 20460. Office location and telephone number: Rm 101FF, Crystal Mall #2, 1921 Jefferson Davis Hwy., Arlington, VA, (703) 305–5229.

C. Magnitude of Residues

Residue data were provided for four different application schemes to catfish ponds. In all cases, the application rate or concentration (0.01 ppm) in the water was the same as that authorized in the section 18 exemptions. In three ponds, the treatments were made every 5 days (versus proposed 7–day interval) with the total number of applications being 7, 13 or 19 (for total treatment periods of 30, 60 or 90 days). The maximum DCA-containing residues in catfish fillets for the three treatment patterns were 0.90, 1.76 and 1.52 ppm, respectively. The values apparently reflect averages of triplicate analyses. The highest residue from an individual analysis is 1.88 ppm. The fourth pond (described as an efficacy study) more closely resembled the proposed emergency use in that the 0.01 ppm water treatments were made every 7 days, although more applications were made (17 over 112 days versus maximum of 9 requested in the section 18). Fillets were collected after the final treatment and found to contain 0.59–1.16 ppm total DCA-containing residues. Based on these data, EPA concludes that a 2.0 ppm time-limited tolerance should be established for residues of diuron and its metabolites convertible to 3,4-dichloroaniline in catfish fillets.

There are no livestock feed items associated with the proposed use in catfish ponds. Therefore, tolerances are not required for residues of diuron and metabolites in meat, milk, poultry and eggs. Tolerances of 1 ppm are established for residues of diuron in the meat, fat and meat byproducts of cattle, goats, hogs, horses and sheep (40 CFR 180.106) in conjunction with registered uses of the herbicide.

D. International Residue Limits

There are no Codex, Canadian, or Mexican tolerances or maximum residue limits for diuron in catfish. Therefore, harmonization with international tolerances is not an issue for this tolerance.

E. Rotational Crop Restrictions

Since the requested use is for catfish ponds, which are essentially permanent structures, there are no rotational crops that would be planted in the treated areas. Thus, no plantback intervals need to be specified for rotational crops.

V. Conclusion

Therefore, the tolerance is established for combined residues of diuron and its metabolites convertible to 3,4-dichloroaniline in catfish fillets at 2.0 ppm.

VI. Objections and Hearing Requests

The new FFDCA section 408(g) provides essentially the same process for persons to ''object'' to a tolerance regulation as was provided in the old section 408 and in section 409. However, the period for filing objections is 60 days, rather than 30 days. EPA currently has procedural regulations which govern the submission of objections and hearing requests. These regulations will require some modification to reflect the new law. However, until those modifications can be made, EPA will continue to use those procedural regulations with appropriate adjustments to reflect the new law.

Any person may, by September 28, 1999, file written objections to any aspect of this regulation and may also request a hearing on those objections. Objections and hearing requests must be filed with the Hearing Clerk, at the address given under the ''ADDRESSES'' section (40 CFR 178.20). A copy of the objections and/or hearing requests filed with the Hearing Clerk should be submitted to the OPP docket for this rulemaking. The objections submitted must specify the provisions of the regulation deemed objectionable and the grounds for the objections (40 CFR 178.25). Each objection must be accompanied by the fee prescribed by 40 CFR 180.33(i). EPA is authorized to waive any fee requirement ''when in the judgement of the Administrator such a waiver or refund is equitable and not contrary to the purpose of this subsection.'' For additional information regarding tolerance objection fee waivers, contact James Tompkins, Registration Division (7505C), Office of Pesticide Programs, Environmental Protection Agency, 401 M St., SW., Washington, DC 20460. Office location, telephone number, and e-mail address: Rm. 239, Crystal Mall #2, 1921 Jefferson Davis Hwy., Arlington, VA, (703) 305–5697, tompkins.jim@epa.gov. Requests for waiver of tolerance objection fees should be sent to James Hollins, Information Resources and Services Division (7502C), Office of Pesticide Programs, Environmental Protection Agency, 401 M St., SW., Washington, DC 20460.

If a hearing is requested, the objections must include a statement of the factual issues on which a hearing is requested, the requestor's contentions on such issues, and a summary of any evidence relied upon by the requestor (40 CFR 178.27). A request for a hearing will be granted if the Administrator determines that the material submitted shows the following: There is genuine and substantial issue of fact; there is a reasonable possibility that available evidence identified by the requestor would, if established, resolve one or more of such issues in favor of the requestor, taking into account uncontested claims or facts to the contrary; and resolution of the factual issues in the manner sought by the requestor would be adequate to justify the action requested (40 CFR 178.32). Information submitted in connection with an objection or hearing request may be claimed confidential by marking any part or all of that information as CBI. Information so marked will not be disclosed except in accordance with procedures set forth in 40 CFR part 2. A copy of the information that does not contain CBI must be submitted for inclusion in the public record. Information not marked confidential may be disclosed publicly by EPA without prior notice.

VII. Public Record and Electronic Submissions

EPA has established a record for this regulation under docket control number [OPP–300881] (including any comments and data submitted electronically). A public version of this record, including printed, paper versions of electronic comments, which does not include any information claimed as CBI, is available for inspection from 8:30 a.m. to 4 p.m., Monday through Friday, excluding legal holidays. The public record is located in Room 119 of the Public Information and Records Integrity Branch, Information Resources and Services Division (7502C), Office of Pesticide Programs, Environmental Protection Agency, Crystal Mall #2, 1921 Jefferson Davis Hwy., Arlington, VA.

Objections and hearing requests may be sent by e-mail directly to EPA at:

opp-docket@epa.gov

E-mailed objections and hearing requests must be submitted as an ASCII file avoiding the use of special characters and any form of encryption.

The official record for this regulation, as well as the public version, as described in this unit will be kept in paper form. Accordingly, EPA will transfer any copies of objections and hearing requests received electronically into printed, paper form as they are received and will place the paper copies in the official record which will also include all comments submitted directly in writing. The official record is the paper record maintained at the Virginia address in ''ADDRESSES'' at the beginning of this document.

VIII. Regulatory Assessment Requirements

A. Certain Acts and Executive Orders

This final rule establishes a tolerance under section 408 of the FFDCA. The Office of Management and Budget (OMB) has exempted these types of actions from review under Executive Order 12866, entitled *Regulatory Planning and Review* (58 FR 51735, October 4, 1993). This final rule does not contain any information collections subject to OMB approval under the Paperwork Reduction Act (PRA), 44 U.S.C. 3501 *et seq.*, or impose any enforceable duty or contain any unfunded mandate as described under Title II of the Unfunded Mandates Reform Act of 1995 (UMRA) (Pub. L. 104–4). Nor does it require special considerations as required by Executive Order 12898, entitled *Federal Actions to Address Environmental Justice in Minority Populations and Low-Income Populations* (59 FR 7629, February 16, 1994), or require OMB review in accordance with Executive Order 13045, entitled *Protection of Children from Environmental Health Risks and Safety Risks* (62 FR 19885, April 23, 1997).

In addition, since tolerances and exemptions that are established under FFDCA section 408(l)(6), such as the tolerance in this final rule, do not require the issuance of a proposed rule, the requirements of the Regulatory Flexibility Act (RFA) (5 U.S.C. 601 *et seq.*) do not apply. Nevertheless, the Agency previously assessed whether establishing tolerances, exemptions from tolerances, raising tolerance levels or expanding exemptions might adversely impact small entities and concluded, as a generic matter, that there is no adverse economic impact. The factual basis for the Agency's generic certification for tolerance actions published on May 4, 1981 (46 FR 24950), and was provided to the Chief Counsel for Advocacy of the Small Business Administration.

B. Executive Order 12875

Under Executive Order 12875, entitled *Enhancing the Intergovernmental Partnership* (58 FR 58093, October 28, 1993), EPA may not issue a regulation that is not required by statute and that creates a mandate upon a State, local or tribal government, unless the Federal government provides the funds necessary to pay the direct compliance costs incurred by those governments. If the mandate is unfunded, EPA must provide to OMB a description of the extent of EPA's prior consultation with representatives of affected State, local, and tribal

governments, the nature of their concerns, copies of any written communications from the governments, and a statement supporting the need to issue the regulation. In addition, Executive Order 12875 requires EPA to develop an effective process permitting elected officials and other representatives of State, local, and tribal governments ''to provide meaningful and timely input in the development of regulatory proposals containing significant unfunded mandates.''

Today's rule does not create an unfunded Federal mandate on State, local, or tribal governments. The rule does not impose any enforceable duties on these entities. Accordingly, the requirements of section 1(a) of Executive Order 12875 do not apply to this rule.

C. Executive Order 13084

Under Executive Order 13084, entitled *Consultation and Coordination with Indian Tribal Governments* (63 FR 27655, May 19, 1998), EPA may not issue a regulation that is not required by statute, that significantly or uniquely affects the communities of Indian tribal governments, and that imposes substantial direct compliance costs on those communities, unless the Federal government provides the funds necessary to pay the direct compliance costs incurred by the tribal governments. If the mandate is unfunded, EPA must provide OMB, in a separately identified section of the preamble to the rule, a description of the extent of EPA's prior consultation with representatives of affected tribal governments, a summary of the nature of their concerns, and a statement supporting the need to issue the regulation. In addition, Executive Order 13084 requires EPA to develop an effective process permitting elected officials and other representatives of Indian tribal governments ''to provide meaningful and timely input in the development of regulatory policies on matters that significantly or uniquely affect their communities.''

Today's rule does not significantly or uniquely affect the communities of Indian tribal governments. This action does not involve or impose any requirements that affect Indian tribes. Accordingly, the requirements of section 3(b) of Executive Order 13084 do not apply to this rule.

IX. Submission to Congress and the Comptroller General

The Congressional Review Act, 5 U.S.C. 801 *et seq.*, as added by the Small Business Regulatory Enforcement Fairness Act of 1996, generally provides that before a rule may take effect, the Agency promulgating the rule must submit a rule report, which includes a copy of the rule, to each House of the Congress and the Comptroller General of the United States. EPA will submit a report containing this rule and other required information to the U.S. Senate, the U.S. House of Representatives and the Comptroller General of the United States prior to publication of the rule in the **Federal Register**. This rule is not a ''major rule'' as defined by 5 U.S.C. 804(2).

List of Subjects in 40 CFR Part 180

Environmental protection, Administrative practice and procedure, Agricultural commodities, Pesticides and pests, Reporting and recordkeeping requirements.

Dated: July 14, 1999.

James Jones,

Director, Registration Division, Office of Pesticide Programs.

Therefore, 40 CFR chapter I is amended as follows:

PART 180—[AMENDED]

1. The authority citation for part 180 continues to read as follows:

Authority: 21 U.S.C. 321(q), 346(a) and 371.

2. Section §180.106, is amended by adding new paragraph (b) to read as follows.

§180.106 Diuron; tolerances for residues.

* * * * *

(b) *Section 18 emergency exemptions.* Time-limited tolerances are established for combined residues of the herbicide diuron and its metabolites convertible to 3,4-dichloroaniline in connection with use of the pesticide under section 18 emergency exemptions granted by EPA. These tolerances will expire and are revoked on the dates specified in the following table.

Commodity	Parts per million	Expiration/ Revocation date
Catfish fillets	2 .0	06/30/01

* * * * *

[FR Doc. 99–19591 Filed 7–29–99; 8:45 am]

BILLING CODE 6560–50–F

FEDERAL EMERGENCY MANAGEMENT AGENCY

44 CFR Part 61

RIN 3067–AC35

National Flood Insurance Program (NFIP); Group Flood Insurance Policy

AGENCY: Federal Emergency Management Agency (FEMA).

ACTION: Final rule.

SUMMARY: We (FEMA) adopt as our final rule the interim rule that we published establishing the Group Flood Insurance Policy (GFIP); however, we are changing the term of the policy from thirty-six to thirty-seven months.

EFFECTIVE DATE: July 30, 1999.

FOR FURTHER INFORMATION CONTACT: Charles M. Plaxico, Jr., Federal Emergency Management Agency, Federal Insurance Administration, (202)646–3422, (facsimile) (202)646–4327, or (email) *charles.plaxico@fema.gov.*

SUPPLEMENTARY INFORMATION: On May 1, 1996, we published in the **Federal Register** (Vol. 61, page 19197) an interim final rule that establishes a Group Flood Insurance Policy (GFIP) and authorizes its use for recipients of grant awards under the IFG Program as authorized under § 411 of the Stafford Act (42 U.S.C. 5178). The purpose of that interim final rule was to provide a temporary mechanism for the recipients of IFG grants—often low-income persons or those on fixed incomes—to have flood insurance coverage for a period of three years following a flood loss so that they would have time to recover from the disaster and be in a better position to buy flood insurance for themselves after the expiration of their three-year policy term. We received no comments during the comment period for the interim final rule.

Under § 582 of the National Flood Insurance Reform Act of 1994, disaster victims must buy and maintain flood insurance in order to be eligible for future disaster aid to repair damages for flood losses. Toward that end, we contacted those States that have current GFIPs offering information and our assistance to help current GFIP certificate holders transition from group coverage to an individual policy. We are aware that at least one State needs more time to work with its GFIP certificate holders so that they will continue to be eligible for future Federal disaster assistance flood damages to their property.

This final rule will give both State governments and the GFIP certificate

holders an additional month to make arrangements to buy and maintain flood insurance beyond the current term for the GFIP of thirty-six months.

National Environmental Policy Act

The requirements of 44 CFR Part 10, Environmental Consideration, categorically exclude this final rule. We have not prepared an environmental impact assessment.

Executive Order 12866, Regulatory Planning and Review

This final rule is not a significant regulatory action within the meaning of § 2(f) of E.O. 12866 of September 30, 1993, 58 FR 51735, but attempts to adhere to the regulatory principles set forth in E.O. 12866. The Office of Management and Budget has not reviewed this final rule under E.O. 12866.

Paperwork Reduction Act

This final rule does not contain a collection of information and therefore is not subject to the provisions of the Paperwork Reduction Act of 1995.

Executive Order 12612, Federalism

This final rule involves no policies that have federalism implications under E.O. 12612, Federalism, dated October 26, 1987.

Executive Order 12778, Civil Justice Reform

This final rule meets the applicable standards of § 2(b)(2) of E.O. 12778.

Congressional Review of Agency Rulemaking.

We have sent this final rule to the Congress and to the General Accounting Office under the Congressional Review of Agency Rulemaking Act, Pub. L. 104–121. The rule is not a ''major rule'' within the meaning of that Act. It is an administrative action in support of normal day-to-day activities. It does not result in nor is it likely to result in an annual effect on the economy of $100,000,000 or more. It will not result in a major increase in costs or prices for consumers, individual industries, Federal, State, or local government agencies, or geographic regions. It will not have ''significant adverse effects'' on competition, employment, investment, productivity, innovation, or on the ability of United States-based enterprises to compete with foreign-based enterprises. This final rule is exempt (1) from the requirements of the Regulatory Flexibility Act, and (2) from the Paperwork Reduction Act. The rule is not an unfunded Federal mandate within the meaning of the Unfunded Mandates Reform Act of 1995, Pub. L. 104–4. It does not meet the $100,000,000 threshold of that Act, and any enforceable duties are imposed as a condition of Federal assistance or a duty arising from participation in a voluntary Federal program.

List of Subjects in 44 CFR Part 61

Flood insurance.

Accordingly, we adopt the interim rule amending 44 CFR Part 61, which was published at 61 FR 19197 on May 1, 1996, as the final rule with the following change:

PART 61—INSURANCE COVERAGE AND RATES

1. The authority citation for Part 61 continues to read as follows:

Authority: 42 U.S.C. 4001 *et seq.*; Reorganization Plan No. 3 of 1978, 43 FR 41943, 3 CFR, 1978 Comp., p. 329; E.O. 12127 of Mar. 31, 1979, 44 FR 19367, 3 CFR, 1979 Comp., p. 376.

2. Section 61.17 is revised to read as follows:

§ 61.17 Group Flood Insurance Policy.

(a) A Group Flood Insurance Policy (GFIP) is a policy covering all individuals named by a State as recipients under § 411 of the Stafford Act (42 U.S.C. 5178) of an Individual and Family Grant (IFG) program award for flood damage as a result of a major disaster declaration by the President.

(b) The premium for the GFIP, initially, is a flat fee of $200 per policyholder. Thereafter, the premium may be adjusted to reflect NFIP loss experience and any adjustment of benefits under the IFG program.

(c) The amount of coverage will equal the maximum grant amount established under § 411 of the Stafford Act (42 U.S.C. 5178).

(d) The term of the GFIP will be 37 months and will begin 60 days from the date of the disaster declaration.

(e) Coverage for individual grantees begins on the thirtieth day after the NFIP receives the required data for individual grantees and their premium payments.

(f) A Certificate of Flood Insurance will be sent to each individual insured under the GFIP.

(g) The GFIP is the Standard Flood Insurance Policy Dwelling Form (a copy of which is included in Appendix A(1) of this part), except that:

(1) The GFIP provides coverage for losses caused by land subsidence, sewer backup, or seepage of water without regard to the requirement in paragraph B.3. of Article 3 that the structure be insured to 80 percent of its replacement cost or the maximum amount of insurance available under the NFIP.

(2) Article 7, Deductibles, does not apply to the GFIP. Instead, a special deductible of $200 (applicable separately to any building loss and any contents loss) applies to insured flood-damage losses sustained by the insured property in the course of any subsequent flooding event during the term of the GFIP. The separate deductible applicable to Article 3 B.3 does not apply.

(3) Article 9 E., Cancellation of Policy by You, does not apply to the GFIP.

(4) Article 9 G., Policy Renewal, does not apply to the GFIP.

(h) A notice will be sent to the GFIP certificate holders approximately 60 days before the end of the 3-year term of the GFIP. The notice will:

(1) Encourage them to contact a local insurance agent or producer or a private insurance company selling NFIP policies under the Write Your Own program of the NFIP to apply for a conventional NFIP Standard Flood Insurance Policy; and

(2) Advise them as to the amount of coverage they must maintain in order not to jeopardize their eligibility for future disaster assistance. The amount of flood insurance coverage to be maintained by certificate holders will be provided to the NFIP by the IFG program or the State with its own fully funded disaster assistance program.

(Catalog of Federal Domestic Assistance No. 83.100, ''Flood Insurance''; No. 83.516, ''Disaster Assistance'')

Dated: July 21, 1999.

Jo Ann Howard,

Administrator, Federal Insurance Administration.

[FR Doc. 99–19417 Filed 7–29–99; 8:45 am]

BILLING CODE 6718–03–P

FEDERAL EMERGENCY MANAGEMENT AGENCY

44 CFR Part 65

[Docket No. FEMA–7292]

Changes in Flood Elevation Determinations

AGENCY: Federal Emergency Management Agency (FEMA).

ACTION: Interim rule.

SUMMARY: This interim rule lists communities where modification of the base (1% annual chance) flood elevations is appropriate because of new scientific or technical data. New flood insurance premium rates will be calculated from the modified base flood

elevations for new buildings and their contents.

DATES: These modified base flood elevations are currently in effect on the dates listed in the table and revise the Flood Insurance Rate Map(s) in effect prior to this determination for each listed community.

From the date of the second publication of these changes in a newspaper of local circulation, any person has ninety (90) days in which to request through the community that the Associate Director for Mitigation reconsider the changes. The modified elevations may be changed during the 90-day period.

ADDRESSES: The modified base flood elevations for each community are available for inspection at the office of the Chief Executive Officer of each community. The respective addresses are listed in the following table.

FOR FURTHER INFORMATION CONTACT: Matthew B. Miller, P.E., Chief, Hazards Study Branch, Mitigation Directorate, 500 C Street SW., Washington, DC 20472, (202) 646–3461, or (e-mail) matt.miller@fema.gov.

SUPPLEMENTARY INFORMATION: The modified base flood elevations are not listed for each community in this interim rule. However, the address of the Chief Executive Officer of the community where the modified base flood elevation determinations are available for inspection is provided.

Any request for reconsideration must be based upon knowledge of changed conditions, or upon new scientific or technical data.

The modifications are made pursuant to Section 201 of the Flood Disaster Protection Act of 1973, 42 U.S.C. 4105, and are in accordance with the National Flood Insurance Act of 1968, 42 U.S.C. 4001 *et seq.*, and with 44 CFR Part 65.

For rating purposes, the currently effective community number is shown and must be used for all new policies and renewals.

The modified base flood elevations are the basis for the floodplain management measures that the community is required to either adopt or to show evidence of being already in effect in order to qualify or to remain qualified for participation in the National Flood Insurance Program (NFIP).

These modified elevations, together with the floodplain management criteria required by 44 CFR 60.3, are the minimum that are required. They should not be construed to mean that the community must change any existing ordinances that are more stringent in their floodplain management requirements. The community may at any time enact stricter requirements of its own, or pursuant to policies established by other Federal, State, or regional entities.

The changes in base flood elevations are in accordance with 44 CFR 65.4.

National Environmental Policy Act

This rule is categorically excluded from the requirements of 44 CFR Part 10, Environmental Consideration. No environmental impact assessment has been prepared.

Regulatory Flexibility Act

The Associate Director for Mitigation certifies that this rule is exempt from the requirements of the Regulatory Flexibility Act because modified base flood elevations are required by the Flood Disaster Protection Act of 1973, 42 U.S.C. 4105, and are required to maintain community eligibility in the NFIP. No regulatory flexibility analysis has been prepared.

Regulatory Classification

This interim rule is not a significant regulatory action under the criteria of Section 3(f) of Executive Order 12866 of September 30, 1993, Regulatory Planning and Review, 58 FR 51735.

Executive Order 12612, Federalism

This rule involves no policies that have federalism implications under Executive Order 12612, Federalism, dated October 26, 1987.

Executive Order 12778, Civil Justice Reform

This rule meets the applicable standards of Section 2(b)(2) of Executive Order 12778.

List of Subjects in 44 CFR Part 65

Flood insurance, Floodplains, Reporting and recordkeeping requirements.

Accordingly, 44 CFR Part 65 is amended to read as follows:

PART 65—[AMENDED]

1. The authority citation for Part 65 continues to read as follows:

Authority: 42 U.S.C. 4001 *et seq.*; Reorganization Plan No. 3 of 1978, 3 CFR, 1978 Comp., p. 329; E.O. 12127, 44 FR 19367, 3 CFR, 1979 Comp., p. 376.

§ 65.4 [Amended]

2. The tables published under the authority of § 65.4 are amended as follows:

State and county	Location	Dates and name of newspaper where notice was published	Chief executive officer of community	Effective date of modification	Community No.
Arizona: Pima	Unincorporated Areas.	May 6, 1999, May 13, 1999, *Arizona Daily Star.*	The Honorable Sharon Bronson, Chairperson, Pima County, Board of Supervisors, 130 West Congress, 11th Floor, Tucson, Arizona 85701.	Apr. 8, 1999	040073
Arizona: Pima	Unincorporated Areas.	May 11, 1999, May 18, 1999, *Arizona Daily Star.*	The Honorable Sharon Bronson, Chairperson, Pima County, Board of Supervisors, 130 West Congress, 11th Floor, Tucson, Arizona 85701.	Apr. 6, 1999	040073
Arizona: Pima	City of Tucson	May 11, 1999, May 18, 1999, *Arizona Daily Star.*	The Honorable George Miller, Mayor, City of Tucson, P.O. Box 27210, Tucson, Arizona 85726.	Apr. 6, 1999	040076
Arizona: Navajo ...	City of Winslow ...	May 19, 1999, May 26, 1999, *Winslow Mail.*	The Honorable James L. Boles, Mayor, City of Winslow, 21 Williamson Avenue, Winslow, Arizona 86047.	Apr. 28, 1999	040072
Arkansas: Craighead.	City of Jonesboro	May 28, 1999, June 4, 1999, *Jonesboro Sun.*	The Honorable Hubert Brodell, Mayor, City of Jonesboro, P.O. Box 1845, Jonesboro, Arkansas 72403–1845.	Apr. 22, 1999	050048

State and county	Location	Dates and name of newspaper where notice was published	Chief executive officer of community	Effective date of modification	Community No.
California:					
Sonoma	City of Cotati	May 20, 1999, May 27, 1999, *Sonoma County Independent*.	The Honorable Harold Berkmeier, Mayor, City of Cotati, 201 West Sierra Avenue, Cotati, California 94931.	Apr. 21, 1999	060377
Riverside	City of Lake Elsinore.	May 21, 1999, May 28, 1999, *Lake Elsinore Valley Sun Tribune*.	The Honorable Genie Kelley, Mayor, City of Lake Elsinore, 130 South Main Street, Lake Elsinore, California 92530.	Apr. 22, 1999	060636
Riverside	Unincorporated Areas.	May 21, 1999, May 28, 1999, *Lake Elsinore Valley Sun-Tribune*.	The Honorable John Tavaglione, Chairman, Riverside County, Board of Supervisors, P.O. Box 1646, Riverside, California 92502.	Apr. 22, 1999	060245
San Diego	Unincorporated Areas.	May 21, 1999, May 28, 1999, *San Diego Daily Transcript*.	The Honorable Pam Slater, Chairperson, San Diego County, Board of Supervisors, 1600 Pacific Highway, Room 335, San Diego, California 92101.	Apr. 30, 1999	060284
Colorado:					
Boulder	Unincorporated Areas.	June 4, 1999, June 11, 1999, *Daily Camera*.	The Honorable Ron Stewart, Chairman, Boulder County, Board of Commissioners, P.O. Box 471, Boulder, Colorado 80306–0471.	May 14, 1999	080023
Boulder	City of Longmont	June 4, 1999, June 11, 1999, *Longmont Daily Times Call*.	The Honorable Leona Stoecker, Mayor, City of Longmont, 350 Kimbark Street, Longmont, Colorado 80501.	May 14, 1999	080027
Adams and Jefferson.	City of Westminster.	May 20, 1999, May 27, 1999, *Westminster Window*.	The Honorable Nancy M. Heil, Mayor, City of Westminster, 4800 West 92nd Avenue, Westminster, Colorado 80030.	Apr. 23, 1999	080008
Kansas: Sedgwick	City of Wichita	May 13, 1999, May 20, 1999, *Wichita Eagle*.	The Honorable Bob Knight, Mayor, City of Wichita, City Hall, 455 North Main Street, Wichita, Kansas 67202.	Apr. 8, 1999	200328
Louisiana: Catahoula Parish.	Unincorporated Areas.	May 19, 1999, May 26, 1999, *Catahoula News Booster*.	The Honorable Emmitt Taylor, President, Catahoula Parish Police Jury, P.O. Box 258, Harrisonburg, Louisiana 71340.	Apr. 13, 1999	220047
Missouri:					
St. Louis	City of Florissant	May 21, 1999, May 28, 1999, *Watchman Advocate*.	The Honorable James J. Egan, Mayor, City of Florissant, City Hall, 955 Rue St. Francois, Florissant, Missouri 63031.	Apr. 16, 1999	290352
St. Louis	Unincorporated Areas.	May 21, 1999, May 28, 1999, *St. Louis Countian*.	The Honorable Buzz Westfall, St. Louis County Executive, 41 South Central Avenue, Clayton, Missouri 63105.	Apr. 16, 1999	290327
New Mexico: Bernalillo.	City of Albuquerque.	May 21, 1999, May 28, 1999, *Albuquerque Journal*.	The Honorable Jim Baca, Mayor, City of Albuquerque, P.O. Box 1293, Albuquerque, New Mexico 87103.	Apr. 15, 1999	350002
Texas:					
Bell	City of Belton	May 6, 1999, May 13, 1999, *The Belton Journal*.	The Honorable Charley Powell, Mayor, City of Belton, P.O. Box 120, Belton, Texas 76513.	Apr. 1, 1999	480028
Comal	Unincorporated Areas.	May 7, 1999, May 14, 1999, *The Herald Zeitung*.	The Honorable Danny Shell, County Judge, Comal County, 150 North Seguin Avenue, New Braunfels, Texas 78130.	Apr. 1, 1999	485463
Dallas	City of Dallas	May 5, 1999, May 12, 1999, *Dallas Morning News*.	The Honorable Ron Kirk, Mayor, City of Dallas, City Hall, 1500 Marilla, Dallas, Texas 75201.	Aug. 10, 1999	480171
Denton	Town of Flower Mound.	May 19, 1999, May 26, 1999, *Denton Record-Chronicle*.	The Honorable Lori De Luca, Mayor, Town of Flower Mound, 2121 Cross Timbers Drive, Flower Mound, Texas 75028.	Apr. 12, 1999	480777
Tarrant	City of Hurst	June 3, 1999, June 10, 1999, *Fort Worth Star-Telegram*.	The Honorable Bill Souder, Mayor, City of Hurst, 1505 Precinct Line Road, Hurst, Texas 76054.	Apr. 28, 1999	480601

State and county	Location	Dates and name of newspaper where notice was published	Chief executive officer of community	Effective date of modification	Community No.
Collin	City of Plano	May 5, 1999, May 12, 1999, *Plano Star Courier.*	The Honorable John Longstreet, Mayor, City of Plano, P.O. Box 860358, Plano, Texas 75086–0358.	Aug. 10, 1999	480140

(Catalog of Federal Domestic Assistance No. 83.100, ''Flood Insurance.'')

Dated: July 20, 1999.

Michael J. Armstrong,

Associate Director for Mitigation.

[FR Doc. 99–19567 Filed 7–29–99; 8:45 am]

BILLING CODE 6718–04–P

FEDERAL EMERGENCY MANAGEMENT AGENCY

44 CFR Part 65

[Docket No. FEMA–7293]

Changes in Flood Elevation Determinations

AGENCY: Federal Emergency Management Agency, FEMA.

ACTION: Interim rule.

SUMMARY: This interim rule lists communities where modification of the base (1% annual chance) flood elevations is appropriate because of new scientific or technical data. New flood insurance premium rates will be calculated from the modified base flood elevations for new buildings and their contents.

DATES: These modified base flood elevations are currently in effect on the dates listed in the table and revise the Flood Insurance Rate Map(s) (FIRMs) in effect prior to this determination for each listed community.

From the date of the second publication of these changes in a newspaper of local circulation, any person has ninety (90) days in which to request through the community that the Associate Director reconsider the changes. The modified elevations may be changed during the 90-day period.

ADDRESSES: The modified base flood elevations for each community are available for inspection at the office of the Chief Executive Officer of each community. The respective addresses are listed in the following table.

FOR FURTHER INFORMATION CONTACT: Matthew B. Miller, P.E., Chief, Hazards Study Branch, Mitigation Directorate, Federal Emergency Management Agency, 500 C Street SW., Washington, DC 20472, (202) 646–3461, or (email) matt.miller@fema.gov.

SUPPLEMENTARY INFORMATION: The modified base flood elevations are not listed for each community in this interim rule. However, the address of the Chief Executive Officer of the community where the modified base flood elevation determinations are available for inspection is provided.

Any request for reconsideration must be based upon knowledge of changed conditions, or upon new scientific or technical data.

The modifications are made pursuant to section 201 of the Flood Disaster Protection Act of 1973, 42 U.S.C. 4105, and are in accordance with the National Flood Insurance Act of 1968, 42 U.S.C. 4001 *et seq.*, and with 44 CFR part 65.

For rating purposes, the currently effective community number is shown and must be used for all new policies and renewals.

The modified base flood elevations are the basis for the floodplain management measures that the community is required to either adopt or to show evidence of being already in effect in order to qualify or to remain qualified for participation in the National Flood Insurance Program.

These modified elevations, together with the floodplain management criteria required by 44 CFR 60.3, are the minimum that are required. They should not be construed to mean that the community must change any existing ordinances that are more stringent in their floodplain management requirements. The community may at any time enact stricter requirements of its own, or pursuant to policies established by other Federal, state or regional entities.

The changes in base flood elevations are in accordance with 44 CFR 65.4.

National Environmental Policy Act

This rule is categorically excluded from the requirements of 44 CFR Part 10, Environmental Consideration. No environmental impact assessment has been prepared.

Regulatory Flexibility Act

The Associate Director, Mitigation Directorate, certifies that this rule is exempt from the requirements of the Regulatory Flexibility Act because modified base flood elevations are required by the Flood Disaster Protection Act of 1973, 42 U.S.C. 4105, and are required to maintain community eligibility in the National Flood Insurance Program. No regulatory flexibility analysis has been prepared.

Regulatory Classification

This interim rule is not a significant regulatory action under the criteria of section 3(f) of Executive Order 12866 of September 30, 1993, Regulatory Planning and Review, 58 FR 51735.

Executive Order 12612, Federalism

This rule involves no policies that have federalism implications under Executive Order 12612, Federalism, dated October 26, 1987.

Executive Order 12778, Civil Justice Reform

This rule meets the applicable standards of section 2(b)(2) of Executive Order 12778.

List of Subjects in 44 CFR Part 65

Flood insurance, Floodplains, Reporting and recordkeeping requirements. Accordingly, 44 CFR part 65 is amended to read as follows:

PART 65—[AMENDED]

1. The authority citation for part 65 continues to read as follows:

Authority: 42 U.S.C. 4001 *et seq.*; Reorganization Plan No. 3 of 1978, 3 CFR, 1978 Comp., p. 329; E.O. 12127, 44 FR 19367, 3 CFR, 1979 Comp., p. 376.

§ 65.4 [Amended]

2. The tables published under the authority of § 65.4 are amended as follows:

State and county	Location	Dates and name of newspaper where notice was published	Chief executive officer of community	Effective date of modification	Community No.
Alabama: Jefferson.	Unincorporated Areas.	May 12, 1999, May 19, 1999, *Birmingham News*.	Mr. Gary White, President of the Jefferson County Board of Commissioners, Courthouse, Room A–360, Birmingham, Alabama 35263.	Aug. 17, 1999	010217 E
Connecticut:					
Fairfield	Town of Wilton	June 17, 1999, June 24, 1999, *Wilton Bulletin*.	Mr. Robert H. Russell, First Selectman of the Town of Wilton, Wilton Town Hall, 238 Danbury Road, Wilton, Connecticut 06897.	Sept. 22, 1999	090020 C
New Haven ...	Town of Madison	March 16, 1999, March 23, 1999, *Shoreline Times*.	Mr. Thomas Rylander, First Selectman for the Town of Madison, 8 Campus Drive, Madison, Connecticut 06443.	Mar. 1, 1999	090079 C
Florida:					
Orange	City of Ocoee	June 24, 1999, July 1, 1999, *The Orlando Sentinel*.	The Honorable S. Scott Vandergrift, Mayor of the City of Ocoee, City Hall, 150 North Lakeshore Drive, Ocoee, Florida 34761–2258.	June 17, 1999	120185 C
Orange	Unincorporated Areas.	June 24, 1999, July 1, 1999, *The Orlando Sentinel*.	Dr. M. Krishnamurthy, P.E., Manager, Orange County Public Works Division, Stormwater Management Department, 4200 South John Young Parkway, Orlando, Florida 32839–9205.	June 17, 1999	120179 C
Sarasota	City of Sarasota ..	March 23, 1999, March 30, 1999, *Sarasota Herald-Tribune*.	Mr. David R. Sollenberger, Manager of the City of Sarasota, P.O. Box 1058, Sarasota, Florida 34236.	Mar. 17, 1999	125150 B
Georgia: Cherokee.	City of Canton	March 5, 1999, March 12, 1999, *Cherokee Tribute*.	The Honorable Cecil Pruett, Mayor of the City of Canton, 687 Marietta Highway, Canton, Georgia 30114.	June 10, 1999	130039 C
Illinois:					
Will	City of Crest Hill ..	March 25, 1999, April 1, 1999, *The Herald-News*.	The Honorable Donald R. Randich, Mayor of the City of Crest Hill, 1610 Plainfield Road, Crest Hill, Illinois 60435.	June 30, 1999	170699 D
McHenry	Village of Cary	February 26, 1999, March 5, 1999, *The Northwest Herald*.	The Honorable Donald Huffer, Mayor of the Village of Cary, 255 Stonegate Road, Cary, Illinois 60013.	June 3, 1999	170475
Henderson	Village of Gulfport	March 31, 1999, April 7, 1999, *Oquawka Current*.	Mr. Ed Ronner, President of the Village of Gulfport, Rural Route 1, Box G84, Carmen, Illinois 61425.	Mar. 22, 1999	170280 C
Lake	Village of Gurnee	January 21, 1999, February 3, 1999, *Daily Herald*.	The Honorable Richard A. Welton, Mayor of the Village of Gurnee, 325 North O'Plaine Road, Gurnee, Illinois 60031.	Jan. 24, 1999	170365 F
Kane	Village of Hampshire.	April 28, 1999, May 5, 1999, *Hampshire Register-News*.	Mr. William Schmidt, Hampshire Village President, P.O. Box 457, 234 South State Street, Hampshire, Illinois 60140.	July 27, 1999	170327 C
Henderson	Unincorporated Areas.	March 31, 1999, April 7, 1999,*Oquawka Current*.	Mr. Marion Brown, Henderson County Chairman, P.O. Box 308, Oquawka, Illinois 61469.	Mar. 22, 1999	170277
Kane	Unincorporated Areas.	February 26, 1999, March 5, 1999, *Kane County Chronicle*.	Dr. Michael W. McCoy, Chairman of the Kane County Board of Commissioners, 719 South Batavia Avenue, Geneva, Illinois 60134.	Feb. 19,1999	170896
Lake	Unincorporated Areas.	May 13, 1999, May 20, 1999, *The News Sun*.	Mr. Jim LaBelle, Chairman of the Lake County Board, 18 North County Street, 10th Floor, Waukegan, Illinois 60085.	Aug. 18, 1999	170357 F
McHenry	Unincorporated Areas.	February 26, 1999, March 5, 1999, *The Northwest Herald*.	Mr. Michael Tryon, McHenry County Board Chairperson, McHenry County Government Center, 220 North Seminary Avenue, Woodstock, Illinois 60098.	June 3, 1999	170732
Cook	Village of South Barrington.	May 11, 1999, May 18, 1999, *Daily Herald*.	The Honorable Patricia Graft, Mayor of the Village of South Barrington, 30 South Barrington Road, South Barrington, Illinois 60010.	Aug. 16, 1999	170161 C

State and county	Location	Dates and name of newspaper where notice was published	Chief executive officer of community	Effective date of modification	Community No.
Lake	City of Waukegan	May 14, 1999, May 21, 1999, *The News-Sun*.	The Honorable Bill Durkin, Mayor of the City of Waukegan, 106 North Utica, Waukegan, Illinois 60085.	May 7, 1999	170397 F
Will	Unincorporated Areas.	May 17, 1999, May 24, 1999, *Herald-News*.	Mr. Charles R. Adelman, Will County Executive, 302 North Chicago Street, Joliet, Illinois 60432.	May 10, 1999	170695 E
Indiana: Allen	City of New Haven.	February 25, 1999, March 4, 1999, *The Journal Gazette*.	The Honorable Lynn Shaw, Mayor of the City of New Haven, City Administration Building, P.O. Box 570, New Haven, Indiana 46774.	June 2, 1999	180004 D
Kentucky: Fayette	Lexington-Fayette Urban County Government.	June 23, 1999, June 30, 1999, *Lexington Herald*.	The Honorable Pam Miller, Mayor of the Lexington-Fayette Urban County Government, 200 East Main Street, 12th Floor, Lexington-Fayette Government Building, Lexington, Kentucky 40507.	June 16, 1999	210067 C
Massachusetts: Middlesex.	Town of Billerica	May 10, 1999, May 17, 1999, *Lowell Sun*.	Mr. Richard A. Montuori, Billerica Town Manager, Billerica Town Hall, 365 Boston Road, Billerica, Massachusetts 01821.	Aug. 15, 1999	250183 C
Minnesota: Anoka	City of Coon Rapids.	April 9, 1999, April 16, 1999, *Coon Rapids Herald*.	The Honorable Lonni McCauley, Mayor of the City of Coon Rapids, 11155 Robinson Drive, Coon Rapids, Minnesota 55433.	July 15, 1999	270011 A
New Jersey: Mercer.	Township of Hamilton.	April 14, 1999, April 21, 1999, *The Times*.	The Honorable John Sacchinelli, Mayor of the Township of Hamilton, 6101 13th Street, Mays Landing, New Jersey 08330.	Apr. 1, 1999	340246
New York:					
Monroe	Town of Brighton	May 12, 1999, May 19, 1999, *Brighton-Pittsford Post*.	Ms. Sandra L. Frankel, Supervisor of the Town of Brighton, 2300 Elmwood Avenue, Rochester, New York 14618.	Nov. 8, 1999	360410 B
Rockland	Village of Sloatsburg.	June 15, 1999, June 22, 1999, *Rockland Journal-News*.	The Honorable Samuel J. Abate, Mayor of the Village of Sloatsburg, Village Hall, 96 Orange Turnpike, Sloatsburg, New York 10974.	Dec. 1, 1999	36090 C
North Carolina:					
Durham	Unincorporated Areas.	May 24, 1999, *The Herald-Sun*.	Mr. David F. Thompson, Durham County Manager, County Administration Complex, 2nd Floor, 200 East Main Street, Durham, North Carolina 27701.	June 16, 1999	370085 G
Forsyth	Unincorporated Areas.	March 15, 1999, March 22, 1999, *Winston-Salem Journal*.	Mr. Graham Pervier, County Manager, Hall of Justice, Room 700, Winston-Salem, North Carolina 27101.	June 20, 1999	37549 H
Guilford	City of Greensboro.	May 25, 1999, June 1, 1999, *News and Record*.	The Honorable Carolyn S. Allen, Mayor of the City of Greensboro, One Governmental Plaza, P.O. Box 3136, Greensboro, North Carolina 27402.	May 17, 1999	375351 C
Ohio: Lake	Village of Madison	March 30, 1999, April 6, 1999, *The News-Herald*.	The Honorable David G. Reed, Jr., Mayor of the Village of Madison, 126 West Main Street, Madison, Ohio 44057–0007.	Mar. 23, 1999	390316 B
Pennsylvania:					
Lancaster	Township of East Donegal.	April 28, 1999, May 5, 1999, *Lancaster Newspaper*.	Mr. Allen D. Esbenshade, President, Board of Supervisors, Township Municipal Office, 190 Rock Point Road, Marietta, Pennsylvania 17547.	Apr. 16, 1999	421768 B
Dauphin	Township of Lower Paxton.	March 2, 1999, March 9, 1999, *The Patriot News*.	Mr. George Wolfe, Lower Paxton Township Manager, 75 South Houcks Road, Suite 207, Harrisburg, Pennsylvania 17109.	Feb. 23, 1999	420384 B
Berks	Township of Maidencreek.	April 23, 1999, April 30, 1999, *Reading Eagle/Reading Times*.	Mr. Karl A. Bolognese, Chairman of the Maidencreek, Township Board of Supervisors, P.O. Box 529, Blandon, Pennsylvania 19510.	July 29, 1999	421078 E

State and county	Location	Dates and name of newspaper where notice was published	Chief executive officer of community	Effective date of modification	Community No.
Lebanon	Township of North Londonderry.	March 29, 1999, April 5, 1999, *Londonderry Daily News*.	Mr. Paul Garber, Township of North Londonderry Manager, 655 East Ridge Road, Palmyra, Pennsylvania 17078.	Sept. 22, 1999	420577 B
Lancaster	Township of Rapho.	April 28, 1999, May 5, 1999, *Lancaster Newspapers*.	Ms. Nancy Hawliwell, Rapho Town Manager, 971 North Colebrook Road, Manheim, Pennsylvania 17545.	Apr. 16, 1999	421781 B
South Carolina:					
Anderson	Unicorporated Areas.	June 3, 1999, June 10, 1999, *Anderson Independent-Mail*.	Mr. Joey Preston, Anderson County Administrator, P.O. Box 8002, Anderson, South Carolina 29622.	Sept. 8, 1999	450013 B
Charleston	Unincorporated Areas.	March 3, 1999, March 10, 1999, *The Post and Courier*.	Mr. Roland H. Windham, Jr., Charleston County Administrator, 2 Court House Square, Room 401, Charleston, South Carolina 29401.	Feb. 24, 1999	455413
Tennessee:					
Sullivan	City of Bristol	May 21, 1999, May 28, 1999, *Bristol Herald-Courier*.	The Honorable Elmer Doak, Mayor of the City of Bristol, P.O. Box 1189, Bristol, Tennessee 37621.	May 14, 1999	470182 B
Madison	City of Jackson ...	March 16, 1999, *The Jackson Sun*.	The Honorable Charles Farmer, Mayor of the City of Jackson, Jackson City Hall, 121 East Main Street, Suite 301, Jackson, Tennessee 38302.	Apr. 9, 1999	470113 D
Madison	Unincorporated Areas.	March 16, 1999, *The Jackson Sun*.	The Honorable Dr. J. Alex Leech, Mayor of Madison County, 100 East Main Street, Suite 302, Jackson, Tennessee 38301.	Apr. 9, 1999	470112 D
Shelby	Unincorporated Areas.	May 31, 1999, June 7, 1999, *The Commercial Appeal*.	The Honorable Jim Rout, Mayor of Shelby County, 160 North Main Street, Suite 850, Memphis, Tennessee 38103.	May 24, 1999	470214 E
Virginia: Arlington	Unincorporated Areas.	January 21, 1999, January 28, 1999, *The Arlington Journal*.	Mr. William T. Donahue, County Manager, 2100 Clarendon Boulevard, Suite 813, Arlington, Virginia 22201.	Apr. 28, 1999	515520
Wisconsin:					
Oconto	City of Oconto	April 28, 1999, May 5, 1999, *Oconto County Review*.	The Honorable Joseph Bralick, Mayor of the City of Oconto, 1210 Main Street, Oconto, Wisconsin 54153.	Aug. 3, 1999	550297 B
Oconto	Unincorporated Areas.	April 28, 1999, May 5, 1999, *Oconto County Review*.	Mr. Kevin Hamann, Oconto County Administrative Coordinator, 301 Washington Street, Oconto, Wisconsin 54153.	Aug. 3, 1999	550294 A

(Catalog of Federal Domestic Assistance No. 83.100, ''Flood Insurance.'')

Dated: July 19, 1999.

Michael J. Armstrong,

Associate Director for Mitigation.

[FR Doc. 99–19566 Filed 7–29–99; 8:45 am]

BILLING CODE 6718–04–P

FEDERAL EMERGENCY MANAGEMENT AGENCY

44 CFR Part 65

Changes in Flood Elevation Determinations

AGENCY: Federal Emergency Management Agency (FEMA).

ACTION: Final rule.

SUMMARY: Modified base (1% annual chance) flood elevations are finalized for the communities listed below. These modified elevations will be used to calculate flood insurance premium rates for new buildings and their contents.

EFFECTIVE DATES: The effective dates for these modified base flood elevations are indicated on the following table and revise the Flood Insurance Rate Map(s) in effect for each listed community prior to this date.

ADDRESSES: The modified base flood elevations for each community are available for inspection at the office of the Chief Executive Officer of each community. The respective addresses are listed in the following table.

FOR FURTHER INFORMATION CONTACT: Matthew B. Miller, P.E., Chief, Hazards Study Branch, Mitigation Directorate, 500 C Street SW., Washington, DC 20472, (202) 646–3461, or (e-mail) matt.miller@fema.gov.

SUPPLEMENTARY INFORMATION: The Federal Emergency Management Agency makes the final determinations listed below of the final determinations of modified base flood elevations for each community listed. These modified elevations have been published in newspapers of local circulation and ninety (90) days have elapsed since that publication. The Associate Director has resolved any appeals resulting from this notification.

The modified base flood elevations are not listed for each community in

this notice. However, this rule includes the address of the Chief Executive Officer of the community where the modified base flood elevation determinations are available for inspection.

The modifications are made pursuant to Section 206 of the Flood Disaster Protection Act of 1973, 42 U.S.C. 4105, and are in accordance with the National Flood Insurance Act of 1968, 42 U.S.C. 4001 et seq., and with 44 CFR Part 65.

For rating purposes, the currently effective community number is shown and must be used for all new policies and renewals.

The modified base flood elevations are the basis for the floodplain management measures that the community is required to either adopt or to show evidence of being already in effect in order to qualify or to remain qualified for participation in the National Flood Insurance Program (NFIP).

These modified elevations, together with the floodplain management criteria required by 44 CFR 60.3, are the minimum that are required. They should not be construed to mean that the community must change any existing ordinances that are more stringent in their floodplain management requirements. The community may at any time enact stricter requirements of its own, or pursuant to policies established by other Federal, State, or regional entities.

These modified elevations are used to meet the floodplain management requirements of the NFIP and are also used to calculate the appropriate flood insurance premium rates for new buildings built after these elevations are made final, and for the contents in these buildings.

The changes in base flood elevations are in accordance with 44 CFR 65.4.

National Environmental Policy Act

This rule is categorically excluded from the requirements of 44 CFR Part 10, Environmental Consideration. No environmental impact assessment has been prepared.

Regulatory Flexibility Act

The Associate Director for Mitigation certifies that this rule is exempt from the requirements of the Regulatory Flexibility Act because modified base flood elevations are required by the Flood Disaster Protection Act of 1973, 42 U.S.C. 4105, and are required to maintain community eligibility in the NFIP. No regulatory flexibility analysis has been prepared.

Regulatory Classification

This final rule is not a significant regulatory action under the criteria of Section 3(f) of Executive Order 12866 of September 30, 1993, Regulatory Planning and Review, 58 FR 51735.

Executive Order 12612, Federalism

This rule involves no policies that have federalism implications under Executive Order 12612, Federalism, dated October 26, 1987.

Executive Order 12778, Civil Justice Reform

This rule meets the applicable standards of Section 2(b)(2) of Executive Order 12778.

List of Subjects in 44 CFR Part 65

Flood insurance, Floodplains, Reporting and recordkeeping requirements. Accordingly, 44 CFR Part 65 is amended to read as follows:

PART 65—[AMENDED]

1. The authority citation for Part 65 continues to read as follows:

Authority: 42 U.S.C. 4001 et seq.; Reorganization Plan No. 3 of 1978, 3 CFR, 1978 Comp., p. 329; E.O. 12127, 44 FR 19367, 3 CFR, 1979 Comp., p. 376.

§ 65.4 [Amended]

2. The tables published under the authority of § 65.4 are amended as follows:

BILLING CODE 6718–04–P

State and county	Location	Dates and name of newspaper where notice was published	Chief executive officer of community	Effective date of modification	Community No.
Arizona: Pima (FEMA Docket No. 7276).	Unincorporated Areas.	January 20, 1999, January 27, 1999, *Arizona Daily Star*.	The Honorable Mike Boyd, Chairperson, Pima County, Board of Supervisors, 130 West Congress, Fifth Floor, Tucson, Arizona 85701.	Jan. 5, 1999	040073
California: Riverside (FEMA Docket No. 7280).	City of Murrieta	February 23, 1999, March 2, 1999, *The Press-Enterprise*.	The Honorable Chuck Washington, Mayor, City of Murrieta, 26442 Beckman Court, Murrieta, California 92562.	Feb. 8, 1999	060751
Colorado:					
Pitkin (FEMA Docket No. 7280).	City of Basalt ...	February 10, 1999, February 17, 1999, *Snowmass Sun*.	The Honorable Rick Stevens, Mayor, Town of Basalt, 101 Midland Avenue, Basalt, Colorado 81621.	Jan. 7, 1999	080052
Pitkin (FEMA Docket No. 7280).	Unincorporated Areas.	February 12, 1999, February 19, 1999, *Aspen Times*.	The Honorable Dorothea Farris, Chairperson, Pitkin County, Board of Commissioners, 530 East Main Street, Third Floor, Aspen, Colorado 81611.	Jan. 7, 1999.	080287
Nevada: Clark (FEMA Docket No. 7280).	Unincorporated Areas.	February 5, 1999, February 12, 1999, *Las Vegas Review-Journal*.	The Honorable Yvonne Atkinson Gates, Chairperson, Clark County Board of Supervisors,.	Jan. 12, 1999	320003
Oklahoma: Oklahoma (FEMA Docket No. 7280).	City of Edmond	February 16, 1999, February 23, 1999, *Edmond Evening Sun*.	The Honorable Robert Rudkin, Mayor, City of Edmond, P.O. Box 2970, Edmond, Oklahoma 73083–2970.	Jan. 19, 1999	400252
Oregon:					

State and county	Location	Dates and name of newspaper where notice was published	Chief executive officer of community	Effective date of modification	Community No.
Marion (FEMA Docket No. 7276).	Unincorporated Areas.	January 22, 1999, January 29, 1999, *Statesman Journal*.	The Honorable Randy Franke, Chairman, Marion County, Board of Commissioners, County Courthouse, 100 High Street, Northeast, Salem, Oregon 97301.	Dec. 22, 1998	410154
Marion (FEMA Docket No. 7276).	City of Salem ...	January 22, 1999, January 29, 1999.	The Honorable Michael Swaim, Mayor, City of Salem, 555 Liberty Street, Room 220, Salem, Oregon 97301.	Dec. 22, 1998	410167
Texas Travis (FEMA Docket No. 7280.	City of Austin ...	February 19, 1999, February 26, 1999, *Austin American-Statesman*.	The Honorable Kirk P. Watson, Mayor, City of Austin, 124 West Eighth Street, Austin, Texas 78701.	Jan. 22, 1999	480624
Brazos (FEMA Docket No. 7280).	City of College Station.	February 23, 1999, March 2, 1999, *Bryan-College Station Eagle*.	The Honorable Lynn McIlaney, Mayor City of College Station, P.O. Box 9960, College Station, Texas 77842–0960.	May 31, 1999	480083
Tarrant (FEMA Docket No. 7280).	City of Fort Worth.	February 5, 1999, February 12, 1999, *Fort Worth Star-Telegram*.	The Honorable Kenneth Barr, Mayor, City of Fort Worth, 1000 Throckmorton Street, Fort Worth, Texas 76102–6311.	Jan. 8, 1999	480596
Tarrant (FEMA Docket No. 7280).	City of Hurst	February 10, 1999, February 17, 1999, *Dallas Morning News*.	The Honorable Bill Souder, Mayor, City of Hurst, 1505 Percinct Line road, Hurst, Texas 76054.	Jan. 12, 1999	480601
Denton (FEMA Docket No. 7280).	City of Lewisville.	February 19, 1999, February 26, 1999, *Lewisville News*.	The Honorable Bobbie J. Mitchell, Mayor, City of Lewisville, P.O. Box 299002, Lewisville, Texas 75029–9002.	Jan. 22, 1999	480195
Tarrant (FEMA Docket No. 7280).	City of North Richland Hills.	February 10, 1999, February 17, 1999, *Forth Worth Star-Telegram*.	The Honorable Charles Scoma, Mayor, City of North Richland Hills, P.O. Box 82069, North Richland Hills, Texas 76182–0609.	Jan. 12, 1999	480607
Harris (FEMA Docket No. 7280).	City of Pasadena.	February 17, 1999, February 24, 1999, *Pasadena Citizen*.	The Honorable Johnny Isbell, Mayor, City of Pasadena, P.O. Box 672, Pasadena, Texas 77501–0672.	Jan. 22, 1999	480307
Bexar (FEMA Docket No. 7276).	City of San Antonio.	January 22, 1999, January 29, 1999 *San Antonio Express-News*.	The Honorable Howard Peak, Mayor, City of San Antonio, P.O. Box 839966, San Antonio, Texas 78283–3966.	Dec. 21, 1998	480045
Ellis (FEMA Docket No. 7280).	City of Waxahachie.	February 12, 1999, February 19, 1999, *Waxahachie Daily Light*.	The Honorable Chuck Beatty, Mayor, City of Waxahachie, P.O. Box 757, Waxahachie, Texas 75165.	May 20, 1999	480211
Washington:					
Grays Harbor (FEMA Docket No. 7276).	Unincorporated Areas.	January 22, 1999, January 29, 1999, *Aberdeen Daily World*.	The Honorable Dick Dickson, Chairman, Board of Commissioners, Grays Harbor County, 100 West Broadway, Suite 1, Montesano, Washington 98563.	Jan. 6, 1999	530057
King (FEMA Docket No. 7280).	City of Kent	February 2, 1999, February 9, 1999, *Seattle Times*.	The Honorable Jim White, Mayor, City of Kent, 220 Fourth Avenue South, Kent, Washington 98032–5895.	Jan. 11, 1999	530080
King (FEMA Docket No. 7280).	Unincorporated Areas.	February 2, 1999, *Seattle Times*.	The Honorable Ron Simms, King County Courthouse, 516 Third Avenue, Room 400, Seattle, Washington 98104–2312.	Jan. 11, 1999	530071

(Catalog of Federal Domestic Assistance No. 83.100, ''Flood Insurance'')

Dated: July 20, 1999.

Michael J. Armstrong,

Associate Director for Mitigation.

[FR Doc. 99–19565 Filed 7–29–99; 8:45 am]

BILLING CODE 6718–04–P

FEDERAL EMERGENCY MANAGEMENT AGENCY

44 CFR Part 67

Final Flood Elevation Determinations

AGENCY: Federal Emergency Management Agency (FEMA).

ACTION: Final rule.

SUMMARY: Base (1% annual chance) flood elevations and modified base flood elevations are made final for the communities listed below. The base flood elevations and modified base flood elevations are the basis for the floodplain management measures that each community is required either to adopt or to show evidence of being already in effect in order to qualify or remain qualified for participation in the National Flood Insurance Program (NFIP).

EFFECTIVE DATE: The date of issuance of the Flood Insurance Rate Map (FIRM) showing base flood elevations and modified base flood elevations for each community. This date may be obtained by contacting the office where the FIRM is available for inspection as indicated in the table below.

ADDRESSES: The final base flood elevations for each community are available for inspection at the office of the Chief Executive Officer of each community. The respective addresses are listed in the table below.

FOR FURTHER INFORMATION CONTACT: Matthew B. Miller, P.E., Chief, Hazards Study Branch, Mitigation Directorate, 500 C Street SW., Washington, DC 20472, (202) 646–3461, or (e-mail) matt.miller@fema.gov.

SUPPLEMENTARY INFORMATION: The Federal Emergency Management Agency makes final determinations listed below of base flood elevations and modified base flood elevations for each community listed. The proposed base flood elevations and proposed modified base flood elevations were published in newspapers of local circulation and an opportunity for the community or individuals to appeal the proposed determinations to or through the community was provided for a period of ninety (90) days. The proposed base flood elevations and proposed modified base flood elevations were also published in the **Federal Register**.

This final rule is issued in accordance with Section 110 of the Flood Disaster Protection Act of 1973, 42 U.S.C. 4104, and 44 CFR Part 67.

FEMA has developed criteria for floodplain management in floodprone areas in accordance with 44 CFR Part 60.

Interested lessees and owners of real property are encouraged to review the proof Flood Insurance Study and FIRM available at the address cited below for each community.

The base flood elevations and modified base flood elevations are made final in the communities listed below. Elevations at selected locations in each community are shown.

National Environmental Policy Act

This rule is categorically excluded from the requirements of 44 CFR Part 10, Environmental Consideration. No environmental impact assessment has been prepared.

Regulatory Flexibility Act

The Associate Director for Mitigation certifies that this rule is exempt from the requirements of the Regulatory Flexibility Act because final or modified base flood elevations are required by the Flood Disaster Protection Act of 1973, 42 U.S.C. 4104, and are required to establish and maintain community eligibility in the NFIP. No regulatory flexibility analysis has been prepared.

Regulatory Classification

This final rule is not a significant regulatory action under the criteria of Section 3(f) of Executive Order 12866 of September 30, 1993, Regulatory Planning and Review, 58 FR 51735.

Executive Order 12612, Federalism

This rule involves no policies that have federalism implications under Executive Order 12612, Federalism, dated October 26, 1987.

Executive Order 12778, Civil Justice Reform

This rule meets the applicable standards of Section 2(b)(2) of Executive Order 12778.

List of Subjects in 44 CFR Part 67

Administrative practice and procedure, Flood insurance, Reporting and recordkeeping requirements.

Accordingly, 44 CFR Part 67 is amended to read as follows:

PART 67—[AMENDED]

1. The authority citation for Part 67 continues to read as follows:

Authority: 42 U.S.C. 4001 et seq.; Reorganization Plan No. 3 of 1978, 3 CFR, 1978 Comp., p. 329; E.O. 12127, 44 FR 19367, 3 CFR, 1979 Comp., p. 376.

§ 67.11 [Amended]

2. The tables published under the authority of § 67.11 are amended as follows:

Source of flooding and location	# Depth in feet above ground. *Elevation in feet (NGVD).
ALASKA	
Kenai Peninsula Borough (FEMA Docket No. 7278)	
Kenai River Study:	
Approximately 6.1 miles downstream of confluence with Shikok Creek	*18.5
Approximately 4,500 feet downstream of confluence with Shikok Creek	*35.6
Maps are available for inspection at the Kenai Peninsula Borough Planning and Zoning Office, 210 Fidalgo Avenue, Suite 200, Kenai, Alaska.	
LOUISIANA	
Ball (Town), Rapides Parish (FEMA Docket No. 7278)	
Kitchen Creek:	
At confluence with Flagon Bayou	*132
Approximately 250 feet upstream of confluence of Lateral 1	*151
City Drainage Ditch:	
Approximately 250 feet downstream of Kerlin Road	*124
At Louisiana Highway 1204	*162
Haw Creek Tributary 4:	
Approximately 600 feet upstream of confluence with Haw Creek	*133
Approximately 3,400 feet upstream of confluence with Haw Creek	*161
Haw Creek Lateral 2A:	
At confluence with Lateral 2	*150
Approximately 1,400 feet upstream of Burma Road	*177
Haw Creek Lateral 2:	
Approximately 200 feet upstream of confluence with Haw Creek	*145
Approximately 1,275 feet upstream of Burma Road	*168
Haw Creek Lateral 1:	
Just upstream of confluence with Haw Creek	*140
Approximately 1,700 feet upstream of Hollingsworth Road	*151
Flagon Bayou Tributary 8:	
Approximately 1,480 feet downstream of U.S. Highway 165	*117
Just upstream of U.S. Highway 165	*118
Flagon Bayou:	
Approximately 11,000 feet downstream of confluence of Flagon Bayou Tributary 3	*120

Source of flooding and location	# Depth in feet above ground. *Elevation in feet (NGVD).
Approximately 250 feet upstream of Kansas City Southern Railroad	*141
Haw Creek:	
Approximately 300 feet downstream of confluence of Haw Creek Lateral 1	*138
Approximately 4,100 feet upstream of Burma Road	*169
Kitchen Creek Lateral 1:	
Approximately 700 feet downstream of Missouri Pacific Railroad	*141
Approximately 700 feet upstream of Kitchen Creek Road	*155
Maps are available for inspection at 100 Municipal Lane, Ball, Louisiana.	
Farmerville (Town), Union Parish (FEMA Docket No. 7278)	
Bayou D'Arbonne Lake:	
Approximately 12,400 feet (2.35 miles) downstream of State Routes 15 and 33	*90
At State Routes 15 and 33	*90
Middle Fork Bayou d'Arbonne:	
At State Routes 15 and 33	*90
At confluence of Corney Bayou (located in Union Parish)	*90
Corney Bayou:	
At confluence with Middle Fork Bayou D'Arbonne (located in Union Parish)	*90
Approximately 3,400 feet upstream of confluence with Middle Fork Bayou D'Arbonne	*90
Bayou D'Arbonne Lake Tributary 1:	
Approximately 5,300 feet downstream of Sterlington Highway	*90
Approximately 4,350 feet downstream of Sterlington Highway	*90
Approximately 4,400 feet downstream of Sterlington Highway	*90
Bayou D'Arbonne Lake Tributary 2:	
Approximately 750 feet downstream of Barrom Road	*90
Approximately 475 feet downstream of Barrom Road	*90
Approximately 500 feet downstream of Barrom Road	*90
Maps are available for inspection at 407 South Main Street, Farmerville, Louisiana.	
*The shoreline elevation within the Town of Farmerville is now 90 feet NGVD.	
Lincoln Parish (Unincorporated Areas) (FEMA Docket No. 7278)	
Middle Fork Bayou D'Arbonne:	
Approximately 26,000 feet downstream of State Route 823	*96
Just upstream of U.S. Highway 167	*101

Source of flooding and location	# Depth in feet above ground. *Elevation in feet (NGVD).
Maps are available for inspection at 100 West Texas Street, Ruston, Louisiana.	
LOUISIANA	
Union Parish (Unincorporated Areas) (FEMA Docket No. 7278)	
Corney Bayou:	
At confluence with Middle Fork Bayou D'Arbonne	*90
Approximately 400 feet upstream of U.S. Highway 167	*109
Middle Fork Bayou d'Arbonne:	
At State Routes 15 and 33	*90
Approximately 340 feet upstream of U.S. Highway 167	*111
Ouachita River:	
Approximately 6,150 feet (1.16 miles) downstream of confluence of Bayou DeLoure	*87
Approximately 1,550 feet upstream of confluence of Cypress Bayou	*88
Stowe Creek:	
At State Route 15	*90
Approximately 140 feet upstream of State Route 151	*114
Bayou D'Arbonne Lake:	
At downstream spillway/dam	*90
At State Routes 15 and 33	*90
Maps are available for inspection at the 911 Office, 100 East Bayou, Room 206, Farmerville, Louisiana.	
MISSOURI	
Foristell (City), St. Charles County (FEMA Docket No. 7278)	
Peruque Creek:	
Approximately 10,570 feet (2 miles) downstream of Stringtown Road [1]	*630
Approximately 5,250 feet downstream of Stringtown Road [1]	*646
Stringtown Road is located in Warren County (Unincorporated Areas), Missouri.	
Maps are available for inspection at the City of Foristell City Hall, 10 Highway T, Foristell, Missouri.	
Lee's Summit (City), Cass and Jackson Counties (FEMA Docket No. 7282)	
Raintree Lake: Just west of Ward Road	*960
Maps are available for inspection at the Community Development Office, 207 Southwest Market, Lee's Summit, Missouri.	

Source of flooding and location	# Depth in feet above ground. *Elevation in feet (NGVD).
NEBRASKA	
Howard County (Unincorporated Areas) (FEMA Docket No. 7278)	
Oak Creek:	
Aproximately 7,200 feet downstream of Union Pacific Railroad	*1,842
Approximately 1,200 feet upstream of Naper Road	*1,871
Middle Loup River:	
Approximately 7,000 feet downstream of County Road	*1,899
Approximately 4,700 feet upstream of County Road	*1,914
Maps are available for inspection at the Howard County Roads Department, 408 Elm Street, St. Paul, Nebraska.	
NEVADA	
Douglas County (and Incorporated Areas) (FEMA Docket No. 7274)	
Clear Creek:	
At Douglas County boundary, approximately 200 feet downstream from Center Drive	*4,715
Approximately 200 feet upstream from R19E/R20E line	*4,824
Maps are available for inspection at Douglas County Planning, 1594 Esmeralda Avenue, Room 202, Minden, Nevada.	
OKLAHOMA	
Lincoln County (Unincorporated Areas) (FEMA Docket No. 7278)	
West Captain Creek Tributary 1:	
Approximately 8,000 feet upstream of confluence with West Captain Creek	*940
At Oklahoma—Lincoln County boundary	*950
Maps are available for inspection at the Lincoln County Commissioners Office, 811 Manvel Avenue, #4, Chandler, Oklahoma.	
Newcastle (City), McClain County (FEMA Docket No. 7278)	
Pond Creek:	
Approximately 1,450 feet upstream from confluence with the Canadian River	*1,131
Approximately 800 feet upstream from confluence withTributary 1 of Pond Creek	*1,141
Approximately 100 feet upstream from U.S. Route 62 (Main Street)	*1,182
Approximately 5,225 feet upstream from confluence of Tributary 10 of Pond Creek	*1,243

Source of flooding and location	# Depth in feet above ground. *Elevation in feet (NGVD).
Tributary 4 of Pond Creek:	
At confluence with Pond Creek	*1,148
Approximately 400 feet upstream of Fifth Street	*1,241
Tributary 5.0 of Pond Creek:	
At confluence with Pond Creek	*1,156
Approximately 3,100 feet upstream of confluence with Tributary 5.3 of Pond Creek	*1,244
Tributary 5.1 of Pond Creek:	
At confluence with Tributary 5.0 of Pond Creek	*1,190
Approximately 2,750 feet upstream of State Highway 130 (Fox Lane)	*1,260
Tributary 5.1.1 of Pond creek:	
At confluence with Tributary 5.1 of Pond Creek	*1,200
Approximately 400 feet upstream from State Highway 130 (Fox Lane)	*1,270
Tributary 5.3 of Pond Creek:	
At confluence with Tributary 5.0 of Pond Creek	*1,237
Approximately 710 feet upstream of South 16th Street	*1,265
Tributary 6.0 of Pond Creek:	
At confluence with Pond Creek	*1,160
Approximately 500 feet upstream of North 16th Street	*1,211
Tributary D of Canadian River:	
At confluence with Canadian River	*1,169
Approximately 50 feet upstream of Northwest 16th Street	*1,315
Tributary D1 of Canadian River:	
At confluence with Tributary D of Canadian River	*1,198
Approximately 150 feet downstream from intersection with Long Drive	*1,206
At intersection with Long Drive	*1,207
Maps are available for inspection at 5 North Main, Newcastle, Oklahoma.	
UTAH	
Santa Clara (City), Washington County (FEMA Docket No. 7282)	
Lava Flow Wash:	
Approximately 1,100 feet downstream of Red Mountain Drive	*2,846
Approximately 5,300 feet upstream of Red Mountain Drive	*2,947
Sand Hollow Wash:	
Approximately 2,200 feet downstream of Pearl Rose Drive (extended)	*2,690
Approximately 2,100 feet upstream of Pearl Rose Drive (extended)	*2,728
Santa Clara River:	
Approximately 7,500 feet downstream of Chapel Street	*2,685
Just upstream of Old Barn Road	*2,789
Tuacahn Wash:	
Just upstream of Santa Clara Dike	*2,778
Approximately 7,200 feet upstream of confluence with Lava Flow Wash	*2,934
Maps are available for inspection at the City of Santa Clara City Hall, 2721 Santa Clara Drive, Santa Clara, Utah.	
WASHINGTON	
Bothell (City), King and Snohomish Counties (FEMA Docket No. 7246)	
North Creek:	
At confluence with Sammamish River	*22
At 208th Street Southeast	*123
Maps are available for inspection at the City of Bothell Department of Community Development, 9654 Northeast 182nd Street, Bothell, Washington.	

(Catalog of Federal Domestic Assistance No. 83.100, ''Flood Insurance.'')

Dated: July 20, 1999.

Michael J. Armstrong,

Associate Director for Mitigation.

[FR Doc. 99–19571 Filed 7–29–99; 8:45 am]

BILLING CODE 6718–04–P

FEDERAL EMERGENCY MANAGEMENT AGENCY

44 CFR Part 67

Final Flood Elevation Determinations

AGENCY: Federal Emergency Management Agency (FEMA).

ACTION: Final rule.

SUMMARY: Base (1% annual chance) flood elevations and modified base flood elevations are made final for the communities listed below. The base flood elevations and modified base flood elevations are the basis for the floodplain management measures that each community is required either to adopt or to show evidence of being already in effect in order to qualify or remain qualified for participation in the National Flood Insurance Program (NFIP).

EFFECTIVE DATES: The date of issuance of the Flood Insurance Rate Map (FIRM) showing base flood elevations and modified base flood elevations for each community. This date may be obtained by contacting the office where the maps are available for inspection as indicated on the table below.

ADDRESSES: The final base flood elevations for each community are available for inspection at the office of the Chief Executive Officer of each community. The respective addresses are listed in the table below.

FOR FURTHER INFORMATION CONTACT: Matthew B. Miller, P.E., Chief, Hazards Study Branch, Mitigation Directorate, Federal Emergency Management Agency, 500 C Street SW., Washington, DC 20472, (202) 646–3461, or (email) matt.miller@fema.gov.

SUPPLEMENTARY INFORMATION: The Federal Emergency Management Agency (FEMA or Agency) makes final determinations listed below of base flood elevations and modified base flood elevations for each community listed. The proposed base flood elevations and proposed modified base flood elevations were published in newspapers of local circulation and an opportunity for the community or individuals to appeal the proposed determinations to or through the community was provided for a period of ninety (90) days. The proposed base flood elevations and proposed modified base flood elevations were also published in the **Federal Register**.

This final rule is issued in accordance with section 110 of the Flood Disaster Protection Act of 1973, 42 U.S.C. 4104, and 44 CFR part 67.

The Agency has developed criteria for floodplain management in floodprone areas in accordance with 44 CFR part 60.

Interested lessees and owners of real property are encouraged to review the proof Flood Insurance Study and Flood Insurance Rate Map available at the address cited below for each community.

The base flood elevations and modified base flood elevations are made final in the communities listed below. Elevations at selected locations in each community are shown.

National Environmental Policy Act

This rule is categorically excluded from the requirements of 44 CFR Part 10, Environmental Consideration. No environmental impact assessment has been prepared.

Regulatory Flexibility Act

The Associate Director, Mitigation Directorate, certifies that this rule is exempt from the requirements of the Regulatory Flexibility Act because final or modified base flood elevations are required by the Flood Disaster Protection Act of 1973, 42 U.S.C. 4104, and are required to establish and maintain community eligibility in the

National Flood Insurance Program. No regulatory flexibility analysis has been prepared.

Regulatory Classification

This final rule is not a significant regulatory action under the criteria of section 3(f) of Executive Order 12866 of September 30, 1993, Regulatory Planning and Review, 58 FR 51735.

Executive Order 12612, Federalism

This rule involves no policies that have federalism implications under Executive Order 12612, Federalism, dated October 26, 1987.

Executive Order 12778, Civil Justice Reform

This rule meets the applicable standards of section 2(b)(2) of Executive Order 12778.

Administrative practice and procedure, Flood insurance, Reporting and recordkeeping requirements.

Accordingly, 44 CFR part 67 is amended as follows:

PART 67—[AMENDED]

1. The authority citation for part 67 continues to read as follows:

Authority: 42 U.S.C. 4001 *et seq.*; Reorganization Plan No. 3 of 1978, 3 CFR, 1978 Comp., p. 329; E.O. 12127, 44 FR 19367, 3 CFR, 1979 Comp., p. 376.

§ 67.11 [Amended]

2. The tables published under the authority of § 67.11 are amended as follows:

Source of flooding and location	# Depth in feet above ground. *Elevation in feet (NGVD).
MICHIGAN	
Nashville (Village), Barry County (FEMA Docket No. 7283)	
Thornapple River:	
Approximately 2,800 feet downstream of the confluence of Quaker Brook Creek	*813
Approximately 4,050 feet upstream of Main Street	*817
Maps available for inspection at the Nashville Village Office, 206 North Main Street, Nashville, Michigan.	
Northville (City), Wayne and Oakland Counties (FEMA Docket No. 7275)	
Middle River Rouge:	
Approximately 150 feet upstream of 8 Mile Road	*820
Downstream side of Old Novi Road	*824
Thornton Creek Overflow:	
At confluence with Middle River Rouge	*823
Approximately 30 feet upstream of corporate limits	*823
Maps available for inspection at the Northville City Hall, 215 West Main Street, Northville, Michigan.	
MINNESOTA	
Sauk Rapids (City), Benton County (FEMA Docket No. 7279)	
Mississippi River:	
Downstream corporate limits	*991
Approximately 1.42 miles upstream of State Highway 152 (1st Street South)	*999
County Ditch No. 3: At confluence with Mississippi River	*992
Maps available for inspection at the Sauk Rapids City Hall, 115 North 2nd Avenue, Sauk Rapids, Minnesota 56379–1660.	
NORTH CAROLINA	
Leggett (Town), Edgecomb County (FEMA Docket No. 7287)	
Swift Creek:	
Approximately 1.4 miles downstream of State Route 97	*53
Approximately 2.1 miles upstream of State Route 97	*61
Maps available for inspection at the Leggett Town Hall, Intersection of Highway 33 and 97, Edgecomb, North Carolina.	
OHIO	
Bay Village (City), Cuyahoga County (FEMA Docket No. 7255)	
Wischmeyer Creek:	
Approximately 120 feet downstream of West Lake Road	*605
At the upstream City of Bay Village corporate limits	*651
Maps available for inspection at the Bay Village City Hall, 350 Dover Center Road, Bay Village, Ohio.	
PENNSYLVANIA	
Smithfield (Township), Monroe County (FEMA Docket No. 7259)	
Delaware River:	
Approximately 250 feet upstream of downstream corporate limits	*315
Approximately 1.5 miles downstream of upstream corporate limits	*331
Shawnee Creek:	
At the confluence with the Delaware River	*325
Approximately 80 feet upstream of River Road	*326
Sambo Creek: Approximately 0.9 mile west of the intersection of Valhalla Drive and State Route 209, within the corporate limits of the Township of Smithfield	*452
Cherry Creek: Approximately 500 feet south of the intersection of Broad Street and Interstate 80, within the corporate limits at the Township of Smithfield	*322
Maps available for inspection at the Smithfield Township Municipal Building, Route 209, East Stroudsburg, Pennsylvania.	
RHODE ISLAND	
North Providence (Town), Providence County (FEMA Docket No. 7259)	
Centerdale Brook:	
Upstream side of Woonasquatucket Avenue	*120
Approximately 100 feet upstream of South Locust Avenue	*140
Cranberry Brook:	
At confluence with Woonasquatucket River	*81
Downstream side of Humbert Street	*110
West River:	
At downstream corporate limits	*78
Approximately 700 feet downstream of Douglas Pike	*86
Upper Canada Pond Brook:.	
Downstream at corporate limits	*58
Approximately 1,080 feet upstream of corporate limits	*60
Centerdale Brook (Culvert-zone AO): From Woonasquatucket Avenue to approximately 720 feet downstream of Woonasquatucket Avenue	#1
Maps available for inspection at the Building Inspector's Office, 2000 Smith Street, North Providence, Rhode Island.	
SOUTH CAROLINA	
Hollywood (Town), Charleston County (FEMA Docket No. 7287)	
Mellichamp Branch:	
Approximately 600 feet from the upstream side of a breached dam	*8
Approximately 0.63 mile upstream of Towles Road bridge	*811
Maps available for inspection at the Hollywood Town Hall, 6316 Highway 162, Hollywood, South Carolina.	
Ravenel (Town), Charleston County (FEMA Docket No. 7283)	
Mellichamp Branch:	
At downstream side of New Road	*27

Source of flooding and location	# Depth in feet above ground. *Elevation in feet (NGVD).
Approximately 1.3 miles downstream of State Route 165	*11
Maps available for inspection at the Ravenel Town Hall, 5962 Highway 165, Suite 100, Ravenel, South Carolina.	
TENNESSEE	
Cheatham County (Unincorporated Areas) (FEMA Docket Nos. 7279 and 7259)	
Harpeth River:	
Approximately 0.45 mile upstream of Old Pinnacle Road	*498
Approximately 4.1 miles upstream of East Kingston Springs Road	*519
South Harpeth River:	
At the confluence with the Harpeth River	*516
Approximately 0.38 mile downstream of Anderson Road	*516
Sycamore Creek:	
At upstream side of Nashville and Ashland City Railroad	*401
At U.S. Route 41A	*491
Sams Creek:	
Approximately 0.9 mile downstream of most downstream crossing of Sams Creek Road	*404
Approximately 0.8 mile upstream of Deerfoot Drive	*515
Dry Creek:	
Approximately 220 feet upstream of Sams Creek Road	*404
Approximately 300 feet upstream of Dry Creek Road	*425
Pond Creek:	
Approximately 1,700 feet upstream of River Road	*404
At Natier Road	*536
West Fork Pond Creek:	
At confluence with Pond Creek	*413
Approximately 1.17 miles upstream of Pond Creek Road	*456
Maps available for inspection at the Cheatham County Building Commissioner's Office, 210 South Main Street, Ashland City, Tennessee.	
Fayetteville (City), Lincoln County (FEMA Docket No. 7287)	
Wells Creek:	
At the confluence of the Elk River	*673
Approximately 2,000 feet upstream of confluence with the Elk River	*674
Elk River:	
Approximately 350 feet downstream of confluence of Wells Creek	*673
Approximately 4.73 miles upstream of confluence of Stuart Creek	*686
Maps available for inspection at the Fayetteville City Hall, 110 South Elk Avenue, Fayetteville, Tennessee.	
Kingston Springs (Town), Cheatham County (FEMA Docket No. 7259)	
Buffalo Gap Cutoff:	
At the confluence with the Harpeth River	*499
Approximately 0.40 mile upstream of East Kingston Springs Road	*513
Harpeth River:	
Approximately 0.45 mile upstream of Old Pinnacle Road	*498
Approximately 0.03 mile upstream of Interstate Route 40	*513
Maps available for inspection at the Kingston Springs Town Hall, 396 Spring Street, Kingston Springs, Tennessee.	
Lincoln County (Unincorporated Areas) (FEMA Docket No. 7287)	
Norris Creek:	
Approximately 1,450 feet downstream of Old Marrs Road	*680
Approximately 40 feet upstream of Old Marrs Road	*682
Cotton Mill Branch:	
Approximately 600 feet downstream of Brookside Drive	*681
Approximately 0.71 mile upstream of Cedarwood Street	*711
Boonshill Road Branch:	
At confluence with the Elk River	*665
At Old Boonshill Road	*674
Wells Creek:	
At confluence with Elk River	*673
Approximately 898 feet upstream of Private Road	*693
Elk River:	
Approximately 1.1 miles downstream of the confluence with Boonshill Road Branch	*663
Approximately 5.0 miles upstream of the confluence of Stuart Creek	*686
Maps available for inspection at the Lincoln County Courthouse, County Executive's Office, 112 Main Avenue, South, Fayetteville, Tennessee.	
Pegram (Town), Cheatham County (FEMA Docket No. 7259)	
Harpeth River:	
Approximately 0.21 mile upstream of Riveview Drive	*527
Approximately 0.1 mile downstream of East Kingston Springs Road	*508
Maps available for inspection at the Pegram City Hall, 482 Thompson Road, Pegram, Tennessee.	
VERMONT	
Bellows Falls (Village), Windham County (FEMA Docket No. 7283)	
Connecticut River:	
At a point approximately 0.85 mile upstream from Bellows Falls Dam	*299
At a point approximately 500 feet upstream of Bellows Falls Dam	*296
Maps available for inspection at the Town of Rockingham, Town Clerk's Office, Village Square, Rockingham, Vermont.	
Rockingham (Town), Windham County (FEMA Docket No. 7283)	
Connecticut River:	
Approximately 0.77 mile upstream of NEPCO dam	*299
Approximately 1.34 miles upstream of confluence of Commissarry Brook	*306
Williams River:	
At the confluence with Connecticut River	*303
Approximately 1,350 feet upstream of U.S. Route 5 bridge	*303
Maps available for inspection at the Town of Rockingham, Town Clerk's Office, Village Square, Rockingham, Vermont.	
Springfield (Town), Windsor County (FEMA Docket No. 7283)	
Connecticut River:	
At a point approximately 2.2 miles downstream from Cheshire Bridge (State Route 11)	*306
At a point approximately 4.2 miles upstream from Cheshire Bridge (State Route 11)	*308
Black River:	
At the confluence with Connecticut River	*306
Approximately 550 feet downstream of Old State Route 11 bridge	*306
Maps available for inspection at the Springfield Town Hall, Zoning Administrator's Office, 96 Main Street, Springfield, Vermont.	
Thetford (Town), Orange County (FEMA Docket No. 7283)	
Abbott Brook:	
At confluence with West Branch Ompompanoosuc River	*692

Source of flooding and location	# Depth in feet above ground. *Elevation in feet (NGVD).
Approximately 280 feet upstream of State Route 132	*705
Ompompanoosuc River:	
At downstream corporate limits	*412
At upstream corporate limits	*684
West Branch Ompompanoosuc River:	
Approximately 100 feet upstream of Gove Hill Road	*576
At confluence with Abbott Brook	*692
Lake Fairlee:	
At Lake Fairlee Dam	*681
Approximately 700 feet upstream of corporate limits	*681
Maps available for inspection at the Thetford Town Office, Route 113, Thetford Center, Vermont.	
WISCONSIN	
Grant County (Unincorporated Areas) (FEMA Docket No. 7283)	
Wisconsin River:	
Approximately 1.4 miles upstream of Burlington Northern Railroad	*628
At upstream county boundary	*680
Crooked Creek:	
Confluence with the Wisconsin River	*654
At a point approximately 600 feet upstream of the confluence with the Wisconsin River	*655
Maps available for inspection at the Grant County Zoning Office, 125 South Monroe, Lancaster, Wisconsin.	
Ozaukee County (Unincorporated Areas) (FEMA Docket No. 7283)	
Lake Michigan:	
Approximately 2,200 feet east of the intersection of Sandy Beach Road and Sunny Ridge Road	*587
Approximately 1,900 feet east of the intersection of Silver Beach Road and Sauk Trail Road	*588
Maps available for inspection at the Ozaukee County Department of Environmental Health, 121 West Main Street, Room 223, Port Washington, Wisconsin.	

(Catalog of Federal Domestic Assistance No. 83.100, ''Flood Insurance.'')

Dated: July 19, 1999.

Michael J. Armstrong,

Associate Director for Mitigation.

[FR Doc. 99–19570 Filed 7–29–99; 8:45 am]

BILLING CODE 6718–04–P

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Parts 1, 52, 54, and 64

[FCC 99–175]

1998 Biennial Regulatory Review—Streamlined Contributor Reporting Requirements Associated with Administration of Telecommunications Relay Services, North American Numbering Plan, Local Number Portability, and Universal Service Support Mechanisms

AGENCY: Federal Communications Commission.

ACTION: Final rule.

SUMMARY: The Commission combined four reporting requirements so that carriers need only file one worksheet to satisfy the contributor reporting requirements associated with: the universal service support mechanisms; telecommunications relay services; cost recovery mechanism for numbering administration; and cost recovery mechanism for shared costs of long-term local number portability. The Commission also made other modifications designed to rationalize requirements, including changing the revenue measure for assessing contributions to the TRS Fund and numbering administration cost recovery so that contributions will be based on end-user telecommunications revenues.

DATES: Effective August 30, 1999.

FOR FURTHER INFORMATION CONTACT: Scott K. Bergmann, Industry Analysis Division, Common Carrier Bureau, at (202) 418–7102; or Jim Lande, Industry Analysis Division, Common Carrier Bureau at (202) 418–0948.

SUPPLEMENTARY INFORMATION: This is a summary of the Commission's Report and Order released July 14, 1999 (FCC 99–175). The full text of the Report and Order is available for inspection and copying during normal business hours in the FCC Reference Center, Room CY–A257, 445 12th Street, S.W., Washington, D.C. 20554. The complete text also may be purchased from the Commission's copy contractor, International Transcription Service, Inc. (202) 857–3800, 1231 20th St., NW, Washington, D.C. 20036.

I. Summary of the Report and Order

1. In the Report and Order summarized here, the Commission acted to simplify its filing requirements for communications service providers by replacing several different—but largely duplicative—forms with one consolidated form, the Telecommunications Reporting Worksheet. At present, telecommunications carriers and certain telecommunications service providers must comply with separate reporting requirements for their contributions to finance interstate Telecommunications Relay Services Fund, federal universal service support mechanisms, administration of the North American Numbering Plan (NANP), and the shared costs of long-term local number portability.[1] We act here to harmonize these multiple contributor reporting requirements and to minimize the administrative burdens for carriers and service providers. Thus, in lieu of making four separate filings in the spring of 2000, reporting carriers will simply file one copy of the new worksheet on April 1, 2000.[2] We emphasize that we are not imposing new reporting requirements in this proceeding; rather, our goal is to simplify the requirements to the greatest extent possible while continuing to ensure the efficient administration of the support and cost recovery mechanisms.

II. Background

2. In a series of separate proceedings, the Commission has established procedures to finance interstate telecommunications relay services,[3] universal service support mechanisms,[4] administration of the North American Numbering Plan,[5] and shared costs of local number portability.[6] To

[1] See 47 U.S.C. 151, 225, 251, 254. The Communications Act of 1934, as amended, (the Communications Act or the Act) is codified at 47 U.S.C. 151 *et seq.*

[2] The Common Carrier Bureau will release, by Public Notice, the worksheet and instructions to be used for the September 1999 universal service filing. See, infra, paragraph 32.

[3] See Public Law 101–336, § 401, 104 Stat. 327, 366–69 (adding section 225 to the Communications Act of 1934, as amended, 47 U.S.C. 225). See also *Telecommunications Relay Services and the Americans With Disabilities Act of 1990,* Third Report and Order, FCC 93–357, CC Docket No. 90–571, 8 FCC Rcd 5300, 58 FR 39671 (July 26, 1993) (*TRS Third Report and Order*) (''recovering interstate relay costs from all common carriers who provide interstate service on the basis of their interstate revenues will accomplish this goal'').

[4] See 47 U.S.C. 254. See also *Federal-State Joint Board on Universal Service,* Report and Order, FCC 97–157, CC Docket No. 96–45, 12 FCC Rcd 8776, 62 FR 32862 (June 17, 1997) (*Universal Service Order*).

[5] See 47 U.S.C. 251(e)(2). *Administration of the North American Numbering Plan, Toll Free Service Access Codes,* Third Report and Order and Third Report and Order, FCC 97–372, CC Docket No. 92–237, 95–155, 12 FCC Rcd 23040, 62 FR 55179 (October 23, 1997).

[6] See 47 U.S.C. 251(e)(2). See also *Telephone Number Portability,* Third Report and Order, FCC 98–82, CC Docket 95–116, 63 FR 35150 (June 29, 1998) (*LNP Cost Recovery Order*). This Report and Order is limited to the cost recovery mechanism for

accomplish each of these goals, contributions are collected from telecommunications carriers and certain other providers of telecommunications services. As currently structured, our rules require telecommunications carriers having interstate revenues to file, at different times throughout the year, a number of contributor reporting worksheets that reflect often duplicative reporting requirements. Such carriers must file four forms (Form 431, TRS Fund Worksheet;[7] Form 457, Universal Service Worksheet;[8] Form 496, NANPA Funding Worksheet;[9] and Form 487, LNP Worksheet[10]) containing revenue and other data on which contributions to support or cost recovery mechanisms are based. For each of these forms, with the exception of the Universal Service Worksheet, carriers seeking confidential treatment of the data submitted in these forms must also file separate requests for nondisclosure with the Commission.[11] In addition to these contributor reporting requirements, all carriers must also file data concerning contact information for an agent for service of process located in the District of Columbia.[12]

3. On September 25, 1998, the Commission released a Notice of Proposed Rulemaking and Notice of Inquiry, 63 FR 54090 (October 8, 1998), to initiate this proceeding.[13] Twenty-eight parties filed comments and ten parties filed reply comments to the Notice.

III. Streamlining Contributor Reporting Requirements

A. Use of a Consolidated Worksheet

4. We adopt a new Telecommunications Reporting Worksheet to replace the four existing worksheets used to collect contributor data. The new worksheet will also be used by carriers to identify agents for service of process, as required by section 413 of the Act. We note that carriers and administrators were nearly unanimous in their support of this proposal, indicating that it would result in tangible administrative savings. We also conclude that adopting one worksheet to satisfy these obligations will reduce confusion for carriers and should increase compliance, particularly by smaller carriers. Finally, we believe that adopting a consolidated worksheet and granting administrators the ability to share revenue data will reduce the costs for administrators and, thereby, further effect savings overall.

5. To consolidate the worksheets, we amend the corresponding sections of the Commission's rules for universal service, TRS, local number portability, and numbering administration, so that those rule sections now refer to the Telecommunications Reporting Worksheet.[14] To the same end, we also amend our rules concerning agents for service of process in section 1.47 to provide for the use of the worksheet.[15] Attached, as Appendix D to the Report and Order, is the initial Telecommunications Reporting Worksheet (including both the April and the streamlined September versions) that will be used for the September 1, 1999 filing.[16] The new Telecommunications Reporting Worksheet will provide the necessary information while reducing to the lowest possible level the burden for carriers and service providers.

6. We do not adopt, however, the Commission's proposal to use the Telecommunications Reporting Worksheet to collect revenue and plant data required under section 43.21(c) of the Commission's rules.[17]

B. Timing Issues

1. Uniform Filing Date

7. Consolidating the multiple existing filings into the Telecommunications Reporting Worksheet will reduce the number of times that carriers will need to assemble data and report it. We direct the Bureau to utilize a single filing date for the Telecommunications Reporting Worksheet for the purposes of universal service, TRS, NANP, and local number portability.[18] Our decision to adopt a single filing date is bolstered by all of the commenters to address this proposal. Since we adopt the first iteration of the Telecommunications Reporting Worksheet in this order, we direct that, for the first year's filing, the Telecommunications Reporting Worksheet should be filed on April 1st.

8. We clarify that the new Telecommunications Reporting Worksheet will become effective upon approval by the Office of Management and Budget (OMB), but not less than thirty days from publication in the **Federal Register**. It is our intention that contributors to the universal service support mechanisms should use the streamlined Form 499–S version (FCC Form 499S) to satisfy the September 1, 1999 universal service filing. However, because we are required to seek approval from the Office of Management and Budget for this revised information collection, it is possible that the new form may not be available for use for the September 1999 filing. We direct the Bureau to announce by Public Notice whether contributors should file the new September version or whether contributors should file, for a final time, the existing Universal Service Worksheet. For the purposes of TRS, NANP, LNP, universal service, the Form 499–A version of the worksheet will be used to satisfy the April 1, 2000 filing. In addition, the worksheet will be available to be used by carriers to satisfy their section 413 obligations concerning agents for service of process,[19] as soon as it is approved by OMB, but not less than thirty days after publication in the **Federal Register**. This timeframe should give administrators sufficient time to prepare their systems for the new worksheet and should give filers sufficient time to become familiar with the new worksheet.

2. September 1st Filing Date for Universal Service Support Mechanisms

9. We conclude that a more streamlined form is acceptable for the September 1st filing. Accordingly, we adopt a ''short form'' for purposes of the

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the shared costs of long-term local number portability.

[7] See 47 CFR 64.604(c)(4)(iii)(B). See also *Telecommunications Relay Services and the Americans With Disabilities Act of 1990,* Order, DA 98–2481, CC Docket No. 90–571 (rel. Dec. 2, 1998) (*1999 TRS Fund Worksheet Order*).

[8] See 47 CFR 54.711. *Common Carrier Bureau Announces Release of Revised Universal Service Worksheet (FCC Form 457) To Reflect Change in Reporting of Revenues From Inside Wiring Maintenance,* Public Notice, DA 99–432, CC Docket No. 96–45 (rel. Mar. 5, 1999) (*1999 Universal Service Worksheet Notice*).

[9] See 47 CFR 52.16. See also *Common Carrier Bureau Announces Release of 1999 North American Numbering Plan Funding Worksheet,* FCC Form 496, Public Notice, 13 FCC Rcd 17888, DA 98–1865 (rel. Sept. 15, 1998) (*1999 NANP Funding Worksheet Notice*).

[10] See 47 CFR 52.32. See also *All Telecommunications Carriers Must Begin Contributing To the Regional Database Costs for Long-Term Number Portability in 1999,* Public Notice, DA 99–544, CC Docket No. 95–116 (rel. Mar. 15, 1999) (*1999 LNP Worksheet Notice*).

[11] See 47 CFR 0.459.

[12] See 47 U.S.C. 413; 47 CFR 1.47(h).

[13] *Contributor Reporting Requirements Notice,* 13 FCC Rcd 19295, 63 FR 54090 (October 8, 1998).

[14] See Attachment to this Summary (Rules Changes).

[15] See Attachment to this Summary (Rules Changes).

[16] See Section III. B. of this Summary (concerning Timing Issues).

[17] See *Contributor Reporting Requirements Notice,* 13 FCC Rcd 19295, 19309, 63 FR 54090 (October 8, 1998); 47 CFR 43.21(c).

[18] Agent for service of process data required pursuant to section 413 of the Act is not necessarily filed at one time of the year, but at the time the carrier changes its agent for service of process in the District of Columbia. This requirement will remain unchanged. See 47 CFR 1.47(h).

[19] See Section III. B. of the Order.

September 1st filing that will omit data that is not essential for the mid-year calculation of universal service contributions.

E. Filing Location(s)

10. We conclude that subject carriers and service providers need only file one copy of their completed Telecommunications Reporting Worksheet, rather than separate copies with each administrator. We facilitate a single filing location by instructing the administrators to develop procedures for collecting, validating, and distributing the contributor data provided in the new Telecommunications Reporting Worksheet.[20]

F. Procedures for Future Changes to the Telecommunications Reporting Worksheet

11. We adopt our proposal and delegate authority to make future changes to the Telecommunications Reporting Worksheet to the Chief of the Common Carrier Bureau.[21] The Bureau already has broad authority to waive, reduce, or eliminate the contributor reporting requirements for universal service, and the Bureau has latitude with respect to the administration of the NANP, LNP, and TRS contributor reporting requirements. These delegations extend to administrative aspects of the requirements, e.g., where and when worksheets are filed, incorporating edits to reflect Commission changes to the substance of the mechanisms, and other similar details.

12. So that these delegations are consistent, we amend the Commission's rules to grant the Common Carrier Bureau delegated authority, in keeping with the current delegation for universal service purposes, to waive, reduce, modify, or eliminate the contributor reporting requirements for the TRS, LNP, and NANP mechanisms, as necessary to preserve the sound and efficient administration of these support and cost recovery mechanisms.[22] We specify that the Bureau has the authority to ''modify'' these reporting requirements as a matter of clarification, because we believe that this authority is implied within the existing grant. We reaffirm that this delegation extends only to making changes to the administrative aspects of the reporting requirements, not to the substance of the underlying programs.

G. Information Sharing and Delegation of Data Entry Functions Between Administrators

13. We amend our rules to allow the administrators to share confidential contributor information with one another for the purposes of comparing individual contributors' revenue, contact, and payment history information. Based on our experience with the limited sharing provisions currently allowed under our rules and on the record in this proceeding, we conclude that the ability to share contributor data will assist the administrators in monitoring compliance with the contribution requirements by revealing inconsistencies between revenue data reported to the different administrators. This sharing of information will also enhance the administrators' performance of their collection functions and thereby better ensure the integrity and efficient administration of the support and cost recovery mechanisms. Moreover, we amend our rules to ensure that such information cannot be used for purposes unrelated to the administration of the mechanisms; thus, ensuring proper treatment of confidential contributor information.[23]

14. Starting with the April 2000 filing of the consolidated worksheet, the administrators will have a practical need to share carrier-provided information because we direct in this order that filers need only submit one copy of their completed worksheets.[24] Rather than mandate particular data sharing procedures, we order the administrators to develop efficient and effective procedures for collecting, validating, and distributing the centrally-filed contributor data amongst themselves. We expect, for example, that it might be more cost effective to have one administrator perform the data entry and preliminary verification functions for more than one of the support and cost recovery mechanisms. Whatever their decision, we direct the administrators to file with the Bureau, within 90 days after release of this order, a summary of their proposed procedures for distributing the data from the worksheet.

15. We conclude that the costs of collecting, validating, and distributing the carrier-provided information—and, any savings derived from consolidating redundant administrative tasks—should be allocated equitably among the administrators. Accordingly, we order the administrators to include in their filed summary a description of how related costs will be equitably apportioned. We delegate to the Bureau the authority to review the administrators' summary, including the proposed cost allocation plan.

16. To preserve the integrity of the support and cost recovery mechanisms, it is important to ensure that all contributor data is collected. We thus expect that the summarized procedures should reflect the administrators' commitment to ensuring that all required data is collected and validated.

H. Additional Confidentiality Issues

17. We adopt our proposal to permit carriers filing the Telecommunications Reporting Worksheet to certify that the revenue data contained in their submissions are privileged or confidential commercial or financial information and that disclosure of such information would likely cause substantial harm to the competitive position of the entity filing the worksheet.[25] As proposed, we amend our rules so that filers will be able to make this certification on their Telecommunications Reporting Worksheet and request Commission nondisclosure of information contained in the worksheet simply by checking a box on the worksheet, in lieu of submitting a separate request pursuant to section 0.459 of the Commission's rules.

18. We make clear, however, that simply requesting confidential treatment by means of this check-box does not necessarily entitle the filer to nondisclosure. Indeed, if the Commission is to receive a request for disclosure of the information on the worksheets, or if the Commission proposes to disclose the information, the filer would be required to make the full showing required under our rules.[26]

[20] See Section III. G. (discussing data entry of the Telecommunications Reporting Worksheet) of the Order. The Bureau will announce by Public Notice the location for filing the April 2000 Telecommunications Reporting Worksheet.

[21] See *Contributor Reporting Requirements Notice,* 13 FCC Rcd 19295, 19319–20, 63 FR 54090 (October 8, 1998).

[22] See Appendix B, Rules Amended.

[23] See Section III.H. (concerning Confidentiality Issues) of the Order.

[24] See Section III.E. (discussing the filing location for the consolidated worksheet) of the Order. The Bureau will announce by Public Notice the location for filing the April 2000 Telecommunications Reporting Worksheet.

[25] See Appendix D, Telecommunications Reporting Worksheet. We note that Blooston requests that the Commission grant confidential treatment for other information on the worksheet, such as the facsimile numbers and e-mail addresses of the contact persons. Any such request for confidential treatment would have to be separately pleaded pursuant to section 0.459. 47 CFR 0.459. We note, however, that the Commission does not plan to routinely release this information.

[26] See 47 CFR 0.459. See also *Examination of Current Policy Concerning the Treatment of*

For example, we expect that the Commission would be disinclined to withhold information related to the size of an individual carrier's contribution (information which third parties could potentially use to estimate that carrier's revenues) in an enforcement action against a carrier for failure to make a required contribution to one of the support or cost recovery mechanisms.

19. In light of our decision to allow administrators to share contributor revenue data, we take additional measures to ensure the nondisclosure of confidential submissions. We accordingly modify our rules to extend each administrator's confidentiality obligations to the data obtained from other funds. Moreover, we amend our rules to ensure that the administrators shall only use contributor data—whether obtained directly from contributors or from administrators—for the purpose administering the support and cost recovery mechanisms.[27]

I. Electronic Filing

20. We conclude, based on our experience in other proceedings, that making available an electronic filing system for the Telecommunications Reporting Worksheet may allow filers and administrators to reduce costs and improve accuracy. Accordingly, we take initial steps in this proceeding to develop and move to an electronic filing system. We expect, however, that the costs and benefits of an electronic filing system can vary significantly depending on the design of the system. Indeed, in light of the complexities raised in the record by both carriers and administrators, we conclude that it is imperative for the development of and the transition to an eventual electronic filing system to be conducted with great involvement from the administrators and carriers.[28]

21. As an initial step, we direct the administrators to assess and report to the Bureau, within 180 days of the release of this order, on the feasibility of implementing electronic filing. We expect the administrators to address the potential start-up and on-going operating costs to the administrators and carriers of an electronic system. The administrators should also address measures and costs associated with ensuring the accuracy and security of filed contributor data. We agree with those commenters that state that any proposal for electronic filing should not require expensive start-up costs for filers.[29] Moreover, we conclude that any electronic filing proposal must satisfy a cost-benefit analysis and instruct the administrators to conduct such an analysis. Finally, we restate our commitment to making electronic filing and other electronic applications accessible to persons with disabilities to the fullest extent possible.[30] Therefore, the administrators' report should address their ability—both now and on a continuing basis—to make electronic systems accessible to persons with disabilities.

IV. Contributions to TRS and NANPA Mechanisms

A. Overview

22. We adopt our proposals to alter the revenue bases for the TRS and NANP mechanisms so that end-user telecommunications revenues will be used to calculate contributions for all four mechanisms. In addition, we also alter the current practices for assessing minimum contributions to the TRS and NANP mechanisms to lessen regulatory burdens on small carriers and telecommunications service providers.

23. As a preliminary matter, we reject MCI's procedural argument that the Commission may not alter the revenue base or minimum contributions rules because it did not give adequate notice of these changes. Section 553(b) of the Administrative Procedures Act (APA) requires that an agency afford interested parties adequate notice of, and an opportunity to comment on, the provisions that appear in the agency's final regulations.[31] Courts have interpreted this to require that an agency provide ''sufficient factual detail and rationale for the rule to permit interested parties to comment meaningfully.''[32] The *Contributor Reporting Requirements Notice*, 63 FR 54090 (October 8, 1998), appeared in the **Federal Register**, and it contained adequate, indeed explicit, notice of the provisions we adopt today. We also observe that the caption to this docket specifically references the four underlying mechanisms; a point which we believe is not essential to satisfy the requirements of the APA, but that further undercuts MCI's claim that it did not have adequate notice of these proposals. Moreover, MCI cannot claim any actual lack of notice, as it has participated fully in this proceeding, filing both initial and reply comments. Accordingly, we believe that no further notice is required to comply with the notice provisions of the APA.

B. Basis for Assessing Contributions

24. In light of the Commission's experience since adopting revenue bases for TRS and NANP and in light of our efforts to streamline contributor reporting requirements, we modify our rules for contributions to the TRS and NANP mechanisms so that contributions will be based on end-user telecommunications revenues. Basing contributions to these mechanisms on end-user telecommunications revenue will effectively carry out the statutory mandates in section 225 and 251 for financing of TRS and NANP.[33] In addition to fulfilling the statutory directives, moving to an end-user telecommunications revenue basis will reduce carriers' administrative expenses associated with these reporting requirements. Indeed, given our proposal to create a unified contributor collection worksheet, we believe that changing the funding basis to end-user telecommunications revenue will appreciably reduce administrative burdens overall for carriers.

25. Basing contributions on end-user telecommunications revenues is consistent with the statutory language of section 225 and its requirement that ''costs caused by interstate telecommunications relay services shall be recovered from all subscribers for every interstate service.''[34] Recovering interstate relay costs from all common carriers that provide interstate service on the basis of their interstate revenues will accomplish this goal. End users are a reasonable proxy for subscribers, so collecting contributions from carriers based on revenue derived from end users satisfies section 225.

26. Similarly, collecting contributions to the NANP cost recovery on the basis of end-user telecommunications satisfies the requirements of section 251(e). Section 251(e) of the Act directs that ''[t]he cost of establishing

Confidential Information Submitted to the Commission, FCC 98–184, GC Docket No. 96–55, 63 FR 44161 (August 18, 1998) (listing the showings required in a request that information be withheld and stating that the Commission may defer action on such requests until a formal request for public inspection has been made).

[27] We note that the TRS rules enable the TRS administrator to use data obtained from contributors to be used for calculating the regulatory fees of interstate common carriers, and aggregating such fee payments for submission to the Commission. We do not alter these provisions.

[28] See, e.g., MCI Comments at 5; GTE Comments at 4; Blooston Reply Comments at 7–9.

[29] See, e.g., Blooston Comments at 15–16; MCI Comments at 5.

[30] Electronic filing is subject to the program accessibility requirements of section 1.850 of our rules. 47 CFR 1.850. See also Workforce Investment Act of 1998, Public Law 105–220, 112 Stat. 936 (Aug. 7, 1998).

[31] 5 U.S.C. 553.

[32] *Florida Power & Light Co. v. United States*, 846 F.2d 765, 771 (D.C. Cir. 1988), cert. denied, 490 U.S. 1045 (1989).

[33] See 47 U.S.C. 225, 251(e).

[34] 47 U.S.C. 225(d)(3)(B).

telecommunications numbering administration arrangements and number portability shall be borne by all telecommunications carriers on a competitively neutral basis as determined by the Commission.'' [35] The end-user telecommunications revenue basis satisfies the section 251 directive that contributions be assessed on a competitively neutral basis. In particular, the Commission found this basis to be competitively neutral because it does not give one service provider an appreciable, incremental cost advantage when competing for a subscriber. Further, basing contributions on end-user telecommunications revenues will prevent contributions to the NANP administration cost recovery from disparately affecting the ability of carriers to earn a normal return. We affirm this analysis and conclude that collecting contributions to the NANP administration cost recovery based on end-user telecommunications revenues will be competitively neutral.[36]

27. In the case of NANP, we note that section 251(e)(2) requires that the ''cost of establishing telecommunications numbering administration arrangements . . . shall be borne by all telecommunications carriers on a competitively neutral basis. . . .'' [37] Given the statutory directive that contributions be collected from ''all telecommunications carriers,'' we require carriers that provided telecommunications service during the base year and that have no end-user telecommunications revenue to make a fixed contribution of twenty-five dollars ($25) to the NANP cost recovery mechanism.[38] We conclude that assessing this sum will satisfy the statutory language of section 251(e)(2) and at the same time will not be economically burdensome for these primarily-large wholesale carriers. Finally, we observe that although an end-user telecommunications revenue basis would otherwise relieve pure wholesalers, which have no end-user revenue, from directly bearing costs of number administration, the end-user method does not exclude wholesale revenues from the revenue base that determines carriers' contributions. As the Commission explained in the *Universal Service Order*, 62 FR 32862 (June 17, 1997), wholesale charges are built into retail rates, and thus the revenue basis still reflects wholesale revenue.[39]

28. To minimize confusion for contributors and the administrators, we wish to make the transition to contributions based on end-user telecommunications revenues as soon as possible. For purposes of TRS, we recognize that many contributors are still making monthly installment payments toward their funding year 1999 contribution (which covers the April 26, 1999 through March 26, 2000 period) and we make clear that those contributions to the TRS Fund for the current funding period will continue to be based on gross telecommunications revenues. Because the contributor data needed to calculate TRS contributions for the funding year 2000 will not be available until April 2000, we will extend the current TRS funding period, so that contributions to the TRS Fund will continue to be based on gross telecommunications revenues and the current fund factor through the end of June 2000.[40] As of July 1, 2000 contributions to the TRS Fund will be based on end-user telecommunications revenues. A new factor will be developed in time for contributions in July 2000 and we will shift the fiscal year for TRS, so that the funding period will run from July 1st of each year through June 30th of the following year.

29. Indeed, we will shift the fiscal years for both TRS and NANP, so that the funding periods for these mechanisms will be more closely timed with the receipt of annual contributor data in the April filing of the new consolidated worksheet. We also make clear that contributions to the NANP cost recovery will continue to be based on net telecommunications revenues through the end of the current funding year, which covers fund administration from March 1999 through February 2000. The NANP Billing and Collection Agent will begin collecting contributions based on end-user telecommunications revenues for the funding year 2000. So that we may transition the NANP funding period to run from July 1st of each year through June 30th of the following year, we direct that the funding year 2000 will cover the sixteen month period from March 2000 through June 2001. We direct that, for purposes of the NANP funding year 2000, the Billing and Collection Agent will use contributor data filed in the September consolidated worksheet to develop the fund factor and should use the contributor data filed in the April consolidated worksheet to perform a ''true-up'' for the contributions in July 2000.[41] Thereafter, the NANP funding period will return to the twelve month cycle from July to June with contributions based on the April filing of the worksheet.

C. Minimum and Fixed Annual Contributions to TRS and NANPA Mechanisms

30. We modify our proposals and amend our rules to reduce substantially the one hundred dollar minimum contributions to a twenty-five dollar minimum. Our experience with the TRS and NANP mechanisms persuades us that it is possible to lower the one hundred dollar minimum while protecting the administrative integrity and efficiency of the TRS and NANP mechanisms.

V. Procedural Matters

A. Final Paperwork Reduction Act Analysis

31. As required by the Paperwork Reduction Act of 1995, the *Contributor Reporting Requirements Notice*, 63 FR 54090 (October 8, 1998), invited the

[35] 47 U.S.C. 251(e)(2). Even though there is no explicit statutory requirement to do so in section 225, we conclude that the principle of competitive neutrality is consistent with section 225 and that basing contributions to the TRS Fund on a competitively neutral mechanism would advance the intent embodied in the Congressional goal of ''a pro-competitive, de-regulatory national policy framework.'' See Joint Explanatory Statement of the Committee of Conference, S. Conf. Rep. No. 230, 104th Cong., 2d Sess. 113 (1996).

[36] See, e.g., BellSouth Comments at 4–5; IDT Comments at 16; Star Comments at 2–4. We note that several Bell Operating Companies argued to the United States Court of Appeals for the 8th Circuit that the net telecommunications revenue methodology would not be competitively neutral if states do not permit carriers to flow through their numbering administration costs in the prices that they charge their competitors for telecommunications services and facilities. *California* v. *FCC*, 124 F.3d 934 (8th Cir., 1997). The Court of Appeals ruled that petitioners' contentions were speculative and not ripe for review because no state had concluded that carriers could not include numbering administration charges in the prices for services or facilities sold to other telecommunications service providers. Id. at 944. Adoption of an end-user telecommunications revenue basis should moot this issue.

[37] 47 U.S.C. 251(e)(2).

[38] While the Commission proposed in the Notice a fixed contribution of $100 for carriers with no end-user telecommunications revenues, we believe that the $25 contribution will be easier to administer, since it is consistent with the $25 minimum contribution rule that we adopt for contributors with end-user telecommunications revenues. See Section IV. C. of the Order.

[39] See *Universal Service Order*, 12 FCC Rcd 8776, 9207, 62 FR 32862 (June 17, 1997).

[40] See *Telecommunications Relay Services and the Americans with Disabilities Act of 1990*, Order, DA 98–2481, CC Docket No. 90–571 (rel. Dec. 2, 1998) (determining contribution factor for the April 26, 1999 through March 26, 2000 period).

[41] A ''true-up'' will be necessary because the September worksheet reports only half year revenue data and because it may not collect data from all NANP contributors, e.g., some telecommunications carriers that are de minimis for universal service purposes will not file the September worksheet. We nevertheless expect that the revisions performed in the ''true-up'' will be minor in terms of contributors added and contributions adjusted.

general public and the Office of Management and Budget (OMB) to comment on the proposed information collection requirements contained in the Notice, in particular, the Telecommunications Reporting Worksheet. On December 9, 1998, OMB approved the proposed information collection, as submitted to OMB.[42] In this Report and Order, we adopt the proposed Telecommunications Reporting Worksheet, but modify our proposal to reflect comments received from OMB and other commenters. The revised Telecommunications Reporting Worksheet is subject to approval by OMB. The worksheet that we adopt in this Order reflects our efforts to collect the information necessary to implement the congressional directives, while reducing to the lowest possible level the burden on carriers and service providers.[43]

B. Final Regulatory Flexibility Act Analysis

32. As required by the Regulatory Flexibility Act (RFA),[44] the Commission has prepared a Final Regulatory Flexibility Analysis (FRFA) of the possible significant economic impact on small entities of the policies and rules adopted in this Order. A copy of this FRFA is set forth as part of this summary. The Office of Public Affairs, Reference Operations Division, will send a copy of this Order, including the FRFA, to the Chief Counsel for Advocacy of the Small Business Administration.

VI. Ordering Clauses

33. *Accordingly, it is ordered,* pursuant to sections 1, 4(i), 4(j), 11, 201–205, 210, 214, 218, 225, 251, 254, 303(r), 332, and 403 of the Communications Act of 1934, as amended, 47 U.S.C. 151, 154(i), 154(j), 161, 201–205, 210, 214, 218, 225, 251, 254, 303(r), 332 and 403 that this Order is hereby Adopted.

34. *It is further ordered* that the rule changes set forth in Appendix B are hereby *adopted,* effective thirty (30) days from the date of publication in the **Federal Register**. The information collection adopted herein is contingent upon approval by the Office of Management and Budget, but, in any event, will not become effective before thirty (30) days after publication in the **Federal Register**.

35. *It is further ordered* that the Commission's Office of Public Affairs, Reference Operations Division, *shall send* a copy of this *order,* including the Final Regulatory Flexibility Analysis, to the Chief Counsel for Advocacy of the Small Business Administration.

Final Regulatory Flexibility Act Analysis

36. In compliance with the Regulatory Flexibility Act (RFA),[45] an Initial Regulatory Flexibility Analysis (IRFA) was incorporated into the *Contributor Reporting Requirements Notice,* 63 FR 54090 (October 8, 1998). The Commission sought written public comment on the proposals in the Notice, including comment on the IRFA. The comments received are discussed below. This present Final Regulatory Flexibility Analysis (FRFA) conforms to the RFA.[46]

I. Need for, and Objectives of, the Contributor Reporting Requirements Order:

37. The Commission undertakes this examination of its contributor reporting requirements[47] as a part of its 1998 biennial review of regulations as required by section 11 of the Communications Act, as amended.[48] This Order simplifies the Commission's filing requirements by consolidating several different forms currently filed under our existing rules associated with the Telecommunications Relay Services (TRS) Fund,[49] federal universal service support mechanisms,[50] the cost recovery mechanism for the North American Numbering Plan (NANP) administration,[51] and the cost recovery mechanism for long-term local number portability (LNP) administration.[52] This Order also establishes end-user telecommunications revenues as the basis for contributions to the NANP and TRS mechanisms—making consistent the revenue bases for all four support and cost recovery mechanisms. Our objective is to reduce or eliminate unnecessary or duplicative regulatory requirements, consistent with section 11 of the Act,[53] and the Telecommunications Act of 1996.[54]

II. Summary of Significant Issues Raised by Public Comments in Response to the IRFA

38. Only one party filed comments addressing the Commission's compliance with the RFA,[55] but many parties commented on the Commission's proposals to streamline the Commission's reporting requirements. As noted above, the record provided by all of these commenting parties clearly supports the Commission's efforts to reduce the amount of paperwork required by the current contributor reporting requirements.[56] Consistent with those comments, this Order reduces significantly the amount of paperwork required of telecommunications carriers.

39. In comments to the Notice, GST argues that the proposed Telecommunications Reporting Worksheet is particularly burdensome for small carriers because it assumes that small carriers have developed sophisticated accounting infrastructure.[57] We disagree with GST's assessment and note that the worksheet provides flexibility for carriers that do not have sophisticated accounting systems. In contrast to GST's portrayal, the categories of revenue sought in the worksheet correspond to major categories of service, reflecting our expectation that most carriers track the relative magnitudes of their major product offerings for internal management reporting and cost accounting purposes. GST offers no evidence to the contrary. The worksheet collects the minimum amount of information necessary to ensure that individual carriers and segments of the industry are contributing on a fair and equitable basis. Further, the worksheet and its instructions incorporate alternative, less burdensome approaches where it has been determined that supplying certain information is particularly burdensome for certain carriers. Thus, for example, the worksheet permits carriers to use good

[42] In its approval of the proposed worksheet, OMB requests that the Commission address several issues. See Section V.A. of the Order for a discussion of those issues.

[43] See Sections III.B. of the Order (discussing data requested in the worksheet); and V.A. of the Order (discussing comments on the proposed information collections).

[44] See 5 U.S.C. 604. The RFA, see 5 U.S.C. 601 et. seq., has been amended by the Contract With America Advancement Act of 1996, Public Law 104–121, 110 Stat. 847 (1996) (CWAAA). Title II of the CWAAA is the Small Business Regulatory Enforcement Fairness Act of 1996 (SBREFA).

[45] See 5 U.S.C. 603. The RFA, see 5 U.S.C. 601 et. seq., has been amended by the Contract With America Advancement Act of 1996, Public Law 104–121, 110 Stat. 847 (1996) (CWAAA). Title II of the CWAAA is the Small Business Regulatory Enforcement Fairness Act of 1996 (SBREFA).

[46] See 5 U.S.C. 604.

[47] See 47 CFR 64.601 et seq.; 47 CFR 54.1 et seq.; 47 CFR 52.1 et seq.; 47 CFR 52.21 et seq.

[48] 47 U.S.C. 161.

[49] 47 CFR 64.601 et seq.

[50] 47 CFR 54.1 et seq., 69.1 et seq.

[51] 47 CFR 52.1 et seq.

[52] 47 CFR 52.21 et seq.

[53] 47 U.S.C. 161.

[54] Telecommunications Act of 1996, Public Law 104–104, 110 Stat. 56 (1996 Act), codified at 47 U.S.C. 151 et seq. See Joint Explanatory Statement of the Committee of Conference, S. Conf. Rep. No. 230, 104th Cong., 2d Sess. 113 (1996) (Joint Explanatory Statement).

[55] See GST Comments at 15.

[56] See Section III.B. (discussing use of a consolidated worksheet) of the Order.

[57] See GST Comments at 7, 9, 15.

faith estimates to determine interstate and international revenues where these figures cannot be directly determined from corporate books of account or subsidiary records. Similarly, we adopt a streamlined version of the worksheet to satisfy the September universal service filing and to reduce costs for carriers.

40. While not in direct response to the IRFA, both NECA and Blooston encourage the Commission not to implement an electronic filing system that would require costly investments by small carriers.[58] We agree that proposals for electronic filing of the Telecommunications Reporting Worksheet should not require expensive start-up costs for filers, so that all carriers, including small entities, should be able to utilize a more efficient system.[59]

IV. Description and Estimate of the Number of Small Entities to Which the Rules Will Apply:

41. The Commission's contributor reporting requirements apply to a wide range of entities, including all telecommunications carriers and other providers of interstate telecommunications that offer telecommunications for a fee.[60] Thus, we expect that the rules adopted in this Order will have a positive economic impact on a substantial number of small entities. Based on the number of carriers that file the existing forms—and this Order does not increase the number of entities that must comply with these requirements—we predict that not more than 5,000 entities, total, will file the worksheet. Of those 5,000 potential filers, we do not know how many are small entities, but we offer below a detailed estimate of the number of small entities within each of several major carrier-type categories. We state, again, that the economic impact of these proposals is, of course, a positive and beneficial impact, in the form of reduced regulatory burdens and recordkeeping requirements, for these entities.

42. To estimate the number of small entities that would benefit from this positive economic impact, we first consider the statutory definition of ''small entity'' under the RFA. The RFA generally defines ''small entity'' as having the same meaning as the term ''small business,'' ''small organization,'' and ''small governmental jurisdiction.''[61] In addition, the term ''small business'' has the same meaning as the term ''small business concern'' under the Small Business Act, unless the Commission has developed one or more definitions that are appropriate to its activities.[62] Under the Small Business Act, a ''small business concern'' is one that: (1) is independently owned and operated; (2) is not dominant in its field of operation; and (3) meets any additional criteria established by the Small Business Administration (SBA).[63] The SBA has defined a small business for Standard Industrial Classification (SIC) categories 4812 (Radiotelephone Communications) and 4813 (Telephone Communications, Except Radiotelephone) to be small entities when they have no more than 1,500 employees.[64] We first discuss the number of small telephone companies falling within these SIC categories, then attempt to refine further those estimates to correspond with the categories of telephone companies that are commonly used under our rules.

43. The most reliable source of information regarding the total numbers of certain common carrier and related providers nationwide, as well as the numbers of commercial wireless entities, appears to be data the Commission publishes annually in its *Carrier Locator* report, derived from filings made in connection with the Telecommunications Relay Service (TRS).[65] According to data in the most recent report, there are 3,604 interstate carriers.[66] These carriers include, inter alia, local exchange carriers, wireline carriers and service providers, interexchange carriers, competitive access providers, operator service providers, pay telephone operators, providers of telephone toll service, providers of telephone exchange service, and resellers.

44. Although some affected incumbent local exchange carriers (ILECs) may have 1,500 or fewer employees, we do not believe that such entities should be considered small entities within the meaning of the RFA because they are either dominant in their field of operations or are not independently owned and operated, and therefore by definition not ''small entities'' or ''small business concerns'' under the RFA. Accordingly, our use of the terms ''small entities'' and ''small businesses'' does not encompass small ILECs. Out of an abundance of caution, however, for regulatory flexibility analysis purposes, we will separately consider small ILECs within this analysis and use the term ''small ILECs'' to refer to any ILECs that arguably might be defined by the SBA as ''small business concerns.''[67]

45. Total Number of Telephone Companies Affected. The United States Bureau of the Census (''the Census Bureau'') reports that, at the end of 1992, there were 3,497 firms engaged in providing telephone services, as defined therein, for at least one year.[68] This number contains a variety of different categories of carriers, including local exchange carriers, interexchange carriers, competitive access providers, cellular carriers, mobile service carriers, operator service providers, pay telephone operators, PCS providers, covered SMR providers, and resellers. It seems certain that some of those 3,497 telephone service firms may not qualify as small entities or small incumbent LECs because they are not ''independently owned and operated.''[69] For example, a PCS provider that is affiliated with an interexchange carrier having more than 1,500 employees would not meet the definition of a small business. It seems

[58] NECA Comments at 4; Blooston Reply Comments at 9.

[59] See Section III.I. (discussing electronic filing) of the Order.

[60] 47 CFR 52.17 (applying to all telecommunications carriers), 52.32 (applying to all telecommunications carriers), 54.703 (applying to every telecommunications carrier that provides interstate telecommunications services, every provider of interstate telecommunications that offers telecommunications for a fee on a non-common carrier basis, and certain payphone providers), 64.604(c)(4)(iii)(A) (applying to every carrier providing interstate telecommunications services). We note that the Commission's rules for universal service exempt certain small contributors, i.e., contributors that have revenue below a stated threshold. 47 CFR 54.705.

[61] 5 U.S.C. 601(6).

[62] 5 U.S.C. 601(3) (incorporating by reference the definition of ''small business concern'' in 5 U.S.C. 632). Pursuant to 5 U.S.C. 601(3), the statutory definition of a small business applies ''unless an agency after consultation with the Office of Advocacy of the Small Business Administration and after opportunity for public comment, establishes one or more definitions of such term which are appropriate to the activities of the agency and publishes such definition in the Federal Register.''

[63] 15 U.S.C. 632. See, e.g., *Brown Transport Truckload, Inc.* v. *Southern Wipers, Inc.*, 176 B.R. 82 (N.D. Ga. 1994).

[64] 13 CFR 121.201.

[65] FCC, *Carrier Locator: Interstate Service Providers*, Figure 1 (Jan. 1999) (*Carrier Locator*). See also 47 CFR 64.601 *et seq.*

[66] *Carrier Locator* at Fig. 1.

[67] See 13 CFR 121.201, Standard Industrial Classification (SIC) 4813. Since the time of the Commission's 1996 decision, *Implementation of the Local Competition Provisions in the Telecommunications Act of 1996*, First Report and Order, 11 FCC Rcd 15499, 16144–45 (1996), 61 FR 45476 (August 29, 1996), the Commission has consistently addressed in its regulatory flexibility analyses the impact of its rules on such ILECs.

[68] United States Department of Commerce, Bureau of the Census, 1992 Census of Transportation, Communications, and Utilities: Establishment and Firm Size, at Firm Size 1–123 (1995) (''1992 Census'').

[69] 15 U.S.C. 632(a)(1).

reasonable to conclude, therefore, that fewer than 3,497 telephone service firms are small entity telephone service firms or small incumbent LECs that may be affected by the decisions and rule changes adopted in this Order.

46. Wireline Carriers and Service Providers. SBA has developed a definition of small entities for telephone communications companies other than radiotelephone companies. The Census Bureau reports that, there were 2,321 such telephone companies in operation for at least one year at the end of 1992.[70] According to SBA's definition, a small business telephone company other than a radiotelephone company is one employing no more than 1,500 persons.[71] All but 26 of the 2,321 non-radiotelephone companies listed by the Census Bureau were reported to have fewer than 1,000 employees. Thus, even if all 26 of those companies had more than 1,500 employees, there would still be 2,295 non-radiotelephone companies that might qualify as small entities or small incumbent LECs. Although it seems certain that some of these carriers are not independently owned and operated, we are unable at this time to estimate with greater precision the number of wireline carriers and service providers that would qualify as small business concerns under SBA's definition. Consequently, we estimate that there are fewer than 2,295 small entity telephone communications companies other than radiotelephone companies that may be affected by the decisions and rule changes adopted in this Order.

47. Local Exchange Carriers, Interexchange Carriers, Competitive Access Providers, Operator Service Providers, and Resellers. Neither the Commission nor SBA has developed a definition of small local exchange carriers (LECs), interexchange carriers (IXCs), competitive access providers (CAPs), operator service providers (OSPs), or resellers. The closest applicable definition for these carrier-types under SBA rules is for telephone communications companies other than radiotelephone (wireless) companies.[72] The most reliable source of information regarding the number of these carriers nationwide of which we are aware appears to be the data that we collect annually in connection with the Telecommunications Relay Service (TRS).[73] According to our most recent data, there are 1,410 LECs, 151 IXCs, 129 CAPs, 32 OSPs, and 351 resellers.[74] Although it seems certain that some of these carriers are not independently owned and operated, or have more than 1,500 employees, we are unable at this time to estimate with greater precision the number of these carriers that would qualify as small business concerns under SBA's definition. Consequently, we estimate that there are fewer than 1,410 small entity LECs or small incumbent LECs, 151 IXCs, 129 CAPs, 32 OSPs, and 351 resellers that may be affected by the decisions and rule changes adopted in this Order.

48. Wireless (Radiotelephone) Carriers. SBA has developed a definition of small entities for radiotelephone (wireless) companies. The Census Bureau reports that there were 1,176 such companies in operation for at least one year at the end of 1992.[75] According to SBA's definition, a small business radiotelephone company is one employing no more than 1,500 persons.[76] The Census Bureau also reported that 1,164 of those radiotelephone companies had fewer than 1,000 employees. Thus, even if all of the remaining 12 companies had more than 1,500 employees, there would still be 1,164 radiotelephone companies that might qualify as small entities if they are independently owned and operated. Although it seems certain that some of these carriers are not independently owned and operated, we are unable at this time to estimate with greater precision the number of radiotelephone carriers and service providers that would qualify as small business concerns under SBA's definition. Consequently, we estimate that there are fewer than 1,164 small entity radiotelephone companies that may be affected by the decisions and rule changes adopted in this Order.

49. Cellular, PCS, SMR and Other Mobile Service Providers. In an effort to further refine our calculation of the number of radiotelephone companies that may be affected by the rules adopted herein, we consider the data that we collect annually in connection with the TRS for the subcategories Wireless Telephony (which includes Cellular, PCS, and SMR) and Other Mobile Service Providers. Neither the Commission nor the SBA has developed a definition of small entities specifically applicable to these broad subcategories, so we will utilize the closest applicable definition under SBA rules—which, for both categories, is for telephone companies other than radiotelephone (wireless) companies.[77] To the extent that the Commission has adopted definitions for small entities providing PCS and SMR services, we discuss those definitions below. According to our most recent TRS data, 732 companies reported that they are engaged in the provision of Wireless Telephony services and 23 companies reported that they are engaged in the provision of Other Mobile Services.[78] Although it seems certain that some of these carriers are not independently owned and operated, or have more than 1,500 employees, we are unable at this time to estimate with greater precision the number of Wireless Telephony Providers and Other Mobile Service Providers, except as described below, that would qualify as small business concerns under SBA's definition. Consequently, we estimate that there are fewer than 732 small entity Wireless Telephony Providers and fewer than 23 small entity Other Mobile Service Providers that might be affected by the decisions and rule changes adopted in this Order.

50. Broadband PCS Licensees. The broadband PCS spectrum is divided into six frequency blocks designated A through F, and the Commission has held auctions for each block. The Commission defined ''small entity'' for Blocks C and F as an entity that has average gross revenues of less than $40 million in the three previous calendar years.[79] For Block F, an additional classification for ''very small business'' was added, and is defined as an entity that, together with its affiliates, has average gross revenues of not more than $15 million for the preceding three calendar years.[80] These regulations defining ''small entity'' in the context of broadband PCS auctions have been approved by SBA.[81] No small businesses within the SBA-approved definition bid successfully for licenses in Blocks A and B. There were 90 winning bidders that qualified as small entities in the Block C auctions. A total of 93 small

[70] 1992 Census, supra, at Firm Size 1–123.

[71] 13 CFR 121.201, SIC Code 4813.

[72] 13 CFR 121.210, SIC Code 4813.

[73] See 47 CFR 64.601 et seq.; *Carrier Locator* at Fig. 1.

[74] *Carrier Locator* at Fig. 1. The total for resellers includes both toll resellers and local resellers.

[75] United States Department of Commerce, Bureau of the Census, 1992 Census of Transportation, Communications, and Utilities: Establishment and Firm Size, at Firm Size 1–123 (1995) (''1992 Census'').

[76] 13 CFR 121.201, SIC Code 4812.

[77] Id.

[78] *Carrier Locator* at Fig. 1.

[79] See *Amendment of Parts 20 and 24 of the Commission's Rules—Broadband PCS Competitive Bidding and the Commercial Mobile Radio Service Spectrum Cap*, Report and Order, FCC 96–278, WT Docket No. 96–59, ¶¶ 57–60 (June 24, 1996), 61 FR 33859 (July 1, 1996); see also 47 CFR 24.720(b).

[80] Id., at ¶ 60.

[81] *Implementation of Section 309(j) of the Communications Act—Competitive Bidding*, PP Docket No. 93–253, Fifth Report and Order, 9 FCC Rcd 5532, 5581–84, 59 FR 63210 (December 7, 1994).

and very small business bidders won approximately 40% of the 1,479 licenses for Blocks D, E, and F. However, licenses for Blocks C through F have not been awarded fully, therefore there are few, if any, small businesses currently providing PCS services. Based on this information, we estimate that the number of small broadband PCS licenses will include the 90 winning C Block bidders and the 93 qualifying bidders in the D, E, and F blocks, for a total of 183 small PCS providers as defined by the SBA and the Commissioner's auction rules.

51. SMR Licensees. Pursuant to 47 CFR 90.814(b)(1), the Commission has defined ''small entity'' in auctions for geographic area 800 MHz and 900 MHz SMR licenses as a firm that had average annual gross revenues of less than $15 million in the three previous calendar years. The definition of a ''small entity'' in the context of 800 MHz SMR has been approved by the SBA,[82] and approval for the 900 MHz SMR definition has been sought. The rules proposed in this FRFA may apply to SMR providers in the 800 MHz and 900 MHz bands that either hold geographic area licenses or have obtained extended implementation authorizations. We do not know how many firms provide 800 MHz or 900 MHz geographic area SMR service pursuant to extended implementation authorizations, nor how many of these providers have annual revenues of less than $15 million. We assume, for purposes of this FRFA, that all of the extended implementation authorizations may be held by small entities, that may be affected by the decisions and rule changes adopted in this Order.

52. The Commission recently held auctions for geographic area licenses in the 900 MHz SMR band. There were 60 winning bidders who qualified as small entities in the 900 MHz auction. Based on this information, we conclude that the number of geographic area SMR licensees that may be affected by the decisions and rule changes adopted in this Order includes these 60 small entities. No auctions have been held for 800 MHz geographic area SMR licenses. Therefore, no small entities currently hold these licenses. A total of 525 licenses will be awarded for the upper 200 channels in the 800 MHz geographic area SMR auction. The Commission, however, has not yet determined how many licenses will be awarded for the lower 230 channels in the 800 MHz geographic area SMR auction. There is no basis, moreover, on which to estimate how many small entities will win these licenses. Given that nearly all radiotelephone companies have fewer than 1,000 employees and that no reliable estimate of the number of prospective 800 MHz licensees can be made, we assume, for purposes of this FRFA, that all of the licenses may be awarded to small entities who may be affected by the decisions and rule changes adopted in this Order.

53. 220 MHz Radio Service—Phase I Licensees. The 220 MHz service has both Phase I and Phase II licenses. There are approximately 1,515 such non-nationwide licensees and four nationwide licensees currently authorized to operate in the 220 MHz band. The Commission has not developed a definition of small entities specifically applicable to such incumbent 220 MHZ Phase I licensees. To estimate the number of such licensees that are small businesses, we apply the definition under the SBA rules applicable to Radiotelephone Communications companies.[83] According to the Bureau of the Census, only 12 radiotelephone firms out of a total of 1,178 such firms which operated during 1992 had 1,000 or more employees.[84] Therefore, if this general ratio continues to 1999 in the context of Phase I 220 MHz licensees, we estimate that nearly all such licensees are small businesses under the SBA's definition.

54. 220 MHz Radio Service—Phase II Licensees. The Phase II 220 MHz service is a new service, and is subject to spectrum auctions. The Commission has adopted criteria for defining small businesses and very small businesses for purposes of determining their eligibility for special provisions such as bidding credits and installment payments. We have defined a small business as an entity that, together with its affiliates and controlling principals, has average gross revenues not exceeding $15 million for the preceding three years. Additionally, a very small business is defined as an entity that, together with its affiliates and controlling principals, has average gross revenues that are not more than $3 million for the preceding three years. An auction of Phase II licenses commenced on September 15, 1998, and closed on October 22, 1998. 908 licenses were auctioned in 3 different-sized geographic areas: three nationwide licenses, 30 Regional Economic Area Group Licenses, and 875 Economic Area (EA) Licenses. Of the 908 licenses auctioned, 693 were sold. Companies claiming small business status won: one of the Nationwide licenses, 67% of the Regional licenses, and 54% of the EA licenses. As of January 22, 1999, the Commission announced that it was prepared to grant 654 of the Phase II licenses won at auction.

55. Paging. The Commission has proposed a two-tier definition of small businesses in the context of auctioning licenses in the Common Carrier Paging and exclusive Private Carrier Paging services.[85] Under the proposal, a small business will be defined as either (1) an entity that, together with its affiliates and controlling principals, has average gross revenues for the three preceding years of not more than $3 million, or (2) an entity that, together with affiliates and controlling principals, has average gross revenues for the three preceding calendar years of not more than $15 million. Because the SBA has not yet approved this definition for paging services, we will utilize the SBA's definition applicable to radiotelephone companies, i.e., an entity employing no more than 1,500 persons.[86] At present, there are approximately 24,000 Private Paging licenses and 74,000 Common Carrier Paging licenses. According to the most recent *Carrier Locator* data, 137 carriers reported that they were engaged in the provision of either paging or messaging services, which are placed together in the data.[87] We do not have data specifying the number of these carriers that are not independently owned and operated or have more than 1,500 employees, and thus are unable at this time to estimate with greater precision the number of paging carriers that would qualify as small business concerns under the SBA's definition. Consequently, we estimate that there are fewer than 137 small paging carriers that may be affected by the decisions

[82] See *Amendment of Parts 2 and 90 of the Commission's Rules to Provide for the Use of 200 Channels Outside the Designated Filing Areas in the 896–901 MHz and the 935–940 MHz Bands Allotted to the Specialized Mobile Radio Pool*, PR Docket No. 89–583, Second Order on Reconsideration and Seventh Report and Order, 11 FCC Rcd 2639, 2693–702, 60 FR 48913 (September 21, 1995); *Amendment of Part 90 of the Commission's Rules to Facilitate Future Development of SMR Systems in the 800 MHz Frequency Band*, PR Docket No. 93–144, First Report and Order, Eighth Report and Order, and Second Further Notice of Proposed Rulemaking, 11 FCC Rcd 1463, 61 FR 06212 (February 16, 1996).

[83] 13 CFR 121.201, SIC Code 4812. This definition provides that a small entity is a radiotelephone company employing no more than 1,500 persons.

[84] U.S. Bureau of the Census, U.S. Department of Commerce, 1992 Census of Transportation, Communications, and Utilities, UC92–S–1, Subject Series, Establishment and Firm Size, Table 5, Employment Size of Firms; 1992, SIC code 4812 (issued May 1995).

[85] See 47 CFR 20.9(a)(1) (noting that private paging services may be treated as common carriage services).

[86] 13 CFR 121.201, SIC Code 4812.

[87] *Carrier Locator* at Fig. 1.

and rule changes adopted in this Order. We estimate that the majority of private and common carrier paging providers would qualify as small entities under the SBA definition.

56. Narrowband PCS. The Commission has auctioned nationwide and regional licenses for narrowband PCS. There are 11 nationwide and 30 regional licensees for narrowband PCS. The Commission does not have sufficient information to determine whether any of these licensees are small businesses within the SBA-approved definition for radiotelephone companies. At present, there have been no auctions held for the major trading area (MTA) and basic trading area (BTA) narrowband PCS licenses. The Commission anticipates a total of 561 MTA licenses and 2,958 BTA licenses will be awarded by auction. Such auctions have not yet been scheduled, however. Given that nearly all radiotelephone companies have no more than 1,500 employees and that no reliable estimate of the number of prospective MTA and BTA narrowband licensees can be made, we assume, for purposes of this FRFA, that all of the licenses will be awarded to small entities, as that term is defined by the SBA.

57. Rural Radiotelephone Service. The Commission has not adopted a definition of small entity specific to the Rural Radiotelephone Service.[88] A significant subset of the Rural Radiotelephone Service is the Basic Exchange Telephone Radio Systems (BETRS).[89] We will use the SBA's definition applicable to radiotelephone companies, i.e., an entity employing no more than 1,500 persons.[90] There are approximately 1,000 licensees in the Rural Radiotelephone Service, and we estimate that almost all of them qualify as small entities under the SBA's definition.

58. Air-Ground Radiotelephone Service. The Commission has not adopted a definition of small entity specific to the Air-Ground Radiotelephone Service.[91] Accordingly, we will use the SBA's definition applicable to radiotelephone companies, i.e., an entity employing no more than 1,500 persons.[92] There are approximately 100 licensees in the Air-Ground Radiotelephone Service, and we estimate that almost all of them qualify as small entities under the SBA definition.

59. Private Land Mobile Radio (PLMR). PLMR systems serve an essential role in a range of industrial, business, land transportation, and public safety activities.[93] These radios are used by companies of all sizes operating in all U.S. business categories. The Commission has not developed a definition of small entity specifically applicable to PLMR licensees due to the vast array of PLMR users. For the purpose of determining whether a licensee is a small business as defined by the SBA, each licensee would need to be evaluated within its own business area.

60. The Commission is unable at this time to estimate the number of, if any, small businesses which could be impacted by the rules. However, the Commission's 1994 Annual Report on PLMRs [94] indicates that at the end of fiscal year 1994 there were 1,087,267 licensees operating 12,481,989 transmitters in the PLMR bands below 512 MHz. Because any entity engaged in a commercial activity is eligible to hold a PLMR license, the proposed rules in this context could potentially impact every small business in the United States.

61. Fixed Microwave Services. Microwave services include common carrier,[95] private-operational fixed,[96] and broadcast auxiliary radio services.[97] At present, there are approximately 22,015 common carrier fixed licensees in the microwave services. The Commission has not yet defined a small business with respect to microwave services. For purposes of this FRFA, we will utilize the SBA's definition applicable to radiotelephone companies—i.e., an entity with no more than 1,500 persons.[98] We estimate, for this purpose, that all of the Fixed Microwave licensees (excluding broadcast auxiliary licensees) would qualify as small entities under the SBA definition for radiotelephone companies.

62. Offshore Radiotelephone Service. This service operates on several UHF TV broadcast channels that are not used for TV broadcasting in the coastal area of the states bordering the Gulf of Mexico.[99] At present, there are approximately 55 licensees in this service. We are unable at this time to estimate the number of licensees that would qualify as small entities under the SBA's definition for radiotelephone communications.

63. Wireless Communications Services. This service can be used for fixed, mobile, radio location and digital audio broadcasting satellite uses. The Commission defined ''small business'' for the wireless communications services (WCS) auction as an entity with average gross revenues of $40 million for each of the three preceding years, and a ''very small business'' as an entity with average gross revenues of $15 million for each of the three preceding years. The Commission auctioned geographic area licenses in the WCS service. In the auction, there were seven winning bidders that qualified as very small business entities, and one that qualified as a small business entity. We conclude that the number of geographic area WCS licensees that may be affected by the decisions and rule changes adopted in this Order includes these eight entities.

IV. Description of Projected Reporting, Recordkeeping, and Other Compliance Requirements:

64. The decisions and rule changes adopted in this Order will reduce the reporting and recordkeeping requirements on telecommunications service providers regulated under the Communications Act. As currently structured, telecommunications carriers and other service providers having interstate revenues are required to file, at different times throughout the year, a number of contributor reporting worksheets that often reflect duplicative reporting requirements. In this Order, the Commission reduces these regulatory burdens by combining the multiple worksheets into one unified Telecommunications Reporting Worksheet. In addition, the Commission

[88] The service is defined in section 22.99 of the Commission's rules, 47 CFR 22.99.

[89] BETRS is defined in sections 22.757 and 22.759 of the Commission's rules, 47 CFR 22.757, 22.759.

[90] 13 CFR 121.201, SIC Code 4812.

[91] The service is defined in section 22.99 of the Commission's rules, 47 CFR 22.99.

[92] 13 CFR 121.201, SIC Code 4812.

[93] See 47 CFR 20.9(a)(2) (noting that certain Industrial/Business Pool service may be treated as common carriage service).

[94] Federal Communications Commission, 60th Annual Report, Fiscal Year 1994, at 116.

[95] 47 CFR 101 *et seq.* (formerly, Part 21 of the Commission's rules).

[96] Persons eligible under Parts 80 and 90 of the Commission's rules can use Private Operational-Fixed Microwave services. See 47 CFR Parts 80 and 90. Stations in this service are called operational-fixed to distinguish them from common carrier and public fixed stations. Only the licensee may use the operational-fixed station, and only for communications related to the licensee's commercial, industrial, or safety operations.

[97] Auxiliary Microwave Service is governed by Part 74 of Title 47 of the Commission's Rules. See 47 CFR 74 et seq. Available to licensees of broadcast stations and to broadcast and cable network entities, broadcast auxiliary microwave stations are used for relaying broadcast television signals from the studio to the transmitter, or between two points such as a main studio and an auxiliary studio. The service also includes mobile TV pickups, which relay signals from a remote location back to the studio.

[98] 13 CFR 121.201, SIC Code 4812.

[99] This service is governed by Subpart I of Part 22 of the Commission's Rules. See 47 CFR 22.1001–22.1037.

further reduces carrier filing burdens by allowing carriers to use the proposed Telecommunications Reporting Worksheet to designate agents for service of process pursuant to section 413 of the Communications Act of 1934, as amended.[100] We expect that, by adopting these proposals, telecommunications service providers will experience an appreciable reduction in reporting, recordkeeping, and other compliance burdens.

V. Steps Taken to Minimize Significant Economic Impact on Small Entities, and Significant Alternatives Considered:

65. In the *Contributor Reporting Requirements Notice*, 63 FR 54090 (October 8, 1998), the Commission sought comment on ways to simplify its contributor reporting requirements and, in particular, whether a unified worksheet would reduce regulatory and administrative burden on reporting carriers.[101] Commenters were nearly unanimous in their support of the Commission's proposals in the Notice. In response to numerous proposals to modify the data collected in the worksheet, the Commission developed the final Telecommunications Reporting Worksheet so that it will collect the minimum information necessary to ensure the equitable and efficient funding of the support and cost recovery mechanisms.[102] Accordingly, we conclude that the impact of this proceeding should be beneficial to small businesses because the decisions and rule changes adopted in this Order will reduce the reporting or recordkeeping requirements on all communications common carriers.

Report to Congress: The Commission will send a copy of the *Contributor Reporting Requirements Order*, including this FRFA, in a report to be sent to Congress pursuant to the Small Business Regulatory Enforcement Fairness Act of 1996.[103] In addition, the Commission will send a copy of the Order, including this FRFA, to the Chief Counsel for Advocacy of the Small Business Administration. A copy of the Order and FRFA (or summaries thereof) will also be published in the **Federal Register**.[104]

[100] 47 U.S.C. 413.

[101] See *Contributor Reporting Requirements Notice*, 13 FCC Rcd 19295, 19304, 63 FR 54090 (October 8, 1998).

[102] See Sections III. B. of the Order (discussing the use of a consolidated worksheet), and III.D.2.b. of the Order (discussing the September universal service filing).

[103] See 5 U.S.C. 801(a)(1)(A).

[104] See 5 U.S.C. 604(b).

List of Subjects

47 CFR Part 1

Communications common carriers, Reporting and recordkeeping requirements, Telecommunications, Telephone.

47 CFR Part 52

Communications common carriers, Numbering administration, Number portability, Reporting and recordkeeping requirements, Telecommunications, Telephone.

47 CFR Part 54

Communications common carriers, Reporting and recordkeeping requirements, Telecommunications, Telephone, Universal service.

Communications common carriers, Reporting and recordkeeping requirements, Telecommunications, Telephone, Universal service.

47 CFR Part 64

Communications common carriers, Reporting and recordkeeping requirements, Telecommunications, Telecommunications relay services, Telephone.

Federal Communications Commission.

Shirley S. Suggs,

Chief, Publications Branch.

Rule Changes

Parts 1, 52, 54, and 64 of the Code of Federal Regulations are amended as follows:

PART 1—PRACTICE AND PROCEDURE

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

Authority: 47 U.S.C. 151, 154(i), 154(j), 155, 225, and 303(r), 309.

2. Section 1.47(h) is revised to read as follows:

§ 1.47 Service of documents and proof of service.

* * * * *

(h) Every common carrier subject to the Communications Act of 1934, as amended, shall designate an agent in the District of Columbia, and may designate additional agents if it so chooses, upon whom service of all notices, process, orders, decisions, and requirements of the Commission may be made for and on behalf of said carrier in any proceeding before the Commission. Such designation shall include, for both the carrier and its designated agents, a name, business address, telephone or voicemail number, facsimile number, and, if available, Internet e-mail address. The carrier shall additionally list any other names by which it is known or under which it does business, and, if the carrier is an affiliated company, the parent, holding, or management company. Within thirty (30) days of the commencement of provision of service, each carrier shall file such information with the Formal Complaints and Investigations Branch of the Common Carrier Bureau. Carriers may file a hard copy of the relevant portion of the Telecommunications Reporting Worksheet, as delineated by the Commission in the **Federal Register**, to satisfy this requirement. Each Telecommunications Reporting Worksheet filed annually by a common carrier must contain a name, business address, telephone or voicemail number, facsimile number, and, if available, Internet e-mail address for its designated agents, regardless of whether such information has been revised since the previous filing. Carriers must notify the Commission within one week of any changes in their designation information by filing revised portions of the Telecommunications Reporting Worksheet with the Formal Complaints and Investigations Branch of the Common Carrier Bureau. A paper copy of this designation list shall be maintained in the Office of the Secretary of the Commission. Service of any notice, process, orders, decisions or requirements of the Commission may be made upon such carrier by leaving a copy thereof with such designated agent at his office or usual place of residence. If a carrier fails to designate such an agent, service of any notice or other process in any proceeding before the Commission, or of any order, decision, or requirement of the Commission, may be made by posting such notice, process, order, requirement, or decision in the Office of the Secretary of the Commission.

PART 52—NUMBERING

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

Authority: Sec. 1, 2 , 4, 5, 48 Stat. 1066, as amended; 47 U.S.C. 151, 152, 154, 155 unless otherwise noted. Interpret or apply secs. 3, 4, 201–205, 207–209, 218, 225–7, 251–2, 271 and 332, 48 Stat. 1070, as amended, 1077; 47 U.S.C. 153, 154, 201–205, 207–09, 218, 225–7, 251–2, 271 and 332 unless otherwise noted.

4. Section 52.16 is amended by revising paragraphs (b) and (c) to read as follows:

§ 52.16 Billing and Collection Agent.

* * * * *

(b) Distribute to carriers the ''Telecommunications Reporting Worksheet,'' described in § 52.17(b).

(c) Keep confidential all data obtained from carriers and not disclose such data in company-specific form unless authorized by the Commission. Subject to any restrictions imposed by the Chief of the Common Carrier Bureau, the B & C Agent may share data obtained from carriers with the administrators of the universal service support mechanism (See 47 CFR 54.701 of this chapter), the TRS Fund (See 47 CFR 64.604(c)(4)(iii)(H) of this chapter), and the local number portability cost recovery (See 47 CFR 52.32). The B & C Agent shall keep confidential all data obtained from other administrators. The B & C Agent shall use such data, from carriers or administrators, only for calculating, collecting and verifying payments. The Commission shall have access to all data reported to the Administrator. Contributors may make requests for Commission nondisclosure of company-specific revenue information under § 0.459 of this chapter by so indicating on the Telecommunications Reporting Worksheet at the time that the subject data are submitted. The Commission shall make all decisions regarding nondisclosure of company-specific information.

* * * * *

5. Section 52.17 is revised to read as follows:

§ 52.17 Costs of number administration.

All telecommunications carriers in the United States shall contribute on a competitively neutral basis to meet the costs of establishing numbering administration.

(a) Contributions to support numbering administration shall be the product of the contributors' end-user telecommunications revenues for the prior calendar year and a contribution factor determined annually by the Chief of the Common Carrier Bureau; such contributions to be no less than twenty-five dollars ($25). The contribution factor shall be based on the ratio of expected number administration expenses to end-user telecommunications revenues. Carriers that have no end-user telecommunications revenues shall contribute twenty-five dollars ($25). In the event that contributions exceed or are inadequate to cover administrative costs, the contribution factor for the following year shall be adjusted by an appropriate amount.

(b) All telecommunications carriers in the United States shall complete and submit a ''Telecommunications Reporting Worksheet'' (as published by the Commission in the **Federal Register**), which sets forth the information needed to calculate contributions referred to in paragraph (a) of this section. The worksheet shall be certified to by an officer of the contributor, and subject to verification by the Commission or the B & C Agent at the discretion of the Commission. The Chief of the Common Carrier Bureau may waive, reduce, modify, or eliminate contributor reporting requirements that prove unnecessary and require additional reporting requirements that the Bureau deems necessary to the sound and efficient administration of the number administration cost recovery.

6. Section 52.32 is amended by revising paragraphs (b) and (c) and by adding paragraph (d) to read as follows:

§ 52.32 Allocation of the shared costs of long-term number portability.

* * * * *

(b) All telecommunications carriers providing service in the United States shall complete and submit a ''Telecommunications Reporting Worksheet'' (as published by the Commission in the **Federal Register**), which sets forth the information needed to calculate contributions referred to in paragraph (a) of this section. The worksheet shall be certified to by an officer of the contributor, and subject to verification by the Commission or the administrator at the discretion of the Commission. The Chief of the Common Carrier Bureau may waive, reduce, modify, or eliminate contributor reporting requirements that prove unnecessary and require additional reporting requirements that the Bureau deems necessary to the sound and efficient administration of long-term number portability.

(c) Local number portability administrators shall keep all data obtained from contributors confidential and shall not disclose such data in company-specific form unless directed to do so by the Commission. Subject to any restrictions imposed by the Chief of the Common Carrier Bureau, the local number portability administrators may share data obtained from carriers with the administrators of the universal service support mechanism (See 47 CFR 54.701 of this chapter), the TRS Fund (See 47 CFR 64.604(c)(4)(iii)(H) of this chapter), and the North American Numbering Plan cost recovery (See 47 CFR 52.16). The local number portability administrators shall keep confidential all data obtained from other administrators. The administrators shall use such data, from carriers or administrators, only for purposes of administering local number portability. The Commission shall have access to all data reported to the Administrator. Contributors may make requests for Commission nondisclosure of company-specific revenue information under § 0.459 of this chapter by so indicating on the Telecommunications Reporting Worksheet at the time that the subject data are submitted. The Commission shall make all decisions regarding nondisclosure of company-specific information.

(d) Once a telecommunications carrier has been allocated, pursuant to paragraph (a)(1) or (a)(2) of this section, its portion of the shared costs of long-term number portability attributable to a regional database, the carrier shall treat that portion as a carrier-specific cost directly related to providing number portability.

PART 54—UNIVERSAL SERVICE

7. The authority citation for part 54 continues to read as follows:

Authority: 47 U.S.C. 1, 4(i), 201, 205, 214, and 254 unless otherwise noted.

8. Section 54.708 is revised to read as follows:

§ 54.708 De minimis exemption.

If a contributor's contribution to universal service in any given year is less than $10,000 that contributor will not be required to submit a contribution or Telecommunications Reporting Worksheet for that year unless it is required to do so to by our rules governing Telecommunications Relay Service (47 CFR 64.601 *et seq.* of this chapter), numbering administration (47 CFR 52.1 *et seq.* of this chapter), or shared costs of local number portability (47 CFR 52.21 *et seq.* of this chapter). If a contributor improperly claims exemption from the contribution requirement, it will subject to the criminal provisions of sections 220(d) and (e) of the Act regarding willful false submissions and will be required to pay the amounts withheld plus interest.

9. Section 54.709 is amended by revising paragraphs (a) introductory text, (a)(2), and (d) to read as follows:

§ 54.709 Computations of required contributions to universal service support mechanisms.

(a) Contributions to the universal service support mechanisms shall be based on contributors' end-user telecommunications revenues and contribution factors determined quarterly by the Commission.

* * * * *

(2) The quarterly universal service contribution factors shall be based on the ratio of total projected quarterly expenses of the universal service support programs to total end-user telecommunications revenues. The Commission shall determine two contribution factors, one of which shall be applied to interstate and international end-user telecommunications revenues and the other of which shall be applied to interstate, intrastate, and international end-user telecommunications revenues. The Commission shall approve the Administrator's quarterly projected costs of universal service support programs, taking into account demand for support and administrative expenses. The total subject revenues shall be compiled by the Administrator based on information contained in the Telecommunications Reporting Worksheets described in § 54.711(a).

* * * * *

(d) If a contributor fails to file a Telecommunications Reporting Worksheet by the date on which it is due, the Administrator shall bill that contributor based on whatever relevant data the Administrator has available, including, but not limited to, the number of lines presubscribed to the contributor and data from previous years, taking into consideration any estimated changes in such data.

10. Section 54.711 is revised to read as follows:

§ 54.711 Contributor reporting requirements.

(a) Contributions shall be calculated and filed in accordance with the Telecommunications Reporting Worksheet which shall be published in the **Federal Register**. The Telecommunications Reporting Worksheet sets forth information that the contributor must submit to the Administrator on a semi-annual basis. The Commission shall announce by Public Notice published in the **Federal Register** and on its website the manner of payment and dates by which payments must be made. An officer of the contributor must certify to the truth and accuracy of the Telecommunications Reporting Worksheet, and the Commission or the Administrator may verify any information contained in the Telecommunications Reporting Worksheet at the discretion of the Commission. Inaccurate or untruthful information contained in the Telecommunications Reporting Worksheet may lead to prosecution under the criminal provisions of Title 18 of the United States Code. The Administrator shall advise the Commission of any enforcement issues that arise and provide any suggested response.

(b) The Commission shall have access to all data reported to the Administrator. Contributors may make requests for Commission nondisclosure of company-specific revenue information under § 0.459 of this chapter by so indicating on the Telecommunications Reporting Worksheet at the time that the subject data are submitted. The Commission shall make all decisions regarding nondisclosure of company-specific information. The Administrator shall keep confidential all data obtained from contributors, shall not use such data except for purposes of administering the universal service support programs, and shall not disclose such data in company-specific form unless directed to do so by the Commission. Subject to any restrictions imposed by the Chief of the Common Carrier Bureau, the Universal Service Administrator may share data obtained from contributors with the administrators of the North American Numbering Plan administration cost recovery (See 47 CFR 52.16 of this chapter), the local number portability cost recovery (See 47 CFR 52.32 of this chapter), and the TRS Fund (See 47 CFR 64.604(c)(4)(iii)(H) of this chapter). The Administrator shall keep confidential all data obtained from other administrators and shall not use such data except for purposes of administering the universal service support mechanisms.

(c) The Bureau may waive, reduce, modify, or eliminate contributor reporting requirements that prove unnecessary and require additional reporting requirements that the Bureau deems necessary to the sound and efficient administration of the universal service support mechanisms.

11. Section 54.713 is revised to read as follows:

§ 54.713 Contributors' failure to report or to contribute.

A contributor that fails to file a Telecommunications Reporting Worksheet and subsequently is billed by the Administrator shall pay the amount for which it is billed. The Administrator may bill a contributor a separate assessment for reasonable costs incurred because of that contributor's filing of an untruthful or inaccurate Telecommunications Reporting Worksheet, failure to file the Telecommunications Reporting Worksheet, or late payment of contributions. Failure to file the Telecommunications Reporting Worksheet or to submit required quarterly contributions may subject the contributor to the enforcement provisions of the Act and any other applicable law. The Administrator shall advise the Commission of any enforcement issues that arise and provide any suggested response. Once a contributor complies with the Telecommunications Reporting Worksheet filing requirements, the Administrator may refund any overpayments made by the contributor, less any fees, interest, or costs.

PART 64—MISCELLANEOUS RULES RELATING TO COMMON CARRIERS

12. The authority citation for part 64 continues to read as follows:

Authority: 47 U.S.C. 10, 201, 218, 226, 228, 332, unless otherwise noted.

13. Section 64.604 is amended by revising paragraphs (c)(4)(iii)(A), (B), and (I) to read as follows:

§ 64.604 Mandatory minimum standards.

* * * * *

(c) * * *

(4) * * *

(iii) * * *

(A) *Contributions.* Every carrier providing interstate telecommunications services shall contribute to the TRS Fund on the basis of its relative share of interstate end-user telecommunications revenues as described herein. Contributions shall be made by all carriers who provide interstate services, including, but not limited to, cellular telephone and paging, mobile radio, operator services, personal communications service (PCS), access (including subscriber line charges), alternative access and special access, packet-switched, WATS, 800, 900, message telephone service (MTS), private line, telex, telegraph, video, satellite, intraLATA, international and resale services.

(B) *Contribution computations.* Contributors' contribution to the TRS Fund shall be the product of their subject revenues for the prior calendar year and a contribution factor determined annually by the Commission. The contribution factor shall be based on the ratio between expected TRS Fund expenses to interstate end-user telecommunications revenues. In the event that contributions exceed TRS payments and administrative costs, the contribution factor for the following year will be adjusted by an appropriate amount, taking into consideration projected cost and usage changes. In the event that contributions are inadequate, the fund administrator may request authority from the Commission to borrow funds

commercially, with such debt secured by future years contributions. Each subject carrier must contribute at least $25 per year. Carriers whose annual contributions total less than $1,200 must pay the entire contribution at the beginning of the contribution period. Carriers whose contributions total $1,200 or more may divide their contributions into equal monthly payments. Carriers shall complete and submit, and contributions shall be based on, a ''Telecommunications Reporting Worksheet'' (as published by the Commission in the **Federal Register**). The worksheet shall be certified to by an officer of the contributor, and subject to verification by the Commission or the administrator at the discretion of the Commission. Contributors' statements in the worksheet shall be subject to the provisions of section 220 of the Communications Act of 1934, as amended. The fund administrator may bill contributors a separate assessment for reasonable administrative expenses and interest resulting from improper filing or overdue contributions. The Chief of the Common Carrier Bureau may waive, reduce, modify, or eliminate contributor reporting requirements that prove unnecessary and require additional reporting requirements that the Bureau deems necessary to the sound and efficient administration of the TRS Fund.

* * * * *

(I) *Information filed with the administrator.* The administrator shall keep all data obtained from contributors and TRS providers confidential and shall not disclose such data in company-specific form unless directed to do so by the Commission. Subject to any restrictions imposed by the Chief of the Common Carrier Bureau, the TRS Fund administrator may share data obtained from carriers with the administrators of the universal service support mechanisms (See 47 CFR 54.701 of this chapter), the North American Numbering Plan administration cost recovery (See 47 CFR 52.16 of this chapter), and the long-term local number portability cost recovery (See 47 CFR 52.32 of this chapter). The TRS Fund Administrator shall keep confidential all data obtained from other administrators. The administrator shall not use such data, from carriers or administrators, except for purposes of administering the TRS Fund, calculating the regulatory fees of interstate common carriers, and aggregating such fee payments for submission to the Commission. The Commission shall have access to all data reported to the administrator, and authority to audit TRS providers. Contributors may make requests for Commission nondisclosure of company-specific revenue information under § 0.459 of this chapter by so indicating on the Telecommunications Reporting Worksheet at the time that the subject data are submitted. The Commission shall make all decisions regarding nondisclosure of company-specific information.

* * * * *

[FR Doc. 99–19686 Filed 7–29–99; 8:45 am]

BILLING CODE 6712–01–P

Proposed Rules

Federal Register
Vol. 64, No. 146
Friday, July 30, 1999

This section of the FEDERAL REGISTER contains notices to the public of the proposed issuance of rules and regulations. The purpose of these notices is to give interested persons an opportunity to participate in the rule making prior to the adoption of the final rules.

OFFICE OF PERSONNEL MANAGEMENT

5 CFR Part 317

RIN 3206–AI75

Employment in the Senior Executive Service

AGENCY: Office of Personnel Management.

ACTION: Proposed rule with request for comments.

SUMMARY: The Office of Personnel Management (OPM) is proposing to amend its regulations governing career and limited appointments to the Senior Executive Service (SES) and Qualifications Review Board (QRB) certification. The proposed regulations emphasize the importance of executive leadership qualifications in agency SES selection criteria; strengthen merit principles; increase SES staffing flexibilities to help agencies recruit the brightest and most diverse executive cadre possible; and provide for delegating QRB administration to agencies via individual delegation agreements. In addition, there will be procedural modifications to streamline the SES application process, reduce paperwork requirements, and improve the QRB certification process.

DATES: Comments on the proposed regulations must be received on or before September 28, 1999.

ADDRESS: Send or deliver written comments to Ms. Joyce Edwards, Director, Office of Executive Resources Management, Room 6484, 1900 E Street NW., Washington, DC 20415.

FOR FURTHER INFORMATION CONTACT: Marcia K. Staten at 202–606–1832, FAX 202–606–2126, or email to mkstaten@opm.gov.

SUPPLEMENTARY INFORMATION: The success of the Senior Executive Service (SES) rests in the ability of agencies to employ highly competent, motivated, and diverse professionals dedicated to public service with the requisite leadership expertise to meet the challenges facing the Government and the Nation into the next century.

In April 1998, OPM widely circulated a ''Draft Framework for Improving the Senior Executive Service'' to focus attention on the importance of executive leadership and to stimulate discussion about the SES. OPM wanted stakeholders to think about whether the way the senior executive cadre is selected, developed, and managed today will produce the kind of executives equipped to meet the leadership challenges of the 21st century. The Framework was an outline of ideas in four broad areas: SES structure, staffing flexibility, performance management and accountability, and development and continuing learning.

From April through November, OPM held briefings and discussions with nearly 40 different groups of stakeholders, including senior executives and candidates, the human resources community, public administration organizations, and professional associations. OPM also received over 50 written comments from departments and agencies, individual executives and other interested persons, and various organizations. Although stakeholder views varied widely, there was consensus on many ideas, including increasing agency flexibility for SES staffing. Specifically, there was general support for improving the SES selection process to ensure that leadership and executive qualifications are the major selection criteria, reducing the paperwork burden on applicants and agencies, considering options for delegating QRB administration, and increasing agency authority to make limited term appointments.

OPM formed a work group of agency human resources professionals, who administer executive resources programs, to help identify solutions to the staffing issues raised by the Framework initiative. OPM also sought the views of senior executives who have served as members of QRBs. Some solutions will require changes to OPM regulations, while others may be accomplished administratively through procedural or process changes. These regulatory proposals are the result of the comments and suggestions from the senior executives and the work group. The proposed regulations require agency selection criteria to address executive leadership expertise, provide for delegating QRB administration on an agency-by-agency basis via written delegation agreements, clarify current restrictions on converting noncareer appointees in their current or successor positions, increase agency focus on performance during the probationary period, and expand the pool of limited appointment authorities currently delegated to agencies.

In addition to the improvements achieved through regulatory change, OPM will make modifications to internal procedures and other requirements to streamline the SES application process, reduce paperwork requirements, and improve the QRB certification process. These modifications will include alternative methods for documenting executive qualifications for presentation to QRBs, improved guidance and instructions to QRBs to ensure that members fully understand their role and responsibilities, and more specific and detailed feedback to agencies on QRB disapprovals.

These flexibilities were designed to facilitate agency efforts to hire a diverse and talented cadre of senior executives.

Emphasis on Executive Leadership

The law at 5 U.S.C. 3393 requires agency Executive Resources Boards to conduct the merit staffing process for career entry into the SES, including reviewing the executive qualifications of each career SES candidate. During the discussions of the Framework on improving the SES, it was confirmed that, in many agencies, the selection criteria focus primarily on candidates' professional or technical qualifications, and therefore consideration of executive qualifications is not getting the full attention intended by the legislation. The key characteristics of an SES position are the executive leadership responsibilities, and therefore selection criteria should focus primarily on these qualifications. In order to strengthen that focus and encourage agencies to fully integrate consideration of executive leadership qualifications into their selection processes, the proposed regulations incorporate the statutory requirements. Agency latitude to design the merit staffing process, including how to consider executive qualifications in the merit staffing process, is unchanged.

In addition to the regulatory change, OPM is modifying procedural

requirements for documenting executive qualifications for presentation to QRBs to provide alternative methods and options for agency use. These changes are intended to give agencies additional flexibility, reduce the paperwork burden on applicants, and improve the QRB certification process.

Delegating QRB Administration

The law at 5 U.S.C. 3393 requires OPM to establish QRBs to certify the executive qualifications of candidates for initial career appointment to the SES. In enacting this provision, Congress indicated that this would provide an independent peer review, which would ensure that appointments to the SES are based primarily on executive qualifications, rather than on technical or professional qualifications. While OPM's broad statutory authority at 5 U.S.C. 1104 includes the authority to delegate QRB administration to agencies, OPM has traditionally held that OPM-convened QRBs assured that the focus of the certification is on the executive qualifications and safeguarded Congressional intent. However, as we have moved in recent years toward increasing agencies' flexibility to manage their executive resources, OPM has agreed to consider delegating QRB administration to agencies, on an agency-by-agency basis via individual delegation agreements; provided that the focus on leadership and executive expertise is maintained and merit system principles are preserved. The proposed regulation authorizes delegated agreements, under specific conditions. The agreements will be designed to ensure an independent peer review, set the scope of the delegation, address agency QRB operations, prescribe reporting requirements, and provide for OPM oversight.

In addition to this regulatory change, OPM is modifying procedures and paperwork associated with QRB administration to address concerns that the process focuses on paper over substance and to provide more specific and detailed feedback to agencies on QRB disapprovals.

Noncareer Conversion Restriction

The current regulation at 5 CFR 317.502(e) precludes QRB certification of a noncareer SES employee for career appointment in the employee's current position or a successor to that position, because there is no bona-fide vacancy for which to hold competition. This regulation was intended to preserve the merit principle of fair and open competition in merit selections. Since the regulation was promulgated, however, questions have arisen about the definition of ''noncareer SES employee.'' The proposed regulation strengthens and clarifies the intent of the current regulation by expanding coverage to noncareer-type employees, including noncareer SES appointees and Schedule C appointees, or the equivalent.

SES Probationary Period

Performance Assessment

The SES statute (Pub. L. 95–454) establishes a 1-year probationary period for new career SES appointees. It requires that an individual's initial appointment as a career SES appointee could not become final until that individual completes one year of service as a career appointee (5 U.S.C. 3393(d)). OPM has long held that the probationary period is an extension of the examining process to be used to determine an individual's ability to actually perform as an executive. The law also includes provisions to facilitate removal of appointees during probation for unacceptable performance or conduct (5 U.S.C. 3592).

During the Framework discussions, stakeholders expressed concern about the lack of attention that agencies have given to SES probation and explored options for making more effective use of the probationary period as the vehicle for assessing whether or not the new appointees are performing as executives. The proposed regulation requires agencies to assess the performance of career appointees before the end of the probationary period and make an official determination that the appointee is performing at the level of excellence expected of a senior executive.

Training and Development.

By law (5 U.S.C. 3393(c)(2)), OPM prescribes criteria for establishing executive qualifications for career appointment, but these criteria must provide for consideration of demonstrated executive experience, successful participation in an OPM-approved candidate development program, and possession of special or unique qualities that indicate a likelihood of executive success. In support of candidates with special or unique qualities, OPM requires a detailed development plan for obtaining the full complement of executive qualifications. Stakeholders indicated that stronger oversight is needed in cases where the QRB certifies candidates on the basis of special and unique qualifications to verify that the executive development activities promised by the agency are accomplished. The proposed regulation requires agencies to address the executive development activities outlined in the development plans during the appointee's probationary period.

Pool of Limited Appointment Authorities

Under 5 CFR 317.601, agencies currently have been provided a pool of limited appointment authorities equal to 2 percent of their total SES space allocation that they may use without prior OPM approval. Use of these pool authorities is restricted to appointments of individuals with career or career-type appointments outside the SES. Agencies have found this flexibility very helpful. Many have made full use of the delegated pool of authorities and have expressed a need for increased authorities. The proposed regulation increases the delegated pool of limited authorities from 2 percent to 3 percent.

In exercising these authorities, agencies must continue to comply with all other statutory and regulatory provisions affecting limited appointments, e.g., that an appointment be made only to a general position; that the appointee must meet the qualifications required for the position; and that the appointment is to a non-continuing, project-type position. OPM will continue to monitor use of this appointment to ensure compliance with the statutory 5 percent limit on SES limited appointments Governmentwide and that appointments are being made in accordance with statutory and regulatory provisions.

Regulatory Flexibility Act

I certify that these regulations will not have a significant economic impact on a substantial number of small entities because the regulations pertain only to Federal employees and agencies.

List of Subjects in 5 CFR Part 317

Government employees.

Office of Personnel Management.

Janice R. Lachance,

Director.

Accordingly, OPM proposes to amend 5 CFR part 317 as follows:

PART 317—EMPLOYMENT IN THE SENIOR EXECUTIVE SERVICE

1. The authority citation for part 317 continues to read as follows:

Authority: 5 U.S.C. 3392, 3393, 3393a, 3395, 3397, 3593 and 3596.

Subpart E—Career Appointments

2. Amend § 317.501 by revising the first sentence of paragraph (c)(2) and paragraph (c)(6), to read as follows:

§ 317.501 Recruitment and selection for initial SES career appointment.

* * * * *

(c) * * *

(2) Provide that the ERB consider the executive and technical qualifications of each candidate, other than those found ineligible because they do not meet the requirements of the vacancy announcement. * * *

* * * * *

(6) Provide that the appointing authority select from among the candidates identified as best qualified by the ERB and certify the candidate's executive and technical qualifications.

* * * * *

3. Section 317.502 is revised to read as follows:

§ 317.502 Qualifications Review Board certification.

(a) This section covers Qualifications Review Boards convened by:

(1) The Office of Personnel Management (OPM); or

(2) An agency, under a written delegation agreement with OPM.

(b) General Provisions:

(1) A Qualifications Review Board (QRB) must certify the executive/managerial qualifications of a candidate before initial career appointment may be made to an SES position. More than one-half of the members of a QRB must be SES career appointees.

(2) Requests for certification of a candidate by a QRB must contain such information as prescribed by OPM, including evidence that merit staffing procedures were followed and that the appointing authority certified the candidate's executive and technical qualifications for the position.

(3) Qualifications Review Board certification of executive qualifications must be based on demonstrated executive experience; successful completion of an OPM-approved candidate development program; or possession of special or unique qualities that indicate a likelihood of executive success. Any existing time limit on a previously approved certification is removed.

(4) OPM may determine the disposition of requests for QRB certification if the QRB has not yet acted when:

(i) The agency head leaves office or announces an intention to leave office;

(ii) The President has nominated a new agency head; or

(iii) There is a Presidential transition.

(5) An action to convert a ''noncareer-type'' employee to a career SES appointment in the employee's current position or a successor to that position will not be forwarded to a QRB. A ''noncareer-type'' employee includes a noncareer SES appointee, a Schedule C appointee, or equivalent.

(6) A new QRB certification is required for an individual to be reappointed as an SES career appointee following separation of the individual from an SES career appointment if:

(i) The individaul was removed during the SES probationary period for performance or disciplinary reasons; or

(ii) The individual completed an SES probationary period, or did not have to serve one, and was removed for a reason that made the individual ineligible for reinstatement to the SES under subpart G of this part.

(c) Agencies may request the authority to convene Qualifications Review Boards. OPM may delegate such authority via written delegation agreement on an individual agency-by-agency basis. The delegation agreement will:

(1) Delegate the authority to the head of the agency;

(2) Provide for QRB operations that result in certification of candidates on the basis of executive qualifications and in the preservation of merit principles.

(3) Address the composition of the Boards to ensure an independent peer review.

(4) Prescribe documentation, reporting, and record retention requirements.

(5) Provide for OPM oversight.

4. Amend § 317.503 by revising paragraph (a); redesignating paragraphs (b) through (f) as paragraphs (c) through (g), respectively; adding a new paragraph (b); and revising the last sentence in newly redesignated paragraph (f) to read as follows:

§ 317.503 Probationary period.

(a) An individual's initial appointment as an SES career appointee becomes final only after the individual has served a 1-year probationary period as a career appointee; there has been an assessment of the appointee's performance during the probationary period; and the appointing authority has certified that the appointee performed at the level of excellence expected of a senior executive during the probationary period.

(b) When a career appointee's executive qualifications have been certified by a Qualifications Review Board on the basis of special or unique qualities, as described in § 317.502(b)(3), the probationary assessment must address any executive development activities the agency identified in support of the request for QRB certification.

* * * * *

(f) * * * The individual, however, need not be recertified by a QRB unless the individual was removed for performance or disciplinary reasons.

* * * * *

5. In subpart F, the heading for the subpart is revised to read as follows:

Subpart F—Noncareer and Limited Appointments

6. Amend § 317.601, paragraph (c)(1), by revising the first sentence to read as follows:

§ 317.601 Authorization.

* * * * *

(c) * * *

(1) Agencies are provided a pool of limited appointment authorities equal to 3 percent of their Senior Executive Service (SES) position allocation, or one authority, whichever is greater. * * *

[FR Doc. 99–19487 Filed 7–29–99; 8:45 am]

BILLING CODE 6325–01–P

DEPARTMENT OF AGRICULTURE

Federal Crop Insurance Corporation

7 CFR Part 457

Common Crop Insurance Regulations; Potato Crop Insurance Certified Seed Endorsement

AGENCY: Federal Crop Insurance Corporation.

ACTION: Proposed rule.

SUMMARY: The Federal Crop Insurance Corporation (FCIC) hereby proposes to amend the Potato Crop Insurance Certified Seed Endorsement. The intended effect of this action is to improve the insurance coverage to better meet the needs of the insured.

DATES: Written comments and opinions on this proposed rule will be accepted until close of business September 28, 1999 and will be considered when the rule is to be made final.

ADDRESSES: Interested persons are invited to submit written comments to the Director, Product Development Division, Federal Crop Insurance Corporation, United States Department of Agriculture, 9435 Holmes Road, Kansas City, MO 64131. Comments may also be sent via the Internet to DIRECTORPDD@RM.FCIC.USDA.GOV. A copy of each response will be

available for public inspection and copying from 7:00 a.m. to 4:30 p.m., CST, Monday through Friday, except holidays, at the above address.

FOR FURTHER INFORMATION CONTACT: For further information, contact Rob Coultis, Insurance Management Specialist, Research and Development, Product Development Division, Federal Crop Insurance Corporation, at the Kansas City, MO address listed above, telephone (816) 926–7730.

SUPPLEMENTARY INFORMATION:

Executive Order 12866

The Office of Management and Budget (OMB) has determined this rule to be exempt for the purposes of Executive Order No. 12866 and, therefore, has not been reviewed by OMB.

Paperwork Reduction Act of 1995

Under the provisions of the Paperwork Reduction Act of 1995 (44 U.S.C. chapter 35), the collections of information for this rule have been previously approved by the Office of Management and Budget (OMB) under control number 0563–0053 through April 30, 2001. The amendments set forth in this rule do not revise the content or alter the frequency of reporting for any of the forms or information collections cleared under the above-referenced docket.

Unfunded Mandates Reform Act of 1995

Title II of the Unfunded Mandates Reform Act of 1995 (UMRA), establishes requirements for Federal agencies to assess the effects of their regulatory actions on State, local, and tribal governments and the private sector. This rule contains no Federal mandates (under the regulatory provisions of title II of the UMRA) for State, local, and tribal governments or the private sector. Therefore, this rule is not subject to the requirements of sections 202 and 205 of the UMRA.

Executive Order 12612

It has been determined under section 6(a) of Executive Order 12612, Federalism, that this rule does not have sufficient federalism implication to warrant the preparation of a Federalism Assessment. The provisions contained in this rule will not have a substantial direct effect on States or their political subdivisions, or on the distribution of power and responsibilities among the various levels of government.

Regulatory Flexibility Act

This regulation will not have a significant impact on a substantial number of small entities. New provisions included in this rule will not impact small entities to a greater extent than large entities. The amount of work required of the insurance companies delivering and servicing these policies will not increase significantly from the amount of work currently required. Therefore, this action is determined to be exempt from the provisions of the Regulatory Flexibility Act (5 U.S.C. 605) and no Regulatory Flexibility Analysis was prepared.

Federal Assistance Program

This program is listed in the Catalog of Federal Domestic Assistance under No. 10.450.

Executive Order 12372

This program is not subject to the provisions of Executive Order 12372 which requires intergovernmental consultation with State and local officials. See the Notice related to 7 CFR part 3015, subpart V, published at 48 FR 29115, June 24, 1983.

Executive Order 12988

This rule has been reviewed in accordance with Executive Order 12988 on civil justice reform. The provisions of this rule will not have a retroactive effect. The provisions of this rule will preempt State and local laws to the extent such State and local laws are inconsistent herewith. The administrative appeal provisions published at 7 CFR part 11 must be exhausted before any action against FCIC for judicial review may be brought.

Environmental Evaluation

This action is not expected to have a significant impact on the quality of the human environment, health, and safety. Therefore, neither an Environmental Assessment nor an Environmental Impact Statement is needed.

Background

FCIC proposes to amend the Common Crop Insurance Regulations (7 CFR part 457) by revising 7 CFR 457.145, Potato Crop Insurance Certified Seed Endorsement, effective for the 2000 and succeeding crop years. The principal changes to the provisions for insuring seed potatoes are as follows:

1. Paragraph 5—Clarify to indicate that the certified seed production guarantee per acre is the same as the per acre production guarantee used under the terms of the Northern Potato Crop Provisions. (Reductions for acreage increases above certain levels remain in place.)

2. Paragraph 8—Revise the claim computation so that an indemnity can be paid when seed production meets the standards of the state in which it is grown, but the actual amount of production is lower than the production guarantee. Current provisions provide a payment only when production fails to meet applicable state standards for certified seed potatoes and do not take into account the actual amount of production from the insured acreage.

3. Paragraph 9—Revise to include the notice requirements when production fails certification.

4. A new paragraph 10 is added to specify that acreage covered under the revised endorsement will be insured using the same unit structure as is in place for the coverage provided under the Basic Provisions and the Northern Potato Crop Provisions. In the event certified seed acreage is not grown in the same optional or basic units as acreage covered under the Basic Provisions and the Northern Potato Crop Provisions, certified seed units will be established in accordance with the unit division provisions contained in the Basic Provisions and the Northern Potato Crop Provisions. Examples are provided for clarity.

5. A new paragraph 11 is added and includes provisions regarding uninsured causes of loss that are currently contained in section 8.

List of Subjects in 7 CFR Part 457

Crop insurance, Certified seed potatoes.

Proposed Rule

Accordingly, as set forth in the preamble, the Federal Crop Insurance Corporation proposes to amend 7 CFR part 457 as follows:

PART 457—COMMON CROP INSURANCE REGULATIONS

1. The authority citation for 7 CFR part 457 continues to read as follows:

Authority: 7 U.S.C. 1506(l) and 1506(p).

2. Amend § 457.145 as follows:

a. Revise the introductory text and paragraph 5.

b. Revise paragraph 8.

c. Revise paragraph 9.

d. Add a new paragraph 10.

e. Add a new paragraph 11.

g. The revisions and additions to § 457.145 read as follows:

§ 457.145 Potato crop insurance Certified Seed Endorsement.

The potato Certified Seed Endorsement provisions for the 2000 and succeeding crop years are as follows:

* * * * *

5. Your certified seed production guarantee per-acre will be the per-acre

production guarantee used to cover the same acreage under the terms of the Northern Potato Crop Provisions. However, unless a written agreement provides otherwise, if the total amount of insurable certified seed acreage you have for the current crop year is greater than 125 percent of your average number of acres entered into and passing certification in the potato certified seed program in the three previous calendar years, your certified seed production guarantee for each unit will be reduced as follows:

* * * * *

8. If, due to insurable causes occurring within the insurance period, the amount of certified seed you produce is less than your certified seed production guarantee, we will settle your claim by:

(a) Multiplying the insured acreage by its respective certified seed production guarantee;

(b) Multiplying each result in section 9(a) by the dollar amount per hundredweight contained in the Special Provisions for production covered under this endorsement;

(c) Totaling the results of section 9(b);

(d) Multiplying the number of hundredweight of production that qualify as certified seed and any amount of production lost due to uninsured causes, or that does not qualify as certified seed due to uninsured causes, by the dollar amount per hundredweight contained in the Special Provisions for production covered under this endorsement;

(e) Subtracting the result of section 9(d) from the result of section 9(c); and

(f) Multiplying the result of section 9(e) by your share.

9. You must notify us of any loss under this endorsement not later than 14 days after you receive notice from the state certification agency that any acreage or production has failed certification.

10. Acreage covered under the terms of this endorsement will have the same unit structure as provided under the Basic Provisions and the Northern Potato Crop Provisions. For example, if you have two optional units (00101 and 00102) for Northern Potato Crop coverage and you elect this endorsement, you will also have two optional units (00201 and 00202) for certified seed coverage provided that certified seed is grown in both units 00101 and 00102. Or, if you have two basic units (0100 and 0200) for Northern Potato Crop coverage and you elect this endorsement, you will also have two basic units (00300 and 00400) for certified seed coverage provided that certified seed is grown in both units 00100 and 00200. In the event certified seed acreage is not grown in the same optional or basic units as acreage covered under the Basic Provisions and the Northern Potato Crop Provisions, certified seed units will be established in accordance with the unit division provisions contained in the Basic Provisions and the Northern Potato Crop Provisions. For example, if a basic unit is divided into two optional units for potato acreage covered under the Basic Provisions and the Northern Potato Crop Provisions, but certified seed is grown in only one of those optional units, the certified seed acreage will be insured as one basic unit.

11. Any production that does not qualify as certified seed because of varietal mixing or your failure to follow the standard practices and procedures required for certification will be considered as lost due to uninsured causes.

Signed in Washington, DC, on July 26, 1999.

Kenneth D. Ackerman,

Manager, Federal Crop Insurance Corporation.

[FR Doc. 99–19562 Filed 7–29–99; 8:45 am]

BILLING CODE 3410–08–P

NUCLEAR REGULATORY COMMISSION

10 CFR Part 70

RIN 3150–AF22

Domestic Licensing of Special Nuclear Material; Possession of a Critical Mass of Special Nuclear Material

AGENCY: Nuclear Regulatory Commission.

ACTION: Proposed rule.

SUMMARY: The U.S. Nuclear Regulatory Commission (NRC) is proposing to amend its regulations governing the domestic licensing of special nuclear material (SNM) for licensees authorized to possess a critical mass of SNM, that are engaged in one of the following activities: enriched uranium processing; fabrication of uranium fuel or fuel assemblies; uranium enrichment; enriched uranium hexafluoride conversion; plutonium processing; fabrication of mixed-oxide fuel or fuel assemblies; scrap recovery of special nuclear material; or any other activity involving a critical mass of SNM that the Commission determines could significantly affect public health and safety or the environment. The proposed amendments would identify appropriate consequence criteria and the level of protection needed to prevent or mitigate accidents that exceed these criteria; require affected licensees to perform an integrated safety analysis (ISA) to identify potential accidents at the facility and the items relied on for safety necessary to prevent these potential accidents and/or mitigate their consequences; require the implementation of measures to ensure that the items relied on for safety are available and reliable to perform their function when needed; require the inclusion of the safety bases, including a summary of the ISA, with the license application; and allow for licensees to make certain changes to their safety program and facilities without prior NRC approval.

DATES: The comment period expires October 13, 1999. Comments received after this date will be considered if it is practical to do so, but, the Commission is able to ensure consideration only for comments received on or before this date.

ADDRESSES: Submit comments to: Secretary of the Commission, U.S. Nuclear Regulatory Commission, Washington, DC, 20555–0001, Attention: Rulemakings and Adjudications Staff.

Deliver comments to: 11555 Rockville Pike, Rockville, Maryland, between 7:30 a.m. and 4:15 p.m. on Federal workdays.

You may also provide comments via NRC's interactive rulemaking website through the NRC home page (http://www.nrc.gov). From the home page, select ''Rulemaking'' from the tool bar at the bottom of the page. The interactive rulemaking website can then be accessed by selecting ''Rulemaking Forum.'' This site provides the ability to upload comments as files (any format), if your web browser supports that function. For information about the interactive rulemaking website, contact Ms. Carol Gallagher by telephone at (301) 415–5905 or e-mail cag@nrc.gov.

FOR FURTHER INFORMATION CONTACT: Theodore S. Sherr, Office of Nuclear Material Safety and Safeguards, U.S. Nuclear Regulatory Commission, Washington, DC, 20555–0001, telephone (301) 415–7218; e-mail tss@nrc.gov.

SUPPLEMENTARY INFORMATION:

I. Background
II. Description of Proposed Action

I. Background

A near-criticality incident at a low enriched fuel fabrication facility in May 1991 prompted NRC to review its safety regulations for licensees that possess and process large quantities of SNM. [See NUREG–1324, ''Proposed Method

for Regulating Major Materials Licensees'' (U.S. Nuclear Regulatory Commission, 1992) for additional details on the review.] As a result of this review, the Commission and the staff recognized the need for revision of the regulatory base for these licensees, especially for those possessing a critical mass of SNM. Further, the NRC staff concluded that to increase confidence in the margin of safety at a facility possessing this type and amount of material, a licensee should perform an ISA. An ISA is a systematic analysis that identifies:

(1) Plant and external hazards and their potential for initiating accident sequences;

(2) The potential accident sequences, their likelihood, and consequences; and

(3) The structures, systems, equipment, components, and activities of personnel relied on to prevent or mitigate potential accidents at a facility.

NRC held public meetings with the nuclear industry on this issue during May and November 1995. The Nuclear Energy Institute (NEI) explained, to the Commission, industry's position on the need for revision of NRC regulations, in 10 CFR Part 70, at a July 2, 1996, meeting, and in a subsequent filing of a Petition for Rulemaking (PRM–70–7) in September 1996. NRC published in the **Federal Register** a notice of receipt of the PRM and requested public comments on August 21, 1996 (61 FR 60057). The PRM requested that NRC amend Part 70 to:

(1) Add a definition for a uranium processing and fuel fabrication plant;

(2) Require the performance of an ISA, or acceptable alternative, at uranium processing, fuel fabrication, and enrichment plants; and

(3) Include a requirement for backfit analysis, under certain circumstances, within Part 70.

In SECY–97–137, dated June 30, 1997, the staff proposed a resolution to the NEI PRM and recommended that the Commission direct the staff to proceed with rulemaking. The staff's recommended approach to rulemaking included the basic elements of the PRM, with some modification. In brief, staff's proposed resolution was to revise Part 70 to include the following major elements:

(1) Performance of a formal ISA, that would form the basis for a licensee's safety program. This requirement would apply to all licensed facilities or activities, subject to NRC regulation, that are authorized to possess SNM in quantities sufficient to constitute a potential for nuclear criticality (except power reactors and the gaseous diffusion plants regulated under 10 CFR Part 76);

(2) Establishment of criteria to identify the adverse consequences that licensees must protect against;

(3) Inclusion of the safety bases in a license application (i.e., the identification of the potential accidents, the items relied on for safety to prevent these accidents and/or mitigate their consequences, and the measures needed to ensure the availability and reliability of these items);

(4) Ability of licensees, based on the results of an ISA, to make certain changes without NRC prior approval; and

(5) Consideration by the Commission, after licensees' initial conduct and implementation of the ISA, of a qualitative backfitting mechanism to enhance regulatory stability.

In an SRM dated August 22, 1997, the Commission ''. . . approved the staff's proposal to revise Part 70'' and directed the NRC staff to ''. . . submit a draft proposed rule . . . by July 31, 1998.''

A draft proposed rule was provided to the Commission in SECY–98–185, ''Proposed Rulemaking—Revised Requirements for the Domestic Licensing of Special Nuclear Material,'' dated July 30, 1998. The draft proposed rule reflected the approach recommended in SECY–97–137. In particular, the safety basis for a facility, including the ISA results, would be submitted as part of an application to NRC, for review, and incorporated in the license. Also in SECY 98–185, the staff recommended that a qualitative backfit mechanism should be considered for implementation only after the safety basis, including the results of the ISA, is established and incorporated in the license, and after licensees and staff have gained experience with the implementation of the ISA requirement.

In response to SECY–98–185, the Commission issued an SRM dated December 1, 1998, which directed the staff not to publish the draft proposed rule for public comment. Instead, the Commission directed the staff to obtain stakeholder input and revise the draft proposed rule. In that SRM, the Commission also directed the staff to:

(1) Decide what is fundamental for NRC's regulatory purposes for inclusion as part of the license or docket and what can be justified from a public health and safety and cost-benefit basis, and assure that Part 70 captures for submittal those few significant changes that currently would require license amendments;

(2) Require licensees/applicants to address baseline design criteria and develop a preliminary ISA for new processes and new facilities;

(3) Justify, on a health and safety or cost-benefit basis, any requirement to conduct a decommissioning ISA;

(4) Require that any new backfit pass a cost-benefit test, without the ''substantial'' increase in safety test;

(5) Require the reporting of certain significant events because of their potential to impact worker or public health and safety;

(6) Clarify the basis for use of chemical safety and chemical consequence criteria, particularly within the context of the Memoranda of Understanding with the Occupational Safety and Health Administration (OSHA) and other government agencies;

(7) Critically review the Standard Review Plan (SRP) to ensure that by providing specific acceptance criteria, it does not inadvertently prevent licensees or applicants from suggesting alternate means of demonstrating compliance with the rule; and

(8) Request input on how applicable ISA methodologies should be employed in the licensing of new technologies for use within new or existing facilities.

As directed in the SRM, stakeholder input was solicited and obtained at public meetings held in December 1998 and January and March 1999. A website was established to facilitate communication with stakeholders and to solicit further input. The nuclear industry submitted comments by letters and postings on the website. This revised proposed rule incorporates much of the December 1, 1998 SRM direction and reflects language responsive to many of the comments received. It appears that most of the major concerns with the earlier draft proposed rule have been resolved.

II. Description of Proposed Action

The proposed rule grants the NEI September 1996 PRM in part and modifies the petitioner's proposal as indicated in the following discussion.

The Commission is proposing to modify Part 70 to provide increased confidence in the margin of safety at certain facilities authorized to process a critical mass of SNM. The Commission believes that this objective can be best accomplished through a risk-informed and performance-based regulatory approach that includes:

(1) The identification of appropriate risk levels, considering consequence criteria and the level of protection needed to prevent accidents that could exceed such criteria;

(2) The performance of an ISA to identify potential accidents at the

facility and the items relied on for safety;

(3) The implementation of measures to ensure that the items relied on for safety are available and reliable to perform their function when needed;

(4) The inclusion of the safety bases, including the ISA summary, in the license application; and

(5) The allowance for licensees to make certain changes to their safety program and facilities without prior NRC approval.

The Commission's approach agrees in principle with the NEI petition. However, in contrast to the petition's suggestion that the ISA requirement be limited to ''. . . uranium processing, fuel fabrication, and uranium enrichment plant licensees,'' the Commission would require the performance of an ISA for a broader range of Part 70 licensees that are authorized to possess a critical mass of SNM. The Part 70 licensees that would be affected include licensees engaged in one of the following activities: enriched uranium processing; fabrication of uranium fuel or fuel assemblies; uranium enrichment; enriched uranium hexafluoride conversion; plutonium processing; fabrication of mixed-oxide fuel or fuel assemblies; scrap recovery of special nuclear material; or any other activity involving a critical mass of SNM that the Commission determines could significantly affect public health and safety. The proposed rule would not apply to licensees authorized to possess SNM under 10 CFR Parts 50, 60, 72, and 76.

Furthermore, the Commission is not currently proposing, as suggested in the NEI petition, to include a backfit provision in Part 70. Based on the discussions at public meetings held on May 28, 1998, and March 23, 1999, the purpose of the NEI-proposed backfit provision is to ensure that NRC staff does not impose safety controls that are not necessary to satisfy the performance requirements of Part 70, unless a quantitative cost-benefit analysis justifies this action. The Commission believes that once the safety basis, including the ISA summary, is incorporated in the license application, and the NRC staff has gained sufficient experience with implementation of the ISA requirements, a qualitative backfit mechanism could be considered. Without a baseline determination of risk, as provided by the initial ISA process, it is not clear how a determination of incremental risk, as needed for a backfit analysis, would be accomplished. Furthermore, although NEI previously stated that a quantitative backfit approach is currently feasible, it would appear that a quantitative determination of incremental risk would require a Probabilistic Risk Assessment, to which the industry has been strongly opposed. The Commission requests public comment on its intent to defer consideration of a qualitative backfit provision in Part 70; any specific suggestions for backfit provisions that would specifically address fuel cycle backfit needs and the information that would be available to conduct the associated analysis; and what would constitute a reasonable period of time, including supporting rationale, before a backfit provision should be implemented.

The majority of the proposed modifications to Part 70 are found in a new Subpart H, ''Additional Requirements for Certain Licensees Authorized to Possess a Critical Mass of Special Nuclear Material,'' that consists of 10 CFR 70.60 through 70.74. These proposed modifications to Part 70, discussed in detail below, are required to increase confidence in the margin of safety and are in general accordance with the approach approved by the Commission in its SRMs of August 22, 1997, and December 1, 1998.

Section 70.4 Definitions

Definitions of the following 12 terms would be added to this section to provide a clear understanding of the meaning of the new Subpart H: ''Acute'', ''Available and reliable to perform their function when needed'', ''Configuration management'', ''Critical mass of SNM'', ''Double contingency'', ''Hazardous materials produced from licensed materials'', ''Integrated safety analysis'', ''Integrated safety analysis summary'', ''Items relied on for safety'', ''Management measures'', ''Unacceptable performance deficiencies'', and ''Worker.''

Section 70.14 Foreign Military Aircraft

This paragraph reflects an administrative change to renumber the paragraph from 70.13a.

Section 70.17 Specific Exemptions

This paragraph reflects an administrative change to renumber the paragraph from 70.14.

Section 70.50 Reporting Requirements

Paragraph (c) would be reworded to include information to be transmitted when making verbal or written reports to NRC. The new information derives from the specifics of the new Subpart H, such as sequence of events and whether the event was evaluated in the ISA. To the extent the new information is also applicable to licensees not subject to Subpart H, the information was added with no differentiation noted. The new information that would only apply to Subpart H licensees is noted.

Section 70.60 Applicability

This section lists the types of NRC licensees or applicants who would be subject to the new Part 70, Subpart H. The Commission has decided that the new requirements should not apply to all licensees authorized to possess critical masses of SNM. Instead, the Commission has identified a subset of these licensees that, based on the risk associated with operations at these facilities, should be subject to the new requirements. This change would exclude certain facilities (e.g., those authorized only to store SNM or use SNM in sealed form for research and educational purposes) from the new requirements, because of the relatively low level of risk at these facilities. In general, the new Subpart is intended to ensure that the significant accidents that are possible at fuel fabrication facilities (and the other listed facility types) have been analyzed in advance, and that appropriate controls or measures are established to ensure adequate protection of workers,[1] public, and the environment. The requirements and provisions in Subpart H are in addition to, and not a substitute for, other applicable requirements, including those of the U.S. Environmental Protection Agency (EPA) and the U.S. Department of Labor, OSHA. The requirements being added by NRC only apply to NRC's areas of responsibility (radiological safety and chemical safety directly related to licensed radioactive material). In this regard, the requirements for hazards and accident analyses that NRC is adding are intended to complement and be consistent with the parallel OSHA and EPA regulations.

The regulation states that Subpart H does not apply to decommissioning activities. NRC notes that the existing regulation [§ 70.38(g)(4)(iii)] requires an approved decommissioning plan (DP) that includes ''a description of methods used to ensure protection of workers and the environment against radiation hazards during decommissioning.'' Because the DP is submitted for NRC approval before initiation of ''. . . procedures and activities necessary to carry out decommissioning of the site or

[1] A worker, in the context of this rulemaking, is defined as an individual whose assigned duties in the course of employment involve exposure to radiation and/or radioactive material from licensed and unlicensed sources of radiation (i.e., an individual who is subject to an *occupational* dose as in 10 CFR 20.1003).

separate building or outdoor area,'' the DP will continue to be the vehicle for regulatory approval of the licensee's practices for protection of health and safety during decommissioning. The ISA should provide valuable information with respect to developing the DP and the use of the ISA in this manner is encouraged.

Section 70.61 Performance Requirements

In the past, the regulation of licensees authorized to possess SNM, under 10 CFR Parts 20 and 70, has concentrated on radiation protection for persons involved in nuclear activities conducted under normal operations. The proposed amendments to Part 70 would explicitly address potential exposures to workers or members of the public and environmental releases as a result of accidents. Part 20 continues to be NRC's standard for protection of workers and public from radiation during normal operations, anticipated upsets (e.g., minor process upsets that are likely to occur one or more times during the life of the facility), and accidents. Although it is the Commission's intent that the regulations in Part 20 also be observed to the extent practicable during an emergency, it is not the Commission's intent that the Part 20 requirements apply as the design standard for all possible accidents at the facility, irrespective of the likelihood of those accidents. Because accidents are unanticipated events that usually occur over a relatively short period of time, the Part 70 changes seek to assure adequate protection of workers, members of the public, and the environment by limiting the risk (combined likelihood and consequence) of such accidents.

There are three risk-informed performance requirements for the rule, each of which is set out in 10 CFR 70.61: (1) Section 70.61(b) states that high-consequence events must meet a likelihood standard of highly unlikely; (2) section 70.61(c) requires that intermediate-consequence events must meet a likelihood standard of unlikely; and (3) section 70.61(d) requires that risk of nuclear criticality be limited by assuring that all processes must remain subcritical under any normal or credible abnormal conditions. The term ''performance requirements'' thus considers together consequences and likelihood. For regulatory purposes, each performance requirement is considered an equivalent level of risk. For example, the acceptable likelihood of intermediate-consequence events is allowed to be greater than the acceptable likelihood for high-consequence events.

A risk-informed approach must consider not only the consequences of potential accidents, but also their likelihood of occurrence. As mentioned above, the performance requirements rely on the terms ''unlikely'' and ''highly unlikely'' to focus on the risk of accidents. However, the Commission has decided not to include quantitative definitions ''unlikely'' and ''highly unlikely'' in the proposed rule, because a single definition for each term, that would apply to all the facilities regulated by Part 70, may not be appropriate. Depending on the type of facility and its complexity, the number of potential accidents and their consequences could differ markedly. Therefore, to ensure that the overall facility risk from accidents is acceptable for different types of facilities, the rule requires applicants to develop, for NRC approval (see § 70.65), the meaning of ''unlikely'' and ''highly unlikely'' specific to their processes and facility. To accommodate this development, the Commission believes that the SRP is the appropriate document to include guidelines for licensees to use. A draft ''Standard Review Plan for the Review of a License Application for a Fuel Cycle Facility'' has been developed. The draft SRP provides one acceptable approach for the meaning of ''unlikely'' and ''highly unlikely'' that can be applied to existing fuel cycle facilities.

The general approach for complying with the performance requirements is that, at the time of licensing, each hazard (e.g., fire, chemical, electrical, industrial) that can potentially affect radiological safety is identified and evaluated, in an ISA, by the licensee. The impact of accidents, both internal and external, associated with these hazards is compared with the three performance requirements. Any (and all) structures, systems, components, or human actions, for which credit is taken in the ISA for mitigating (reducing the consequence of) or preventing (reducing the likelihood of) the accident such that all three performance requirements are satisfied, must be identified as an ''item relied on for safety.'' ''Items relied on for safety'' is a term that is defined in 10 CFR 70.4, and in this approach, the applicant has a great deal of flexibility in selecting and identifying the actual ''items.'' For example, they can be defined at the systems-level, component-level, or sub-component-level. ''Management measures'' [see discussion in 10 CFR 70.62(d)] are applied to each item in a graded fashion to ensure that it will perform its safety function when needed. The combination of the set of ''items relied on for safety'' and the ''management measures'' applied to each item will determine the extent of the licensee's programmatic and design requirements, consistent with the facility risk, and will ensure that at any given time, the facility risk is maintained safe and protected from accidents (viz., satisfies the performance requirements).

The proposed performance requirements also address certain chemical hazards that result from the processing of licensed nuclear material. The question of the extent of NRC's authority to regulate chemical hazards at its fuel cycle facilities was raised after an accident in 1986 at a Part 40 licensed facility, in which a cylinder of uranium hexafluoride ruptured and resulted in a worker fatality. The cause of the worker's death was the inhalation of hydrogen fluoride gas, which was produced from the chemical reaction of uranium hexafluoride and water (humidity in air). Partly as a result of the coordinated Federal response and resulting Congressional investigation into that accident, NRC and the OSHA entered into an MOU, in 1988, that clarified the agencies' interpretations of their respective responsibilities for the regulation of chemical hazards at nuclear facilities. The MOU identified the following four areas of responsibility. Generally, NRC covers the first three areas, whereas OSHA covers the fourth area:

(1) Radiation risk produced by radioactive materials;

(2) Chemical risk produced by radioactive materials;

(3) Plant conditions that affect the safety of radioactive materials; and

(4) Plant conditions that result in an occupational risk, but do not affect the safety of licensed radioactive materials.

One goal of the performance requirements in § 70.61 is to be consistent with the NRC–OSHA MOU. Therefore, the performance requirements in § 70.61 include explicit standards for the MOU's first two areas of responsibility. In addition, the third MOU area of responsibility is specifically evaluated by licensees under the ISA requirements of § 70.62(c)(1)(iii). As an example of the third MOU area, if the failure of a chemical system adjacent to a nuclear system could affect the safety of the nuclear system such that the radiation dose (and associated likelihood of that accident) exceeded a performance requirement, the chemical system failure would be within the scope of the ISA and the means to prevent the chemical system failure from impacting

the nuclear system would be within NRC's regulatory purview.

OSHA provided comments, by a letter dated February 1, 1999, on a draft of the rule that had been revised to be consistent with the MOU. In that letter, OSHA expressed concerns that the rule language would preempt OSHA from enforcing any of its standards, rules or other requirements with respect to chemical hazards at the facilities covered by the NRC draft rule. This concern is based on case law under the OSH Act. The pertinent provision in the OSH Act states:

> ''(b)(1) Nothing in this chapter shall apply to working conditions of employees with respect to which other Federal agencies, and State agencies acting under section 2021 of title 42, exercise statutory authority to prescribe or enforce standards or regulations affecting occupational safety or health.'' [29 U.S.C. 653(b)(1)]

NRC staff subsequently met with OSHA officials on February 25, 1999, and some clarifications and further information were provided at that meeting. As a result of the meeting discussions, some changes were made to the rule language to more clearly specify the scope of NRC involvement. However, these changes do not fully resolve the basic preemption issue. The problems identified with the rule are not unique, i.e., the preemption issue is generic and may already exist for any NRC-licensed facilities where there are requirements to analyze hazards. At the February 25 meeting, OSHA confirmed that the rule language is consistent with the October 21, 1988 MOU; indicated that they have no suggested changes to the MOU; and indicated that they are not opposed to the proposed rule. The Commission's view is that the proposed rule is consistent with NRC responsibilities and authority under the Atomic Energy Act, and consistent with the OSHA MOU. The only resolution of the preemption issue appears to be a legislative modification of the OSH Act. Public comments would be appreciated on any options that may have been overlooked.

Within each performance requirement, NRC recognizes that the proposed radiological standards are more restrictive, in terms of acute health effects to workers or the public, than the chemical standards for a given consequence (high or intermediate) and that this is consistent with current regulatory practice. The choice of each criterion is discussed below in a paragraph-by-paragraph discussion of § 70.61.

The use of any of the performance requirements is not intended to imply that the specified worker or public radiation dose or chemical exposure constitutes an acceptable criterion for an emergency dose to a worker or the public. Rather, these values have been proposed in this section as a reference value, to be used by licensees in the ISA (a forward-looking analysis) to establish controls (i.e., items relied on for safety and associated management measures) necessary to protect workers from potential accidents with low or exceedingly low probabilities of occurrence that are not expected to occur during the operating life of the facility.

Section 70.61(b). This section addresses performance requirements for high-consequence events.

The consequences identified in § 70.61(b) of the proposed rule are referred to as ''high-consequence events'' and include accidental exposure of a worker or an individual located outside of the controlled area to high levels of radiation or hazardous chemicals. These accidents, if they occurred, would represent radiation doses to a worker or an individual located outside of the controlled area at levels with clinically observable biological damage or concentrations of hazardous chemicals produced from licensed material at which death or life-threatening injury could occur. The goal is to ensure an acceptable level of risk by limiting the combination of the likelihood of occurrence and the identified consequences. Thus, high-consequence events must be sufficiently mitigated to a lower consequence or prevented such that the event is highly unlikely (or lower). The application of ''items relied on for safety'' provides this prevention or mitigation function.

Section 70.61(b)(1). An acute exposure of a worker to a radiation dose of 1 Sv (100 rem) or greater total effective dose equivalent (TEDE) is considered to be a high-consequence event. According to the National Council on Radiation Protection and Measurements (NCRP, 1971), life-saving actions—including the ''* * * search for and removal of injured persons, or entry to prevent conditions that would probably injure numbers of people''—should be undertaken only when the ''* * * planned dose to the whole body shall not exceed 100 rems.'' This is consistent with a later NCRP position (NCRP, 1987) on emergency occupational exposures, that states ''* * * when the exposure may approach or exceed 1 Gy (100 rad) of low-LET [linear energy transfer] radiation (or an equivalent high-LET exposure) to a large portion of the body, in a short time, the worker needs to understand not only the potential for acute effects but he or she should also have an appreciation of the substantial increase in his or her lifetime risk of cancer.''

Section 70.61(b)(2). The exposure of an individual located outside of the controlled area to a radiation dose of 0.25 Sv (25 rem) or greater TEDE is considered a high-consequence event. This is generally consistent with the criterion established in 10 CFR 100.11, ''Determination of exclusion area, low population zone, and population center distance,'' and 10 CFR 50.34, ''Contents of applications; technical information,'' where a whole-body dose of 0.25 Sv (25 rem) is used to determine the dimensions of the exclusion area and low-population zone required for siting nuclear power reactors.

Section 70.61(b)(3). The intake of 30 mg of soluble uranium by an individual located outside of the controlled area is considered a high-consequence event. This choice, which is based on a review of the available literature [Pacific Northwest Laboratories (PNL), 1994], is consistent with the selection of 30 mg of uranium as a criterion that was discussed during the Part 76 rulemaking, ''Certification of Gaseous Diffusion Plants.'' In particular, the final rule that established Part 76 (59 FR 48944; September 23, 1994) stated that ''The NRC will consider whether the potential consequences of a reasonable spectrum of postulated accident scenarios exceed * * * uranium intakes of 30 milligrams. * * *'' The final rule also stated that ''The Commission's intended use of chemical toxicity considerations in Part 76 is consistent with its practice elsewhere [e.g., 10 CFR 20.1201(e)], and prevents any potential regulatory gap in public protection against toxic effects of soluble uranium.''

Section 70.61(b)(4). An acute chemical exposure to hazardous chemicals produced from licensed material at concentrations that either (1) could cause death or life-threatening injuries to a worker; or (2) could cause irreversible health effects to an individual located outside of the controlled area, is considered a high-consequence event. Chemical consequence criteria corresponding to anticipated adverse health effects to humans from acute exposures (i.e., a single exposure or multiple exposures occurring within a short time—24 hours or less) have been developed, or are under development, by a number of organizations. Of particular interest, the National Advisory Committee for Acute Guideline Levels for Hazardous Substances is developing Acute Exposure Guideline Limits (AEGLs) that

will eventually cover approximately 400 industrial chemicals and pesticides. The committee, which works under the auspices of the EPA and the National Academy of Sciences, has identified a priority list of approximately 85 chemicals. Consequence criteria for 12 of these have currently been developed and criteria for approximately 30 additional chemicals per year are expected. Another set of chemical consequence criteria, the Emergency Response Planning Guidelines (ERPGs), has been developed by the American Industrial Hygiene Association to provide estimates of concentration ranges where defined adverse health effects might be observed because of short exposures to hazardous chemicals. ERPG criteria are widely used by those involved in assessing or responding to the release of hazardous chemicals including ''* * * community emergency planners and response specialists, air dispersion modelers, industrial process safety engineers, implementers of environmental regulations such as the Superfund Amendment and Reauthorization Act, industrial hygienists, and toxicologists, transportation safety engineers, fire protection specialists, and government agencies. * * *'' (*DOE Risk Management Quarterly,* 1997). Despite their general acceptance, there are currently only approximately 80 ERPG criteria available, and some chemicals of importance (e.g., nitric acid) are not covered.

The qualitative language in the performance requirement allows the applicant/licensee to propose and adopt an appropriate standard, which may be an AEGL or ERPG standard, or where there is no AEGL or ERPG value available, the applicant may develop or adopt a criterion that is comparable in severity to those that have been established for other chemicals. For example, for the worker performance requirement, existing criteria that can be used by licensees to define appropriate concentration levels to satisfy the performance requirement are the AEGL–3 and ERPG–3. AEGL–3 is defined as ''The airborne concentration (expressed in ppm or mg/m^3) of a substance at or above which it is predicted that the general population, including susceptible, but excluding hypersusceptible, individuals, could experience life-threatening effects or death.'' ERPG–3 is defined as ''The maximum airborne concentration below which it is believed that nearly all individuals could be exposed for up to 1 hour without experiencing or developing life-threatening health effects.'' Similarly, for the public, AEGL–2 is defined as ''The airborne concentration (expressed in ppm or mg/m^3) of a substance at or above which it is predicted that the general population, including susceptible, but excluding hypersusceptible, individuals, could experience irreversible or other serious, long-lasting effects or impaired ability to escape,'' and ERPG–2 is defined as ''The maximum airborne concentration below which it is believed that nearly all individuals could be exposed for up to 1 hour without experiencing or developing irreversible or other health effects or symptoms that could impair an individual's ability to take protective action.''

Section 70.61(c). This section addresses performance requirements for intermediate-consequence events.

The consequences identified in § 70.61(c) of the proposed rule are referred to as ''intermediate-consequence events'' and include accidental exposure of a worker or an individual outside of the controlled area to levels of radiation or hazardous chemicals that generally correspond to permanent injury to a worker, transient injury to a non-worker, or significant releases of radioactive material to the environment. The goal is to ensure an acceptable level of risk by limiting the combination of the likelihood of occurrence and the identified consequences. Thus, ''intermediate-consequence events'' must be sufficiently mitigated to a lower consequence or prevented such that the event is unlikely (or lower). The application of ''items relied on for safety'' provides this prevention or mitigation function.

Section 70.61(c)(1). A worker radiation dose between 0.25 Sv (25 rem) and 1 Sv (100 rem) TEDE is considered an intermediate-consequence event [over 1 Sv (100 rem) is a high-consequence event]. This value was chosen because of the use of 0.25 Sv (25 rem) as a criterion in existing NRC regulations. For example, in 10 CFR 20.2202, ''Notification of incidents,'' immediate notification is required of a licensee if an individual receives ''. . . a total effective dose equivalent of 0.25 Sv (25 rem) or more.'' Also, in 10 CFR 20.1206, ''Planned special exposures,'' a licensee may authorize an adult worker to receive a dose in excess of normal occupational exposure limits if a dose of this magnitude does not exceed 5 times the annual dose limits [i.e., 0.25 Sv (25 rem)] during an individual's lifetime. In addition, EPA's Protective Action Guides (U.S. Environmental Protection Agency, 1992) and NRC's regulatory guidance (Regulatory Guide 8.29, 1996) identify 0.25 Sv (25 rem) as the whole-body dose limit to workers for life-saving actions and protection of large populations. NCRP has also stated that a TEDE of 0.25 Sv (25 rem) corresponds to the once-in-a-lifetime accidental or emergency dose for workers.

Section 70.61(c)(2). A dose to any individual located outside of the controlled area between 0.05 Sv (5 rem) and 0.25 Sv (25 rem) is considered an intermediate-consequence event. NRC has used a 0.05-Sv (5-rem) exposure criterion in a number of its existing regulations. For example, 10 CFR 72.106, ''Controlled area of an ISFSI or MRS,'' states that ''Any individual located on or beyond the nearest boundary of the controlled area shall not receive a dose greater than 5 rem to the whole body or any organ from any design basis accident.'' In addition, in the regulation of the above-ground portion of the geologic repository, 10 CFR 60.136, states that ''. . . for [accidents], no individual located on or beyond any point on the boundary of the preclosure controlled area will receive . . . a total effective dose equivalent of 5 rem. . . .'' A TEDE of 0.05 Sv (5 rem) is also the upper limit of EPA's Protective Action Guides of between 0.01 to 0.05 Sv (1 to 5 rem) for emergency evacuation of members of the public in the event of an accidental release that could result in inhalation, ingestion, or absorption of radioactive materials.

Section 70.61(c)(3). The release of radioactive material to the environment outside the restricted area in concentrations that, if averaged over a period of 24 hours, exceed 5000 times the values specified in Table 2 of Appendix B to Part 20, is considered an intermediate-consequence event. In contrast to the other consequences criteria that directly protect workers and members of the public, the intent of this criterion is to ensure protection of the environment from the occurrence of accidents at certain facilities authorized to process greater than critical mass quantities of SNM. This implements NRC's responsibility for protecting the environment, in accordance with the Atomic Energy Act of 1954, *et seq.*, and the National Environmental Policy Act of 1969, *et seq.*

The value established for the environmental consequence criterion is identical to the NRC Abnormal Occurrence (AO) criterion that addresses the discharge or dispersal of radioactive material from its intended place of confinement (Section 208 of the Energy Reorganization Act of 1974, as amended, requires that AOs be reported

to Congress annually). In particular, AO reporting criterion 1.B.1 requires the reporting of an event that involves ''. . . the release of radioactive material to an unrestricted area in concentrations which, if averaged over a period of 24 hours, exceed 5000 times the values specified in Table 2 of Appendix B to 10 CFR Part 20, unless the licensee has demonstrated compliance with 10 CFR 20.1301 using 10 CFR 20.1302(b)(1) or 10 CFR 20.1302(b)(2)(ii)'' [December 19, 1996; 61 *FR* 67072]. The concentrations listed in Table 2 of Appendix B to Part 20 apply to radioactive materials in air and water effluents to unrestricted areas. NRC established these concentrations based on an implicit effective dose equivalent limit of 0.5 mSv/yr (50 mrem/yr) for each medium, assuming an individual were continuously exposed to the listed concentrations present in an unrestricted area for a year.

If an individual were continuously exposed for 1 day to concentrations of radioactive material 5000 times greater than the values listed in Appendix B to Part 20, the projected dose would be about 6.8 mSv (680 mrem), or 5000×0.5 mSv/yr $\times$ 1 day $\times$ 1 yr/365 days. In addition, a release of radioactive material, from a facility, resulting in these concentrations, would be expected to cause some environmental contamination in the area affected by the release. This contamination would pose a longer-term hazard to the environment and members of the public until it was properly remediated. Depending on the extent of environmental contamination caused by such a release, the contamination could require considerable licensee resources to remediate. For these reasons, NRC considered the existing AO reporting criterion for discharge or dispersal of radioactive material as an appropriate consequence criterion in this rulemaking.

Section 70.61(c)(4). An acute chemical exposure to hazardous chemicals produced from licensed material at concentrations that either; (a) to a worker, could cause irreversible health effects (but at concentrations below those which could cause death or life-threatening effects); or (b) to an individual located outside of the controlled area, could cause notable discomfort (but at concentrations below those which could cause irreversible effects), is considered an intermediate-consequence event. Chemical consequence criteria corresponding to anticipated adverse health effects to humans from acute exposures (i.e., a single exposure or multiple exposures occurring within a short time—24 hours or less) have been developed, or are under development, by a number of organizations. Of particular interest, two existing standards, AEGL–2 and ERPG–2, can be used to define the concentration level for irreversible health effects, and two existing standards, AEGL–1 and ERPG–1, can be used to define the concentration level for notable discomfort. The qualitative language in the performance requirement allows the applicant/licensee to adopt and propose an appropriate standard, which may be an AEGL or ERPG standard, or where there is no AEGL or ERPG value available, the applicant may develop or adopt a criterion that is comparable in severity to those that have been established for other chemicals.

Section 70.61(d). This section addresses performance requirements for an accidental nuclear criticality.

The third performance requirement states that the risk of nuclear criticality accidents must be limited by assuring that under normal and credible abnormal conditions, all nuclear processes are subcritical, including use of an approved margin of subcriticality for safety. It also requires that preventive controls and measures shall be the primary means of protection against nuclear criticality accidents. Although detecting and mitigating the consequences of a nuclear criticality are important objectives (e.g., for establishing alarm systems), the prevention of a criticality is a primary NRC objective.

The basis for this provision is the NRC strategic plan (NUREG–1614, Vol. 1), which, for nuclear materials safety, states NRC's performance goal of ''. . . no accidental criticality involving licensed material.'' The language chosen for this performance requirement closely follows the language of the applicable industry standard, ANSI/ANS Standard 8.1–1983, ''Nuclear Criticality Safety in Operations with Fissionable Materials Outside Reactors.''

Section 70.61(e). This section addresses items relied on for safety and management measures.

Paragraph 70.61(e) would require that each engineered or administrative control or control system that is needed to meet the performance requirements be designated as an item relied on for safety. This means that any control or control system that is necessary to maintain the acceptable combination of consequence and likelihood for an accident is designated an item relied on for safety. The importance of this section is that, once a control is designated as an item relied on for safety, it falls into the envelope of the safety program required by section 70.62. For example, records will be kept regarding the item, and management measures such as the configuration control program are applied to the item and to changes that affect the item, to ensure that the item will be available and reliable to perform its function when needed.

The failure of an item relied on for safety does not necessarily mean that an accident will occur which will cause one of the consequences listed in the performance requirements to be exceeded. Some control systems may have parallel (redundant or diverse) control systems that would continue to prevent the accident. The need for such defense-in-depth and single-failure resistance would ideally be based on the severity and likelihood of the potential accident. In other cases, the failure of an item may mean that the particular accident sequence is no longer ''highly unlikely'', or ''unlikely.'' In these cases, the performance requirement is not met, and the expectation would be that a management measure would exist (possibly in the form of an operating procedure) that ensured that the facility would not operate in a condition that exceeds the performance requirement. For example, a facility that relies on emergency power could not operate for an extended time in the absence of an emergency power source even if grid power is available. In this manner, the items relied on for safety and the management measures complement each other to ensure adequate protection from accidents at any given time.

Section 70.61(f). This section addresses the term ''controlled area'' used in the performance requirements.

Section 70.61(f) requires licensees to identify a controlled area consistent with the use of that term in Part 20, and provides clarification regarding the activities that may occur inside the controlled area. The function of this term is to delimit an area over which the licensee exercises control of activities. Control includes the power to exclude individuals, if necessary. The size of the controlled area is not specified in the regulation because it will be dependent upon the particular activities that are conducted at the site and their relationship to the licensed activities. [Within the controlled area will be a restricted area (as defined in § 20.1003), access to which is controlled by the licensee for purposes of radiation safety.]

Individuals who do not receive an occupational dose (as that term is used in Part 20) in the controlled area will be subject to the dose limits for members of the public in 10 CFR 20.1301.

However, the Commission recognizes that certain licensees may have ongoing activities at their site (i.e., within the controlled area) that are not related to the licensed activities. For example, a non-nuclear facility may be adjacent to the nuclear facility but both are within the controlled area (which may be defined similar to the site boundary). This raises a question regarding the appropriate accident standard for these individuals. Protection of the individuals at the non-nuclear facility must consider that the nature of many potential accidents at a fuel cycle facility is such that there may not be sufficient time during which to take action to exclude individuals from the controlled area. Therefore, for purposes of the ISA accident evaluation, the rule explicitly contains two options for these individuals (as well as an implicit third option). In the first option, the licensee evaluates, in the ISA, the risk at its location (as opposed to that at any point at or beyond the controlled area boundary) and determines that it meets the performance requirements for members of the public. In the second option, performance requirements for workers may be applied to individuals in the controlled area if the provisions of § 70.61(f)(2) are satisfied. These conditions ensure that the individuals are aware of the risks to them from the potential accidents at the nuclear facility and have received appropriate training and access to information. This parallels and is consistent with the use of the term, ''Exclusion area'', by 10 CFR Parts 50 and 100, which states, ''Activities unrelated to operation of the reactor may be permitted in an exclusion area under appropriate limitations, provided that no significant hazards to the public health and safety will result.'' The implied third option is to define (or redefine) a controlled area such that within it only activities associated with the licensed nuclear facility are permitted.

The Commission's intent is that the ISA does not evaluate compliance with the accident standards for individuals who make infrequent visits to the controlled area and restricted area (e.g., visitors). Use of the ISA to determine the risks to these individuals would need to consider second-order effects such as the probability of the individual being present at the time that the unlikely (or highly unlikely) accident occurred. This level of detail is unnecessary to accomplish the purpose of this rule (viz., to document and maintain the safety basis of the facility design and operations). Application of the Part 20 regulations provides adequate protection for these individuals. In addition, the provisions (i.e., performance requirements) to protect workers and non-workers during accidents should, implicitly, provide a degree of protection to the infrequently present individuals.

Section 70.62 Safety Program and Integrated Safety Analysis

This paragraph addresses the safety program, that includes process safety information, ISA, and management measures. The performance of an ISA, and the establishment of measures to ensure the availability and reliability of items relied on for safety when needed, are the means by which licensees demonstrate an adequate level of protection at their facilities. The ISA is a systematic analysis to identify plant and external hazards and their potential for initiating accident sequences; the potential accident sequences and their consequences; and the site, structures, systems, equipment, components, and activities of personnel relied on for safety. As used here, ''integrated'' means joint consideration of, and protection from, all relevant hazards, including radiological, criticality, fire, and chemical. The structure of the safety program recognizes the critical role that the ISA plays in identifying potential accidents and the items relied on for safety. However, it also recognizes that the performance of the ISA, by itself, will not ensure adequate protection. Instead, an effective management system is needed to ensure that the items relied on for safety are available and reliable to perform their function when needed. Detailed requirements for each part of the safety program are included in this section.

Section 70.62(a). Each licensee would be required to establish and maintain a safety program that demonstrates compliance with the performance requirements of § 70.61. Although the ISA would be the primary tool in identifying the potential accidents requiring consequence mitigation and accident prevention, process safety information would be used to develop the ISA, and management measures would be used to ensure the availability and reliability of items relied on for safety identified through the ISA. The management measures may be graded according to the risk importance associated with an item relied on for safety.

The licensee is also required to establish and maintain records demonstrating that it has, and continues to meet, the requirement of this section. These records serve two major purposes. First, they can supplement information that has been submitted as part of the license application. Second, records are often needed to demonstrate licensee compliance with applicable regulations and license commitments. It is important, therefore, that an appropriate system of recordkeeping be implemented to allow easy retrieval of required information.

Finally, each licensee would also be required to establish and maintain a log documenting each discovery that an item relied on for safety has failed to perform its function either in the context of the performance requirements of § 70.61 or on demand. The phrase ''* * * in the context of the performance requirements of § 70.61'' means that items relied on for safety that fail would require logging even if their failures did not result in process upsets or accidents but could have resulted in the accident conditions they are protecting against, had all conditions been optimum for the accident. This would not include failures during times, such as routine maintenance on an item, when the item or measure was clearly documented to not be available. The log must contain: (a) The identity of the item that failed and the safety function affected; (b) date of discovery of the failure; (c) duration of time that the item was unable to perform its function; (d) any other affected items relied on for safety and their safety function; (e) affected processes; (f) the cause of the failure; (g) whether the failure was in the context of performance requirements, or on demand, or both; and (h) any corrective or compensatory actions taken. The log should be initiated at the time of discovery and updated promptly at the completion of each investigation of a failure of an item relied on for safety. The purpose of the log is to assist NRC in determining whether items relied on for safety are, in fact, available and reliable and in detecting system problems that may impact ISA evaluations.

Section 70.62(b). This paragraph would require the licensee to maintain process-safety information pertaining to the hazards of the materials used or produced in the process, the technology of the process, and the equipment in the process. NRC confidence in the margin of safety at its licensed facilities depends, in part, on the ability of licensees to maintain a set of current, accurate, and complete records available for NRC inspection. The process-safety information should be used in support of development of an ISA.

Section 70.62(c). This paragraph proposes requirements for conducting

an ISA. There are four major steps in performing an ISA:

(1) Identify all hazards at the facility, including both radiological and non-radiological hazards. Hazardous materials, their location, and quantities, should be identified, as well as all hazardous conditions, such as high temperature and high pressure. In addition, any interactions that could result in the generation of hazardous materials or conditions should be identified.

(2) Analyze the hazards to identify how they might result in potential accidents. These accidents could be caused by process deviations or other events internal to the plant, or by credible external events, including natural phenomena such as floods, earthquakes, etc. To accomplish the task of identifying potential accidents, the licensee needs to ensure that detailed and accurate information about plant processes is maintained and made available to the personnel performing the ISA.

(3) Determine the consequences of each accident that has been identified. For an accident with consequences at a ''high'' or ''intermediate level,'' as defined in 10 CFR 70.61, the likelihood of such an accident must be shown to be commensurate with the consequences, as required in 10 CFR 70.61.

(4) Identify the items relied on for safety (i.e., those items that are relied on to prevent accidents or to mitigate their consequences, identified in the ISA). These items are needed to reduce the consequences or likelihood of the accidents to acceptable levels. The identification of items relied on for safety is required only for accidents with consequences at a high or intermediate level, as defined in 10 CFR 70.61.

It is expected that the licensee or applicant would perform the ISA using a ''team'' of individuals with expertise in engineering and process operations related to the system being evaluated; the team should include persons with experience in nuclear criticality safety, radiation safety, fire safety, and chemical process safety, as warranted by the materials and potential hazards associated with the process being evaluated. At least one member of the ISA team should be an individual who has experience and knowledge that is specific to the process being evaluated. Finally, at least one individual in the team must be knowledgeable in the specific ISA methodology being used.

Current Part 70 licensees, for whom the rule applies, would be required to develop plans and submit them to NRC within 6 months of the effective date of the rule. Each plan would identify the processes that would be subject to an ISA, the ISA approach that would be implemented for each process, and the schedule for completing the analysis of each process. Licensees would be expected to complete their ISA within 4 years of the effective date of the rule; correct any unacceptable vulnerabilities identified; and submit the results to NRC for approval in the form of an ISA summary that contains the information required by 10 CFR 70.65(b). Pending the correction of any unacceptable vulnerabilities, licensees would be expected to implement appropriate compensatory measures to ensure adequate protection until the vulnerability can be more appropriately corrected.

Applicants for licenses to operate new facilities or new processes at existing facilities would be expected to design their facilities or processes to protect against the occurrence of the adverse consequences identified in 10 CFR 70.61, using the baseline design criteria 10 CFR 70.64(a). Before operation, applicants would be expected to update their ISAs, based on as-built conditions and submit the results to NRC as ISA summaries, along with the applications, following the requirements in 10 CFR 70.65(b).

The Commission believes that sufficient flexibility is permitted in the ISA methodology chosen to be able to accommodate a wide range of technologies. However, to assure that sufficient flexibility exists, the Commission is requesting comments on this matter.

Section 70.62(d). Although the ISA would play a critical role in identifying potential accidents and the items relied on for safety, the performance of an ISA would not, by itself, ensure adequate protection. In addition, as would be provided for in 10 CFR 70.62(d), an effective management system would be needed to ensure that the items relied on for safety are available and reliable to perform their function when needed. As stated before, management measures may be graded to better implement the results of the ISA.

Management measures are functions performed by the licensee, in general on a continuing basis, that are applied to items relied on for safety. Management measures include: (a) Configuration management; (b) maintenance; (c) training and qualifications; (d) procedures; (e) audits and assessments; (f) incident investigations; (g) records management; and (h) other quality assurance elements. Changes in the configuration of the facility need to be carefully controlled to ensure consistency among the facility design and operational requirements, the physical configuration, and the facility documentation. Maintenance measures must be in place to ensure the availability and reliability of all hardware, identified as items relied on for safety, to perform their function when needed. Training measures must be established to ensure that all personnel relied on for safety are appropriately trained to perform their safety functions. Periodic audits and assessments of licensee safety programs must be performed to ensure that facility operations are conducted in compliance with NRC regulations and protect the worker and the public health and safety and the environment. When abnormal events occur, investigations of those events must be carried out to determine the root cause and identify corrective actions to prevent their recurrence and to ensure that they do not lead to more serious consequences. Finally, to demonstrate compliance with NRC regulations, records that document safety program activities must be maintained for the life of the facility.

This section also would require that the safety program ensure that each item relied on for safety would perform its intended function when needed and in the context of the performance requirements of this section. The utility of the two modifying requirements, ''when needed,'' and ''in the context of the performance requirements of this section,'' is clarified as follows:

The phrase ''when needed'' is used to acknowledge that a particular safety control need not be continuously functioning. For example, it may not be operational during maintenance or calibration testing, or may not be required when the process is not operational or when special nuclear material is not present. However, the phrase, when needed, does not relieve a licensee from compliance with the performance requirements. For example, if a particular component is out for maintenance, the licensee must consider credible event sequences in developing the ISA and identifying items relied on for safety—a high-consequence event sequence still has to be highly unlikely. Compliance with the performance requirements in these cases can be established by various means including identification of additional items relied on for safety (and application of safety program management measures to them), or by limiting operations or placing the plant in a different operating mode during the maintenance of the item relied on for safety.

To illustrate, a loss of offsite power during a one-week maintenance outage of the emergency diesel generator that is relied on for safety would still be a credible event sequence. If the loss of power, combined with the generator's inoperable status, could result in a combination of dose and likelihood that exceeds a performance requirement, then the licensee would not be in compliance with the performance requirements of § 70.61. A licensee cannot claim, after the maintenance, that since the power was not lost, the generator was available when needed. The concept is that the ISA is used as a risk-informed, forward-look at the credible facility hazards and their effects on plant systems and modes of operation. The rule would require that each item necessary to comply with the performance requirements be identified as important to safety and placed under the safety program management controls. In identifying each item, the ISA must consider various modes of operation and the likelihood that a given safety control will be inoperable (e.g., because of being off-line for maintenance) during credible event sequences.

The section would also require that the safety control perform its function ''* * *in the context of the performance requirements of this section.'' This phrase indicates that the function of interest is the one credited in the ISA to meet certain consequence criteria with a certain frequency. Second, this phrase would require that additional safety controls be defined in cases where one control does not result in compliance with the performance requirement or has periods when it is inoperable. Using the loss of offsite power example again, a licensee would still be required to meet the risk-informed performance requirements of the rule when an emergency diesel generator used as an item relied on for safety is not operable or out of service for maintenance.

Section 70.64 Requirements for New Facilities or New Processes at Existing Facilities

This section deals with baseline design criteria for new facilities or new processes at existing facilities.

A major feature of the proposed amendments to Part 70 is the requirement that licensees and applicants for a license perform an ISA and use the ISA process to develop risk-informed decisions regarding facility safety. The ISA process is applied to existing designs to identify risk insights on those areas that warrant additional preventive or mitigative measures. For new facilities, the proposed rule would require the performance of the ISA before construction [see the existing § 70.21(f) and § 70.23(a)(7)], and the updating of the ISA before beginning operations. For new processes and facilities, the Commission recognizes that good engineering practice dictates that certain minimum requirements be applied as design and safety considerations for any new nuclear process or facility. In addition, a fundamental element of NRC's safety philosophy is that designs and operations should provide for defense-in-depth protection against accidents. Therefore, the Commission has specified baseline design criteria in § 70.64 that are similar in use to the general design criteria in Part 50 Appendix A; Part 72, Subpart F; and 10 CFR 60.131. The baseline design criteria identify 10 initial safety design considerations, including: (a) Quality standards and records; (b) natural phenomena hazards; (c) fire protection; (d) environmental and dynamic effects [2]; (e) chemical protection; (f) emergency capability; (g) utility services; (h) inspection, testing, and maintenance; (i) criticality control; and (j) instrumentation and controls. The baseline design criteria do not provide relief from compliance with the safety performance requirements of § 70.61. The baseline design criteria are generally an acceptable set of initial design safety considerations, which may not be sufficient to ensure adequate safety for all new processes and facilities. The ISA process is intended to identify additional safety features that may be needed. On the other hand, the Commission recognizes that there may be processes or facilities for which some of the baseline design criteria may not be necessary or appropriate, based on the results of the ISA. For these processes and facilities, any design features that are inconsistent with the baseline design criteria should be identified and justified.

Using the baseline design criteria and considering defense-in-depth practices in the design should result in a new facility design that is based on providing successive levels of protection such that health and safety will not be wholly dependent on any single element of the design, construction, maintenance, or operation of the facility. The net effect of incorporating defense-in-depth practices is a conservatively designed facility and system that will exhibit greater tolerance for failures and external challenges. The risk insights obtained through performance of the ISA can be then used to supplement the final design by focusing attention on the prevention and mitigation of the potential accidents having higher-risk.

Section 70.65 Additional Content of Applications

In addition to the information that currently must be submitted to NRC, under § 70.22, for a license application, this section requires additional information to be submitted to demonstrate compliance with the proposed new subpart. In particular, this additional information would need to include a description of the applicant's safety program established under § 70.62, a description of the management measures, and an ISA summary.

The ISA summary would contain: (a) A description of the site and the facility; (b) a description of the team qualifications and ISA methodology; (c) the processes analyzed in the ISA and the maximum consequences of each; (d) a demonstration of how the licensee meets the requirements for criticality monitoring and alarms in § 70.24; (e) a demonstration of how the licensee meets the performance requirements of § 70.61 and, if applicable, § 70.64; (f) a list of items relied on for safety and a description of their safety function; (g) a description of the proposed standards used to assess the consequences from acute chemical exposures; and (h) the definitions of ''likely'', ''unlikely'', ''highly unlikely'', and ''credible'' as used in the ISA.

The plant and process descriptions, ISA team qualifications and methods, and definitions of terms used in the ISA, are all needed to fully understand the facility and the ISA and how it was developed. Although some of the facility information is also requested in § 70.22, there may be information about the facility which would be too detailed for inclusion in the general site description, but would be needed to be included here to understand the ISA and ISA results. The demonstration of how the licensee meets §§ 70.24, 70.61, and 70.64 is a critical element in determining whether the applicant understands and complies with the regulations and can operate the facility safely. Another critical element is the applicant's identification of the items relied on for safety. Through the ISA

[2] Environmental and dynamic effects are effects that could be caused by ambient conditions. For example, an item relied on for safety will need to function within its expected environment (i.e., under normal operating conditions, expected accident conditions, etc.). These conditions could include high temperatures, or a corrosive environment. It could also include dynamic changes in surrounding conditions caused by an accident (e.g., the bursting of a high-pressure pipe).

process, the applicant should have identified potential accidents that can occur in individual processes and in the facility as a whole. As discussed earlier, these accidents are prevented or their consequences mitigated using controls that are identified in the ISA summary as items relied on for safety. It is important for NRC staff to review the items relied on for safety, that were identified as such by the applicant or licensee, to determine whether potential accidents are adequately prevented or mitigated. Since items relied on for safety play a key role in assuring that the performance requirements are met, and because the applicant has great flexibility in selecting and identifying what the actual ''items'' are (as discussed in relation to § 70.61), the items relied on for safety would be clearly and unambiguously identified on a list. This list of items is then managed and controlled by the applicant through the management measures in § 70.61 to ensure that they continue to perform the safety function required. By evaluating the ISA methodology, and the ISA summary, supplemented by reviewing the ISA and other information, as needed, at the licensee's facility, the staff can better understand the potential hazards at the facility, how the applicant plans to address these hazards, and thereby have confidence in the safety basis on which the license will be issued.

The ISA summary would be required to be submitted on the docket in conjunction with the license application but would not be considered part of the license. The ISA, on which the ISA summary is based, would be maintained current at the licensee's facility and available for NRC review, but it would not be submitted and docketed. The information and commitments contained in the license application that are incorporated into the license conditions cannot be changed without prior review and approval of NRC staff, at which time a license amendment is issued. Although the ISA summary will be on the docket, since it is not part of the license it can be changed without a license amendment, unless it reflects a change that cannot be made without prior approval per § 70.72(c). However, the information used to perform the ISA, and the ISA summary, both form integral parts of the safety basis for issuance of the license and therefore must be maintained to adequately represent the current status of the facility. So that NRC knows the current status of the facility, changes to these documents, on which NRC based its safety conclusion, are to be submitted to NRC, as discussed in § 70.72.

Section 70.66 Additional Requirements for the Approval of License Applications

In addition to the requirements found in the existing rule (i.e., 10 CFR 70.23), the Commission must determine that the requirements in the new subpart, 10 CFR 70.60 through 70.66, will be satisfied.

Section 70.72 Facility Changes and Change Process

This section deals with changes to site, structures, systems, equipment, components, and activities of personnel after a license application has been approved.

Past incidents at fuel cycle facilities have often resulted from changes not fully analyzed, not authorized by licensee management, or not adequately understood by facility personnel. Therefore, effective control of changes to a facility's site, structures, systems, equipment, components, and activities of personnel is a key element in assuring safety at that facility. This section would require the licensee to establish and use a system to evaluate changes and the potential impacts of those changes before implementing them. By using this system to evaluate, implement and track changes to the facility, the licensee can make certain changes without NRC pre-approval. If the change affects information contained in the ISA summary, the licensee would be required to notify NRC within 90 days of the change by submitting updated ISA summary pages in that time. For changes that affect the on-site documentation, such as the ISA, management measures or process-safety information, the licensee would be required to notify NRC within 12 months of the change. This update frequency would allow NRC staff to review the changes being made to the facility in enough time to ensure that the licensee's evaluations of potential impacts to health and safety were accurate. It also allows NRC staff to maintain relatively current facility and safety information on the docket at all times. In addition, maintaining the license and ISA summary so that they reflect the current configuration of the facility would facilitate a relatively simple, cost-effective license renewal process. The Commission is particularly interested in comments concerning the 90 day time period for submitting updated ISA summary pages that reflect changes to a facility's site, structures, systems, equipment, components, and activities of personnel.

Some changes, however, would require NRC pre-approval before they can be implemented. These are changes that are considered major and could have a significant impact on health and safety. The staff considered two options for the types of changes that would require NRC pre-approval. Option 1 is consistent with the types of changes that have required pre-approval at Part 70 licensees in the past, and which the staff believes would require NRC pre-approval for only a relatively few significant changes. Option 2 is consistent with the change control process required for Part 50 licensees (power reactors) and which the staff believes would require more requests for NRC pre-approval.

The advantages of Option 1 are that it focuses on the most significant changes to the facility and is equivalent to looking at the highest risk changes. It contains very little subjective criteria and is therefore easier to implement and inspect. It also would likely only result in a few license amendments a year which is generally consistent with the past practice at these facilities. Since Option 1 would permit more changes without NRC pre-approval, a relatively short timeframe (90 days) for submitting updated ISA summary pages is required in order for NRC to have information that reflects the current status of the facility and to be confident that adequate protection is still provided with the changes, as reflected in the ISA summary. The advantages of Option 2 are that NRC would have more control over the changes at the facilities, i.e., staff expects that more changes would be reviewed by the staff before being implemented; thus, it would be less likely that NRC would have a concern with a change after the fact; and it is consistent with the change control process at power reactors, where changes are reported only after 12 months.

The proposed rule language reflects Option 1.

Section 70.73 Renewal of Licenses

Under the proposed amendments to Part 70, changes to site, structures, systems, equipment, components, and activities of personnel made by the licensee pursuant to § 70.72 would be documented on a continuing basis on-site. A description of those changes would also be sent to NRC periodically. This process is intended to keep the documents, which support the license, current and thereby establish a ''living'' license. In the past, the license renewal process was burdensome to NRC and the licensee because all changes made to the facility since the last license renewal

would be reviewed at one time. However, with the proposed ''living license,'' changes to the facility will be reviewed by NRC either before changes are made, or relatively shortly thereafter. As a result, review of the license renewal application is expected to be performed with minimal additional review of the licensee's safety program. This approval would be contingent on the licensee satisfying any requirements associated with the National Environmental Policy Act of 1969 as implemented in 10 CFR Part 51.

Section 70.74 Additional Reporting Requirements

The new requirements that would be incorporated in the proposed amendments to Part 70 would revise the reporting of events to NRC. This new approach, based on consideration of the risk and consequences established in 10 CFR 70.61(b) is intended to replace and expand on the approach licensees have currently been using for reporting criticality events under Bulletin 91–01. The new approach would cover all types of events, not just criticality events, and establish a timeframe for reporting that is scaled according to risk. The new reporting requirements are intended to supplement the requirements in the existing Parts 20 and 70 and elsewhere in the regulations. A more detailed discussion of the new requirements is found in the following discussion of Appendix A to Part 70.

Appendix A Reportable Events

The reporting of events supports NRC's need to be aware of conditions that could result in an imminent danger to the worker or to public health and safety or to the environment. In particular, NRC needs to be aware of licensee efforts to address potential emergencies. Further, once safe conditions have been restored after an event, NRC has an interest in disseminating information on the event to the nuclear industry and other interested parties, to reduce the likelihood that the event will occur in the future. Also, in the event of an accident, NRC must be able to respond accurately to requests for information by the public and the media. Finally, NRC must evaluate the performance of individual licensees and the industry as a whole to fulfill its statutory mandate to protect the health and safety of the worker and the public and the environment.

Licensee reporting of events would consist of two reporting classes based on the hazard—reports that must be made in 1 hour and those to be reported within 24 hours. According to this approach, licensees would report events based on two criteria: (1) Whether actual consequences have occurred or whether a potential for such consequences exists; and (2) the seriousness of the consequences. The events that must be reported within the shortest timeframe (1 hour) are high-consequence events. These events encompass unintended criticalities and loss of criticality controls, and loss of chemical controls or the occurrence of chemical exposures that exceed the performance requirements in § 70.61(b).

Less serious events or failure to meet the performance requirements for reasons not otherwise specifically stated, that have occurred shall be reported within 24 hours. These include chemical exposure to licensed material or hazardous chemicals that exceed the lower threshold limits in § 70.61(c)(4), and events that were dismissed in the ISA based on likelihood.

Events that could potentially lead to exceeding the performance requirements in § 70.61 should also be reported. External events, such as a hurricane, tornado, earthquake, flood, or fire, either internal or external to the plant, that affected or could have affected a facility, must be reported within 24 hours. This reporting requirement would capture, for example, a tornado that strikes a facility, an earthquake motion experienced by a facility, or any type of fire. Since these events could have affected a facility, NRC would want to know about such events to assess a licensee's conclusion of whether any detrimental effects did in fact occur, or could have occurred in the absence of controls that were present but not part of the safety basis. Another category of potential events that would be reported is one that involves the existence of an unsafe condition that is not identified in the ISA. This condition could be caused by a deviation from established safe operating conditions, by an unanticipated and unanalyzed set of circumstances, or by an improper analysis. This type of event would be reported within 24 hours.

The proposed rule also would require concurrent reporting of events when a news release is made or if other Government agencies are notified, as is done under 10 CFR Part 50.72, to support NRC's ability to be responsive to questions concerning the safety of NRC-licensed facilities.

References

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U.S. Nuclear Regulatory Commission, ''Proposed Methods for Regulating Major Materials Licensees,'' NUREG–1324, Washington, DC, February 1992.

U.S. Nuclear Regulatory Commission/ Occupational Safety and Health Administration (OSHA), ''Memorandum of Understanding Between NRC and OSHA; Worker Protection at NRC-Licensed Facilities'' (53 FR 43950; October 31, 1988).

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U.S. Nuclear Regulatory Commission, ''Abnormal Occurrence Reports: Implementation of Section 208 of Energy Reorganization Act of 1974'' (61 FR 67072; December 19, 1996).

U.S. Nuclear Regulatory Commission, ''Site Decommissioning Management Plan,'' NUREG–1444, Washington, DC, October 1993.

U.S. Nuclear Regulatory Commission, ''Strategic Plan, Fiscal Year 1997—Fiscal Year 2002,'' NUREG–1614, Washington, DC, September 1997.

U.S. Environmental Protection Agency, ''Manual of Protective Action Guides and Protective Actions for Nuclear Incidents,'' EPA–400–R–92–001, May 1992.

U.S. Nuclear Regulatory Commission, ''Instruction Concerning Risks from Occupational Radiation Exposure,'' Regulatory Guide 8.29, Rev. 1, February 1996.

Theide, L., ''Emergency Information Where It's Needed,'' DOE Risk Management Quarterly, Vol 5, No 2, Richland, WA, May 1997.

These documents are available for inspection and copying for a fee at the NRC Public Document Room, 2120 L Street, NW (Lower Level), Washington DC 20555–0001.

Copies of NUREG–1324, NUREG–1614, and NUREG–1444 may also be purchased from the Superintendent of Documents, U.S. Government Printing Office, P.O. Box 37082, Washington DC 20402–9328. Copies are also available

from the National Technical Information Service, 5285 Port Royal Road, Springfield VA 22161.

Regulatory Guide 8.29 may be purchased from the Government Printing Office (GPO) at the current GPO price. Information on current GPO prices may be obtained by contacting the Superintendent of Documents, U.S. Government Printing Office, P.O. Box 37082, Washington DC 20402–9328. Issued guides may also be purchased from the National Technical Information Service on a standing-order basis. Details on this service may be obtained by writing NTIS, 5285 Port Royal Road, Springfield, VA 22161.

Copies of the following draft regulatory guidance documents may be requested by writing to U.S. Nuclear Regulatory Commission, Reproduction and Distribution Services, Washington, DC 20555–0001: ''Standard Review Plan for the Review of a License Application for a Fuel Cycle Facility'' (Draft NUREG–1520); and ''Integrated Safety Analysis Guidance Document'' (Draft NUREG–1513).

Plain Language

The Presidential Memorandum dated June 1, 1998, entitled ''Plain Language in Government Writing,'' directed that the Federal government's writing be in plain language. The NRC requests comments on this proposed rule specifically with respect to the clarity and effectiveness of the language used. Comments should be sent to the address listed above.

Finding of No Significant Environmental Impact: Availability

The Commission has determined, under the National Environmental Policy Act of 1969, as amended, and the Commission's regulations in Subpart A of 10 CFR Part 51, that this rule, if adopted, would not be a major Federal action significantly affecting the quality of the human environment, and therefore an environmental impact statement is not required.

The proposed amendments to Part 70 are intended to provide increased confidence in the margin of safety at certain facilities that possess a critical mass of SNM. To accomplish this objective, the amendments: (1) Identify appropriate consequence criteria and the level of protection needed to prevent or mitigate accidents that exceed such criteria; (2) require affected licensees to perform an integrated safety analysis (ISA) to identify potential accidents at the facility and the items relied on for safety; (3) require the implementation of measures to ensure that the items relied on for safety are available and reliable to perform their function when needed; and (4) require the inclusion of the safety bases, as reflected in the ISA summary, in the license application. The language, in the proposed rule, that defines an environmental consequence of concern, is relevant to the question of environmental impact. Licensees would be required to provide an adequate level of protection against a ''* * * release of radioactive material to the environment outside the restricted area in concentrations that, if averaged over 24 hours, exceed 5000 times the values specified in Table 2 of Appendix B to 10 CFR Part 20.'' Implementation of the new amendments, including the requirement to protect against events that could damage the environment, is expected to result in a significant improvement in licensees' (and NRC's) understanding of the risks at their facilities and their ability to ensure that those risks are acceptable. For existing licensees, any deficiencies identified in the ISA would need to be promptly addressed. For new licensees, operations would not begin unless licensees demonstrated an adequate level of protection against potential accidents identified in the ISA. As a result, the safety and environmental impact of the new amendments is positive. There will be less adverse impact on the environment from operations carried out in accordance with the proposed rule than if those operations were carried out in accordance with the existing Part 70 regulation.

The determination of this Environmental Assessment is that there will be no significant offsite impact on the public from this action. However, the general public should note that NRC welcomes public participation. NRC has also committed to complying with Executive Order (EO) 12898, ''Federal Actions to Address Environmental Justice in Minority Populations and Low-Income Populations,'' dated February 11, 1994, in all its actions. Therefore, NRC has also determined that there are no disproportionate, high, and adverse impacts on minority and low-income populations. In the letter and spirit of EO 12898, NRC is requesting public comment on any environmental justice considerations or questions that the public thinks may be related to this proposed rule, but somehow were not addressed. Comments on any aspect of the Environmental Assessment, including environmental justice, may be submitted to NRC, as indicated under the **ADDRESSES** heading.

NRC has sent a copy of the Environmental Assessment and this proposed rule to all State Liaison Officers and requested their comments on the Environmental Assessment. The Environmental Assessment is available for inspection at the NRC Public Document Room, 2120 L Street NW. (Lower Level), Washington, DC and the Part 70 website. Single copies of the environmental assessment are available from Barry Mendelsohn, Office of Nuclear Material Safety and Safeguards, U.S. Nuclear Regulatory Commission, Washington, DC, 20555–0001, telephone (301) 415–7262; e-mail: btm1@nrc.gov.

Paperwork Reduction Act Statement

This proposed rule amends information collection requirements that are subject to the Paperwork Reduction Act of 1995 (44 U.S.C. 3501, *et seq.*). This rule has been submitted to the Office of Management and Budget (OMB) for review and approval of the paperwork requirements.

The public reporting burden for this information collection is estimated to average 99 hours per *response*, and the recordkeeping burden is estimated to average 560 hours per licensee, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the information collection. NRC is seeking public comment on the potential impact of the information collections contained in the proposed rule and on the following issues:

1. Is the proposed information collection necessary for the proper performance of NRC's function? Will the information have practical utility?
2. Is the burden estimate accurate?
3. Is there a way to enhance the quality, utility, and clarity of the information to be collected?
4. How can the burden of the information collection be minimized, including the use of automated collection techniques?

Send comments on any aspect of this proposed information collection, including suggestions for reducing the burden, to the Records Management Branch (T–6–F33), U.S. Nuclear Regulatory Commission, Washington, DC 20555–0001, or by Internet electronic mail at bjs1@nrc.gov; and to the Desk Officer, Office of Information and Regulatory Affairs, NEOB–10202 (3150–0009), Office of Management and Budget, Washington, DC 20503.

Comments to OMB on the information collections or on the above issues should be submitted by August 30, 1999. Comments received after this date will be considered if it is practical to do so, but assurance of consideration cannot be given to comments received after this date.

Public Protection Notification

If a means used to impose an information collection does not display a currently valid OMB control number, the NRC may not conduct nor sponsor, and a person is not required to respond to, the information collection.

Regulatory Analysis

The Commission has prepared a draft Regulatory Analysis on this proposed regulation. The analysis examines the benefits and costs of the alternatives considered by the Commission. The draft Regulatory Analysis is available for inspection in the NRC Public Document Room, 2120 L Street NW (Lower Level), Washington, DC and the Part 70 website. Single copies of the analysis may be obtained from Barry T. Mendelsohn, Office of Nuclear Material Safety and Safeguards, U.S. Nuclear Regulatory Commission, Washington, DC, telephone (301) 415–7262, e-mail: btm1@nrc.gov.

The Commission requests public comment on the draft Regulatory Analysis. Comments on the draft analysis may be submitted to NRC as indicated under the **ADDRESSES** heading.

Regulatory Flexibility Certification

As required by the Regulatory Flexibility Act, as amended, 5 U.S.C. 605(b), the Commission certifies that this proposed rule, if adopted, would not have a significant economic impact on a substantial number of small entities. This proposed rule would affect facilities that are authorized to possess a critical mass of SNM and who are engaged in one of the following activities: (a) enriched uranium processing; (b) fabrication of uranium fuel or fuel assemblies; (c) uranium enrichment; (d) enriched uranium hexafluoride conversion; (e) plutonium processing; (f) fabrication of mixed-oxide fuel or fuel assemblies; (g) scrap recovery of special nuclear material; or (h) any other activity involving a critical mass of SNM that the Commission determines could significantly affect public health and safety or the environment. These licensees do not fall within the scope of the definition of ''small entities'' set forth in the Regulatory Flexibility Act, nor the size standards published by NRC (10 CFR 2.810).

Voluntary Consensus Standards

The National Technology Transfer Act of 1995, Pub. L. 104–113, requires that Federal Agencies use technical standards that are developed or adopted by voluntary consensus standards bodies unless the use of such a standard is inconsistent with applicable law or otherwise impractical. In this proposed rule, the NRC proposes to use the following voluntary consensus standard, ANSI/ANS Standard 8.1–1983, ''Nuclear Criticality Safety in Operations with Fissionable Material Outside Reactors,'' developed by the American Nuclear Society. Portions of the standard were used in the definition of double contingency and in § 70.61(d). The NRC invites comment on the applicability and use of other standards.

Backfit Analysis

NRC has determined that the backfit rule does not apply to this proposed rule; therefore, a backfit analysis is not required for this proposed rule because these amendments do not involve any provisions that would impose backfits as defined in 10 CFR Chapter I.

List of Subjects in 10 CFR Part 70

Criminal penalties, Hazardous materials transportation, Material control and accounting, Nuclear materials, Packaging and containers, Radiation protection, Reporting and recordkeeping requirements, Scientific equipment, Security measures, Special nuclear material.

For the reasons set out in the preamble and under the authority of the Atomic Energy Act of 1954, as amended; the Energy Reorganization Act of 1974, as amended; and 5 U.S.C. 553, NRC is proposing to adopt the following amendments to Part 70.

PART 70—DOMESTIC LICENSING OF SPECIAL NUCLEAR MATERIAL

1. The authority citation for part 70 continues to read as follows:

Authority: Secs. 51, 53, 161, 182, 183, 68 Stat. 929, 930, 948, 953, 954, as amended, sec. 234, 83 Stat. 444, as amended (42 U.S.C. 2071, 2073, 2201, 2232, 2233, 2282, 2297f); secs. 201, as amended, 202, 204, 206, 88 Stat. 1242, as amended, 1244, 1245, 1246 (42 U.S.C. 5841, 5842, 5845, 5846). Sec. 193, 104 Stat. 2835, as amended by Pub. L. 104–134, 110 Stat. 1321, 1321–349 (42 U.S.C. 2243).

Sections 70.1(c) and 70.20a(b) also issued under secs. 135, 141, Pub. L. 97–425, 96 Stat. 2232, 2241 (42 U.S.C. 10155, 10161). Section 70.7 also issued under Pub. L. 95–601, sec. 10, 92 Stat. 2951 (42 U.S.C. 5851). Section 70.21(g) also issued under sec. 122, 68 Stat. 939 (42 U.S.C. 2152). Section 70.31 also issued under sec. 57d, Pub. L. 93–377, 88 Stat. 475 (42 U.S.C. 2077). Sections 70.36 and 70.44 also issued under sec. 184, 68 Stat. 954, as amended (42 U.S.C. 2234). Section 70.61 also issued under secs. 186, 187, 68 Stat. 955 (42 U.S.C. 2236, 2237). Section 70.62 also issued under sec. 108, 68 Stat. 939, as amended (42 U.S.C. 2138).

2. The undesignated center heading ''GENERAL PROVISIONS'' is redesignated as ''Subpart A—General Provisions.''

3. In § 70.4, the definitions of Acute, Available and reliable to perform their function when needed, Configuration management, Critical mass of special nuclear material, Double contingency, Hazardous chemicals produced from licensed material, Integrated safety analysis (ISA), Integrated safety analysis summary, Items relied on for safety, Management measures, Unacceptable performance deficiencies, and Worker are added, in alphabetical order, as follows:

§ 70.4 Definitions.

* * * * *

Acute as used in this part means a single radiation dose or chemical exposure event or multiple radiation dose or chemical exposure events occurring within a short time (24 hours or less).

* * * * *

Available and reliable to perform their function when needed as used in subpart H of this part means that, based upon the analyzed, credible conditions in the integrated safety analysis, items relied on for safety will perform their intended safety function when needed and management measures will be implemented that ensure continuous compliance with the performance requirements of § 70.61 of this part, considering factors such as necessary maintenance, operating limits, common cause failures, and the likelihood and consequences of failure or degradation of the items and measures.

* * * * *

Configuration management (CM) means ensuring, as part of the safety program, oversight and control of design information, safety information, and modifications (both temporary and permanent) that might impact the ability of items relied on for safety to perform their function when needed.

* * * * *

Critical mass of special nuclear material (SNM) means special nuclear material in a quantity exceeding 700 grams of contained uranium-235; 520 grams of uranium-233; 450 grams of plutonium; 1500 grams of contained uranium-235, if no uranium enriched to more than 4 percent by weight of uranium-235 is present; 450 grams of any combination thereof; or one-half such quantities if massive moderators or reflectors made of graphite, heavy water, or beryllium may be present.

* * * * *

Double contingency means a process design that incorporates sufficient factors of safety to require at least two

unlikely, independent, and concurrent changes in process conditions before a criticality accident is possible.

* * * * *

Hazardous chemicals produced from licensed materials means substances having licensed material as precursor compound(s) or substances that physically or chemically interact with licensed materials; that are toxic, explosive, flammable, corrosive, or reactive to the extent that they can endanger life or health if not adequately controlled. These include substances commingled with licensed material, and include substances such as hydrogen fluoride that is produced by the reaction of uranium hexafluoride and water, but do not include substances prior to process addition to licensed material or after process separation from licensed material.

Integrated safety analysis (ISA) means a systematic analysis to identify plant and external hazards and their potential for initiating accident sequences, the potential accident sequences, their likelihood and consequences, and the items relied on for safety. As used here, *integrated* means joint consideration of, and protection from, all relevant hazards, including radiological, nuclear criticality, fire, and chemical. However, with respect to compliance with the regulations of this part, the NRC requirement is limited to consideration of the effects of all relevant hazards on radiological safety, prevention of nuclear criticality accidents, or chemical hazards directly associated with NRC licensed radioactive material.

Integrated safety analysis summary means the document submitted with the license application, license amendment application, or license renewal application that provides a synopsis of the results of the integrated safety analysis and contains the information specified in § 70.65(b).

Items relied on for safety means structures, systems, equipment, components, and activities of personnel that are relied on to prevent potential accidents at a facility that could exceed the performance requirements in § 70.61 or to mitigate their potential consequences. This does not limit the licensee from identifying additional structures, systems, equipment, components, or activities of personnel (i.e., beyond those in the minimum set necessary for compliance with the performance requirements) as items relied on for safety.

* * * * *

Management measures mean the functions performed by the licensee, generally on a continuing basis, that are applied to items relied upon for safety, to ensure the items are available and reliable to perform their functions when needed. Management measures include configuration management, maintenance, training and qualifications, procedures, audits and assessments, incident investigations, records management, and other quality assurance elements.

* * * * *

Unacceptable performance deficiencies mean deficiencies in the items relied on for safety or the management measures that need to be corrected to ensure an adequate level of protection as defined in 10 CFR 70.61(b), (c), or (d).

* * * * *

Worker means an individual whose assigned duties in the course of employment involve exposure to radiation and/or radioactive material from licensed and unlicensed sources of radiation (i.e., an individual who is subject to an *occupational* dose as in 20 CFR 20.1003).

4. In § 70.8 paragraph (b) is revised to read as follows.

§ 70.8 Information collection requirements: OMB approval.

* * * * *

(b) The approved information collection requirements contained in this part appear in §§ 70.9, 70.17, 70.19, 70.20a, 70.20b, 70.21, 70.22, 70.24, 70.25, 70.32, 70.33, 70.34, 70.38, 70.39, 70.42, 70.50, 70.51, 70.52, 70.53, 70.57, 70.58, 70.59, 70.61, 70.62, 70.64, 70.65, 70.72, 70.73, 70.74 and Appendix A.

* * * * *

5. The undesignated center heading ''EXEMPTIONS'' is redesignated as ''Subpart B—Exemptions.''

§§ 70.13a and 70.14 [Redesignated]

6. Sections 70.13a and 70.14 are redesignated as §§ 70.14 and 70.17, respectively.

7. The undesignated center heading ''GENERAL LICENSES'' is redesignated as ''Subpart C—General Licenses.''

8. The undesignated center heading ''LICENSE APPLICATIONS'' is redesignated as ''Subpart D—License Applications.''

9. The undesignated center heading ''LICENSES'' is redesignated as ''Subpart E—Licenses.''

10. The undesignated center heading ''ACQUISITION, USE AND TRANSFER OF SPECIAL NUCLEAR MATERIAL, CREDITORS' RIGHTS,'' is redesignated as ''Subpart F—Acquisition, Use, and Transfer of Special Nuclear Material, Creditors' Rights.''

11. The undesignated center heading ''SPECIAL NUCLEAR MATERIAL CONTROL RECORDS, REPORTS AND INSPECTIONS'' is redesignated as ''Subpart G—Special Nuclear Material Control Records, Reports, and Inspections.''

12. In § 70.50 paragraph (c) is revised and paragraph (d) is added to read as follows.

§ 70.50 Reporting requirements.

* * * *

(c) Preparation and submission of reports. Reports made by licensees in response to the requirements of this section must be made as follows:

(1) Licensees shall make reports required by paragraphs (a) and (b) of this section, and by § 70.74 and appendix A of this part if applicable, by telephone to the NRC Operations Center.[3] To the extent that the information is available at the time of notification, the information provided in these reports must include:

(i) Caller's name, position title and call back telephone number;

(ii) Date, time, and exact location of the event;

(iii) Description of the event, including;

(A) Radiological or chemical hazards involved including isotopes, quantities, and chemical and physical form of any material released;

(B) Actual or potential health and safety consequences to the workers, the public, and the environment, including relevant chemical and radiation data for actual personnel exposures to radiation or radioactive materials or chemicals (e.g., level of radiation exposure, concentration of chemicals, and duration of exposure);

(C) The sequence of occurrences leading to the event, including degradation or failure of structures, systems, equipment, components, and activities of personnel relied on to prevent potential accidents or mitigate their consequences; and

(D) Whether the remaining structures, systems, equipment, components, and activities of personnel relied on to prevent potential accidents or mitigate their consequences are available and reliable to perform their function.

(iv) External conditions affecting the event;

(v) Additional actions taken by the licensee in response to the event;

(vi) Status of the event (e.g., whether the event is on-going or was terminated);

(vii) Current and planned site status, including any declared emergency class;

[3] The commercial telephone number for the NRC Operations Center is (301) 816–5100.

(viii) Notifications related to the event that were made or are planned to any local, State, or other Federal agencies;

(ix) Status of any press releases related to the event that were made or are planned.

(2) Written report. Each licensee who makes a report required by paragraph (a) or (b) of this section, or by § 70.74 and appendix A of this part if applicable, shall submit a written follow-up report within 30 days of the initial report. Written reports prepared pursuant to other regulations may be submitted to fulfill this requirement if the report contains all of the necessary information and the appropriate distribution is made. These written reports must be sent to the U.S. Nuclear Regulatory Commission, Document Control Desk, Washington, DC 20555, with a copy to the appropriate NRC regional office listed in appendix D of 10 CFR part 20. The reports must include the following:

(i) Complete applicable information required by § 70.50(c)(1);

(ii) The probable cause of the event, including all factors that contributed to the event and the manufacturer and model number (if applicable) of any equipment that failed or malfunctioned;

(iii) Corrective actions taken or planned to prevent occurrence of similar or identical events in the future and the results of any evaluations or assessments; and

(iv) For licensees subject to subpart H of this part, whether the event was identified and evaluated in the Integrated Safety Analysis.

(d) The provisions of § 70.50 do not apply to licensees subject to § 50.72. They do apply to those part 50 licensees possessing material licensed under part 70 who are not subject to the notification requirements in § 50.72.

13. The undesignated center heading ''MODIFICATION AND REVOCATION OF LICENSES'' is redesignated as ''Subpart I—Modification and Revocation of Licenses.''

§§ 70.61 and 70.62 [Redesignated]

14. Sections 70.61 and 70.62 are redesignated as §§ 70.81 and 70.82, respectively.

15. The undesignated center heading ''ENFORCEMENT'' is redesignated as ''Subpart J—Enforcement.''

§§ 70.71 and 70.72 [Redesignated]

16. Sections 70.71 and 70.72 are redesignated as §§ 70.91 and 70.92, respectively.

17. In part 70, a new subpart H (§§ 70.60–70.74) is added to read as follows:

Subpart H—Additional Requirements for Certain Licensees Authorized to Possess a Critical Mass of Special Nuclear Material

Sec.
70.60 Applicability.
70.61 Performance requirements.
70.62 Safety program and integrated safety analysis.
70.64 Requirements for new facilities or new processes at existing facilities.
70.65 Additional content of applications.
70.66 Additional requirements for approval of license application.
70.72 Facility changes and change process.
70.73 Renewal of licenses.
70.74 Additional reporting requirements.

§ 70.60 Applicability.

The regulations in § 70.61 through § 70.74 apply, in addition to other applicable Commission regulations, to each applicant or licensee that is or plans to be: authorized to possess greater than a critical mass of special nuclear material, and engaged in enriched uranium processing, fabrication of uranium fuel or fuel assemblies, uranium enrichment, enriched uranium hexafluoride conversion, plutonium processing, fabrication of mixed-oxide fuel or fuel assemblies, scrap recovery of special nuclear material, or any other activity that the Commission determines could significantly affect public health and safety. The regulations in § 70.61 through § 70.74 do not apply to decommissioning activities performed pursuant to other applicable Commission regulations including § 70.25 and § 70.38 of this Part. Also, the regulations in § 70.61 through § 70.74 do not apply to activities that are certified by the Commission pursuant to Part 76 of this chapter or licensed by the Commission pursuant to other parts of this chapter.

§ 70.61 Performance requirements.

(a) Each applicant or licensee shall evaluate, in the integrated safety analysis performed in accordance with § 70.62, its compliance with the performance requirements in paragraphs (b), (c), and (d) of this section.

(b) The risk of each credible high-consequence event must be limited, unless the event is highly unlikely, through the application of engineered controls, administrative controls, or both, that reduce the likelihood of occurrence of the event or its consequence. Application of additional controls is not required for those high-consequence events demonstrated to be highly unlikely. High-consequence events are those internally or externally initiated events that result in:

(1) An acute worker dose of 1 Sv (100 rem) or greater total effective dose equivalent;

(2) An acute dose of 0.25 Sv (25 rem) or greater total effective dose equivalent to any individual located outside the controlled area identified pursuant to paragraph (f) of this section;

(3) An intake of 30 mg or greater of uranium in soluble form by any individual located outside the controlled area identified pursuant to paragraph (f) of this section; or

(4) An acute chemical exposure to an individual from licensed material or hazardous chemicals produced from licensed material that:

(i) Could endanger the life of a worker, or

(ii) Could lead to irreversible or other serious, long-lasting health effects to any individual located outside the controlled area identified pursuant to paragraph (f) of this section. If an applicant possesses or plans to possess quantities of material capable of such chemical exposures, then the applicant shall propose appropriate quantitative standards for these health effects, as part of the information submitted pursuant to § 70.65 of this part.

(c) The risk of each credible intermediate-consequence event must be limited, unless the event is unlikely, through the application of engineered controls, administrative controls, or both, that reduce the likelihood of occurrence of the event or its consequence. Application of additional controls is not required for those intermediate-consequence events demonstrated to be unlikely. Intermediate-consequence events are those internally or externally initiated events, that are not high-consequence events, that result in:

(1) An acute worker dose of 0.25 Sv (25 rem) or greater total effective dose equivalent;

(2) An acute dose of 0.05 Sv (5 rem) or greater total effective dose equivalent to any individual located outside the controlled area identified pursuant to paragraph (f) of this section;

(3) A 24-hour averaged release of radioactive material outside the restricted area in concentrations exceeding 5000 times the values in table 2 of appendix B to 10 CFR part 20; or

(4) An acute chemical exposure to an individual from licensed material or hazardous chemicals produced from licensed material that:

(i) Could lead to irreversible or other serious, long-lasting health effects to a worker, or

(ii) Could cause mild transient health effects to any individual located outside the controlled area as specified in

paragraph (f) of this section. If an applicant possesses or plans to possess quantities of material capable of such chemical exposures, then the applicant shall propose appropriate quantitative standards for these health effects, as part of the information submitted pursuant to § 70.65 of this part.

(d) In addition to complying with paragraphs (b) and (c) of this section, the risk of nuclear criticality accidents must be limited by assuring that under normal and credible abnormal conditions, all nuclear processes are subcritical, including use of an approved margin of subcriticality for safety. Preventive controls and measures must be the primary means of protection against nuclear criticality accidents.

(e) Each engineered or administrative control or control system necessary to comply with paragraphs (b), (c), or (d) of this section shall be designated as an item relied on for safety. The safety program, established and maintained pursuant to § 70.62 of this part, shall ensure that each item relied on for safety will be available and reliable to perform its intended function when needed and in the context of the performance requirements of this section.

(f) Each licensee must establish a controlled area, as defined in § 20.1003, in which the licensee retains the authority to determine all activities, including exclusion or removal of personnel and property from the area. For the purpose of complying with the performance requirements of this section, individuals who are not workers, as defined in § 70.4, may be permitted to perform ongoing activities (e.g., at a facility not related to the licensed activities) in the controlled area, if the licensee:

(1) Demonstrates and documents, in the integrated safety analysis, that the risk for those individuals at the location of their activities does not exceed the performance requirements of paragraphs (b)(2), (b)(3), (b)(4)(ii), (c)(2), and (c)(4)(ii) of this section; or

(2) Provides: training in accordance with 10 CFR 19.12(a)(1)–(5) to these individuals to ensure that they are aware of the risks associated with accidents involving the licensed activities as determined by the integrated safety analysis, and conspicuously posts and maintains notices stating where the information in 10 CFR 19.11(a) may be examined by these individuals. Under these conditions, the performance requirements for workers specified in paragraphs (b) and (c) of this section may be applied to these individuals.

§ 70.62 Safety program and integrated safety analysis.

(a) Safety program. (1) Each licensee shall establish and maintain a safety program that demonstrates compliance with the performance requirements of § 70.61. The safety program may be graded such that management measures applied are commensurate with the reduction of the risk attributable to that item. The three elements of the safety program; namely, process safety information, integrated safety analysis, and management measures, are described in paragraphs (b) through (d) of this section.

(2) Each licensee shall establish and maintain records that demonstrate compliance with the requirements of paragraphs (b) through (d) of this section.

(3) Each licensee shall establish and maintain a log, available for NRC inspection, documenting each discovery that an item relied on for safety or management measure has failed to perform its function either in the context of the performance requirements of § 70.61 or upon demand. This log must identify the item relied on for safety or management measure that has failed and the safety function affected, the date of discovery, date (or estimated date) of the failure, duration (or estimated duration) of the time that the item was unable to perform its function, any other affected items relied on for safety or management measures and their safety function, affected processes, cause of the failure, whether the failure was in the context of the performance requirements or upon demand or both, and any corrective or compensatory action that was taken. The log must be initiated at the time of discovery and updated promptly upon the conclusion of each investigation of a failure of an item relied on for safety or management measure.

(b) Process safety information. Each licensee or applicant shall maintain process safety information to enable the performance of an integrated safety analysis. This process safety information must include information pertaining to the hazards of the materials used or produced in the process, information pertaining to the technology of the process, and information pertaining to the equipment in the process.

(c) Integrated safety analysis. (1) Each licensee or applicant shall conduct an integrated safety analysis, that is of appropriate detail for the complexity of the process, that identifies:

(i) Radiological hazards related to possessing or processing licensed material at its facility;

(ii) Chemical hazards of licensed material and hazardous chemicals produced from licensed material;

(iii) Facility hazards which could affect the safety of licensed materials and thus present an increased radiological risk;

(iv) Potential accident sequences caused by process deviations or other events internal to the plant and credible external events, including natural phenomena;

(v) The consequence and the likelihood of occurrence of each potential accident sequence identified pursuant to paragraph (c)(1)(iv) of this section, and the methods used to determine the consequences and likelihoods; and

(vi) Each item relied on for safety identified pursuant to § 70.61(e) of this part, the characteristics of its preventive, mitigative, or other safety function, and the assumptions and conditions under which the item is relied upon to support compliance with the performance requirements of § 70.61.

(2) Integrated safety analysis team qualifications. In order to assure the adequacy of the integrated safety analysis, the analysis must be performed by a team with expertise in engineering and process operations. The team shall include at least one person who has experience and knowledge specific to each process being evaluated, and persons who have experience in nuclear criticality safety, radiation safety, fire safety, and chemical process safety. One member of the team must be knowledgeable in the specific integrated safety analysis methodology being used.

(3) Requirements for existing licensees. Notwithstanding other provisions regarding the effective date for part 70, subpart H, requirements, licensees shall comply with the provisions in paragraphs (c)(3)(i), (ii), and (iii) of this section beginning on [the date of publication of the final rule]. Individuals holding an NRC license on [the date of publication of the final rule] shall, with regard to existing licensed activities:

(i) Within 6 months of the effective date of the rule, submit for NRC approval, a plan that describes the integrated safety analysis approach that will be used, the processes that will be analyzed, and the schedule for completing the analysis of each process.

(ii) Within 4 years of the effective date of the rule, complete an integrated safety analysis, correct all unacceptable performance deficiencies, and submit an integrated safety analysis summary in accordance with § 70.65 or the approved

plan submitted under paragraph (c)(3)(i) of this section.

(iii) Pending the correction of unacceptable performance deficiencies identified during the conduct of the integrated safety analysis, the licensee shall implement appropriate compensatory measures to ensure adequate protection.

(d) Management measures. Each applicant or licensee shall establish management measures to provide continuing assurance of compliance with the performance requirements of § 70.61. The measures applied to a particular engineered or administrative control or control system may be commensurate with the reduction of the risk attributable to that control or control system. The management measures shall ensure that engineered and administrative controls and control systems that are identified as items relied on for safety pursuant to § 70.61(e) of this part are designed, implemented, and maintained, as necessary, to ensure they are available and reliable to perform their function when needed, in the context of compliance with the performance requirements of § 70.61 of this part.

§ 70.64 Requirements for new facilities or new processes at existing facilities.

(a) Baseline design criteria. Each prospective applicant or licensee shall address the following baseline design criteria in the design of new facilities. Each existing licensee shall address the following baseline design criteria in the design of new processes at existing facilities that require a license amendment under § 70.72. The baseline design criteria must be applied to the design of new facilities and new processes, but do not require retrofits to existing facilities or existing processes (e.g., those housing or adjacent to the new process); however, all facilities and processes must comply with the performance requirements in § 70.61. Licensees shall maintain the application of these criteria unless the evaluation performed pursuant to paragraph (c) of this section demonstrates that a given item is not relied on for safety or does not require adherence to the specified criteria.

(1) *Quality standards and records.* The design must be developed and implemented in accordance with management measures, to provide adequate assurance that items relied on for safety will be available and reliable to perform their function when needed. Appropriate records of these items must be maintained by or under the control of the licensee throughout the life of the facility.

(2) *Natural phenomena hazards.* The design must provide for adequate protection against natural phenomena with consideration of the most severe documented historical events for the site.

(3) *Fire protection.* The design must provide for adequate protection against fires and explosions.

(4) *Environmental and dynamic effects.* The design must provide for adequate protection from environmental conditions and dynamic effects associated with normal operations, maintenance, testing, and postulated accidents that could lead to loss of safety functions.

(5) *Chemical protection.* The design must provide for adequate protection against chemical risks produced from licensed material, plant conditions which affect the safety of licensed material, and hazardous chemicals produced from licensed material.

(6) *Emergency capability.* The design must provide for emergency capability to maintain control of:

(i) Licensed material;

(ii) Evacuation of personnel; and

(iii) Onsite emergency facilities and services that facilitate the use of available offsite services.

(7) *Utility services.* The design must provide for continued operation of essential utility services.

(8) *Inspection, testing, and maintenance.* The design of items relied on for safety must provide for adequate inspection, testing, and maintenance, to ensure their availability and reliability to perform their function when needed.

(9) *Criticality control.* The design must provide for criticality control including adherence to the double contingency principle.

(10) *Instrumentation and controls.* The design must provide for inclusion of instrumentation and control systems to monitor and control the behavior of items relied on for safety.

(b) Facility and system design and plant layout must be based on defense-in-depth practices.[4] The design process must incorporate, to the extent practicable:

(1) Preference for the selection of engineered controls over administrative controls to increase overall system reliability; and

(2) Features that enhance safety by reducing challenges to items relied on for safety.

§ 70.65 Additional content of applications.

(a) In addition to the contents required by § 70.22, each application must include a description of the applicant's safety program established under § 70.62, including the integrated safety analysis summary and a description of the management measures.

(b) The integrated safety analysis summary must be submitted with the license or renewal application (and amendment application as necessary), but shall not be incorporated in the license. However, changes to the integrated safety analysis summary shall meet the conditions of § 70.72. The integrated safety analysis summary must contain:

(1) A general description of the site with emphasis on those factors that could affect safety (i.e., meteorology, seismology);

(2) A general description of the facility with emphasis on those areas that could affect safety, including an identification of the controlled area boundaries;

(3) A description of each process (defined as a single reasonably simple integrated unit operation within an overall production line) analyzed in the integrated safety analysis in sufficient detail to understand the theory of operation; and, for each process, the hazards that were identified in the integrated safety analysis pursuant to § 70.62(c)(1)(i)–(iii) and a general description of the types of accident sequences;

(4) Information that demonstrates the licensee's compliance with the performance requirements of § 70.61; the requirements for criticality monitoring and alarms in § 70.24; and, if applicable, the requirements of § 70.64;

(5) A description of the team, qualifications, and the methods used to perform the integrated safety analysis;

(6) A list briefly describing all items relied on for safety which are identified pursuant to § 70.61(e) in sufficient detail to understand their functions in relation to the performance requirements of § 70.61;

(7) A description of the proposed quantitative standards used to assess the consequences from acute chemical

[4] As used in § 70.64, defense-in-depth practices means a design philosophy, applied from the outset and through completion of the design, that is based on providing successive levels of protection such that health and safety will not be wholly dependent upon any single element of the design, construction, maintenance, or operation of the facility. The net effect of incorporating defense-in-depth practices is a conservatively designed facility and system that will exhibit greater tolerance to failures and external challenges. The risk insights obtained through performance of the integrated safety analysis can be then used to supplement the final design by focusing attention on the prevention and mitigation of the higher-risk potential accidents.

exposure to licensed material or chemicals produced from licensed materials which are on-site, or expected to be on-site as described in § 70.61(b)(4) and (c)(4);

(8) A descriptive list that identifies all items relied on for safety that are the sole item preventing or mitigating an accident sequence that exceeds the performance requirements of § 70.61; and

(9) A description of the definitions of likely, unlikely, highly unlikely, and credible as used in the evaluations in the integrated safety analysis.

§ 70.66 Additional requirements for approval of license application.

An application for a license from an applicant subject to subpart H will be approved if the Commission determines that the applicant has complied with the requirements of § 70.21, § 70.22, § 70.23 and § 70.60 through § 70.65.

§ 70.72 Facility changes and change process.

(a) The licensee shall establish a configuration management system to evaluate, implement, and track each change to the site, structures, processes, systems, equipment, components, computer programs, and activities of personnel. This system must be documented in written procedures and must assure that the following are addressed prior to implementing any change:

(1) The technical basis for the change;

(2) Impact of the change on safety and health or control of licensed material;

(3) Modifications to existing operating procedures including any necessary training or retraining before operation;

(4) Authorization requirements for the change;

(5) For temporary changes, the approved duration (e.g., expiration date) of the change; and

(6) The impacts or modifications to the integrated safety analysis, integrated safety analysis summary, or other safety program information, developed in accordance with § 70.62.

(b) Any change to site, structures, processes, systems, equipment, components, computer programs, and activities of personnel must be evaluated by the licensee as specified in paragraph (a) of this section, before the change is implemented. The evaluation of the change must determine, before the change is implemented, if an amendment to the license is required to be submitted in accordance with § 70.34.

(c) The licensee may make changes to the site, structures, processes, systems, equipment, components, computer programs, and activities of personnel, without prior Commission approval, if the change:

(1) Does not:

(i) Create new types [5] of accident sequences that, unless mitigated or prevented, would exceed the performance requirements of § 70.61 and that have not previously been described in the integrated safety analysis summary; or

(ii) Use new processes, technologies, or control systems for which the licensee has no prior experience;

(2) Does not remove, without at least an equivalent replacement of the safety function, an item relied on for safety that is listed in the integrated safety analysis summary;

(3) Does not alter any item relied on for safety, listed in the integrated safety analysis summary, that is the sole item preventing or mitigating an accident sequence that exceeds the performance requirements of § 70.61; and

(4) Is not otherwise prohibited by this section, license condition, or order.

(d)(1) For any changes that affect the integrated safety analysis summary, as submitted in accordance with § 70.65, but do not require NRC pre-approval, the licensee shall submit revised pages to the integrated safety analysis summary, to NRC, within 90 days of the change.

(2) For changes that require pre-approval under § 70.72, the licensee shall submit an amendment request to the NRC in accordance with § 70.34 and § 70.65.

(3) A brief summary of all changes to the records required by § 70.62(a)(2) of this part, that are made without prior Commission approval, must be submitted to NRC every 12 months.

(e) If a change covered by § 70.72 is made, the affected on-site documentation must be updated promptly.

(f) The licensee shall maintain records of changes to its facility carried out under this section. These records must include a written evaluation that provides the bases for the determination that the changes do not require prior Commission approval under paragraph (c) or (d) of this section. These records must be maintained until termination of the license.

[5] Any change in the defining characteristics of the elements of an accident sequence may change the ''type'' of the accident sequence for a given process. For example, a new type of accident could involve a different initiator, significant changes in the consequence, or a change in the safety function of a control (e.g., temperature limiting device versus a flow limiting device).

§ 70.73 Renewal of licenses.

Applications for renewal of a license must be filed in accordance with §§ 2.109, 70.21, 70.22, 70.33, 70.38, and 70.65. Information contained in previous applications, statements, or reports filed with the Commission under the license may be incorporated by reference, provided that these references are clear and specific.

§ 70.74 Additional reporting requirements.

(a) *Reports to NRC Operations Center.* (1) Each licensee shall report to the NRC Operations Center the events described in appendix A to part 70.

(2) Reports must be made by a knowledgeable licensee representative and by any method that will ensure compliance with the required time period for reporting.

(3) The information provided must include a description of the event and other related information as described in § 70.50(c)(1).

(4) Follow-up information to the reports must be provided until all information required to be reported in § 70.50(c)(1) of this part is complete.

(5) Each licensee shall provide reasonable assurance that reliable communication with the NRC Operations Center is available during each event.

(b) Written reports. Each licensee who makes a report required by paragraph (a)(1) of this section shall submit a written follow-up report within 30 days of the initial report. The written report must contain the information as described in § 70.50(c)(2).

18. Appendix A to part 70 is added to read as follows:

Appendix A to Part 70—Reportable Safety Events

As required by 10 CFR 70.74, licensees subject to the requirements in subpart H of part 70, shall report:

(a) One hour reports. Events to be reported to the NRC Operations Center within 1 hour of discovery, supplemented with the information in 10 CFR 70.50(c)(1) as it becomes available, followed by a written report within 30 days:

(1) An inadvertent nuclear criticality.

(2) An acute intake by an individual of 30 mg or greater of uranium in a soluble form.

(3) An acute chemical exposure to an individual from licensed material or hazardous chemicals produced from licensed material that exceeds the quantitative standards established to satisfy the requirements in § 70.61(b)(4).

(4) An event or condition such that no items relied on for safety, as documented in the Integrated Safety Analysis summary, remain available and reliable, in an accident sequence evaluated in the Integrated Safety Analysis, to perform their function:

(i) In the context of the performance requirements in § 70.61(b) and § 70.61(c), or

(ii) Prevent a nuclear criticality accident (i.e., loss of all controls in a particular sequence).

(5) Loss of controls such that only one item relied on for safety, as documented in the Integrated Safety Analysis summary, remains available and reliable to prevent a nuclear criticality accident, and has been in this state for greater than eight hours.

(b) Twenty-four hour reports. Events to be reported to the NRC Operations Center within 24 hours of discovery, supplemented with the information in 10 CFR 70.50(c)(1) as it becomes available, followed by a written report within 30 days:

(1) Any event or condition that results in the facility being in a state that was not analyzed, was improperly analyzed, or is different from that analyzed in the Integrated Safety Analysis, and which results in failure to meet the performance requirements of § 70.61.

(2) Loss or degradation of items relied on for safety that results in failure to meet the performance requirement of § 70.61.

(3) An acute chemical exposure to an individual from licensed material or hazardous chemicals produced from licensed materials that exceeds the quantitative standards that satisfy the requirements of § 70.61(c)(4).

(4) Any natural phenomenon or other external event, including fires internal and external to the facility, that has affected or may have affected the intended safety function or availability or reliability of one or more items relied on for safety.

(5) An occurrence of an event or process deviation that was considered in the Integrated Safety Analysis and:

(i) Was dismissed due to its likelihood; or

(ii) Was categorized as unlikely and whose associated unmitigated consequences would have exceeded those in § 70.61(b) had the item(s) relied on for safety not performed their safety function(s).

(c) Concurrent Reports. Any event or situation, related to the health and safety of the public or onsite personnel, or protection of the environment, for which a news release is planned or notification to other government agencies has been or will be made, shall be reported to the NRC Operations Center concurrent to the news release or other notification.

For the Nuclear Regulatory Commission.

Dated at Rockville, Maryland, this 23rd day of July, 1999.

Annette Vietti-Cook,

Secretary of the Commission.

[FR Doc. 99–19363 Filed 7–29–99; 8:45 am]

BILLING CODE 7590–01–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 71

[Airspace Docket No. 99–AAL–14]

Proposed Establishment of Class E Airspace; Kalskag, AK

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Notice of proposed rulemaking.

SUMMARY: This action proposes to establish Class E airspace at Kalskag, AK. The establishment of Global Positioning System (GPS) instrument approach procedures at Kalskag Airport have made this action necessary. The Kalskag Airport status will change from Visual Flight Rules (VFR) to Instrument Flight Rules (IFR). Adoption of this proposal would result in adequate controlled airspace for aircraft flying IFR procedures at Kalskag, AK.

DATES: Comments must be received on or before September 13, 1999.

ADDRESSES: Send comments on the proposal in triplicate to: Manager, Operations Branch, AAL–530, Docket No. 99–AAL–14, Federal Aviation Administration, 222 West 7th Avenue, Box 14, Anchorage, AK 99513–7587.

The official docket may be examined in the Office of the Regional Counsel for the Alaskan Region at the same address.

An informal docket may also be examined during normal business hours in the Office of the Manager, Operations Branch, Air Traffic Division, at the address shown above and on the Internet at Alaskan Region's homepage at http://www.alaska.faa.gov/at or at address http://162.58.28.41/at.

FOR FURTHER INFORMATION CONTACT: Bob Durand, Operations Branch, Federal Aviation Administration, 222 West 7th Avenue, Box 14, Anchorage, AK 99513–7587; telephone number (907) 271–5898; fax: (907) 271–2850; email: Bob.Durand@faa.gov. Internet address: http://www.alaska.faa.gov/at or at address http://162.58.28.41/at.

SUPPLEMENTARY INFORMATION:

Comments Invited

Interested parties are invited to participate in this proposed rulemaking by submitting such written data, views, or arguments as they may desire. Comments that provide the factual basis supporting the views and suggestions presented are particularly helpful in developing reasoned regulatory decisions on the proposal. Comments are specifically invited on the overall regulatory, aeronautical, economic, environmental, and energy-related aspects of the proposal. Communications should identify the airspace docket number and be submitted in triplicate to the address listed above. Commenters wishing the FAA to acknowledge receipt of their comments on this notice must submit with those comments a self-addressed, stamped postcard on which the following statement is made: ''Comments to Airspace Docket No. 99–AAL–14.'' The postcard will be date/time stamped and returned to the commenter. All communications received on or before the specified closing date for comments will be considered before taking action on the proposed rule. The proposal contained in this notice may be changed in light of comments received. All comments submitted will be available for examination in the Operations Branch, Air Traffic Division, Federal Aviation Administration, 222 West 7th Avenue, Box 14, Anchorage, AK, both before and after the closing date for comments. A report summarizing each substantive public contact with FAA personnel concerned with this rulemaking will be filed in the docket.

Availability of NPRM's

An electronic copy of this document may be downloaded, using a modem and suitable communications software, from the FAA regulations section of the Fedworld electronic bulletin board service (telephone: 703–321–3339) or the **Federal Register**'s electronic bulletin board service (telephone: 202–512–1661).

Internet users may reach the **Federal Register**'s web page for access to recently published rulemaking documents at http://www.access.gpo.gov/su__docs/aces/aces140.html.

Any person may obtain a copy of this Notice of Proposed Rulemaking (NPRM) by submitting a request to the Operations Branch, AAL–530, Federal Aviation Administration, 222 West 7th Avenue, Box 14, Anchorage, AK 99513–7587. Communications must identify the notice number of this NPRM. Persons interested in being placed on a mailing list for future NPRM's should contact the individual(s) identified in the **FOR FURTHER INFORMATION CONTACT** section.

The Proposal

The FAA proposes to amend 14 CFR part 71 by establishing Class E airspace at Kalskag, AK, due to the establishment of two GPS instrument approach procedures. The intended effect of this proposal is to provide controlled

airspace for IFR operations at Kalskag, AK.

The area would be depicted on aeronautical charts for pilot reference. The coordinates for this airspace docket are based on North American Datum 83. The Class E airspace areas designated as 700/1200 foot transition areas are published in paragraph 6005 in FAA Order 7400.9F, *Airspace Designations and Reporting Points,* dated September 10, 1998, and effective September 16, 1998, which is incorporated by reference in 14 CFR 71.1 (63 FR 50139; September 21, 1998). The Class E airspace designations listed in this document would be published subsequently in the Order.

The FAA has determined that this proposed regulation only involves an established body of technical regulations for which frequent and routine amendments are necessary to keep them operationally current. It, therefore —(1) is not a ''significant regulatory action'' under Executive Order 12866; (2) is not a ''significant rule'' under DOT Regulatory Policies and Procedures (44 FR 11034; February 26, 1979); and (3) does not warrant preparation of a regulatory evaluation as the anticipated impact is so minimal. Since this is a routine matter that will only affect air traffic procedures and air navigation, it is certified that this rule, when promulgated, will not have a significant economic impact on a substantial number of small entities under the criteria of the Regulatory Flexibility Act.

List of Subjects in 14 CFR Part 71

Airspace, Incorporation by reference, Navigation (air).

The Proposed Amendment

In consideration of the foregoing, the Federal Aviation Administration proposes to amend 14 CFR part 71 as follows:

PART 71— DESIGNATION OF CLASS A, CLASS B, CLASS C, CLASS D, AND CLASS E AIRSPACE AREAS; AIRWAYS; ROUTES; AND REPORTING POINTS

1. The authority citation for 14 CFR part 71 continues to read as follows:

Authority: 49 U.S.C. 106(g), 40103, 40113, 40120; E.O. 10854, 24 FR 9565, 3 CFR, 1959–1963 Comp., p. 389.

§ 71.1 [Amended]

2. The incorporation by reference in 14 CFR 71.1 of Federal Aviation Administration Order 7400.9F, *Airspace Designations and Reporting Points,* dated September 10, 1998, and effective September 16, 1998, is to be amended as follows:

* * * * *

Paragraph 6005 Class E airspace extending upward from 700 feet or more above the surface of the earth.

* * * * *

AAL AK E5 Kalskag, AK [New]

Kalskag Airport
(Lat. 61°32′11″N., long. 160°20′29″W.)

That airspace extending upward from 700 feet above the surface within 6.8-mile radius of the Kalskag Airport, excluding that airspace within the St. Marys, AK, Class E airspace area.

* * * * *

Issued in Anchorage, AK, on July 23, 1999.

Trent S. Cummings,

Assistant Manager, Air Traffic Division, Alaskan Region.

[FR Doc. 99–19618 Filed 7–29–99; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 71

[Airspace Docket No. 99–AAL–12]

Proposed Revision of Class E Airspace; Point Lay, AK

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Notice of proposed rulemaking.

SUMMARY: This action proposes to revise Class E airspace at Point Lay, AK. This establishment of a Nondirectional Radio Beacon (NDB) instrument approach to runway (RWY) 5 and Global Positioning System (GPS) instrument approach procedures to RWY 5 and RWY 23 at Point Lay Airport have made this action necessary. Adoption of this proposal would result in adequate controlled airspace for aircraft flying IFR procedures at Point Lay, AK.

DATES: Comments must be received on or before September 13, 1999.

ADDRESSES: Send comments on the proposal in triplicate to: Manager, Operations Branch, AAL–530, Docket No. 99–AAL–12, Federal Aviation Administration, 222 West 7th Avenue, Box 14, Anchorage, AK 99513–7587.

The official docket may be examined in the Office of the Regional Counsel for the Alaskan Region at the same address.

An informal docket may also be examined during normal business hours in the Office of the Manager, Operations Branch, Air Traffic Division, at the address shown above and on the Internet at Alaskan Region's homepage at http://www.alaska.faa.gov/at or at address http://162.58.28.41/at.

FOR FURTHER INFORMATION CONTACT: Bob Durand, Operations Branch, Federal Aviation Administration, 222 West 7th Avenue, Box 14, Anchorage, AK 99513–7587; telephone number (907) 271–5898; fax: (907) 271–2850; email: Bob.Durand@faa.gov. Internet address: http://www.alaska.faa.gov/at or at address http://162.58.28.41/at.

SUPPLEMENTARY INFORMATION:

Comments Invited

Interested parties are invited to participate in this proposed rulemaking by submitting such written data, views, or arguments as they may desire. Comments that provide the factual basis supporting the views and suggestions presented are particularly helpful in developing reasoned regulatory decisions on the proposal. Comments are specifically invited on the overall regulatory, aeronautical, economic, environmental, and energy-related aspects of the proposal. Communications should identify the airspace docket number and be submitted in triplicate to the address listed above. Commenters wishing the FAA to acknowledge receipt of their comments on this notice must submit with those comments a self-addressed, stamped postcard on which the following statement is made: ''Comments to Airspace Docket No. 99–AAL–12.'' The postcard will be date/time stamped and returned to the commenter. All communications received on or before the specified closing date for comments will be considered before taking action on the proposed rule. The proposal contained in this notice may be changed in light of comments received. All comments submitted will be available for examination in the Operations Branch, Air Traffic Division, Federal Aviation Administration, 222 West 7th Avenue, Box 14, Anchorage, AK, both before and after the closing date for comments. A report summarizing each substantive public contact with FAA personnel concerned with this rulemaking will be filed in the docket.

Availability of NPRM's

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Internet users may reach the **Federal Register**'s web page for access to

recently published rulemaking documents at http://www.access.gpo.gov/su__docs/aces/aces140.html.

Any person may obtain a copy of this Notice of Proposed Rulemaking (NPRM) by submitting a request to the Operations Branch, AAL–530, Federal Aviation Administration, 222 West 7th Avenue, Box 14, Anchorage, AK 99513–7587. Communications must identify the notice number of this NPRM. Persons interested in being placed on a mailing list for future NPRM's should contact the individual(s) identified in the **FOR FURTHER INFORMATION CONTACT** section.

The Proposal

The FAA proposes to amend 14 CFR part 71 by revising Class E airspace at Point Lay, AK, due to the establishment of three new instrument approach procedures: GPS and NDB instrument approach procedures to RWY 5 and a GPS instrument approach to RWY 23. The intended effect of this proposal is to provide additional controlled airspace for IFR operations at Point Lay, AK.

The area would be depicted on aeronautical charts for pilot reference. The coordinates for this airspace docket are based on North American Datum 83. The Class E airspace areas designated as 700/1200 foot transition areas are published in paragraph 6005 in FAA Order 7400.9F, *Airspace Designations and Reporting Points,* dated September 10, 1998, and effective September 16, 1998, which is incorporated by reference in 14 CFR 71.1 (63 FR 50139; September 21, 1998). The Class E airspace designations listed in this document would be published subsequently in the Order.

The FAA has determined that this proposed regulation only involves an established body of technical regulations for which frequent and routine amendments are necessary to keep them operationally current. It, therefore—(1) is not a ''significant regulatory action'' under Executive Order 12866; (2) is not a ''significant rule'' under DOT Regulatory Policies and Procedures (44 FR 11034; February 26, 1979); and (3) does not warrant preparation of a regulatory evaluation as the anticipated impact is so minimal. Since this is a routine matter that will only affect air traffic procedures and air navigation, it is certified that this rule, when promulgated, will not have a significant economic impact on a substantial number of small entities under the criteria of the Regulatory Flexibility Act.

List of Subjects in 14 CFR Part 71

Airspace, Incorporation by reference, Navigation (air).

The Proposed Amendment

In consideration of the foregoing, the Federal Aviation Administration proposes to amend 14 CFR part 71 as follows:

PART 71—DESIGNATION OF CLASS A, CLASS B, CLASS C, CLASS D, AND CLASS E AIRSPACE AREAS; AIRWAYS; ROUTES; AND REPORTING POINTS

1. The authority citation for 14 CFR part 71 continues to read as follows:

Authority: 49 U.S.C. 106(g), 40103, 40113, 40120; E.O. 10854, 24 FR 9565, 3 CFR, 1959–1963 Comp., p. 389.

§ 71.1 [Amended]

2. The incorporation by reference in 14 CFR 71.1 of Federal Aviation Administration Order 7400.9F, *Airspace Designations and Reporting Points,* dated September 10, 1998, and effective September 16, 1998, is to be amended as follows:

* * * * *

Paragraph 6005 Class E airspace extending upward from 700 feet or more above the surface of the earth.

* * * * *

AAL AK E5 Point Lay, AK [Revised]

Point Lay Airport

(Lat. 69° 43′ 56″ N., long. 163° 03′ 40″ W.)

That airspace extending upward from 700 feet above the surface within 8-mile radius of the Point Lay Airport; and that airspace extending upward from 1,200 feet above the surface within an area bounded by lat. 69° 50′ 30″ N long. 161° 41′ 30″ W, to lat. 69° 28′ 45″ N long. 163° 32′ 30″ W, to lat. 69° 42′ 35″ N long. 163° 57′ 30″ W, to lat. 70° 05′ 20″ N long. 162° 04′ 35″ W, to the beginning point; and that airspace 4 miles either side of a line from lat. 69° 47′ 37″ N long. 162° 33′ 03″ W to lat. 69° 05′ 17″ N long. 159° 59′ 43″ W; and that airspace within 6 miles radius of lat. 68° 51′ 00″ N long 166° 00′ 00″ W; and that airspace 6 miles either side of a line from of lat. 68° 51′ 00″ N long 166° 00′ 00″ W to lat 69° 36′ 45″ N long. 163° 30′ 00″ W.

* * * * *

Issued in Anchorage, AK, on July 23, 1999.

Trent S. Cummings,

Assistant Manager, Air Traffic Division, Alaskan Region.

[FR Doc. 99–19617 Filed 7–29–99; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 71

[Airspace Docket No. 99–AAL–11]

Proposed Establishment of Class E Airspace; Platinum, AK

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Notice of proposed rulemaking.

SUMMARY: This action proposes to establish Class E airspace at Platinum, AK. The establishment of a Global Positioning System (GPS) instrument approach procedure at Platinum Airport has made this action necessary. The Platinum Airport status will change from Visual Flight Rules (VFR) to Instrument Flight Rules (IFR). Adoption of this proposal would result in adequate controlled airspace for aircraft flying IFR procedures at Platinum, AK.

DATES: Comments must be received on or before September 13, 1999.

ADDRESSES: Send comments on the proposal in triplicate to: Manager, Operations Branch, AAL–530, Docket No. 99–AAL–11, Federal Aviation Administration, 222 West 7th Avenue, Box 14, Anchorage, AK 99513–7587.

The official docket may be examined in the Office of the Regional Counsel for the Alaskan Region at the same address.

An informal docket may also be examined during normal business hours in the Office of the Manager, Operations Branch, Air Traffic Division, at the address shown above and on the Internet at Alaskan Region's homepage at http://www.alaska.faa.gov/at or at address http://162.58.28.41/at.

FOR FURTHER INFORMATION CONTACT: Bob Durand, Operations Branch, Federal Aviation Administration, 222 West 7th Avenue, Box 14, Anchorage, AK 99513–7587; telephone number (907) 271–5898; fax: (907) 271–2850; email: Bob.Durand@faa.gov. Internet address: http://www.alaska.faa.gov/at or at address http://162.58.28.41/at.

SUPPLEMENTARY INFORMATION:

Comments Invited

Interested parties are invited to participate in this proposed rulemaking by submitting such written data, views, or arguments as they may desire. Comments that provide the factual basis supporting the views and suggestions presented are particularly helpful in developing reasoned regulatory decisions on the proposal. Comments are specifically invited on the overall regulatory, aeronautical, economic,

environmental, and energy-related aspects of the proposal. Communications should identify the airspace docket number and be submitted in triplicate to the address listed above. Commenters wishing the FAA to acknowledge receipt of their comments on this notice must submit with those comments a self-addressed, stamped postcard on which the following statement is made: ''Comments to Airspace Docket No. 99-AAL–11.'' The postcard will be date/time stamped and returned to the commenter. All communications received on or before the specified closing date for comments will be considered before taking action on the proposed rule. The proposal contained in this notice may be changed in light of comments received. All comments submitted will be available for examination in the Operations Branch, Air Traffic Division, Federal Aviation Administration, 222 West 7th Avenue, Box 14, Anchorage, AK, both before and after the closing date for comments. A report summarizing each substantive public contact with FAA personnel concerned with this rulemaking will be filed in the docket.

Availability of NPRM's

An electronic copy of this document may be downloaded, using a modem and suitable communications software, from the FAA regulations section of the Fedworld electronic bulletin board service (telephone: 703–321–3339) or the **Federal Register**'s electronic bulletin board service (telephone: 202–512–1661).

Internet users may reach the **Federal Register**'s web page for access to recently published rulemaking documents at http://www.access.gpo.gov/su__docs/aces/aces140.html.

Any person may obtain a copy of this Notice of Proposed Rulemaking (NPRM) by submitting a request to the Operations Branch, AAL–530, Federal Aviation Administration, 222 West 7th Avenue, Box 14, Anchorage, AK 99513–7587. Communications must identify the notice number of this NPRM. Persons interested in being placed on a mailing list for future NPRM's should contact the individual(s) identified in the **FOR FURTHER INFORMATION CONTACT** section.

The Proposal

The FAA proposes to amend 14 CFR part 71 by establishing Class E airspace at Platinum, AK, due to the establishment of two GPS instrument approach procedures. The intended effect of this proposal is to provide additional controlled airspace for IFR operations at Platinum, AK.

The area would be depicted on aeronautical charts for pilot reference. The coordinates for this airspace docket are based on North American Datum 83. The Class E airspace areas designated as 700/1200 foot transition areas are published in paragraph 6005 in FAA Order 7400.9F, *Airspace Designations and Reporting Points*, dated September 10, 1998, and effective September 16, 1998, which is incorporated by reference in 14 CFR 71.1 (63 FR 50139; September 21, 1998). The Class E airspace designations listed in this document would be published subsequently in the Order.

The FAA has determined that this proposed regulation only involves an established body of technical regulations for which frequent and routine amendments are necessary to keep them operationally current. It, therefore—(1) is not a ''significant regulatory action'' under Executive Order 12866; (2) is not a ''significant rule'' under DOT Regulatory Policies and Procedures (44 FR 11034; February 26, 1979); and (3) does not warrant preparation of a regulatory evaluation as the anticipated impact is so minimal. Since this is a routine matter that will only affect air traffic procedures and air navigation, it is certified that this rule, when promulgated, will not have a significant economic impact on a substantial number of small entities under the criteria of the Regulatory Flexibility Act.

List of Subjects in 14 CFR Part 71

Airspace, Incorporation by reference, Navigation (air).

The Proposed Amendment

In consideration of the foregoing, the Federal Aviation Administration proposes to amend 14 CFR part 71 as follows:

PART 71—DESIGNATION OF CLASS A, CLASS B, CLASS C, CLASS D, AND CLASS E AIRSPACE AREAS; AIRWAYS; ROUTES; AND REPORTING POINTS

1. The authority citation for 14 CFR part 71 continues to read as follows:

Authority: 49 U.S.C. 106(g), 40103, 40113, 40120; E.O. 10854, 24 FR 9565, 3 CFR, 1959–1963 Comp., p. 389.

§ 71.1 [Amended]

2. The incorporation by reference in 14 CFR 71.1 of Federal Aviation Administration Order 7400.9F, *Airspace Designations and Reporting Points*, dated September 10, 1998, and effective September 16, 1998, is to be amended as follows:

* * * * *

Paragraph 6005 Class E airspace extending upward from 700 feet or more above the surface of the earth.

* * * * *

AAL AK E5 Platinum, AK [New]

Platinum Airport
(Lat. 59°00′41″ N., long. 161°49′11″ W.)
Togiak NDB
(Lat. 59°03′50″ N., long. 160°22′27″ W.)
Kipnuk VOR
(Lat. 59°56′34″ N., long. 164°01′51″ W.)
Oscarville NDB
(Lat. 60°47′29″ N., long. 161°52′22″ W.)

That airspace extending upward from 700 feet above the surface within 5.5-mile radius of the Platinum Airport; and that airspace extending upward from 1,200 feet above the surface 4 miles either side of a line from the Togiak NDB to lat. 59°19′00″ N. long. 161°52′00″ W., and 4 miles either side of a line from Kipnuk VOR to lat. 59°19′00″ N. long. 161°52′00″ W., and 4 miles either side of a line from Oscarville NDB to lat. 59°19′00″ N. long. 161°52′00″ W., and 4 miles either side of a line extending from lat. 59°19′00″ N. long. 161°52′00″ W. to lat. 59°09′58″ N. long 161°57′39″ W. to lat. 59°05′27″ N. long. 161°53′31″ W.

* * * * *

Issued in Anchorage, AK, on July 23, 1999.

Trent S. Cummings,

Assistant Manager, Air Traffic Division, Alaskan Region.

[FR Doc. 99–19616 Filed 7–29–99; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 71

[Airspace Docket No. 99–AAL–10]

Proposed Establishment of Class E Airspace; St. Michael, AK

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Notice of proposed rulemaking.

SUMMARY: This action proposes to establish Class E airspace at St. Michael, AK. The establishment of Global Positioning System (GPS) instrument approach procedures at St. Michael Airport has made this action necessary. The St. Michael Airport status will change from Visual Flight Rules (VFR) to Instrument Flight Rules (IFR). Adoption of this proposal would result in adequate controlled airspace for aircraft flying IFR procedures at St. Michael, AK.

DATES: Comments must be received on or before September 13, 1999.

ADDRESSES: Send comments on the proposal in triplicate to: Manager, Operations Branch, AAL–530, Docket No. 99–AAL–10, Federal Aviation Administration, 222 West 7th Avenue, Box 14, Anchorage, AK 99513–7587.

The official docket may be examined in the Office of the Regional Counsel for the Alaskan Region at the same address.

An informal docket may also be examined during normal business hours in the Office of the Manager, Operations Branch, Air Traffic Division, at the address shown above and on the Internet at Alaskan Region's homepage at http://www.alaska.faa.gov/at or at address http://162.58.28.41/at.

FOR FURTHER INFORMATION CONTACT: Bob Durand, Operations Branch, Federal Aviation Administration, 222 West 7th Avenue, Box 14, Anchorage, AK 99513–7587; telephone number (907) 271–5898; fax: (907) 271–2850; email: Bob.Durand@faa.gov. Internet address: http://www.alaska.faa.gov/at or at address http://162.58.28.41/at.

SUPPLEMENTARY INFORMATION:

Comments Invited

Interested parties are invited to participate in this proposed rulemaking by submitting such written data, views, or arguments as they may desire. Comments that provide the factual basis supporting the views and suggestions presented are particularly helpful in developing reasoned regulatory decisions on the proposal. Comments are specifically invited on the overall regulatory, aeronautical, economic, environmental, and energy-related aspects of the proposal. Communications should identify the airspace docket number and be submitted in triplicate to the address listed above. Commenters wishing the FAA to acknowledge receipt of their comments on this notice must submit with those comments a self-addressed, stamped postcard on which the following statement is made: ''Comments to Airspace Docket No. 99–AAL–10.'' The postcard will be date/time stamped and returned to the commenter. All communications received on or before the specified closing date for comments will be considered before taking action on the proposed rule. The proposal contained in this notice may be changed in light of comments received. All comments submitted will be available for examination in the Operations Branch, Air Traffic Division, Federal Aviation Administration, 222 West 7th Avenue, Box 14, Anchorage, AK, both before and after the closing date for comments. A report summarizing each substantive public contact with FAA personnel concerned with this rulemaking will be filed in the docket.

Availability of NPRM's

An electronic copy of this document may be downloaded, using a modem and suitable communications software, from the FAA regulations section of the Fedworld electronic bulletin board service (telephone: 703–321–3339) or the Federal Register's electronic bulletin board service (telephone: 202–512–1661).

Internet users may reach the Federal Register's web page for access to recently published rulemaking documents at http://www.access.gpo.gov/su__docs/aces/aces140.html.

Any person may obtain a copy of this Notice of Proposed Rulemaking (NPRM) by submitting a request to the Operations Branch, AAL–530, Federal Aviation Administration, 222 West 7th Avenue, Box 14, Anchorage, AK 99513–7587. Communications must identify the notice number of this NPRM. Persons interested in being placed on a mailing list for future NPRM's should contact the individual(s) identified in the **FOR FURTHER INFORMATION CONTACT SECTION.**

The Proposal

The FAA proposes to amend 14 CFR part 71 by establishing Class E airspace at St. Michael, AK, due to the establishment of two GPS instrument approach procedures. The intended effect of this proposal is to provide additional controlled airspace for IFR operations at St. Michael, AK.

The area would be depicted on aeronautical charts for pilot reference. The coordinates for this airspace docket are based on North American Datum 83. The Class E airspace areas designated as 700/1200 foot transition areas are published in paragraph 6005 in FAA Order 7400.9F, *Airspace Designations and Reporting Points,* dated September 10, 1998, and effective September 16, 1998, which is incorporated by reference in 14 CFR 71.1 (63 FR 50139; September 21, 1998). The Class E airspace designations listed in this document would be published subsequently in the Order.

The FAA has determined that this proposed regulation only involves an established body of technical regulations for which frequent and routine amendments are necessary to keep them operationally current. It, therefore—(1) is not a ''significant regulatory action'' under Executive Order 12866; (2) is not a ''significant rule'' under DOT Regulatory Policies and Procedures (44 FR 11034; February 26, 1979); and (3) does not warrant preparation of a regulatory evaluation as the anticipated impact is so minimal. Since this is a routine matter that will only affect air traffic procedures and air navigation, it is certified that this rule, when promulgated, will not have a significant economic impact on a substantial number of small entities under the criteria of the Regulatory Flexibility Act.

List of Subjects in 14 CFR Part 71

Airspace, Incorporation by reference, Navigation (air).

The Proposed Amendment

In consideration of the foregoing, the Federal Aviation Administration proposes to amend 14 CFR part 71 as follows:

PART 71—DESIGNATION OF CLASS A, CLASS B, CLASS C, CLASS D, AND CLASS E AIRSPACE AREAS; AIRWAYS; ROUTES; AND REPORTING POINTS

1. The authority citation for 14 CFR part 71 continues to read as follows:

Authority: 49 U.S.C. 106(g), 40103, 40113, 40120; E.O. 10854, 24 FR 9565, 3 CFR, 1959–1963 Comp., p. 389.

§ 71.1 [Amended]

2. The incorporation by reference in 14 CFR 71.1 of Federal Aviation Administration Order 7400.9F, *Airspace Designations and Reporting Points,* dated September 10, 1998, and effective September 16, 1998, is to be amended as follows:

* * * * *

Paragraph 6005 Class E airspace extending upward from 700 feet or more above the surface of the earth.

* * * * *

AAL AK E5 St. Michael, AK [New]

St. Michael Airport
(Lat. 62°29′24″ N., long. 162°06′37″ W.)
Fort Davis NDB
(Lat. 64°29′41″ N., long. 165°18′50″ W.)
North River NDB
(Lat. 63°54′28″ N., long. 160°48′43″ W.)

That airspace extending upward from 700 feet above the surface within 5.8-mile radius of the St. Michael Airport; and that airspace extending upward from 1,200 feet above the surface within an area bounded by lat. 63°54′30″ N long. 161°44′20″ W, to lat. 63°41′00″ N long. 161°04′30″ W, to lat. 63°02′00″ N long. 162°23′05″ W, to lat. 62°50′00″ N long. 164°00′00″ W, to lat. 63°05′00″ N long. 164°00′00″ W, to the beginning point; and that airspace 4 miles northwest of a line from North River NDB to lat. 63°35′44″ N long. 161°44′03″ W; and that airspace 4 miles either side of a line from Fort Davis NDB to lat 63°22′14″ N long.

162°33′13″ W; and that airspace 4 miles either side of a line from Fort Davis NDB to lat. 63°41′11″ N long. 162°02′50″ W; excluding that airspace within the Nome, AK, Class E airspace area.

* * * * *

Issued in Anchorage, AK, on July 23, 1999.

Trent S. Cummings,

Assistant Manager, Air Traffic Division, Alaskan Region.

[FR Doc. 99–19615 Filed 7–29–99; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 71

[Airspace Docket No. 99–AAL–9]

Proposed Establishment of Class E Airspace; Mountain Village, AK

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Notice of proposed rulemaking.

SUMMARY: This action proposes to establish Class E airspace at Mountain Village, AK. The establishment of Global Positioning System (GPS) instrument approach procedures at Mountain Village Airport has made this action necessary. The Mountain Village Airport status will change from Visual Flight Rules (VFR) to Instrument Flight Rules (IFR). Adoption of this proposal would result in adequate controlled airspace for aircraft flying IFR procedures at Mountain Village, AK.

DATES: Comments must be received on or before September 13, 1999.

ADDRESSES: Send comments on the proposal in triplicate to: Manager, Operations Branch, AAL–530, Docket No. 99–AAL–9, Federal Aviation Administration, 222 West 7th Avenue, Box 14, Anchorage, AK 99513–7587.

The official docket may be examined in the Office of the Regional Counsel for the Alaskan Region at the same address.

An informal docket may also be examined during normal business hours in the Office of the Manager, Operations Branch, Air Traffic Division, at the address shown above and on the Internet at Alaskan Region's homepage at http://www.alaska.faa.gov/at or at address http://162.58.28.41/at.

FOR FURTHER INFORMATION CONTACT: Bob Durand, Operations Branch, Federal Aviation Administration, 222 West 7th Avenue, Box 14, Anchorage, AK 99513–7587; telephone number (907) 271–5898; fax: (907) 271–2850; email: Bob.Durand@faa.gov. Internet address: http://www.alaska.faa.gov/at or at address http://162.58.28.41/at.

SUPPLEMENTARY INFORMATION:

Comments Invited

Interested parties are invited to participate in this proposed rulemaking by submitting such written data, views, or arguments as they may desire. Comments that provide the factual basis supporting the views and suggestions presented are particularly helpful in developing reasoned regulatory decisions on the proposal. Comments are specifically invited on the overall regulatory, aeronautical, economic, environmental, and energy-related aspects of the proposal. Communications should identify the airspace docket number and be submitted in triplicate to the address listed above. Commenters wishing the FAA to acknowledge receipt of their comments on this notice must submit with those comments a self-addressed, stamped postcard on which the following statement is made: ''Comments to Airspace Docket No. 99–AAL–9.'' The postcard will be date/time stamped and returned to the commenter. All communications received on or before the specified closing date for comments will be considered before taking action on the proposed rule. The proposal contained in this notice may be changed in light of comments received. All comments submitted will be available for examination in the Operations Branch, Air Traffic Division, Federal Aviation Administration, 222 West 7th Avenue, Box 14, Anchorage, AK, both before and after the closing date for comments. A report summarizing each substantive public contact with FAA personnel concerned with this rulemaking will be filed in the docket.

Availability of NPRM's

An electronic copy of this document may be downloaded, using a modem and suitable communications software, from the FAA regulations section of the Fedworld electronic bulletin board service (telephone: 703–321–3339) or the Federal Register's electronic bulletin board service (telephone: 202–512–1661).

Internet users may reach the Federal Register's web page for access to recently published rulemaking documents at http://www.access.gpo.gov/su_docs/aces/aces140.html.

Any person may obtain a copy of this Notice of Proposed Rulemaking (NPRM) by submitting a request to the Operations Branch, AAL–530, Federal Aviation Administration, 222 West 7th Avenue, Box 14, Anchorage, AK 99513–7587. Communications must identify the notice number of this NPRM. Persons interested in being placed on a mailing list for future NPRM's should contact the individual(s) identified in the **FOR FURTHER INFORMATION CONTACT** section.

The Proposal

The FAA proposes to amend 14 CFR part 71 by establishing Class E airspace at Mountain Village, AK, due to the establishment of two GPS instrument approach procedures. The intended effect of this proposal is to provide additional controlled airspace for IFR operations at Mountain Village, AK.

The area would be depicted on aeronautical charts for pilot reference. The coordinates for this airspace docket are based on North American Datum 83. The Class E airspace areas designated as 700/1200 foot transition areas are published in paragraph 6005 in FAA Order 7400.9F, *Airspace Designations and Reporting Points,* dated September 10, 1998, and effective September 16, 1998, which is incorporated by reference in 14 CFR 71.1 (63 FR 50139; September 21, 1998). The Class E airspace designations listed in this document would be published subsequently in the Order.

The FAA has determined that this proposed regulation only involves an established body of technical regulations for which frequent and routine amendments are necessary to keep them operationally current. It, therefore—(1) is not a ''significant regulatory action'' under Executive Order 12866; (2) is not a ''significant rule'' under DOT Regulatory Policies and Procedures (44 FR 11034; February 26, 1979); and (3) does not warrant preparation of a regulatory evaluation as the anticipated impact is so minimal. Since this is a routine matter that will only affect air traffic procedures and air navigation, it is certified that this rule, when promulgated, will not have a significant economic impact on a substantial number of small entities under the criteria of the Regulatory Flexibility Act.

List of Subjects in 14 CFR Part 71

Airspace, Incorporation by reference, Navigation (air).

The Proposed Amendment

In consideration of the foregoing, the Federal Aviation Administration proposes to amend 14 CFR part 71 as follows:

PART 71—DESIGNATION OF CLASS A, CLASS B, CLASS C, CLASS D, AND CLASS E AIRSPACE AREAS; AIRWAYS; ROUTES; AND REPORTING POINTS

1. The authority citation for 14 CFR part 71 continues to read as follows:

Authority: 49 U.S.C. 106(g), 40103, 40113, 40120; E.O. 10854, 24 FR 9565, 3 CFR, 1959–1963 Comp., p. 389.

§ 71.1 [Amended]

2. The incorporation by reference in 14 CFR 71.1 of Federal Aviation Administration Order 7400.9F, *Airspace Designations and Reporting Points*, dated September 10, 1998, and effective September 16, 1998, is to be amended as follows:

* * * * *

Paragraph 6005 Class E airspace extending upward from 700 feet or more above the surface of the earth.

* * * * *

AAL AK E5 Mountain Village, AK [New]

Mountain Village Airport
(Lat. 62°05′43″ N., long. 163°40′55″ W.)

That airspace extending upward from 700 feet above the surface within 6.3-mile radius of the Mountain Village Airport and that airspace extending upward from 1,200 feet above the surface within 35 miles southeast of the airport extending clockwise from the 139° radial to the 310° radial, excluding that airspace within the St. Marys, AK, Class E airspace area.

* * * * *

Issued in Anchorage, AK, on July 23, 1999.

Trent S. Cummings,

Assistant Manager, Air Traffic Division, Alaskan Region.

[FR Doc. 99–19614 Filed 7–29–99; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 71

[Airspace Docket No. 99–AAL–7]

Proposed Establishment of Class E Airspace; Aniak, AK; Proposed Establishment of Class E Airspace; St. Mary's, AK

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Notice of proposed rulemaking.

SUMMARY: This action proposes to establish Class E (surface area) airspace at Aniak, AK, and St. Mary's, AK. This action is at the request of air taxi operators with flight operations at these airports. Adoption of this proposal would result in additional Class E airspace for aircraft flying Instrument Flight Rules (IFR) procedures at Aniak, AK, and St. Mary's, AK.

DATES: Comments must be received on or before September 13, 1999.

ADDRESSES: Send comments on the proposal in triplicate to:

Manager, Operations Branch, AAL–530, Docket No. 99–AAL–7, Federal Aviation Administration, 222 West 7th Avenue, Box 14, Anchorage, AK 99513–7587.

The official docket may be examined in the Office of the Regional Counsel for the Alaskan Region at the same address.

An informal docket may also be examined during normal business hours in the Office of the Manager, Operations Branch, Air Traffic Division, at the address shown above and on the Internet at Alaskan Region's homepage at http://www.alaska.faa.gov/at or at address http://162.58.28.41/at.

FOR FURTHER INFORMATION CONTACT: Robert van Haastert, Operations Branch, Federal Aviation Administration, 222 West 7th Avenue, Box 14, Anchorage, AK 99513–7587; telephone number (907) 271–5863; fax: (907) 271–2850; email: Robert.van-Haastert@faa.gov. Internet address: http://www.alaska.faa.gov/at or at address http://162.58.28.41/at.

SUPPLEMENTARY INFORMATION:

Comments Invited

Interested parties are invited to participate in this proposed rulemaking by submitting such written data, views, or arguments as they may desire. Comments that provide the factual basis supporting the views and suggestions presented are particularly helpful in developing reasoned regulatory decisions on the proposal. Comments are specifically invited on the overall regulatory, aeronautical, economic, environmental, and energy-related aspects of the proposal. Communications should identify the airspace docket number and be submitted in triplicate to the address listed above. Commenters wishing the FAA to acknowledge receipt of their comments on this notice must submit with those comments a self-addressed, stamped postcard on which the following statement is made: ''Comments to Airspace Docket No. 99-AAL–7.'' The postcard will be date/time stamped and returned to the commenter. All communications received on or before the specified closing date for comments will be considered before taking action on the proposed rule. The proposal contained in this notice may be changed in light of comments received. All comments submitted will be available for examination in the Operations Branch, Air Traffic Division, Federal Aviation Administration, 222 West 7th Avenue, Box 14, Anchorage, AK, both before and after the closing date for comments. A report summarizing each substantive public contact with FAA personnel concerned with this rulemaking will be filed in the docket.

Availability of NPRM's

An electronic copy of this document may be downloaded, using a modem and suitable communications software, from the FAA regulations section of the Fedworld electronic bulletin board service (telephone: 703–321–3339) or the **Federal Register**'s electronic bulletin board service (telephone: 202–512–1661).

Internet users may reach the **Federal Register**'s web page for access to recently published rulemaking documents at http://www.access.gpo.gov/su__docs/aces/aces140.html.

Any person may obtain a copy of this Notice of Proposed Rulemaking (NPRM) by submitting a request to the Operations Branch, AAL–530, Federal Aviation Administration, 222 West 7th Avenue, Box 14, Anchorage, AK 99513–7587. Communications must identify the notice number of this NPRM. Persons interested in being placed on a mailing list for future NPRM's should contact the individual(s) identified in the **FOR FURTHER INFORMATION CONTACT** section.

Background

On March 16, 1999, the FAA initiated Airspace Study 99-AAL–022-NR, Proposal to Establish Surface Areas at Aniak and St. Mary's Airports, at the request of Pen Air, Northern Air Cargo, and Arctic Transportation Services to consider the establishment of additional controlled Class E Airspace. This additional controlled Class E airspace would provide surface areas for aircraft flying IFR at the Aniak and St. Mary's airports.

Concerns expressed included: (1) it is disconcerting to be on an IFR approach knowing that Visual Flight Rule (VFR) aircraft may be in close proximity when the transition is made from IFR to VFR for landing; (2) aircraft are not required to talk on the Common Traffic Advisory Frequency (CTAF); (3) aircraft on instrument approach must mix with VFR aircraft in weather conditions as low as 'clear of clouds' and 'one-mile flight visibility'; and (4) an aircraft on an IFR approach could descend through the clouds and find themselves on a

collision course with uncontrolled VFR traffic.

Changes that would result for VFR pilots with the proposed establishment of these surface areas include: (1) a requirement to maintain basic VFR weather minimums as detailed in 14 CFR part 91 section 155 (§ 91.155) established for Class E airspace to the surface, consisting of three (3) statute miles visibility and cloud clearance of 500 feet below, 1,000 feet above, and 2,000 feet horizontal distance from clouds; (2) if the basic VFR weather minimums (§ 91.155) can not be maintained, then a pilot would be required to fly in accordance with the Special VFR weather minimums contained in § 91.157, i.e., have an Air Traffic Control (ATC) clearance.

Comments were received from Tatonduk Outfitters Limited, Tanana Air Service, and one pilot. Based on the comments received during the airspace study, the FAA decided to proceed with the rulemaking process to establish surface areas at Aniak, AK, and St. Mary's, AK.

The Proposal

The FAA proposes to amend 14 CFR part 71 by establishing Class E airspace at Aniak, AK, and St. Mary's, AK, at the request of air taxi operators with flight operations at these airports. The intended effect of this proposal is to provide additional controlled airspace for IFR operations.

The area would be depicted on aeronautical charts for pilot reference. The coordinates for this airspace docket are based on North American Datum 83. The Class E airspace areas designated as surface areas are published in paragraph 6002 in FAA Order 7400.9F, *Airspace Designations and Reporting Points,* dated September 10, 1998, and effective September 16, 1998, which is incorporated by reference in 14 CFR 71.1 (63 FR 50139; September 21, 1998). The Class E airspace designations listed in this document would be published subsequently in the Order.

The FAA has determined that this proposed regulation only involves an established body of technical regulations for which frequent and routine amendments are necessary to keep them operationally current. It, therefore—(1) is not a ''significant regulatory action'' under Executive Order 12866; (2) is not a ''significant rule'' under DOT Regulatory Policies and Procedures (44 FR 11034; February 26, 1979); and (3) does not warrant preparation of a regulatory evaluation as the anticipated impact is so minimal. Since this is a routine matter that will only affect air traffic procedures and air navigation, it is certified that this rule, when promulgated, will not have a significant economic impact on a substantial number of small entities under the criteria of the Regulatory Flexibility Act.

List of Subjects in 14 CFR Part 71

Airspace, Incorporation by reference, Navigation (air).

The Proposed Amendment

In consideration of the foregoing, the Federal Aviation Administration proposes to amend 14 CFR part 71 as follows:

PART 71—DESIGNATION OF CLASS A, CLASS B, CLASS C, CLASS D, AND CLASS E AIRSPACE AREAS; AIRWAYS; ROUTES; AND REPORTING POINTS

1. The authority citation for 14 CFR part 71 continues to read as follows:

Authority: 49 U.S.C. 106(g), 40103, 40113, 40120; E.O. 10854, 24 FR 9565, 3 CFR, 1959–1963 Comp., p. 389.

§ 71.1 [Amended]

2. The incorporation by reference in 14 CFR 71.1 of Federal Aviation Administration Order 7400.9F, *Airspace Designations and Reporting Points,* dated September 10, 1998, and effective September 16, 1998, is to be amended as follows:

* * * * *

Paragraph 6002 Class E airspace designated as surface areas

* * * * *

AAL AK E2 Aniak, AK [New]

Aniak Airport
(Lat. 61°34′54″ N., long. 159°32′35″ W.)
Aniak NDB
(Lat. 61°35′25″ N., long. 159°35′53″ W.)

Within a 4-mile radius of the Aniak Airport and within 1.5 miles each side of the 300° bearing and the 112° bearing from the Aniak NDB, extending from the 4-mile radius to 6.5 miles and within 2.8 miles each side of the Aniak NDB 229° bearing, extending from the 4-mile radius to 6.5 miles southwest of the airport. This Class E airspace area is effective during the specific dates and times established in advance by a Notice to Airmen. The effective date and time will thereafter be continuously published in the Airport/Facility Directory.

* * * * *

AAL E2 St. Mary's, AK [New]

St. Mary's Airport, AK
(Lat. 62°03′38″ N., long. 163°18′08″ W.)
St. Mary's NDB
(Lat. 62°03′30″ N., long. 163°17′30″ W.)

Within a 4.1-mile radius of the St. Mary's Airport and within 1.5 miles either side of the 339° bearing and 1.5 miles either side of the 001° bearing from the St. Mary's NDB, extending from the 4.1 mile radius to 6.7 miles north of the airport and within 1.5 miles either side of the 197° bearing and 1.5 miles either side of the 185° bearing from the St. Mary's NDB, extending from the 4.1-mile radius to 6.7 miles south of the airport. This Class E airspace area is effective during the specific dates and times established in advance by a Notice to Airmen. The effective date and time will thereafter be continuously published in the Airport/Facility Directory.

* * * * *

Issued in Anchorage, AK, on July 23, 1999.

Trent S. Cummings,

Assistant Manager, Air Traffic Division, Alaskan Region.

[FR Doc. 99–19613 Filed 7–29–99; 8:45 am]

BILLING CODE 4910–13–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 62

[Docket No. #WA–1-0001; FRL–6408–7]

Approval and Promulgation of State Plans For Designated Facilities and Pollutants: Washington

AGENCY: Environmental Protection Agency (EPA).

ACTION: Proposed rule.

SUMMARY: The EPA proposes to approve the section 111(d)/129 State Plan submitted by the State of Washington on January 4, 1999. The State Plan was submitted by Washington to satisfy certain Federal Clean Air Act requirements. In the Final Rules section of this **Federal Register**, the EPA is approving the State's Plan submittal as a direct final rule without prior proposal because the Agency views this as a noncontroversial submittal and anticipates that it will not receive any significant, material, and adverse comments. A detailed rationale for the approval is set forth in the direct final rule and incorporated by reference herein. If no significant, material, and adverse comments are received in response to this rule, no further activity is contemplated in relation to this proposed rule. If the EPA receives adverse comments, the direct final rule will be withdrawn and all public comments received will be addressed in a subsequent final rule based on this proposed rule. The EPA will not institute a second comment period on this action.

DATES: Comments on this proposed rule must be received in writing by August 30, 1999.

ADDRESSES: Written comments should be addressed to Catherine Woo, Environmental Protection Specialist, at

the EPA Regional Office listed below. Copies of the documents relevant to this proposed rule are available for public inspection during normal business hours at the following locations. The interested persons wanting to examine these documents should make an appointment with the appropriate office at least 24 hours before the day of the visit.

Environmental Protection Agency, Region 10, Office of Air Quality, 1200 6th Avenue, Seattle, WA 98101.

The State of Washington, Department of Environmental Quality, P.O. Box 47600, Olympia, Washington 98504.

FOR FURTHER INFORMATION CONTACT: Catherine Woo, Office of Air Quality (OAQ–107), EPA, 1200 6th Avenue, Seattle, WA 98101, (206) 553–1814.

SUPPLEMENTARY INFORMATION: See the information provided in the Direct Final action which is located in the Rules section of this **Federal Register** and incorporated by reference herein.

List of Subjects in 40 CFR Part 62

Environmental protection, Administrative practice and procedure, Air pollution control, Intergovernmental relations, Municipal Waste Combustors, Reporting and recordkeeping requirements.

Dated: July 19, 1999.

Randall F. Smith,

Acting Regional Administrator, Region 10.

[FR Doc. 99–19432 Filed 7–29–99; 8:45 am]

BILLING CODE 6560–50–P

FEDERAL EMERGENCY MANAGEMENT AGENCY

44 CFR Part 67

[Docket No. FEMA–7294]

Proposed Flood Elevation Determinations

AGENCY: Federal Emergency Management Agency (FEMA).

ACTION: Proposed rule.

SUMMARY: Technical information or comments are requested on the proposed base (1% annual chance) flood elevations and proposed base flood elevation modifications for the communities listed below. The base flood elevations and modified base flood elevations are the basis for the floodplain management measures that the community is required either to adopt or to show evidence of being already in effect in order to qualify or remain qualified for participation in the National Flood Insurance Program (NFIP).

DATES: The comment period is ninety (90) days following the second publication of this proposed rule in a newspaper of local circulation in each community.

ADDRESSES: The proposed base flood elevations for each community are available for inspection at the office of the Chief Executive Officer of each community. The respective addresses are listed in the following table.

FOR FURTHER INFORMATION CONTACT: Matthew B. Miller, P.E., Chief, Hazards Study Branch, Mitigation Directorate, 500 C Street SW., Washington, DC 20472, (202) 646–3461, or (e-mail) matt.miller@fema.gov.

SUPPLEMENTARY INFORMATION: The Federal Emergency Management Agency proposes to make determinations of base flood elevations and modified base flood elevations for each community listed below, in accordance with Section 110 of the Flood Disaster Protection Act of 1973, 42 U.S.C. 4104, and 44 CFR 67.4(a).

These proposed base flood and modified base flood elevations, together with the floodplain management criteria required by 44 CFR 60.3, are the minimum that are required. They should not be construed to mean that the community must change any existing ordinances that are more stringent in their floodplain management requirements. The community may at any time enact stricter requirements of its own, or pursuant to policies established by other Federal, State, or regional entities. These proposed elevations are used to meet the floodplain management requirements of the NFIP and are also used to calculate the appropriate flood insurance premium rates for new buildings built after these elevations are made final, and for the contents in these buildings.

National Environmental Policy Act

This proposed rule is categorically excluded from the requirements of 44 CFR Part 10, Environmental Consideration. No environmental impact assessment has been prepared.

Regulatory Flexibility Act

The Associate Director for Mitigation certifies that this proposed rule is exempt from the requirements of the Regulatory Flexibility Act because proposed or modified base flood elevations are required by the Flood Disaster Protection Act of 1973, 42 U.S.C. 4104, and are required to establish and maintain community eligibility in the NFIP. No regulatory flexibility analysis has been prepared.

Regulatory Classification

This proposed rule is not a significant regulatory action under the criteria of Section 3(f) of Executive Order 12866 of September 30, 1993, Regulatory Planning and Review, 58 FR 51735.

Executive Order 12612, Federalism

This proposed rule involves no policies that have federalism implications under Executive Order 12612, Federalism, dated October 26, 1987.

Executive Order 12778, Civil Justice Reform

This proposed rule meets the applicable standards of Section 2(b)(2) of Executive Order 12778.

List of Subjects in 44 CFR Part 67

Administrative practice and procedure, Flood insurance, Reporting and recordkeeping requirements.

Accordingly, 44 CFR Part 67 is proposed to be amended as follows:

PART 67—[AMENDED]

1. The authority citation for Part 67 continues to read as follows:

Authority: 42 U.S.C. 4001 *et seq.*; Reorganization Plan No. 3 of 1978, 3 CFR, 1978 Comp., p. 329; E.O. 12127, 44 FR 19367, 3 CFR, 1979 Comp., p. 376.

§ 67.4 [Amended]

2. The tables published under the authority of § 67.4 are proposed to be amended as follows:

State	City/town/county	Source of flooding	Location	# Depth in feet above ground. *Elevation in feet (NGVD)	
				Existing	Modified
California	Avenal (City) Kings County.	Arroyo Del Camino	Approximately 250 feet downstream of Shasta Street.	None	*801

State	City/town/county	Source of flooding	Location	# Depth in feet above ground. *Elevation in feet (NGVD)	
				Existing	Modified
		.....	Approximately 550 feet upstream of Skyline Boulevard.	None	*861
Maps are available for inspection at City Hall, 919 Skyline Boulevard, Avenal, California. Send comments to The Honorable Ray Elliott, Mayor, City of Avenal, 919 Skyline Boulevard, Avenal, California 93204.					
Idaho	Blaine County (Unincorporated Areas).	Little Wood River	Approximately 1.5 miles downstream of Santa Rosa Lane.	None	*4,754
			Approximately 1.2 miles upstream of Highway 26/93 (Main Street).	None	*4,805
		Middle Branch of Little Wood River.	Approximately 50 feet upstream of Griffin Loop Road.	None	*4,761
			At confluence with Little Wood River, approximately 1,700 feet upstream of Highway 25/93 (Main Street).	None	*4,786
Maps are available for inspection at the Planning & Zoning Department, 206 First Avenue South, Suite 310, Hailey, Idaho 83333. Send comments to The Honorable Mary Ann Mix, Chairman, County Board of Commissioners, 206 First Avenue South, Suite 300, Hailey, Idaho 83333. Maps are available for inspection at the City of Carey, 20516 Main Street, Carey, Idaho. Send comments to The Honorable Richard Baird, Mayor, City of Carey, P.O. Box 6, Carey, Idaho 83320.					
Louisiana	Caddo Parish and Incorporated areas.	Logan Bayou	Approximately 500 feet downstream of Kansas City Southern Railroad.	None	*180
			Approximately 800 feet upstream of Kansas City Southern Railroad.	None	*188
			At Roy Road	None	*193
			Approximately 3,000 feet upstream of Shreveport Blanchard Highway (State Route 173).	None	*200
		Red River	Approximately 5.3 miles downstream of 70th Street (just east of the intersection of Flourney Lucas Road and Youree Drive).	None	*160
			Approximately 8,300 feet upstream of Interstate 220.	None	*174
		Choctaw Bayou	Approximately 7,800 feet downstream of Blanchard Furr Road (tributary backwater area near Kansas City Southern Railroad.	None	*193
			Approximately 100 feet downstream of Blanchard Furr Road.	None	*208
		Caddo Lake	Along shoreline of Caddo Lake, including tributary backwater.	None	*184
Maps are available for inspection at the Caddo Parish Courthouse, 525 Marshall Street, Suite 200, Shreveport, Louisiana. Send comments to The Honorable Michael Williams, Caddo Parish President, Caddo Parish Courthouse, 525 Marshall Street, Suite 200, Shreveport, Louisiana 71101. Maps are available for inspection at the Town of Blanchard Town Hall, 110 Main Street, Blanchard, Louisiana. Send comments to The Honorable Larry Permenter, Mayor, Town of Blanchard, P.O. Box 428, Blanchard, Louisiana 71009. Maps are available for inspection at the Town of Mooringsport Town Hall, 122 West Croom Street, Mooringsport, Louisiana. Send comments to The Honorable Douglas Elder, Mayor, Town of Mooringsport, P.O. Box 9, Mooringsport, Louisiana 71060. Maps are available for inspection at the City of Shreveport City Hall, 1234 Texas Avenue, Shreveport, Louisiana. Send comments to The Honorable Keith Hightower, Mayor, City of Shreveport, P.O. Box 31109, Shreveport, Louisiana 71130.					
Missouri	Independence (City) Jackson County.	Sugar Creek	At Independence Avenue	*818	*816
			At Park Avenue	*916	*914
		Mill Creek	Approximately 250 feet downstream from Kentucky Road.	None	*810
			Approximately 950 feet upstream of South Park Road.	None	*960
		Spring Branch	Approximately 7,500 feet downstream of Missouri State Highway 78.	*750	*750
			At Kiger road	*884	*886
		South Fork, Spring Branch	At confluence with Spring Branch	*813	*823
			Approximately 80 feet upstream of Lee's Summit Road.	*858	*864

State	City/town/county	Source of flooding	Location	# Depth in feet above ground. *Elevation in feet (NGVD)	
				Existing	Modified
		Bundschu Creek	At confluence with the Little Blue River	*739	*739
			Approximately 450 feet downstream from the Union Pacific Railroad.	*749	*748
			At Powell Road	*770	*777
		Crackerneck Creek	At confluence with the Little Blue River	*754	*754
			Approximately 3,750 feet upstream from confluence with the Little Blue River.	*756	*754
			Just upstream of Partridge Drive	*956	*958
		North Fork Crackerneck Creek.	At confluence with Crackerneck Creek	*756	*754
			Approximately 2,500 feet upstream of Viking Road.	*872	*859
		Adair Creek	At confluence with the Little Blue River	*762	*763
			At Noland Road	*908	*911
		Adair Creek Tributary No. 1.	At confluence with Adair Creek	None	*813
			Approximately 40 feet downstream of Interstate 70.	None	*844
		Adair Creek Tributary No. 2.	At confluence with Adair Creek	None	*857
			Approximately 190 feet downstream from Interstate 70.	None	*895
		Rock Creek	Approximately 140 feet downstream from Kentucky Road.	None	*746
			At 32nd Street	*900	*902
Maps are available for inspection at the City of Independence, Department of Public Works (Engineering), 111 East Maple, Independence, Missouri.					
Send comments to The Honorable Ron Stewart, Mayor, City of Independence, 111 East Maple, Independence, Missouri 64050.					
Montana	Yellowstone County (Unincorporated Areas).	Alkali Creek	Approximately 960 feet above confluence with Yellowstone River.	*3,096	*3,096
			Just upstream of Main Street (U.S. Highway 87 and 312).	*3,159	*3,153
			Approximately 2,200 feet downstream of Black Pine Street.	*3,162	*3,159
			Approximately 1,100 feet downstream of Black Pine Street.	*3,166	*3,166
Maps are available for inspection at the Yellowstone County Emergency and General Services Department, 217 North 27th, Room 309, Billings, Montana.					
Send comments to The Honorable Bill Kennedy, Chairperson, Yellowstone County Board of Commissioners, P.O. Box 35000, Billings, Montana 59107.					
North Dakota	Jamestown (City) Stutsman County.	James River	Approximately 1.87 miles (9,875 feet) downstream of Midland Continental Railroad.	*1,378	*1,379
			Approximately 1.64 miles (8,675 feet) upstream of 4th Avenue Northwest.	*1,397	*1,398
			At confluence with James River	*1,392	*1,392
		Pipestem Creek	Approximately 0.21 mile (1,100 feet) above confluence with James River.	*1,392	*1,393
			Approximately 1.04 miles (5,475 feet) upstream of Burlington Northern Railroad.	*1,404	*1,407
Maps are available for inspection at the City of Jamestown, City Hall, 102 3rd Avenue Southeast, Jamestown, North Dakota.					
Send comments to The Honorable Charlie Kourajian, Mayor, City of Jamestown, City Hall, 102 3rd Avenue Southeast, Jamestown, North Dakota 58401.					
Texas	Edinburg (City) Hidalgo County.	North Main Drain	Approximately 2,735 feet downstream of Davis Road.	None	*82
			At downstream side of Chapin Street (formerly part of Hidalgo County).	None	*95
			At confluence of West Main Drain	*95	*95
Maps are available for inspection at 1304 South 25th Street, Edinburg, Texas.					
Send comments to The Honorable Joe Ochoa, Mayor, City of Edinburg, P.O. Box 1079, Edinburg, Texas 78540.					
Texas	Hidalgo County (Unincorpor-ated Areas).	East Lateral Drain	Approximately 2,620 feet downstream of Mile 2 West Road.	None	*59
			Approximately 595 feet upstream of Mile 11 North Road.	None	*70

State	City/town/county	Source of flooding	Location	# Depth in feet above ground. *Elevation in feet (NGVD)	
				Existing	Modified
		North Main Drain	At confluence with Donna Drain	None	*74
			Approximately 1,175 feet upstream of Mile 17 2 Road (Russell Road).	*94	*93
			At Chaplin Road	*95	*95
		West Main Drain	Approximately 2 feet downstream of a drop structure located approximately 1,000 feet downstream of Taylor Road.	None	*124
			Approximately 2,095 feet upstream of Brushliner Road.	None	*202
Maps are available for inspection at 1304 South 25th Street, Edinburg, Texas.					
Send comments to The Honorable Jose E. Pulido, Judge, Hidalgo County, 100 East Cano Street, Edinburg, Texas 78540.					
Texas	Seguin (City) Guadalupe County.	Walnut Branch	Approximately 400 feet downstream of West Kein Street.	*484	*484
			Just upstream of University Lane	*528	*527
			Approximately 200 feet downstream of Interstate 10.	*545	*546
Maps are available for inspection at 210 East Gonzales Street, Seguin, Texas.					
Send comments to The Honorable Mark Stautzenberger, Mayor, City of Seguin, P.O. Box 591, Seguin, Texas 78156.					

(Catalog of Federal Domestic Assistance No. 83.100, ''Flood Insurance.'')

Dated: July 20, 1999.

Michael J. Armstrong,

Associate Director for Mitigation.

[FR Doc. 99–19569 Filed 7–29–99; 8:45 am]

BILLING CODE 6718–04–P

FEDERAL EMERGENCY MANAGEMENT AGENCY

44 CFR Part 67

[Docket No. FEMA–7291]

Proposed Flood Elevation Determinations

AGENCY: Federal Emergency Management Agency, FEMA.

ACTION: Proposed rule.

SUMMARY: Technical information or comments are requested on the proposed base (1% annual chance) flood elevations and proposed base flood elevation modifications for the communities listed below. The base flood elevations are the basis for the floodplain management measures that the community is required either to adopt or to show evidence of being already in effect in order to qualify or remain qualified for participation in the National Flood Insurance Program (NFIP).

DATES: The comment period is ninety (90) days following the second publication of this proposed rule in a newspaper of local circulation in each community.

ADDRESSES: The proposed base flood elevations for each community are available for inspection at the office of the Chief Executive Officer of each community. The respective addresses are listed in the following table.

FOR FURTHER INFORMATION CONTACT: Matthew B. Miller, P.E., Chief, Hazards Study Branch, Mitigation Directorate, Federal Emergency Management Agency, 500 C Street SW., Washington, DC 20472, (202) 646–3461, or (e-mail) matt.miller@fema.gov.

SUPPLEMENTARY INFORMATION: The Federal Emergency Management Agency (FEMA or Agency) proposes to make determinations of base flood elevations and modified base flood elevations for each community listed below, in accordance with section 110 of the Flood Disaster Protection Act of 1973, 42 U.S.C. 4104, and 44 CFR 67.4(a).

These proposed base flood and modified base flood elevations, together with the floodplain management criteria required by 44 CFR 60.3, are the minimum that are required. They should not be construed to mean that the community must change any existing ordinances that are more stringent in their floodplain management requirements. The community may at any time enact stricter requirements of its own, or pursuant to policies established by other Federal, state or regional entities. These proposed elevations are used to meet the floodplain management requirements of the NFIP and are also used to calculate the appropriate flood insurance premium rates for new buildings built after these elevations are made final, and for the contents in these buildings.

National Environmental Policy Act

This proposed rule is categorically excluded from the requirements of 44 CFR Part 10, Environmental Consideration. No environmental impact assessment has been prepared.

Regulatory Flexibility Act

The Associate Director, Mitigation Directorate, certifies that this proposed rule is exempt from the requirements of the Regulatory Flexibility Act because proposed or modified base flood elevations are required by the Flood Disaster Protection Act of 1973, 42 U.S.C. 4104, and are required to establish and maintain community eligibility in the National Flood Insurance Program. As a result, a regulatory flexibility analysis has not been prepared.

Regulatory Classification

This proposed rule is not a significant regulatory action under the criteria of section 3(f) of Executive Order 12866 of September 30, 1993, Regulatory Planning and Review, 58 FR 51735.

Executive Order 12612, Federalism

This proposed rule involves no policies that have federalism implications under Executive Order 12612, Federalism, dated October 26, 1987.

Executive Order 12778, Civil Justice Reform

This proposed rule meets the applicable standards of section 2(b)(2) of Executive Order 12778.

List of Subjects in 44 CFR Part 67

Administrative practice and procedure, Flood insurance, Reporting and recordkeeping requirements.

Accordingly, 44 CFR part 67 is proposed to be amended as follows:

PART 67—[AMENDED]

1. The authority citation for part 67 continues to read as follows:

Authority: 42 U.S.C. 4001 *et seq.*; Reorganization Plan No. 3 of 1978, 3 CFR, 1978 Comp., p. 329; E.O. 12127, 44 FR 19367, 3 CFR, 1979 Comp., p. 376.

§ 67.4 [Amended]

2. The tables published under the authority of § 67.4 are proposed to be amended as follows:

State	City/town/county	Source of flooding	Location	# Depth in feet above ground. *Elevation in feet (NGVD)	
				Existing	Modified
Minnesota	Brown County (Unincorporated Areas).	Minnesota River	Approximately 2.15 miles downstream of Chicago and Northwestern Railroad.	*804	*805
			Downstream side of U.S. Highway 14	*810	*809
		Cottonwood River	At confluence with Minnesota River	*806	*807
			Approximately 1,000 feet downstream of Chicago & Northwestern Railroad Bridge.	*806	*807
		Backwater Effects of the Minnesota River.	Downstream side of the upstream County boundary.	None	*823
Maps available for inspection at the Brown County Planning and Zoning Office, Brown County Courthouse, New Ulm, Minnesota.					
Send comments to Mr. Charles Enter, Brown County Administrator, P.O. Box 248, New Ulm, Minnesota 56073–0248.					
Minnesota	Lake City (City), Wabasha County.	Mississippi River	At downstream corporate limits	*681	*682
			At upstream corporate limits	*681	*682
		Gilbert Creek	Confluence with Mississippi River	*681	*682
			Downstream of U.S. 61 bridge	*681	*682
		Miller Creek	Confluence with Mississippi River	*681	*682
			Approximately 300 feet upstream from U.S. 61 bridge.	*681	*682
Maps available for inspection at the Lake City Hall, 205 West Center Street, Lake City, Minnesota.					
Send comments to The Honorable Willard Bremer, Mayor of the City of Lake City, Lake City City Hall, 205 West Center Street, Lake City, Minnesota 55041.					
Minnesota	Minneota (City), Lyon County.	South Branch Yellow Medicine River.	At downstream corporate limits	None	*1,146
			Approximately 0.93 mile upstream of 1st Street.	None	*1,170
Maps available for inspection at the Minneota City Hall, 129 East 1st Street, Minneota, Minnesota.					
Send comments to The Honorable Joanne Myrvik, Mayor of the City of Minneota, 129 East 1st Street, Minneota, Minnesota 56264.					
Mississippi	Shubuta (Town), Clarke County.	Chickasawhay River	Approximately 2,900 feet downstream of First Street (County Route 612).	None	*191
			Approximately 1.3 miles upstream of First Street (County Route 612).	None	*197
Maps available for inspection at the Shubuta Town Hall, 156 Eucutta Street, Shubuta, Mississippi.					
Send comments to The Honorable Clyde Brown, Mayor of the Town of Shubuta, P.O. Box 416, Shubuta, Mississippi 39360.					
New York	Lowville (Town), Lewis County.	Black River	At approximately 1,080 feet downstream of corporate limits.	None	*738
			Approximately 1.2 miles upstream of Number Four Road.	None	*745
Maps available for inspection at the Lowville Town Hall, 5533 Bostwick, Lowville, New York.					
Send comments to Mr. Arleigh D. Rice, Lowville Town Supervisor, Route 3, Box 8T, Lowville, New York 13367.					
New York	Lowville (Village), Lewis County.	Mill Creek	At downstream corporate limits	None	*744
			Approximately 500 feet upstream of Cedar Street.	None	*873
Maps available for inspection at the Village of Lowville Municipal Building, Code Enforcement Office, 5402 Dayan Street, Lowville, New York.					
Send comments to The Honorable Danny Salmon, Mayor of the Village of Lowville, Municipal Building, 5402 Dayan Street, Lowville, New York 13367.					
New York	New York Mills (Village), Oneida County.	Sauquoit Creek	Approximately 190 feet downstream of Oriskany Boulevard.	None	*422
			Approximately 610 feet upstream of State Route 5A.	*461	*462

State	City/town/county	Source of flooding	Location	# Depth in feet above ground. *Elevation in feet (NGVD)	
				Existing	Modified
Maps available for inspection at the New York Mills Village Clerk's Office, 1 Maple Street, New York Mills, New York.					
Send comments to The Honorable Michael F. Dubiel, Mayor of the Village of New York Mills, 1 Maple Street, New York Mills, New York 13417.					
New York	Whitesboro (Village), Oneida County.	Sauquoit Creek	At downstream corporate limits	*415	*414
			Approximately 1,760 feet upstream of Oriskany Boulevard.	*426	*428
		Mohawk River	At confluence of Sauquoit Creek	*415	*415
			Approximately 1,000 feet upstream side of Mohawk Street.	*415	*414
Maps available for inspection at the Whitesboro Village Hall, 10 Moseley Street, Whitesboro, New York.					
Send comments to The Honorable Joseph G. Malecki, Mayor of the Village of Whitesboro, 10 Moseley Street, Village Hall, Whitesboro, New York 13492.					
New York	Whitestown (Town), Oneida County.	Sauquoit Creek	Upstream side of CONRAIL bridge	*417	*418
			Upstream side of State Route 5A	*459	*461
		Mud Creek	At confluence with Sauquoit Creek	*449	*450
			Approximately 365 feet upstream side of confluence with Sauquoit Creek.	*449	*450
Maps available for inspection at the Whitestown Town Hall, 8 Park Avenue, Whitesboro, New York.					
Send comments to Mr. Matthew Shannon, Whitestown Town Supervisor, 8 Park Avenue, Whitestown Town Hall, Whitesboro, New York 13492–1310.					
New York	Yorkville (Village), Oneida County.	Sauquoit Creek	At upstream side of CONRAIL bridge	*416	*418
			Approximately 310 feet upstream of Oriskany Boulevard.	None	*427
Maps available for inspection at the Yorkville Village Hall, 7 7th Street, Yorkville, New York.					
Send comments to The Honorable Michael A. Mahoney, Mayor of the Village of Yorkville, 69 Cross Street, Yorkville, New York 13495.					
Pennsylvania	Freeport (Borough), Armstrong County.	Buffalo Creek	At confluence with Allegheny River	*769	*768
			Approximately 1,160 feet upstream of CONRAIL spur.	*769	*768
		Allegheny River	At downstream corporate limits/confluence of Buffalo Creek.	*769	*768
			Approximately 0.77 mile upstream of confluence of Buffalo Creek corporate limits.	*770	*769
Maps available for inspection at the Freeport Borough Council Chambers, 414 Market Street, Freeport, Pennsylvania.					
Send comments to Mr. James M. Seagriff, Jr., President of the Freeport Borough Council, 414 Market Street, Freeport, Pennsylvania 16229.					
Pennsylvania	Gilpin (Township), Armstrong County.	Allegheny River	Approximately 1,420 feet downstream of Lock and Dam No. 5.	*772	*771
			Approximately 150 feet upstream of Lock and Dam No. 5.	*772	*771
		Kiskiminetas River	At confluence with the Allegheny River	*772	*771
			Approximately 1,400 feet upstream of the confluence with the Allegheny River.	*772	*771
Maps available for inspection at the Gilpin Township Municipal Building, Route 66, Leechburg, Pennsylvania.					
Send comments to Mr. Dennis Wolfe, Chairman of the Gilpin Township Board of Supervisors, R.D. 1, Box 269, Leechburg, Pennsylvania 15656.					
Pennsylvania	South Buffalo (Township), Armstrong County.	Allegheny River	Approximately 900 feet downstream of CONRAIL.	None	*770
			Approximately 50 feet downstream of Lock and Dam No. 5.	*773	*774

State	City/town/county	Source of flooding	Location	# Depth in feet above ground. *Elevation in feet (NGVD)	
				Existing	Modified
Maps available for inspection at the South Buffalo Township Municipal Office, 384 Iron Bridge Road, Freeport, Pennsylvania.					
Send comments to Mr. Robert L. Van Dyke, Chairman of the South Buffalo Township Board of Supervisors, 384 Iron Bridge Road, Freeport, Pennsylvania 16229.					
Pennsylvania	South Londonderry (Township), Lebanon County.	Spring Creek	Approximately 480 feet downstream of Yorkshire Road.	None	*411
			Approximately 650 feet upstream of Lawn Road.	None	*466
		Tributary to Spring Creek	At the confluence with Spring Creek	None	*441
			Approximately 1,600 feet upstream from the confluence with Spring Creek.	None	*453
Maps available for inspection at the South Londonderry Township Hall, 101 Center Street, Campbell, Pennsylvania.					
Send comments to Mr. Raymond Phillippy, Chairman of the South Londonderry Board of Supervisors, 101 Center Street, Box 3, Campbell, Pennsylvania 17010.					
Rhode Island	Providence (City), Providence County.	Ponding Area 4–1A	Entire shoreline within the City of Providence.	None	*78
		Ponding Area 4–1B	Entire shoreline within the City of Providence.	None	*73
		Ponding Area 4–3	Entire shoreline within the City of Providence.	None	*71
		Ponding Area 4–4	Entire shoreline within the City of Providence.	None	*85
Maps available for inspection at the Providence City Hall, Planning and Development Building, 400 Westminster Street, 5th Floor, Providence, Rhode Island.					
Send comments to The Honorable Vincent Cianci, Mayor of the Town of Providence, 25 Dorrance Street, Providence, Rhode Island 02903.					
Vermont	Wolcott (Town), Lamoille County.	Wild Branch	At the upstream side of Lamoille Valley Railroad.	*676	*677
			Approximately 625 feet upstream of a private drive (approximately 225 feet downstream of upstream corporate limits).	*926	*927
Maps available for inspection at the Wolcott Town Hall, 4186 Vermont Route 15, Wolcott, Vermont.					
Send comments to Mr. Robert D. Harris, Town of Wolcott Selectman, P.O. Box 100, Wolcott, Vermont 05680.					
Virginia	Buena Vista (City), Rockbridge County.	Maury River	Approximately 100 feet upstream from Columbia Mills Dam.	*847	*850
			Approximately 2 miles downstream of 10th Street.	None	*806
			Just downstream of West 29th Street	None	*851
Maps available for inspection at the Buena Vista Municipal Building, 2039 Sycamore Avenue, Buena Vista, Virginia.					
Send comments to The Honorable Harold Kidd, Mayor of the City of Buena Vista, Municipal Building, 2039 Sycamore Avenue, Buena Vista, Virginia 24416.					
Virginia	Glasgow (Town), Rockbridge County.	Maury River	Just upstream of CSX Transportation	*721	*724
			Approximately 1.75 miles upstream from State Route 130.	*730	*737
Maps available for inspection at the Glasgow Town Hall, 1100 Blue Ridge Road, Glasgow, Virginia.					
Send comments to Mr. William S. Knick, Glasgow Town Manager, P.O. Box 326, Glasgow, Virginia 24555.					
Virginia	Lexington (City), Rockbridge County.	Maury River	Approximately 2,600 feet downstream of U.S. Route 11.	*907	*916
			Approximately 3,200 feet upstream of U.S. Route 11.	*916	*926
		Woods Creek	Confluence with Maury River	*912	*920
			Approximately 1,150 feet upstream from Stone Lane.	*916	*920

State	City/town/county	Source of flooding	Location	# Depth in feet above ground. *Elevation in feet (NGVD)	
				Existing	Modified
Maps available for inspection at the Lexington City Hall, 300 East Washington Street, Lexington, Virginia.					
Send comments to The Honorable Homer Derrick, Jr., Mayor of the City of Lexington, 300 East Washington Street, Lexington, Virginia 24450.					
Virginia	Rockbridge County (Unincorporated Areas).	Irish Creek	At confluence with South River	*1,019	*1,024
			Approximately 450 feet upstream from State Route 608.	*1,023	*1,024
		Maury River	Just upstream of CSX Railway	*723	*724
			Approximately 0.6 mile upstream of U.S. Route 11.	*916	*926
		South River	Approximately 1,250 feet downstream from CSX Transportation.	None	*878
			Approximately 1,750 feet upstream of State Route 56.	None	*1,469
Maps available for inspection at the Rockbridge Zoning Office, 150 South Main Street, Lexington, Virginia.					
Send comments to Mr. Donald G. Austin, Rockbridge County Administrator, 150 South Main Street, Lexington, Virginia 24450					
Wisconsin	Fond du Lac County (Unincorporated Areas).	Sevenmile Creek	Approximately 845 feet upstream of the confluence with East Branch Fond du Lac River.	None	*839
			Upstream side of County Route Y	None	*879
		De Neveu Creek	Approximately 1,380 feet downstream of U.S. Highway 45.	*811	*810
			Approximately 1,900 feet upstream of confluence of Unnamed Tributary to De Neveu Creek.	*829	*826
		Unnamed Tributary to Unnamed Tributary to De Neveu Creek.	At confluence with Unnamed Tributary to De Neveu Creek.	None	*826
			At outlet of Lake De Neveu	None	*824
		Lake De Neveu	Entire shoreline within county	None	*864
		Kettle Moraine Lake	Entire shoreline within county	None	*1,025
		Unnamed Tributary to De Neveu Creek.	At confluence with De Neveu Creek	None	*822
			Just upstream of County Route UU	None	*957
Maps available for inspection at the Code Enforcement Office, 160 South Macy Street, Fond du Lac, Wisconsin.					
Send comments to Mr. Allen Buechel, Fond du Lac County Executive, 160 South Macy Street, Fond du Lac, Wisconsin 54935.					

(Catalog of Federal Domestic Assistance No. 83.100, ''Flood Insurance.'')

Dated: July 19, 1999.

Michael J. Armstrong,

Associate Director for Mitigation.

[FR Doc. 99–19568 Filed 7–29–99; 8:45 am]

BILLING CODE 6718–04–P

Notices

Federal Register
Vol. 64, No. 146
Friday, July 30, 1999

This section of the FEDERAL REGISTER contains documents other than rules or proposed rules that are applicable to the public. Notices of hearings and investigations, committee meetings, agency decisions and rulings, delegations of authority, filing of petitions and applications and agency statements of organization and functions are examples of documents appearing in this section.

DEPARTMENT OF AGRICULTURE

Natural Resources Conservation Service

Notice of Proposed Changes to Section IV of the Field Office Technical Guide (FOTG) of the Natural Resources Conservation Service in Indiana

AGENCY: Natural Resources Conservation Service NRCS).

ACTION: Notice of availability of proposed changes in Section IV of the FOTG of the NRCS in Indiana for review and comment.

SUMMARY: It is the intention of NRCS in Indiana to issue a revised conservation practice standards Section IV of the FOTG. The revised standards are Pond Sealing or Lining, Flexible Membrane (Code 521A), Pond Sealing or Lining, Soil Dispersant, Code 521B and Pond Sealing or Lining, Bentonite Sealant, Code 521C. These practices may be used in conservation systems that treat highly erodible land.

DATES: Comments will be received on or before August 30, 1999.

ADDRESSES: Address all requests and comments to Robert L. Eddleman, State conservationist, Natural Resources Conservation Service (NRCS), 6013 Lakeside Blvd., Indianapolis, Indiana 46278. Copies of these standards will be made available upon written request. You may submit electronic requests and comments to joe.gasperi@in.usda.gov.

FOR FURTHER INFORMATION CONTACT: Robert L. Eddleman, 317–290–3200.

SUPPLEMENTARY INFORMATION: Section 343 of the Federal Agriculture Improvement and Reform Act of 1996 states that revisions made after enactment of the law, to NRCS state technical guides used to carry out highly erodible land and wetland provisions of the law, shall be made available for public review and comment. For the next 30 days, the NRCS in Indiana will receive comments relative to the proposed changes. Following that period, a determination will be made by the NRCS in Indiana regarding disposition of those comments and a final determination of changes will be made.

Dated: July 19, 1999.

Robert L. Eddleman,

State Conservationist, Indianapolis, Indiana.

[FR Doc. 99–19441 Filed 7–29–99; 8:45 am]

BILLING CODE 3410–16–M

COMMITTEE FOR PURCHASE FROM PEOPLE WHO ARE BLIND OR SEVERELY DISABLED

Procurement List Proposed Addition and Deletions

AGENCY: Committee for Purchase From People Who Are Blind or Severely Disabled.

ACTION: Proposed addition to and deletions from Procurement List.

SUMMARY: The Committee has received proposals to add to the Procurement List a service to be furnished by nonprofit agencies employing persons who are blind or have other severe disabilities, and to delete commodities previously furnished by such agencies.

Comments must be received on or before: August 30, 1999.

ADDRESSES: Committee for Purchase From People Who Are Blind or Severely Disabled, Crystal Gateway 3, Suite 310, 1215 Jefferson Davis Highway, Arlington, Virginia 22202–4302.

FOR FURTHER INFORMATION CONTACT: Beverly Milkman (703) 603–7740.

SUPPLEMENTARY INFORMATION: This notice is published pursuant to 41 U.S.C. 47(a) (2) and 41 CFR 51–2.3. Its purpose is to provide interested persons an opportunity to submit comments on the possible impact of the proposed actions.

Addition

If the Committee approves the proposed addition, all entities of the Federal Government (except as otherwise indicated) will be required to procure the service listed below from nonprofit agencies employing persons who are blind or have other severe disabilities.

I certify that the following action will not have a significant impact on a substantial number of small entities. The major factors considered for this certification were:

1. The action will not result in any additional reporting, recordkeeping or other compliance requirements for small entities other than the small organizations that will furnish the service to the Government.

2. The action will result in authorizing small entities to furnish the service to the Government.

3. There are no known regulatory alternatives which would accomplish the objectives of the Javits-Wagner-O'Day Act (41 U.S.C. 46–48c) in connection with the service proposed for addition to the Procurement List. Comments on this certification are invited. Commenters should identify the statement(s) underlying the certification on which they are providing additional information.

The following service has been proposed for addition to Procurement List for production by the nonprofit agency listed:

Janitorial/Custodial

Buildings 115, 985, 995, 2525, 2765, 2766, P600T and R–19, Naval Air Station, Whidbey Island, Washington
NPA: New Leaf, Inc., Oak Harbor, Washington

Deletions

I certify that the following action will not have a significant impact on a substantial number of small entities. The major factors considered for this certification were:

1. The action will not result in any additional reporting, recordkeeping or other compliance requirements for small entities.

2. The action will result in authorizing small entities to furnish the commodities to the Government.

3. There are no known regulatory alternatives which would accomplish the objectives of the Javits-Wagner-O'Day Act (41 U.S.C. 46–48c) in connection with the commodities proposed for deletion from the Procurement List.

The following commodities have been proposed for deletion from the Procurement List:

Ladder, Straight (Wood)
5440–00–242–7151

5440–00–814–5084

Beverly L. Milkman,

Executive Director.

[FR Doc. 99–19532 Filed 7–29–99; 8:45 am]

BILLING CODE 6353–01–P

COMMITTEE FOR PURCHASE FROM PEOPLE WHO ARE BLIND OR SEVERELY DISABLED

Procurement List Additions

AGENCY: Committee for Purchase From People Who Are Blind or Severely Disabled.

ACTION: Additions to the Procurement List.

SUMMARY: This action adds to the Procurement List commodities and services to be furnished by nonprofit agencies employing persons who are blind or have other severe disabilities.

EFFECTIVE DATE: August 30, 1999.

ADDRESSES: Committee for Purchase From People Who Are Blind or Severely Disabled, Crystal Gateway 3, Suite 310, 1215 Jefferson Davis Highway, Arlington, Virginia 22202–4302.

FOR FURTHER INFORMATION CONTACT: Beverly Milkman (703) 603–7740.

SUPPLEMENTARY INFORMATION: On April 9, May 14, and June 18, 1999, the Committee for Purchase From People Who Are Blind or Severely Disabled published notices (64 F.R. 17312, 26360 and 32844) of proposed additions to the Procurement List.

After consideration of the material presented to it concerning capability of qualified nonprofit agencies to provide the commodities and services and impact of the additions on the current or most recent contractors, the Committee has determined that the commodities and services listed below are suitable for procurement by the Federal Government under 41 U.S.C. 46–48c and 41 CFR 51–2.4.

I certify that the following action will not have a significant impact on a substantial number of small entities. The major factors considered for this certification were:

1. The action will not result in any additional reporting, recordkeeping or other compliance requirements for small entities other than the small organizations that will furnish the commodities and services to the Government.

2. The action will not have a severe economic impact on current contractors for the commodities and services.

3. The action will result in authorizing small entities to furnish the commodities and services to the Government.

4. There are no known regulatory alternatives which would accomplish the objectives of the Javits-Wagner-O'Day Act (41 U.S.C. 46–48c) in connection with the commodities and services proposed for addition to the Procurement List.

Accordingly, the following commodities and services are hereby added to the Procurement List:

Commodities

Computer Screen (CRT) Wipes
7930–01–454–1138

Phone Wipes, Sanitary
7930–01–454–1139

Hand Cleaner, Heavy Duty Wipes
8520–01–454–1144

Services

Base Supply Center and Operation of Individual Equipment Element Store, Holloman Air Force Base, New Mexico

Grounds Maintenance, Manchester AFRC, 64 Harvey Road, Londonderry, New Hampshire

Grounds Maintenance, Naval and Marine Corps Reserve Center, 5101 North Assembly Street, Spokane, Washington

This action does not affect current contracts awarded prior to the effective date of this addition or options that may be exercised under those contracts.

Beverly L. Milkman,

Executive Director.

[FR Doc. 99–19533 Filed 7–29–99; 8:45 am]

BILLING CODE 6353–01–P

COMMITTEE FOR PURCHASE FROM PEOPLE WHO ARE BLIND OR SEVERELY DISABLED

"Additions to Procurement List" Correction

The Committee has combined and redesignated as JWOD Staffing Services the two services currently on the Committee's Procurement List as Administrative/General Support Services (GSA/FSS Region 7), (Up to 50% of the Government's requirement) which was added to the Procurement List on August 30, 1996 (61 FR 45934) and Temporary Administrative/General Support Services for GSA Regions 1, 2, 3, 4, 5, 6, 8, 9, 10 and National Capitol Region (Up to 50% of the Government's requirement) which was added to the Procurement List on February 28, 1997 (62 FR 9158).

Beverly L. Milkman,

Executive Director.

[FR Doc. 99–19534 Filed 7–29–99; 8:45 am]

BILLING CODE 6353–01–P

DEPARTMENT OF COMMERCE

Foreign-Trade Zones Board

[Docket 37–99]

Foreign-Trade Zone 143—Sacramento, California Area; Application for Expansion

An application has been submitted to the Foreign-Trade Zones (FTZ) Board (the Board) by the Sacramento-Yolo Port District, grantee of FTZ 143, requesting authority to expand its zone to include a site in Chico, California. The application was submitted pursuant to the provisions of the Foreign-Trade Zones Act, as amended (19 U.S.C. 81a–81u), and the regulations of the Board (15 CFR Part 400). It was formally filed on July 16, 1999.

FTZ 143 was approved on August 6, 1987 (Board Order 360, 52 FR. 30698, 8/17/87) and expanded on December 15, 1997 (Board Order 944, 62 FR 67043, 12/23/97). The zone project currently consists of the following sites: Site 1 (686 acres)—within the Port of Sacramento, Industrial Blvd. and Boatman Ave., West Sacramento; and, Site 2 (1,280 acres)—Lincoln Airport Business Park, Aviation Boulevard, Lincoln, some 25 miles northeast of Sacramento.

This application is requesting authority to further expand the general-purpose zone to include an additional site: (Proposed Site 3—1,574 acres)—Chico Municipal Airport complex and adjacent industrial development area, city of Chico, County of Butte. The proposed zone site is divided into three parcels as follows: East Area (300 acres)—east of Cohasset Road on mostly vacant land, Chico; West Area (250 acres)—adjacent to and west of the Chico Municipal Airport, under the jurisdiction of the County of Butte and the city of Chico; and, the Airport Area (1,024 acres)—Chico Municipal Airport complex, Chico, including the Airport Industrial Park (but excluding airport runways and public terminal area). No specific manufacturing requests are being made at this time. Such requests would be made to the Board on a case-by-case basis.

Section 2422 of the Miscellaneous Trade and Technical Correction Act of 1999 (P.L. 106–36) directs the Foreign-Trade Zones Board to expand FTZ 143 to include a site in Chico in accordance with the application described above.

In accordance with the Board's regulations, a member of the FTZ Staff has been designated examiner to review the application and report to the Board.

Public comment on the application may be submitted to the Board's

Executive Secretary at the address below. The closing period for their receipt is August 16, 1999.

A copy of the application and accompanying exhibits will be available for public inspection at each of the following locations:

Office of the Port Director, Sacramento-Yolo Port District, 3251 Beacon Boulevard, Suite 210, West Sacramento, CA 95691

Office of the Executive Secretary, Foreign-Trade Zones Board, Room 3716, U.S. Department of Commerce, 14th & Pennsylvania Avenue, NW, Washington, DC 20230

Dated: July 19, 1999.

Dennis Puccinelli,

Acting Executive Secretary.

[FR Doc. 99–19607 Filed 7–29–99; 8:45 am]

BILLING CODE 3510–DS–P

DEPARTMENT OF COMMERCE

Foreign-Trade Zones Board

[Docket 38–99]

Foreign-Trade Zone 72—Indianapolis, Indiana; Application for Subzone; SMC Pneumatics, Inc.; (Pneumatic Automation Products); Indianapolis, IN

An application has been submitted to the Foreign-Trade Zones Board (the Board) by the Indianapolis Airport Authority, grantee of FTZ 72, requesting special-purpose subzone status for the manufacturing and warehousing facilities of SMC Pneumatics, Inc. (SMC), located in Indianapolis, Indiana. The application was submitted pursuant to the provisions of the Foreign-Trade Zones Act, as amended (19 U.S.C. 81a–81u), and the regulations of the Board (15 CFR part 400). It was formally filed on July 16, 1999.

SMC Pneumatics, Inc. has one site with 391 employees in Indianapolis, Indiana. The site (18.6 acres) is located at 3011 N. Franklin Road in Indianapolis, Indiana. The SMC plant is used for the manufacturing, processing, packaging and distributing of pneumatic automation products and components (primarily HTS 8412, 8413, 8481 and 9026, duty rate ranges from duty-free to 5.3%). Components and materials sourced from abroad (representing about 95% of all parts consumed in manufacturing) include: screws, bolts, engine and motor parts, centrifuges, valves, bearings, electromagnets, insulated cables, and gauges (HTS 7318, 8412, 8421, 8481, 8482, 8505, 8544, 9026, duty rate ranges from duty-free to 9.9%). Some 2.3 percent of the plant's shipments are exported. FTZ procedures would exempt SMC from Customs duty payments on the foreign components used in export production. On its domestic sales, SMC would be able to choose the duty rates during Customs entry procedures that apply to finished pneumatic automation products (duty free to 5.3%) for the foreign inputs noted above. The request indicates that the savings from FTZ procedures would help improve the plant's international competitiveness.

In accordance with the Board's regulations, a member of the FTZ staff has been appointed examiner to investigate the application and report to the Board.

Public comment on the application is invited from interested parties. Submissions (original and 3 copies) shall be addressed to the Board's Executive Secretary at the address below. The closing period for their receipt is September 28, 1999. Rebuttal comments in response to material submitted during the foregoing period may be submitted during the subsequent 15-day period (to October 13, 1999).

A copy of the application and the accompanying exhibits will be available for public inspection at each of the following locations:

U.S. Customs Port of Entry—Indianapolis, Arms Comb Bldg #3, Rm. 30, Indianapolis, In 46251

Office of the Executive Secretary, Foreign-Trade Zones Board, Room 3716, U.S. Department of Commerce 14th and Pennsylvania Avenue, N.W., Washington, D.C. 20230

Dated: July 21, 1999.

Dennis Puccinelli,

Acting Executive Secretary.

[FR Doc. 99–19608 Filed 7–29–99; 8:45 am]

BILLING CODE 3510–DS–P

DEPARTMENT OF COMMERCE

International Trade Administration

[A–570–852]

Preliminary Determination of Sales at Less Than Fair Value and Postponement of Final Determination: Creatine Monohydrate From the People's Republic of China

AGENCY: Import Administration, International Trade Administration, Department of Commerce.

EFFECTIVE DATE: July 30, 1999.

FOR FURTHER INFORMATION CONTACT: Blanche Ziv, Rosa Jeong, Annika O'Hara or Marian Wells, Import Administration, International Trade Administration, U.S. Department of Commerce, 14th Street and Constitution Avenue, NW, Washington, DC 20230; telephone: (202) 482–4207, (202) 482–3853, (202) 482–3798, and (202) 482–6309, respectively.

The Applicable Statute

Unless otherwise indicated, all citations to the Tariff Act of 1930, as amended (''the Act''), are references to the provisions effective January 1, 1995, the effective date of the amendments made to the Act by the Uruguay Round Agreements Act (''URAA''). In addition, unless otherwise indicated, all citations to the Department of Commerce (''Department'') regulations are to the regulations at 19 CFR Part 351 (April 1, 1998).

Preliminary Determination

We preliminarily determine that creatine monohydrate (''creatine'') from the People's Republic of China (''PRC'') is being, or is likely to be, sold in the United States at less than fair value (''LTFV''), as provided in section 733 of the Act. The estimated margins of sales at LTFV are shown in the ''Suspension of Liquidation'' section of this notice.

Case History

Since the initiation of this investigation on March 10, 1999 (64 FR 11835), the following events have occurred:

On March 29, 1999, the United States International Trade Commission (''ITC'') notified the Department of its affirmative preliminary injury determination in this case.

On March 30, 1999, the Department requested comments on the scope of this investigation from the petitioner, the respondents, the PRC's Embassy in Washington, D.C., and the PRC Ministry of Foreign Trade and Economic Cooperation (''MOFTEC''). On April 2, April 5, and April 19, 1999, we received comments on the scope from the petitioner and the respondents. Based on the parties' comments, the Department has revised the description of the scope of this investigation. Specifically, the Department removed from the scope language the Chemical Abstracts Service (''CAS'') registry number for anhydrous creatine, which is chemically distinguishable from creatine monohydrate, the product produced and sold by the petitioner. As described in the June 25, 1999 memorandum from the Team to Deputy Assistant Secretary Richard W. Moreland (''Comments on Scope'') which is on file in Import Administration's Central Records Unit, Room B–099, U.S. Department of Commerce, 14th Street and Constitution Avenue, N.W., Washington, D.C. 20230, this change clarifies that the relief requested by petitioner is only with

respect to creatine monohydrate. The revised scope appears in the ''Scope of Investigation'' section, below.

On April 7, 1999, the Department issued an antidumping questionnaire to MOFTEC with instructions to forward the questionnaire to all producers/exporters of the subject merchandise and that these companies must respond by the due dates.

On April 28, 1999, the Department asked the China Chamber of Commerce of Medicines & Health Products Importers & Exporters (''the Chamber'') to identify any producers/exporters of the subject merchandise in addition to the producers/exporters who had contacted the Department and the producers/exporters identified by the petitioner. We received a response from the Chamber on May 11, 1999.

On April 29, 1999, the Department invited interested parties to provide publicly available information for valuing the factors of production and for surrogate country selection. We received responses on June 7 and June 16, 1999, and additional comments on June 14 and June 22, 1999.

On May 10, and June 1, 1999, the Department received questionnaire responses from (1) Tianjin Tiancheng Pharmaceutical Co., Ltd. (''Tiancheng''); (2) Suzhou Sanjian Fine Chemical Co., Ltd. (''Sanjian''); (3) Blue Science International Trading (Shanghai) Co., Ltd. and Technical Sourcing International (''Blue Science''); (4) Nantong Medicines and Health Products Import and Export Co., Ltd. d/b/a Nantong Foreign Trade Corporation Medicine and Health Products Department (''Nantong''); (5) Shanghai Freemen International Trading Co., Ltd. and Shanghai Greenmen International Trading Co., Ltd. (''Freemen''); and (6) Jiangsu Shuang Qiang Chemical Co. and Wuxian Agricultural Chemical Factory (''SQ''). Tiancheng and Sanjian both produce and export the subject merchandise to the United States, whereas Blue Science, Nantong, and Freemen are exporters and SQ is solely a producer. We issued supplemental questionnaires on June 15, June 16, June 21, and June 22, 1999, to which we received responses on June 22, June 28, and July 6, 1999.

On May 20, 1999, Shanghai Desano International Trading Co., Ltd. (''Desano'') requested that it be considered a respondent in this investigation. On May 26, 1999, we sent an antidumping questionnaire to Desano to which we received a response on June 30, 1999. Desano is solely an exporter of the subject merchandise.

On April 8, 1999, and May 12, 1999, pursuant to the allegation of critical circumstances contained in the petition, the Department requested information regarding shipments of creatine from all respondents participating in this investigation. We received the requested information on May 13 and May 14, 1999. The critical circumstances analysis for the preliminary determination is discussed below under ''Critical Circumstances.''

Postponement of Final Determination and Extension of Provisional Measures

Pursuant to section 735(a)(2) of the Act, on July 19 and July 21, 1999, several respondents requested that, in the event of an affirmative preliminary determination in this investigation, the Department postpone its final determination after the date of the publication of an affirmative preliminary determination in the **Federal Register**. In accordance with 19 CFR 351.210(b), because (1) our preliminary determination is affirmative, (2) the requesting exporters account for a significant proportion of exports of the subject merchandise, and (3) no compelling reasons for denial exist, we are granting the respondents' request and are postponing the final determination until no later than 135 days after the publication of this notice in the **Federal Register**. Suspension of liquidation will be extended accordingly.

Scope of Investigation

For purposes of this investigation, the product covered is creatine monohydrate, which is commonly referred to as ''creatine.'' The chemical name for creatine monohydrate is N-(aminoiminomethyl)-N-methylgycine monohydrate. The Chemical Abstracts Service registry number for this product is 6020–87–7. Creatine monohydrate in its pure form is a white, tasteless, odorless powder, that is a naturally occurring metabolite found in muscle tissue. Creatine monohydrate is provided for in subheading 2925.20.90 of the Harmonized Tariff Schedule of the United States (''HTSUS''). Although the HTSUS subheading and CAS registry number are provided for convenience and customs purposes, the written description of the merchandise under investigation is dispositive.

Period of Investigation

The period of this investigation (''POI'') comprises each exporter's two most recent fiscal quarters prior to the filing of the petition, *i.e.*, July 1 through December 31, 1998.

Nonmarket Economy Country and Market Oriented Industry Status

The Department has treated the PRC as a nonmarket economy (''NME'') country in all past antidumping investigations (*see, e.g., Final Determination of Sales at Less Than Fair Value: Certain Preserved Mushrooms from the People's Republic of China,* 63 FR 72255 (December 31, 1998) (''*Mushrooms*'')). A designation as an NME remains in effect until it is revoked by the Department (see section 771(18)(C) of the Act).

The respondents in this investigation have not requested a revocation of the PRC's NME status. We have, therefore, preliminarily determined to continue to treat the PRC as an NME.

Separate Rates

All the respondents, except SQ (which is not an exporter), have requested a separate company-specific rate. Blue Science has stated that it is a trading company which is wholly-owned by persons in Hong Kong. Therefore, in accordance with our past practice, we preliminarily determine that this exporter qualifies for a separate rate and that no separate rates analysis is required for Blue Science (*see, e.g., Final Determination of Sales at Less Than Fair Value: Bicycles from the People's Republic of China,* 61 FR 19026 (April 30, 1996) (''*Bicycles from the PRC*'')). The other respondents which have requested a separate rate have stated that they are privately owned companies with no element of government ownership or control.

The Department's separate rate test is not concerned, in general, with macroeconomic/border-type controls, *e.g.*, export licenses, quotas, and minimum export prices, particularly if these controls are imposed to prevent dumping. The test focuses, rather, on controls over the investment, pricing, and output decision-making process at the individual firm level. See *Certain Cut-to-Length Carbon Steel Plate from Ukraine: Final Determination of Sales at Less than Fair Value,* 62 FR 61754, 61757 (November 19, 1997); *Tapered Roller Bearings and Parts Thereof, Finished and Unfinished, from the People's Republic of China: Final Results of Antidumping Duty Administrative Review,* 62 FR 61276, 61279 (November 17, 1997); and *Honey from the People's Republic of China: Preliminary Determination of Sales at Less than Fair Value,* 60 FR 14725, 14726 (March 20, 1995) (''*Honey*'').

To establish whether a firm is sufficiently independent from government control to be entitled to a

separate rate, the Department analyzes each exporting entity under a test arising out of the *Final Determination of Sales at Less Than Fair Value: Sparklers from the People's Republic of China,* 56 FR 20588 (May 6, 1991) and *Mushrooms.* Under the separate rates criteria, the Department assigns separate rates in NME cases only if the respondents can demonstrate the absence of both *de jure* and *de facto* governmental control over export activities.

1. Absence of *De Jure* Control

The respondents have placed on the record a number of documents to demonstrate absence of *de jure* government control, including the ''Foreign Trade Law of the People's Republic of China'' (''Foreign Trade Law'') and the ''Company Law of the People's Republic of China'' (''Company Law'').

In prior cases, the Department has analyzed the Foreign Trade Law and found that it establishes an absence of *de jure* control. (*See, e.g., Final Determination of Sales at Less Than Fair Value: Certain Partial-Extension Steel Drawer Slides with Rollers from the People's Republic of China,* 60 FR 54472 (October 24, 1995); *see also Mushrooms.*) We have no new information in this proceeding which would cause us to reconsider this determination. For the purposes of this investigation and in prior cases, the Department has also analyzed the Company Law and found that this law establishes mechanisms for private control of companies which indicate an absence of *de jure* control. *See Notice of Preliminary Results of New Shipper Review: Freshwater Crawfish Tail Meat from the People's Republic of China,* 64 FR 8543, 8544 (February 22, 1999).

According to the respondents, creatine exports are not affected by quota allocations or export license requirements. The producers/exporters claim to have the autonomy to set the price at whatever level they wish through independent price negotiations with their foreign customers without government interference.

Accordingly, we preliminarily determine that, within the creatine industry, there is an absence of *de jure* government control over export pricing and marketing decisions of firms.

2. Absence of *De Facto* Control

As stated in previous cases, there is some evidence that certain enactments of the PRC central government have not been implemented uniformly among different sectors and/or jurisdictions in the PRC. (*See Mushrooms.*) Therefore, the Department has determined that an analysis of *de facto* control is critical in determining whether respondents are, in fact, subject to a degree of governmental control which would preclude the Department from assigning separate rates.

The Department typically considers four factors in evaluating whether each respondent is subject to *de facto* governmental control of its export functions: (1) whether the export prices are set by, or subject to, the approval of a governmental authority; (2) whether the respondent has authority to negotiate and sign contracts and other agreements; (3) whether the respondent has autonomy from the government in making decisions regarding the selection of its management; and (4) whether the respondent retains the proceeds of its export sales and makes independent decisions regarding disposition of profits or financing of losses (*see Mushrooms*).

Tiancheng, Sanjian, Nantong, Freemen, and Desano have each asserted the following: (1) they establish their own export prices; (2) they negotiate contracts without guidance from any governmental entities or organizations; (3) they make their own personnel decisions; and (4) they retain the proceeds of their export sales and use profits according to their business needs without any restrictions. Additionally, these five respondents have stated that they do not coordinate or consult with other exporters regarding their pricing. This information supports a preliminary finding that there is an absence of *de facto* governmental control of the export functions of these companies. Consequently, we preliminarily determine that all responding exporters have met the criteria for the application of separate rates.

Use of Facts Available

PRC–Wide Rate

Information on the record of this investigation indicates that there may be producers/exporters of the subject merchandise in the PRC in addition to the companies participating in this investigation. Also, U.S. import statistics indicate that the total quantity of U.S. imports of creatine from the PRC is greater than the total quantity of creatine exported to the U.S. as reported by all PRC creatine exporters that submitted responses in this investigation. Given this discrepancy, it appears that not all PRC exporters of creatine responded to our questionnaire. Accordingly, we are applying a single antidumping deposit rate—the PRC-wide rate—to all exporters in the PRC, other than those specifically identified below under ''Suspension of Liquidation,'' based on our presumption that the export activities of the companies that failed to respond to the Department's questionnaire are controlled by the PRC government (*see, e.g., Bicycles from the PRC*).

As explained below, this PRC-wide antidumping rate is based on adverse facts available. Section 776(a)(2) of the Act provides that ''if an interested party or any other person—(A) withholds information that has been requested by the administering authority or the Commission under this title, (B) fails to provide such information by the deadlines for submission of the information or in the form and manner requested, subject to subsections (c)(1) and (e) of section 782, (C) significantly impedes a proceeding under this title, or (D) provides such information but the information cannot be verified as provided in section 782(i), the administering authority and the Commission shall, subject to section 782(d), use the facts otherwise available in reaching the applicable determination under this title.''

Section 776(b) of the Act provides that adverse inferences may be used when a party has failed to cooperate by not acting to the best of its ability to comply with a request for information. The exporters that decided not to respond in any form to the Department's questionnaire failed to act to the best of their ability in this investigation. Further, absent a response, we must presume government control of these and all other PRC companies for which we cannot make a separate rates determination. Thus, the Department has determined that, in selecting from among the facts otherwise available, an adverse inference is warranted.

As adverse facts available, we are assigning the highest margin in the petition, 153.7 percent, which is higher than any of the calculated margins.

Section 776(c) of the Act provides that where the Department selects from among the facts otherwise available and relies on ''secondary information,'' such as the petition, the Department shall, to the extent practicable, corroborate that information from independent sources reasonably at the Department's disposal. The Statement of Administrative Action accompanying the URAA, H.R. Doc. No. 103–316 (1994) (SAA), states that ''corroborate'' means to determine that the information used has probative value. *See* SAA at 870.

The petitioner's methodology for calculating export price (''EP'') and normal value (''NV'') is discussed in the

Notice of Initiation. To corroborate the petitioner's EP calculations, we compared the prices in the petition for the product to the prices submitted by respondents for the same product in similar volumes. To corroborate the petitioner's NV calculations, we compared the petitioner's factor consumption and surrogate value data for the product to the data reported by the respondents for the most significant factors—chemical inputs, factory overhead, and selling, general, and administrative expenses—and the surrogate values for these factors in the petition to the values selected for the preliminary determination, as discussed below. Our analysis showed that, in general, the petitioner's data was reasonably close to the data submitted by the respondents or to the surrogate values chosen by the Department. (*See* memorandum to the file dated July 22, 1999 (''Corroboration Memo'').) Based on our analysis, we find that the calculations set forth in the petition have probative value.

Company-Specific Rates—Partial Facts Available

Freemen claims that despite its repeated demands, one of its suppliers has refused to provide factors of production data to Freemen. According to Freemen, this supplier, who supplied a relatively small percentage of creatine sold by Freemen, has indicated that it will not participate in any way in this investigation. Freemen has provided all factors of production data from its other suppliers. Similarly, Blue Science asserts that one of its suppliers, which accounts for a small percentage of creatine sold by Blue Science, only produced the subject merchandise on a trial basis and has since terminated production. As such, the supplier was not able to provide complete factors of production data to Blue Science.

We preliminarily determine that the use of adverse facts available is warranted where the factors of production are missing or unusable. Because certain producers of the subject merchandise neither provided complete and accurate factors of production information nor demonstrated satisfactorily why this is not possible, we find that these interested parties have not cooperated to the best of their abilities. Accordingly, as adverse facts available, we have applied a margin of 153.70 percent, the highest margin from the petition, to those sales for which we did not have complete factors of production.

Fair Value Comparisons

To determine whether sales of the subject merchandise by Tiancheng, Sanjian, Blue Science, Nantong, Freemen, and Desano to the United States were made at LTFV, we compared the EP to the NV, as described in the ''Export Price'' and ''Normal Value'' sections of this notice, below. In accordance with section 777A(d)(1)(A)(i) of the Act, we compared POI-wide weighted-average EPs to weighted-average NVs.

Export Price

We used EP methodology in accordance with section 772(a) of the Act, because the subject merchandise was sold directly to unaffiliated customers in the United States prior to importation and CEP methodology was not otherwise appropriate. We calculated EP based on packed CIF or C&F prices to the first unaffiliated purchaser in the United States. Where appropriate, we made deductions from the starting price (gross unit price) for billing adjustments, inland freight from the plant/warehouse to port of exit, brokerage and handling in the PRC, marine insurance and ocean freight. Because certain domestic brokerage and handling, marine insurance, and inland freight were provided by NME companies, we based those charges on surrogate rates from India. (*See* ''Normal Value'' section for further discussion.)

Normal Value

1. Surrogate Country

Section 773(c)(4) of the Act requires the Department to value the NME producer's factors of production, to the extent possible, in one or more market economy countries that: (1) are at a level of economic development comparable to that of the NME, and (2) are significant producers of comparable merchandise. The Department has determined that India, Pakistan, Sri Lanka, Egypt, Indonesia, and the Philippines are countries comparable to the PRC in terms of overall economic development (*see* memorandum from Jeff May, Director, Office of Policy, to Susan Kuhbach, Senior Director, AD/CVD Enforcement, Office 1, March 26, 1999). According to the available information on the record, we have determined that both India and Indonesia are significant producers of comparable merchandise. Although we have no information to indicate that India and Indonesia produce creatine, they do produce other products within the same customs heading and produce other fine chemicals with nutritional characteristics. Of these two countries, India produces and exports more merchandise than Indonesia under United National Standard International Trade Classification Revised number 514.82, ''carboxyamide-function compounds (including saccharin and its salts) and imine-function compounds,'' the heading which includes creatine. Accordingly, we have calculated NV using mainly Indian values, and in some cases Indonesian values, for the PRC producers' factors of production. We have obtained and relied upon publicly available information wherever possible.

2. Factors of Production

In accordance with section 773(c) of the Act, we calculated NV based on factors of production reported by the companies in the PRC which produced creatine for the exporters that sold creatine to the United States during the POI. To calculate NV, the reported unit factor quantities were multiplied by publicly available Indian and Indonesian values.

In selecting the surrogate values, we considered the quality, specificity, and contemporaneity of the data. As appropriate, we adjusted input prices to make them delivered prices. Where a producer did not report the distance between the material supplier and the factory, as facts available, we used either the distance to the nearest seaport (if an import value was used as the surrogate value for the factor) or the farthest distance reported for a supplier. Where distances were reported, we added to Indian CIF surrogate values a surrogate freight cost using the shorter of the reported distances from either the closest PRC port to the PRC factory, or from the domestic supplier to the factory. This adjustment is in accordance with the CAFC's decision in *Sigma Corp.* v. *United States*, 117 F. 3d 1401 (Fed.Cir. 1997). For those values not contemporaneous with the POI and quoted in a foreign currency, we adjusted for inflation using wholesale price indices published in the International Monetary Fund's International Financial Statistics.

Many of the inputs in the production and packing of creatine are considered business proprietary data by the respondents. Due to the proprietary nature of this data, we are unable to discuss many of the inputs in this preliminary determination notice. For a complete analysis of surrogate values, see the memorandum from the Team to the file (''Factors of Production Memorandum''), dated July 22, 1999.

We valued labor using the method described in 19 CFR 351.408(c)(3).

To value electricity, we used the 1995 electricity rates reported in the publication *Energy Prices and Taxes*, 4th quarter 1998. We based the value of coal on prices reported in *Energy Prices and Taxes*, 2nd quarter 1998.

We based our calculation of factory overhead, SG&A, and profit on 1992–93 data from the ''Expenditures and Appropriations'' section of the accounts of ''Processing and Manufacturing, Chemicals and products thereof'' from the *Reserve Bank of India Bulletin*, January 1997.

To value truck freight rates, we used a 1994 rate from *The Times of India*. For inland water transportation, we valued boat and barge transportation using the surrogate values found in an August 1993 cable from the US Embassy Bombay. With regard to rail freight, we based our calculation on information from the *Indian Railway Conference Association*.

For packing materials we used import values from the *Monthly Foreign Trade Statistics of India; Volume II Imports*.

Critical Circumstances

In the February 12, 1999 petition, the petitioner alleged that there is a reasonable basis to believe or suspect that critical circumstances exist with respect to imports of creatine from the PRC. In addition, the petitioner requested that the Department issue its preliminary critical circumstances finding on an expedited basis because importers, exporters and producers had an early warning of the proceeding prior to the filing of the petition. The basis for petitioner's contention was that PRC parties had advance knowledge of the petition through a press release dated January 25, 1999, from a public relations firm's website. The press report stated that the petitioner would be filing an antidumping petition with the Department and the ITC in order to seek the imposition of substantial, triple digit dumping duties on all importers of creatine from China.

We examined whether conditions in the industry and published reports and statements provided a basis for inferring knowledge that a proceeding was likely. We preliminarily determine that the January 25, 1999 press report cited by the petitioner is insufficient to show that such information was widely available. Our research of Lexis-Nexis and Internet inquiries revealed nothing to indicate that the press release was reported by any publication. Moreover, the petitioner did not provide the Department with further documentation to support its allegation. Therefore, because there is insufficient evidence on the record indicating the likelihood of a proceeding concerning imports of creatine from the PRC, we have not made an expedited critical circumstances determination.

On April 8, 1999, the Department requested information regarding shipments of creatine for the period September 1998 to June 1999 from all respondents participating in this investigation. On May 13, May 14, May 20 and July 6, 1999, we received the requested information from Tiancheng, Sanjian, Blue Science, Nantong, Freemen and Desano. The information submitted by Desano was limited to shipment data for the period August 1998 to December 1998. Despite our subsequent request for shipment data for the remaining time period (*i.e.*, January 1999 to June 1999), Desano did not provide any additional information. On May 25, 1999, the petitioner argued that, based on the information submitted, critical circumstances existed with respect to imports by Freemen.

Section 733(e)(1) of the Act provides that the Department will determine that critical circumstances exist if there is a reasonable basis to believe or suspect that: (A)(i) there is a history of dumping and material injury by reason of dumped imports in the United States or elsewhere of the subject merchandise, or (ii) the person by whom, or for whose account, the merchandise was imported knew or should have known that the exporter was selling the subject merchandise at less than its fair value and that there was likely to be material injury by reason of such sales, and (B) there have been massive imports of the subject merchandise over a relatively short period.

With respect to the first criterion, we are not aware of any antidumping order in any country on creatine from the PRC. Therefore, we examined whether there was importer knowledge. In determining whether there is a reasonable basis to believe or suspect that an importer knew or should have known that the exporter was selling creatine at less than fair value and thereby causing material injury, the Department must rely on the facts before it at the time the determination is made. The Department normally considers margins of 25 percent or more and a preliminary ITC determination of material injury sufficient to impute knowledge of dumping and the likelihood of resultant material injury.

On April 7, 1999, the ITC preliminary determination found that there was a reasonable indication that the U.S. industry is materially injured. *See*, *Creatine Monohydrate from the People's Republic of China*, 64 FR 16998 (April 7, 1999). Therefore, with respect to the PRC, we preliminarily determine that there is a reasonable basis to believe or suspect that importers knew or should have known that material injury from the dumped merchandise was likely.

In determining whether there are ''massive imports'' over a ''relatively short time period'', the Department ordinarily bases its analysis on import data for at least the three months preceding (the ''base period'') and following (the ''comparison period'') the filing of the petition. Imports normally will be considered massive when imports during the comparison period have increased by 15 percent or more compared to imports during the base period. The Department examines respondent-specific shipment information or aggregate import statistics when respondent-specific shipment information is not available.

To determine whether imports of subject merchandise have been massive over a relatively short period, we compared each respondent's export volume for five months prior to the filing of the petition (September 1998 to January 1999) to that during the five months subsequent to the filing of the petition (February 1999 to June 1999). These periods were selected based on the Department's practice of using the longest period for which information is available from the month that the petition was submitted through the date of the preliminary determination. For all other exporters, we performed the analysis using import statistics.

Based on our analysis, we preliminarily determine that the increase in imports was greater than 15 percent for Freemen and for all producers/exporters of subject merchandise who were not analyzed or who failed to submit a response. As explained above, one respondent—Desano—did not comply with our request for shipment data for the period January 1999 to June 1999. Accordingly, we find that the information Desano submitted is so incomplete that it cannot serve as a reliable basis for reaching a determination regarding massive imports in this investigation. Therefore, pursuant to section 782(e) of the Act, we preliminarily determine that there were massive imports with respect to Desano based on adverse facts available. With regard to the other four respondents, Tiancheng, Nantong, San Jian, and Blue Science, we find that the increase in imports was not greater than 15 percent. *See* Memorandum from Team to Richard W. Moreland, Deputy Assistant Secretary, AD/CVD Enforcement Group I (''Critical

Circumstances Determination''), dated July 22, 1999.

On this basis, we preliminarily determine that critical circumstances exist for Freemen, Desano and all other PRC exporters except Tiancheng, Nantong, San Jian, and Blue Science.

We will make a final determination concerning critical circumstances when we make our final determination of this investigation.

Verification

As provided in section 782(i) of the Act, we will verify all information relied upon in making our final determination.

Suspension of Liquidation

In accordance with section 733(d) of the Act, we are directing the Customs Service to suspend liquidation of all imports of subject merchandise from the PRC entered, or withdrawn from warehouse, for consumption on or after the date of publication of this notice in the **Federal Register**. In addition, for Desano and Freemen, as well as for companies subject to the PRC-wide rate, we are directing Customs to suspend liquidation of any unliquidated entries of subject merchandise entered, or withdrawn from warehouse, for consumption on or after the date 90 days prior to the date of publication of this notice in the **Federal Register**. We will instruct the Customs Service to require a cash deposit or the posting of a bond equal to the weighted-average amount by which the NV exceeds the EP, as indicated in the chart below. These suspension of liquidation instructions will remain in effect until further notice.

Exporter/manufacturer	Weighted-average margin percentage	Critical circumstances
Blue Science International Trading (Shanghai) Co., Ltd	121.36	No.
Nantong Medicines and Health Products Import and Export Co., Ltd	1.63	No.
Shanghai Desano International Trading Co., Ltd	58.82	Yes.
Shanghai Freemen International Trading Co., Ltd., and Shanghai Greenmen International Trading Co., Ltd	139.15	Yes.
Suzhou Sanjian Fine Chemical Co., Ltd	152.67	No.
Tianjin Tiancheng Pharmaceutical Co., Ltd	3.54	No.
PRC-wide Rate	153.70	Yes.

The PRC-wide rate applies to all entries of the subject merchandise except for entries from exporters/factories that are identified individually above.

ITC Notification

In accordance with section 733(f) of the Act, we have notified the ITC of our determination. If our final determination is affirmative, the ITC will determine before the later of 120 days after the date of this preliminary determination or 45 days after our final determination whether these imports are materially injuring, or threaten material injury to, the U.S. industry.

Public Comment

Case briefs or other written comments in six copies must be submitted to the Assistant Secretary for Import Administration no later than November 17, 1999, and rebuttal briefs no later than November 22, 1999. A list of authorities used and an executive summary of issues should accompany any briefs submitted to the Department. Such summary should be limited to five pages total, including footnotes. In accordance with section 774 of the Act, we will hold a public hearing, if requested, to afford interested parties an opportunity to comment on arguments raised in case or rebuttal briefs. Tentatively, the hearing will be held on November 29, 1999 at the U.S. Department of Commerce, 14th Street and Constitution Avenue, N.W., Washington, D.C. 20230. Parties should confirm by telephone the time, date, and place of the hearing 48 hours before the scheduled time.

Interested parties who wish to request a hearing, or to participate if one is requested, must submit a written request to the Assistant Secretary for Import Administration, U.S. Department of Commerce, Room 1870, within 30 days of the publication of this notice. Requests should contain: (1) The party's name, address, and telephone number; (2) the number of participants; and (3) a list of the issues to be discussed. Oral presentations will be limited to issues raised in the briefs. If this investigation proceeds normally, we will make our final determination not later then 135 days after the publication of this notice in the **Federal Register**.

This determination is issued and published in accordance with sections 733(d) and 777(i)(1) of the Act.

Dated: July 22, 1999.

Robert S. LaRussa,

Assistant Secretary for Import Administration.

[FR Doc. 99–19609 Filed 7–29–99; 8:45 am]

BILLING CODE 3510–DS–P

DEPARTMENT OF COMMERCE

International Trade Administration

[A–580–807]

Polyethylene Terephthalate Film, Sheet, and Strip From Korea: Preliminary Results of Antidumping Duty New Shipper Review

AGENCY: Import Administration, International Trade Administration, Department of Commerce.

ACTION: Notice of Preliminary Results of Antidumping Duty New Shipper Review.

SUMMARY: In response to a request from one respondent, the Department of Commerce (the Department) is conducting a new shipper review of the antidumping duty order on polyethylene terephthalate film, sheet, and strip (PET film) from the Republic of Korea. The review covers one manufacturer/exporter of the subject merchandise to the United States and the period July 1, 1998 through December 31, 1998. We preliminary determine that Hyosung Corporation (Hyosung) did not sell subject merchandise below normal value (NV) during the period of review. If these preliminary results are adopted in our final results of review, we will instruct the U.S. Customs Service to assess no antidumping duties for Hyosung for the period covered by this new shipper review.

Interested parties are invited to comment on these preliminary results. Parties who submit argument in this proceeding are requested to submit with the argument: (1) a statement of issues and (2) a summary of the arguments (no longer than five pages, including footnotes).

EFFECTIVE DATE: July 30, 1999.

FOR FURTHER INFORMATION CONTACT: Michael J. Heaney or John Kugelman, AD/CVD Enforcement Group III, Office 8, Import Administration, International Trade Administration, US Department of Commerce, 14th Street and Constitution Avenue, NW, Washington, DC 20230; telephone (202) 482–4475–0649, respectively.

APPLICABLE STATUTE: Unless otherwise indicated, all citations to the Tariff Act of 1930, as amended (the Act) are references to the provisions effective January 1, 1995, the effective date of the amendments made to the Act by the Uruguay Round Agreements Act. In addition, unless otherwise indicated, all citations to the Department's regulations are the regulations codified at 19 CFR Part 351 (1998).

SUPPLEMENTARY INFORMATION:

Background

On December 28, 1998, the Department received a request from Hyosung for a new shipper review pursuant to section 751(a)(2) of the Act and § 351.214(b) of the Department's regulations. On February 2, 1999, we published the notice of initiation for this new shipper review (64 FR 5030).

Scope of the Review

Imports covered by this review are shipments of all gauges of raw, pretreated, or primed polyethylene terephthalate film, sheet, and strip, whether extruded or coextruded. The films excluded from this review are metallized films and other finished films that have had at least one of their surfaces modified by the application of a performance-enhancing resinous or inorganic layer of more than 0.00001 inches (0.254 micrometers) thick. Roller transport cleaning film which has at least one of its surfaces modified by the application of 0.5 micrometers of SBR latex has also been ruled as not within the scope of the order.

PET film is currently classifiable under Harmonized Tariff Schedule (HTS) subheading 3920.62.00.00. The HTS subheading is provided for convenience and for U.S. Customs purposes. The written description remains dispositive as to the scope of the product coverage.

The review covers the period July 1, 1998 through December 31, 1998. The Department is conducting this review in accordance with section 751(a)(2)(B) of the Act.

Fair Value Comparisons

To determine whether sales of PET film in the United States were made at less than fair value, we compared U.S. Price NV, as described in the ''United States Price'' and ''Normal Value'' sections of this notice. In accordance with section 777A(d)(2) of the Act, we calculated monthly weighted-average prices for NV and compared these to individual U.S. transactions.

United States Price (USP)

In calculating USP, the Department treated Hyosung's sales as export price (EP) sales, because the merchandise was sold to unaffiliated U.S. purchasers prior to the date of information and constructed export price (CEP) methodology was not otherwise indicated. *See* section 772(a) of the Act.

EP was based on the delivered price to unaffiliated purchasers in the United States. We made adjustments, where applicable, for Korean inland freight, Korean brokerage charges, ocean freight, marine insurance, U.S. brokerage charges, U.S. inland freight, and U.S. customs duties. We made an addition to EP for duty drawback pursuant to section 772(c)(1)(B) of the Act.

Normal Value (NV)

In order to determine whether there were sufficients sales of PET film in the home market (HM) to serve as a viable basis for calculating NV, we compared the volume of HM sales of PET film to the volume of PET film sold in the United States, in accordance with section 773(a)(1)(C). Hyosung's aggregate volume of HM sales of the foreign like product was greater than five percent of its respective aggregate volume of U.S. sales of the subject merchandise. Therefore, we have based NV on HM sales.

In accordance with section 773(a)(6) of the Act, we adjusted NV, where appropriate, by deducting home market packing expenses and adding U.S. packing expenses. We also adjusted NV for differences in credit expenses, warehousing expenses, and postage fees. We made a deduction from NV for inland freight.

Level of Trade

In accordance with section 773(a)(1)(B)(i) of the Act, to the extent practicable, we determine NV based on sales in the comparison market at the same level of trade (LOT) as the EP or CEP transaction. The NV LOT is that of the starting price sales in the comparison market or, when NV is based on CV, that of the sales from which we derive SG&A expenses and profit. For EP, the U.S. LOT is also the level of the starting price sale, which is usually from the exporter to the importer. For CEP, it is the level of the constructed sales from the exporter to the importer.

To determine whether NV sales are at a different LOT than EP or CEP sales, we examine stages in the marketing process and selling functions along the chain of distribution between the producer and the unaffiliated customer. If the comparison market sales are at a different LOT, and the difference affects price comparability, as manifested in a pattern of consistent price differences between the sales on which NV is based and comparison market sales at the LOT of the export transaction, we make a LOT adjustment under section 773(a)(7)(A) of the Act. Finally, for CEP sales, if the NV level is more remote from the factory than the CEP level and there is no basis for determining whether the differences in the levels between NV and CEP affects price comparability, we adjust NV under section 773(A)(7)(B) of the Act (the CEP offset provision). (*See e.g.,* Certain Carbon Steel Plate from south Africa, Final Determination of Sales at Less Than Fair Value, 62 FR 61731 (November 19, 1997).)

In implementing these principles in this review, we asked Hyosung to identify the specific differences and similarities in selling functions and/or support services between all phases of marketing in the home market and the United States. Hyosung identified one channel of distribution in the home market: sales to end-users. Hyosung performed a similar level of order processing, delivery arrangement, and customer liaison on each of its HM sales. Therefore, we determine that one LOT exists for all of Hyosung's HM sales.

For the U.S. market Hyosung reported one LOT, EP sales made directly to its U.S. customers. When we compared EP sales to HM sales, we determined that sales in both markets were made at the same LOT. For both EP and HM transactions Hyosung sold directly to the customer and provided similar levels of order processing, delivery arrangement, and customer liaison. Based upon the foregoing, we determined that Hyosung sold at the same LOT in the United States as it did in its home market, and consequently no LOT adjustment is warranted.

Preliminary Results of Review

We preliminarily determine that a margin of 0.00 percent exists for Hyosung for the period July 1, 1998 through December 31, 1998. We will disclose calculations performed in connection with these preliminary results of review within 10 days after the date of any public announcement, or, if there is no public announcement, within 5 days of publication of this notice. Interested parties may submit case briefs and/or written comments no later than 30 days after the date of publication. Rebuttal briefs and rebuttals to written comments, limited to issues raised in such briefs or comments, may be filed no later than 5 days after the deadline for filing case briefs. Any interested party may request a hearing within 30 days of publication. Any hearing, if requested, will be held 2 days after the deadline for filing rebuttal briefs unless the Secretary alters the date. The Department will issue the final results of this new shipper review, which will include the results of its analysis of issues raised in any such written comments, within 90 days after the date of these preliminary results.

Upon completion of this new shipper review, the Department shall determine, and Customs shall assess, antidumping duties on all appropriate entries. We have calculated importer-specific *ad valorem* duty assessment rates based on the total amount of antidumping duties calculated for the examined sales as a percentage of the total value of those sales. These rates will be assessed uniformly on all entries made during the POR. The Department will issue appraisement instructions directly to Customs. The final results of this review shall be the basis for the assessment of antidumping duties on entries of merchandise covered by the determination and for future deposits of estimated duties.

Upon completion of this review, the posting of a bond, or security in lieu of cash deposit, pursuant to section 751(a)(2)(B)(iii) of the Act and § 351.214(e) of the Department's regulations, will no longer be permitted and, should the final results yield a margin of dumping, a cash deposit will be required for each entry of the merchandise.

Furthermore, the following deposit requirements will be effective upon completion of the final results of this new shipper review for all shipments of PET film from the Republic of Korea entered, or withdrawn from warehouse, for consumption on or after the publication date of the final results of this new shipper review, as provided by section 751(a)(1) of the Act: (1) The cash deposit rate for Hyosung will be the rate established in the final results of this new shipper review; (2) for merchandise exported by manufacturers or exporters not covered in this review but covered in the less-than-fair-value (LTFV) investigation or a previous review, the cash deposit will continue to be the most recent rate published in the final determination or final results for which the manufacturer or exporter received a company-specific rate; (3) if the exporter is not a firm covered in this review or the original investigation, but the manufacturer is, the cash deposit rate will be that established for the manufacturer of the merchandise in the final results of this review or the LTFV investigation; and (4) if neither the exporter nor the manufacturer is a firm covered in this or any previous reviews, the cash deposit rate will be 21.5%, the ''all others'' rate established in the LTFV investigation.

This notice also services as a preliminary reminder to importers of their responsibility under 19 CFR 351.402(f) to file a certificate regarding the reimbursement of antidumping duties prior to liquidation of the relevant entries during this review period. Failure to comply with this requirement could result in the Secretary's presumption that reimbursement of antidumping duties occurred and the subsequent assessment of double antidumping duties.

This new shipper review and notice are in accordance with section 751(a)(2)(B) of the Act and 19 CFR 351.214(d).

Dated: July 23, 1999.

Bernard T. Carreau,

Acting Assistant Secretary for Import Administration.

[FR Doc. 99–19606 Filed 7–29–99; 8:45 am]

BILLING CODE 3510–DS–M

DEPARTMENT OF COMMERCE

International Trade Administration

[A–583–815]

Notice of Extension of Time Limit for Antidumping Duty Administrative Review of Welded ASTM A–312 Stainless Steel Pipe From Taiwan

AGENCY: Import Administration, International Trade Administration, Department of Commerce

EFFECTIVE DATE: July 30, 1999.

SUMMARY: The Department of Commerce (the Department) is extending the time limit for the preliminary results of the antidumping duty administrative review of the antidumping order on Welded ASTM A–312 Stainless Steel Pipe from Taiwan, covering the period December 1, 1997 through November 30, 1998.

FOR FURTHER INFORMATION CONTACT: Karla Whalen or Letitia Kress, AD/CVD Enforcement Office 9, Import Administration, International Trade Administration, U.S. Department of Commerce, 14th Street and Constitution Avenue, NW, Room 7866, Washington, DC 20230, telephone (202) 482–1391, or (202) 482–3362, respectively.

SUPPLEMENTARY INFORMATION: Under section 751(a)(3)(A) of the Tariff Act, as amended (the Act), the Department may extend the deadline for completion of an administrative review if it determines that it is not practicable to complete the review within the statutory time limit of 245 days after the last day of the anniversary month for the relevant order. In the instant case, the Department has determined that it is not practicable to complete the review within that statutory time limit. *See* Memorandum from Joseph A. Spetrini to Robert S. LaRussa, dated July 20, 1999. Therefore, in accordance with section 751(a)(3)(A) of the Act, the Department is extending the time limit for the preliminary results until November 1, 1999.

Dated: July 21, 1999.

Barbara E. Tillman,

Acting Deputy Assistant Secretary, Enforcement Group III.

[FR Doc. 99–19605 Filed 7–29–99; 8:45 am]

BILLING CODE 3510–DS–P

DEPARTMENT OF COMMERCE

Minority Business Development Agency

[Docket No. 990713191–9191–01]

RIN 0640–ZA05

Identification of Currently Funded Projects Eligible to be Extended for an Additional Year of Funding in Light of MBDA's Intent to Revise Its Client Service-Delivery Programs

AGENCY: Minority Business Development Agency, Commerce.

ACTION: Notice.

SUMMARY: This notice announces the Minority Business Development Agency's (MBDA) identification of certain currently funded Minority Business Development Centers (MBDC) and Native American Business Development Centers (NABDC) which will be eligible for an additional year of funding beyond the normal three years allowed between competitions.

Providing an additional year of funding will permit MBDA needed time to develop a revision of the work requirements for its client service-delivery programs. It is MBDA's intent to revise the methods and scope of its client service-delivery programs to include use of extensive state-of-the-art information technology to collect and disseminate information for and about minority businesses and markets.

DATES: July 30, 1999.

FOR FURTHER INFORMATION CONTACT: Ms. Juanita Berry at (202) 482–3262.

SUPPLEMENTARY INFORMATION: Under Executive Order 11625, MBDA provides business development services to persons who are members of groups determined by MBDA to be socially or economically disadvantaged, and to business concerns owned and controlled by such individuals. To deliver these services, MBDA intends to broaden the work requirements under its client service-delivery programs. Such programs include the MBDC, NABDC, and the Native American Business Consultant (NABC) programs, all of which are funded through cooperative agreements. The work requirements under these programs will include a less labor-intensive approach with more electronic/digital business information centers for providing business development services. The scope of work for MBDA's broadened client service-delivery programs will include an extensive state-of-the-art information technology to collect and disseminate information for and about minority businesses and markets. The focus of this business information will be in such areas as effective public/private sector partnership strategies; sources of information and their acquisition; organization of information for and about minority business; and operation of on-line business information centers. MBDA intends to implement the new work requirements for its client service-delivery programs through a competition published in the **Federal Register** in the Summer/Fall of 2000, with new cooperative agreements effective 1/1/2001. Consequently, there will be no new competition for MBDCs, NABDCs, and the NABC during 1999.

As part of the transition to the revised client service-delivery programs, MBDA intends to provide an additional year of funding, on a non-competitive basis, to current, eligible MBDCs and NABDCs which will be completing the third year or more of operation on 12/31/99. Such additional funding will be at the total discretion of MBDA based on such factors as the MBDCs' and NABDCs' performance, the availability of funds and Agency priorities. Normally, such Centers would undergo a new competition after three years of operation; however these Centers were funded beyond that period of time in order to establish their 12-month award cycles on a calendar year basis. The additional year of funding, as announced in this Notice, will allow MBDA the necessary time to develop its revised programs and to apply the new work requirements to all MBDCs and NABDCs, effective 1/1/2001. Therefore, the following MBDCs and NABDCs are affected by this notice and will be eligible for an additional year (1/1/2000 through 12/31/2000) of funding on a non-competitive basis: the Alaska MBDC, 60 FR 8636 (February 15, 1995); the New Mexico NABDC, 60 FR 9665 (February 21, 1995); the Mississippi Statewide MBDC, 61 FR 19046 (April 30, 1996); the Newark MBDC, 61 FR 28851 (June 6, 1996); the East Los Angeles, the Cincinnati, the West Los Angeles, and the Oklahoma City MBDCs, 61 FR 29731 (June 12, 1996); the Arizona and the California NABDCs and the Hampton Roads MBDC, 61 FR 43043 (August 20, 1996); the Louisville and the South Carolina Statewide MBDCs, 61 FR 48128 (September 12, 1996); and the New Mexico Statewide MBDC, 61 FR 28850 (June 6, 1996). In conjunction with the eligibility for an additional year of funding, the Ventura County MBDC, 61 FR 29733 (June 12, 1996, under the name Oxnard) will be eligible for a two-month extension (11/1/99 through 12/31/99) in order to establish its 12-month award cycle on a calendar year basis. In addition, the MBDCs located in Miami/Ft. Lauderdale, 60 FR 8639 (February 15, 1995) and in Raleigh/Durham, 60 FR 37877 (June 24, 1995), will be eligible for another year of funding, for the same reasons described above. These MBDCs had previously received an additional year (1/1/99 through 12/31/99) after competitions for the Centers were unsuccessful.

This notice also amends MBDA's prior notices, 63 FR 14900 (March 27, 1998), and 63 FR 14903 (March 27, 1998), in which it was indicated that, after their first year of funding, MBDC and NABDC operators may be eligible to receive up to two additional twelve-month budget periods. In view of MBDA's transition to revise its client service-delivery programs, MBDCs and NABDCs receiving new cooperative agreement awards, which were effective 1/1/99, under the aforementioned **Federal Register** solicitations, will be eligible to receive only one additional budget period (1/1/2000 through 12/31/2000). Such additional funding will also be at the total discretion of MBDA based on such factors as the MBDC's and NABDCs' performance, the availability of funds and Agency priorities. Limiting the eligibility of such Centers to two years of operation will allow MBDA to include all MBDCs and NABDCs and the NABC in the competition under the revised programs which are planned for implementation by 1/1/2001. Accordingly, the following MBDCs and NABDCs are affected by this notice and will be limited to two years of eligibility for operation of Centers: the El Paso, the Philadelphia, the Williamsburg, and the San Jose MBDCs, and the Minnesota, the North Dakota and the Oklahoma NABDCs.

Executive Order 12866

This notice was determined to be not significant for purposes of E.O. 12866.

Administrative Procedure Act

The provisions of the Administrative Procedure Act requiring notice of proposed rulemaking, the opportunity for public participation, and a delay in effective date, are inapplicable because this notice is a matter relating to public property, loans, grants, benefits, or contracts (5 U.S.C. 553(a)(2)).

Regulatory Flexibility Act

Because a notice of proposed rulemaking and opportunities for public comments are not required to be given for this notice by 5 U.S.C. 553 or by any other law, the analytical requirements of the Regulatory Flexibility Act, 5 U.S.C. 601, are inapplicable.

Executive Order 12612

This notice does not contain policies with Federalism implications sufficient to warrant preparation of a Federalism assessment under Executive order 12612.

Authority: 15 U.S.C. 1512 and Executive Order 11625.

Dated: July 23, 1999.

Juanita E. Berry,

Federal Register Liaison Officer, Minority Business Development Agency.

Courtland Cox,

Director, Minority Business Development Agency.

[FR Doc. 99–19516 Filed 7–29–99; 8:45 am]

BILLING CODE 3510–21–M

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

[I.D. 040799A]

Taking and Importing of Marine Mammals; Offshore Seismic Activities in the Beaufort Sea

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

ACTION: Notice of issuance of an incidental harassment authorization.

SUMMARY: In accordance with provisions of the Marine Mammal Protection Act (MMPA) as amended, notification is hereby given that an Incidental Harassment Authorization (IHA) to take small numbers of bowhead whales and other marine mammals by harassment incidental to conducting seismic surveys in the Western Beaufort Sea in state and Federal waters has been issued to Western Geophysical/Western Atlas International of Houston, Texas (Western Geophysical).

DATES: Effective from July 20, 1999, until November 1, 1999, unless extended.

ADDRESSES: The application, authorization, monitoring plan, environmental assessment (EA), and a list of references used in this document are available by writing to Donna Wieting, Chief, Marine Mammal Conservation Division, Office of Protected Resources, NMFS, 1315 East-West Highway, Silver Spring, MD 20910–3225, or by telephoning one of the contacts listed here.

FOR FURTHER INFORMATION CONTACT: Kenneth R. Hollingshead, NMFS, (301) 713–2055, Brad Smith, NMFS, (907) 271–5006.

SUPPLEMENTARY INFORMATION:

Background

Sections 101(a)(5)(A) and (D) of the MMPA (16 U.S.C. 1361 *et seq.*) direct the Secretary of Commerce (Secretary) to allow, upon request, the incidental, but not intentional, taking of small numbers of marine mammals by U.S. citizens who engage in a specified activity (other than commercial fishing) within a specified geographical region if certain findings are made and either regulations are issued or, if the taking is limited to harassment, a notice of a proposed authorization is provided to the public for review.

Permission may be granted if NMFS finds that the taking will have a negligible impact on the species or stock(s) and will not have an unmitigable adverse impact on the availability of the species or stock(s) for subsistence uses and if the permissible methods of taking and requirements pertaining to the monitoring and reporting of such taking are set forth.

On April 10, 1996 (61 FR 15884), NMFS published an interim rule establishing, among other things, procedures for issuing incidental harassment authorizations under section 101(a)(5)(D) of the MMPA in Arctic waters. For additional information on the procedures to be followed for this authorization, please refer to that document.

Summary of Request

On March 24, 1999, NMFS received an application from Western Geophysical requesting an authorization for the harassment of small numbers of several species of marine mammals incidental to conducting seismic surveys during the open water season in the Beaufort Sea between western Camden Bay and Harrison Bay off northern Alaska. Weather permitting, the survey is expected to take place between approximately July 1 and mid- to late-October, 1999. However, only a small portion of the area between western Camden Bay and Harrison Bay will be surveyed this year. A detailed description of the work proposed for 1999 is contained in the application (Western Geophysical, 1999) and is available upon request (see **ADDRESSES**).

Disturbance by seismic noise is the principal means of taking by this activity. Support vessels and aircraft will provide a potential secondary source of noise. The physical presence of vessels and aircraft could also lead to non-acoustic effects on marine mammals involving visual or other cues.

Seismic surveys are used to obtain data about geological formations several thousands of feet deep. The proposed seismic operation is an ocean bottom cable (OBC) survey. For this activity, OBC surveys involve dropping cables from a ship to the ocean bottom, forming a patch consisting of 4 parallel cables 8.9 kilometers (km) (4.8 nautical miles (nm)) long, separated by approximately 600 meters (m) (1,968 feet (ft)) from each other. Hydrophones and geophones, attached to the cables, are used to detect seismic energy reflected back from underground rock strata. The source of this energy is a submerged acoustic source, called a seismic airgun array, that releases compressed air into the water, creating an acoustical energy pulse that is directed downward toward the seabed. The source level planned for this project - a maximum of 247 dB re 1 μPa-m or 22.3 bar-meters (zero to peak), or a maximum of 252 dB re 1 μPa-m or 39 bar-meters (peak-to-peak) - will be from an airgun array with a air discharge volume of 1,210 in^3. This compares to the 1,500 in^3 array used on Western Geophysical's primary source vessel in 1998 and will be the only airgun array used by Western Geophysical in the Beaufort Sea this year.

It is anticipated that 34 seismic lines will be run for each patch, covering an area 5.0 km by 15.7 km (2.7 nm by 8.1 nm), centered over the patch. Source lines for one patch will overlap with those for adjacent patches.

After sufficient data have been recorded to allow accurate mapping of the rock strata, the cables are lifted onto the deck of a cable-retrieval vessel, moved to a new location (ranging from several hundred to a few thousand feet away), and placed onto the seabed again. For a more detailed description of the seismic operation, please refer to the 1999 application from Western Geophysical.

Depending upon ambient noise conditions and the sensitivity of the receptor, underwater sounds produced by open water seismic operations may be detectable a substantial distance away from the activity. Any sound that is detectable is (at least in theory) capable of eliciting a disturbance reaction by a marine mammal or of masking a signal of comparable frequency (Western Geophysical, 1999). An incidental harassment take is presumed to occur when marine mammals in the vicinity of the seismic source, the seismic vessel, other vessels, or aircraft react to the generated sounds or to visual cues.

Seismic pulses are known to cause strong avoidance reactions by many of the bowhead whales occurring within a distance of several kilometers and may sometimes cause avoidance or other changes in bowhead behavior at considerably greater distances (Richardson *et al.*, 1995; Rexford, 1996; MMS, 1997). It is also possible that seismic pulses may disturb some other marine mammal species occurring in the area.

Although some limited masking of low-frequency sounds (e.g., whale calls) is a possibility, the intermittent nature of seismic source pulses (<1 second in duration every 16 to 24 seconds) will limit the extent of masking. Bowhead whales are known to continue calling in the presence of seismic survey sounds, and their calls can be heard between seismic pulses (LGL and Greeneridge, 1997, 1998, 1999a; Richardson *et al.*, 1986). Masking effects are expected to

be absent in the case of belugas, given that sounds important to them are predominantly at much higher frequencies than are airgun sounds (Western Geophysical, 1999).

Hearing damage is not expected to occur during the project. It is not positively known whether the hearing systems of marine mammals very close to an airgun might be subject to temporary or permanent hearing impairment (Richardson *et al.*, 1995). However, planned monitoring and mitigation measures (described later in this document) are designed to avoid sudden onsets of seismic pulses at full power, to detect marine mammals occurring near the array, and to avoid exposing them to sound pulses that have any possibility of causing hearing impairment.

When the received levels of noise exceed some behavioral reaction threshold, cetaceans will show disturbance reactions. The levels, frequencies, and types of noise that will elicit a response vary between and within species, individuals, locations, and seasons. Behavioral changes may be subtle alterations in surface, respiration, and dive cycles. More conspicuous responses include changes in activity or aerial displays, movement away from the sound source, or complete avoidance of the area. The reaction threshold and degree of response are related to the activity of the animal at the time of the disturbance. Whales engaged in active behaviors, such as feeding, socializing, or mating, are less likely than resting animals to show overt behavioral reactions, unless the disturbance is directly threatening.

Bowhead Whales

Various studies (Reeves *et al.*, 1984, Fraker *et al.*, 1985, Richardson *et al.*, 1986, Ljungblad *et al.*, 1988) have reported that, when an operating seismic vessel approaches within a few kilometers, most bowhead whales exhibit strong avoidance behavior and changes in surfacing, respiration, and dive cycles. In studies prior to 1996, bowheads exposed to seismic pulses from vessels more than 7.5 km (4.0 nm) away rarely showed observable avoidance of the vessel, but their surface, respiration, and dive cycles appeared altered in a manner similar to that observed in whales exposed at a closer distance (Western Geophysical, 1999).

Within a 6– to 99–km (3.2 to 53.5 nm) range, it has not been possible to determine a specific distance at which subtle behavioral changes no longer occur (Richardson and Malme, 1993), given the high variability observed in bowhead whale behavior (Western Geophysical, 1999). However, in three studies of bowhead whales and one of gray whales, surfacing-dive cycles have been unusually rapid in the presence of seimic noise, with fewer breaths per surfacing and longer intervals between breaths (Richardson *et al.*, 1986; Koski and Johnson, 1987; Ljungblad *et al.*, 1988; Malme *et al.*, 1988). This pattern of subtle effects was evident among bowheads 6 km to at least 73 km (3.2 to 39 nm) from seismic vessels. However, in the pre–1996 studies, active avoidance usually was not apparent unless the seismic vessel was closer than about 6 to 8 km (3.2 to 4.3 nm)(Western Geophysical, 1999).

Inupiat whalers believe that migrating bowheads are sometimes displaced at distances considerably greater than 6 to 8 km (3.3 to 4.3 nm)(Rexford, 1996). Also, whalers have mentioned that bowheads sometimes seem more ''skittish'' and more difficult to approach when seismic exploration is underway in the area. Results from the 1996–1998 BP Exploration (Alaska)(BP) and Western Geophysical seismic monitoring program indicate that most bowheads avoided an area within about 20 km (12.4 mi) of nearshore seismic operations (Miller *et al.*, 1998, 1999). The received levels of the seismic pulse at 20 km range were about 115–130 dB re 1 μPa_{rms} @ 1 m). It is possible that, when additional data are available and analyzed, it may be demonstrated that isolated bowheads avoid seismic vessels at distance beyond 20 km (10.8 nm). Also, the ''skittish'' behavior may be related to the observed subtle changes in the behavior of bowheads exposed to seismic pulses from distant seismic vessels (Richardson *et al.*, 1986).

Gray Whales

The reactions of gray whales to seismic pulses are similar to those of bowheads, but apparently are limited to animals exposed to higher levels of seismic pulses. Migrating gray whales along the California coast were noted to slow their speed of swimming, turn away from seismic noise sources, and increase their respiration rates. Malme *et al.* (1983, 1984, 1988) concluded that approximately 50 percent showed avoidance when the average received pulse level was 170 dB (re 1 μPa). By some behavioral measures, clear effects were evident at average pulse levels of 160+dB; less consistent results were suspected at levels of 140–160 dB. Recent research on migrating gray whales showed responses similar to those observed in the earlier research when the source was moored in the migration corridor 2 km (1.1 nm) from shore. However, when the source was placed offshore (4 km (2.2 nm) from shore) of the migration corridor, the avoidance response was not evident on track plots (Tyack and Clark, 1998).

Beluga

The beluga is the only species of toothed whale (Odontoceti) expected to be encountered in the Beaufort Sea. Because the beluga hearing threshold at frequencies below 100 Hz (where most of the energy from airgun arrays is concentrated) is poor (125 dB re 1 μPa) or more depending upon frequency (Johnson *et al.*, 1989; Richardson *et al.*, 1991, 1995), beluga are not predicted to be strongly influenced by seismic noise. However, because of the high source levels of seismic pulses, airgun sounds sometimes may be audible to beluga at distances of 100 km (54 nm)(Richardson and Wursig, 1997). The reaction distance for beluga, although presently unknown, is expected to be less than that for bowheads, given the presumed poorer sensitivity of belugas than that of bowheads for low-frequency sounds (Western Geophysical, 1999).

Ringed, Largha and Bearded Seals

No detailed studies of reactions by seals to noise from open water seismic exploration have been published (Richardson *et al.*, 1995). However, there are some data on the reactions of seals to various types of impulsive sounds (LGL and Greeneridge, 1997, 1998, 1999a; J. Parsons as quoted in Greene, *et al.* 1985; Anon., 1975; Mate and Harvey, 1985). These studies indicate that ice seals typically either tolerate or habituate to seismic noise produced from open water sources.

Underwater audiograms have been obtained using behavioral methods for three species of phocinid seals: ringed, harbor, and harp seals (*Pagophilus groenlandicus*). These audiograms were reviewed in Richardson *et al.* (1995) and Kastak and Schusterman (1998). Below 30–50 kHz, the hearing threshold of phocinids is essentially flat down to at least 1 kHz and ranges between 60 and 85 dB (re 1 μPa @ 1 m). There are few data on hearing sensitivity of phocinid seals below 1 kHz. NMFS considers harbor seals to have a hearing threshold of 70–85 dB at 1 kHz (60 FR 53753, October 17, 1995), and recent measurements for a harbor seal indicate that, below 1 kHz, its thresholds deteriorate gradually to 96 dB (re 1 μPa @ 1 m) at 100 Hz (Kastak and Schusterman, 1998).

Recent studies have provided some data are available on the reactions of seals to various types of impulsive sounds (see LGL and Greeneridge, 1997,

1998, 1999a; Thompson *et al*. 1998). These references indicate that it is unlikely that pinnipeds would be harassed or injured by low frequency sounds from a seismic source unless they were within relatively close proximity of the seismic array. For permanent injury, pinnipeds would likely need to remain in the high-noise field for extended periods of time. Existing evidence also suggests that, while seals may be capable of hearing sounds from seismic arrays, they appear to tolerate intense pulsatile sounds without known effect once they learn that there is no danger associated with the noise (see, for example, NMFS/Washington Department of Wildlife, 1995). In addition, they will apparently not abandon feeding or breeding areas due to exposure to these noise sources (Richardson *et al*., 1991) and may habituate to certain noises over time. Since seismic work is fairly common in Beaufort Sea waters, pinnipeds have been previously exposed to seismic noise and may not react to it after initial exposure.

For a discussion on the anticipated effects of ships, boats, and aircraft, on marine mammals and their food sources, please refer to the application (Western Geophysical, 1999). Information on these effects is incorporated in this document by citation.

Numbers of Marine Mammals Expected to be Taken

Western Geophysical estimates that the following numbers of marine mammals may be subject to Level B harassment, as defined in 50 CFR 216.3:

Species	*Population Size*	*Harassment Takes in 1999*	
		Possible	*Probable*
Bowhead	9,900		
160 dB criterion	-	1,000	<500
20 km criterion	-	2,500	1,250
Gray whale	26,600	<10	0
Beluga	39,258	250	<150
Ringed seal*	1-1.5 million	400	<200
Spotted seal*	>200,000	10	<2
Bearded seal*	>300,000	50	<15

* Some individual seals may be harassed more than once.

Effects of Seismic Noise and Other Activities on Subsistence Needs

The disturbance and potential displacement of marine mammals by sounds from seismic activities are the principle concerns related to subsistence use of the area. The harvest of marine mammals (mainly bowhead whales, ringed seals, and bearded seals) is central to the culture and subsistence economies of the coastal North Slope communities. In particular, if migrating bowhead whales are displaced farther offshore by elevated noise levels, the harvest of these whales could be more difficult and dangerous for hunters. The harvest could also be affected if bowheads become more skittish when exposed to seismic noise.

Nuiqsut is the community closest to the area of the proposed activity, and it harvests bowhead whales only during the fall whaling season. In recent years, Nuiqsut whalers typically take two to four whales each season (Western Geophysical, 1999). Nuiqsut whalers concentrate their efforts on areas north and east of Cross Island, generally in water depths greater than 20 m

(65 ft). Cross Island, the principal field camp location for Nuiqsut whalers, is located within the general area of the proposed seismic area. Thus, the possibility and timing of potential seismic operations in the Cross Island area requires Western Geophysical to provide NMFS with either a Plan of Cooperation with North Slope Borough residents or to identify measures that have been or will be taken to avoid any unmitigable adverse impact on subsistence needs. Western Geophysical's application has identified those measures that will be taken to minimize any adverse effect on subsistence. In addition, the timing of seismic operations in and east of the Cross Island area has been addressed in a Conflict and Avoidance Agreement (C&AA) with the Nuiqsut whalers and the Alaska Eskimo Whaling Commission (AEWC).

Whalers from the village of Kaktovik search for whales east, north, and west of the village. Kaktovik is located 60 km (32.4 nm) east of the easternmost end of Western Geophysical's planned 1999 seismic exploration area. The westernmost reported harvest location was about 21 km (11.3 nm) west of Kaktovik, near 70°10'N, 144°W (Kaleak, 1996). That site is approximately 40 km (21.6 nm) east of the closest part of Western Geophysical's planned seismic exploration area for 1999 (Western Geophysical, 1999).

Whalers from the village of Barrow search for bowhead whales much further from the planned seismic area, >200 km (>108 nm) west (Western Geophysical, 1999).

The location of the proposed seismic activity is south of the center of the westward migration route of bowhead whales, but there is some overlap. Seismic monitoring results from 1996–1998 indicate that most bowheads avoid the area within about 20 km (11 nm) around the array when it is operating. In addition, bowheads may be able to hear the sounds emitted by the seismic array out to a distance of 50 km (27 nm) or more, depending on the ambient noise level and the efficiency of sound propagation along the path between the seismic vessel and the whale (Miller *et al*., 1997). Western Geophysical (1999) believes it is unlikely that changes in migration route will occur at distances greater than 25 km (13 nm) from an array of maximum volume of 1,210 in^3 operating in water less than 30 m (100 ft) deep. However, subtle changes in behavior might occur out to longer distances. Inupiat whalers believe that bowheads begin to divert from their normal migration path more than 35 miles (56 km) away (MMS, 1997).

It is recognized that it is difficult to determine the maximum distance at which reactions occur (Moore and Clark, 1992). As a result, Western Geophysical are participating in a C&AA with the whalers to reduce any potential interference with the hunt. Also, it is believed that the monitoring plan proposed by Western Geophysical (1999; also see LGL Ltd. and Greeneridge Sciences Inc, 1999b) will provide information that will help resolve uncertainties about the effects of seismic exploration on the accessibility of bowheads to hunters.

Many Nuiqsut hunters hunt seals intermittently year-round. However, during recent years, most seal hunting

has been during the early summer in open water. In summer, boat crews hunt ringed, spotted and bearded seals. The most important sealing area for Nuiqsut hunters is off the Colville delta, extending as far west as Fish Creek and as far east as Pingok Island. This area overlaps with the westernmost portion of the planned seismic area. In this area, during summer, sealing occurs by boat when hunters apparently concentrate on bearded seals. However, these subsistence hunters have not perceived any interference from recent open-water seismic activities in the Alaskan Beaufort Sea. Therefore, because Western Geophysical is proposing similar mitigation and consultation procedures this year, it is unlikely that seismic activities would have more than a negligible impact on Nuiqsut seal hunting.

Comments and Responses

A notice of receipt of the application and proposed authorization was published on May 28, 1999 (64 FR 28992), and a 30-day public comment period was provided on the application and proposed authorization. During the comment period, comments regarding this application were received from the Marine Mammal Commission (MMC), LGL Ltd. environmental research associates on behalf of the applicant, and Greenpeace Alaska (Greenpeace).

MMPA Concerns

Comment 1: LGL Ltd provided information updating and correcting the **Federal Register** notice that Western has no intention to use an array larger than 1,210 in^3 during 1999.

Response: Thank you for providing this information.

Comment 2: LGL Ltd questioned the statement in the **Federal Register** document that the proposed seismic activity occurs in waters generally too shallow and distant from the edge of the pack ice for most marine mammals, and that this statement is not consistent with the IHA Application and the EA. LGL notes that 5 of the 6 marine mammal species requested for taking occur within the seismic area; only the beluga remains (with a few exceptions) far offshore near the ice edge.

Response: NMFS agrees.

Comment 3: Greenpeace believes that NMFS and Western Geophysical have failed to provide the evidence necessary to justify issuance of the IHA by relying on outdated, incomplete and inaccurate information on the zone of influence of seismic operations on bowhead whales.

Response: To make a determination of negligible impact on marine mammal stocks or a finding of not having an unmitigable adverse impact on subsistence uses of marine mammals, NMFS relies on the best scientific information available. The latest scientific information has been obtained through a 3-year program of data collection and analysis, including aerial surveys and acoustic monitoring. Greenpeace does not identify any additional sources of information not already considered by NMFS or Western Geophysical. Western Geophysical's IHA application and the notice of proposed authorization note that, in addition to the known responses of bowhead whales out to a distance of several kilometers, less conspicuous and/or less frequent effects may extend to greater distances. The draft final monitoring report describing the 1996 through 1998 monitoring results (Richardson [ed.], 1999) shows that (1) 1996, 1997 and 1998 seismic programs did not greatly influence the position of the overall migration corridor; (2) the aerial surveys showed avoidance of the area within 20 km (12 mi) of seismic operations, plus partial avoidance of the area 20–30 km (12–19 mi) away, and (3) based on 1998 research, there is no evidence that bowhead disturbance extended 37 km (23 mi) offshore of the northern edge of the seismic exploration area. For additional information on the estimated zones that seismic airgun noise may have an effect on bowhead whales, please refer to the proposed authorization notice mentioned in this document.

Scientists, at least, recognize that it is difficult (for to determine the maximum distance at which disturbance and avoidance reactions may have an adverse impact on subsistence needs (Moore and Clark, 1992). Inupiat whalers, on the other hand, believe that whales exhibit avoidance reactions as far as 30 miles (48 km) away (MMS, 1997). As a result, Western Geophysical has developed a C&AA with the whalers to reduce any potential interference with the hunt.

Also, it is believed that the monitoring plan proposed by Western Geophysical (LGL Ltd., LGL Alaska Research Associates, and Greeneridge, 1999), revised on the basis of comments received during this public comment period and at the Peer-Review Workshop, will provide information that will help resolve uncertainties about the effects of seismic exploration on the bowhead whales and the accessibility of bowheads to hunters.

Comment 4: Greenpeace believes the scientific evidence remains inadequate to determine whether hearing or behavior of marine mammals may be damaged temporarily or permanently by seismic operations. This makes it impossible to put adequate mitigation measures into place when there is inadequate knowledge about the impacts of seismic operations on cetaceans' hearing and behavior.

Response: The impact of airguns on bowhead hearing and behavior has been addressed in several documents, including Western Geophysical's application, the supporting EA, and in LGL Ltd and Greeneridge Sciences (1998) and most recently in LGL Ltd, LGL Alaska Research Associates, and Greeneridge Sciences (1999). Without an ability to collect empirical information on physical impacts from airguns on large marine mammals, scientists must rely on surrogate species and make conservative assumptions based upon findings for those species. For bowhead and beluga whales, NMFS and Western Geophysical use the best scientific information available which indicates that a safety zone set at the 180 dB (re 1 μPa) isopleth will protect bowhead and beluga whales from potential serious injury. Furthermore, the avoidance reactions by bowheads and the offshore migration corridor of belugas minimize the number of bowheads and belugas entering or approaching the 180 dB zone. Only one bowhead and no belugas have been seen in that zone during the 1996, 1997, and 1998 monitoring projects (Richardson *et al.*, 1999). Because there are potential behavioral effects on bowhead whales by seismic activities, an IHA is warranted. Under the IHA, NMFS will require Western Geophysical to incorporate mitigation and monitoring measures approved by the 1999 Peer Review Workshop participants to reduce potential impacts on whales and seals to the lowest level practicable.

Comment 5: Greenpeace notes that NMFS fails to place restrictions on seismic operations during times of limited or zero visibility.

Response: Observers monitor the safety zones and zones of potential harassment around the seismic source whenever visibility permits, and the source is either on or within 30 minutes of powering up. This year observers will be aided by high-intensity lighting for monitoring the safety zone at night. Assessments of takes by harassment will be made based upon the percentage of time spent observing in relation to the total time for seismic operations. Because: (1) relatively few marine mammals are expected in the area during the time of the survey, (2) the vessels are underway at low speeds while conducting seismic surveys, theoretically allowing animals sufficient time to move away from any

annoyances, and (3) documented observations indicate that bowhead whales avoid active seismic survey areas, few marine mammals, and no bowheads, are expected to approach the vessel. Therefore, terminating surveys at night and during inclement weather is not warranted, in part since to do so could extend the seismic season into the peak bowhead migration period resulting in an increased level of harassment of that species.

Comment 6: Greenpeace states that the issuance of an IHA will result in significant and unmitigable impacts to subsistence communities and the Arctic marine environment.

Response: Section 101(a)(5)(D)(i)(II) of the MMPA requires NMFS to ensure that any taking will not have an unmitigable adverse impact on the availability of the species or stock(s) for subsistence uses. NMFS relies on two factors in determining if there will be an unmitigable adverse impact on subsistence uses: First, the impact resulting from the specified activity must be likely to reduce the availability of the species to a level insufficient for a harvest to meet subsistence needs by (1) causing the marine mammals to abandon or avoid hunting areas, (2) directly displacing subsistence users, or (3) placing physical barriers between the marine mammals and subsistence hunters. Second, it must be an impact that cannot be sufficiently mitigated by other measures to increase the availability of marine mammals to allow subsistence needs to be met (50 CFR 216.103). This standard of determining impact does not require the elimination of adverse impacts, but it does require mitigation sufficient to meet subsistence requirements. However, the MMPA also requires that, where applicable, the measures will ensure the least practicable impact on the availability of marine mammals for taking for subsistence uses. In previous years, these conditions were met through the AEWC/oil industry's C&AA which required seismic operations to move west of Cross Island no later than September 1 or when whalers commenced the bowhead hunting season, whichever was earlier. A signed C&AA allows NMFS to conclude that there will not be an unmitigable adverse impact on the subsistence needs of the Arctic Slope whalers this year due to seismic activities.

Comment 7: LGL Limited notes that the mitigation section of the **Federal Register** document does not mention that Western Geophysical plans to participate in a C&AA with the whalers in order to avoid interference with the autumn bowhead hunt. While the C&AA is mentioned in the previous section (regarding impacts on subsistence uses), Western Geophysical and LGL Ltd view the C&AA as one of the primary mitigation measures, as it addresses the requirement to identify measures to ensure the ''least practicable adverse impact on ...availability for subsistence uses.''

Response: Thank you for the comment.

Comment 8: Greenpeace contends that Western Geophysical's proposed marine mammal monitoring program fails to adequately monitor the impact of seismic operations on marine mammals.

Response: NMFS disagrees. Section 101(a)(5)(D)(ii)(II) of the MMPA requires authorizations issued under this section to prescribe, where applicable, requirements pertaining to the monitoring and reporting of such taking by harassment, including requirements for independent peer review of proposed monitoring plans or other research proposals where the proposed activity may affect the availability of a species or stock for taking for subsistence purposes.

Western Geophysical's proposed monitoring plan for 1999 and the results from Western Geophysical's 1998 Beaufort Sea research were the subject of a scientific peer-review workshop held in Seattle, WA, on June 30 and July 1, 1999. As a result of that workshop, Western Geophysical is amending its monitoring plan and will submit that plan to NMFS for approval prior to commencement of the bowhead season. Modifications to the original plan for monitoring during the bowhead season (if seismic surveys are continuing at that time) include (1) an extension of the aerial survey grid by an extra 15 km (8 nm) east and west to approximately 65 km (35 nm) westward and 65 km eastward of the seismic survey; this will address the issues (a) how far west of the seismic area do bowhead whales remain farther offshore than usual if bowheads are displaced offshore by seismic and (b) where the bowhead whale deflection from the migration track due to seismic noise begins; (2) an increase in the number of aerial survey track lines from 14 to 18; and (3) commencing the aerial surveys on September 1, rather than September 4; and (4) additional autonomous seafloor acoustic recorders offshore from the area of seismic operations.

Comment 9: The MMC recommends that the peer-review group established to review the proposed monitoring and mitigation programs be asked to consider the following questions: (1) Whether continuation of the marine mammal observations in association with seismic surveys in the nearshore waters of the Alaska Beaufort Sea beyond 1999 is likely to produce significant new information on either the short- or long-term effects of seismic surveys on marine mammals that occur in the area, (2) whether the types of site-specific monitoring programs conducted to date are sufficient to verify that seismic surveys and related activities have negligible effects on the distributions, sizes, and populations, and (3) if the answer to either issue is no, how should the monitoring requirements be revised to better meet the intent and provisions of the MMPA?

Response: NMFS believes that at a minimum, shipboard monitoring of the safety zone must continue to implement mitigation measures to protect marine mammals from potential serious injury. The Scientific Peer Review Workshop participants concluded that the current research and monitoring proposed here by Western Geophysical and by BPX for oil development at Northstar (see 64 FR 9965, March 1, 1999), coupled with existing projects to monitor bowhead population abundance (trends in abundance) should provide information necessary to determine overall cumulative impacts on bowhead whales. Existing projects include those by the North Slope Borough (spring bowhead census), the MMS autumn aerial survey, and the MMS-funded photo-identification of bowhead whales being conducted as part of an on-going (1998–2000) bowhead feeding study. Provided trends in bowhead abundance continue to be positive, NMFS presumes industrial development on the North Slope is not adversely affecting the bowhead population. Similar work is underway for ringed seals.

Comment 10: Greenpeace believes that NMFS ignores cumulative impacts from oil exploration and development in the Arctic on subsistence communities, the bowhead whale, other marine mammals, and the Arctic marine environment.

Response: Information on the cumulative impacts on the marine environment from Beaufort Sea oil and gas leasing and development activities, including seismic, in the area under discussion has been addressed previously in several environmental impact statements (EIS) prepared by the Minerals Management Service (MMS) (Final EISs for Lease Sale 124 and 144 completed in 1990 and 1996). More recently, cumulative impacts from oil exploration and development were extensively discussed and evaluated in the U.S. Army Corps of Engineer's Final Environmental Impact Statement (FEIS) on the Northstar Oil Development

Project (Corps, 1999). NMFS was a cooperating agency under the National Environmental Policy Act (NEPA) in the preparation of that document. Additional discussion on cumulative impacts from seismic activities in conjunction with offshore oil and gas exploration and development can be found in the EA prepared for this action (NMFS, 1999). NMFS notes that because the Northstar Project construction has been delayed until after the 1999 open water season, other than commercial barge traffic, there are no identified activities that might cause a cumulative impact on the whales, seals or subsistence needs of the North Slope this season.

Comment 11: Noting that the activity for which an IHA authorization is requested is part of an effort likely to be continued in subsequent years and to eventually lead to drilling and other activities associated with oil and gas exploration and production, the MMC questions whether there is sufficient basis for concluding that this year's activities, coupled with past and possible future activities will not have a non-negligible cumulative effects on any of the potentially affected marine mammal species or their availability to Alaska Natives for subsistence uses. As a result, the MMC recommends that NMFS, if it has not already done so, assess whether the monitoring required as a condition of this and possible future IHAs will be adequate to detect possible non-negligible cumulative effects and, if not, what needs to be done to ensure that any such effects will be detected before they reach significant levels and could be irreversible.

Response: Please see response to comment 9.

Comment 12: Greenpeace noted that the results of Western Geophysical's 1998 marine mammal monitoring program are not available for review along with its 1999 IHA application. The results of the 1998 monitoring program should be available for public review prior to the close of the public comment period.

Response: The preliminary results of the 1998 monitoring program are contained in the 90-day report, which was issued in January 1999, and in the IHA application. The draft final report for 1998 was due on April 30, 1999. Because the draft final report was expanded to contain an analysis of several previous years' data, the availability of this report was delayed until late May, when it was reviewed by NMFS scientists and participants at the peer review workshop. While monitoring reports are available to the public for review, there is no requirement for these documents to be made available for formal public review and comment. Reviewers are encouraged to rely on the 90-day report and reports from prior years if they wish to analyze the previous years' data. As noted by Greenpeace in their letter, the 1996 and 1997 monitoring reports have been reviewed by them.

Endangered Species Act (ESA) Concerns

Comment 13: Without clarification, Greenpeace believes that issuance of the IHA would violate the ESA.

Response: NMFS disagrees, noting that the issuance of an IHA to Western Geophysical triggers section 7 of the ESA, as the issuance of the IHA is a Federal action (please refer to the section titled ESA later in this document). However, the major Federal agency for offshore oil and gas lease activities is the MMS. Consultation under section 7 for lease sale 144 was concluded on November 16, 1995 with a finding that the action was not likely to jeopardize the continued existence of listed species under the jurisdiction of NMFS. This finding is consistent with the conclusions and recommendations contained within the Arctic Region Biological Opinion issued to MMS under section 7 of the ESA by NMFS on November 23, 1988.

Reinitiation of formal consultation under section 7 is warranted only when there is new scientific information that has the potential to call into question the scientific and commercial data used in the previous biological opinion. At this time, NMFS does not consider the recent findings on impacts to listed marine species from the disturbance from seismic surveys sufficient to reinitiate consultation.

NEPA Concerns

Comment 14: Greenpeace believes that the EA fails to adequately analyze the full scope and cumulative impacts of current and proposed offshore exploration and development activities in the Beaufort Sea. Greenpeace maintains that the impacts from seismic operations cannot be assessed separately from cumulative impacts from offshore exploratory drilling, development and transportation activities that may follow or are already occurring. This includes the impact of global warming on the Arctic environment.

Response: Please see response to comment 10.

Mitigation

This year, Western Geophysical will reduce its airgun array from the 1,500 in^3 used in 1998 to 1,210 in^3 and investigate whether it is practical to modify the design to reduce horizontal propagation of sound. These changes are expected to result in lower received levels and, therefore, smaller safety ranges and reduced takes by harassment than in 1998. However, because the 1,210 in^3 array is a subset (with some minor variations) of the 1,500 in^3 array (with 4 guns not firing), NMFS is limiting the IHA authorization for a taking by harassment to no more than 12 airguns totaling 1,210 in^3 during the 1999 open water seismic survey. Vessel-based observers will monitor marine mammal presence in the vicinity of the seismic array throughout the seismic program. To avoid the potential for serious injury to marine mammals, Western Geophysical will power down the seismic source if pinnipeds are sighted within the area delineated by the 190 dB isopleth or 240 m (787.4 ft) from the array operating at 5 m (16.4 ft) depth or 80 m (262.5 ft) from the array operating at 2 m (6.6 ft) depth. Western Geophysical will power down the seismic source if bowhead, gray, or beluga whales are sighted within the area delineated by the 180 dB isopleth or within 750 m (2,460.6 ft) of the array operating at 5 m (16.4 ft) depth or 360 m (1,181.1 ft) of the array operating at 2 m (6.6 ft) depth. However, because these safety zones were based on measurements near the 1998 seismic array plus theoretical adjustments for the smaller array size in 1999, within the first 10 days of Beaufort Sea operations in 1999, Western Geophysical will measure and analyze the sounds from Western's 1999 array operating at both 5 m (16.4 ft) and 2 m (6.6 ft) depths. This information will be provided to NMFS, along with the contractor's recommendation as to whether any adjustments in the safety radii are needed to meet the 190 and 180 dB_{rms} shutdown criteria.

In addition, Western Geophysical will ramp-up the seismic source to operating levels at a rate no greater than 6 dB/min anytime the array has not been firing for 1–2 minutes (depending upon vessel speed). Ramp-up will begin with an air volume discharge not exceeding 80 in^3 with additional guns added at intervals appropriate to limit the rate of increase to 6 dB/min.

Monitoring

As part of its application, Western Geophysical provided a monitoring plan for assessing impacts to marine mammals from seismic surveys in the Beaufort Sea. This monitoring plan is described in Western Geophysical (1999) and in LGL Ltd., LGL Alaska Research Associates, and Greeneridge Sciences (1999). This monitoring plan

has been peer-reviewed by NMFS, AEWC and industry scientists and others at a workshop held in Seattle, WA on June 30 and July 1, 1999. Suggested modifications to the monitoring plan as a result of the workshop (most notably those summarized previously in the response to comment 8) will need to be incorporated into the Plan prior to formal acceptance by NMFS. During the 1999 open-water season, Western Geophysical will conduct the following:

Vessel-based Visual Monitoring

One or two biologist-observers aboard the seismic vessel will search for and observe marine mammals whenever seismic operations are in progress, and for at least 30 minutes prior to planned start of shooting. These observers will scan the area immediately around the vessels with reticle binoculars during the daytime supplemented with night-vision equipment during the night (prior to mid-August, there are no hours of darkness). In addition, Western Geophysical will experiment with illumination of the safety zone with high-intensity lighting.

A total of four observers (three trained biologists and one Inupiat observer/communicator) will be based aboard the seismic vessel. Use of four observers is an increase over 1998 and will allow two observers to be on duty simultaneously for up to 50 percent of the active airgun hours. Use of two observers will increase the probability of detecting marine mammals and two observers will be required to be on duty whenever the seismic array is ramped up. Individual watches will normally be limited to no more than 4 consecutive hours.

When mammals are detected within or about to enter the safety zone designated to prevent injury to the animals (see Mitigation), the geophysical crew leader will be notified so that shutdown procedures can be implemented immediately.

Aerial Surveys

If the seismic program continues after August 31, Western Geophysical will conduct daily aerial surveys, weather permitting, from September 1, 1999, for a period of 13–14 days, or, if seismic work ends before September 13, until one day after seismic work ends. The primary objective will be to document the occurrence, distribution, and movements of bowhead and (secondarily) beluga and gray whales in and near the area where they might be affected by the seismic pulses. These observations will be used to estimate the level of harassment takes and to assess the possibility that seismic operations affect the accessibility of bowhead whales for subsistence hunting. Pinnipeds will be recorded when seen. Aerial surveys will be at an altitude of 300 m (1,000 ft) above sea level. Western Geophysical will fly at 457 m (1500 ft) altitude over areas where whaling is occurring on that date to avoid direct overflights of whaleboats and Cross Island, where whalers from Nuiqsut are based during their fall whale hunt.

The daily aerial surveys are proposed to cover a grid of 18 north-south lines spaced 8 km (4.3 nm) apart and will extend seaward to about the 100 m (328 ft) depth contour (typically about 65 km (35 nm) offshore. This grid will extend from about 65 km (35 nm) east to 65 km (35 nm) west of the area in which seismic operations are underway on that date. This design will provide extended coverage to the west to determine the westward extent of the offshore displacement of whales by seismic. In 1999, the additional ''intensive'' grid survey will not be conducted as in previous years.

Detailed information on the survey program can be found in Western Geophysical (1999) and in LGL Ltd., LGL Alaska Research Associates, and Greeneridge Sciences Inc. (1999), which are incorporated in this document by citation.

Acoustical Measurements

The acoustic measurement program for 1999 is designed to continue the acoustic work conducted in 1996 through 1998 (see LGL and Greeneridge Sciences Inc., 1997, 1998, 1999). The acoustic measurement program is planned to include (1) vessel-based acoustic measurements, (2) OBC-based acoustic measurements, and, if seismic operations continue into September, (3) use of air-dropped sonobuoys and (4) bottom-mounted acoustical recorders.

(1) A vessel-based acoustical measurement program will be conducted for a few days early in the seismic program. The objectives of this survey will be as follows: (a) to measure the levels and other characteristics of the horizontally propagating seismic survey sounds from the type of airgun array to be used in 1999 as a function of distance and aspect relative to the seismic source vessel and in relation to the operating depth of the airguns, and (b) to measure the levels and frequency composition of the vessel sounds emitted by vessels used regularly during the 1999 program in those cases when these vessels have not previously been measured adequately.

(2) Western Geophysical and Greeneridge Sciences will use recorded signals from Western's OBC system to help document horizontal propagation of the seismic survey pulses.

(3) Sonobuoys will be dropped and monitored from bowhead survey aircraft during September 1 through 13, 1999 (if the seismic operations are continuing at that time). Sonobuoys will provide data on characteristics of seismic pulses (and signal-to-ambient ratios) at offshore locations, including some of those places where bowhead whales are observed.

(4) Autonomous seafloor acoustic recorders will be placed on the sea bottom at two locations offshore of the seismic operation area, and at one location about 40 km (25 mi) to the east, to record low-frequency sounds nearly continuously for up to 3 weeks at a time during September (if seismic operations are continuing at that time). Information includes characteristics of the seismic pulses, ambient noise, and bowhead calls.

For a more detailed description of planned monitoring activities, please refer to the application and supporting document (Western Geophysical, 1999; LGL Ltd., LGL Alaska Research Associates, and Greeneridge Sciences, 1999).

Estimates of Marine Mammal Take

Estimates of takes by harassment will be made through vessel and, if seismic operations continue into September, aerial surveys. Western Geophysical will estimate the number of (a) marine mammals observed within the area ensonified strongly by the seismic vessel; (b) marine mammals observed showing apparent reactions to seismic pulses (e.g., heading away from the seismic vessel in an atypical direction); (c) marine mammals subject to take by type (a) or (b) when no monitoring observations were possible; and (d) bowheads displaced seaward from the main migration corridor.

Reporting

Western Geophysical will provide an initial report on 1999 activities to NMFS within 90 days of the completion of the seismic program. This report will provide dates and locations of seismic operations, details of marine mammal sightings, estimates of the amount and nature of all takes by harassment, and any apparent effects on accessibility of marine mammals to subsistence users.

A final technical report will be provided by Western Geophysical within 20 working days of receipt of the document from the contractor, but no later than April 30, 2000. The final

technical report will contain a description of the methods, results, and interpretation of all monitoring tasks. This report will be subject to review and comment by NMFS. Any recommendations made by NMFS will need to be addressed in the final report prior to formal acceptance by NMFS.

Consultation

Under section 7 of the ESA, NMFS has completed consultation on the issuance of this authorization.

NEPA

In conjunction with the 1996 notice of proposed authorization (61 FR 26501, May 28, 1996) for open water seismic operations in the Beaufort Sea, NMFS released an EA that addressed the impacts on the human environment from issuance of the authorization and the alternatives to the proposed action. No comments were received on that document and, on July 18, 1996, NMFS concluded that neither implementation of the proposed authorization for the harassment of small numbers of several species of marine mammals incidental to conducting seismic surveys during the open water season in the U.S. Beaufort Sea nor the alternatives to that action would significantly affect the quality of the human environment. As a result, the preparation of an EIS on this action is not required by section 102(2) of NEPA or its implementing regulations.

While this year's activity is a continuation of the seismic work conducted between 1996 and 1998, NMFS determined that a new EA was warranted based on the proposed construction of the Northstar project, the collection of data from 1996 through 1998 on Beaufort Sea marine mammals and the impacts of seismic activities on these mammals, and the analysis of scientific data indicating that bowheads avoid nearshore seismic operations by up to about 20 km (10.8 nm). Accordingly, a review of the impacts expected from the issuance of an IHA has been assessed in detail in the EA and in this document, and NMFS has determined that there will be no more than a negligible impact on marine mammals from the issuance of the harassment authorization and that there will not be any unmitigable impacts to subsistence communities, provided the mitigation measures required under the authorization are implemented. As a result, NMFS has again determined that neither implementation of the authorization for the harassment of small numbers of several species of marine mammals incidental to conducting seismic surveys during the open water season in the U.S. Beaufort Sea nor the alternatives to that action would significantly affect the quality of the human environment. As a result, the preparation of an EIS on this action is not required by section 102(2) of NEPA or its implementing regulations.

Conclusions

Based on the evidence provided in the application, the EA, and this document, and taking into consideration the comments submitted on the EA, application, and proposed authorization notice, NMFS has determined that there will be no more than a negligible impact on marine mammals from the issuance of the harassment authorization to Western Geophysical and that there will not be any unmitigable adverse impacts to subsistence communities, provided the mitigation measures required under the authorization are implemented. NMFS has determined that the short-term impact of conducting seismic surveys in the U.S. Beaufort Sea will result, at worst, in a temporary modification in behavior by certain species of cetaceans and possibly pinnipeds. While behavioral and avoidance reactions may be made by these species in response to the resultant noise, this behavioral change is expected to have a negligible impact on the animals.

While the number of potential incidental harassment takes will depend on the distribution and abundance of marine mammals (which vary annually due to variable ice conditions and other factors) in the area of seismic operations, the number of potential harassment takings is estimated to be small. In addition, no take by death and/or serious injury is anticipated, and the potential for temporary or permanent hearing impairment will be avoided through the incorporation of the mitigation measures mentioned in this document and required by the authorization. No rookeries, mating grounds, areas of concentrated feeding, or other areas of special significance for marine mammals occur within or near the planned area of operations during the season of operations.

Because bowhead whales are east of the seismic area in the Canadian Beaufort Sea until late August/early September, seismic activities are not expected to impact bowhead whales or the subsistence hunting of bowhead whales prior to that date. After September 1, 1999, if seismic activities continue beyond that date, aerial survey flights for bowhead whale assessments will be initiated. Depending upon the date of cessation of seismic activities (expected to be no later than September 10, 1999), NMFS estimates that fewer than 750 bowheads will be harassed incidental to seismic-related activities.

Appropriate mitigation measures to avoid an unmitigable adverse impact on the availability of bowhead whales for subsistence needs have been the subject of consultation between Western Geophysical and subsistence users. This C&AA, which consists of three main components: (1) Communications, (2) conflict avoidance, and (3) dispute resolution, has been concluded for the 1999 open-water seismic season.

Also, while open-water seismic exploration in the U.S. Beaufort Sea has some potential to influence seal hunting activities by residents of Nuiqsut, because (1) the peak sealing season is during the winter months, (2) the main summer sealing is off the Colville Delta, and (3) the zone of influence by seismic sources on seals and beluga is fairly small, NMFS believes that Western Geophysical's seismic survey will not have an unmitigable adverse impact on the availability of these stocks for subsistence uses.

Since NMFS is assured that the taking would not result in more than the incidental harassment (as defined by the MMPA Amendments of 1994) of small numbers of certain species of marine mammals, would have only a negligible impact on these stocks, would not have an unmitigable adverse impact on the availability of these stocks for subsistence uses, and would result in the least practicable impact on the stocks, NMFS has determined that the requirements of section 101(a)(5)(D) of the MMPA have been met and the authorization can be issued.

Authorization

Accordingly, NMFS has issued an IHA to Western Geophysical for the herein described seismic survey during the 1999 open water season provided the mitigation, monitoring, and reporting requirements described in this document and in the IHA are undertaken.

Dated: July 20, 1999.

Art Jeffers,

Acting Director, Office of Protected Resources, National Marine Fisheries Service.

[FR Doc. 99–19462 Filed 7–29–99; 8:45 am]

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DEPARTMENT OF COMMERCE

Patent and Trademark Office

[Docket No: 990406087–9087–01]

RIN 0651–ZA03

Interim Supplemental Examination Guidelines for Determining the Applicability of 35 U.S.C. 112 ¶ 6

AGENCY: Patent and Trademark Office, Commerce.

ACTION: Notice.

SUMMARY: The Patent and Trademark Office (PTO) requests comments from the public regarding interim supplemental examination guidelines to be used by office personnel in their review of patent applications to determine when 35 U.S.C. 112 ¶ 6 should be applied to a given claim limitation.

DATES: The interim supplemental examination guidelines are effective July 30, 1999.

Written comments on the interim supplemental examination guidelines will be accepted by the PTO until September 28, 1999.

ADDRESSES: Written comments should be addressed to the attention of Magdalen Greenlief, Box Comments, Assistant Commissioner for Patents, Washington, DC 20231 or to Ray Chen, Office of the Solicitor, P.O. Box 15667, Arlington, Virginia 22215, or by facsimile transmission to (703) 305–8825, or by electronic mail at *magdalen.greenlief@uspto.gov* or *ray.chen@uspto.gov*.

Written comments will be made available for public inspection in Suite 910, Crystal Park 2, 2121 Crystal Drive, Arlington, Virginia 22202. In addition, comments provided in machine readable format will be available through the PTO's Website at *http://www.uspto.gov*.

FOR FURTHER INFORMATION CONTACT: Magdalen Greenlief, Box Comments, Assistant Commissioner for Patents, Washington, DC 20231 or Ray Chen, Office of the Solicitor, P.O. Box 15667, Arlington, Virginia 22215, or by facsimile transmission to (703) 305–8825, or by electronic mail at *magdalen.greenlief@uspto.gov* or *ray.chen@uspto.gov*.

SUPPLEMENTARY INFORMATION: The following interim supplemental examination guidelines are being published for public comment. In May 1994, the PTO issued guidelines implementing the change in examination practice necessitated by the Federal Circuit's decision in *In re Donaldson Co.*, 16 F.3d 1189, 29 USPQ2d 1845 (Fed. Cir. 1994)(en banc). Since *Donaldson*, several decisions by the Federal Circuit have analyzed: (1) When a particular claim limitation invokes 35 U.S.C. 112 ¶ 6; and (2) the duty of the applicant to describe the corresponding structure, material, or acts that perform the function recited in a means-plus-function limitation. In order to clarify these issues, the PTO is issuing these interim supplemental examination guidelines to assist PTO personnel in the examination of patent applications to determine: (1) Whether a claim limitation invokes 35 U.S.C. 112 ¶ 6; and (2) whether the written description adequately describes the corresponding structure, material, or acts needed to support a claim limitation under 35 U.S.C. 112 ¶ 6.

It has been determined that these interim supplemental examination guidelines are not a significant rule for purposes of Executive Order 12866. Because these supplemental examination guidelines are interpretive rules and general statements of policy, they are exempt from notice and comment rulemaking under 5 U.S.C. 553(b)(A). The collection of information for the filing and processing of a patent application has been reviewed and previously approved by the Office of Management and Budget under the following control numbers: 0651–0031 and 0651–0032. These supplemental examination guidelines involve no additional collection of information subject to the Paperwork Reduction Act, 44 U.S.C. ch. 35. Notwithstanding any other provision of law, no person is required to respond nor shall a person be subject to a penalty for failure to comply with a collection of information subject to the requirements of the Paperwork Reduction Act unless that collection of information displays a currently valid OMB Control Number.

Members of the public may present written comments on these supplemental examination guidelines. Written comments should include the following information:

—Name and affiliation of the individual responding; and

—An indication of whether the comments offered represent views of the respondent's organization or are the respondent's personal views.

The PTO is particularly interested in comments relating to the 3-prong analysis as to when a claim limitation will be interpreted by PTO personnel to invoke 35 U.S.C. 112 ¶ 6. The PTO is also interested in comments relating to the analysis as to when a ''means-'' (or ''step-'') plus-function claim limitation satisfies the requirements of 35 U.S.C. § 112 ¶ 2.

I. Interim Supplemental Examination Guidelines for Claims Subject to 35 U.S.C. 112 ¶ 6

In February 1994, the Court of Appeals for the Federal Circuit (Federal Circuit) held in an *en banc* decision that ''the 'broadest reasonable interpretation' that an examiner may give means-plus-function language is that statutorily mandated in [35 U.S.C. 112 ¶ 6] * * * [T]he PTO may not disregard the structure disclosed in the specification corresponding to such language when rendering a patentability determination.'' *In re Donaldson Co.*, 16 F.3d 1189, 1194–95, 29 USPQ2d 1845, 1850 (Fed. Cir. 1994) (en banc). In May 1994, the PTO issued guidelines implementing changes in examination practice in response to *Donaldson. See Means or Step Plus Function Limitation Under 35 U.S.C. § 112, ¶ 6;* Notice, 1162 *Off. Gaz. Pat. Office* 59 (May 17, 1994) (''1994 Guidelines'').

The 1994 Guidelines note that there is no ''magic'' language that invokes 35 U.S.C. 112 ¶ 6.[1] However, to establish uniformity to the extent possible, in view of the recent case law, and to make the prosecution record clear, these interim guidelines supplement the 1994 Guidelines in assisting examiners to determine when 35 U.S.C. 112 ¶ 6 should be applied. To the extent these supplemental guidelines are inconsistent with the 1994 Guidelines, the supplemental guidelines are controlling.

The PTO must apply 35 U.S.C. 112 ¶ 6 in appropriate cases, and give claims their broadest reasonable interpretation, in light of and consistent with the written description of the invention in the application.[2] Thus, a claim limitation will be interpreted to invoke 35 U.S.C. 112 ¶ 6 if it meets the following 3-prong analysis:

(1) the claim limitations must use the phrase ''means for'' or ''step for''; [3]

(2) the ''means for'' or ''step for'' must be modified by functional language; [4] and

(3) the phrase ''means for'' or ''step for'' must not be modified by structure, material or acts for achieving the specified function.[5]

With respect to the first prong of this analysis, a claim element that does not include the phrase ''means for'' or ''step for'' will not be considered to invoke 35 U.S.C. 112 ¶ 6. If an applicant wishes to have the claim limitation treated under 35 U.S.C. 112 ¶ 6, applicant must either: (1) Amend the claim to include the phrase ''means for'' or ''step for'' in accordance with these interim

guidelines; or (2) show that even though the phrase ''means for'' or ''step for'' is not used, the claim limitation is written as a function to be performed and does not provide any structure, material, or acts which would preclude application of 35 U.S.C. 112 ¶ 6.[6]

Accordingly, these interim guidelines provide applicants with the opportunity to either invoke or not invoke 35 U.S.C. 112 ¶ 6 based upon a clear and simple set of criteria.

II. Procedures for Determining Whether the Written Description Adequately Describes the Corresponding Structure, Material, or Acts Necessary To Support a Claim Limitation Which Invokes 35 U.S.C. 112 ¶ 6

If a claim limitation invokes 35 U.S.C. 112 ¶ 6, it must be interpreted to cover the corresponding structure, materials, or acts in the specification and ''equivalents thereof.'' [7] If the written description fails to set forth the supporting structure, material or acts corresponding to the means- (or step-) plus-function, the claim may not meet the requirement of 35 U.S.C. 112 ¶ 2:

> Although [35 U.S.C. 112 ¶ 6] statutorily provides that one may use means-plus-function language in a claim, one is still subject to the requirement that a claim 'particularly point out and distinctly claim' the invention. Therefore, if one employs means-plus-function language in a claim, one must set forth in the specification an adequate disclosure showing what is meant by that language. If an applicant fails to set forth an adequate disclosure, the applicant has in effect failed to particularly point out and distinctly claim the invention as required by [35 U.S.C. 112 ¶ 2].[8]

Whether a claim reciting an element in means- (or step-) plus-function language fails to comply with 35 U.S.C. 112 ¶ 2 because the specification does not disclose adequate structure (or material or acts) for performing the recited function is closely related to the question of whether the specification meets the description requirement in 35 U.S.C. 112 ¶ 1.[9] However, 35 U.S.C. 112 ¶ 6 does not impose any requirements in addition to those imposed by 35 U.S.C. 112 ¶ 1.[10] Conversely, the invocation of 35 U.S.C. 112 ¶ 6 does not exempt an applicant from compliance with 35 U.S.C. 112 ¶¶ 1 and 2.[11]

The written description does not have to explicitly describe the structure (or material or acts) corresponding to a means- (or step-) plus-function limitation to particularly point out and distinctly claim the invention as required by 35 U.S.C. 112 ¶ 2.[12] Rather, disclosure of structure corresponding to a means-plus-function limitation may be implicit in the written description if it would have been clear to those skilled in the art what structure must perform the function recited in the means-plus-function limitation.[13] However, the claims must still be analyzed to determine whether there exists corresponding adequate support for such claim under 35 U.S.C. 112 ¶ 1.[14]

Therefore, a means-(or step-) plus-function claim limitation satisfies 35 U.S.C. 112 ¶ 2 if: (1) The written description links or associates particular structure, materials, or acts to the function recited in a means-(or step-) plus-function claim limitation; or (2) it is clear based on the facts of the application that one skilled in the art would have known what structure, materials, or acts perform the function recited in a means- (or step-) plus-function limitation.

37 CFR 1.75(d)(1) provides, in part, that ''the terms and phrases used in the claims must find clear support or antecedent basis in the description so that the meaning of the terms in the claims may be ascertainable by reference to the description.'' In the situation in which the written description only implicitly or inherently sets forth the structure, materials, or acts corresponding to a means- (or step-) plus-function, and the examiner concludes that one skilled in the art would recognize what structure, materials, or acts perform the function recited in a means- (or step-) plus-function, the examiner should either: (1) Have the applicant clarify the record by amending the written description such that it expressly recites what structure, materials, or acts perform the function recited in the claim element;[15] or (2) state on the record what structure, materials, or acts perform the function recited in the means- (or step-) plus-function limitation.

In implementing the change in examination practice necessitated by *Donaldson*, the PTO set forth a two-step process for making a *prima facie* case of equivalence of a prior art element during *ex parte* examination. First, the examiner must find that the prior art element performs the function specified in the claim element, and, second, the examiner must find that the prior art element is not excluded by any explicit definition provided in the specification for an equivalent.[16] This two-step process is not superseded by these interim supplemental guidelines, and is consistent with the requirement that the PTO give claims their broadest reasonable interpretation.[17] The specification need not describe the equivalents of the structures, materials, or acts corresponding to the means- (or step-) plus-function claim element.[18] Where, however, the specification is silent as to what constitutes equivalents, the burden is placed upon the applicant to show that a prior art element which performs the claimed function is not an equivalent of the structure, material, or acts disclosed in the specification.[19]

Endnotes

[1] *See* 1994 Guidelines at 59.

[2] *See In re Donaldson Co.,* 16 F.3d 1189, 1194, 29 USPQ2d 1845, 1850 (Fed. Cir. 1994) (en banc) (stating that 35 U.S.C. 112 ¶ 6 ''merely sets a limit on how broadly the PTO may construe means-plus-function language under the rubric of 'reasonable interpretation' ''). The Federal Circuit has held that applicants (and reexamination patentees) before the PTO have the opportunity and the obligation to define their inventions precisely during proceedings before the PTO. *See In re Morris,* 127 F.3d 1048, 1056–57, 44 USPQ2d 1023, 1029–30 (Fed. Cir. 1997) (35 U.S.C. 112 ¶ 2 places the burden of precise claim drafting on the applicant); *In re Zletz,* 893 F.2d 319, 322, 13 USPQ2d 1320, 1322 (Fed. Cir. 1989) (manner of claim interpretation that is used by courts in litigation is not the manner of claim interpretation that is applicable during prosecution of a pending application before the PTO); *Sage Products Inc.* v. *Devon Industries Inc.,* 126 F.3d 1420, 1425, 44 USPQ2d 1103, 1107 (Fed. Cir. 1997) (patentee who had a clear opportunity to negotiate broader claims during prosecution but did not do so, may not seek to expand the claims through the doctrine of equivalents, for it is the patentee, not the public, who must bear the cost of its failure to seek protection for this foreseeable alteration of its claimed structure). Thus, applicants and reexamination patentees before the PTO have an opportunity and obligation to specify, consistent with these supplemental guidelines, when a claim limitation invokes 35 U.S.C. 112 ¶ 6.

[3] *Cf. Seal-Flex, Inc.* v. *Athletic Track and Court Construction,* 172 F.3d 836, 849–50, 50 USPQ2d 1225, 1233–34 (Fed. Cir. 1999) (Radar, J., concurring) (use of the phrase ''step for'' in a method claim raises a presumption that 35 U.S.C. 112 ¶ 6 applies, whereas, use of the word ''step'' by itself or the phrase ''step of'' does not invoke a presumption that 35 U.S.C. 112 ¶ 6 applies); *Ethicon, Inc.* v. *United States Surgical Corp.,* 135 F.3d 1456, 1463, 45 USPQ2d 1545, 1550 (Fed. Cir. 1998) (''use of the word 'means' gives rise to 'a presumption that the inventor used the term advisedly to invoke the statutory mandates for means-plus-function clauses' ''); *O.I. Corp.* v. *Tekmar,* 115 F.3d 1576, 1583, 42 USPQ2d 1777, 1782 (Fed. Cir. 1997) (method claim that paralleled means-plus-function apparatus claim but lacked ''step for'' language did not invoke 35 U.S.C. 112 ¶ 6). Thus, absent an express recitation of ''means for'' or ''step for'' in the limitation, the broadest reasonable interpretation will not be limited to ''corresponding structure * * * and equivalents thereof.'' *Cf. Morris,* 127 F.3d at 1055, 44 USPQ2d at 1028 (''no comparable mandate in the patent statute that relates the claim scope of non-§ 112 ¶ 6

claims to particular matter found in the specification'').

[4] *See York Prod., Inc.* v. *Central Tractor Farm & Family Center,* 99 F.3d 1568, 1574, 40 USPQ2d 1619, 1624 (Fed. Cir. 1996) (holding that a claim limitation containing the term ''means'' does not invoke 35 U.S.C. 112 ¶ 6 if the claim limitation does not link the term ''means'' to a specific function).

[5] *See Seal-Flex,* 172 F.3d at 849, 50 USPQ2d at 1234 (Radar, J., concurring) (''Even when a claim element uses language that generally falls under the step-plus-function format, however, 112 ¶ 6 still does not apply when the claim limitation itself recites sufficient acts for performing the specified function''). *Cf. Rodime PLC* v. *Seagate Technology, Inc.,* 174 F.3d 1294, 1303–04, 50 USPQ2d 1429, 1435–36 (Fed. Cir. 1999) (holding ''positioning means for moving'' does not invoke 35 U.S.C. 112, ¶ 6 because the claim further provides a list of the structure underlying the means and the detailed recitation of the structure for performing the moving function removes this element from the purview of 35 U.S.C. 112, ¶ 6); *Cole* v. *Kimberly-Clark Corp.,* 102 F.3d 524, 531, 41 USPQ2d 1001, 1006 (Fed. Cir. 1996) (holding ''perforation means * * * for tearing'' does not invoke 35 U.S.C. 112 ¶ 6 because the claim describes the structure supporting the tearing function (i.e., perforation)). In other cases, the Federal Circuit has held otherwise. *See Unidynamics Corp.* v. *Automatic Prod. Int'l,* 157 F.3d 1311, 1319, 48 USPQ2d 1099, 1104 (Fed. Cir. 1998) (holding ''spring means'' does invoke 35 U.S.C. 112 ¶ 6). During examination, however, applicants have the opportunity and the obligation to define their inventions precisely, including whether a claim limitation invokes 35 U.S.C. 112 ¶ 6. Thus, if the phrase ''means for'' or ''step for'' is modified by structure, material or acts for achieving the specified function, the PTO will not apply 35 U.S.C. 112 ¶ 6 until such modifying language is deleted from the claim limitation. See also *supra* note 1.

[6] While traditional ''means for'' or ''step for'' language does not automatically make an element a means-(or step-) plus-function element, conversely, lack of such language does not prevent a limitation from being construed as a means-(or step-) plus-function limitation. *See Signtech USA, Ltd.* v. *Vutek, Inc.,* 174 F.3d 1352, 1356, 50 USPQ2d 1372, 1374–75 (Fed. Cir. 1999) (''ink delivery means positioned on * * *'' invokes 35 U.S.C. 112 ¶ 6 since the phrase ''ink delivery means'' is equivalent to ''means for ink delivery''); *Al-Site Corp.* v. *VSI International Inc.,* 174 F.3d 1308, 1318, 50 USPQ2d 1161, 1166–67 (Fed. Cir. 1999) (although the claim elements ''eyeglass hanger member'' and ''eyeglass contacting member'' include a function, these claim elements do not invoke 35 U.S.C. 112 ¶ 6 because the claims themselves contain sufficient structural limitations for performing those functions); *Seal-Flex,* 172 F.3d at 849, 50 USPQ2d at 1234 (Radar, J., concurring) (''claim elements without express step-plus-function language may nevertheless fall within 112 ¶ 6 if they merely claim the underlying function without recitation of acts for performing that function * * * In general terms, the 'underlying function' of a method claim element corresponds to what that element ultimately accomplishes in relationship to what the other elements of the claim and the claim as a whole accomplish. 'Acts,' on the other hand, correspond to how the function is accomplished.); *Personalized Media Communications LLC* v. *ITC,* 161 F.3d 696, 703–04, 48 USPQ2d 1880, 1886–87 (Fed. Cir. 1998); *Mas-Hamilton Group* v. *LaGard Inc.,* 156 F.3d 1206, 1213, 48 USPQ2d 1010, 1016 (Fed. Cir. 1998) (''lever moving element for moving the lever'' and ''movable link member for holding the lever * * * and for releasing the lever'' were construed as means-plus-function limitations invoking 35 U.S.C. 112 ¶ 6 since the claimed limitations were described in terms of their function not their mechanical structure).

[7] *See* 35 U.S.C. 112 ¶ 6. *See also B. Braun Medical, Inc.* v. *Abbott Lab.,* 124 F.3d 1419, 1424, 43 USPQ2d 1896, 1899 (Fed. Cir. 1997).

[8] *See Donaldson,* 16 F.3d at 1195, 29 USPQ2d at 1850; *see also B. Braun Medical,* 124 F.3d at 1425, 43 USPQ2d at 1900; *and In re Dossel,* 115 F.3d 942, 946, 42 USPQ2d 1881, 1884–85 (Fed. Cir. 1997).

[9] *See In re Noll,* 545 F.2d 141, 149, 191 USPQ 721, 727 (CCPA 1976) (unless the means-plus-function language is itself unclear, a claim limitation written in means-plus-function language meets the definiteness requirement in 35 U.S.C. 112 ¶ 2 so long as the specification meets the written description requirement in 35 U.S.C. 112 ¶ 1).

[10] *See In re Knowlton,* 481 F.2d 1357, 1366, 178 USPQ 486, 492–93 (CCPA 1973).

[11] *See Donaldson,* 16 F.3d at 1195, 29 USPQ2d at 1850; *Knowlton,* 481 F.2d at 1366, 178 USPQ at 493.

[12] *See Dossel,* 115 F.3d at 946, 42 USPQ2d at 1885. Under proper circumstances, drawings may provide a written description of an invention as required by 35 U.S.C. ¶ 112. *Vas-Cath, Inc.* v. *Mahurkar,* 935 F.2d 1555, 1565, 19 USPQ2d 1111, 1118 (Fed. Cir. 1991).

[13] *See Dossel,* 115 F.3d at 946–47, 42 USPQ2d at 1885 (''Clearly, a unit which receives digital data, performs complex mathematical computations and outputs the results to a display must be implemented by or on a general or special purpose computer (although it is not clear why the written description does not simply state 'computer' or some equivalent phrase.)'').

[14] In considering whether there is 35 U.S.C. 112 ¶ 1 support for the claim limitation, the examiner must consider not only the original disclosure contained in the summary and detailed description of the invention portions of the specification, but also the original claims, abstract, and drawings. *See In re Mott,* 539 F.2d 1291, 1299, 190 USPQ 536, 542–43 (CCPA 1976) (claims); *In re Anderson,* 471 F.2d 1237, 1240, 176 USPQ 331, 333 (CCPA 1973) (claims); *In re Armbruster,* 512 F.2d 676, 678–79, 185 USPQ 152, 153–54 (CCPA 1975) (abstract); *Anderson,* 471 F.2d at 1240, 176 USPQ at 333 (abstract); *Vas-Cath Inc.* v. *Mahurkar,* 935 F.2d at 1564, 19 USPQ2d at 1117 (drawings); *In re Wolfensperger,* 302 F.2d 950, 955–57, 133 USPQ 537, 541–43 (CCPA 1962) (drawings).

[15] Even if the disclosure implicitly sets forth the structure, materials, or acts corresponding to a means-(or step-) plus-function claim element in compliance with 35 U.S.C. 112 ¶¶ 1 and 2, the PTO may still require the applicant to amend the specification pursuant to 37 CFR 1.75(d) and MPEP 608.01(o) to explicitly state, with reference to the terms and phrases of the claim element, what structure, materials, or acts perform the function recited in the claim element. *See* 35 U.S.C. 112 ¶ 6 (''An element in a claim for a combination may be expressed as a means or step for performing a specified function without the recital of structure, material, or acts in support thereof, and such claim shall be construed to cover the corresponding structure, material, or acts *described in the specification* and equivalents thereof.'' (emphasis added)); *see also B. Braun Medical,* 124 F.3d at 1424, 43 USPQ2d at 1900 (holding that ''pursuant to this provision [35 U.S.C. 112 ¶ 6], structure disclosed in the specification is 'corresponding' structure only if the specification or prosecution history clearly links or associates that structure to the function recited in the claim. This duty to link or associate structure to function is the quid pro quo for the convenience of employing 112, paragraph 6.''); *Wolfensperger,* 302 F.2d at 955, 133 USPQ at 542 (just because the disclosure provides support for a claim element does not mean that the PTO cannot enforce its requirement that the terms and phrases used in the claims find clear support or antecedent basis in the written description).

[16] *See Means or Step Plus Function Limitation Under 35 U.S.C. 112, ¶ 6;* 1162 Off. *Gaz. Pat. Office* at 59–60.

[17] *See Donaldson,* 16 F.3d at 1194, 29 USPQ2d at 1850 (stating that 35 U.S.C. 112 ¶ 6 ''merely sets a limit on how broadly the PTO may construe means-plus-function language under the rubric of 'reasonable interpretation' '').

[18] *See Noll,* 545 F.2d at 149–50, 191 USPQ at 727 (the meaning of equivalents is well understood in patent law, and an applicant need not describe in his specification the full range of equivalents of his invention) (citation omitted). *Cf. Hybritech Incorporated* v. *Monoclonal Antibodies, Inc.,* 802 F.2d 1367, 1384, 231 USPQ 81, 94 (Fed. Cir. 1986) (''a patent need not teach, and preferably omits, what is well known in the art'').

[19] *See* 1994 Guidelines at 60; *see also In re Mulder,* 716 F.2d 1542, 1549, 219 USPQ 189, 196 (Fed. Cir. 1983).

Dated: July 21, 1999.

Q. Todd Dickinson,

Acting Assistant Secretary of Commerce and Acting Commissioner of Patents and Trademarks.

[FR Doc. 99–19368 Filed 7–29–99; 8:45 am]

BILLING CODE 3510–16–P

COMMITTEE FOR THE IMPLEMENTATION OF TEXTILE AGREEMENTS

Regulations to Prevent Circumvention of Textiles and Textile Products Agreements

July 27, 1999.

AGENCY: Committee for the Implementation of Textile Agreements (CITA).

ACTION: Issuing a directive to the Commissioner of Customs directing Customs to issue regulations regarding the denial of entry of shipments from companies determined to be illegally transshipping.

FOR FURTHER INFORMATION CONTACT: Janet Heinzen, International Trade Specialist, Office of Textiles and Apparel, U.S. Department of Commerce, (202) 482–4212.

SUPPLEMENTARY INFORMATION:

Authority: Section 204 of the Agricultural Act of 1956, as amended (7 U.S.C. 1854); Executive Order 11651 of March 3, 1972, as amended; Executive Order 12475 of May 9, 1984, as amended.

Under Title 19, Section 12.130 of the Code of Federal Regulations, U.S. Customs is required to make a country of origin determination of textiles and textile products. Such determination may be made on the basis of information provided by the importer or, at the discretion of U.S. Customs, on the best information available. In order to develop such information, U.S. Customs often has conducted on-site verification of production in foreign countries.

The Chairman of CITA has authorized U.S. Customs to deny entry of certain textiles and textile products subject to Section 204 of the Agricultural Act of 1956 if U.S. Customs on-site verification of production is not permitted (see **Federal Register** notice 61 FR 33793, published on June 28, 1996). Based on information obtained, including through on-site verifications, U.S. Customs reports that some companies have been found to be illegally transshipping, have been closed, or have been unable to produce records to verify production. In order to secure compliance with U.S. law, including Section 204 and U.S. customs law, to carry out textile and textile product agreements, and to avoid circumvention of textile agreements, CITA directs the Commissioner of Customs as soon as possible to issue regulations permitting U.S. Customs to deny entry to textiles and textile products where the declared manufacturer has been named in a CITA directive as a company found to be illegally transshipping, closed or unable to produce records to verify production.

In future directives, the Chairman of CITA may direct U.S. Customs to deny entry to textiles and textile products allegedly manufactured in companies found to be illegally transshipping, closed, or unable to produce records to verify production. CITA will publish such directives, including the names of such companies, in the Federal Register.

Troy H. Cribb

Chairman, Committee for the implementation of Textile Agreements

Committee for the Implementation of Textile Agreements

July 27, 1999.

Commissioner of Customs
Department of Treasury, Washington, DC 20229

Dear Commissioner: Under Title 19, Section 12.130 of the Code of Federal Regulations, U.S. Customs is required to make a country of origin determination of textiles and textile products. Such determination may be made on the basis of information provided by the importer or, at the discretion of U.S. Customs, on the best information available. In order to develop such information, U.S. Customs has often conducted on-site verification of production in foreign countries.

The Chairman of the Committee for the Implementation of Textile Agreements (CITA) has authorized the Commissioner of Customs to deny entry of certain textiles and textile products subject to Section 204 of the Agricultural Act of 1956 if U.S. Customs on-site verification of production is not permitted (see 61 FR 33793, dated June 24, 1996). Based on information obtained, including through on-site verifications, U.S. Customs reports that some companies have been found to be illegally transshipping, have been closed, or have been unable to produce records to verify production. In order to secure compliance with U.S. law, including Section 204 and U.S. customs law, to carry out textile and textile product agreements, and to avoid circumvention of textile agreements, CITA directs the Commissioner of Customs, as soon as possible, to issue regulations permitting U.S. Customs to deny entry to textiles and textile products where the declared manufacturer has been named in a CITA directive as a company found to be illegally transshipping, closed or unable to produce records to verify production.

In future directives, the Chairman of CITA may direct U.S. Customs to deny entry to textiles and textile products allegedly manufactured in companies found to be illegally transshipping, closed, or unable to produce records to verify production. CITA will publish such directives, including the names of such companies, in the Federal Register.

CITA has determined that these actions fall within the foreign affairs exception of the rulemaking provisions of 5 U.S.C. 553(a)(1).

Sincerely,

Troy H. Cribb

Chairman, Committee for the Implementation of Textile Agreements

[FR Doc. 99–19610 Filed 7–29–99; 8:45 am]

BILLING CODE 3510–DR–F

COMMITTEE FOR THE IMPLEMENTATION OF TEXTILE AGREEMENTS

Denying Entry to Textiles and Textile Products Allegedly Produced in Certain Companies in Macau

July 27, 1999.

AGENCY: Committee for the Implementation of Textile Agreements (CITA).

ACTION: Issuing a directive to the Commissioner of Customs directing Customs to deny entry to shipments allegedly manufactured in certain companies in Macau.

EFFECTIVE DATE: September 1, 1999.

FOR FURTHER INFORMATION CONTACT: Janet Heinzen, International Trade Specialist, Office of Textiles and Apparel, U.S. Department of Commerce, (202) 482–4212.

SUPPLEMENTARY INFORMATION:

Authority: Section 204 of the Agricultural Act of 1956, as amended (7 U.S.C. 1854); Executive Order 12475 of May 9, 1984, as amended.

The U.S. Customs Service has conducted on-site verification of textile and textile product production in a number of foreign countries. Based on information obtained through on-site verifications and from other sources, U.S. Customs has informed CITA that certain companies were illegally transshipping, were closed, or were unable to produce records to verify production. The Chairman of CITA has directed the U.S. Customs Service to issue regulations regarding the denial of entry of shipments from such companies (see related notice concerning regulations to prevent circumvention published elsewhere in this issue of the **Federal Register**). In order to secure compliance with U.S. law, including Section 204 and U.S. customs law, to carry out textile and textile product agreements, and to avoid circumvention of textile agreements, the Chairman of CITA is directing the U.S. Customs Service to deny entry to textiles and textile products allegedly manufactured by the companies listed in the attached directive; Customs has informed CITA that these companies were found to have been illegally

transshipping, closed, or unable to produce records to verify production.

Should CITA determine that this list should be amended, such amendments will be published in the Federal Register.

Troy H. Cribb,

Chairman, Committee for the Implementation of Textile Agreements.

Committee for the Implementation of Textile Agreements

July 27, 1999.

Commissioner of Customs,
Department of the Treasury, Washington, DC 20229.

Dear Commissioner: The U.S. Customs Service has conducted on-site verification of textile and textile product production in a number of foreign countries. Based on information obtained through on-site verifications and from other sources, U.S. Customs has informed CITA that certain companies were illegally transshipping, were closed, or were unable to produce records to verify production. The Chairman of CITA has directed the U.S. Customs Service to issue regulations regarding the denial of entry of shipments from such companies (see related directive concerning regulations to prevent circumvention published elsewhere in this issue of the **Federal Register**). In order to secure compliance with U.S. law, including Section 204 and U.S. customs law, to carry out textile and textile product agreements, and to avoid circumvention of textile agreements, the Chairman of CITA directs the U.S. Customs Service, effective for goods exported on and after September 1, 1999, to deny entry to textiles and textile products allegedly manufactured by the Macau companies listed below; Customs has informed CITA that these companies were found to have been illegally transshipping, closed, or unable to produce records to verify production:

1. Artistica, Fabrica
2. Broadwell Garment Factory
3. Chan Chan, Fabrica de Artigos de Vestuario
4. Cheong Long, Fabrica de Art de Vestuario
5. Chi Fat, Fabrica de Vestuario
6. Chi Fung Garment Factory
7. Cidade Nova
8. E. Tin Chong Ou, Fabrica de Fia. Vestuario
9. Ever Long, Fabrica de Art de Vestuario (AKA Wan Long, Wing Long)
10. Fok Seng
11. Harvest Garment Factory
12. Henford, Fabrica de Art de Vestuario
13. Heng Tai, Fabrica de Vestuario
14. Hip Seng
15. Iu Fai
16. Ka Fung
17. Kai Fu
18. Kai Son, Fabrica de Vestuario
19. Kai Tak, Fabrica de Vestuario
20. Kai Vai Hung
21. Kin Cheong, Fabrica de Artigos de Vestuario
22. King Cheong, Fabrica de Vestuario
23. Knitsway, Fabrica de Artigos de Vestuario
24. Kong Lei
25. Kuck Chon
26. Kun Cheong
27. Lai Kong, Fabrica de Artigos de Vestuario
28. Leon Garment Factory Limited
29. Ling Chu, Fabrica de Artigos de Vestuario
30. Luen Tai
31. Macau Ltd., Fabrica de Artigos de Vestuario
32. Man Heng
33. Man Ka
34. Manway Lda., Fabrica de Artigos de Vestuario
35. Mao Cheong Limited, Fabrica de Artigos Vestuario
36. Mei I, Fabrica de Artigos de Vestuario
37. Ming Tak
38. Nam Pan Garment Factory
39. Nation Garment
40. Ngan Wu
41. Ou Ion
42. Pak Seak
43. Perfect Garments
44. Po Che
45. Richness, Fabrica de Artigos de Vestuario
46. Sai Land Garment Factory
47. Sam Yu Garment Factory
48. San Fu Lai, Fabrica de Artigos de Vestuario
49. San Hoi Seng
50. Seng Wai, Fabrica de Malhas
51. Seng Yee
52. Shan Lee, Fabrica de Artigos de Vestuario
53. Shing Un, Fabrica de Artigos de Vestuario
54. Sing Wai, Fabrica de Artigos de Vestuario
55. Strong Billion
56. Sufficient
57. Tai Ku, Fabrica de E. Artigos de Vestuario
58. Tak Mei
59. Tak Weng Heng
60. Tim Pou, Fabrica de Artigos de Vestuario
61. Tin Sin Overseas
62. Tong Heng, Fabrica de Vestuario
63. Tong Hoi Garment Factory
64. Tong Lee, Fabrica de Artigos de Vestuario
65. Uni-Leader, Fabrica de Vestuario
66. Va Tai, Fabrica de Vestuario
67. Vang Tak, Fabrica de Vestuario
68. Veng Fat Tak
69. Veng Kuong Meng
70. Vo Wong
71. Wai Dai Meng
72. Wai Lung Garment Factory
73. Wai Wa
74. Weng Iat, Fabrica de Artigos de Vestuario
75. Weng Wa Garment Factory Limited
76. Winton Garment Factory
77. World Wide Knitting Factory

The Committee for the Implementation of Textile Agreements has determined that these actions fall within the foreign affairs exception to the rulemaking provisions of 5 U.S.C. 553(a)(1).

Sincerely,

Troy H. Cribb,

Chairman, Committee for the Implementation of Textile Agreements.

[FR Doc. 99–19611 Filed 7–29–99; 8:45 am]

BILLING CODE 3510–DR–F

COMMODITY FUTURES TRADING COMMISSION

New York Mercantile Exchange, Comex Division, Amendment To Petition for Exemption From the Dual Trading Prohibition in Affected Contract Markets

AGENCY: Commodity Futures Trading Commission.

ACTION: Notice of amendment and update to a petition for exemption from the prohibition on dual trading in an affected contract market.

SUMMARY: The New York Mercantile Exchange (''NYMEX'' or ''Exchange''), Comex Division (''Comex''), has submitted to the Commodity Futures Trading Commission (''Commission'') an additional update to the Commodity Exchange, Inc., October 21, 1993 petition for exemption from the prohibition against dual trading in two contract markets. The additional amendment requests an exemption for a new affected contract market. Copies of the entire file, including any future submissions, will be available to the public upon request, except to the extent the Exchange has requested confidential treatment.

ADDRESSES: Copies of the file are available from the Office of the Secretariat, Commodity Futures Trading Commission, Three Lafayette Centre, 1155 21st Street, NW, Washington, DC 20581. Reference should be made to the Comex dual trading exemption petition file.

FOR FURTHER INFORMATION CONTACT: Duane C. Andresen, Special Counsel, Division of Trading and Markets, Commodity Futures Trading Commission, Three Lafayette Centre, 1155 21st Street, NW, Washington, DC 20581; telephone: (202) 418–5490.

SUPPLEMENTARY INFORMATION: Pursuant to sections 4j(a)(1) and (3) of the Commodity Exchange Act (''Act'') and Commission Regulation 155.5 thereunder, a board of trade may submit a petition to the Commission to exempt any of its affected contract markets (markets with an average daily trading volume equal to or in excess of 8,000 contracts for four consecutive quarters) from the prohibition against dual trading. Regulation 155.5(d)(6) authorizes the Director of the Division of Trading and Markets to publish notice of each exemption petition deemed complete under Regulation 155.5(d) and to make the petition available to the public as required by section 4j(a)(5) of the Act.

Comex originally submitted a petition for dual trading exemptions for its gold,

silver, and copper futures contracts and options on gold future contracts on October 21, 1993. After the Commission requested additional information, Comex submitted a corrected petition on November 30, 1993. That petition was made available to the public by a notice of availability published in the **Federal Register** on December 22, 1993.[1] On January 21, 1997, in response to a Commission letter offering the opportunity to update its petition, Comex submitted an updated petition. On May 6, 1997, the Commission issued an Order granting dual trading exemptions to Comex for its gold and silver futures contracts, the only affected contract markets as of that date. This Order provided that if other Comex contracts become affected contract markets after the date of the Order, the Commission may expand the Order in response to an updated petition that includes those contracts. Pursuant to that provision, Comex submitted an update to its petition dated June 25, 1999, requesting an exemption from the dual trading prohibition for the copper futures contract market.

Copies of the file containing all these materials and any future submissions, except to the extent the Exchange has requested confidential treatment in accordance with 17 CFR 145.9, are available for inspection at the Commission's Office of the Secretariat, Three Lafayette Centre, 1155 21st Street, NW, Washington, DC 20581, and may be obtained by mail at that address or by telephone at (202) 418–5100.

Petition materials subject to Comex's request for confidential treatment may be available upon request pursuant to the Freedom of Information Act (''FOIA'') (5 U.S.C. § 552) and the Commission's regulations thereunder (17 CFR Part 145), except to the extent they are entitled to confidential treatment as set forth in 17 CFR 145.5 and 145.9. Request for copies of such materials should be made to FOIA, Privacy, and Sunshine Act Compliance Staff of the Office of the Secretariat at the above address in accordance with 17 CFR 145.7 and 145.87.

Comex timely submitted its amended petition before June 30, 1999, the effective date of the dual trading prohibition in the newly affected contract market. Therefore, application of the prohibition to the contract market covered by the petition amendment has been suspended in accordance with Commission Regulation 155.5(d)(5) and will remain suspended until the petition is acted upon.

[1] 58 FR 67777 (December 22, 1993).

Issued in Washington, DC, on July 27, 1999.

Alan L. Seifert,

Deputy Director, Division of Trading and Markets.

[FR Doc. 99–19573 Filed 7–29–99; 8:45 am]

BILLING CODE 6351–01–M

CONSUMER PRODUCT SAFETY COMMISSION

Proposed Collection of Information Under OMB Review; Mouthing Behavior Study

AGENCY: Consumer Product Safety Commission (CPSC).

ACTION: Notice.

SUMMARY: As the Paperwork Reduction Act of 1995 (44 U.S.C. Chapter 35) requires, the U.S. Consumer Product Safety Commission (CPSC or Commission) announces that the Information Collection Request (ICR) described below has been forwarded to the Office of Management and Budget (OMB) for review and comment. The proposed collection of information consists of a study to observe 200 children ages 3 months through 35 months to record what items they put in their mouths and for how long. The study also includes a telephone survey of the parents of about 400 children between 36 and 72 months old to estimate the mouthing behavior of these children. The information will help the Commission assess the risks associated with children mouthing products containing potentially harmful substances. Comments on the study should be submitted to OMB and CPSC.

DATES: Written comments must be received on or before August 30, 1999.

ADDRESSES: Written comments should be captioned ''Mouthing Behavior Study'' and mailed to the Office of Information and Regulatory Affairs, Office of Management and Budget, Attention: Desk Officer for CPSC, 725 17th Street, NW, Washington, DC 20503. Copies of comments also may be: mailed to the Office of the Secretary, Consumer Product Safety Commission, Washington, D.C. 20207; delivered to the Office of the Secretary, Consumer Product Safety Commission, Room 502, 4330 East-West Highway, Bethesda, Maryland, telephone (301) 504–0800; or filed by telefacsimile to (301) 504–0127 or by email to cpsc-os@cpsc.gov.

FOR FURTHER INFORMATION OR A COPY CONTACT: Celestine T. Kiss, Engineering Psychologist, Consumer Product Safety Commission, Washington, D.C. 20207; 301–504–0468 ext. 1284 or by email to ckiss@cpsc.gov.

SUPPLEMENTARY INFORMATION:

A. Background

The U.S. Consumer Product Safety Commission staff is investigating the potential exposure and health risks to children from teethers, rattles, and toys that are made of polyvinyl chloride (PVC) that contains various dialkyl phthalate (DAP) plasticizers, especially diisononyl phthalate (DINP). Manufacturers use plasticizers to soften the PVC. Tests using animals exposed to high levels of certain DAP plasticizers have caused concerns that PVC children's products might present a risk of liver or other organ toxicity to children. Whether DINP would cause toxic effects in humans depends on the amount of DINP that is ingested. Thus, determining the amount of time children have DINP-containing products in their mouths is one important component of the risk assessment.

The CPSC staff recently released a report, *The Risk of Chronic Toxicity Associated with Exposure to Diisononyl Phthalate (DINP) in Children's Products (Dec. 1998),* which concluded that, based on the best available information, few, if any, children are at risk of liver or other organ toxicity from PVC toys that contain DINP. This was based on estimates of the amount of DINP ingested, which indicated that DINP exposure did not reach a potentially harmful level. However, the staff believes that there are a number of uncertainties in this assessment, particularly regarding the types of toys that children are mouthing and how long they typically mouth these toys. In addition, the staff at that time did not address the potential carcinogenic risk from DINP, which is being investigated by a Chronic Hazard Advisory Panel (CHAP) appointed by the Commission. After the CHAP provides advice on the carcinogenic risk of DINP, accurate exposure data will be needed in order to perform a risk assessment. Therefore, CPSC will perform this study to gather better data on which to base the health-risk assessment.

Under the Paperwork Reduction Act of 1995 (the PRA) (44 U.S.C 3501–3520), Federal agencies must obtain approval from the Office of Management and Budget (OMB) for each collection of information they conduct or sponsor. ''Collection of information'' is defined in 44 U.S.C. 3502(3) and 5 CFR 1320.3(c) and includes agency requests or requirements that members of the public submit reports, keep records, or provide information to the agency or a third party. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information

unless it displays a currently valid OMB control number.

Section 3506(c)(2)(A) of the PRA (44 U.S.C. 3506(c)(2)(A)) requires Federal agencies to provide a 60-day notice in the **Federal Register** concerning each proposed collection of information before submitting the collection to OMB for approval. The **Federal Register** notice with a 60-day comment period soliciting comments on this collection of information was published on March 11, 1999 (64 FR 12153) (corrected comment submission date published March 22, 1999 (64 FR 13854)). One comment was received, from the Toy Manufacturers of America, Inc. (TMA). The points raised in that comment are addressed in the request for approval of this collection of information that was submitted to OMB.

B. Description of the Collection of Information

This extensive exposure study is intended to obtain a better estimate of the amount of time children mouth products that could contain phthalates. The CPSC is also interested in how mouthing time varies with age, gender, and socioeconomic strata. The Commission also can use information from this study to assess potential hazards associated with other children's products, such as exposure to lead. The title of this collection of information is ''Mouthing Behavior Study.''

The observation portion of the study involves 200 children between 3 and 35 months old. The observations will be conducted over 2 days for 3 hours per day. For 20 continuous minutes out of each half-hour, the child's mouthing activities will be recorded. This will include (1) the specific object being mouthed, (2) the length of the mouthing episode and (3) whether the object was placed to the lips, or put into the mouth. Mouthing is defined, for purposes of this study, as placing any item to the child's lips, tongue, and/or into the mouth.

In addition to the observations, a contractor will conduct a telephone survey to determine mouthing behaviors of 400 children from 36 to 72 months old, as reported by the parent. This age group will not be observed.

The Commission will use all this information to estimate the frequency and duration of children's mouthing activities, by age. Interested persons may obtain a copy of the request to OMB for approval, containing a more detailed description of the intended study, from the Commission's Office of the Secretary.

C. Burden on Respondents

Two hundred subjects will be used for the observation portion of the study. Each subject's total participation time will be approximately 13 hours. For most of this time, however, the child and the caregiver will be engaged in their regular activities. (Time spent in the normal course of a respondent's activities does not count as part of the burden of a collection of information. 5 CFR 1320.3(b)(2).)

The Commission's staff estimates that each child in the observation study, and the persons associated with that child (including parents and other caregivers), will spend an average total of about 4.5 hours among them in reacting specifically to the observer. This is calculated by estimating 15 minutes for one person to participate in the telephone interview, 1 hour for one person to observe the subject and fill out the questionnaire, 15 minutes for that person to report the results to the contractor, 1 hour each for two persons during the in-home interview/habituation period (2 hours total), and an average of 30 person-minutes of interaction relating to the study for each of the 2 observation sessions (1 hour total). Therefore, the total burden hours for these respondents will be about 900 hours (200 x 4.5 hours).

The number of subjects required for the older children telephone survey portion of the study is 400. Each subject's total time will be approximately 1.5 hours. This is calculated by estimating 15 minutes for the initial phone interview, 1 hour observing the subject and filling out the questionnaire, and 15 minutes for reporting the results to the contractor by telephone. Therefore, the total burden hours for the telephone survey will be about 600 hours. Thus, the estimated one-time reporting burden for this collection is 1500 hours.

D. Requests for Comments

Send comments regarding the burden estimate, or any other aspect of the information collection, including suggestions for reducing the burden, to the addresses given at the beginning of this notice.

Dated: July 27, 1999.

Sadye E. Dunn,

Secretary, U.S. Consumer Product Safety Commission.

[FR Doc. 99–19624 Filed 7–29–99; 8:45 am]

BILLING CODE 6355–01–P

DEPARTMENT OF DEFENSE

Office of the Secretary

Proposed Collection; Comment Request

AGENCY: Office of the Under Secretary of Defense (Personnel and Readiness).

ACTION: Notice.

In compliance with Section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, the Office of the Under Secretary of Defense (Personnel and Readiness) announces the following proposed reinstatement of a public information collection and seeks public comment on the provisions thereof. Comments are invited on: (a) Whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of burden of the proposed information collection; (c) ways to enhance the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden of the information collection on respondents, including through the use of automated collection techniques or other forms of information technology.

DATES: Consideration will be given to all comments received by September 28, 1999.

ADDRESSES: Written comments and recommendations on the proposed information collection should be sent to the Office of the Under Secretary of Defense (Personal and Readiness) (Force Management Policy/Military Personnel Policy/Armed Forces Chaplains Board), ATTN: CAPT Russell Gunter, CHC, UNS, 4000 Defense Pentagon, Room 1B652, Washington, DC 20301–4000.

FOR FURTHER INFORMATION CONTACT: To request more information on this proposed information collection or to obtain a copy of the proposal and associated collection instruments, please write to the above address or call at (703) 697–9015.

Title, Associated Form, and OMB Number: Appointment of Chaplains for the Military Services; DD Form 2088 and DD Form 2741; OMB Control Number 0704–0190.

Needs and Uses: This information collection requirement is necessary to ensure that religious organizations seeking to endorse chaplains are eligible and that applicants qualified for the military chaplain services are endorsed by those religious organizations. Two forms are associated with this program to collect the necessary information. The DD Form 2741, ''Ecclesiastical

Endorsing Organization Verification/Reverification Information,'' requests basic demographic information about the religious denominations seeking to supply chaplains. It requests the name of an official authorized to represent the organization to the Military Services, and it requires the organization to certify that it is authorized by its membership to act as the sole agency for the purpose of certifying and endorsing clergy to serve as military chaplains. The DD Form 2088, ''Ecclesiastical Endorsing Agent Certification,'' is used by religious denominations to certify that a member of their clergy is professionally qualified to become a chaplain. It requests information about name, address, professional experience, and previous military experience to be used in determining grade, date or rank, and eligibility for promotion for appointees to the chaplain services.

Affected Public: Not-for-profit institutions.

Annual Burden Hours: 1,187.

Number or Respondents: 724.

Responses per Respondent: 1.

Average Burden per Respondent: 20 minutes.

Frequency: On occasion/annually.

SUPPLEMENTARY INFORMATION:

Summary of Information Collection

The DD Form 2741, ''Ecclesiastical Endorsing Organization Verification/Reverification Information,'' requests basic demographic information about the religious denominations seeking to supply chaplains. It requests the name of an official authorized to represent the organization to the Military Services, and it requires the organization to certify that it is authorized by its membership to act as the sole agency for the purpose of certifying and endorsing clergy to serve as military chaplains. The DD Form 2088, ''Ecclesiastical Endorsing Agent Certification,'' is used by religious denominations to certify that a member of their clergy is professionally qualified to become a chaplain. It requests information about name, address, professional experience, and previous military experience to be used in determining grade, date of rank, and eligibility for promoting for appointees to the chaplain services.

Dated: July 26, 1999.

L.M. Bynum,

Alternate OSD Federal Register Liaison Officer, Department of Defense.

[FR Doc. 99–19467 Filed 7–29–99; 8:45 am]

BILLING CODE 5001–10–M

DEPARTMENT OF DEFENSE

Office of the Secretary

Kosovo C3ISR Operations and Lessons Learned Meeting

AGENCY: Task Force on Kosovo C3ISR Operations and Lessons Learned.

ACTION: Notice of closed meeting.

SUMMARY: The Task Force on Kosovo C3ISR Operations and Lessons Learned will meet in closed session on 28–30 July 1999. The purpose of the meeting is to review information collected during site visits and prepare a briefing and report on lessons learned from the Kosovo operations. Much of the information at issue is highly classified.

The Task Force serves as a senior advisory board that will provide recommendations to the Assistant Secretary of Defense (Command, Control and Intelligence) (ASD(C3I) and the Secretary of Defense on improving the application of intelligence and other supporting information to the battlefield. Towards that end, the Task Force will determine both near term and longer term technical and operational improvements to command, control, communications, intelligence, surveillance and reconnaissance (C3ISR) systems that provided and/or are still providing support to NATO operations in the Balkans. This notice is being published less than 15 days prior to the scheduled meeting due to the need for expedited completion of the Quick Look Assessment.

In accordance with section 10(d) of the Federal Advisory Committee Act, Public Law 92–453, as amended (5 U.S.C. App II (1988), it has been determined that this meeting concerns matters listed in 5 U.S.C. 552b(c)(1)(1988), and that, accordingly, this meeting will be closed to the public. It is anticipated that classified matters of national security will be discussed throughout the meeting.

DATES: 28–30 July 1999, 0800–1700 hrs.

ADDRESSES: 1001 N 19th Street, Suite 800, Rosslyn, VA.

FOR FURTHER INFORMATION: Contact Colonel David M. Komar, 703–607–0591.

Dated; July 26, 1999.

L.M. Bynum,

Alternate OSD Federal Register Liaison Officer, Department of Defense.

[FR Doc. 99–19468 Filed 7–29–99; 8:45 am]

BILLING CODE 5001–01–M

DEPARTMENT OF DEFENSE

Defense Logistics Agency

Privacy Act of 1974; Systems of Records

AGENCY: Defense Logistics Agency, DOD.

ACTION: Notice to alter a system of records.

SUMMARY: The Defense Logistics Agency proposes to alter a system of records notice in its inventory of record systems subject to the Privacy Act of 1974 (5 U.S.C. 552a), as amended.

DATES: This action will be effective without further notice on August 30, 1999, unless comments are received that would result in a contrary determination.

ADDRESSES: Send comments to the Privacy Act Officer, Headquarters, Defense Logistics Agency, ATTN: CAAR, 8725 John J. Kingman Road, Suite 2533, Fort Belvior, VA 22060–6221.

FOR FURTHER INFORMATION CONTACT: Ms. Susan Salus at (703) 767–6183.

SUPPLEMENTARY INFORMATION: The Defense Logistics Agency notices for systems of records subject to the Privacy Act of 1974 (5 U.S.C. 552a), as amended, have been published in the **Federal Register** and are available from the address above.

The proposed system report, as required by 5 U.S.C. 552a(r) of the Privacy Act of 1974, as amended, was submitted on July 14, 1999, to the House Committee on Government Reform, the Senate Committee on Governmental Affairs, and the Office of Management and Budget (OMB) pursuant to paragraph 4c of Appendix I to OMB Circular No. A–130, 'Federal Agency Responsibilities for Maintaining Records About Individuals,' dated February 8, 1996 (February 20, 1996, 61 FR 6427).

Dated: July 26, 1999.

L.M. Bynum,

Alternate OSD Federal Register Liaison Officer, Department of Defense.

DELETION

S161.50 DLA-I

SYSTEM NAME:

Traffic Violations File *(February 22, 1993, 58 FR 10854).*

Reason: These files are being consolidated into the system of records, S161.40 DLA-I, Vehicle Accident Investigation Files.

ALTERATION

S161.40 DLA-I

SYSTEM NAME:

Vehicle Accident Investigation Files *(February 22, 1993, 58 FR 10854).*

CHANGES:

SYSTEM IDENTIFIER:

Delete entry and replace with 'S500.41 CAAS'.

SYSTEM NAME:

Delete entry and replace with 'Vehicle/Traffic Incident Files.'

* * * * *

CATEGORIES OF INDIVIDUALS COVERED BY THE SYSTEM:

Delete entry and replace with 'Any person involved in a vehicle traffic accident or traffic incident on property controlled by the Defense Logistics Agency (DLA), and individuals involved in traffic incidents while operating or occupying a DLA-controlled vehicle.'

CATEGORIES OF RECORDS IN THE SYSTEM:

Delete entry and replace with 'The file includes name, addresses, social security number, telephone numbers, vehicle description and data, vehicle license data, operator license data, insurance data, emergency contact and similar data. The file also includes reports, sketches, photographs, medical reports and related papers concerning traffic accident investigation and case disposition, traffic tickets, documents relating to withdrawal of driving privileges, substance influence reports, and reports of corrective or disciplinary action taken.'

AUTHORITY FOR MAINTENANCE OF THE SYSTEM:

Delete entry and replace with '10 U.S.C. 133, Under Secretary of Defense for Acquisition and Technology; National Highway Safety Act of 1966 (23 U.S.C. 401, Highway Safety, et seq.); and E.O. 9397 (SSN).'

PURPOSE(S):

Delete entry and replace with 'The files are maintained to monitor and correct vehicle accidents and traffic incidents. Information is maintained for the purpose of accident cause identification and to formulate accident prevention programs for improvement in traffic patterns and for preparation of statistical reports required by higher authority. Information is also maintained to identify traffic offenders, to initiate corrective or disciplinary action against the offenders, to enforce applicable traffic regulations, and to promote safety. Information is used by personnel offices for processing of workers' compensation cases and similar claims and by medical and emergency personnel to make medical and safety determinations about individuals involved in accidents.'

ROUTINE USES OF RECORDS MAINTAINED IN THE SYSTEM, INCLUDING CATEGORIES OF USERS AND THE PURPOSES OF SUCH USES:

Replace the second and third paragraphs with 'To medical and emergency personnel to make medical and safety determinations about individuals involved in accidents.'

Add a new paragraph 'To the Department of Labor, Office of Workers' Compensation for the purpose of processing workers' compensation claims.'

* * * * *

S500.41 CAAS

SYSTEM NAME:

Vehicle/Traffic Incident Files.

SYSTEM LOCATION:

Heads of Defense Logistics Agency Primary Level Field Activities (PLFAs). Official mailing addresses are published as an appendix to DLA's compilation of systems of records notices.

CATEGORIES OF INDIVIDUALS COVERED BY THE SYSTEM:

Any person involved in a vehicle traffic accident or traffic incident on property controlled by the Defense Logistics Agency (DLA), and individuals involved in traffic incidents while operating or occupying a DLA-controlled vehicle.

CATEGORIES OF RECORDS IN THE SYSTEM:

The file includes name, addresses, social security number, telephone numbers, vehicle description and data, vehicle license data, operator license data, insurance data, emergency contact and similar data. The file also includes reports, sketches, photographs, medical reports and related papers concerning traffic accident investigation and case disposition, traffic tickets, documents relating to withdrawal of driving privileges, substance influence reports, and reports of corrective or disciplinary action taken.

AUTHORITY FOR MAINTENANCE OF THE SYSTEM:

10 U.S.C. 133, Under Secretary of Defense for Acquisition and Technology; National Highway Safety Act of 1966 (23 U.S.C. 401, Highway Safety, et seq.); and E.O. 9397 (SSN).

PURPOSE(S):

Information is maintained for purposes of accident cause identification and to formulate accident prevention programs for improvement in traffic patterns and for preparation of statistical reports required by higher authority.

Information is used by Security Officers and DLA Police to determine actions required to correct the cause of the accident. In cases involving personal injury, to provide verification in processing workmen's compensation cases.

Claims Officers to determine validity of clams against U.S. Government, when such are filed by a person involved in an accident.

DoD Medical personnel to make medical determinations about individuals involved in accidents.

ROUTINE USES OF RECORDS MAINTAINED IN THE SYSTEM, INCLUDING CATEGORIES OF USERS AND THE PURPOSES OF SUCH USES:

In addition to those disclosures generally permitted under 5 U.S.C. 552a(b) of the Privacy Act, these records or information contained therein may specifically be disclosed outside the DoD as a routine use pursuant to 5 U.S.C. 552a(b)(3) as follows:

To medical and emergency personnel to make medical and safety determinations about individuals involved in accidents.

To the Department of Labor, Office of Workers' Compensation for the purpose of processing workers' compensation claims.

The 'Blanket Routine Uses' set forth at the beginning of DLA's compilation of systems of records notices apply to this system.

POLICIES AND PRACTICES FOR STORING, RETRIEVING, ACCESSING, RETAINING, AND DISPOSING OF RECORDS IN THE SYSTEM:

STORAGE:

Records are maintained in paper and electronic form.

RETRIEVABILITY:

Retrieved by name of person involved, Social Security Number, ticket or police report number.

SAFEGUARDS:

Records are maintained in areas accessible only to DLA personnel who must use the records to perform their duties. The computer files are password protected with access restricted to authorized users. Records are secured in locked or guarded buildings, locked offices, or locked cabinets during nonduty hours.

RETENTION AND DISPOSAL:

Destroy after 2 years; however, where the possibility for a claim exists, the record will be destroyed after 6 years, 3 months.

SYSTEM MANAGER(S) AND ADDRESS:

Heads of PLFAs who are responsible for the DLA installation or vehicle involved. Official mailing addresses are published as an appendix to DLA's compilation of systems of records notices.

NOTIFICATION PROCEDURE:

Individuals seeking to determine whether information about themselves is contained in this system should address written inquiries to the Privacy Act Officer of the PLFA involved. Official mailing addresses are published as an appendix to DLA's compilation of systems of records notices.

Individual must provide full name, date of incident, and the location of the incident.

RECORD ACCESS PROCEDURES:

Individuals seeking access to information about themselves contained in this system should address written inquiries to the Privacy Act Officer of the PLFA involved. Official mailing addresses are published as an appendix to DLA's compilation of systems of records notices.

Individual must provide full name, date of incident, and the location of the incident.

For personal visits, the individual should be able to provide some acceptable identification, such as, driver's license or employing agency identification card. Some verbal information may be required to verify the file.

CONTESTING RECORD PROCEDURES:

The DLA rules for accessing records, for contesting contents and appealing initial agency determinations are contained in DLA Regulation 5400.21, 32 CFR part 323, or may be obtained from the Privacy Act Officer, Headquarters, Defense Logistics Agency, ATTN: CAAR, 8725 John J. Kingman Road, Suite 2533, Fort Belvoir, VA 22060–6221.

RECORD SOURCE CATEGORIES:

Individuals involved in accidents, traffic offenders, witnesses, security and police force personnel, law enforcement agencies, and medical and emergency personnel.

EXEMPTIONS CLAIMED FOR THE SYSTEM:

None.

[FR Doc. 99–19470 Filed 7–29–99; 8:45 am]

BILLING CODE 5001–10–F

DEPARTMENT OF DEFENSE

Department of the Navy

Privacy Act of 1974; System of Records

AGENCY: Department of the Navy, DoD.

ACTION: Notice to alter a system of records.

SUMMARY: The Department of the Navy proposes to alter a system of records notice in its inventory of record systems subject to the Privacy Act of 1974 (5 U.S.C. 552a), as amended. The alteration adds a routine use to an existing system of records.

DATES: This action will be effective on August 30, 1999, unless comments are received that would result in a contrary determination.

ADDRESSES: Send comments to the Department of the Navy, PA/FOIA Policy Branch, Chief of Naval Operations (N09B30), 2000 Navy Pentagon, Washington, DC 20350–2000.

FOR FURTHER INFORMATION CONTACT: Mrs. Doris Lama at (202) 685–6545 or DSN 325–6545.

SUPPLEMENTARY INFORMATION: The Department of the Navy's record system notices for records systems subject to the Privacy Act of 1974 (5 U.S.C. 552a), as amended, have been published in the **Federal Register** and are available from the address above.

The proposed system report, as required by 5 U.S.C. 552a(r) of the Privacy Act was submitted on July 15, 1999, to the House Committee on Government Reform, the Senate Committee on Governmental Affairs, and the Office of Management and Budget (OMB) pursuant to paragraph 4c of Appendix I to OMB Circular No. A–130, 'Federal Agency Responsibilities for Maintaining Records About Individuals,' dated February 8, 1996, (61 FR 6427, February 20, 1996).

Dated: July 26, 1999.

L. M. Bynum,

Alternate OSD Federal Register Liaison Officer, Department of Defense.

N05813–1

SYSTEM NAME:

Ethics File *(February 22, 1993, 58 FR 10775).*

CHANGES:

* * * * *

SYSTEM NAME:

Add 'Professional Responsibility/' to beginning of entry.

SYSTEM LOCATION:

Delete entry and replace with 'Office of the Judge Advocate General (Code 13), Department of the Navy, Washington Navy Yard, 1322 Patterson Avenue SE, Suite 3000, Washington, DC 20374-5066.

Judge Advocate Division, Research and Civil Law Branch, 2 Navy Annex, Washington, DC 20380-1775.'

CATEGORIES OF INDIVIDUALS COVERED BY THE SYSTEM:

Delete entry and replace with 'Civilian and military lawyers who have practiced, or are practicing, in proceedings conducted under the supervision and cognizance of the Judge Advocate General of the Navy (JAG), and whose professional or personal conduct has been the subject of a professional responsibility/ethics complaint or investigation.'

CATEGORIES OF RECORDS IN THE SYSTEM:

Delete entry and replace with 'Reports of investigation, correspondence, and court papers relating to the professional responsibility/ethics complaint brought against attorneys.'

AUTHORITY FOR MAINTENANCE OF THE SYSTEM:

Delete entry and replace with '5 U.S.C. 301, Departmental Regulations; 10 U.S.C. 826, 827; 32 CFR part 776; Rule for Courts-Martial 109, Manual for Courts-Martial; and Judge Advocate General Instruction 5803.1.'

PURPOSE(S):

Delete entry and replace with 'To record the disposition of professional responsibility/ethics complaints; to provide a record of individual lawyers who are not authorized to practice as legal assistance attorneys before courts-martial or other proceedings conducted under the Uniform Code of Military Justice (UCMJ), or in Navy and Marine Corps administrative proceedings, and to document professional responsibility/ethics violations and corrective action taken.'

ROUTINE USES OF RECORDS MAINTAINED IN THE SYSTEM, INCLUDING CATEGORIES OF USERS AND THE PURPOSES OF SUCH USES:

Add a new paragraph 'To attorney licensing and/or disciplinary authorities as required to support professional responsibility investigations and proceedings.'

* * * * *

RETENTION AND DISPOSAL:

Delete entry and replace with 'Records are maintained in office for a minimum of two years. Records are retained for as long as an attorney remains subject to JAG-imposed limitations on practice. Records pertaining to unsubstantiated complaints, or to attorneys who are no

longer subject to limitations on practice, are destroyed after 10 years.'

* * * * *

N05813–1

SYSTEM NAME:

Professional Responsibility/Ethics File.

SYSTEM LOCATION:

Office of the Judge Advocate General (Code 13), Department of the Navy, Washington Navy Yard, 1322 Patterson Avenue SE, Suite 3000, Washington, DC 20374-5066.

Judge Advocate Division, Research and Civil Law Branch, 2 Navy Annex, Washington, DC 20380-1775.

CATEGORIES OF INDIVIDUALS COVERED BY THE SYSTEM:

Civilian and military lawyers who have practiced, or are practicing, in proceedings conducted under the supervision and cognizance of the Judge Advocate General of the Navy (JAG), and whose professional or personal conduct has been the subject of a professional responsibility/ethics complaint or investigation.

CATEGORIES OF RECORDS IN THE SYSTEM:

Reports of investigation, correspondence, and court papers relating to the professional responsibility/ethics complaint brought against attorneys.

AUTHORITY FOR MAINTENANCE OF THE SYSTEM:

5 U.S.C. 301, Departmental Regulations; 10 U.S.C. 826, 827; 32 CFR part 776; Rule for Courts-Martial 109, Manual for Courts-Martial; and Judge Advocate General Instruction 5803.1.

PURPOSE(S):

To record the disposition of professional responsibility/ethics complaints; to provide a record of individual lawyers who are not authorized to practice as legal assistance attorneys before courts-martial or other proceedings conducted under the Uniform Code of Military Justice (UCMJ), or in Navy and Marine Corps administrative proceedings, and to document professional responsibility/ethics violations and corrective action taken.

ROUTINE USES OF RECORDS MAINTAINED IN THE SYSTEM, INCLUDING CATEGORIES OF USERS AND THE PURPOSES OF SUCH USES:

In addition to those disclosures generally permitted under 5 U.S.C. 552a(b) of the Privacy Act, these records or information contained therein may specifically be disclosed outside the DoD as a routine use pursuant to 5 U.S.C. 552a(b)(3) as follows:

To attorney licensing and/or disciplinary authorities as required to support professional responsibility investigations and proceedings.

The 'Blanket Routine Uses' that appear at the beginning of the Navy's compilation of systems of records notices apply to this system.

POLICIES AND PRACTICES FOR STORING, RETRIEVING, ACCESSING, RETAINING, AND DISPOSING OF RECORDS IN THE SYSTEM:

STORAGE:

File folders.

RETRIEVABILITY:

Files are kept in alphabetical order according to the last name of the attorney concerned.

SAFEGUARDS:

Files are maintained in file cabinets and other storage devices under the control of authorized personnel during working hours; the office space in which the file cabinets and storage devices are located is locked outside official working hours.

RETENTION AND DISPOSAL:

Records are maintained in office for a minimum of two years. Records are retained for as long as an attorney remains subject to JAG-imposed limitations on practice. Records pertaining to unsubstantiated complaints, or to attorneys who are no longer subject to limitations on practice, are destroyed after 10 years.

SYSTEM MANAGER(S) AND ADDRESS:

Assistant Judge Advocate General (Civil Law), Office of the Judge Advocate General, Department of the Navy, Washington Navy Yard, 1322 Patterson Avenue SE, Suite 3000, Washington, DC 20374-5066.

Director, Judge Advocate Division, 2 Navy Annex, Washington, DC 20380-1775.

NOTIFICATION PROCEDURE:

Individuals seeking to determine whether this system contains information about themselves should address written inquiries to the Deputy Assistant Judge Advocate General (Administrative Law), Office of the Judge Advocate General, Department of the Navy, 1322 Patterson Avenue SE, Suite 3000, Washington, DC 20374-5066; or in the case of USMC attorneys, Judge Advocate Division, Research and Civil Law Branch, 2 Navy Annex, Washington, DC 20380-1775.

The written request should include the full name of the individual concerned and must be signed.

Personal visits may be made to the Deputy Assistant Judge Advocate General (Administrative Law), Suite 7000, Presidential Towers, Arlington, Virginia, or in the case of USMC attorneys, Room 5E588, The Pentagon, Arlington, Virginia, during normal working hours, Monday through Friday, 8 a.m. to 4:30 p.m. Individuals making such visits should be able to provide some acceptable identification, e.g., Armed Forces identification card, driver's license, etc.

RECORD ACCESS PROCEDURES:

Individuals seeking access to information about themselves contained in this system should address written inquiries to the Deputy Assistant Judge Advocate General (Administrative Law), Office of the Judge Advocate General, Department of the Navy, 1322 Patterson Avenue SE, Suite 3000, Washington, DC 20374-5066; or in the case of USMC attorneys, Judge Advocate Division, Research and Civil Law Branch, 2 Navy Annex, Washington, DC 20380-1775.

The written request should include the full name of the individual concerned and must be signed.

Personal visits may be made to the Deputy Assistant Judge Advocate General (Administrative Law), Suite 7000, Presidential Towers, Arlington, Virginia, or in the case of USMC attorneys, Room 5E588, The Pentagon, Arlington, Virginia, during normal working hours, Monday through Friday, 8 a.m. to 4:30 p.m. Individuals making such visits should be able to provide some acceptable identification, e.g., Armed Forces identification card, driver's license, etc.

CONTESTING RECORD PROCEDURES:

The Navy's rules for accessing records, and for contesting contents and appealing initial agency determinations are published in Secretary of the Navy Instruction 5211.5; 32 CFR part 701; or may be obtained from the system manager.

RECORD SOURCE CATEGORIES:

Correspondence from individuals, military judges, staff judge advocates, and other military personnel; correspondence from the Judge Advocate General of other branches of the Armed Forces; investigative reports from Naval Criminal Investigative Service and other offices, correspondence from other military and civilian authorities and copies of court papers.

EXEMPTIONS CLAIMED FOR THE SYSTEM:

None.

[FR Doc. 99–19469 Filed 7–29–99; 8:45 am]

BILLING CODE 5001–10–F

DEPARTMENT OF EDUCATION

Notice of Proposed Information Collection Requests

AGENCY: Department of Education.

ACTION: Notice.

SUMMARY: The Leader, Information Management Group, Office of the Chief Information Officer, invites comments on the proposed information collection requests as required by the Paperwork Reduction Act of 1995.

DATES: Interested persons are invited to submit comments on or before September 28, 1999.

SUPPLEMENTARY INFORMATION: Section 3506 of the Paperwork Reduction Act of 1995 (44 U.S.C. Chapter 35) requires that the Office of Management and Budget (OMB) provide interested Federal agencies and the public an early opportunity to comment on information collection requests. OMB may amend or waive the requirement for public consultation to the extent that public participation in the approval process would defeat the purpose of the information collection, violate State or Federal law, or substantially interfere with any agency's ability to perform its statutory obligations. The Leader, Information Management Group, Office of the Chief Information Officer, publishes that notice containing proposed information collection requests prior to submission of these requests to OMB. Each proposed information collection, grouped by office, contains the following: (1) Type of review requested, e.g. new, revision, extension, existing or reinstatement; (2) Title; (3) Summary of the collection; (4) Description of the need for, and proposed use of, the information; (5) Respondents and frequency of collection; and (6) Reporting and/or Recordkeeping burden. OMB invites public comment.

The Department of Education is especially interested in public comment addressing the following issues: (1) Is this collection necessary to the proper functions of the Department; (2) will this information be processed and used in a timely manner; (3) is the estimate of burden accurate; (4) how might the Department enhance the quality, utility, and clarity of the information to be collected; and (5) how might the Department minimize the burden of this collection on the respondents, including through the use of information technology.

Dated: July 26, 1999.

William E. Burrow,

Leader, Information Management Group, Office of the Chief Information Officer.

Office of Postsecondary Education

Type of Review: Reinstatement.

Title: Reporting Instructions and Forms for the National Resources and Foreign Language and Area Studies Fellowship Program.

Frequency: Annually.

Affected Public: Individuals or households; Not-for-profit institutions.

Reporting and Recordkeeping Burden:

Responses: 1,267.

Burden Hours: 1,491.

Abstract: These instructions and forms provide the U.S. Department of Education the information needed to determine whether grantees have made substantial progress toward meeting their objectives, and to monitor and evaluate these programs.

Requests for copies of this information collection should be addressed to Vivian Reese, U.S. Department of Education, 400 Maryland Avenue, S.W., Room 5624, Regional Office Building 3, Washington, DC 20202–4651, or should be electronically mailed to the Internet address Vivian__Reese@ed.gov, or should be faxed to 202–708–9346.

For questions regarding burden and/or the collection activity requirements, contact Joseph Schubart at 202–708–9266 or by e-mail at joe__schubart@ed.gov. Individuals who use a telecommunications device for the deaf (TDD) may call the Federal Information Relay Service (FIRS) at 1–800–877–8339.

[FR Doc. 99–19491 Filed 7–29–99; 8:45 am]

BILLING CODE 4000–01–P

DEPARTMENT OF EDUCATION

Proposed Information Collection Requests

AGENCY: Department of Education.

SUMMARY: The Leader, Information Management Group, Office of the Chief Information Officer, invites comments on the proposed information collection requests as required by the Paperwork Reduction Act of 1995.

DATES: Interested persons are invited to submit comments on or before September 28, 1999.

SUPPLEMENTARY INFORMATION: Section 3506 of the Paperwork Reduction Act of 1995 (44 U.S.C. Chapter 35) requires that the Office of Management and Budget (OMB) provide interested Federal agencies and the public an early opportunity to comment on information collection requests. OMB may amend or waive the requirement for public consultation to the extent that public participation in the approval process would defeat the purpose of the information collection, violate State or Federal law, or substantially interfere with any agency's ability to perform its statutory obligations. The Leader, Information Management Group, Office of the Chief Information Officer, publishes that notice containing proposed information collection requests prior to submission of these requests to OMB. Each proposed information collection, grouped by office, contains the following: (1) Type of review requested, e.g. new, revision, extension, existing or reinstatement; (2) Title; (3) Summary of the collection; (4) Description of the need for, and proposed use of, the information; (5) Respondents and frequency of collection; and (6) Reporting and/or Recordkeeping burden. OMB invites public comment.

The Department of Education is especially interested in public comment addressing the following issues: (1) Is this collection necessary to the proper functions of the Department; (2) will this information be processed and used in a timely manner; (3) is the estimate of burden accurate; (4) how might the Department enhance the quality, utility, and clarity of the information to be collected; and (5) how might the Department minimize the burden of this collection on the respondents, including through the use of information technology.

Dated: July 27, 1999.

William E. Burrow,

Leader, Information Management Group, Office of the Chief Information Officer.

Office of the Under Secretary

Type of Review: New.

Title: Early Implementation Survey of Gaining Early Awareness and Readiness for Undergraduate Program (GEAR UP) Grantees.

Frequency: One time.

Affected Public: Not-for-profit institutions; State, local or Tribal Gov't, SEAs or LEAs.

Reporting and Recordkeeping Hour Burden:

Responses: 300.

Burden Hours: 300.

Abstract: This study will provide information necessary for selecting sites for the in-depth evaluation of Gaining Early Awareness and Readiness for Undergraduate Programs (GEAR UP) grantees and information on the early implementation of the grants.

Requests for copies of this information collection should be addressed to Vivian Reese, U.S. Department of Education, 400 Maryland Avenue, S.W., Room 5624, Regional Office Building 3, Washington, D.C. 20202–4651, or should be electronically mailed to the Internet address *Vivian*__Reese@ed.gov, or should be faxed to 202–708–9346.

For questions regarding burden and/or the collection activity requirements, contact Joseph Schubart at 202–708–9266 or electronically at his Internet address Joe__Schubart@ed.gov. Individuals who use a telecommunications device for the deaf (TDD) may call the Federal Information Relay Service (FIRS) at 1–800–877–8339.

[FR Doc. 99–19517 Filed 7–29–99; 8:45 am]

BILLING CODE 4000–01–U

DEPARTMENT OF EDUCATION

[CFDA No. 84:031]

William D. Ford Federal Direct Loan Program; Correction

ACTION: Correction notice.

SUMMARY: On July 6, 1999, a notice was published in the **Federal Register** (64 FR 36542–36546) announcing the annual update to the income percentage factors for 1999 which are used to calculate the borrower's monthly payment amount under the income contingent repayment plan in the William D. Ford Direct Loan Program. This information is revised annually to reflect changes in the consumer price index.

On page 36542, the last sentence in the summary paragraph, the notice incorrectly stated that ''these updates are effective from July 1, 2000 to June 30, 2001.'' This notice corrects the sentence to read ''These updates are effective from July 1, 1999 to June 30, 2000.''

FOR FURTHER INFORMATION CONTACT: Donald Watson, U.S. Department of Education, Room 3045, ROB–3, 400 Maryland Avenue, SW, Washington, DC 20202–5400. Telephone: (202) 708–8242. If you use a telecommunications device for the deaf (TDD), you may call the Federal Information Relay Service (FIRS) at 1–800–877–8339 between 8 a.m. and 8 p.m., Eastern Time, Monday through Friday.

Individuals with disabilities may obtain this document in an alternate format (e.g., Braille, large print, audiotape or computer diskette) on request to the contact person listed in the preceding paragraph.

Electronic Access to This Document

You may review this document, as well as all other Department of Education documents published in the **Federal Register**, in text or Adobe Portable Document Format (PDF) on the Internet at the following sites:

http://ocfo.ed.gov/fedreg.htm
http://www.ed.gov/news.html

To use the PDF, you must have the Adobe Acrobat Reader Program with Search, which is available free at either of the previous sites. If you have questions about using the PDF, call the U.S. Government Printing Office (GPO), toll free, at 1–888–293–6498; or in the Washington, DC area at (202) 512–1530.

Note: The official version of this document is the document published in the **Federal Register**. Free internet access to the official edition of the **Federal Register** and the Code of Federal Regulations is available on GPO access at: http://www.access.gpo.gov/nara/index.html

(Program Authority: 20 U.S.C. 1087 *et seq.*)

Dated: July 27, 1999.

Greg Woods,

Chief Operating Officer.

[FR Doc. 99–19627 Filed 7–29–99; 8:45 am]

BILLING CODE 4000–01–P

DEPARTMENT OF ENERGY

Availability of the Draft Environmental Impact Statement (EIS) for the Treatment and Management of Sodium-Bonded Spent Nuclear Fuel

AGENCY: Department of Energy.

ACTION: Notice of availability.

SUMMARY: The Department of Energy announces the availability of the ''Draft Environmental Impact Statement for the Treatment and Management of Sodium-Bonded Spent Nuclear Fuel'' (DOE/EIS–0306D) for public review and comment. This draft EIS, prepared under the National Environmental Policy Act (NEPA), assesses the potential environmental impacts associated with the treatment and management of the Department's sodium-bonded spent nuclear fuel in one or more spent nuclear fuel management facilities: Argonne National Laboratory-West at the Idaho National Engineering and Environmental Laboratory (near Idaho Falls, Idaho) and either the F-Canyon or Building 105–L at the Savannah River Site (near Aiken, South Carolina). The Department is considering ways to prepare the sodium-bonded spent nuclear fuel for disposal in a geologic repository. Such treatment would remove or stabilize the chemically reactive sodium in the fuel. The EIS evaluates reasonable alternatives for treatment of the Department's sodium-bonded spent nuclear fuel and a no-action alternative. The Department has no preferred alternative at this time.

DATES: The Department invites the general public, other Federal agencies, Tribal, State and local Governments to provide comments on this draft EIS. The 45-day comment period extends through September 13, 1999. To ensure consideration in the preparation of the final EIS, comments should be transmitted or postmarked by September 13, 1999. Comments submitted after that date will be considered to the extent practicable. The information obtained during the comment period will assist the Department in preparing the final EIS, which is scheduled to be completed by December 31, 1999.

During the review period, the Department will hold public hearings to discuss the proposed action and to receive oral and written comments on the draft EIS. The hearings are scheduled for the following dates, times, and locations.

August 17, 1999, (6:00 p.m. to 9:00 p.m.), North Augusta Community Center, 495 Brookside Avenue, North Augusta, South Carolina 29842, (803) 441–4290

August 24, 1999, (6:00 p.m. to 9:00 p.m.), Owyhee Plaza Hotel, 1109 Main Street, Boise, Idaho 83702, (208) 343–4611

August 26, 1999, (6:00 p.m. to 9:00 p.m.), Shilo Inn, 780 Lindsay Boulevard, Idaho Falls, Idaho 83402, (208) 523–0088

August 31, 1999, (2:00 p.m. to 5:00 p.m.), Hyatt Regency Crystal City, 2799 Jefferson Davis Highway, Arlington, Virginia 22202, (703) 418–1234

The format for the hearings will include an opportunity for informal discussions with project personnel before and after the formal presentation. After the presentation, there will be an opportunity to provide comments on the draft EIS to Departmental representatives. The Department encourages those providing oral comments at the hearings to also submit them in writing. Comment forms will be available at the hearings for those who prefer to submit their comments in writing.

The Department will make transcripts of the draft EIS hearings, copies of background documents, and other materials related to the proposed project and development of the EIS available for public review in the following reading rooms:

Washington, D.C.: U. S. Department of Energy, Freedom of Information Reading Room, Forrestal Building, Room 1E–190,

1000 Independence Avenue, S.W., Washington, D.C. 20585–0117, 202–586–3142

Idaho Falls, Idaho: Idaho National Engineering and Environmental Laboratory, DOE-Idaho Operations Office Public Reading Room, 1776 Science Center Drive, Idaho Falls, Idaho 83415, 208–526–0271

Richland, Washington: DOE Public Reading Room, 2770 University Drive, CIC, Room 101L, Richland, Washington 99352, 509–372–7443

Albuquerque, New Mexico: University of New Mexico, Government Information Department, Zimmerman Library, Albuquerque, New Mexico 87131, 505–277–0582

Aiken, South Carolina: University of South Carolina-Gregg Graniteville Library, 471 University Parkway, Aiken, South Carolina 29803, 803–648–6851

Oak Ridge, Tennessee: DOE Public Reading Room, 230 Warehouse Road, Building 1916–T–2, Suite 300, Oak Ridge, Tennessee 37831, 423–241–4780 and the DOE Information Resource Center, 105 Broadway Avenue, Oak Ridge, Tennessee 37830, 423–241–4582

ADDRESSES: Written comments on the draft EIS, requests for special arrangements to enable participation in the hearings (e.g., an interpreter for the hearing impaired), requests to be placed on the EIS distribution list, and questions concerning the project should be sent to: Ms. Susan M. Lesica, EIS Document Manager, Office of Nuclear Facilities Management, Office of Nuclear Energy, Science and Technology, U.S. Department of Energy, NE–40, 19901 Germantown Road, Germantown, Maryland 20874–1290.

Comments and requests may also be submitted by toll free facsimile to (877) 621–8288 or telephone (877) 450–6904. Comments and requests may also be submitted by electronic mail to emtEIS@hq.doe.gov.

FOR FURTHER INFORMATION CONTACT: For general information on the Department's National Environmental Policy Act (NEPA) process, please contact: Ms. Carol M. Borgstrom, Director, Office of NEPA Policy and Assistance (EH–42), Office of Environment, Safety and Health, U.S. Department of Energy, 1000 Independence Avenue, SW Washington, DC 20585–0119; or telephone (202) 586–4600 or leave a message at 1–800–472–2756.

SUPPLEMENTARY INFORMATION: The Department is responsible for the safe and efficient management of several types of spent nuclear fuel including its ultimate disposition (that is expected to be disposal in a geologic repository). Some Departmental spent fuels may be suitable for disposal with little or no stabilizing treatment. Other spent fuel types may not be suitable for disposal without significant treatment or stabilization.

One type of spent nuclear fuel that may not be suitable for disposal without treatment is sodium-bonded spent nuclear fuel. Sodium-bonded spent nuclear fuel contains metallic sodium, a highly chemically reactive material. Metallic sodium reacts vigorously with water or moist air producing heat, potentially explosive hydrogen gas, and sodium hydroxide, a corrosive substance. Sodium metal was used as a heat transfer medium within the stainless steel cladding of sodium-bonded fuel and as coolant in the nuclear reactors in which these fuels were used. To the extent possible, the highly reactive sodium has been removed from external surfaces of these fuels after their use, but a portion remains bonded to the uranium metal alloy fuel within the cladding and cannot be removed without further treatment. The presence of reactive or pyrophoric material such as metallic sodium, could complicate the process of qualifying and licensing such spent fuel for disposal, which would require data and predictive analyses sufficient to demonstrate that emplacement of the spent fuel would not adversely affect a repository's ability to protect the environment and public health.

The Department believes that treatment to remove metallic sodium and convert this spent nuclear fuel into a compact waste form would facilitate disposal qualification of this fuel. Technologies for spent nuclear fuel treatment that might facilitate such qualification should, therefore, be considered in deciding how to manage Department-owned sodium-bonded fuels. The EIS analyzes, under the proposed action, six reasonable alternatives that employ one or more of the following technology options: electrometallurgical treatment; the plutonium-uranium extraction process; packaging in high-integrity cans; and the melt and dilute treatment process. The EIS also evaluates a no action alternative, under which the sodium-bonded spent nuclear fuel would continue to be stored indefinitely; The Department would pursue research and development of a new treatment technology or would directly dispose of the sodium-bonded spent nuclear fuel in high-integrity cans without treatment.

The Department has not identified a preferred alternative in the draft EIS. Environmental analysis in this EIS, public comments, the findings of an independent cost study and a nonproliferation report that are being prepared concurrently with the EIS, as well as other program policy factors, will be considered in determining a preferred alternative in the final EIS. A Record of Decision will be issued no sooner than 30 days after the final EIS has been distributed.

Issued in Washington, D.C., this 22, day of July 1999.

William D. Magwood, IV,

Director, Office of Nuclear Energy, Science and Technology.

[FR Doc. 99–19522 Filed 7–29–99; 8:45 am]

BILLING CODE 6450–01–P

DEPARTMENT OF ENERGY

Energy Information Administration

Agency Information Collection Under Review by the Office of Management and Budget

AGENCY: Energy Information Administration, Department of Energy.

ACTION: Submission for OMB review; comment request.

SUMMARY: The Energy Information Administration (EIA) has submitted the energy information collection(s) listed at the end of this notice to the Office of Management and Budget (OMB) for review under section 3507(a)(1)(D)of the Paperwork Reduction Act of 1995 (Pub. L. 104–13). The listing does not include collections of information contained in new or revised regulations, which are to be submitted under section 3507(d)(1)(A) of the Paperwork Reduction Act, nor management and procurement assistance requirements collected by the Department of Energy (DOE). Each entry contains the following information: (1) Collection number and title; (2) summary of the collection of information (includes sponsor (the DOE component)), current OMB document number (if applicable), type of request (new, revision, extension, or reinstatement); response obligation (mandatory, voluntary, or required to obtain or retain benefits); (3) a description of the need and proposed use of the information; (4) description of the likely respondents; and (5) estimate of total annual reporting burden (average hours per response × proposed frequency of response per year × estimated number of likely respondents.)

DATES: Comments must be filed on or before August 30, 1999. If you anticipate that you will be submitting comments but find it difficult to do so within the time allowed by this notice, you should advise the OMB DOE Desk Officer listed below of your intention to do so as soon as possible. The Desk Officer may be telephoned at (202) 395–3084. (Also,

please notify the EIA contact listed below.)

ADDRESSES: Address comments to the Department of Energy Desk Officer, Office of Information and Regulatory Affairs, Office of Management and Budget, 726 Jackson Place NW, Washington, DC 20503. (Comments should also be addressed to the Office of Statistical Standards at the address below.)

FOR FURTHER INFORMATION CONTACT: Requests for additional information should be directed to Grace Sutherland, Statistics and Methods Group, (EI–70), Forrestal Building, U.S. Department of Energy, Washington, DC 20585. Mrs. Sutherland may be reached by telephone at (202) 426-1068; by FAX at (202) 426–1083; or e-mail at grace.sutherland@eia.doe.gov.

SUPPLEMENTARY INFORMATION: The energy information collections submitted to OMB for review were:

1. EIA–14, 182, 782A/B/C, 821, 856, 863, 877, 878, and 888, ''Petroleum Marketing Program.''
2. Energy Information Administration, OMB No. 1905–0174, Extension, Mandatory.
3. The Petroleum Marketing Program surveys collect information on costs, sales, prices, and distribution for crude oil and petroleum products. Data are published in petroleum publications and in multifuel reports.
4. Respondents are refiners, first purchasers, gas plant operators, resellers/retailers, motor gasoline wholesalers, suppliers, distributors and importers.
5. 138,729 hours (1.2 hrs. × 3.4 responses per year × 34,876 respondents).

Statutory Authority: 44 U.S.C. 3506(a)(2)(A) of the Paperwork Reduction Act of 1995 (Pub. L. 104–13).

Issued in Washington, DC, July 26, 1999.

Lynda T. Carlson,

Director, Statistics and Methods Group, Energy Information Administration.

[FR Doc. 99–19521 Filed 7–29–99; 8:45 am]

BILLING CODE 6450–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. CP99–584–000]

Koch Gateway Pipeline Company; Notice of Application

July 26, 1999.

Take notice that on July 16, 1999, Koch Gateway Pipeline Company (Koch), P.O. Box 1478, Houston, Texas 77521–1478, filed in Docket No. CP99–584–000 under section 7(c) of the Natural Gas Act, for authority to construct and operate 3.9 miles of 24-inch loop pipeline in Mobile County, Alabama, all as more fully set forth in the application which is on file with the Commission and open to public inspection. This filing may be viewed on the web at http://www.ferc.us/online/rims.htm. Call 202–208–2222 for assistance. The name, address, and telephone number of the person to whom correspondence and communications concerning this application should be addressed is: Kyle Stephens, Director of Certificates, Koch Gateway Pipeline Company, P.O. Box 1478 Houston, Texas 77251–1478, Tel: (713) 544–7309, Fax: (713) 544–4818.

Koch states that the cost of the proposed facilities is $6,095,000. Koch is proposing this construction so that it can transport 15,000 Dth per day (Dth/d) for Southern Services, Inc., (SCS) acting as agent for Alabama Power Company (APC). This gas will be used by APC to fuel gas fired electric generation facilities being constructed at Plant Barry. Gas will be provided to Koch for APC's account at primary receipts points by APC's upstream suppliers, these volumes will then be shipped by Koch to an interconnection with Bay Gas on Koch's Index 301–8–10 line. Bay Gas will then transport the volumes on its intrastate line to APC's Plant Barry. Koch states that the proposed looping will allow it to inject the additional 15,000 Dth/d into the system of Bay Gas for delivery to Plant Barry. Service on Koch's system for APC will be provided under its Rate Schedule FTS.

Any person desiring to participate in the hearing process or to make any protest with reference to said application should on or before August 16, 1999, file with the Federal Energy Regulatory Commission, 888 First Street, NE, Washington, DC 20426, a motion to intervene or a protest in accordance with the requirements of the Commission's rules of practice and procedure (18 CFR 385.214 or 385.211) and the regulations under the Natural Gas Act (18 CFR 157.10). All protests filed with the Commission will be considered by it in determining the appropriate action to be taken but will not serve to make the protestants parties to the proceeding. The Commission's rules require that protestors provide copies of their protest to the party or parties directly involved. Any person wishing to become a party to a proceeding or to participate as a party in any hearing therein must file a motion to intervene in accordance with the Commission's rules.

Any person obtaining intervener status will be placed on the service list maintained by the Secretary of the Commission and will receive copies of all documents filed by the applicant and by every one of the interveners. An intervener can file for rehearing of any Commission order and can petition for court review of any such order. However, an intervener must submit copies of comments or any other filing it makes with the Commission to every other intervener in the proceeding, as well as 14 copies with the Commission.

A person does not have to intervene, however in order to have comments considered. A person, instead, may submit two copies of comments to the Secretary of the Commission. Commenters will be placed on the Commission's environmental mailing list, will receive copies of environmental documents and will be able to participate in meeting associated with the Commission's environmental review process. Commenters will not be required to serve copies of filed documents on all other parties. However, commenters will not receive copies of all documents filed by other parties or issued by the Commission and will not have the right to seek rehearing or appeal the Commission's final order to a federal court.

The Commission will consider all comments and concerns equally, whether filed by commenters or those requesting intervener status.

Take further notice that, pursuant to the authority contained in an subject to the jurisdiction conferred upon the Federal Energy Regulatory Commission by sections 7 and 15 of the Natural Gas Act and the Commission's Rules of Practice and Procedure, a hearing will be held without further notice before the Commission or its designee on this application if no motion to intervene is filed within the time required therein, if the Commission on its own review of the matter finds that grant of the certificate is required by the public convenience and necessity. If a motion for leave to intervene is timely filed, or if the Commission on its own motion believes that a formal hearing is required, further notice of such hearing will be duly given.

Under the procedure herein provided for, unless otherwise advised, it will be unnecessary for Koch to appear or to be represented at the hearing.

David P. Boergers,

Secretary.

[FR Doc. 99–19524 Filed 7–29–99; 8:45 am]

BILLING CODE 6717–01–M

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

Order Granting Rehearing for Purpose of Further Consideration, Granting Late Motions To Intervene and Establishing Procedures for Additional Late Motions To Intervene and Answers

Issued July 26, 1999.

Before Commissioners: James J. Hoecker, Chairman; Vicky A. Bailey, William L. Massey, Linda Breathitt, and Curt Hébert, Jr.

In the matter of Docket Nos.: ER96–2573–003, ER94–24–030, ER98–13–010, ER99–1751–002, ER97–654–010, ER95–428–019, ER96–25–016, ER94–968–027, ER98–1005–006, ER95–1615–018, ER99–1004–002, ER93–730–013, ER96–2921–015, ER95–1625–020, ER99–1714–001, ER98–830–005, ER98–4400–002, ER95–1007–013, ER98–6–007, ER98–107–007, ER97–2261–010, ER94–1384–023, ER96–2408–013, ER94–1685–025, ER95–892–043, ER96–2652–031, ER99–894–002, ER99–893–002, ER99–892–002, ER99–892–002, ER99–891–002, ER95–393–023, ER99–1722–001, ER97–4587–001, ER99–1801–002, ER99–2082–001, ER99–2080–001, ER99–2081–001, ER99–2083–001, ER99–2079–001, ER98–4540–001, ER94–1188–028, ER99–2108–001, ER99–1125–002, ER98–1278–004; Southern Company Services, Inc., Enron Power Marketing, Inc., Enron Energy Services, Inc., Aquila Energy Marketing Corporation, Engage Energy US, L.P., El Paso Power Services Company, Coral Power, L.L.C., Electric Clearinghouse, Inc., Merchant Energy Group of the Americas, Entergy Power Marketing Corp., Entergy Nuclear Generation Company, Cinergy Capital & Trading, Inc., Duke Energy Trading and Marketing, L.L.C., PG&E Energy Trading Power, L.P., Lake Road Generating Company, L.P., Millenium Power Partners, L.P., Pittsfield Generating Company, L.P., Logan Generating Company, L.P., USGen New England, Inc., Sithe Power Marketing, Inc., Constellation Power Source, Inc., Morgan Stanley Capital Group Inc., Avista Energy, Inc., Citizens Power Sales, CL Power Sales (1–5), L.L.C., CL Power Sales (6–10), L.L.C., CL Power Sales 11, L.L.C., CL Power Sales 12, L.L.C., CL Power Sales 13, L.L.C., CL Power Sales 14, L.L.C., CL Power Sales 15, L.L.C., Hartford Power Sales, L.L.C., Williams Energy Marketing & Trading Company, Williams Generation CompanyHazelton, Reliant Energy Services, Inc., Reliant Energy Coolwater, L.L.C., Reliant Energy Mandalay, L.L.C., Reliant Energy Ellwood, L.L.C., Reliant Energy Etiwanda, L.L.C., Reliant Energy Ormond Beach, L.L.C., Louisville Gas and Electric Company and Kentucky Utilities Company, LG&E Energy Marketing Inc., LG&E Capital Corp., LG&E Westmoreland Renssalaer, Western Kentucky Energy Corp.

Southern Company Services, Inc. and Southern Company Energy Marketing L.P.; Electricity Consumers Resource Council and American Iron & Steel Institute (Industrial Customers); Virginia Electric and Power Company (Virginia Power); Enron Power Marketing, Inc. and Enron Energy Services, Inc.; Aquila Energy Marketing Corporation; Engage Energy US, L.P. (Engage Energy); El Paso Power Services Company; Coalition for a Competitive Electricity Market and National Energy Marketers Association (CCEM); the Ad Hoc Marketing and Power Producer Group; PG&E Energy Trading Power, L.P., Lake Road Generating Company, L.P., Millennium Power Partners, L.P., Pittsfield Generating Company, L.P., Logan Generating Company, L.P., USGen New England, Inc., Sithe Power Marketing, Inc., and Constellation Power Source, Inc.; Electric Power Supply Association (EPSA); Morgan Stanley Capital Group Inc. and Avista Energy, Inc.; Edison Electric Institute (EEI); Citizens Power Marketing Affiliates; Williams Energy Marketing & Trading Company and Williams Generation Company-Hazelton; and Reliant Energy Services, Inc., Reliant Energy Coolwater, L.L.C., Reliant Energy Mandalay, L.L.C., Reliant Energy Ellwood, L.L.C., Reliant Energy Etiwanda, L.L.C., and Reliant Energy Ormond Beach, L.L.C. filed timely requests for rehearing of the Commission's order issued in this proceeding. *Southern Company Services, Inc., et al.*, 87 FERC ¶ 61,214 (1999) (*Southern*). Louisville Gas and Electric Company and Kentucky Utilities Company (LG&E and Kentucky Utilities), LG&E Energy Marketing Inc., LG&E Capital Corp., LG&E Westmoreland Renssalaer, and Western Kentucky Energy Corp. filed a late request for rehearing.

In the absence of Commission action within 30 days, the requests for rehearing would be deemed denied. 18 CFR § 385.713. In order to allow additional time for consideration of the matters raised, rehearing of the order is hereby granted for the limited purpose of further consideration.

In addition, Virginia Power, Engage Energy, CCEM, EPSA, EEI, Industrial Customers, LG&E and Kentucky Utilities filed motions for late intervention. The *Southern* order was an exception to the Commission's general practice of not permitting late interventions for the purpose of filing requests for rehearing; the order delayed the effectiveness of the new reporting requirements announced therein pending Commission action on the requests for rehearing of that order and the order also stated that the Commission would entertain late motions to intervene in this proceeding for the purpose of filing requests for rehearing. In view of the aforementioned exception to the Commission's general practice, no undue prejudice or delay would result from granting the late interventions. Accordingly, we grant the motions for late intervention for good cause shown.

We will also make an exception to the Commission's general practice of not allowing answers to requests for rehearing. Accordingly, we will allow parties to file answers to the requests for rehearing, and we will entertain late motions to intervene from other interested persons for the purpose of filing answers to the requests for rehearing. Such answers and late motions to intervene should be filed on or before 30 days from the date of this order.

By the Commission.

David P. Boergers,

Secretary.

[FR Doc. 99–19527 Filed 7–29–99; 8:45 am]

BILLING CODE 6717–01–M

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. CP99–585–000]

Texas Eastern Transmission Corporation Transcontinental Gas Pipe Line Corporation; Notice of Application

July 26, 1999.

Take notice that on July 19, 1999, Texas Eastern Transmission Corporation (Texas Eastern), P.O. Box 1642, Houston, Texas 77251–1642, and Transcontinental Gas Pipe Line Corporation (Transco), P.O. Box 1396, Houston, Texas 77251–1396 filed, in Docket No. CP99–585–000, a joint application pursuant to Sections 7(b) of the Natural Gas Act and Part 157 of the Commission's Regulations for an order permitting and approving the abandonment of transportation service, as more fully set forth in the application which is on file with the Commission and open to public inspection. The application may be viewed on the web at www.ferc.fed.us/online/rims.htm. Call (202) 208–2222 for assistance.

Specifically, Texas Eastern and Transco request permission to abandon transportation service as described in Texas Eastern's Gas Transportation Agreement under Rate Schedule X–96 and Transco's Rate Schedule X–201. Texas Eastern and Transco state that the transportation service rendered under these rate schedules should be abandoned as it is no longer needed and all the parties have agreed to terminate the service.

Any questions regarding this application should be directed to S.E.

Tillman, Director of Regulatory Affairs for Texas Eastern, P.O. Box 1642, Houston, Texas 77251–1642 at (713) 627–5113 or Alfred E. White, Jr., Senior Attorney for Transco, P.O. Box 1396, Houston Texas 77251–1396 at (713) 215–2000.

Any person desiring to be heard or to make any protest with reference to said application should on or before August 16, 1999, file with the Federal Energy Regulatory Commission, 888 First Street, N.E., Washington, D.C. 20426, a motion to intervene or a protest in accordance with the requirements of the Commission's Rules of Practice and Procedure (18 CFR 385.214 and 385.211) and the regulations under the Natural Gas Act (18 CFR 157.10). All protests filed with the Commission will be considered by it in determining the appropriate action to be taken but will not serve to make the protestants parties to the proceeding. Any person wishing to become a party in any proceeding herein must file a motion to intervene in accordance with the Commission's rules.

Take further notice that, pursuant to the authority contained in and subject to the jurisdiction conferred upon the Commission by Sections 7 and 15 of the Natural Gas Act and the Commission's Rules of Practice and Procedure, a hearing will be held without further notice before the Commission or its designee on this application if no protest or motion to intervene is filed within the time required herein. At that time, the Commission on its own review of the matter will determine whether granting permission and approval for the proposed abandonment is required by the public convenience and necessity. If a motion for leave to intervene is timely filed, or if the Commission on its own motion believes that formal hearing is required, further notice of such hearing will be duly given.

Under the procedure herein provided for, unless otherwise advised, it will be unnecessary for Texas Eastern or Transco to appear or to be represented at the hearing.

David P. Boergers,

Secretary.

[FR Doc. 99–19526 Filed 7–29–99; 8:45 am]

BILLING CODE 6717–01–M

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. ER99–2769–001, et al.]

Foote Creek III L.L.C., et al.; Electric Rate and Corporate Regulation Filings

July 20, 1999.

Take notice that the following filings have been made with the Commission:

1. Foote Creek III, LLC

[Docket No. ER99–2769–001]

Take notice that on July 15, 1999, Foote Creek III, LLC tendered for filing its compliance filing, Supplement No. 1, to the Foote Creek III, LLC, FERC Electric Tariff, Original Volume No. 1, revising its FERC Electric Tariff, Original Volume No. 1 to allow sales to any purchaser.

Comment date: August 4, 1999, in accordance with Standard Paragraph E at the end of this notice.

2. AES Alamitos, L.L.C., AES Huntington Beach, L.L.C. and AES Redondo Beach, L.L.C.

[Docket Nos. ER98–2184–004, ER98–2185–004, ER98–2186–004, ER98–2184–004, ER98–2185–004, and ER98–2186–004]

Take notice that on July 15, 1999, AES Alamitos, L.L.C., AES Huntington Beach, L.L.C. and AES Redondo Beach, L.L.C. (AES Companies), tendered for filing under Section 205 of the Federal Power Act an executed long-term electric service agreement, as amended, between the AES Companies and Williams Energy Services Company.

Comment date: August 4, 1999, in accordance with Standard Paragraph E at the end of this notice.

3. Pacific Gas and Electric Company

[Docket No. ER99–2884–001]

Take notice that on July 15, 1999, Pacific Gas and Electric Company (PG&E), tendered for filing as part of its Electric Service Tariff, Volume No. 6, revised tariff sheets. PG&E states that the revisions to the sheets removes an incorrect reference to a superseded version of the California ISO's Grid Management Charge and is submitted to comply with the Commission's July 1, 1999 Order, in the above-referenced docket. PG&E requests an effective date of July 1, 1999.

PG&E states that this filing has been served on the California Public Utilities Commission, San Francisco Bay Area Rapid Transit District and all parties listed on the official service list in the above-referenced docket.

Comment date: August 4, 1999, in accordance with Standard Paragraph E at the end of this notice.

4. Carolina Power & Light Company

[Docket No. ER99–3570–000]

Take notice that on July 14, 1999, Carolina Power & Light Company (CP&L), tendered for filing an executed Service Agreement with Tractebel Energy Marketing, Inc. under the provisions of CP&L's Market-Based Rates Tariff, FERC Electric Tariff No. 4. This Service Agreement supersedes the un-executed Agreement originally filed in Docket No. ER98–3385–000 and approved effective May 18, 1998.

Copies of the filing were served upon the North Carolina Utilities Commission and the South Carolina Public Service Commission.

Comment date: August 3, 1999, in accordance with Standard Paragraph E at the end of this notice.

5. The Legacy Energy Group, LLC

[Docket Nos. ER99–3571–000]

Take notice that on July 14, 1999, The Legacy Energy Group, Inc. (Legacy), submitted a Notice of Succession pursuant to Section 35.16 of the Commission's Regulations, 18 CFR 35.16. As a result of a name change, Legacy is succeeding to the Rate Schedule FERC No. 1 of The Legacy Group, Inc., effective June 11, 1999.

Comment date: August 3, 1999, in accordance with Standard Paragraph E at the end of this notice.

6. Alliant Energy Corporate Services Inc.

[Docket No. ER99–3572–000]

Take notice that on July 14, 1999, Alliant Energy Corporate Services Inc. (ALTM), tendered for filing a signed Service Agreement under ALTM's Market Based Wholesale Power Sales Tariff (MR–1) between itself and Commonwealth Edison Company (CE).

ALTM respectfully requests a waiver of the Commission's notice requirements, and an effective date of July 13, 1999.

Comment date: August 3, 1999, in accordance with Standard Paragraph E at the end of this notice.

7. Southern Indiana Gas & Electric

[Docket No. ER99–3573–000]

Take notice that on July 15, 1999, Southern Indiana Gas & Electric Company (SIGECO), tendered for filing two (2) Service Agreements for market based rate power sales under its Market Based Rate Tariff with DTE Energy Trading, Inc., and East Kentucky Power Cooperative, Inc.

Copies of the filing were served upon each of the parties to the Service Agreements.

Comment date: August 4, 1999, in accordance with Standard Paragraph E at the end of this notice.

8. PP&L, Inc.

[Docket No. ER99–3574–000]

Take notice that on July 15, 1999, PP&L, Inc. (PP&L), tendered for filing a partially executed Service Agreement dated July 13, 1999, with Edison Mission Marketing & Trading, Inc. (EMMT) under PP&L's Market-Based Rate and Resale of Transmission Rights Tariff, FERC Electric Tariff, Revised Volume No. 5. The Service Agreement adds EMMT as an eligible customer under the Tariff.

PP&L requests an effective date of July 15, 1999, for the Service Agreement.

PP&L states that copies of this filing have been supplied to EMMT and to the Pennsylvania Public Utility Commission.

Comment date: August 4, 1999, in accordance with Standard Paragraph E at the end of this notice.

9. Tampa Electric Company

[Docket No. ER99–3575–000]

Take notice that on July 15, 1999, Tampa Electric Company (Tampa Electric), tendered for filing a service agreement with the Reedy Creek Improvement District (RCID) under Tampa Electric's Market-Based Sales Tariff.

Tampa Electric proposes that the service agreement be made effective on July 1, 1999.

Copies of the filing have been served on RCID and the Florida Public Service Commission.

Comment date: August 4, 1999, in accordance with Standard Paragraph E at the end of this notice.

10. Northern States Power Company

[Docket No. ER99–3576–000]

Take notice that on July 15, 1999, Northern States Power Company (Minnesota) (NSP), tendered for filing the Connection Agreement No. 57 for the Grove City Point of Connection, and Connection Agreement No. 58 for the Airtech Point of Connection (Agreements), between NSP and Cooperative Power Association (CPA). These Agreements recognize two new points of delivery between NSP and CPA.

NSP requests that the Commission accept the Agreements effective July 14, 1999, and requests waiver of the Commission's notice requirements in order for the revisions to be accepted for filing on the date requested.

Comment date: August 4, 1999, in accordance with Standard Paragraph E at the end of this notice.

11. Carolina Power & Light Company

[Docket No. ER99–3577–000]

Take notice that on July 15, 1999, Carolina Power & Light Company (CP&L), tendered for filing a Service Agreement for Short-Term Firm Point-to-Point Transmission Service with Reliant Energy Services, Inc. Service to this Eligible Customer will be in accordance with the terms and conditions of Carolina Power & Light Company's Open Access Transmission Tariff.

CP&L is requesting an effective date of July 6, 1999 for this Agreement.

Copies of the filing were served upon the North Carolina Utilities Commission and the South Carolina Public Service Commission.

Comment date: August 4, 1999, in accordance with Standard Paragraph E at the end of this notice.

12. Carolina Power & Light Company

[Docket No. ER99–3578–000]

Take notice that on July 15, 1999, Carolina Power & Light Company (CP&L), tendered for filing Service Agreements for Short-Term Firm Point-to-Point Transmission Service and Non-Firm Point-to-Point Transmission Service with TXU Energy Trading Company. Service to this Eligible Customer will be in accordance with the terms and conditions of Carolina Power & Light Company's Open Access Transmission Tariff.

CP&L is requesting an effective date of July 7, 1999 for each Agreement.

Copies of the filing were served upon the North Carolina Utilities Commission and the South Carolina Public Service Commission.

Comment date: August 4, 1999, in accordance with Standard Paragraph E at the end of this notice.

13. Fitchburg Gas and Electric Light Company

[Docket No. ER99–3579–000]

Take notice that on July 15, 1999, Fitchburg Gas and Electric Light Company (Fitchburg), tendered for filing under Part 35 of the Commission's Regulations, 18 CFR Part 35, the Entitlement Sale and Administrative Services Agreement between Fitchburg Gas and Electric Light Company and Select Energy, Inc., dated May 17, 1999 (the Agreement).

Fitchburg requests that the Agreement be permitted to become effective August 30, 1999.

Copies of the filing were served upon the Massachusetts Department of Telecommunications and Energy.

Comment date: August 4, 1999, in accordance with Standard Paragraph E at the end of this notice.

14. Allegheny Power Service Corporation, on behalf of Monongahela Power Company, The Potomac Edison Company and West Penn Power Company (Allegheny Power)

[Docket No. ER99–3581–000]

Take notice that on July 15, 1999, Allegheny Power Service Corporation on behalf of Monongahela Power Company, The Potomac Edison Company and West Penn Power Company (Allegheny Power) and West Penn Power Company (Allegheny Energy), tendered for filing Amendment Nos. 1 and 2 to Supplement No. 3 to the Market Rate Tariff and Amendment Nos. 1 and 2 to Supplement No. 6 to the Standard Generation Service Tariff to incorporate Netting Agreements with Rainbow Energy Marketing Corp. into the tariff provisions.

Allegheny Power and Allegheny Energy request a waiver of notice requirements to make the Amendments effective as of the effective dates therein, June 16, 1999.

Copies of the filing have been provided to the Public Utilities Commission of Ohio, the Pennsylvania Public Utility Commission, the Maryland Public Service Commission, the Virginia State Corporation Commission, the West Virginia Public Service Commission, and all parties of record.

Comment date: August 4, 1999, in accordance with Standard Paragraph E at the end of this notice.

15. Allegheny Power Service Corporation, on behalf of Monongahela Power Company, The Potomac Edison Company and West Penn Power Company (Allegheny Power)

[Docket No. ER99–3582–000]

Take notice that on July 15, 1999, Allegheny Power Service Corporation on behalf of Monongahela Power Company, The Potomac Edison Company and West Penn Power Company (d/b/a Allegheny Energy) tendered for filing Amendment Nos. 1 and 2 to Supplement No. 10 to the Market Rate Tariff and Amendment Nos. 1 and 2 to Supplement No. 8 to the Standard Generation Service Tariff to incorporate Netting Agreements with CNG Power Services into the tariff provisions.

Allegheny Power and Allegheny Energy request a waiver of notice

requirements to make the Amendments effective as of the effective dates therein, June 21, 1999.

Copies of the filing have been provided to the Public Utilities Commission of Ohio, the Pennsylvania Public Utility Commission, the Maryland Public Service Commission, the Virginia State Corporation Commission, the West Virginia Public Service Commission, and all parties of record.

Comment date: August 4, 1999, in accordance with Standard Paragraph E at the end of this notice.

16. Pacific Gas and Electric Company

[Docket No. ER99–3603–000]

Take notice that on July 16, 1999, Pacific Gas and Electric Company (PG&E), tendered for filing a proposed unexecuted Must-Run Service Agreement (Agreement) for the 35 MVar/45MW synchronous condenser/emergency gas turbine located at the FMC Substation in San Jose, California. Under the Agreement PG&E proposes to provide reliability must-run services to the California Independent System Operator Corporation.

Copies of this filing have been served upon the California Public Utilities Commission and the California Independent System Operator Corporation.

Comment date: August 5, 1999, in accordance with Standard Paragraph E at the end of this notice.

Standard Paragraphs

E. Any person desiring to be heard or to protest such filing should file a motion to intervene or protest with the Federal Energy Regulatory Commission, 888 First Street, N.E., Washington, D.C. 20426, in accordance with Rules 211 and 214 of the Commission's Rules of Practice and Procedure (18 CFR 385.211 and 385.214). All such motions or protests should be filed on or before the comment date. Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceeding. Any person wishing to become a party must file a motion to intervene. Copies of these filings are on file with the Commission and are available for public inspection. This filing may also be viewed on the Internet at http://www.ferc.fed.us/online/rims.htm (call 202–208–2222 for assistance).

Linwood A. Watson, Jr.,

Acting Secretary.

[FR Doc. 99–19486 Filed 7–29–99; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. EC99–93–000, et al.]

Niagara Mohawk Power Corporation, et al.; Electric Rate and Corporate Regulation Filings

July 21, 1999.

Take notice that the following filings have been made with the Commission:

1. Niagara Mohawk Power Corporation, Rochester Gas and Electric Corporation, N.G. Energy, Inc.; and Oswego Harbor Power LC.

[Docket No. EC99–93–000]

Take notice that on July 16, 1999 Niagara Mohawk Power Corporation, Rochester Gas and Electric Corporation, N.G. Energy, Inc. and Oswego Harbor Power LC, tendered for filing an application pursuant to Section 203 of the Federal Power Act seeking authorization for the sale of facilities under Section 203 of the Federal Power Act.

Comment date: August 16, 1999, in accordance with Standard Paragraph E at the end of this notice.

2. California Independent System Operator and Corporation

[Docket Nos. EC96–19–047 and ER96–1663–049]

Take notice that on July 8, 1999, the California Independent System Operator Corporation (IS) tendered for filing a supplemental compliance filing in the above-identified dockets. The filing consists of an amendment to the IS's Bylaws that would extend the initial term of the IS's Board of Governors to March 31, 2000.

The IS states that this filing has been served upon all persons on the official service list in the above-identified dockets.

Comment date: August 9, 1999, in accordance with Standard Paragraph E at the end of this notice.

3. Glen Park Associates Limited Partnership, Niagara Mohawk Power Corporation, Northbrook New York, L.L.C.

[Docket Nos. EC99–94–000 and ER99–3623–000]

Take notice that on July 16, 1999, Glen Park Associates Limited Partnership (Glen Park), Niagara Mohawk Power Corporation (NMPC), and Northbrook New York, L.L.C. (Northbrook) (collectively Applicants) submitted for filing an application seeking an order pursuant to Section 203 of the Federal Power Act (FPA) authorizing Glen Park and NMPC to transfer to Northbrook interests in certain transmission facilities at the 32.65 MW Glen Park Hydroelectric Project on the Black River in Jefferson County, NY, in association with Northbrook's acquisition of the project. Also submitted by the Applicants pursuant to Section 205 of the FPA was an application requesting acceptance and approval of three agreements pertaining to the sale of power from the project. Approval of those filings will enable Northbrook to acquire the project and sell project output to NMPC. Applicants have also filed in a separate docket an application seeking a transfer of the license for the project pursuant to Section 8 of the FPA.

Copies of these filings have been served on the New York Public Service Commission.

Comment date: August 16, 1999, in accordance with Standard Paragraph E at the end of this notice.

4. Guadalupe Power Partners, LP

[Docket No. EG99–196–000]

Take notice that on July 16, 1999, Guadalupe Power Partners, LP (Guadalupe Power), with its principal offices at 4100 Spring Valley Road, Suite 1001, Dallas, Texas 75244, filed with the Federal Energy Regulatory Commission an application for redetermination of exempt wholesale generator status pursuant to Section 32 of the Public Utility Holding Company Act of 1935, as amended, and Part 365 of the Commission's regulations.

Guadalupe Power is a Delaware limited partnership which will construct, own and operate a 1000 MW natural gas-fired generating facility within the region governed by the Electric Reliability Council of Texas (ERCOT) and sell electricity at wholesale.

Comment date: August 11, 1999, in accordance with Standard Paragraph E at the end of this notice. The Commission will limit its consideration of comments to those that concern the adequacy or accuracy of the application.

5. Lakewood Cogeneration Limited Partnership

[Docket No. EG99–197–000]

Take notice that on July 15, 1999, Lakewood Cogeneration Limited Partnership, 123 Energy Way, Lakewood, New Jersey 08701, filed with the Federal Energy Regulatory Commission an application for determination of exempt wholesale generator status pursuant to Part 365 of the Commission's regulations.

Lakewood Cogeneration Limited Partnership owns a facility with a

maximum capacity of approximately 238 MW located in Lakewood Township, New Jersey and is a Delaware limited partnership and consists of HCE Lakewood, Inc. as a 2 percent general partner, HYDRA–CO Enterprises, Inc. as a 78 percent limited partner, and TPC Lakewood, Inc. as a 20 percent limited partner. HCE Lakewood, Inc. is owned 100% by HYDRA–CO Enterprises, Inc., a New York corporation (''HYDRA–CO''). HYDRA–CO is a direct subsidiary of CMS Generation Co., a Michigan corporation, which is a wholly-owned indirect subsidiary of CMS Energy Corporation, also a Michigan corporation.

Comment date: August 11, 1999, in accordance with Standard Paragraph E at the end of this notice.

6. Torco Energy Marketing, Inc., Alliance Power Marketing, Inc., Central Hudson Enterprises Corporation, North American Energy, Inc., TransCurrent, LC, Energy Unlimited, Inc., Phibro Inc., and Rainbow Energy Marketing Corporation

[Docket No. ER92–429–019, ER96–1818–014, ER97–2869–008, ER98–242–007, ER98–1297–003, ER98–1622–005, ER95–430–020, ER94–1061–021]

Take notice that on July 15, 1999, the above-mentioned power marketers filed quarterly reports with the Commission in the above-mentioned proceedings for information only. These filings are available for public inspection and copying in the Public Reference Room or on the web at www.ferc.fed.us/online/rims.htm for viewing and downloading (call 202–208–2222 for assistance).

7. Russell Energy Services Company Docket No.

[ER96–2882–011]

Take notice that on July 13, 1999, the above-mentioned power marketer filed a quarterly report with the Commission in the above-mentioned proceeding for information only. This filing is available for public inspection and copying in the Public Reference Room or on the web at www.ferc.fed.us/online/rims.htm for viewing and downloading (call 202–208–2222 for assistance).

8. Wolverine Power Supply Cooperative, Inc., Northeast Empire Limited Partnership #1, Northeast Empire Limited Partnership #2, TransCanada Power, and Fina Energy Services Company

[Docket Nos. ER98–411–009, ER98–4183–001, ER98–1125–004, ER95–692–017, and ER97–2413–009]

Take notice that on July 16, 1999, the above-mentioned power marketers filed quarterly reports with the Commission in the above-mentioned proceedings for information only. These filings are available for public inspection and copying in the Public Reference Room or on the web at www.ferc.fed.us/online/rims.htm for viewing and downloading (call 202–208–2222 for assistance).

9. Grayling Generating Station L.P. and Central Hudson Gas & Electric Corporation

[Docket Nos. ER99–791–000 and ER97–2872–000]

Take notice that on July 8, 1999, the above-mentioned affiliated power producers and/or public utilities filed their quarterly reports for the quarter ending June 30, 1999.

10. Allegheny Power Service Corporation, on behalf of Monongahela Power Company, The Potomac Edison Company and West Penn Power Company (Allegheny Power)

[Docket No. ER99–3583–000]

Take notice that on July 15, 1999, Allegheny Power Service Corporation on behalf of Monongahela Power Company, The Potomac Edison Company and West Penn Power Company (d/b/a Allegheny Power), tendered for filing Amendment Nos. 1 and 2 to Supplement No. 7 to the Market Rate Tariff and Amendment Nos. 1 and 2 to Supplement No. 34 to the Standard Generation Service Tariff to incorporate Netting Agreements with Delmarva Power and Light Co., into the tariff provisions.

Allegheny Power and Allegheny Energy request a waiver of notice requirements to make the Amendments effective as of the effective dates therein, June 23, 1999.

Copies of the filing have been provided to the Public Utilities Commission of Ohio, the Pennsylvania Public Utility Commission, the Maryland Public Service Commission, the Virginia State Corporation Commission, the West Virginia Public Service Commission, and all parties of record.

Comment date: August 4, 1999, in accordance with Standard Paragraph E at the end of this notice.

11. Allegheny Power Service Corporation, on behalf of Monongahela Power Company, The Potomac Edison Company and West Penn Power Company (Allegheny Power)

[Docket No. ER99–3584–000]

Take notice that on July 15, 1999, Allegheny Power Service Corporation on behalf of Monongahela Power Company, The Potomac Edison Company and West Penn Power Company (d/b/a Allegheny Power), tendered for filing Amendment Nos. 1 and 2 to Supplement No. 6 to the Market Rate Tariff and Amendment Nos. 1 and 2 to Supplement No. 19 to the Standard Generation Service Tariff to incorporate Netting Agreements with Baltimore Gas and Electric Company into the tariff provisions.

Allegheny Power and Allegheny Energy request a waiver of notice requirements to make the Amendments effective as of the effective dates therein, June 16, 1999.

Copies of the filing have been provided to the Public Utilities Commission of Ohio, the Pennsylvania Public Utility Commission, the Maryland Public Service Commission, the Virginia State Corporation Commission, the West Virginia Public Service Commission, and all parties of record.

Comment date: August 4, 1999, in accordance with Standard Paragraph E at the end of this notice.

12. Entergy Services, Inc.

[Docket No. ER99–3585–000]

Take notice that on July 15, 1999, Entergy Services, Inc., on behalf of Entergy Arkansas, Inc., Entergy Gulf States, Inc., Entergy Louisiana, Inc., Entergy Mississippi, Inc., and Entergy New Orleans, Inc., (collectively, the Entergy Operating Companies) tendered for filing a Firm Point-to-Point Transportation Agreement between Entergy Services, Inc., as agent for the Entergy Operating Companies, and Ameren Services Company.

Comment date: August 4, 1999, in accordance with Standard Paragraph E at the end of this notice.

13. Minnesota Power, Inc.

[Docket No. ER99–3586–000]

Take notice that on July 15, 1999, Minnesota Power, Inc. (Minnesota Power), tendered for filing an updated market power analysis in compliance with the Commission's order issued in Docket No. ER96–1823 on July 15, 1996.

Comment date: August 4, 1999, in accordance with Standard Paragraph E at the end of this notice.

14. Central Power and Light Company

[Docket No. ER99–3587–000]

Take notice that on July 15, 1999, Central Power and Light Company (CPL), tendered for filing an executed interconnection agreements between CPL and the City of Brownsville, Texas, operating by and through the Public Utilities Board of Brownsville (Brownsville).

CPL requests an effective date of December 3, 1998, for each of the interconnection agreements and therefore requests waiver of the Commission's notice requirement.

CPL states that it has served a copy of the filing on the Public Utility Commission of Texas, Brownsville and the Public Utility Commission of Texas.

Comment date: August 4, 1999, in accordance with Standard Paragraph E at the end of this notice.

15. Puget Sound Energy, Inc.

[Docket No. ER99–3588–000]

Take notice that on July 15, 1999, Puget Sound Energy, Inc. (PSE), tendered for filing an unexecuted Service Agreement under the provisions of PSE's market-based rates tariff, FERC Electric Tariff, First Revised Volume No. 8, with El Paso Electric (El Paso).

PSE respectfully requests the Commission waive its prior notice of filing requirements and permit this filing to become effective as of July 16, 1999.

A copy of the filing was served upon El Paso.

Comment date: August 4, 1999, in accordance with Standard Paragraph E at the end of this notice.

16. Puget Sound Energy, Inc.

[Docket No. ER99–3589–000]

Take notice that on July 15, 1999, Puget Sound Energy, Inc. (PSE), tendered for filing an unexecuted Service Agreement under the provisions of PSE's market-based rates tariff, FERC Electric Tariff, First Revised Volume No. 8, with Destec Power Services, Inc., (Destec).

A copy of the filing was served upon Destec.

Comment date: August 4, 1999, in accordance with Standard Paragraph E at the end of this notice.

17. Puget Sound Energy, Inc.

[Docket No. ER99–3590–000]

Take notice that on July 15, 1999, Puget Sound Energy, Inc. (PSE), tendered for filing a Service Agreement under the provisions of PSE's market-based rates tariff, FERC Electric Tariff, First Revised Volume No. 8, with City of Santa Clara Electric Department (Santa Clara).

A copy of the filing was served upon Santa Clara.

Comment date: August 4, 1999, in accordance with Standard Paragraph E at the end of this notice.

18. Puget Sound Energy, Inc.

[Docket No. ER99–3591–000]

Take notice that on July 15, 1999, Puget Sound Energy, Inc. (PSE), tendered for filing a Service Agreement under the provisions of PSE's market-based rates tariff, FERC Electric Tariff, First Revised Volume No. 8, with City Utilities of Springfield (Springfield).

A copy of the filing was served upon Springfield.

Comment date: August 4, 1999, in accordance with Standard Paragraph E at the end of this notice.

19. Wisconsin Electric Power Company

[Docket No. ER99–3592–000]

Take notice that on July 15, 1999 the above-mentioned public utility filed its quarterly report for the quarter ending June 30, 1999.

Comment date: August 4, 1999, in accordance with Standard Paragraph E at the end of this notice.

20. Puget Sound Energy, Inc.

[Docket No. ER99–3593–000]

Take notice that on July 15, 1999, Puget Sound Energy, Inc. (PSE), tendered for filing a Service Agreement under the provisions of PSE's market-based rates tariff, FERC Electric Tariff, First Revised Volume No. 8, with ConAgra Energy Services, Inc. (ConAgra).

A copy of the filing was served upon ConAgra.

Comment date: August 4, 1999, in accordance with Standard Paragraph E at the end of this notice.

21. Puget Sound Energy, Inc.

[Docket No. ER99–3594–000]

Take notice that on July 15, 1999, Puget Sound Energy, Inc. (PSE), tendered for filing a Service Agreement under the provisions of PSE's market-based rates tariff, FERC Electric Tariff, First Revised Volume No. 8, with El Paso Energy Marketing Company (El Paso Energy).

A copy of the filing was served upon El Paso Energy.

Comment date: August 4, 1999, in accordance with Standard Paragraph E at the end of this notice.

22. Central Power and Light Company

[Docket No. ER99–3595–000]

Take notice that on July 15, 1999, Central Power and Light Company (CPL), tendered for filing an Interconnection Agreement between CPL and Ingleside Cogeneration Limited Partnership (Ingleside).

CPL requests an effective date for the Interconnection Agreement of June 25, 1999.

Accordingly, CPL requests waiver of the Commission's notice requirements.

CPL states that a copy of the filing was served on Ingleside and the Public Utility Commission of Texas.

Comment date: August 4, 1999, in accordance with Standard Paragraph E at the end of this notice.

23. Arizona Public Service Company

[Docket No. ER99–3596–000]

That notice that on July 15, 1999, Arizona Public Service Company (APS), tendered for filing a revised Contract Demand Exhibit I to APS-FERC Rate Schedule No. 192 between APS and the City of Williams (Williams) for the Operating Year 1999. Current rate levels are unaffected, and revenue levels will decrease from those currently being assessed, and no other significant change in service to these or any other customer results from the revisions proposed herein. No new or modifications to existing facilities are required as a result of these revisions.

Copies of this filing have been served on the City of Williams and the Arizona Corporation Commission.

Comment date: August 4, 1999, in accordance with Standard Paragraph E at the end of this notice.

24. WICOR Energy Services, Inc.

[Docket No. ER99–3597–000]

Take notice that on July 15, 1999, WICOR Energy Services, Inc. (WESI), requested the Commission to terminate its Electric Rate Schedule No. 1.

WESI states that it has made no sales pursuant to Rate Schedule No. 1 and therefore requests that the Commission waive the sixty-day prior notice requirement in Section 35.15(a) of the Commission's Regulations.

Comment date: August 4, 1999, in accordance with Standard Paragraph E at the end of this notice.

25. Duke Power (a Division of Duke Energy Corporation)

[Docket No. ER99–3598–000]

Take notice that on July 15, 1999, Duke Power (Duke), a division of Duke Energy Corporation, tendered for filing a Service Agreement with Ameren Energy Service Company (Ameren) for power sales at market-based rates.

Duke requests that the proposed Service Agreement be permitted to become effective on June 18, 1999.

Duke states that this filing is in accordance with Part 35 of the Commission's Regulations and a copy has been served on the North Carolina Utilities Commission.

Comment date: August 4, 1999, in accordance with Standard Paragraph E at the end of this notice.

26. Puget Sound Energy, Inc.

[Docket No. ER99–3599–000]

Take notice that on July 15, 1999, Puget Sound Energy, Inc. (PSE),

tendered for filing a Service Agreement under the provisions of PSE's market-based rates tariff, FERC Electric Tariff, First Revised Volume No. 8, with Coral Power, L.L.C. (Coral Power).

A copy of the filing was served upon Coral Power.

Comment date: August 4, 1999, in accordance with Standard Paragraph E at the end of this notice.

27. Puget Sound Energy, Inc.

[Docket No. ER99–3600–000]

Take notice that on July 15, 1999, Puget Sound Energy, Inc. (PSE), tendered for filing a Service Agreement under the provisions of PSE's market-based rates tariff, FERC Electric Tariff, First Revised Volume No. 8, with City of Riverside, California (Riverside).

A copy of the filing was served upon Riverside.

Comment date: August 4, 1999, in accordance with Standard Paragraph E at the end of this notice.

28. Puget Sound Energy, Inc.

[Docket No. ER99–3601–000]

Take notice that on July 15, 1999, Puget Sound Energy, Inc. (PSE), tendered for filing a Service Agreement under the provisions of PSE's market-based rates tariff, FERC Electric Tariff, First Revised Volume No. 8, with Cook Inlet Energy Supply (CIES).

A copy of the filing was served upon CIES.

Comment date: August 4, 1999, in accordance with Standard Paragraph E at the end of this notice.

29. FirstEnergy System

[Docket No. ER99–3602–000]

Take notice that on July 15, 1999, FirstEnergy System tendered for filing a Service Agreement to provide Firm Point-to-Point Transmission Service for Louisville Gas & Electric Company, the Transmission Customer. Services are being provided under the FirstEnergy System Open Access Transmission Tariff submitted for filing by the Federal Energy Regulatory Commission in Docket No. ER97–412–000.

The proposed effective date under this Service Agreement is July 6, 1999, for the above mentioned Service Agreement in this filing.

Comment date: August 4, 1999, in accordance with Standard Paragraph E at the end of this notice.

Standard Paragraphs

E. Any person desiring to be heard or to protest such filing should file a motion to intervene or protest with the Federal Energy Regulatory Commission, 888 First Street, N.E., Washington, D.C. 20426, in accordance with Rules 211 and 214 of the Commission's Rules of Practice and Procedure (18 CFR 385.211 and 385.214). All such motions or protests should be filed on or before the comment date. Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceeding. Any person wishing to become a party must file a motion to intervene. Copies of these filings are on file with the Commission and are available for public inspection. This filing may also be viewed on the Internet at http://www.ferc.fed.us/online/rims.htm (call 202–208–2222 for assistance).

David P. Boergers,

Secretary.

[FR Doc. 99–19528 Filed 7–29–99; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

Notice of Application Accepted for Filing and Soliciting Motions To Intervene, Protests, and Comments

July 26, 1999.

Take notice that the following hydroelectric application has been filed with the Commission and is available for public inspection:

a. *Type of Application:* Preliminary Permit.

b. *Project No.:* 11775–000.

c. *Date filed:* June 28, 1999.

d. *Applicant:* Universal Electric Power Corporation.

e. *Name of Project:* Warrior Lake Dam Hydroelectric Project.

f. *Location:* On Black Warrior River, Hale County, Alabama. The project would utilize the U.S. Army Corps of Engineer's Warrior Lake Dam.

g. *Filed Pursuant to:* Federal Power Act, 16 U.S.C. §§ 791(a)–825(r).

h. *Applicant Contact:* Gregory S. Feltenberger, Universal Electric Power Corporation, 1145 Highbrook Street, Akron, OH 44301, (330) 535–7115.

i. *FERC Contact:* Hèctor M. Pèrez, hector.perez@ferc.fed.us, 202–219–2843, or Robert Bell, robert.bell@ferc.fed.us, 202–219–2806.

j. *Deadline for filing motions to intervene, protest and comments:* 60 days from the issuance date of this notice.

All documents (original and eight copies) should be filed with: David P. Boergers, Secretary, Federal Energy Regulatory Commission, 888 First Street, NE, Washington, DC 20426.

The Commission's Rules of Practice and Procedure require all interveners filing documents with the Commission to serve a copy of that document on each person in the official service list for the project. Further, if an intervener files comments or documents with the Commission relating to the merits of an issue that may affect the responsibilities of a particular resource energy, they must also serve a copy of the document on that resource agency.

k. The project would use the U.S. Army Corps of Engineer's Warrior Lake Dam and would consist of the following facilities: (1) Two new 180-foot-long, 96-inch-diameter penstocks at the outlet works; (2) a new powerhouse containing two generating units having a total installed capacity of 3 MW; (3) a new tailrace; (4) a new 1100-foot-long, 14.7=KV transmission line; and (5) other appurtenances.

The project would have an annual generation of 18,000 Mwh and project power would be sold to a local utility.

l. A copy of the application is available for inspection and reproduction at the Commission's Public Reference Room, located at 888 First Street, NE, Room 2A, Washington, DC 20426, or by calling (202) 208–1371. The application may be viewed on http://www.ferc.fed.us/rims.htm (call (202) 208–2222 for assistance). A copy is also available for inspection and reproduction at the address in item h above.

Preliminary Permit—Anyone desiring to file a competing application for preliminary permit for a proposed project must submit the competing application itself, or a notice of intent to file such an application, to the Commission on or before the specified comment date for the particular application (see 18 CFR 4.36). Submission of a timely notice of intent allows an interested person to file the competing preliminary permit application no later than 30 days after the specified comment date for the particular application. A competing preliminary permit application must conform with 18 CFR 4.30(b) and 4.36.

Preliminary Permit—Any qualified development applicant desiring to file a competing development application must submit to the Commission, on or before a specified comment date for the particular application, either a competing development application or a notice of intent to file such an application. Submission of a timely notice of intent to file a development application allows an interested person to file the competing application no later than 120 days after the specified comment date for the particular application. A competing license application must conform with 18 CFR 4.30(b) and 4.36.

Notice of intent—A notice of intent must specify the exact name, business address, and telephone number of the prospective applicant, and must include an unequivocal statement of intent to submit, if such application may be filed, either a preliminary permit application or a development application (specify which type of application). A notice of intent must be served on the applicant(s) named in this public notice.

Proposed Scope of Studies under Permit—A preliminary permit, if issued, does not authorize construction. The term of the proposed preliminary permit would be 36 months. The work proposed under the preliminary permit would include economic analysis, preparation of preliminary engineering plans, and a study of environmental impacts. Based on the results of these studies, the Applicant would decide whether to proceed with the preparation of a development application to construct and operate the project.

Comments, Protests, or Motions to Intervene—Anyone may submit comments, a protest, or a motion to intervene in accordance with the requirements of Rules of Practice and Procedure, 18 CFR 385.210, .211, .214. In determining the appropriate action to take, the Commission will consider all protests or other comments filed, but only those who file a motion to intervene in accordance with the Commission's Rules may become a party to the proceeding. Any comments, protests, or motions to intervene must be received on or before the specified comment date for the particular application.

Filing and Service of Responsive Documents—Any filings must bear in all capital letters the title ''COMMENTS'', ''NOTICE OF INTENT TO FILE COMPETING APPLICATION'', ''COMPETING APPLICATION'', ''PROTESTS'', ''MOTION TO INTERVENE'', as applicable, and the Project Number of the particular application to which the filing refers. Any of the above-named documents must be filed by providing the original and the number of copies provided by the Commission's regulations to: The Secretary, Federal Energy Regulatory Commission, 888 First Street, NE, Washington, DC 20426. An additional copy must be sent to Director, Division of Project Review, Federal Energy Regulatory Commission, at the above-named mentioned address. A copy of any notice of intent, competing application or motion to intervene must also be served upon each representative of the Applicant specified in the particular application.

Agency Comments—Federal, state, and local agencies are invited to file comments on the described application. A copy of the application may be obtained by agencies directly from the Applicant. If an agency does not file comments within the time specified for filing comments, it will be presumed to have no comments. One copy of an agency's comments must also be sent to the Applicant's representatives.

David P. Boergers,

Secretary.

[FR Doc. 99–19523 Filed 7–29–99; 8:45 am]

BILLING CODE 6717–01–M

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

Notice of Application Accepted for Filing and Soliciting Motions To Intervene, Protests, and Comments

July 26, 1999.

Take notice that the following hydroelectric application has been filed with the Commission and is available for public inspection:

a. *Type of Application:* Preliminary Permit.

b. *Project No.:* 11774–000.

c. *Date Filed:* June 28, 1999.

d. *Applicant:* Universal Electric Power Corporation.

e. *Name of Project:* Bartlett Dam Hydroelectric Project.

f. *Location:* On Verde River in Maricopa County, Arizona. The project would utilize the Bureau of Reclamation's Bartlett Dam.

g. *Filed Pursuant to:* Federal Power Act, 16 U.S.C. §§ 791(a)–825(r).

h. *Applicant Contact:* Gregory S. Feltenberger, Universal Electric Power Corporation, 1145 Highbrook Street, Akron, OH 44301, (330) 535–7115.

i. *FERC Contact:* Héctor M. Pérez, hector.perez@ferc.fed.us, 202–219–2843, or Robert Bell, robert.bell@ferc.fed.us, (202) 210–2806.

j. *Deadline for filing motions to intervene, protest and comments: 60 days from the issuance date of this notice.*

All documents (original and eight copies) should be filed with: David P. Boergers, Secretary, Federal Energy Regulatory Commission, 888 First Street, NE, Washington, DC 20426.

The Commission's Rules of Practice and Procedure require all interveners filing documents with the Commission to serve a copy of that document on each person in the official service list for the project. Further, if an intervener files comments or documents with the Commission relating to the merits of an issue that may affect the responsibilities of a particular resource agency, they must also serve a copy of the document on that resource agency.

k. *The project would consist of the following facilities:* (1) Four 200-foot-long and 96-inch-diameter steel penstocks at the outlet works; (2) a powerhouse with four turbine generator units with a total installed capacity of 9.7 megawatts; (3) a tailrace consisting of an exhaust apron; (4) 14.7–kV, 20-mile-long transmission lines; and (5) other appurtenances.

l. A copy of the application is available for inspection and reproduction at the Commission's Public Reference Room located at 888 First Street, NE, Room 2A, Washington, DC 20426, or by calling (202) 208–1371. The application may be viewed on http://www.ferc.fed.us/rims.htm (call (202) 208–2222 for assistance). A copy is also available for inspection and reproduction at the address in item h above.

Preliminary Permit—Anyone desiring to file a competing application for preliminary permit for a proposed project must submit the competing application itself, or a notice of intent to file such an application, to the Commission on or before the specified comment date for the particular application (see 18 CFR 4.36). Submission of a timely notice of intent allows an interested person to file the competing preliminary permit application no later than 30 days after the specified comment date for the particular application. A competing preliminary permit application must conform with 18 CFR 4.30(b) and 4.36.

Preliminary Permit—Any qualified development applicant desiring a file a competing development application must submit to the Commission, on or before a specified comment date for the particular application, either a competing development application or a notice of intent to file such an application. Submission of a timely notice of intent to file a development application allows an interested person to file the competing application no later than 120 days after the specified comment date for the particular application. A competing license application must conform with 18 CFR 4.30(b) and 4.36.

Notice of intent—a notice of intent must specify the exact name, business address, and telephone number of the prospective applicant, and must include an unequivocal statement of intent to submit, if such an application may be filed, either a preliminary permit application or a development

application (specify which type of application). A notice of intent must be served on the applicant(s) named in this public notice.

Proposed Scope of Studies under Permit—A preliminary permit, if issued, does not authorize construction. The term of the proposed preliminary permit would be 36 months. The work proposed under the preliminary permit would include economic analysis, preparation of preliminary engineering plans, and a study of environmental impacts. Based on the results of these studies, the Applicant would decide whether to proceed with the preparation of a development application to construct and operate the project.

Comments, Protests, or Motions to Intervene—Anyone may submit comments, a protest, or a motion to intervene in accordance with the requirements of Rules of Practice and Procedure, 18 CFR 385.210, .211, .214. In determining the appropriate action to take, the Commission will consider all protests or other comments filed, but only those who file a motion to intervene in accordance with the Commission's Rules may become a party to the proceeding. Any comments, protests, or motions to intervene must be received on or before the specified comment date for the particular application.

Filing and Service of Responsive Documents—Any filings must bear in all capital letters the title ''COMMENTS'', ''NOTICE OF INTENT TO FILE COMPETING APPLICATION'', ''COMPETING APPLICATION'', ''PROTEST'', ''MOTION TO INTERVENE'', as applicable, and the Project Number of the particular application to which the filing refers. Any of the above-named documents must be filed by providing the original and the number of copies provided by the Commission's regulations to: The Secretary, Federal Energy Regulatory Commission, 888 First Street, NE., Washington, DC 20426. An additional copy must be sent to Director, Division of Project Review, Federal Energy Regulatory Commission, at the above-mentioned address. A copy of any notice of intent, competing application or motion to intervene must also be served upon each representative of the Applicant specified in the particular application.

Agency Comments—Federal, state, and local agencies are invited to file comments on the described application. A copy of the application may be obtained by agencies directly from the Applicant. If an agency does not file comments within the time specified for filing comments, it will be presumed to have no comments. One copy of an agency's comments must also be sent to the Applicant's representatives.

David P. Boergers,

Secretary.

[FR Doc. 99–19525 Filed 7–29–99; 8:45 am]

BILLING CODE 6712–01–M

ENVIRONMENTAL PROTECTION AGENCY

[FRL–6410–6]

Agency Information Collection Activities; Design for the Environment Reporting; Submission of ICR No. 1768.02 to OMB; Agency Information Collection Activities

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice of submission to OMB.

SUMMARY: In compliance with the Paperwork Reduction Act (44 U.S.C. 3501 *et seq.*), this document announces that the Information Collection Request (ICR) entitled: ''DfE Collection of Impact Data on Technical Information,'' [EPA ICR No. 1768.02; OMB Control No. 2070–0152] has been forwarded to the Office of Management and Budget (OMB) for review and approval pursuant to the OMB procedures in 5 CFR 1320.12. The ICR, which is abstracted below, describes the nature of the information collection and its estimated cost and burden.

The Agency is requesting that OMB renew for 3 years the existing approval for this ICR, which is scheduled to expire on October 31, 1999. A **Federal Register** notice announcing the Agency's intent to seek the renewal of this ICR and the 60-day public comment opportunity, requesting comments on the request and the contents of the ICR, was issued on March 12, 1999 (64 FR 12314). EPA did not receive any comments on this ICR during the comment period.

DATES: Additional comments may be submitted on or before August 30, 1999.

FOR FURTHER INFORMATION CONTACT: Sandy Farmer at EPA by phone on (202) 260–2740, by e-mail: ''farmer.sandy@epamail.epa.gov,'' or download a copy of the ICR off the Internet at http://www.epa.gov/icr/icr.htm and refer to EPA ICR No. 1768.02.

ADDRESSES: Send comments, referencing EPA ICR No. 1768.02 and OMB Control No. 2070–0152, to the following addresses:

Ms. Sandy Farmer, U.S. Environmental Protection Agency, Regulatory Information Division (Mail Code: 2137), 401 M Street, SW, Washington, DC 20460;

and to:

Office of Information and Regulatory Affairs, Office of Management and Budget (OMB), Attention: Desk Officer for EPA, 725 17th Street, NW, Washington, DC 20503.

SUPPLEMENTARY INFORMATION:

Review Requested: This is a request to renew a currently approved information collection pursuant to 5 CFR 1320.12.

ICR Numbers: EPA ICR No. 1768.02; OMB Control No. 2070–0152.

Current Expiration Date: Current OMB approval expires on October 31, 1999.

Title: DfE Collection of Impact Data on Technical Information.

Abstract: EPA's Design for the Environment (DfE) program is a voluntary, non-regulatory approach to encourage industry to adopt technologies and use materials that result in lower levels of pollution, lessened reliance on toxic materials, higher energy efficiency and lower environmental health risks. Through DfE, EPA creates partnerships with industry, professional organizations, state and local governments, other federal agencies and the public to develop and disseminate technical information.

This information collection is a generic ICR for a series of surveys, referred to as DfE Technical Information Impact Studies, to undertake data collection in support of EPA's DfE program. The studies will focus on various industrial sectors such as printing, printed wiring board circuitry and dry cleaning. The purpose of all DfE Technical Information Impact Studies is to evaluate the impact of DfE technical information on industry practices, use of materials and waste generation. In each case, EPA, often in collaboration with industry associations and universities, will have developed technical information for industry on the use of product reclamation processes and other workplace practices that may lower health risks to workers and prevent pollution. The proposed studies will each involve two separate surveys of owners or operators of target industry establishments. The initial survey will establish a baseline representing pre-technical information receipt. A follow-up survey will be administered approximately two years later to establish longer-term impacts of the technical materials. The overall goal of this before-and-after design is to understand the impacts of DfE technical information on workplace practices and

technologies that generate or prevent pollution. This generic ICR will allow EPA to conduct a series of small, conceptually interrelated surveys. It will permit the DfE program the ability to collect information in a timely manner and to evaluate the effectiveness of the technical materials EPA provides to industry. EPA will be the principal user of information developed from the survey findings, but EPA expects that tens of thousands of small businesses in a variety of industry sectors will benefit from the results of the studies.

Responses to the collection of information are voluntary. Respondents may claim all or part of a notice confidential. EPA will disclose information that is covered by a claim of confidentiality only to the extent permitted by, and in accordance with, the procedures in TSCA section 14 and 40 CFR part 2.

Burden Statement: The annual public reporting burden for this collection of information is estimated to be 2 hours per response for an estimated 7,500 respondents making one or more submissions of information annually. These estimates include the time needed to review instructions; develop, acquire, install and utilize technology and systems for the purposes of collecting, validating and verifying information, processing and maintaining information, and disclosing and providing information; adjust the existing ways to comply with any previously applicable instructions and requirements; train personnel to be able to respond to a collection of information; search data sources; complete and review the collection of information; and transmit or otherwise disclose the information. No person is required to respond to a collection of information unless it displays a currently valid OMB control number. The OMB control numbers for these regulations are displayed in 40 CFR Part 9.

Respondents/Affected Entities: Entities potentially affected by this action are companies or industries that are part of industry sectors that may interact with EPA in the Agency's DfE program.

Estimated No. of Respondents: 7,500.

Estimated Total Annual Burden on Respondents: 15,000 hours.

Frequency of Collection: On occasion.

Changes in Burden Estimates

There is an increase (from 1,000 hours to 15,000 hours) in the total estimated respondent burden as compared with that identified in the information collection request most recently approved by OMB. This increase reflects the expectation that greater numbers of respondents in more industry sectors will participate in surveys, as EPA's DfE program becomes better known and more popular and increases its scope. The earlier ICR anticipated 800 annual respondents to surveys, whereas the current request projects 7,500 respondents annually.

According to the procedures prescribed in 5 CFR 1320.12, EPA has submitted this ICR to OMB for review and approval. Any comments related to the renewal of this ICR should be submitted within 30 days of this notice, as described above.

Dated: July 26, 1999.

Stephen T. Vineski,

Acting Director, Regulatory Information Division.

[FR Doc. 99–19589 Filed 7–29–99; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

[FRL–6410–5]

Agency Information Collection Activities: Submission for OMB Review; Comment Request; Notice of Intent for Storm Water Discharges Associated With Construction Activity Under a NPDES General Permit

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice.

SUMMARY: In compliance with the Paperwork Reduction Act (44 U.S.C. 3501 *et seq.*), this document announces that the following Information Collection Request (ICR) has been forwarded to the Office of Management and Budget (OMB) for review and approval: Notice of Intent for Storm Water Discharges Associated with Construction Activity under a NPDES General Permit, OMB Control No. 2040–0188, EPA ICR No. 1842.02, which expires on September 30, 1999. The ICR describes the nature of the information collection and its expected burden and cost; where appropriate, it includes the actual data collection instrument.

DATES: Comments must be submitted on or before August 30, 1999.

FOR FURTHER INFORMATION CONTACT: Sandy Farmer at EPA by phone at (202) 260–2740, by email at farmer.sandy@epa.gov, or download a copy of the ICR off the Internet at http://www.epa.gov/icr and refer to EPA ICR No. 1842.02.

SUPPLEMENTARY INFORMATION:

Title: Notice of Intent for Storm Water Discharges Associated with Construction Activity under a NPDES General Permit (OMB Control No. 2040–0188; EPA ICR No. 1842.02, expires on 9/30/99). This is a request for extension of a currently approved collection.

Abstract: This ICR calculates the burden and costs associated with the preparation of the Notice of Intent (NOI) for Storm Water Discharges Associated with Construction Activity under a NPDES General Permit, and the Storm Water Pollution Prevention Plan (SWPPP). EPA uses the data contained in the NOIs to track facilities covered by the storm water general permit and assess permit compliance. EPA has developed a format for construction NOIs. The standardized one-page form is called: Notice of Intent (NOI) for Storm Water Discharges Associated with Construction Activity Under a NPDES General Permit. This form is a revision of an existing form entitled, ''NOI for Storm Water Discharges Associated with Industrial Activity Under a NPDES General Permit.'' The new construction NOI only requires the respondent to note whether or not a SWPPP has been prepared. The following information is requested (the questions that are on the new NOI which are not on the existing NOI are indicated by asterisks at the end of the item):

- Name, address, phone number of the facility.
- Status of the owner/operator (whether federal, state, public, or private).
- Name and location of the project (City, State, ZIP, Latitude, Longitude, County)*.
- Whether the facility is located on Indian Country Lands.
- Whether a Storm Water Pollution Prevention Plan (SWPPP) has been prepared.*
- Optional: location for viewing SWPPP and telephone number for scheduling viewing times: Address, City, State, ZIP.*
- The name of the receiving water.
- Estimated construction start date and completion date.
- The estimated area to be disturbed (to nearest acre).
- An estimate of the likelihood of a discharge.*
- Whether any protected species or critical habitat in the project area.
- Which section of Part I.B.3.e.(2) of the permit through which permit eligibility with regard to protection of endangered species is satisfied.

Responses are required to obtain coverage under the NPDES General Permit for storm water discharges associated with construction activities.

An agency may not conduct or sponsor, and a person is not required to

respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control numbers for EPA's regulations are listed in 40 CFR part 9 and 48 CFR Chapter 15. The **Federal Register** document required under 5 CFR 1320.8(d), soliciting comments on this collection of information was published on 06/02/97 (62 FR 29826); two comments were received.

Burden Statement: The annual public reporting and recordkeeping burden for this collection of information is estimated to average 40.5 hours per response. Burden means the total time, effort, or financial resources expended by persons to generate, maintain, retain, or disclose or provide information to or for a Federal agency. This includes the time needed to review instructions; develop, acquire, install, and utilize technology and systems for the purposes of collecting, validating, and verifying information, processing and maintaining information, and disclosing and providing information; adjust the existing ways to comply with any previously applicable instructions and requirements; train personnel to be able to respond to a collection of information; search data sources; complete and review the collection of information; and transmit or otherwise disclose the information.

Respondents/Affected Entities: Owners/Operators of construction activities.

Estimated Number of Respondents: 186,121.

Frequency of Response: Varies.

Estimated Total Annual Hour Burden: 7,697,707 hours.

Estimated Total Annualized Cost Burden (non-labor costs): $2,045,000.

Send comments on the Agency's need for this information, the accuracy of the provided burden estimates, and any suggested methods for minimizing respondent burden, including through the use of automated collection techniques to the following addresses. Please refer to EPA ICR No. 1842.02 and OMB Control No. 2040–0188 in any correspondence.

Ms. Sandy Farmer, U.S. Environmental Protection Agency, Office of Policy, Regulatory Information Division (2137), 401 M Street, SW, Washington, DC 20460;

and

Office of Information and Regulatory Affairs, Office of Management and Budget, Attention: Desk Officer for EPA, 725 17th Street, NW, Washington, DC 20503.

Dated: July 26, 1999.

Stephen T. Vineski,

Acting Director, Regulatory Information Division.

[FR Doc. 99–19590 Filed 7–29–99; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

[FRL–6410–4]

Retrofit/Rebuild Requirements for 1993 and Earlier Model Year Urban Buses; Public Review of a Notification of Intent To Certify Equipment

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice of agency receipt of a notification of intent to certify equipment and initiation of 45 day public review and comment period.

SUMMARY: The Agency has received a request to amend a notification of intent to certify urban bus retrofit/rebuild equipment pursuant to 40 CFR part 85, subpart O from the Engelhard Corporation (Engelhard) to include life cycle costs. On March 20, 1998 (63 FR 13660) EPA certified a Engelhard retrofit catalytic muffler which demonstrated a 25% reduction in particulate matter (PM) for 1992–1993 Cummins L–10 electronically-controlled (EC) petroleum-fueled diesel engines (that are not originally equipped with aftertreatment devices). In the original notification dated October 18, 1996, Engelhard provided life cycle cost information applicable only to the L-10 EC engines.

In a letter dated April 20, 1998, Engelhard requested that the March 20, 1998 certification be amended to include all pre-1994 Cummins L–10 engines and ''all other 4-stroke urban bus engines''. Based on this request, EPA published a notice in the **Federal Register** on November 30, 1998 (63 FR 65780) for public review and comment. In the November 30 notice, EPA provided a summary of the notification amendment request and identified the engines that are being considered for inclusion in the, ''all other 4-stroke urban bus engine'' classification under the urban bus retrofit/rebuild program for which the catalytic muffler would be applicable. EPA has received comments on the November document and they are currently being reviewed.

Today's document is in response to a letter dated December 4, 1998 from Engelhard requesting that a second amendment be made to the October 18, 1996 notification of intent to certify. Engelhard is specifically requesting that the life cycle costs apply for the equipment and all engine models referenced in the November 30, 1998 **Federal Register** notice. Engelhard has submitted pricing information along with the guarantee that the equipment would be offered to all affected operators for less than the incremental life cycle cost ceiling of $2000 (in 1992 dollars). EPA notes that, if certified to comply with life cycle cost requirements of the urban bus retrofit program, this equipment would trigger program requirements for the 25% reduction standard for specific engines. If certified as a trigger of this standard, then urban bus operators using compliance option 1 will be required to use this retrofit/rebuild equipment or other equipment certified to provide a 25% or greater reduction PM at the time of engine rebuild or replacement for specified engine models.

Pursuant to section 85.1407(a)(7), today's **Federal Register** document summarizes the notification below, announces that the notification is available for public review and comment, and initiates a 45-day period during which comments can be submitted. The Agency will review the additional information submitted relative to the notification of intent to certify, as well as comments received, to determine whether this equipment may be certified to comply with the life cycle requirements of the program.

The Engelhard letters dated April 20, 1998 and December 4, 1998, and the original notification of intent to certify, as well as other materials specifically relevant to it, are contained in category XVII–A of Public Docket A–93–42, entitled ''Certification of Urban Bus Retrofit/Rebuild Equipment.'' This docket is at the address below.

Today's notice initiates a 45-day period during which the Agency will accept written comments relevant to whether or not the equipment as described herein should be certified for life-cycle costs for the applicable engines. Comments should be provided in writing to Public Docket A–93–42, Category XVII–A, at the address below. An identical copy should be submitted to Anthony Erb, also at the address below.

DATES: Comments must be submitted on or before September 13, 1999.

ADDRESSES: Submit separate copies of comments to the two following addresses:

1. U.S. Environmental Protection Agency, Public Docket A–93–42 (Category XVII-A), Room M–1500, 401 M Street S.W., Washington, D.C. 20460.

2. Anthony Erb, Engine Compliance and Programs Group, Engine Programs & Compliance Division (6403J), 401 ''M'' Street S.W., Washington, D.C. 20460.

Docket items may be inspected from 8:00 a.m. until 5:30 p.m., Monday through Friday. As provided in 40 CFR Part 2, a reasonable fee may be charged by the Agency for copying docket materials.

FOR FURTHER INFORMATION CONTACT: Anthony Erb, Engine Programs & Compliance Division (6403J), U.S. Environmental Protection Agency, 401 M Street S.W., Washington, D.C. 20460. Telephone: (202) 564–9259.

SUPPLEMENTARY INFORMATION:

I. Background

On April 21, 1993, the Agency published final Retrofit/Rebuild Requirements for 1993 and Earlier model Year Urban Buses (58 FR 21359). The retrofit/rebuild program is intended to reduce the ambient levels of particulate matter (PM) in urban areas and is limited to 1993 and earlier model year (MY) urban buses operating in metropolitan areas with 1980 populations of 750,000 or more, whose engines are rebuilt or replaced after January 1, 1995. Operators of the affected buses are required to choose between two compliance programs: Program 1 sets particulate matter emissions requirements for each urban bus engine in an operator's fleet which is rebuilt or replaced; Program 2 is a fleet averaging program that establishes specific annual target levels for average PM emissions from urban buses in an operator's fleet.

Certification of retrofit/rebuild equipment is a key element of the retrofit/rebuild. To show compliance under either of the compliance programs, operators of the affected buses must use equipment that has been certified by the Agency. Emissions requirements under either of the two compliance programs depend on the availability of certified retrofit/rebuild equipment for each engine model. To be used for Program 1, equipment must be certified as meeting a 0.10 g/bhp-hr PM standard or as achieving a 25 percent reduction in PM. Equipment used for Program 2 must be certified as providing some level of PM reduction that would in turn be claimed by urban bus operators when calculating their average fleet PM levels attained under the program. For Program 1, information on life cycle costs must be submitted in the notification of intent to certify in order for certification of the equipment to initiate (or trigger) program requirements. To trigger program requirements, the certifier must guarantee that the equipment will be available to all affected operators for a life cycle cost of $7,940 or less at the 0.10 g/bhp-hr PM level, or for a life cycle cost of $2,000 or less for the 25 percent or greater reduction in PM. Both of these values are based on 1992 dollars.

II. Notification of Intent to Certify

By a notification of intent to certify signed November 18, 1996, Engelhard applied for certification of equipment applicable to all Cummins L–10 engines that were originally manufactured prior to and including 1993. The notification of intent to certify stated that the candidate equipment would reduce PM emissions 25 percent or more on petroleum-fueled diesel engines that are rebuilt to Cummins specifications.

The candidate equipment consists of a ''catalytic converter muffler'' or CMX™, that is a muffler containing an oxidation catalyst. The CMX is intended to replace the standard muffler previously installed in the engine exhaust system. The CMX is intended to be maintenance free, requiring no service for the full in-use compliance period. The engine fuel to be used with this equipment is standard diesel fuel with a maximum sulfur content of 0.05 weight % sulfur.

Life cycle cost information was submitted with the original notification, along with a guarantee that the equipment would be offered to all affected operators for less than the incremental life cycle cost ceiling. EPA's certification of this equipment on March 20, 1998 triggered the requirements for operators using compliance option 1, to reduce PM by 25% when rebuilding or replacing 1992–1993 Cummins L–10 EC models. As a trigger of this standard, urban bus operators were required to use this retrofit/rebuild equipment, or other equipment certified to provide a PM reduction on any applicable engine rebuilt on or after September 21, 1998.

In a letter to EPA dated April 20, 1998, Engelhard requested that the March 20, 1998 certification be amended to include all pre-1994 Cummins L–10 models and all other 4-stroke urban bus engines. Table A of this document provides a listing of the additional 4-stroke urban bus engines to which the candidate equipment is believed to be applicable. EPA requested comment on the appropriateness of the engines currently listed in Table A and information on any additional engines for which this certification may be applicable in the **Federal Register** document that was published on November 30, 1998.

Identification of the engines in this classification was deemed to be necessary based on a letter from Engelhard dated March 16, 1998 which states that the inclusion of ''all other 4-stroke engines'' in the Engine Control Systems certification dated January 29, 1998 (63 FR 4445) was causing confusion in the marketplace because it was not clear which engines were included in the ''all other 4-stroke engine'' classification. Accordingly, this notice sought to clarify this matter by identifying the applicable engines. EPA requested additional information on the appropriateness of the engines identified in Table A of this document for this classification. As stated in the notice, it is EPA's intent that the list of engines will apply to the candidate Engelhard certification discussed herein, the Engine Control Systems certification referenced above and to future notifications of intent to certify equipment under the urban bus retrofit regulations that include engines in the ''all other 4-stroke'' classification. Comments have been received and are currently being reviewed relative to the April 20, 1998 amendment request.

The equipment to be applied to the engines is a ''Catalytic Converter Muffler'' or CMX™, that is a muffler containing an oxidation catalyst. The CMX is intended to replace the standard muffler previously installed in the engine exhaust system. The CMX is intended to be maintenance free, requiring no service for the full in-use compliance period. The engine fuel to be used with this equipment is standard diesel fuel with a maximum sulfur content of 0.05 wt.% sulfur.

Engelhard has requested approval for all Cummins L–10 engines and all other urban bus 4-stroke engines manufactured prior to and including 1993. As a basis for this certification, Engelhard presented exhaust emission data from testing a 1987 240hp Cummins L–10 engine, control parts list number 0777 (CPL# 0777) along with test data to support this certification. Detailed information on the emission test data presented can be found in the November 30, 1998, **Federal Register** document (63 FR 65780).

In the amendment request of December 4, 1998, Engelhard has provided life cycle cost data relative to the engines that are listed in the April 20, 1998 amendment request. This amendment request to include the life cycle costs, if approved for certification, will trigger new rebuild requirements for specified models listed in Table A.

If the Agency certifies the candidate Engelhard equipment within the applicable life cycle cost, operators will be affected as follows. Under Program 1, this equipment would be available for all rebuilds of applicable Cummins L–10 urban bus engines and other 4-stroke urban bus engines listed in Table A following the effective date of certification. For the following 4-stroke urban bus engines as listed in footnote 3, certification within life cycle cost limits, would trigger the requirement to use this or other equipment certified to produce a 25% reduction of: Caterpillar 8 cylinder engines, General Motors 6 cylinder and 8 cylinder engines, International Harvester/Navistar 8 cylinder engines, MAN 6 and 8 cylinder engines, Saab-Scania 6 cylinder engines, and Volvo 6 cylinder engines installed in applicable urban buses. With regard to the Cummins L–10 models included in Table A, triggering equipment was certified by EPA on December 13, 1995 (60 FR 64046).

The requirement to use certified equipment demonstrating at least a 25% reduction in PM will continue until such time as equipment is certified that triggers the 0.10 g/bhp-hr emission standard for less than a life cycle cost of $7,940 (in 1992 dollars). If the Agency certifies the candidate Engelhard equipment, then operators who choose to comply with Program 2 and install this equipment may use the PM emission level(s) established during the certification review process in their calculations for fleet level as specified in the program regulations. Emission levels proposed by Engelhard are provided in Table A as well.

TABLE A.—ENGELHARD RETROFIT/REBUILD CERTIFICATION LEVELS FOR 4-STROKE ENGINES[1]

Cummins/other engine family	Control parts list (CPL)	Manufacture dates	New engine PM level	Retrofit PM level with CMX	Retrofit PM level with CMX and Cummins Kit
343B	780	11/20/85 to 12/31/87	0.58	0.44	0.26
343B	0781	11/20/85 to 12/31/87	0.59	0.44	0.26
343C	0774	11/20/85 to 12/31/89	0.46	0.34	0.26
343C	0777	11/20/85 to 12/31/89	0.61	0.46	0.26
343C	0996	12/04/87 to 08/19/88	0.61	0.46	0.26
343C	1226	07/26/88 to 12/31/90	0.50	0.38	0.26
343F	1226	07/12/90 to 08/26/92	0.45	0.34	0.26
343F	1441	12/18/90 to 12/31/92	0.46	0.34	0.26
343F	1622	04/24/92 to 12/31/92	0.46	0.34	0.26
343F	1624	04/24/92 to 12/31/92	0.45	0.34	0.26
Other[2] 4-stroke engines, Caterpillar, GM, INT. HARV., Navistar, MAN, Saab-Scania, Volvo.	(4)	Pre-1988	0.50	0.38	N/A
Other[2] 4-stroke engines, Caterpillar, GM, INT. HARV., Navistar, MAN, Saab-Scania, Volvo.		1988 to 1993	(3)	25% reduction from certfication PM levels.	(4)

[1] The New Engine PM certification levels for Cummins engines are based on the certification level or the average test audit result for each engine family. It is noted that for engine famly 343F, although the PM standard for 1991 and 1992 was 0.25 g/bhp-hr and the NOx standard was 5.0 g/bhp-hr, Cummins certified the 1226, 1441, 1622, and 1624 CPLs to a Federal Emission Limit (FEL) of 0.49 g/bhp-hr PM and 5.6 g/bhp-hr NOx under the averaging, banking and trading program.

[2] Applicable to the following 4-stroke engines: Caterpillar 8 cylinder engines, General Motors 6 cylinder and 8 cylinder engines, International Harvester/Navistar 8 cylinder engines, MAN 6 and 8 cylinder engines, Saab-Scania 6 cylinder engines, and Volvo 6 cylinder engines installed in applicable urban buses.

[3] Certification level.

[4] Not applicable

At a minimum, EPA expects to evaluate this notification of intent to certify, and other materials submitted as applicable, to determine whether there is adequate demonstration of compliance with: (1) the certification requirements of section 85.1406, including whether the testing accurately proves the claimed emission reduction or emission levels; and, (2) the requirements of section 85.1407 for a notification of intent to certify.

The Agency requests that those commenting also consider these regulatory requirements, plus provide comments on any experience or knowledge concerning: (a) Problems with installing, maintaining, and/or using the candidate equipment on applicable engines; and, (b) whether the equipment is compatible with affected vehicles.

The date of this notice initiates a 45-day period during which the Agency will accept written comments relevant to whether or not the equipment described in the Engelhard notification of intent to certify should be certified pursuant to the urban bus retrofit/rebuild regulations. Interested parties are encouraged to review the notification of intent to certify and provide comment during the 45-day period. Please send separate copies of your comments to each of the above two addresses.

The Agency will review this notification of intent to certify, along with comments received from interested parties, and attempt to resolve or clarify issues as necessary. During the review process, the Agency may add additional documents to the docket as a result of the review process. These documents will also be available for public review and comment within the 45-day period.

Robert Perciasepe,

Assistant Administrator for Air and Radiation.

[FR Doc. 99–19588 Filed 7–29–99; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

[FRL–6410–9]

Environmental Laboratory Advisory Board; Notice of Charter Renewal

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice.

SUMMARY: The Charter for the Environmental Protection Agency's (EPA) Environmental Laboratory Advisory Board (ELAB) will be renewed for an additional two-year period, as a necessary committee which is in the public interest, in accordance with the provisions of the Federal Advisory Committee Act (FACA), 5 U.S.C. App. 2 section 9(c). The purpose of ELAB is to provide advice and recommendations to the Administrator of EPA on issues associated with the systems and standards of accreditation for environmental laboratories.

It is determined that ELAB is in the public interest in connection with the performance of duties imposed on the Agency by law.

Inquiries may be directed to Elizabeth Dutrow, Designated Federal Officer, ELAB, U.S. EPA, 401 M Street, SW., (8724R), Washington, DC 20460.

Dated: July 13, 1999.

Henry L. Longest II,

Acting Assistant Administrator, Office of Research and Development.

[FR Doc. 99–19586 Filed 7–29–99; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

[ER–FRL–6244–8]

Environmental Impact Statements; Notice of Availability

Responsible Agency: Office of Federal Activities, General Information (202) 564–7167 OR (202) 564–7153.

Weekly receipt of Environmental Impact Statements, Filed July 19, 1999 Through July 23, 1999, Pursuant to 40 CFR 1506.9.

EIS No. 990253, FINAL EIS, FHW, MN, MN–TH–14 Corridor Reconstruction, MN–TH–60 to I–35, Funding and COE Section 404 Permit Issuance, Blue Earth, Waseca and Steele Counties, MN, Due: August 30, 1999, Contact: Cheryl Martin (651) 291–6120.

EIS No. 990254, DRAFT EIS, FHW, VA, ADOPTION—Grundy Flood Damage Reduction/Highway Upgrade Project, Implementation, Town of Grundy, Buchanan County, CA, Due: August 30, 1999, Contact: Doris Bush (540) 645–1667.

U.S. Department of Transportation's, Federal Highway Administration (FHW) has adopted the Corps of Engineer's, Air National Guard FEIS #950407 filed 8–30–95. FHW was not a Cooperating Agency for the above final EIS. Recirculation of the document is necessary under Section 1506.3(b) of the Council on Environmental Quality Regulations.

EIS No. 990255, DRAFT EIS, FHW, WV, US–35, Funding and COE Section 404 Permit, Mason and Putnam Counties, WV, Due: September 23, 1999, Contact: David E. Bender (304) 347–5928.

EIS No. 990256, FINAL EIS, UMC, AZ, Yuma Marine Corps Air Station (MCAS), To Improve Ordnance Handling and Storage, Construct a new Combat Aircraft Loading Area (CALA); New Station Ordnance Area and Relocation of MCAS Yuma, AZ, Due: August 30, 1999, Contact: Richard Samrah (520) 341–3163.

EIS No. 990257, DRAFT EIS, AFS, MT, Good Creek Resource Management Project, Implementation, Vegetation Treatments and Other Activities to Restore Watershed, Flathead National Forest, Tally Lake Ranger District, Flathead County, MT, Due: September 13, 1999, Contact: Bryan Donner (406) 863–5408.

EIS No. 990258, FINAL EIS, FHW, PA, Central Bradford County Traffic Improvement Project, Construction US 6 Highway through Towanda Borough and North Towanda Township to US 220, Bradford County, PA, Due: August 30, 1999, Contact: Ronald W. Carmichael, PE (717) 221–3461.

EIS No. 990259, FINAL EIS, DOC, PR, VI, Corals and Reef Associated Plants and Invertebrates, Fishery Management Plan, Amendment I Marine Conservation District (MCD), Exclusive Economic Zone (EEZ), Puerto Islands and U.S. Virgin Islands, PR and VI, Due: August 30, 1999, Contact: William Hogarth (727) 570–5305.

EIS No. 990260, DRAFT EIS, FHW, NY, Albany Shaker Road and Watervliet Shakey Road Improvement Project, Construction and Reconstruction, Funding and COE Section 404 Permit, Town of Colonie, Albany County, NY, Due: September 15, 1999, Contact: Harold J. Brown (518) 431–4137.

EIS No. 990261, DRAFT EIS, USN, Surveillance Towed Array Sensor System (SURTASS) Low Frequency Active (LFA), To Improved Capability to Detect Quieter and Harder-to-Find Foreign Submarines, Implementation, Due: October 28, 1999, Contact: Kim DaPaul (703) 604–1233.

EIS No. 990262, DRAFT EIS, DOE, Sodium-Bonded Spent Nuclear Fuel for the Treatment and Management, Candidate Sites are Argonne National Laboratory-West (ANL–W) Located within the boundaries of the Idaho National Laboratory I and the Savannah River Sites (SRS) F-Area and L Area, SC, Due: September 13, 1999, Contact: Susan M. Lesica (301) 903–8755.

EIS No. 990263, FINAL EIS, FRC, MA, Holyoke Hydroelectric Relicensing Project. ((FERC) Nos. 2004–073 and 11607–000), Construction, Operation and Maintenance, Located on the Connecticut River, Hampshire, Hampden and Franklin Counties, MA, Due: August 30, 1999, Contact: Allan E. Creamer (202) 219–0365.

EIS No. 990264, FINAL EIS, BLM, UT, Grand Staircase-Escalante National Monument Management Plan, Implementation, Cedar City, UT, Due: August 30, 1999, Contact: Jerry Meredith (435) 865–5100.

EIS No. 990265, DRAFT EIS, APH, Fruit Fly Cooperative Control Program, Eradication Program, Implementation, Due: October 12, 1999, Contact: Harold T. Smith (310) 734–8565.

Amended Notices

EIS No. 990162, DRAFT EIS, USN, GU, Surplus Navy Property Identified in the Guam Land Use Plan (GLUP '94) for Disposal and Reuse, Implementation, GU, Due: September 15, 1999, Contact: Gerald Gibbons (808) 471–9338. Published FR 05–21–99—Review Period extended from 7–6–99 to 9–15–99.

Dated: July 27, 1999.

William D. Dickerson,

Director, NEPA Compliance Division, Office of Federal Activities.

[FR Doc. 99–19625 Filed 7–29–99; 8:45 am]

BILLING CODE 6560–50–M

ENVIRONMENTAL PROTECTION AGENCY

[ER–FRL–6244–9]

Environmental Impact Statements and Regulations; Availability of EPA Comments

Availability of EPA comments prepared July 06, 1999 Through July 09, 1999 pursuant to the Environmental Review Process (ERP), under Section 309 of the Clean Air Act and Section 102(2)(c) of that National Environmental Policy Act as amended. Requests for

copies of EPA comments can be directed to the Office of Federal Activities at (202) 564–7167.

An explanation of the ratings assigned to draft environmental impact statements (EISs) published in FR dated April 09, 1999 (64 FR 17362).

Draft EISs

ERP No. D–AFS–J65300–MT Rating EC2, Tobacco Root Vegetation Management Plan, Restore and Maintain a Mix Vegetation, Beaverhead-Deer Lodge National Forest, Madison Ranger District, Madison County, MT.

Summary: EPA expressed environmental concerns with potential adverse impacts to wetlands and requests disclosure of management practices in the final EIS.

ERP No. D–AFS–J65305–UT Rating EC2, Pretty Tree Bench Vegetation Project, Implementation, Dixie National Forest, Escalante Ranger District, Garfield County, UT

Summary: EPA expressed environmental concerns regarding wetlands, sediment impacts and trends in visibility improvement impairment in potentially impacted National Parks. EPA requested additional information on these issues.

ERP No. D–FHW–B40086–CT Rating EO2, CT 82/85/11 Corridor Transportation Improvements, Funding and COE Section 404 Permit, in the Towns of Salem, Montville, East Lyme and Waterford, CT.

Summary: EPA has objection to the proposed action since it is likely that any of the expressway alternatives described in the EIS would cause or contribute to significant degradation of the aquatic ecosystem. EPA supports further consideration of a community sensitive upgrade and further exploration of a parkway concept.

ERP No. DS–FAA–F51040–IN Rating EC2, Indianapolis International Airport Master Plan Development, Updated/New Information, Establishing New Air Traffic Procedures to Restore, Construct and Operate, Runway 5L/23R Parallel to existing Runway 14/32 and connecting to Runways 5R/23L and 5L/23R, Airport Layout Plan Approval, Funding and US COE Section 404 Permit, Marion County, IN.

Summary: EPA expressed environmental concerns related to the potential adverse impacts on wetlands and bat habitat.

Final EISs

ERP No. F–AFS–J65256–CO, Lakewood Raw Water Pipeline for Continued Operation, Maintenance, Reconstruction and/or Replacement, Application for Easement, Roosevelt National Forest, Boulder Ranger District, in the City of Boulder, CO.

Summary: Review of the Final Supplemental EIS was not deemed necessary. No formal comment letter was sent to the preparing agency.

ERP No. F–AFS–K65184–CA, Rock Creek Recreational Trails Management Plan, Implementation, Eldorado National Forest, Georgetown Ranger District, Eldorado County, CA.

Summary: Review of the Final EIS has been completed and the project found to be satisfactory. No formal comment letter was sent to the preparing agency.

ERP No. F–DOE–K08021–CA, Sutter Power Plant Project, Operation and Maintenance of a High-Voltage Electric Transmission, 500 megawatt (MW) Gas Fueled, Sutter County, CA.

Summary: EPA continues to express concerns about the adverse impact to wetlands.

ERP No. F–FHW–F40369–WI, US 141 Highway Transportation Project, Improvement between WI–22 and WI–64 (LeMere Road-6th Road), Funding and COE Section 4 Permit, Marinette and Oconto Counties, WI.

Summary: EPA expressed environmental objections on the basis of the projected secondary impacts to the Baraboo Range National Natural Landmark (BRNNL) area. The secondary impacts (due to the increased potential for development) to the BRNNL from a bridge build alternative or a Year-Round ferry alternative are significant, therefore EPA recommends selection of the NO Build alternative (FI) or Seasonal 24-Vehicle ferry alternative (F2).

ERP No. F–NAS–K59011–CA, Programmatic EIS—NASA Ames Aerodynamic Testing Program, Implementation, Analyzation of the Noise Envelope of Future Wind Tunnel Testing at the National Full-Scale Aerodynamic Complex (NFAC), NASA Ames Research Center, Moffet Field, Santa Clara County, CA.

ERP No. F–NAS–K59011–CA, Programmatic EIS—NASA Ames Aerodynamic Testing Program, Implementation, Analyzation of the Noise Envelope of Future Wind Tunnel Testing at the National Full-Scale Aerodynamic Complex (NFAC), NASA Ames Research Center, Moffet Field, Santa Clara County, CA.

Summary: Review of the Final EIS was not deemed necessary. No formal comment letter was sent to the preparing agency.

Dated: July 27, 1999.

William D. Dickerson,

Director, NEPA Compliance Division, Office of Federal Activities.

[FR Doc. 99–19626 Filed 7–29–99; 8:45 am]

BILLING CODE 6560–50–M

ENVIRONMENTAL PROTECTION AGENCY

[PB–402404–NH/RI; FRL–6091–3]

Lead-Based Paint Activities in Target Housing and Child-Occupied Facilities; States of Rhode Island and New Hampshire Authorization Applications

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice; request for comments and opportunity for public hearing.

SUMMARY: On April 30, 1999, Rhode Island and on June 30, 1999, New Hampshire submitted applications for EPA approval to administer and enforce training and certification requirements, training program accreditation requirements, and work practice standards for lead-based paint activities in target housing and child-occupied facilities under section 402 of the Toxic Substances Control Act (TSCA). This notice announces the receipt of the applications from Rhode Island and New Hampshire and the opening of a public comment period that will last for 45 days. Rhode Island and New Hampshire have provided individual State self-certifications of lead programs meeting the requirements for approval under section 404 of TSCA. Therefore, pursuant to section 404, each of these State programs is deemed authorized as of the date of submission. If EPA subsequently finds that a program does not meet all the requirements for approval of a State program, EPA will work with the State to correct any deficiencies in order to approve the program. If the deficiencies are not corrected, a notice of disapproval will be issued in the **Federal Register** and a Federal program will be implemented in the State whose program has been disapproved.

DATES: Individuals should submit comments on the authorization applications on or before September 13, 1999. In addition, a public hearing request may be submitted by September 13, 1999. If a public hearing is requested and granted, the hearing date and time will be announced in the **Federal Register**.

ADDRESSES: Submit in duplicate all written comments and/or requests for a public hearing, identified by docket

control number ''PB–402404–NH/RI'' to: Environmental Protection Agency, Region I, (CPT), Suite 1100, One Congress Street, Boston, MA 02114–2023. Comments and a request for a public hearing may be submitted electronically to BRYSON.JAMESM@epamail.epa.gov. Please follow the instructions in Unit IV. of this document. No confidential business information (CBI) should be submitted through e-mail.

FOR FURTHER INFORMATION CONTACT: James M. Bryson, Regional Abatement Coordinator, Environmental Protection Agency, Region I, (CPT), Suite 1100, One Congress Street, Boston, MA 02214–2023. Telephone: 617–918–1524, e-mail: BRYSON.JAMESM@epamail.epa.gov.

SUPPLEMENTARY INFORMATION:

I. Background

On October 28, 1992, the Housing and Community Development Act of 1992, Public Law 102-550, became law. Title X of that statute is the Residential Lead-Based Paint Hazard Reduction Act of 1992. That Act amended the Toxic Substances Control Act (''TSCA'') (15 U.S.C. 2601 *et seq.*) by adding Title IV (15 U.S.C. 2681–92) which is entitled ''Lead Exposure Reduction.''

Section 402 of TSCA (15 U.S.C. 2682) authorizes and directs EPA to promulgate final regulations governing lead-based paint activities in target housing, public and commercial buildings, bridges and other structures. Those regulations are to ensure that individuals engaged in such activities are properly trained, that training programs are accredited, and that individuals engaged in those activities are certified and follow documented work practice standards. Under section 404, a State may seek authorization from EPA to administer and enforce its own lead-based paint activities program.

On August 29, 1996 (61 FR 45777) (FRL–5389–9), EPA promulgated final TSCA section 402/404 regulations governing lead-based paint activities in target housing and child-occupied facilities (a subset of public buildings). Those regulations are codified at 40 CFR part 745, and allow both States and Indian Tribes to apply for program authorization. On August 31, 1998, EPA was required to institute the Federal program in States or Indian Country not having an authorized program, as provided by section 404(h) of TSCA. States and Indian Tribes that choose to apply for program authorization must submit a complete application to the appropriate Regional EPA office for review. EPA is required to review those applications within 180 days of receipt of the complete application. To receive EPA approval, a State or Indian Tribe must demonstrate that its program is at least as protective of human health and the environment as the Federal program, and that its program provides adequate enforcement. EPA's regulations (40 CFR part 745, subpart Q) provide the detailed requirements a State or Tribal program must meet in order to obtain EPA approval.

A State may choose to certify that its lead-based paint activities program meets the requirements for EPA approval by submitting a letter signed by the Governor or Attorney General stating that the program meets the requirements of section 404(b) of TSCA and concluding, based on the required program analysis, that the State program is at least as protective as the Federal program and that the State program provides adequate enforcement.

Upon submission of such certification letter, along with a complete program application, the program is deemed authorized. This authorization is retracted, however, if upon review, EPA subsequently determines that the program is not at least as protective of human health and the environment as the Federal program, and/or does not provide for adequate enforcement, and the State does not correct the deficiencies necessary to make it so. Section 404(b) of TSCA provides that before authorizing a State program, EPA must provide notice and an opportunity for a public hearing on the application. Therefore, by this notice EPA is soliciting public comment on whether the applications submitted by the States of Rhode Island and New Hampshire meet the requirements for EPA approval. This notice also provides an opportunity to request a public hearing on the applications. If a hearing is requested and granted, EPA will issue a **Federal Register** notice announcing the date, time, and place of the hearing. If EPA's final decision on the application is a disapproval, this will be discussed in another **Federal Register** Notice.

II. State Program Description Summary

The Rhode Island and New Hampshire programs: (1) Require abatement permits prior to the commencement of abatement activity; (2) investigate tips and complaints, and enforce certification, accreditation, and permitting requirements for all disciplines and for all abatement-related activities, including training; and (3) provide for the suspension and/or revocation of the accreditation of training providers, as well as of the certifications of individuals and firms engaged in lead abatement practices.

The following are summaries of the programs proposed by Rhode Island and New Hampshire.

Rhode Island

The State of Rhode Island and Providence Plantations submitted a Lead Poisoning Prevention Program established by Title 23, Chapter 24.6 of the Rhode Island General Laws (RIGL), the Rhode Island Department of Health Rules and Regulations for Lead Poisoning Prevention (R23-24.6-PB), enacted February 1992 and last amended October 1997, and Rhode Island Department of Environmental Management Air Pollution Control Regulation No 24--Removal of Lead Based Paint from Exterior Surfaces, enacted April 1993.

This program includes: (1) Statewide standards for lead-based paint, dust, soil, and water hazard identification and remediation; (2) approval and monitoring of training programs for lead hazard reduction and environmental lead inspection personnel; (3) licensure of lead hazard reduction contractors, supervisors and workers; (4) certification of environmental lead inspectors and inspector technicians; (5) oversight of lead poisoning cases and evaluation of trends in blood lead levels utilizing the Department of Health Lead Surveillance System and the Department of Health Adult Blood Lead Registry; (6) a full range of clinical and environmental lead-related testing services provided by the RI Department of Health- Division of Laboratories; and (7) health education and community outreach activities to promote lead safe behavior and conditions.

This overall program has been implemented by the RI Department of Health Office of Occupational & Radiological Health and Office of Environmental Health Risk Assessment, the RI Department of Environmental Management Office of Compliance and Inspections, and the RI Department of the Attorney General.

New Hampshire

The State of New Hampshire has submitted a Lead Poisoning Prevention Program established by the New Hampshire Revised Statutes Annotated Chapter 130-A, and New Hampshire Chapter He-P 1600, the Lead Poisoning Prevention and Control Rules. This program includes: (1) Licensure and certification requirements for those professionals who carry out lead abatement and inspection activities; (2) procedures and requirements for the accreditation and reaccreditation of training providers; (3) work practice standards for conducting lead-based

paint activities; (4) certification requirements for laboratories performing tests to detect or measure lead in human body fluids and tissues; (5) reporting requirements for laboratories who conduct blood lead analysis on adults or children residing in New Hampshire; and (6) procedures and requirements for enforcement of the rules within the state. The program has been implemented by the Department of Health & Human Services, Office of Community and Public Health.

III. Public Record and Electronic Submissions

The official record for this action, as well as the public version, has been established under docket control number ''PB–402404–NH/RI.'' Copies of this notice, and all comments received on the applications are available for inspection in the EPA Region I Office from 7:30 a.m. to 4 p.m., Monday through Friday, excluding legal holidays. The docket is located at the EPA Region I Library, Suite 1100, One Congress Street, Boston, MA 02114-2023. Commenters are encouraged not to include CBI in their comments. However, any information submitted and claimed as CBI must be clearly identified as such and marked ''confidential,'' ''CBI,'' or with some other appropriate designation. In addition, a commenter submitting such information must prepare a nonconfidential version (in duplicate) that can be placed in the public record. Any information so marked will be handled in accordance with the procedures contained in 40 CFR part 2. Comments and information not claimed as CBI at the time of submission will be placed in the public record.

Electronic comments can be sent directly to EPA at:

BRYSON.JAMESM@epamail.epa.gov

Electronic comments must be submitted as an ASCII file avoiding the use of special characters and any form of encryption. Comments and data will also be accepted on disks in WordPerfect 5.1/6.1 or ASCII file format. All comments and data in electronic form must be identified by the docket control number ''PB–402404–NH/RI.'' Electronic comments on this document may be filed online at many Federal Depository Libraries. Information claimed as CBI should not be submitted electronically.

IV. Regulatory Assessment Requirements

A. Certain Acts and Executive Orders

EPA's actions on State or Tribal lead-based paint activities program applications are informal adjudications, not rules. Therefore, the requirements of the Regulatory Flexibility Act (RFA, 5 U.S.C. 601 *et seq.*), the Congressional Review Act (5 U.S.C. 801 *et seq.*), Executive Order 12866 (''Regulatory Planning and Review,'' 58 FR 51735, October 4, 1993), and Executive Order 13045 (''Protection of Children from Environmental Health Risks and Safety Risks,'' 62 FR 1985, April 23, 1997), do not apply to this action. This action does not contain any Federal mandates, and therefore is not subject to the requirements of the Unfunded Mandates Reform Act (2 U.S.C. 1531-1538). In addition, this action does not contain any information collection requirements and therefore does not require review or approval by the Office of Management and Budget (OMB) under the Paperwork Reduction Act (44 U.S.C. 3501 *et seq.*).

B. Executive Order 12875

Under Executive Order 12875, entitled ''Enhancing Intergovernmental Partnerships'' (58 FR 58093, October 28, 1993), EPA may not issue a regulation that is not required by statute and that creates a mandate upon a State, local, or Tribal government, unless the Federal government provides the funds necessary to pay the direct compliance costs incurred by those governments. If the mandate is unfunded, EPA must provide to OMB a description of the extent of EPA's prior consultation with representatives of affected State, local, and Tribal governments, the nature of their concerns, copies of any written communications from the governments, and a statement supporting the need to issue the regulation. In addition, Executive Order 12875 requires EPA to develop an effective process permitting elected officials and other representatives of State, local, and Tribal governments ''to provide meaningful and timely input in the development of regulatory proposals containing significant unfunded mandates.'' Today's action does not create an unfunded Federal mandate on State, local, or Tribal governments. This action does not impose any enforceable duties on these entities. Accordingly, the requirements of section 1(a) of Executive Order 12875 do not apply to this action.

C. Executive Order 13084

Under Executive Order 13084, entitled ''Consultation and Coordination with Indian Tribal Governments'' (63 FR 27655, May 19, 1998), EPA may not issue a regulation that is not required by statute, that significantly or uniquely affects the communities of Indian tribal governments, and that imposes substantial direct compliance costs on those communities, unless the Federal government provides the funds necessary to pay the direct compliance costs incurred by the Tribal governments. If the mandate is unfunded, EPA must provide OMB, in a separately identified section of the preamble to the rule, a description of the extent of EPA's prior consultation with representatives of affected Tribal governments, a summary of the nature of their concerns, and a statement supporting the need to issue the regulation. In addition, Executive Order 13084 requires EPA to develop an effective process permitting elected and other representatives of Indian tribal governments ''to provide meaningful and timely input in the development of regulatory policies on matters that significantly or uniquely affect their communities.'' Today's action does not significantly or uniquely affect the communities of Indian tribal governments. This action does not involve or impose any requirements that affect Indian Tribes. Accordingly, the requirements of section 3(b) of Executive Order 13084 do not apply to this action.

Authority: 15 U.S.C. 2682, 2684.

List of Subjects

Environmental protection, Hazardous substances, Lead, Reporting and recordkeeping requirements.

Dated: July 19, 1999.

John P. DeVillars,

Regional Administrator, Region I.

[FR Doc. 99–19592 Filed 7–29–99; 8:45 am]

BILLING CODE 6560–50–F

ENVIRONMENTAL PROTECTION AGENCY

[OPP–34161C; FRL–6097–2]

Methyl Parathion; Notice of Time Change for Public Meeting on Revised Organophosphate Risk Assessments

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice.

SUMMARY: EPA will hold a public meeting to present the revised risk assessments for one organophosphate pesticide, methyl parathion, to interested stakeholders. This public meeting, called a ''Technical Briefing,'' will provide an opportunity for stakeholders to learn about the data, information, and methodologies that the Agency used in revising its risk assessments for methyl parathion. In addition, representatives of the U.S.

Department of Agriculture (USDA) will provide ideas on possible risk management for methyl parathion.

DATES: The technical briefing will be held on Monday, August 2, 1999, from 3 p.m. to 6 p.m.

ADDRESSES: The technical briefing will be held at the Holiday Inn-Old Town, 625 First St., Alexandria, VA, (703) 548–6300.

FOR FURTHER INFORMATION CONTACT: Karen Angulo, Special Review and Registration Division (7508C), Office of Pesticide Programs, Environmental Protection Agency, 401 M St., SW., Washington, DC 20460; telephone number: (703) 308–8004; e-mail address: angulo.karen@epa.gov.

SUPPLEMENTARY INFORMATION:

I. General Information

A. Does this Action Apply to Me?

This action applies to the public in general. As such, the Agency has not attempted to specifically describe all the entities potentially affected by this action. The Agency believes that a wide range of stakeholders will be interested in technical briefings on organophosphates, including environmental, human health, and agricultural advocates, the chemical industry, pesticide users, and members of the public interested in the use of pesticides on food. If you have any questions regarding the applicability of this action to a particular entity, consult the person listed in the ''FOR FURTHER INFORMATION CONTACT'' section.

B. How Can I Get Additional Information, Including Copies of this Document or Other Related Documents?

1. *Electronically*. You may obtain electronic copies of this document and certain other available documents from the EPA Internet Home Page at http://www.epa.gov/. On the Home Page select ''Laws and Regulations'' and then look up the entry for this document under the '' **Federal Register**—Environmental Documents.'' You can also go directly to the **Federal Register** listings at http://www.epa.gov/fedrgstr/.

A brief summary of the methyl parathion revised risk assessments is now available at: http://www.epa.gov/pesticides/op/status.htm/, as well as in paper as part of the public version of the official record as described in Unit I.B.2. of this document. To access information about the revised risk assessments, which are scheduled for release on the day of the technical briefing, for the organophosphate pesticide methyl parathion, go directly to the Home Page for the Office of Pesticide Programs at http://www.epa.gov/pesticides/op/.

2. *In person*. The Agency has established an official record for this action under docket control number OPP–34161C. The official record consists of the documents specifically referenced in this action, any public comments received during the applicable comment period, and other information related to this action, including information claimed as Confidential Business Information (CBI). This official record includes the documents that are physically located in the docket, as well as the documents that are referenced in those documents. The public version of the official record does not include any information claimed as CBI. The public version of the official record, which includes printed, paper versions of any electronic comments submitted during the applicable comment period, is available for inspection in Rm. 119, Crystal Mall #2, 1921 Jefferson Davis Hwy., Arlington, VA, from 8:30 a.m. to 4 p.m., Monday through Friday, excluding legal holidays. The Public Information and Records Integrity Branch telephone number is (703) 305–5805.

II. What Action has EPA Taken?

This document announces the Agency's intention to hold a technical briefing for the organophosphate pesticide, methyl parathion. The Agency is presenting the revised risk assessments for methyl parathion to interested stakeholders. Technical briefings are designed to provide stakeholders with an opportunity to become even more informed about an organophosphate's risk assessment. EPA will describe in detail the revised risk assessments, including: The major points (e.g., contributors to risk estimates); how public comment on the preliminary risk assessments affected the revised risk assessments; and the pesticide use information/data that was used in developing the revised risk assessments. Stakeholders will have an opportunity to ask

clarifying questions. In addition, representatives of the USDA will provide ideas on possible risk management for methyl parathion.

Technical briefings are part of the pilot public participation process that EPA and USDA are now using for involving the public in the reassessment of pesticide tolerances under the Food Quality Protection Act (FQPA), and the reregistration of individual organophosphate pesticides under the Federal Insecticide, Fungicide, and Rodenticide Act (FIFRA). The pilot public participation process was developed as part of the EPA-USDA Tolerance Reassessment Advisory Committee (TRAC), which was established in April 1998 as a subcommittee under the auspices of EPA's National Advisory Council for Environmental Policy and Technology. A goal of the pilot public participation process is to find a more effective way for the public to participate at critical junctures in the Agency's development of organophosphate risk assessment and risk management decisions. EPA and USDA began implementing this pilot process in August 1998 in response to Vice President Gore's directive to increase transparency and opportunities for stakeholder consultation.

On the day of the technical briefing, in addition to making copies available at the meeting site, the Agency will also release for public viewing the methyl parathion revised risk assessments and related documents to the Public Information and Records Integrity Branch and the OPP Internet web site that are described in Unit I.B.1. of this document. In the near future, the Agency will issue a **Federal Register** notice to provide an opportunity for a 60-day public participation period during which the public may submit recommendations and proposals for transition.

List of Subjects

Environmental protection, Chemicals, Pesticides and pests.

Dated: July 27, 1999.

Jack E. Housenger,

Acting Director, Special Review and Reregistration Division, Office of Pesticide Programs.

[FR Doc. 99–19725 Filed 7–28–99; 2:49 pm]

BILLING CODE 6560–50–F

FEDERAL COMMUNICATIONS COMMISSION

Notice of Public Information Collection(s) Being Reviewed by the Federal Communications Commission, Comments Requested

July 26, 1999.

SUMMARY: The Federal Communications Commission, as part of its continuing effort to reduce paperwork burden invites the general public and other Federal agencies to take this opportunity to comment on the following information collection, as required by the Paperwork Reduction Act of 1995, Public Law 104–13. An agency may not conduct or sponsor a collection of information unless it displays a currently valid control number. No person shall be subject to any penalty for failing to comply with a collection of information subject to the Paperwork Reduction Act (PRA) that does not display a valid control number. Comments are requested concerning (a) whether the proposed collection of information is necessary for the proper performance of the functions of the Commission, including whether the information shall have practical utility; (b) the accuracy of the Commission's burden estimate; (c) ways to enhance the quality, utility, and clarity of the information collected; and (d) ways to minimize the burden of the collection of information on the respondents, including the use of automated collection techniques or other forms of information technology.

DATES: Written comments should be submitted on or before September 28, 1999. If you anticipate that you will be submitting comments, but find it difficult to do so within the period of time allowed by this notice, you should advise the contact listed below as soon as possible.

ADDRESSES: Direct all comments to Les Smith, Federal Communications Commissions, 445 12th Street, SW., Room 1–A804, Washington, DC 20554 or via the Internet to lesmith@fcc.gov.

FOR FURTHER INFORMATION CONTACT: For additional information or copies of the information collections contact Les Smith at (202) 418–0217 or via the Internet at lesmith@fcc.gov.

SUPPLEMENTARY INFORMATION:

OMB Control Number: 3060–0564.

Title: Section 76.924 Allocation to service cost categories.

Form Number: N/A.

Type of Review: Extension of a currently approved collection.

Respondents: Business and other for-profit entities.

Number of Respondents: 50.

Estimated Time Per Response: 40 hours.

Frequency of Response: Once.

Total Annual Burden: 2,000 hours.

Total Annual Costs: $0.

Needs and Uses: Section 76.924 of the Commission's rules specifies cost accounting and cost allocation requirements for regulated cable operators. Section 76.924 was established as part of the cable rate regulation requirements set forth in the Cable Television Consumer Protection and Competition Act of 1992 (''1992 Cable Act''). This collection (3060–0564) accounts for the burden imposed on cable operators to rearrange their accounting records to be in compliance with the requirements set forth in Section 76.924. At this time, that burden should be considered a one-time only recordkeeping requirement for new cable operators. The original requirements set forth in Section 76.924 became effective July 21, 1993. Existing operators are therefore assumed to have already rearranged their accounting records and are in compliance with this recordkeeping requirement.

Information derived from accounting records that are arranged in compliance with Section 76.924 is used by the cable operators themselves when completing rate filings and by local franchising authorities when reviewing rate filings.

Federal Communications Commission.

William F. Caton,

Deputy Secretary.

[FR Doc. 99–19475 Filed 7–29–99; 8:45 am]

BILLING CODE 6712–01–P

FEDERAL COMMUNICATIONS COMMISSION

Notice of Public Information Collection(s) Submitted to OMB for Review and Approval

July 22, 1999.

SUMMARY: The Federal Communications Commission, as part of its continuing effort to reduce paperwork burden invites the general public and other Federal agencies to take this opportunity to comment on the following information collection, as required by the Paperwork Reduction Act of 1995, Public Law 104–13. An agency may not conduct or sponsor a collection of information unless it displays a currently valid control number. No person shall be subject to any penalty for failing to comply with a collection of information subject to the Paperwork Reduction Act (PRA) that does not display a valid control number. Comments are requested concerning (a)

whether the proposed collection of information is necessary for the proper performance of the functions of the Commission, including whether the information shall have practical utility; (b) the accuracy of the Commission's burden estimate; (c) ways to enhance the quality, utility, and clarity of the information collected; and (d) ways to minimize the burden of the collection of information on the respondents, including the use of automated collection techniques or other forms of information technology.

DATES: Written comments should be submitted on or before August 30, 1999. If you anticipate that you will be submitting comments, but find it difficult to do so within the period of time allowed by this notice, you should advise the contact listed below as soon as possible.

ADDRESSES: Direct all comments to Les Smith, Federal Communications Commissions, Room 1–A804, 445 12th Street, SW., Washington, DC 20554 or via the Internet to lesmith@fcc.gov.

FOR FURTHER INFORMATION CONTACT: For additional information or copies of the information collections contact Les Smith at (202) 418–0217 or via the Internet at lesmith@fcc.gov.

SUPPLEMENTARY INFORMATION:

OMB Control Number: 3060–0139.

Title: Application for Antenna Structure Registration and Antenna Structure.

Form Numbers: FCC 854, FCC 854 R, and FCC 854 ULS.

Type of Review: Extension of a currently approved collection.

Respondents: Business or other for-profit entities; Not-for-profit institutions; Individuals or households; and State, Local, or Tribal Government.

Number of Respondents: 4,500.

Estimated Time Per Response: 5 mins. (50 responses/yr.).

Frequency of Response: On occasion reporting requirements; Third party disclosure.

Total Annual Burden: 6,750 hours.

Total Annual Cost: $181,800.

Needs and Uses: FCC Forms 854/854 R are to register structures used for wire or radio communication services within the United States, or to make changes to an existing registered structure, or to notify the Commission of the dismantlement of a structure. This revision seeks approval to combine FCC FCC Forms 854 ULS and 854 O, due to the costs involved in programming separate forms for electronic filing. FCC 854 ULS will collect Taxpayer Information Number (TIN) of the antenna structure owner. Additionally, the form collects a Sub-Group Identification Number (SGIN) in cases where an entity such as a governmental entity or academic institution is divided into separate groups where each is responsible for its own registration. Antenna structure owners will be required to file either the current form or the new form, depending upon the timeframe in which the Antenna Structure Registration database is converted to ULS. Owners will be required to file the current form 854 until such time as a public notice is issued announcing conversion to ULS and requirements to begin using the Form 854 ULS, then Form 854 process will no longer be available.

OMB Control Number: 3060–0801.

Title: Amendment of the Commission's Rules Regarding Installment Payment Financing for Personal Communications (PCS) Licenses, FCC 98–176, WT Docket No. 97–82, Fourth Report and Order, 13 FCC Rcd 15,743 (1988), 63 FR 50,791 (September 23, 1998).

Form Numbers: N/A.

Type of Review: Extension of a currently approved collection.

Respondents: Business or other for-profit entities; Not-for-profit institutions; Individuals or households; and State, Local, or Tribal Government.

Number of Respondents: 750.

Estimated Time Per Response: 15 mins. (0.25 hrs.).

Frequency of Response: One time reporting requirement.

Total Annual Burden: 188 hours.

Total Annual Cost: None.

Needs and Uses: The Fourth Report and Order, in WT Docket No. 97–82, 47 CFR 1.2105 (a)(2)(xi), 24.709 (a)(5), requires each applicant for C Block Broadband PCS Spectrum to attach to its short-form application a statement indicating (under penalty of perjury) whether or not the applicant has ever been in default on any FCC licensees or has ever been delinquent on any non-tax debt owed to any Federal agency. This information allows the FCC to determine the amount of the upfront payment to be paid by each applicant and will help to ensure that C Block Auctions are conducted fairly and efficiently, thereby speeding the flow of payments to the U.S. Treasury and accelerating the provisions of PCS Spectrum to the public.

Federal Communications Commission.

William F. Caton,

Assistant Secretary.

[FR Doc. 99–19471 Filed 7–29–99; 8:45 am]

BILLING CODE 6712–01–P

FEDERAL COMMUNICATIONS COMMISSION

Notice of Public Information Collection(s) Being Submitted to OMB for Review and Approval.

July 23, 1999.

SUMMARY: The Federal Communications Commission, as part of its continuing effort to reduce paperwork burden invites the general public and other Federal agencies to take this opportunity to comment on the following information collection, as required by the Paperwork Reduction Act of 1995, Public Law 104–13. An agency may not conduct or sponsor a collection of information unless it displays a currently valid control number. No person shall be subject to any penalty for failing to comply with a collection of information subject to the Paperwork Reduction Act (PRA) that does not display a valid control number. Comments are requested concerning (a) whether the proposed collection of information is necessary for the proper performance of the functions of the Commission, including whether the information shall have practical utility; (b) the accuracy of the Commission's burden estimate; (c) ways to enhance the quality, utility, and clarity of the information collected; and (d) ways to minimize the burden of the collection of information on the respondents, including the use of automated collection techniques or other forms of information technology.

DATES: Written comments should be submitted on or before August 30, 1999. If you anticipate that you will be submitting comments, but find it difficult to do so within the period of time allowed by this notice, you should advise the contact listed below as soon as possible.

ADDRESSES: Direct all comments to Les Smith, Federal Communications Commission, Room 1–A804, 445 12th Street, S.W., Washington, DC 20554 or via the Internet to lesmith@fcc.gov.

FOR FURTHER INFORMATION CONTACT: For additional information or copies of the information collections contact Les Smith at (202) 418–0217 or via the Internet at lesmith@fcc.gov.

SUPPLEMENTARY INFORMATION:

OMB Control Number: 3060–0329.

Title: Equipment Authorization—Verification, 47 CFR 2.955.

Form Number: N/A.

Type of Review: Extension of a currently approved collection.

Respondents: Business or other for-profit entities.

Number of Respondents: 5,655.

Estimate Time Per Response: 18 hours (avg.).

Frequency of Response: Recordkeeping; On occasion reporting requirements.

Total Annual Burden: 101,790 hours.

Total Annual Costs: $1,131,000.

Needs and Uses: The FCC's Rules require verification of compliance to establish technical standards for certain Part 15 and Part 18 devices. Technical data are gathered and retained by the equipment manufacturers in order to verify compliance with these regulations. The information may be used to determine that the equipment marketed complies with the applicable Commission rules and that the operation of the equipment is consistent with the initially documented test results. The information is essential to controlling potential interference to radio communications.

OMB Control Number: 3060–0704.

Title: Policy and Rules Concerning the Interstate, Interexchange Marketplace; Implementation of Section 254(g) of the Communications Act of 1934, as amended, CC Docket No. 96–61.

Form Number: None .

Type of Review: Revision of a currently approved collection.

Respondents: Business or other for-profit entities.

Number of Respondents: 519.

Estimate Time Per Response: 0.5 to 20.0 hours.

Frequency of Response: Recordkeeping; On occasion reporting requirements; Third party disclosure.

Total Annual Burden: 158,935 hours.

Total Annual Costs: $435,000.

Needs and Uses: In CC Docket No. 96–61, the FCC reinstates the public disclosure requirement and also requires that nondominant interexchange carriers that have Internet websites past this information on-line in a timely and easily accessible manner. The information collection requirements must be disclosed to the public to ensure that consumers have access to the information they need to select a telecommunications carrier and to bring to the Commission's attention, possible violations of the Communications Act without a specific public disclosure requirement.

Federal Communications Commission.

William F. Caton,

Deputy Secretary.

[FR Doc. 99–19472 Filed 7–29–99; 8:45 am]

BILLING CODE 6712–01–P

FEDERAL COMMUNICATIONS COMMISSION

Notice of Public Information Collection(s) Being Submitted to OMB for Review and Approval

July 21, 1999.

SUMMARY: The Federal Communications Commissions, as part of its continuing effort to reduce paperwork burden invites the general public and other Federal agencies to take this opportunity to comment on the following information collection, as required by the Paperwork Reduction Act of 1995, Public Law 104–13. An agency may not conduct or sponsor a collection of information unless it displays a currently valid control number. No person shall be subject to any penalty for failing to comply with a collection of information subject to the Paperwork Reduction Act (PRA) that does not display a valid control number. Comments are requested concerning (a) whether the proposed collection of information is necessary for the proper performance of the functions of the Commission, including whether the information shall have practical utility; (b) the accuracy of the Commission's burden estimate; (c) ways to enhance the quality, utility, and clarity of the information collected; and (d) ways to minimize the burden of the collection of information on the respondents, including the use of automated collection techniques or other forms of information technology.

DATES: Written comments should be submitted on or before August 30, 1999. If you anticipate that you will be submitting comments, but find it difficult to do so within the period of time allowed by this notice, you should advise the contact listed below as soon as possible.

ADDRESSES: Direct all comments to Les Smith, Federal Communications Commission, Room 1–A804, 445 12th Street, S.W., Washington, DC 20554 or via the Internet to lesmith@fcc.gov.

FOR FURTHER INFORMATION CONTACT: For additional information or copies of the information collections contact Les Smith at (202) 418–0217 or via the Internet at lesmith@fcc.gov.

SUPPLEMENTARY INFORMATION:

OMB Control Number: 3060–0003.

Title: Application Form 610 for Amateur Operator/Primary Station License.

Form Number: FCC 610.

Type of Review: Revision of a currently approved collection.

Respondents: Individuals or households.

Number of Respondents: 79,000.

Estimate Time Per Response: 20 mins. (0.33 hrs.).

Frequency of Response: On occasion reporting requirements.

Total Annual Burden: 26,070 hours.

Total Annual Costs: $208,000.

Needs and Uses: FCC's Rules, 47 CFR 97.17, 97.19, and 97.519; the Communications Act of 1934, as amended; and International Treaties require that applicants file the FCC Form 610 to apply for a new or modified Amateur Operator/Primary Station License. Form 610 may also be used to renew an Amateur Operator/Primary Station License. Commission staff use the data to determine eligibility for radio station authorization and to issue radio station/operator licenses. Data are also used by Compliance and Information Bureau personnel in conjunction with Field Engineers for enforcement and interference resolution purposes. The Commission implemented a program change in which it has eliminated mailing of FCC Form 610 R, and applicants may choose to file for renewal electronically via the VEC program or file FCC Form 610 manually.

OMB Control Number: 3060–0069.

Title: Application for Commercial Radio Operator License.

Form Number: FCC 756.

Type of Review: Revision of a currently approved collection.

Respondents: Individuals or households.

Number of Respondents: 13,250.

Estimate Time Per Response: 20 mins. (0.33 hrs.).

Frequency of Response: On occasion reporting requirements.

Total Annual Burden: 4,373 hours.

Total Annual Costs: $211,749.

Needs and Uses: Form 756 is used by the FCC, as authorized under Section 303 (1) (1) of the Communications Act of 1934, as amended, to issue radio operator licenses to those persons found to be qualified. To properly identify oneself for an operator's license, applicants must provide their full name, date of birth, and a recent photograph. (A photograph is required of applicants for radiotelegraph licenses in accordance with Paragraph 3870 of Article 55 of the International Radio Regulations.) This form is being revised to delete the payment information, since this information is already being collected when an applicant files FCC Form 159 (Fee Remittance Advice) to make a payment to the FCC.

Federal Communications Commission.

William F. Caton,

Deputy Secretary.

[FR Doc. 99–19473 Filed 7–29–99; 8:45 am]

BILLING CODE 6712–01–P

FEDERAL COMMUNICATIONS COMMISSION

Notice of Public Information Collection(s) Submitted to OMB for Review and Approval

July 23, 1999.

SUMMARY: The Federal Communications Commission, as part of its continuing effort to reduce paperwork burden invites the general public and other Federal agencies to take this opportunity to comment on the following information collection(s), as required by the Paperwork Reduction Act of 1995, Public Law 104–13. An agency may not conduct or sponsor a collection of information unless it displays a currently valid control number. No person shall be subject to any penalty for failing to comply with a collection of information subject to the Paperwork Reduction Act (PRA) that does not display a valid control number. Comments are requested concerning (a) whether the proposed collection of information is necessary for the proper performance of the functions of the Commission, including whether the information shall have practical utility; (b) the accuracy of the Commission's burden estimate; (c) ways to enhance the quality, utility, and clarity of the information collected; and (d) ways to minimize the burden of the collection of information on the respondents, including the use of automated collection techniques or other forms of information technology.

DATES: Written comments should be submitted on or before August 30, 1999. If you anticipate that you will be submitting comments, but find it difficult to do so within the period of time allowed by this notice, you should advise the contact listed below as soon as possible.

ADDRESSES: Direct all comments to Judy Boley, Federal Communications Commission, Room 1–C804, 445 12th Street, SW, Washington, DC 20554 or via the Internet to jboley@fcc.gov.

FOR FURTHER INFORMATION CONTACT: For additional information or copies of the information collection(s), contact Judy Boley at 202–418–0214 or via the Internet at jboley@fcc.gov.

SUPPLEMENTARY INFORMATION:

OMB Control Number: 3060–0854.

Title: Truth-in-Billing Format—CC Docket No. 98–170.

Form Number: N/A.

Type of Review: Revision of a currently approved collection.

Respondents: Business or other for-profit.

Number of Respondents: 3,099.

Estimated Time Per Response: 1 to 80 hours.

Frequency of Response: On occasion reporting requirement, third party disclosure requirement.

Total Annual Burden: 194,388 hours.

Total Annual Cost: $1,800,000–$9,000,000.

Needs and Uses: This is a resubmission of the information collection requirements contained in CC Docket 98–170, Truth-in-Billing and Billing Format Order. On July 2, 1999, the Office of Management and Budget (OMB) disapproved both the collection itself and the Commission's request for emergency approval. The Commission has addressed the concerns expressed by OMB in a separate cover letter accompanying the request for OMB approval.

Increasingly, consumers are concerned about telephone bills that do not provide sufficient information in a user-friendly format to enable them to understand the services being provided and the charges assessed, and to identify the entities providing those services. Lack of clarity in telephone bills has been a significant contributing factor in the growth of telecommunications-related fraud such as slamming (unauthorized changes in a consumer's telecommunications carrier) and cramming (unauthorized charges appearing on a consumer's telephone bill).

In the attached First Report and Order (Order), the Commission is effecting the following collections of information to ensure that telephone bills contain the information necessary for consumers to determine the validity of charges assessed on the bills and to combat telecommunications fraud. They are as follows: (a) Clear identification of service providers; (b) separation of charges by service provider and highlighting new service provider information; (c) full and non-misleading billed charges; and (d) clear and conspicuous disclosure of inquiry contacts.

The information will be used by consumers to help them understand their telephone bills.

Consumers need this information to protect themselves against fraud and to resolve billing disputes on their own.

Federal Communications Commission.

William F. Caton,

Deputy Secretary.

[FR Doc. 99–19474 Filed 7–29–99; 8:45 am]

BILLING CODE 6712–01–P

DEPARTMENT OF ENERGY

Federal Deposit Insurance Corporation

Sunshine Act of Meeting; Notice of Agency Meeting

Pursuant to the provisions of the ''Government in the Sunshine Act'' (5 U.S.C. 552b), notice is hereby given that at 10:40 a.m. on Tuesday, July 27, 1999, the Board of Directors of the Federal Deposit Insurance Corporation met in closed session to consider matters relating to the Corporation's corporate and supervisory activities.

In calling the meeting, the Board determined, on motion of Vice Chairman Andrew C. Hove, Jr., seconded by Ms. Julie L. Williams, acting in the place and stead of Director John D. Hawke, Jr. (Comptroller of the Currency), concurred in by Director Ellen S. Seidman (Director, Office of Thrift Supervision), and Chairman Donna Tanoue, that Corporation business required its consideration of the matters on less than seven days' notice to the public; that no earlier notice of the meeting was practicable; that the public interest did not require consideration of the matters in a meeting open to public observation; and that the matters could be considered in a closed meeting by authority of subsections (c)(2), (c)(4), (c)(6), (c)(8), (c)(9)(A)(ii), (c)(9)(B), and (c)(10) of the ''Government in the Sunshine Act'' (5 U.S.C. 552b(c)(2), (c)(4), (c)(6), (c)(8), (c)(9)(A)(ii), (c)(9)(B), and (c)(10)).

The meeting was held in the Board Room of the FDIC Building located at 550—17th Street, N.W., Washington, D.C.

Dated: July 27, 1999.

Federal Deposit Insurance Corporation.

James D. LaPierre,

Deputy Executive Secretary.

[FR Doc. 99–19702 Filed 7–28–99; 12:16 pm]

BILLING CODE 6714–01–M

FEDERAL RESERVE SYSTEM

Change in Bank Control Notices; Acquisitions of Shares of Banks or Bank Holding Companies

The notificants listed below have applied under the Change in Bank Control Act (12 U.S.C. 1817(j)) and §

225.41 of the Board's Regulation Y (12 CFR 225.41) to acquire a bank or bank holding company. The factors that are considered in acting on the notices are set forth in paragraph 7 of the Act (12 U.S.C. 1817(j)(7)).

The notices are available for immediate inspection at the Federal Reserve Bank indicated. The notices also will be available for inspection at the offices of the Board of Governors. Interested persons may express their views in writing to the Reserve Bank indicated for that notice or to the offices of the Board of Governors. Comments must be received not later than August 13, 1999.

A. Federal Reserve Bank of St. Louis (Randall C. Sumner, Vice President) 411 Locust Street, St. Louis, Missouri 63102-2034:

1. Ben Harry Morgan and Tina Marie Morgan, Marshfield, Missouri; to retain voting shares of Southern Missouri Bancshares, Inc., Marshfield, Missouri, and thereby indirectly retain voting shares of Southern Missouri Bank of Marshfield, Marshfield, Missouri.

Board of Governors of the Federal Reserve System, July 26, 1999.

Robert deV. Frierson,

Associate Secretary of the Board.

[FR Doc. 99–19493 Filed 7–29–99; 8:45 am]

BILLING CODE 6210–01–F

FEDERAL RESERVE SYSTEM

Formations of, Acquisitions by, and Mergers of Bank Holding Companies

The companies listed in this notice have applied to the Board for approval, pursuant to the Bank Holding Company Act of 1956 (12 U.S.C. 1841 *et seq.*) (BHC Act), Regulation Y (12 CFR Part 225), and all other applicable statutes and regulations to become a bank holding company and/or to acquire the assets or the ownership of, control of, or the power to vote shares of a bank or bank holding company and all of the banks and nonbanking companies owned by the bank holding company, including the companies listed below.

The applications listed below, as well as other related filings required by the Board, are available for immediate inspection at the Federal Reserve Bank indicated. The application also will be available for inspection at the offices of the Board of Governors. Interested persons may express their views in writing on the standards enumerated in the BHC Act (12 U.S.C. 1842(c)). If the proposal also involves the acquisition of a nonbanking company, the review also includes whether the acquisition of the nonbanking company complies with the standards in section 4 of the BHC Act (12 U.S.C. 1843). Unless otherwise noted, nonbanking activities will be conducted throughout the United States.

Unless otherwise noted, comments regarding each of these applications must be received at the Reserve Bank indicated or the offices of the Board of Governors not later than August 23, 1999.

A. Federal Reserve Bank of Chicago (Philip Jackson, Applications Officer) 230 South LaSalle Street, Chicago, Illinois 60690-1413:

1. Illini Corporation, Springfield, Illinois; to acquire 100 percent of the voting shares of Farmers State Bank of Camp Point, Camp Point, Illinois.

Board of Governors of the Federal Reserve System, July 26, 1999.

Robert deV. Frierson,

Associate Secretary of the Board.

[FR Doc. 99–19492 Filed 7–29–99; 8:45 am]

BILLING CODE 6210–01–F

FEDERAL RETIREMENT THRIFT INVESTMENT BOARD

Sunshine Act Meeting

TIME AND DATE: 10:00 a.m. (EDT) August 9, 1999.

PLACE: 4th Floor, Conference Room 4506, 1250 H Street, N.W., Washington, D.C.

STATUS: Open.

MATTERS TO BE CONSIDERED:

1. Approval of the minutes of the July 12, 1999, Board member meeting.
2. Thrift Savings Plan activity report by the Executive Director.
3. Review of investment policy.
4. Review of Arthur Andersen semiannual financial review.

CONTACT PERSON FOR MORE INFORMATION: Thomas J. Trabucco, Director, Office of External Affairs, (202) 942–1640.

Elizabeth S. Woodruff,

Secretary to the Board of Federal Retirement Thrift Investment Board.

[FR Doc. 99–19674 Filed 7–27–99; 5:12 pm]

BILLING CODE 6760–01–M

FEDERAL TRADE COMMISSION

[File No. 9323074]

Fleet Finance Inc., et al.; Analysis To Aid Public Comment

AGENCY: Federal Trade Commission.

ACTION: Proposed consent agreement.

SUMMARY: The consent agreement in this matter settles alleged violations of federal law prohibiting unfair or deceptive acts or practices or unfair methods of competition. The attached Analysis to Aid Public Comment describes both the allegations in the draft complaint that accompanies the consent agreement and the terms of the consent order—embodied in the consent order—that would settle these allegations.

DATES: Comments must be received on or before September 28, 1999.

ADDRESSES: Comments should be directed to: FTC/Office of the Secretary, Room 159, 600 Pennsylvania Avenue, NW, Washington, DC 20580.

FOR FURTHER INFORMATION CONTACT: Carole L. Reynolds or Thomas E. Kane, FTC/S–4429, 601 Pennsylvania Avenue, NW, Washington, DC 20580, (202) 326–3230 or (202) 326–2304.

SUPPLEMENTARY INFORMATION: Pursuant to Section 6(f) of the Federal Trade Commission Act, 38 Stat. 721, 15 U.S.C. 46, and Section 2.34 of the Commission's Rules of Practice, 16 CFR 2.34, notice is hereby given that the above-captioned consent agreement containing a consent order to cease and desist, having been filed with and accepted, subject to final approval, by the Commission, has been placed on the public record for a period of sixty (60) days. The following Analysis to Aid Public Comment describes the terms of the consent agreement, and the allegations in the complaint. An electronic copy of the full text of the consent agreement package can be obtained from the FTC Home Page (for July 26, 1999), on the World Wide Web, at ''http://www.ftc.gov/os/actions97.htm.'' A paper copy can be obtained from the FTC Public Reference Room, Room H–130, 600 Pennsylvania Avenue, NW, Washington, DC 20580, either in person or by calling (202) 326–3627.

Public comment is invited. Comments should be directed to: FTC/Office of the Secretary, room 159, 600 Pennsylvania Avenue, NW, Washington, DC 20580. Two paper copies of each comment should be filed, and should be accompanied, if possible, by a 3½ inch diskette containing an electronic copy of the comment. Such comments or views will be considered by the Commission and will be available for inspesction and copying at its principal office in accordance with Section 4.9(b)(6)(ii) of the Commission's Rules of Practice (16 CFR 4.9(b)(6)(ii).

Analysis of Proposed Consent Order To Aid Public Comment

The Federal Trade Commission has accepted an agreement, subject to final

approval, to a proposed consent order from Fleet Finance, Inc., Home Equity U.S.A, Inc. (Rhode Island), and Home Equity U.S.A., Inc. (Delaware) (collectively referred to as ''respondents'').

The proposed order would settle charges that Fleet Finance, Inc., incorporated in Delaware (''Fleet Finance''), and a related, now-defunct corporation, Fleet Finance, Inc., which was incorporated in Rhode Island, violated the Truth in Lending Act (''TILA''), and its implementing Regulation Z, and the Federal Trade Commission Act (''FTC Act''). The TILA and Regulation Z require creditors to provide consumers with written disclosures of the costs and terms of consumer credit transactions and also establish various substantive protections for consumers, including the right of recission in certain mortgage transactions. Section 5 of the FTC Act prohibits, *inter alia*, deceptive acts or practices in or affecting commerce.

The proposed order has been placed on the public record for sixty (60) days for reception of comments by interested persons. Comments received during this period will become part of the public record. After sixty (60) days, the Commission will again review the agreement and the comments received and will decide whether it should withdraw from the agreement or make final the agreement's proposed order.

The complaint alleges that Fleet Finance [1] has extended consumer credit transactions in which Fleet Finance acquired or retained a security interest in the consumers' principal dwellings and failed to provide the consumers with the right to rescind the credit transactions by: (a) Failing to provide consumers with notices of the right to rescind; (b) waiving consumers' right to rescind, and disbursing funds, pursuant to rescission waivers that were insufficient; and (c) failing to take actions terminating the security interest and returning any money and property given by the consumers when consumers exercise their right to rescind. According to the complaint, these practices violate Sections 125(a), (b) and (d) of the TILA, 15 U.S.C. 1635(a), (b), and (d); and Sections 226.23(a), (b), (c), (d) and (e) of Regulation Z, 12 CFR 226.23(a), (b), (c), (d) and (e); and constitute deceptive acts or practices in violation of Section 5(a) of the FTC Act, 15 U.S.C. 45(a). The complaint also alleges that Fleet Finance purchased consumer loan transactions through assignments in which Fleet Finance acquired or retained security interests in the consumers' principal dwellings that failed in these same ways to provide the consumers with the right to rescind the credit transactions. The complaint alleges that, based on Fleet Finance's assignee liability in Section 131 of the TILA, 15 U.S.C. 1641, such purchases violate these same sections of the TILA and Regulation Z; and constitute deceptive acts or practices in violation of Section 5(a) of the FTC Act, 15 U.S.C. 45(a).

The complaint alleges that, in extending consumer credit transactions, Fleet Finance also has failed to provide consumers with all TILA disclosures of the costs and terms of credit and/or to provide all TILA disclosures prior to consummation of credit transactions. According to the complaint, these failures violate Sections 121 and 128 of the TILA, 15 U.S.C. 1631 and 1638; and Sections 226.17 and 226.18 of Regulation Z, 12 CFR 226.17 and 226.18 of Regulation Z, 12 CFR 226.17 and 226.18; and constitute deceptive acts or practices in violation of Section 5(a) of the FTC Act, 15 U.S.C. 45(a). The complaint also alleges that Fleet Finance has purchased consumer credit transactions through assignments that failed to provide all the TILA disclosures of the costs and terms of credit and/or failed to provide all the disclosures prior to consummation of credit transactions. According to the complaint, based on Fleet Finance's assignee liability in Section 131 of the TILA, 15 U.S.C. 1641, such purchases violate Sections 121 and 128 of the TILA, 15 U.S.C. 1631 and 1638, and Sections 226.17 and 226.18 of Regulation Z, 12 CFR 226.17 and 226.18; and constitute deceptive acts or practices in violation of Section 5(a) of the FTC Act, 15 U.S.C. 45(a).

The complaint further alleges that Fleet Finance, in consumer credit transactions that it extended, has failed to provide or failed to provide accurately certain TILA disclosures, including but not limited to the annual percentage rate; the number, amount, and timing of payments scheduled to repay the obligation; and the total of payments. These failures allegedly violate Sections 107 and 128 of the TILA, 15 U.S.C. 1606 and 1638; and Sections 226.18(e), (g) and (h) and 2226.22 of Regulation Z, 12 CFR 226.18(e), (g) and (h) and 226.22; and constitute deceptive acts or practices in violation of Section 5(a) of the FTC Act, 15 U.S.C. 45(a). The complaint also alleges that Fleet Finance purchased consumer credit transactions through assignments that failed to provide or failed to provide accurately the TILA disclosures listed above in this paragraph. The complaint alleges that, based on Fleet Finance's assignee liability in Section 131 of the TILA, 15 U.S.C. 1641, such purchases violate Section 128 of the TILA, 15 U.S.C. 1638, and Sections 226.18(a), (g) and (h) of Regulation Z, 12 CFR 226.18(a), (g), and (h); and constitute deceptive acts or practices in violation of Section 5(a) of the FTC Act, 15 U.S.C. 45(a).

The complaint also alleges that, in consumer credit transactions it extended, Fleet Finance has failed to retain TILA disclosures, TILA notices of the right to rescind, promissory notes and/or other evidence of the terms and conditions of consumer credit transactions for two years after the date disclosures are required to be made or action is required to be taken concerning the transaction. The compliant alleges that these acts and practices violate Section 226.25(a) of Regulation Z, 12 CFR 226.25(a). The complaint further alleges that Fleet Finance has purchased consumer credit transactions through assignments that failed to retain the documents and other evidence described above in this paragraph. According to the complaint, based on Fleet Finance's assignee liability in Section 131 of the TILA, 15 U.S.C. 1641, such purchases violate Section 226.25(a) of Regulation Z, 12 CFR 226.25(a).

To remedy the violations charged and to prevent respondents from engaging in similar acts and practices in the future, the proposed order contains a consumer redress program and injunctive provisions. The order requires respondents to pay $1.3 million for the redress program and administrative costs. Specific aspects of the redress program are contained in Appendix A to the proposed order. The program applies to certain consumers whose mortgage loans were originated or purchased by Fleet Finance, or Fleet Finance incorporated in Rhode Island (''Fleet Finance (RI)''), during January 1, 1990–December 31, 1993. It covers certain consumers whose mortgage loans, *inter alia*, were either paid off to or written off by Fleet Finance, Fleet Finance (RI), or Fleet Financial Group, Inc. (''FFG''), a parent corporation, except by foreclosure (''eligible consumers'' or ''ECs''), or were paid off by foreclosure by Fleet Finance, Fleet Finance (RI), or FFG (''eligible foreclosed consumers'' or ''EFCs''), or who contact an 800-number set up

[1] Fleet Finance is the entity charged in the complain as engaging in specified violations of the TILA, Regulation Z and the FTC Act. Fleet Finance, as well as successor corporations, Home Equity U.S.A., Inc. (Rhode Island) and Home Equity U.S.A., Inc. (Delaware), are respondents in the Agreement Containing Consent Order.

under the proposed order and who provide information showing they are, in essence, ECs or EFCs (''qualified consumers'' or ''QCs'').[2]

With ten business days after service of the order, respondents will deliver to the independent agent that will conduct the redress program two lists of the ECs and EFCs in their records.[3] The independent agent will then add those consumers, who are not on such lists, that the Division of Enforcement of the Commission's Bureau of Consumer Protection (''DOE'') specifies are ECs or EFCs and provides to the independent agent (*i.e.*, consumers who have contacted Commission staff in the past several years regarding such loans). The independent agent will mail to all consumers on the two enhanced lists a letter substantially identical to the letter attached as Appendix B to the order (''Appendix B letter'') and a claim form substantially identical to the form attached as Appendix C to the order (''Claim Form''). Consumers receiving the Appendix B letter and the Claim Form will have sixty days from the date of their Appendix B letter to return their Claim Form to the independent agent.

As noted above, the order also permits consumers who learn about this settlement and think they might fall within the definitions of either an ''eligible consumer'' or an ''eligible foreclosed consumer'' (even though they are not on the two enhanced lists) to call an 800-number staffed by the independent agent within sixty days after the date of the order.[4] The independent agent will inform the consumers that they must submit to the independent agent, within ninety days after the date of the order, documents showing that they meet the definition of an EC or an EFC (even though they are not on the two enhanced lists). Within 120 days after the date of the order, the independent agent will review any documents submitted, decide which consumers, if any, qualify for a redress payment, and submit to DOE a list of those consumers for that Division's approval. If the independent agent is unable to decide whether a particular consumer qualifies, the independent agent will forward the consumer's documents to DOE, who will make the determination.

After receiving the list of consumers whom DOE has deemed ''qualified consumers,'' the independent agent will calculate, and submit to DOE for approval, the amount of redress that, according to the independent agent, should go to each consumer (''proposed amount''). This proposed amount will be the same for each consumer who receives a redress payment. The independent agent will calculate the proposed amount by dividing the ''total available redress'' by the number of consumers permitted to receive a redress payment. The ''total available for redress'' will be the $1.3 million paid by respondents, minus: the amount of the independent agent's estimated fees; $10,000 to be reserved for contingencies; and an additional amount, if the independent agent deems it appropriate, to be reserved to pay the redress fund's tax liabilities.[5] The number of consumers permitted to receive a redress payment will be the total of (1) those consumers who were sent an Appendix B letter and submitted a Claim Form, and (2) those consumers who were deemed qualified consumers under Paragraph VIII of Appendix A. The amount of the redress payment to each consumer will not exceed $1000. In addition, no consumer will receive more than one payment, regardless of the number of transactions he or she may have had that were either extended or purchased by Fleet Finance or Fleet Finance (RI).[6]

After DOE reviews the proposed amount, makes any necessary corrections, and informs the independent agent of the approved amount, the independent agent will mail checks in the approved amount to all consumers permitted to receive a redress payment. Along with each check, the independent agent will mail a letter substantially identical to the letter attached to the order as Appendix D and the Commission's consumer education pamphlet pertaining to home equity loans. Consumers will have ninety days after their checks are mailed to cash them.[7]

Those consumers who are not deemed ''qualified consumers'' by DOE will receive a letter substantially identical to the letter attached to the order as Appendix E. The independent agent will maintain a toll-free number for consumers covered by the order that will be included on all appendix B, D, and E letters.

The order prohibits respondents from communicating with ECs or EFCs concerning the redress program, except for refer consumers to the 800-number provided by the independent agent, until the Commission staff has notified respondents that the redress program has been completed.

The proposed order prohibits respondents from misrepresenting the following in connection with any extension of consumer credit or advertisement to promote any extension of credit: the annual percentage rate; the number, amount, and timing of payments scheduled to repay the obligation and the total of payments; the right to rescind the credit transaction; or any term or condition of financing for any consumer credit transaction. The injunctive provisions also require respondents to make all the disclosures required by the provisions of the TILA, as amended, and Regulation Z and the Regulation Z Commentary, as amended, that govern transaction, such as the annual percentage rate, the total of payments, and the number, amount, and timing of scheduled payments.

In connection with rescindable credit transactions under Regulation Z, as amended, the proposed order prohibits respondents from: (1) Failing to deliver to consumers two copies of a proper Notice of Right to Rescind, as required by Regulation Z, as amended; (2) modifying or waiving a consumer's right to rescind the transaction unless the consumer gives the applicable respondent a dated written statement that describes a bona fide personal financial emergency, specifically modifies or waives the right to rescind the credit transaction, and bears the signature of all consumers entitled to rescind the credit transactions, as required by Regulation Z, as amended; (3) disbursing any money (other than to escrow), performing any service, or delivering any material unless and until (a) time has expired for receipt of the rescission notice and the applicable respondent has not received notice of the rescission from the consumer, (b) consumers entitled to waive their right to rescind do so during the three-day

[2] *See* proposed order, definition nos. 10–11. Such consumers must meet definition nos. 9(a) and 9(c), or definition nos. 10(a) and 10(c). Such consumers need not meet definition nos. 9(b) or 10(b), which require consumers' names to be reflected in certain records.

[3] If, before the date of service of the order, respondents have provided final copies of such lists, they will submit a sworn statement to that effect and need not provide additional lists after the order is served.

[4] The ''date of the order'' refers to the date when the order is served on respondents, which will not occur until after the end of the sixty-day comment that begins today.

[5] *See* Appendix A, Par. IX.

[6] If all consumers permitted to receive a redress payment have received the $1000 maximum and funds remain after payment of administrative costs, the remaining funds will be paid to the United States Treasury.

[7] The independent agent will redeposit the funds from any undeposited checks into the redress fund. If DOE determines that the redress fund has enough money to merit a second-round distribution to consumers, DOE will instruct the independent agent to conduct such a distribution. If a second-round distribution is not feasible, the independent agent will pay the funds from the undeposited checks to the Treasury instead.

rescission period, or (c) after midnight of the third business day following the later of consummation of the credit transaction, delivery of the rescission notice, or delivery of all material disclosures required by the TILA and Regulation Z, as amended, the applicable respondent obtains a signed written statement from all consumers entitled to rescind the credit transaction stating that three business days have passed since the later of consummation of the credit transaction, delivery of the rescission notice of delivery of all material disclosures, and no consumer has rescinded the credit transaction; and (4) failing to take all actions necessary to terminate the security interest created under the consumer's credit transaction and return any money that the consumer has given in connection with the credit transaction when the consumer exercises his or right to rescind, as required by Regulation Z, as amended.

The proposed order also prohibits respondents from failing to make all disclosures, and in the manner, required by the TILA and Regulation Z, as amended, and from failing in any other manner to meet the requirements of the TILA and Regulation Z, as amended, including but not limited to 15 U.S.C. 1615, as amended.

The proposed order also prohibits respondents from purchasing any consumer credit transaction in which the disclosures required by Sections 121, 122, 125, and 128 of the TILA, 15 U.S.C. 1631, 1632, 1635, and 1638, as amended, violate, on their face, any provisions of the TILA, Regulation Z and the Commentary, as amended, by, for example, inaccuracies or incompleteness or absence of disclosures required by the TILA, Regulation Z, and the Regulation Z Commentary.

The purpose of this analysis is to facilitate public comment on the proposed order, and it is not intended to constitute an official interpretation of the agreement and proposed order or to modify its terms in any way.

By direction of the Commission.

Donald S. Clark,

Secretary.

[FR Doc. 99–19519 Filed 7–29–99; 8:45 am]

BILLING CODE 6750–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Government-Owned Inventions; Availability for Licensing

AGENCY: Centers for Disease Control and Prevention (CDC), Department of Health and Human Services (DHHS).

ACTION: Notice.

The inventions named in this notice are owned by agencies of the United States Government and are available for licensing in the United States (U.S.) in accordance with 35 U.S.C. 207 to achieve expeditious commercialization of results of federally funded research and development. Foreign patent applications are filed on selected inventions to extend market coverage for U.S. companies and may also be available for licensing.

ADDRESSES: Licensing information and copies of the U.S. patent applications listed below may be obtained by writing to Thomas E. O'Toole, M.P.H., Deputy Director, Technology Transfer Office, Centers for Disease Control and Prevention (CDC), Mailstop E–67, 1600 Clifton Rd., Atlanta, GA 30333, telephone (404) 639–6266. Please note that a signed Confidential Disclosure Agreement will be required to receive copies of the patent application.

PCR and Serological Diagnosis Using the ARP Gene and Its Protein

Methods for specific and highly sensitive detection of Treponema pallidum infection compromising the use of specific antigenic proteins and peptides unique to Treponema pallidum are provided. These methods are directed to the differential detection of specific Treponema infections enabling the identification of causative agents for specific Treponema disease states. Methods are particularly useful for detection of primary syphilis at early stages of infection.

Inventors: Hsi Liu *et al.*

U.S. Patent Application SN: not yet assigned.

(CDC Ref. #: I–040–98/0)

Method and Apparatus for Cough Sound Analysis

This invention is a fast, simple, and reliable method and apparatus for recording cough sounds for diagnosing pulmonary disorders and diseases. Generated data can be used to diagnose pulmonary disorders and diseases as well as track the effectiveness of treatment regimens over time. The simple, noninvasive method allows screening of at-risk individuals and early detection of pulmonary disorders and diseases which may allow earlier treatment or environmental modification, reducing the risk of irreversible injury to pulmonary function.

Inventors: William Goldsmith *et al.*

U.S. Patent Application SN: not yet assigned.

(CDC Ref. #: I–020–99/0)

Method and Apparatus for Safety Testing Optical Systems for Hazardous Locations

Method of determining the ignition characteristics of an optical source emitting optical power into a hazardous environment. The invention will allow testing laboratories to efficiently and accurately vary the irradiance of optical sources for certifying the safety of optical systems in hazardous locations. This new method will improve the accuracy of tests, simplifies test setup, reduces setup time, and reduces component inventory. The use of fiber tapers, rather than external components, reduces the risk of human exposure to potentially dangerous optical beams.

Inventors: Thomas Dubaniewicz *et al.*

U.S. Patent Application SN: not yet received.

(CDC Ref. #: I–015–97/0)

Methods and Compositions for Opsonophagocytic Assays

This invention describes the use of immunoassays for the detection of functional antibodies and the analysis of vaccine efficacy, particularly relating to Streptococcus pneumoniae. This method of pneumococcal vaccine measurement using ''functional'' opsonophagocytic assays is compliant with the new FDA requirements and is a significant improvement over existing assays. The invention measures vaccine efficacy and allows simultaneous detection of functional antibodies generated by multiple serotypes of a pathogen. Antibody response is easier and faster to measure and output is significantly increased.

Inventors: Joseph E. Martinez *t al.*

U.S. Patent Application SN: not yet received.

(CDC Ref. #: I–006–99/0)

Dated: July 26, 1999.

Joseph R. Carter,

Acting Associate Director for Management and Operations, Centers for Disease Control and Prevention (CDC).

[FR Doc. 99–19499 Filed 7–29–99; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Translation Advisory Committee for Diabetes Prevention and Control Programs: Meeting

In accordance with section 10(a)(2) of the Federal Advisory Committee Act (Pub. L. 92–463), the Centers for Disease Control and Prevention (CDC) announces the following committee meeting.

Name: Translation Advisory Committee for Diabetes Prevention and Control Programs.

Times and Dates: 9 a.m.–6 p.m., September 15, 1999; 9 a.m.–1 p.m., September 16, 1999.

Place: Holiday Inn Select, 130 Clairemont Avenue, Decatur, Georgia 30030, telephone 404/371–0204.

Status: Open to the public, limited only by the space available. The meeting room accommodates approximately 50 people.

Purpose: This committee is charged with advising the Director, CDC, regarding policy issues and broad strategies for diabetes translation activities and control programs designed to reduce risk factors, health services utilization, costs, morbidity, and mortality associated with diabetes and its complications. The Committee identifies research advances and technologies ready for translation into widespread community practice; recommends broad public health strategies to be implemented through public health interventions; identifies opportunities for surveillance and epidemiologic assessment of diabetes and related complications; and for the purpose of assuring the most effective use and organization of resources, maintains liaison and coordination of programs within the Federal, voluntary, and private sectors involved in the provision of services to people with diabetes.

Matters to be Discussed: The Guide to Community Preventive Services, under the auspices of the U.S. Public Health Service, a Task Force on Community Preventive Services is developing a Guide to Community Preventive Services. The Guide will summarize what is known about the effectiveness of population-based interventions for prevention and control. Where data exist, the Guide will also summarize information on the cost-effectiveness of these interventions. Based on available evidence, the Guide will provide recommendations on these population-based interventions and methods for their delivery.

Agenda items are subject to change as priorities dictate.

Contact person for more information: Norma Loner, Committee Management Specialist, Division of Diabetes Translation, National Center for Chronic Disease Prevention and Health Promotion, CDC, 4770 Buford Highway, NE, M/S K–10, Atlanta, Georgia 30341–3717, telephone 770/488–5376.

The Director, Management Analysis and Services Office has been delegated the authority to sign **Federal Register** notices pertaining to announcements of meetings and other committee management activities for both the Centers for Disease Control and Prevention and the Agency for Toxic Substances and Disease Registry.

Dated: July 26, 1999.

Carolyn J. Russell,

Director, Management Analysis and Services Office, Centers for Disease Control and Prevention.

[FR Doc. 99–19497 Filed 7–29–99; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Fees for Sanitation Inspections of Cruise Ships

AGENCY: Centers for Disease Control and Prevention (CDC), Department of Health and Human Services (HHS).

ACTION: Notice.

SUMMARY: This notice announces fees for vessel sanitation inspections for fiscal year 2000, October 1, 1999, through September 30, 2000.

EFFECTIVE DATE: October 1, 1999.

FOR FURTHER INFORMATION CONTACT: David L. Forney, Chief, Vessel Sanitation Program, National Center for Environmental Health, Centers for Disease Control and Prevention (CDC), 4770 Buford Highway, NE, Mailstop F–16, Atlanta, Georgia 30341–3724, telephone (770) 488–7333, E-mail: dlf1@cdc.gov.

SUPPLEMENTARY INFORMATION:

Purpose and Background

The fee schedule for sanitation inspections of passenger cruise ships currently inspected under the Vessel Sanitation Program (VSP) was first published in the **Federal Register** on November 24, 1987 (52 FR 45019), and CDC began collecting fees on March 1, 1988. Since then, CDC has published the fee schedule annually. This notice announces fees effective October 1, 1999.

The formula used to determine the fees is as follows:

$$\text{Average cost per inspection} = \frac{\text{Total Cost of VSP}}{\text{Weighted No. of Annual Inspections}}$$

The average cost per inspection is multiplied by a size/cost factor to determine the fee for vessels in each size category. The size/cost factor was established in the proposed fee schedule published in the **Federal Register** on July 17, 1987 (52 FR 27060) and revised in a schedule published in the **Federal Register** on November 28, 1989 (54 FR 48942). The revised size/cost factor is presented in Appendix A.

Fee

The fee schedule is presented in Appendix A and will be effective October 1, 1999, through September 30, 2000; however, should a substantial increase occur in the cost of air transportation, it may be necessary to readjust the fees before September 30, 2000, since travel constitutes a sizable portion of the program's costs. If such a readjustment in the fee schedule is necessary, a notice will be published in the **Federal Register** 30 days before the effective date.

Applicability

The fees will be applicable to all passenger cruise vessels for which inspections are conducted as part of CDC's VSP.

Dated: July 26, 1999.

Joseph R. Carter,

Acting Associate Director for Management and Operations, Centers for Disease Control and Prevention (CDC).

Appendix A

SIZE/COST FACTOR

Vessel size	GRT [1]	Average cost X
Extra Small	<3,001	0.25
Small	3,001–15,000 ...	0.50
Medium	15,001–30,000	1.00
Large	30,001–60,000	1.50
Extra Large	>60,000	2.00

FEE SCHEDULE OCTOBER 1, 1999–SEPTEMBER 30, 2000

Vessel size	GRT [1]	Fee ($)
Extra Small	<3,001	1,075
Small	3,001–15,000	2,150
Medium	15,001–30,000	4,300
Large	30,001–60,000	6,450
Extra Large	>60,000	8,600

[1] GRT—Gross Register Tonnage in cubic feet, as shown in Lloyd's Register of Shipping.

Inspections and reinspections involve the same procedure, require the same amount of time, and are, therefore, charged at the same rate.

[FR Doc. 99–19498 Filed 7–29–99; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Medical Child Support Working Group

AGENCY: Administration for Children and Families, DHHS.

ACTION: Notice of open meeting.

SUMMARY: Pursuant to Section 10(a)(2) of the Federal Advisory Committee Act (FACA), notice is given of the fourth meeting of the Medical Child Support Working Group (MCSWG). The Medical Child Support Working Group was jointly established by the Secretaries of the Department of Labor (DOL) and the Department of Health and Human Services (DHHS) under section 401(a) of the Child Support Performance and Incentive Act of 1998. The purpose of the MCSWG is to identify the impediments to the effective enforcement of medical support by State child support enforcement agencies, and to submit to the Secretaries of DOL and DHHS a report containing recommendations for appropriate measures to address those impediments.

DATES: The meeting of the MCSWG will be held on Thursday, August 12, 1999, from approximately noon to approximately 6:30 p.m., and on Friday, August 13, 1999, from 8:30 a.m. to approximately 4 p.m.

ADDRESSES: The meeting will be held in Parlor H, on the sixth floor of the Palmer House Hilton and Towers, 17 East Monroe Street, Chicago, IL, 60603. All interested parties are invited to attend this public meeting. Seating may be limited and will be available on a first-come, first-served basis. Persons needing special assistance, such as sign language interpretation or other special accommodation, should contact the Executive Director of the Medical Child Support Working Group, Office of Child Support Enforcement at the address listed below.

FOR FURTHER INFORMATION CONTACT: Ms. Samara Weinstein, Executive Director Child Support Working Group, Office of Child Support Enforcement, Fourth Floor East, 370 L'Enfant Promenade, SW, Washington, DC 20447 (telephone (202) 401–6953; fax (202) 401–5559; e-mail: sweinstein@acf.dhhs.gov). These are not toll-free numbers. The date, location and time for subsequent MCSWG meetings will be announced in advance in the **Federal Register**.

SUPPLEMENTARY INFORMATION: Pursuant to section 10(a)(2) of the Federal Advisory Committee Act, as amended (5 U.S.C. Appendix 2) (FACA) notice is given of a meeting of the Medical Child Support Working Group (MCSWG). The Medical Child Support Working Group was jointly established by the Secretaries of the Department of Labor (DOL) and the Department of Health and Human Services (DHHS) under section 401(a) of the Child Support Performance and Incentive Act of 1998 (Pub. L. 105–200).

The purpose of the MCSWG is to identify the impediments to the effective enforcement of medical support by State child support enforcement agencies, and to submit to the Secretaries of DOL and DHHS a report containing recommendations for appropriate measures to address those impediments. This report will include: (1) Recommendations based on assessments of the form and content of the National Medical Support Notice, as issued under interim regulations; (2) appropriate measures that establish the priority of withholding of child support obligations, medical support obligations arrearages in such obligations, and in the case of a medical support obligation, the employee's portion of any health care coverage premium, by such State agencies in light of the restrictions on garnishment provided under title III of the Consumer Credit Protection Act (15 U.S.C. 1671–1677); (3) appropriate procedures for coordinating the provision, enforcement, and transition of health care coverage under the State programs for child support, Medicaid and the Child Health Insurance Program; (4) appropriate measures to improve the availability of alternate types of medical support that are aside from health care coverage offered through the noncustodial parent's health plan, and unrelated to the noncustodial parent's employer, including measures that establish a noncustodial parent's responsibility to share the cost of premiums, co-payments, deductibles, or payments for services not covered under a child's existing health coverage; (5) recommendations on whether reasonable cost should remain a consideration under section 452(f) of the Social Security Act; and (6) appropriate measures for eliminating any other impediments to the effective enforcement of medical support orders that the MCSWG deems necessary.

The membership of the MCSWG was jointly appointed by the Secretaries of DOL and DHHS, and includes representatives of: (1) DOL; (2) DHHS; (3) State Child Support Enforcement Directors; (4) State Medicaid Directors; (5) employers, including owners of small businesses and their trade and industry representatives and certified human resource and payroll professionals; (6) plan administrators and plan sponsors of group health plans (as defined in section 607(1)) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1167(1)); (7) children potentially eligible for medical support, such as child advocacy organizations; (8) State medical child support organizations; and (9) organizations representing State child support programs.

AGENDA: The agenda for this meeting includes a discussion of the issues to be contained in the MCSWG's report to the Secretaries containing recommendations for appropriate measures to address the impediments to the effective enforcement of medical child support as listed above. At the May, 1999, meeting, the MCSWG formed four (4) sub-committees to discuss barriers, issues, options, and recommendations in the interim between full MCSWG meetings. At this August, 1999, meeting, the four sub-committees will present their initial issues and recommendations to the full MCSWG for further discussion and consideration.

PUBLIC PARTICIPATION: Members of the public wishing to present oral statements to the MCSWG should forward their requests to Samara Weinstein, MCSWG Executive Director, as soon as possible and at least four days before the meeting. Such requests should be made by telephone, fax machine, or mail, as shown above. Time permitting, the Chairs of the MCSWG will attempt to accommodate all such requests by reserving time for presentations. The order of persons making such presentations will be assigned in the order in which the requests are received. Members of the public are encouraged to limit oral statements to five minutes, but extended

written statements may be submitted for the record. Members of the public also may submit written statements for distribution to the MCSWG membership and inclusion in the public record without presenting oral statements. Such written statements should be sent to the MCSWG Executive Director, as shown above, by mail or fax at least five business days before the meeting.

Minutes of all public meetings and other documents made available to the MCSWG will be available for public inspection and copying at both the DOL and DHHS. At DHHS, these documents will be available at the MCSWG Executive Director's Office, Office of Child Support Enforcement (OCSE), Administration for Children and Families, U.S. Department of Health and Human Services, Aerospace Building, Fourth Floor—East, 370 L'Enfant Promenade, SW, Washington, DC from 8:30 a.m. to 5:30 p.m. Questions regarding the availability of documents from DHHS should be directed to Andrew J. Hagan, OCSE (telephone (202) 401–5375). This is not a toll-free number. Any written comments on the minutes should be directed to Ms. Samara Weinstein, Executive Director of the Working Groups, as shown above.

Dated: July 26, 1999.

David Gray Ross,

Commissioner, Office of Child Support Enforcement.

[FR Doc. 99–19602 Filed 7–29–99; 8:45 am]

BILLING CODE 4184–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Reallotment of Funds for FY 1998 Low Income Home Energy Assistance Program (LIHEAP)

AGENCY: Office of Community Services, ACF, DHHS.

ACTION: Notice of determination concerning funds available for reallotment.

SUMMARY: In accordance with section 2607(b)(1) of the Omnibus Budget Reconciliation Act of 1981 (42 U.S.C. 8621 *et seq.*), as amended, a notice was published in the **Federal Register** on June 8, 1999 announcing the Secretary's preliminary determination that $2,381,450.52 in FY 1998 Low Income Home Energy Assistance Program (LIHEAP) funds may be available for reallotment to other LIHEAP grantees. We received a comment from one of the grantees with excess carryover funds indicating that a further review of records revealed that the amount of funds available for reallotment is reduced by $172,597. No additional comments were received. Therefore, the amount of funds available for reallotment is $2,208,853.52.

It has now been determined that the funds will be realloted to all LIHEAP grantees based on the normal allocation formula. No subgrantees or other entities may apply for these funds.

FOR FURTHER INFORMATION CONTACT: Janet Fox, Director, Division of Energy Assistance, Office of Community Services, 370 L'Enfant Promenade, SW, Washington, DC 20447; telephone number (202) 401–9351.

Dated: July 27, 1999.

Donald Sykes,

Director, Office of Community Services.

[FR Doc. 99–19601 Filed 7–29–99; 8:45 am]

BILLING CODE 4184–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. 97P–0350]

Obstetrics and Gynecology Devices; Reclassification of Home Uterine Activity Monitor

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice of panel recommendation.

SUMMARY: The Food and Drug Administration (FDA) is announcing for public comment the recommendation of the Obstetrics and Gynecology Devices Panel (the Panel) to reclassify the home uterine activity monitor (HUAM) from class III to class II. The Panel made this recommendation after reviewing the reclassification petition submitted by Corometrics Medical Systems, Inc., and other publicly available information. FDA also is announcing for public comment its tentative findings on the Panel's recommendation. After considering any public comments on the Panel's recommendation and FDA's tentative findings, FDA will approve or deny the reclassification petition by order in the form of a letter to the petitioner. FDA's decision on the reclassification petition will be announced in the **Federal Register**. Elsewhere in this issue of the **Federal Register**, FDA is publishing a notice of availability of a guidance document that provides 510(k) applicants with specific directions regarding data and information that should be submitted to FDA in 510(k) submissions for HUAM's.

DATES: Written comments by October 28, 1999.

ADDRESSES: Submit written comments to the Dockets Management Branch (HFA–305), Food and Drug Administration, 5630 Fishers Lane, rm. 1061, Rockville, MD 20852.

FOR FURTHER INFORMATION CONTACT: Colin M. Pollard, Center for Devices and Radiological Health (HFZ–470), Food and Drug Administration, 9200 Corporate Blvd., Rockville, MD 20850, 301–594–1180.

SUPPLEMENTARY INFORMATION:

I. Background (Regulatory Authorities)

The Federal Food, Drug, and Cosmetic Act (the act) (21 U.S.C. 301 *et. seq.*), as amended by the Medical Device Amendments of 1976 (the 1976 amendments) (Public Law 94–295), the Safe Medical Devices Act of 1990 (the SMDA) (Public Law 101–629), and the Food and Drug Administration Modernization Act of 1997 (FDAMA) (Public Law 105–115), established a comprehensive system for the regulation of medical devices intended for human use. Section 513 of the act (21 U.S.C. 360c) established three categories (classes) of devices, depending on the regulatory controls needed to provide reasonable assurance of their safety and effectiveness. The three categories of devices are class I (general controls), class II (special controls), and class III (premarket approval).

Under section 513 of the act, devices that were in commercial distribution before May 28, 1976 (the date of enactment of the 1976 amendments), generally referred to as preamendments devices, are classified after FDA has: (1) Received a recommendation from a device classification panel (an FDA advisory committee); (2) published the panel's recommendation for comment, along with a proposed regulation classifying the device; and (3) published a final regulation classifying the device. FDA has classified most preamendments devices under these procedures.

Devices that were not in commercial distribution prior to May 28, 1976, generally referred to as postamendments devices, are classified automatically by statute (section 513(f) of the act) into class III without any FDA rulemaking process. Those devices remain in class III and require premarket approval, unless and until the device is reclassified into class I or II or FDA issues an order finding the device to be substantially equivalent, under section 513(i) of the act, to a predicate device that does not require premarket approval. The agency determines

whether new devices are substantially equivalent to previously offered devices by means of premarket notification procedures in section 510(k) of the act (21 U.S.C. 360(k)) and 21 CFR part 807 of the regulations.

A preamendments device that has been classified into class III may be marketed, by means of premarket notification procedures, without submission of a premarket approval application (PMA) until FDA issues a final regulation under section 515(b) of the act (21 U.S.C. 360e(b)) requiring premarket approval.

Reclassification of classified postamendments devices is governed by section 513(f)(2) of the act. This section provides that FDA may initiate the reclassification of a device classified into class III under section 513(f)(1) of the act, or the manufacturer or importer of a device may petition the Secretary of Health and Human Services (the Secretary) for the issuance of an order classifying the device in class I or class II. FDA's regulations in § 860.134 (21 CFR 860.134) set forth the procedures for the filing and review of a petition for reclassification of such class III devices. In order to change the classification of the device, it is necessary that the proposed new class have sufficient regulatory controls to provide reasonable assurance of the safety and effectiveness of the device for its intended use.

Under section 513(f)(2)(B)(i) of the act, the Secretary may, for good cause shown, refer a petition to a device classification panel. The Panel shall make a recommendation to the Secretary respecting approval or denial of the petition. Any such recommendation shall contain: (1) A summary of the reasons for the recommendation, (2) a summary of the data upon which the recommendation is based, and (3) an identification of the risks to health (if any) presented by the device with respect to which the petition was filed.

II. Regulatory History of the Device

A. Preamendments Devices

Before enactment of the 1976 amendments, tokodynamometers, integrated into electronic perinatal monitoring systems, were in commercial distribution. A tokodynamometer is a transducer and monitoring system used to make continuous external (abdominal) measurements of intrauterine pressure and provide strip chart tracings of the uterine contractions of a pregnant woman during labor. Preamendments perinatal monitors were marketed as systems for use in clinical settings, with different models for the office or hospital, and intended for clinical evaluation of the fetus and mother. In 1980, FDA classified these preamendments monitors (external uterine contraction monitor (21 CFR 884.2720) and perinatal monitoring system (21 CFR 884.2740) into class II.

B. Premarket Notifications

Between 1984 and 1987, FDA reviewed 510(k)'s for several HUAM's and found these HUAM's to be substantially equivalent to tokodynamometers used in clinical settings. HUAM manufacturers were permitted to market these devices for use in ''low risk at-term'' pregnancies. However, FDA determined that use of the HUAM for ''the early detection of preterm labor (PTL) in high risk patients'' constituted a new intended use. For this new use, FDA determined that the HUAM was not substantially equivalent to any preamendments class I, class II, or class III device not subject to an approved PMA, or to any postamendments device that had been classified into class I or class II for the early detection of PTL. Accordingly, FDA advised HUAM manufacturers that the device was classified into class III under section 513(f)(1) of the act, and that it could not be placed in commercial distribution for early detection of PTL in high risk patients unless it was reclassified under section 513(f)(2), or subject to an approved PMA under section 515 of the act.

C. PMA Reviews and Related Issues

Subsequent to 1987, several PMA's for HUAM's were submitted to FDA and referred to the Panel for its recommendations.

On May 26, 1988, the first PMA the Panel considered was the Tokos' Term Guard™ device. The Panel recommended that this PMA not be approved because the supporting data did not show the individual contribution the monitor made to the early detection of PTL, over and above that attributable to the regimen of daily patient contact (Ref. 1).

On March 6, 1989, the Panel reviewed a PMA submitted by Healthdyne, Inc., for its System 37™ HUAM and recommended that the PMA be found not approvable because the primary study endpoint (physician intervention) was considered too subjective and the study lacked a control group (Ref. 2).

On January 18 and April 4, 1990, the Panel reviewed a PMA submitted by Physiological Diagnostic Systems, Inc., for its Genesis™ HUAM. This PMA was supported by a randomized controlled clinical study that demonstrated the individual contribution of the monitor to the early detection of PTL, as evidenced by cervical dilation at the time of PTL diagnosis. These data, within the study, were compared with the standard care for high risk patients without monitoring. On the basis of this data, the Panel recommended approval of the Genesis™ HUAM for the early detection of PTL in only one high risk patient group (Refs. 3 and 4). Subsequently, on September 12, 1990, FDA approved a PMA for the Genesis™ HUAM. This HUAM is indicated for use, in conjunction with standard high risk care, for the daily at-home measurement of uterine activity in pregnancies ≥24 weeks gestation for women with a history of previous preterm birth. With the Genesis™ system, uterine activity is displayed at a remote location to aid in the early detection of PTL, as evidenced by cervical dilation at the time of PTL diagnosis (Ref. 5).

On June 11, 1990, the Panel reviewed a new PMA from Healthdyne for its System 37™ HUAM. Healthdyne submitted new data and claimed that the System 37™ would identify women, already known to be a high risk for PTL, who were at an even higher risk of preterm birth. The Panel recommended that this PMA not be approved because of inherent study design flaws. In particular, the outcome variable (incidence of preterm birth) had significant intra and interobserver variation, and the study entry criteria were biased (Ref. 6).

On April 29 and 30, 1993, the Panel reviewed a PMA for the DT 100–P HUAM manufactured by Advanced Medical Systems. This HUAM system was indicated for the early detection of PTL in women with twin gestations. The Panel reviewed the PMA and recommended that the PMA be found not approvable because all the key clinical data came from only one site and because significant engineering questions regarding the monitoring system were unanswered.

The Panel also considered several FDA prepared questions on the interpretation of clinical study findings supporting other PMA's under review. In addition, the Panel addressed certain issues relative to the existing draft guidance document entitled ''Premarket Testing Guidelines for Home Uterine Activity Monitors'' (March 31, 1993). Issues discussed included: (1) The use of a random sample of examiners to address intra and interobserver variance; (2) the use of a standard definition for the terms ''preterm labor'' and ''standard of care for high risk patients''; (3) limiting study inclusions

to a minimum gestational age of 20 weeks; and (4) allowing the use of subgroup analysis, except for the purpose of making promotional claims. The Panel also noted the importance of blinding procedures for patients and investigators, but did not go so far as to identify it as a requirement.

During the April 1993 meeting, the Panel stressed that FDA should look at how the HUAM device is promoted and how often it is used for indications for which it is not approved in the context of postapproval studies or annual reporting (Ref. 7). Also, during this meeting, FDA informed the industry that in light of the many published studies on HUAM's, the devices were a good candidate for reclassification and invited them to petition FDA for a change in classification of the devices.

During the Panel meeting of September 2, 1994, FDA sought additional guidance regarding clinical review issues on HUAM PMA's. The Panel reconsidered whether cervical dilation at the time of PTL diagnosis should remain the primary clinical endpoint. Alternative endpoints were discussed and despite the difficulties and imperfections of using cervical dilation, the Panel concluded that this endpoint should remain an acceptable alternative for HUAM efficacy studies (Ref. 8).

During the Panel meeting of April 24, 1995 (Ref. 9), Caremark, Inc., presented the clinical efficacy study results for its First Activity® HUAM. The study included design elements specifically recommended and preferred by the Panel, including a sham control. When compared to standard clinical care for high risk patients, the study showed no added benefit when using an HUAM for either early PTL detection or reduced preterm births. These findings did not persuade the Panel to change its earlier recommendations regarding acceptable elements of study designs.

On September 29, 1995, FDA approved PMA's for Healthdyne's System 37™ and CareLink Corp.'s CareFone™ HUAM's, for the same indication as the Genesis™ HUAM; i.e., in conjunction with standard high risk care, the HUAM was approved for the daily at-home measurement of uterine activity in pregnancies, ≥24 weeks gestation, for women with a history of previous preterm birth. The uterine activity of these devices is also displayed at a remote location to aid in the early detection of PTL.

D. Reclassification Petition

On August 15, 1997, FDA received a petition from Corometrics Medical Systems, Inc., for its Model 770 BMS HUAM system requesting FDA to reclassify the HUAM system from class III to class II under section 513(f)(2) of the act and § 860.134, based on information submitted in the petition (Ref. 10).

Consistent with the act and the regulation, FDA referred the petition to the Panel for its recommendation on the requested change in classification.

III. Device Description

A home uterine activity monitor is an at-home monitoring system that consists of a tocotransducer and abdominal belt, an at-home recorder/memory system, a telephone data transmitter (at-home modem), and a separate data receiving, storage, and display system that is located, remote from the home, in a clinical setting (data receiving center). The device is intended to be used on women with a previous preterm delivery to aid in the detection of PTL.

At home, per instructions by the obstetrician, a pregnant woman secures the tocotransducer around her abdomen for a specified duration and frequency. Uterine muscular distention (tone) changes, indirectly detected by the tocotransducer, are recorded and stored in the recorder/memory. Either immediately after recording or at a later time, the uterine activity data is transmitted via the modem to the data receiving center for clinical evaluation.

The receiving center has a computerized system with specialized software to receive, store, and display the uterine activity data for clinical evaluation at the remote clinical site. Based on the evaluation of the uterine activity tracing, the patient is referred to her obstetrician for further followup to determine whether she has started PTL.

IV. Recommendations of the Panel

In a public meeting on October 7, 1997, the Panel unanimously recommended that the HUAM be reclassified from class III to class II for use in early detection of PTL, as evidenced by cervical dilation at PTL diagnosis, for women with a previous history of preterm birth (Refs. 11 and 12). The Panel believed that class II with special controls of patient registries, bench testing, consensus standards, and clinical validation studies would provide reasonable assurance of the safety and effectiveness the device.

V. Risks to Health

During its review and discussion of the proposed reclassification of the HUAM, the Panel identified certain risks to health they believed were associated with use of the HUAM. The risks were identified as : (1) Off-label use; (2) initiation of a cascade of interventions including bed rest, hospitalization, and medications; and (3) disabilities and psychological concerns, such as quality of life issues. The Panel had other concerns they believed were hazards to health. They identified the specific hazards as needless exposure to tocolytics and steroids resulting from detection of clinically meaningless contractions, alterations in quality of life from false positives, and inability to identify contractions because of a failure of the transducer to be sensitive and specific.

After considering the discussion by the Panel during the reclassification proceedings, reviewing the reclassification petition, medical device reports, and published literature, FDA identified the following risks it believed are associated with use of the HUAM when used in early detection of PTL, as evidenced by cervical dilation at PTL diagnosis, for women with a history of previous preterm birth:

A. Electric Shock and/or Injury

HUAM's are electrically powered devices which can cause electrical shock to the patient or clinician, leading to injury or death. This potential risk is well understood, and it can be mitigated by appropriate system design such as sufficient electrical isolation and other safety measures in accordance with applicable consensus standards.

B. Skin Irritation and Sensitization

HUAM's have accessories that make contact with the skin, namely, the tocotransducer and abdominal belt. Any material that comes in contact with the skin has the potential for causing skin irritation and sensitization. This risk can be lessened, if it occurs, by a consensus standard for material safety.

C. Unnecessary Evaluation and Treatment

Unnecessary evaluation and treatment may result from an imprecise definition of PTL or failure of an HUAM to accurately depict uterine activity. Diagnosis of PTL is often difficult, and many times can only be confirmed retrospectively by the preterm delivery. Nonetheless, the consequences of preterm delivery can be devastating in terms of neonatal morbidity and mortality. There is a concern that the use of an HUAM system can cause unnecessary visits to the clinic which could, in turn, lead to over-diagnosis of PTL and unnecessary treatment with tocolytics for women who have increased uterine activity but are not destined for preterm delivery. Improper device design or a malfunctioning

device can also result in an apparent increase in uterine activity and unnecessary clinical visits, thereby leading to unnecessary treatment with tocolytic agents intended to stop or slow labor.

D. Disabilities and Psychological Issues

Physical disabilities and psychological burdens may result from the clinical management of women diagnosed with PTL. For example, the use of some tocolytic agents sometimes causes temporary or permanent injury to the mother. Moreover, the HUAM regimen coupled with a tocolysis regimen can significantly disrupt a woman's pregnancy and her quality of life. Nonetheless, it is noted that a high risk pregnancy is often psychologically debilitating to the patient, and tocolytics may be prescribed for unmonitored women as well.

E. Other Risks From Use in Unproven Patient Populations

HUAM's have only been approved for use on women who have had a previous preterm delivery. The overuse of HUAM's for other indications, i.e., PTL in the current pregnancy, multiple gestations, etc., were expressed concerns of the Panel. The clinical utility for these other indications has not been proven.

VI. Benefits

HUAM's provide a benefit to high risk patients by helping to detect PTL at an early stage, as evidenced by cervical dilation, thereby allowing for early management of PTL. Early detection of PTL increases the likelihood of successful tocolysis, leading hopefully to the ultimate benefit of fewer preterm births and lower infant mortality and premature births. However, because this is only a monitoring device, FDA has required HUAM manufacturers to show that the devices provide contraction information that contributes to the diagnosis of PTL. Manufacturers are not required to show a reduction in the outcome measures because they are a result of successful intervention after diagnosis.

HUAM technology is well-established with a long history of safe use at home and in the clinical setting. HUAM device design does not vary substantially from manufacturer to manufacturer in terms of underlying technology and clinical performance. Specific design choices are not expected to affect the risk to the patient. Therefore, FDA believes that randomized controlled clinical studies intended to show early PTL detection are no longer necessary and that the special controls described in section IX of this document would provide reasonable assurance of the safety and effectiveness of the device.

VII. Summary of Reasons for Recommendation

After reviewing the data and information contained in the petition and provided by FDA, and after consideration of the open discussions during the Panel meetings and the Panel members' personal knowledge of and clinical experience with the device, the Panel gave the following reasons in support of its recommendation to reclassify the generic type HUAM for use, in conjunction with standard high risk care, in the daily at-home measurement of uterine activity in pregnancies ≥24 weeks gestation for women with a history of previous preterm birth from class III into class II:

1. The Panel believes that general controls by themselves are not sufficient to provide reasonable assurance of safety and effectiveness.

2. The Panel believes that the HUAM should be reclassified into class II because special controls, in addition to general controls, provide reasonable assurance of the safety and effectiveness of the device, and there is sufficient information to establish special controls to provide such assurance.

VIII. Summary of Data Upon Which the Panel Recommendation is Based

The Panel considered a large number of published clinical studies ranging in size, control, study population, and outcome measures (Ref. 10). Statistical analyses of various studies were also considered. The Panel believed that these studies, as an aggregate, established the effectiveness of HUAM's, and qualified their effectiveness as an adjunctive tool for monitoring high risk pregnancies. At least one study showed that when HUAM's are used in combination with daily nursing care, PTL can be detected earlier than it is detected by the standard clinical management of patients at high risk for PTL (Ref. 12). Other studies showed that when used without daily nursing contact, HUAM's detected PTL earlier (as evidenced by cervical dilation at the time of PTL diagnosis) than standard clinical care of a select patient populations (Refs. 5 and 14). On the other hand, some controlled studies showed that, for high risk populations, HUAM's do not contribute to PTL detection rate or a reduction in preterm deliveries when used with daily nursing contact (Refs. 15 and 16). Some studies evaluated HUAM's for managing pregnant women who were at risk for preterm birth for other reasons, e.g., multiple gestation and PTL in the current pregnancy (Refs. 5, 12, 13, 14, 15, and 16). The Panel did not evaluate the evidence for these indications.

Most of the risks associated with HUAM's identified by the Panel were indirect effects attributable to incorrect monitoring information or misinterpretation of monitoring information leading to misdiagnosis. The concern that the use of the device would result in an increase in the number of hospital visits and use of tocolytics was not borne out in the published literature. The potential risk of misdiagnosis is one that is generally mitigated by proper training, adequate labeling, and limited use of the device by the clinician.

Based on the available information, FDA believes that the special controls discussed in section IX of this document are capable of providing reasonable assurance of the safety and effectiveness of the HUAM with regard to the identified risks to health of this device.

IX. Special Controls

In addition to general controls, FDA believes that the special controls (patient registries and guidance document) discussed in this section are adequate to control the risks to health described for this device. Elsewhere in this issue of the **Federal Register**, FDA is publishing a notice of availability of a guidance document entitled ''Home Uterine Activity Monitors: Guidance for the Submission of 510k Premarket Notifications'' that provides 510(k) applicants with specific directions regarding data and information that should be submitted to FDA in 510(k) submissions for HUAM's.

A. Patient Registries

The rationale for using patient registries is that it provides a means for characterizing the nature of the patient population for which the device is actually used and to track information about the labor and delivery of women for whom the device was prescribed. FDA believes that using patient registries, in a structured sampling format, will provide outcome data that will contribute to appropriate use of the device.

B. Guidance Document (Home Uterine Activity Monitors: Guidance for the Submission of Premarket Notifications)

This document incorporates: (1) The consensus standards from professional organizations to provide uniformity, (2) bench testing and validation study information to validate the effectiveness and performance of the device, and (3)

labeling to describe the device's capabilities and discourage off-label use.

1. Bench Testing

Bench testing can validate the ability of the HUAM to operate (independently or in combination with clinical validation studies) as intended, i.e., to collect, store, and transmit data. Bench testing can also address the risk of false positives and the resulting inappropriate management of the patient. Appropriately designed bench testing will ensure that uterine activity, and contractions in particular, are accurately measured and displayed by the device, thereby minimizing false positives associated with the device.

2. Consensus Standards

The International Electrotechnical Commission (IEC) standards 601–1 for medical electrical equipment and 601–1–2 for general safety identify the electrical safety and electromagnetic compatibility aspects for any type electrical device. Adherence to these standards can control the risks of electrical shock and/or injury to the patient and clinician. Copies of these standards may be obtained from IEC, AT3, Rue de Varembe, P.O. Box 131, Geneva, Switzerland, CH–1211. IEC also maintains a site on the world wide web at ''http://www.iec.ch''. Testing in accordance with any of a variety of material safety consensus standards, such as ISO–10993, Biological Evaluation of Medical Devices, Part 1: Evaluation and Testing, can minimize the risks of skin irritation and sensitization caused by the tocotransducer and abdominal belt. Copies of this and other material safety standards may be obtained from International Organization for Standardization, Case Postal, Geneva, Switzerland, CH–1121. ISO also maintains a site on the World Wide Web at ''http://www.iso.org''.

3. Clinical Validation Study

The rationale for using a clinical validation study is to address the risk of false positives and the resulting inappropriate management of the patient. The objective of this limited clinical validation study is to address the remaining performance issues of the device, namely, the recording and data transmission functions that cannot be addressed via bench testing. The system should be tested in a small clinical study, in its intended setting with actual subjects. The study endpoints should address the readability of the received tracings, i.e., are the contractions correctly perceived by the clinician. The outcome of a limited clinical validation study would address and possibly mitigate the risk of unnecessary evaluation and treatment of the patient.

4. Labeling Requirements

Labeling addresses the risk of use of the device in unproved patient populations. Diagnosis of PTL is often difficult, and many times can only be confirmed retrospectively by the actual preterm delivery. Yet, the consequences of preterm delivery can be devastating in terms of neonatal morbidity and mortality. An HUAM system that causes additional visits to a clinic could lead to over-diagnosis of PTL and unnecessary treatment with tocolytics for women who have increased uterine activity but are not destined for preterm delivery. Labeling should provide an accurate description of the device's capabilities and discourage the off-label use of the device and limit the perpetuation of false claims of the device's capabilities.

FDA believes labeling which describes the capabilities and limitations of the HUAM system device can lead to a more informed use of this technology by the clinician, thereby mitigating the risks of unnecessary evaluations and treatments, disabilities, and psychological issues.

X. FDA's Tentative Findings

The Panel and FDA believe that the HUAM should be classified into class II because special controls, in addition to general controls, would provide reasonable assurance of the safety and effectiveness of the device, and there is sufficient information to established special controls to provide such assurance.

XI. References

The following references have been placed on display in the Dockets Management Branch (address above) and may be seen by interested persons between 9 a.m. and 4 p.m., Monday through Friday:

1. Obstetrics and Gynecology Devices Panel Meeting, Summary Minutes, May 26, 1988.

2. Obstetrics and Gynecology Devices Panel Meeting, Summary Minutes, March 6, 1989.

3. Obstetrics and Gynecology Devices Panel Meeting, Summary Minutes, January 18, 1990.

4. Obstetrics and Gynecology Devices Panel Meeting, Summary Minutes, April 4, 1990.

5. Mou, S. M. et al., ''Multicenter Randomized Clinical Trial of Home Uterine Activity Monitoring for Detection of Preterm Labor,'' *American Journal of Obstetrics and Gynecology*, 165(4)1:858–866, 1991.

6. Obstetrics and Gynecology Devices Panel Meeting, Summary Minutes, June 11, 1990.

7. Obstetrics and Gynecology Devices Panel Meeting, Summary Minutes, April 29 and 30, 1993.

8. Obstetrics and Gynecology Devices Panel Meeting, Summary Minutes, September 2, 1994.

9. Obstetrics and Gynecology Devices Panel Meeting, Summary Minutes, April 24, 1995.

10. Reclassification Petition Submitted by Corometrics Medical Systems, Inc., June 5, 1997.

11. Obstetrics and Gynecology Devices Panel Meeting, Transcript, October 7, 1997.

12. Hill, W. C. et al., ''Home Uterine Activity Monitoring is Associated With a Reduction in Preterm Birth,'' *Obstetrics and Gynecology*, 76 (1 Supplement):13s–18s, 1990.

13. Dyson, D. C. et al., ''Prevention of Preterm Birth in High Risk Patients: The Role of Education and Provider Contact versus Home Monitoring,'' *American Journal of Obstertics and Gynecology*, 164(3):756–762, 1991.

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16. Iams, J. D., F. F. Johnson, and R. W. O-Shaughnessy, ''A Prospective Random Trial of Home Uterine Activity Monitoring in Pregnancies at Increased Risk of Preterm Labor, Part II,'' *American Journal of Obstetrics and Gynecology*, 150(3):595–603, 1988.

XII. Environmental Impact

The agency has determined under 21 CFR 25.34(b) that this reclassification action is of a type that does not individually or cumulatively have a significant effect on the human environment. Therefore, neither an environmental assessment nor an environmental impact statement is required.

XIII. Analysis of Impacts

FDA has examined the impacts of the notice under Executive Order 12866 and the Regulatory Flexibility Act (5 U.S.C. 601–612) (as amended by subtitle D of the Small Business Regulatory Fairness Act of 1996 (Public Law 104–121), and the Unfunded Mandates Reform Act of 1995 (Public Law 104–4)). Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential

economic, environmental, public health and safety, and other advantages; distributive impacts; and equity). The agency believes that this reclassification action is consistent with the regulatory philosophy and principles identified in the Executive Order. In addition, the reclassification action is not a significant regulatory action as defined by the Executive Order and so is not subject to review under the Executive Order.

The Regulatory Flexibility Act requires agencies to analyze regulatory options that would minimize any significant impact of a rule on small entities. Reclassification of the device from class III to class II will relieve manufacturers of the cost of complying with the premarket approval requirements in section 515 of the act. Because reclassification will reduce regulatory costs with respect to this device, it will impose no significant economic impact on any small entities, and it may permit small potential competitors to enter the marketplace by lowering their costs. The agency therefore certifies that this reclassification action, if finalized, will not have a significant economic impact on a substantial number of small entities. In addition, this reclassification action will not impose costs of $100 million or more on either the private sector or State, local, and tribal governments in the aggregate, and therefore a summary statement of analysis under section 202(a) of the Unfunded Mandates Reform Act of 1995 is not required.

XIV. Request for Comments

Interested persons may, on or before October 28, 1999, submit to the Dockets Management Branch (address above) written comments regarding this document. Two copies of any comments are to be submitted, except that individuals may submit one copy. Comments are to be identified with the docket number found in brackets in the heading of this document. Received comments may be seen in the office above between 9 a.m. and 4 p.m. Monday through Friday.

Dated: June 30, 1999.

Linda S. Kahan,

Deputy Director for Regulations Policy, Center for Devices and Radiological Health.

[FR Doc. 99–19530 Filed 7–29–99; 8:45 am]

BILLING CODE 4160–01–F

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. 99N–2098]

Computer-Controlled Potentially High Risk Medical Devices—List of Device Types

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

SUMMARY: The Food and Drug Administration (FDA) is announcing the availability of a document entitled ''Computer-Controlled Potentially High Risk Medical Devices—List of Device Types.'' FDA has developed a list of types of computer-controlled, potentially high-risk medical devices that have the potential for the most serious consequences for the patient should they fail because of date-related problems. This list will be useful to FDA, manufacturers, and health care facilities as they prioritize and assess their efforts to prevent potential Year 2000 (Y2K) problems with medical devices. This list has previously been made available on FDA's web site.

FOR FURTHER INFORMATION CONTACT: Thomas B. Shope, Center for Devices and Radiological Health (HFZ–140), Food and Drug Administration, 9200 Corporate Blvd., Rockville, MD 20850, 301–443–3314, ext. 32.

SUPPLEMENTARY INFORMATION:

I. Background

In order to more sharply focus agency efforts related to the possible impact of the Y2K date problem on medical devices, FDA has developed a list of types of computer-controlled, potentially high-risk medical devices that have the potential for the most serious consequences for the patient should they fail. Inclusion of a type of device on this list does not mean that all devices of this type have a date-related problem (are Y2K noncompliant) or, if they are Y2K noncompliant, that they necessarily pose a significant risk to patients. Rather, this list includes those types of devices that could pose a risk to patients if the date-related failure affects the function or operation of the device. FDA will use this list to identify those devices (and manufacturers) that would present the most serious risks to patients if they experienced a Y2K related failure. This will help the agency to focus attention on the devices that could present the highest levels of risk.

The list includes the types of computer-controlled devices whose failure to function as designed or expected could result in immediate and serious adverse health consequences. These potentially high-risk devices are those that are:

1. Used in the direct treatment of a patient where device failure could compromise the treatment or could injure the patient, or
2. Used in the monitoring of vital patient parameters and whose data are immediately necessary for effective treatment, or
3. Necessary to support or sustain life during treatment or patient care.

The list does not include diagnostic devices whose failure would not result in immediate harm to the patient, even though the diagnostic information they provide might be unavailable or incorrect. However, a few diagnostic devices have been included, if the results of calculations or other information processing by the device would not be readily apparent to the user, and a Y2K failure of the device could reasonably lead to serious adverse health consequences before being detected by the user.

This list of computer-controlled potentially high-risk devices will be used by FDA for several purposes and can also provide a guide to health care facilities regarding the types of devices that should receive priority in their assessment and remediation of medical devices.

FDA will identify all manufacturers of these types of devices. These manufacturers will be candidates for further oversight to provide increased assurance that product Y2K status has been carefully assessed and that any Y2K-related upgrade has been developed and tested in accordance with the quality system regulations. That oversight may include facility inspection or audit. FDA will also ascertain whether these manufacturers have made Y2K status information available to users, and that, where appropriate, users have received notification regarding any remedial action that may be necessary.

This list should not be considered a definitive list of all high-risk devices. It was developed by FDA staff based on their assessment of the types of devices that have the greatest potential for direct patient risk should they fail to correctly process date-related information. FDA will update the list, if necessary.

II. Electronic Access

In order to receive a copy of ''Computer-Controlled Potentially High Risk Medical Devices—List of Device Types'' via your fax machine, call the CDRH Facts-On-Demand (FOD) system

at 800–899–0381 or 301–827–0111 from a touch-tone telephone. At the first voice prompt press 1 to access DSMA Facts, at second voice prompt press 2, and then enter the document number (1142) followed by the pound sign (#). Then follow the remaining voice prompts to complete your request.

Persons interested in obtaining a copy of the list may also do so using the World Wide Web (WWW). CDRH maintains an entry on the WWW for easy access to information including text, graphics, and files that may be downloaded to a personal computer with access to the WWW. Updated on a regular basis, the CDRH home page includes ''Computer-Controlled Potentially High Risk Medical Devices—List of Device Types,'' device safety alerts, **Federal Register** reprints, information on premarket submissions (including lists of approved applications and manufacturers' addresses), small manufacturers' assistance, information on video conferencing and electronic submissions, mammography matters, and other device-oriented information. The CDRH home page may be accessed at ''http://www.fda.gov/cdrh''. ''Computer-Controlled Potentially High Risk Medical Devices—List of Device Types'' will also be available at ''http://www.fda.gov/cdrh/yr2000/cdrh/phrds/phrds.html''.

III. List of Potentially High Risk Devices

The following list contains the potentially high-risk device types. Where the generic device type has been classified by FDA, the list includes the section number in Title 21 of the Code of Federal Regulations where the device type is described. For those devices cleared for market through the premarket approval application process or which have not yet been classified, no classification regulation number is given.

A. Classified Devices

(Classification regulation number followed by classification name)
862.1345 Glucose Test System
862.2140 Centrifugal Chemistry Analyzer for Clinical Use
862.2150 Continuous Flow Sequential Multiple Chemistry Analyzer for Clinical Use
862.2160 Discrete Photometric Chemistry Analyzer for Clinical Use
862.2170 Micro Chemistry Analyzer for Clinical Use
868.1150 Indwelling Blood Carbon Dioxide Partial Pressure (P_{CO2}) Analyzer
868.1200 Indwelling Blood Oxygen Partial Pressure (P_{02}) Analyzer
868.1730 Oxygen Uptake Computer
868.2375 Breathing Frequency Monitor
868.2450 Lung Water Monitor
868.5160 Gas Machine for Anesthesia or Analgesia
868.5330 Breathing Gas Mixer
868.5400 Electroanesthesia Apparatus
868.5440 Portable Oxygen Generator
868.5470 Hyperbaric Chamber
868.5610 Membrane Lung (for Long-Term Pulmonary Support)
868.5830 Autotransfusion Apparatus
868.5880 Anesthetic Vaporizer
868.5895 Continuous Ventilator
868.5925 Powered Emergency Ventilator
868.5935 External Negative Pressure Ventilator
868.5955 Intermittent Mandatory Ventilation Attachment
870.1025 Arrhythmia Detector and Alarm
870.1750 External Programmable Pacemaker Pulse Generator
870.3535 Intra-aortic Balloon and Control System
870.3545 Ventricular Bypass (Assist) Device
870.3600 External Pacemaker Pulse Generator
870.3610 Implantable Pacemaker Pulse-Generator
870.3700 Pacemaker Programmers
870.4220 Cardiopulmonary Bypass Heart-Lung Machine Console
870.4320 Cardiopulmonary Bypass Pulsatile Flow Generator
870.4330 Cardiopulmonary Bypass On-Line Blood Gas Monitor
870.4360 Nonroller-Type Cardiopulmonary Bypass Blood Pump
870.4370 Roller-Type Cardiopulmonary Bypass Blood Pump
870.4380 Cardiopulmonary Bypass Pump Speed Control
870.5225 External Counter-Pulsating Device
870.5300 DC-Defibrillator Low Energy (Including Paddles)
876.5270 Implanted Electrical Urinary Continence Device
876.5630 Peritoneal Dialysis System and Accessories
876.5820 Hemodialysis System and Accessories
876.5860 High Permeability Hemodialysis System
876.5870 Sorbent Hemoperfusion System
876.5880 Isolated Kidney Perfusion and Transport System and Accessories
880.5130 Infant Radiant Warmer
880.5400 Neonatal Incubator
880.5410 Neonatal Transport Incubator
880.5725 Infusion Pump
882.5820 Implanted Cerebellar Stimulator
882.5830 Implanted Diaphragmatic/Phrenic Nerve Stimulator
882.5840 Implanted Intracerebral/Subcortical Stimulator For Pain Relief
882.5850 Implanted Spinal Cord Stimulator for Bladder Evacuation
882.5860 Implanted Neuromuscular Stimulator
882.5870 Implanted Peripheral Nerve Stimulator for Pain Relief
882.5880 Implanted Spinal Cord Stimulator for Pain Relief
884.1700 Hysteroscopic Insufflator
884.1730 Laparoscopic Insufflator
884.2660 Fetal Ultrasonic Monitor and Accessories
892.5050* Medical Charged-Particle Radiation Therapy System
892.5300* Medical Neutron Radiation Therapy System
892.5700* Remote Controlled Radionuclide Applicator System
892.5750* Radionuclide Radiation Therapy System
892.5900* X-ray Radiation Therapy System

* The device classifications specified previously with an asterisk include radiation treatment planning systems that are accessories to these device types.

B. Post Medical Device Amendments Class III Devices and Devices not yet Classified

Automated Blood Cell and Plasma Separator for Therapeutic Purposes
Cardioconverter, Implantable Defibrillator, Automatic Implantable Cardioverter
Defibrillator, Implantable, Dual-Chamber
Device, Thermal Ablation, Endometrial
Kit, Test, Alpha-Fetoprotein for Neural Tube Defects
Lipoprotein, Low Density, Removal
Pulse-Generator, Dual Chamber, Implantable
Pulse-Generator, Program Module
Pulse-Generator, Single Chamber
Pulse-Generator, Single Chamber, Sensor Driven, Implantable
Pump, Drug Administration, Closed Loop
Pump, Infusion, Implanted, Programmable
Separator for Therapeutic Purposes, Membrane Automated Blood Cell/Plasma
Stimulator, Cortical, Implanted (for Pain)
Stimulator, Electrical, Implanted, for Parkinsonian Tremor
Stimulator, Sacral Nerve, Implanted
Stimulator, Spinal-Cord, Totally Implanted for Pain Relief
Stimulator, Subcortical, Implanted for Epilepsy
System, Pacing, Temporary, Acute, Internal Atrial Defibrillation
Ventilator, High Frequency

Dated: July 19, 1999.

Linda S. Kahan,

Deputy Director for Regulations Policy, Center for Devices and Radiological Health.

[FR Doc. 99–19476 Filed 7–29–99; 8:45 am]

BILLING CODE 4160–01–F

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. 99D–1458]

Enforcement Policy: Electronic Records; Electronic Signatures—Compliance Policy Guide; Guidance for FDA Personnel

Note: On July 21, 1999 (64 FR 39146), this document was published with some inadvertent errors. For the convenience of the reader, the document is being republished in its entirety.

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

SUMMARY: The Food and Drug Administration (FDA) is announcing the availability of a new Compliance Policy Guide (CPG) section 160.850 entitled ''Enforcement Policy: 21 CFR Part 11; Electronic Records; Electronic Signatures.'' This CPG is intended to represent the agency's current thinking on how to comply with the regulations for electronic records and electronic signatures. It also provides that agency decisions on whether or not to pursue regulatory actions will be based on a case-by-case evaluation. The text of the CPG is included in this document.

DATES: Written comments may be submitted at any time.

ADDRESSES: Submit written requests for single copies of CPG section 160.850 entitled ''Enforcement Policy: 21 CFR Part 11; Electronic Records; Electronic Signatures'' to the Division of Compliance Policy (HFC–230), Office of Enforcement, Office of Regulatory Affairs, Food and Drug Administration, 5600 Fishers Lane, Rockville, MD 20852. Send two self-addressed adhesive labels to assist that office in processing your requests. Written comments should be identified with the docket number found in brackets in the heading of this document and should be sent to the Dockets Management Branch (HFA–305), Food and Drug Administration, 5630 Fishers Lane, rm. 1061, Rockville, MD 20852. A copy of the CPG is available on FDA's website at ''http://www.fda.gov/ora/compliance__ref/cpg/cpggenl/default.htm''. Scroll down the CPG page to locate section 160.850.

FOR FURTHER INFORMATION CONTACT: James F. McCormack, Division of Compliance Policy (HFC–230), Office of Enforcement, Office of Regulatory Affairs, Food and Drug Administration, 5600 Fishers Lane, Rockville, MD 20852, 301–827–0425.

SUPPLEMENTARY INFORMATION: FDA is announcing the availability of a new CPG section 160.850 entitled ''Enforcement Policy: 21 CFR Part 11; Electronic Records; Electronic Signatures.'' The CPG is an update to the Compliance Policy Guides Manual (August 1996 ed.). It is a new CPG and will be included in the next printing of the Compliance Policy Guides Manual. The CPG is intended for FDA personnel and is available electronically to the public. See the **ADDRESSES** section for electronic access to the CPG. The CPG is a level 2 guidance which is being issued consistent with FDA's good guidance practices (62 FR 8961, February 27, 1997). It does not create or confer any rights for or on any person and does not operate to bind FDA or the public. An alternative approach may be used if such approach satisfies the requirements of the applicable statute, regulation, or both.

The text of the CPG follows:

Section 160.850

Title: Enforcement Policy: 21 CFR Part 11; Electronic Records; Electronic Signatures (CPG 7153.17)

Background:

This compliance guidance document is an update to the Compliance Policy Guides Manual (August 1996 edition). This is a new Compliance Policy Guide (CPG) and will be included in the next printing of the Compliance Policy Guides Manual. The CPG is intended for Food and Drug Administration (FDA) personnel and is available electronically to the public. This guidance document represents the agency's current thinking on what is required to be fully compliant with 21 CFR Part 11, ''Electronic Records; Electronic Signatures'' and provides that agency decisions on whether or not to pursue regulatory actions will be based on a case by case evaluation. The CPG does not create or confer any rights for or on any person and does not operate to bind FDA or the public. An alternative approach may be used if such approach satisfies the requirements of the applicable statute, regulation, or both.

In the **Federal Register** of March 20, 1997 at 62 FR 13429, FDA issued a notice of final rulemaking for 21 CFR, Part 11, Electronic Records; Electronic Signatures. The rule went into effect on August 20, 1997. Part 11 is intended to create criteria for electronic recordkeeping technologies while preserving the agency's ability to protect and promote the public health (e.g., by facilitating timely review and approval of safe and effective new medical products, conducting efficient audits of required records, and when necessary pursuing regulatory actions). Part 11 applies to all FDA program areas, but does not mandate electronic recordkeeping. Part 11 describes the technical and procedural requirements that must be met if a person chooses to maintain records electronically and use electronic signatures. Part 11 applies to those records required by an FDA predicate rule and to signatures required by an FDA predicate rule, as well as signatures that are not required, but appear in required records.

Part 11 was developed in concert with industry over a period of six years. Virtually all of the rule's requirements had been suggested by industry comments to a July 21, 1992 Advance Notice of Proposed Rulemaking (at 57 FR 32185). In response to comments to an August 31, 1994 Proposed Rule (at 59 FR 45160), the agency refined and reduced many of the proposed requirements in order to minimize the burden of compliance. The final rule's provisions are consistent with an emerging body of federal and state law as well as commercial standards and practices.

Certain older electronic systems may not have been in full compliance with Part 11 by August 20, 1997, and modification to these so called ''legacy systems'' may take more time. As explained in the preamble to the final rule, Part 11 does not grandfather legacy systems and FDA expects that firms using legacy systems will begin taking steps to achieve full compliance.

Policy:

When persons are not fully compliant with Part 11, decisions on whether or not to pursue regulatory actions will be based on a case by case evaluation, which may include the following:

Nature and extent of Part 11 deviation(s). FDA will consider Part 11 deviations to be more significant if those deviations are numerous, if the deviations make it difficult for the agency to audit or interpret data, or if the deviations undermine the integrity of the data or the electronic system. For example, FDA expects that firms will use file formats that permit the agency to make accurate and complete copies in both human readable and electronic form of audited electronic records. Similarly, FDA would have little confidence in data from firms that do not hold their employees accountable and responsible for actions taken under their electronic signatures.

Effect on product quality and data integrity. For example, FDA would consider the absence of an audit trail to be highly significant when there are data discrepancies and when individuals deny responsibility for record entries. Similarly, lack of operational system checks to enforce event sequencing would be significant if an operator's ability to deviate from the prescribed order of manufacturing steps results in an adulterated or misbranded product.

Adequacy and timeliness of planned corrective measures. Firms should have a reasonable timetable for promptly modifying any systems not in compliance (including legacy systems) to make them Part 11 compliant, and should be able to demonstrate progress in implementing their timetable. FDA expects that Part 11 requirements for procedural controls will already be in place. FDA recognizes that technology based controls may take longer to install in older systems.

Compliance history of the establishment, especially with respect to data integrity. FDA

will consider Part 11 deviations to be more significant if a firm has a history of Part 11 violations or of inadequate or unreliable recordkeeping. Until firms attain full compliance with Part 11, FDA investigators will exercise greater vigilance to detect inconsistencies, unauthorized modifications, poor attributability, and any other problems associated with failure to comply with Part 11.

Regulatory Action Guidance:

Program monitors and center compliance offices should be consulted prior to recommending regulatory action. FDA will consider regulatory action with respect to Part 11 when the electronic records or electronic signatures are unacceptable substitutes for paper records or handwritten signatures, and that therefore, requirements of the applicable regulations (e.g., CGMP and GLP regulations) are not met. Regulatory citations should reference such predicate regulations in addition to Part 11. The following is an example of a regulatory citation for a violation of the device quality system regulations.

Failure to establish and maintain procedures to control all documents that are required by 21 CFR 820.40, and failure to use authority checks to ensure that only authorized individuals can use the system and alter records, as required by 21 CFR 11.10(g). For example, engineering drawings for manufacturing equipment and devices are stored in AutoCAD form on a desktop computer. The storage device was not protected from unauthorized access and modification of the drawings.

Dated: July 23,1999.

William K. Hubbard.

Senior Associate Commissioner for Policy, Planning and Coordination

[FR Doc. 99–19477 Filed 7–29–99; 8:45 am]

BILLING CODE 4160–01–F

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. 99D–1817]

Home Uterine Activity Monitors Guidance; Availability

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

SUMMARY: The Food and Drug Administration (FDA) is announcing the availability of a guidance entitled ''Home Uterine Activity Monitors; Guidance for the Submission of 510(k) Premarket Notifications.'' Elsewhere in this issue of the **Federal Register**, FDA is publishing a notice of the panel recommendation to reclassify home uterine activity monitors (HUAM's) into class II (special controls) and FDA's tentative findings. FDA agrees that these monitors should be reclassified in class II, and the guidance that is the subject of this notice of availability is one of the special controls that FDA believes will provide reasonable assurance of the safety and effectiveness of these devices.

DATES: Submit written comments by October 28, 1999.

ADDRESSES: Submit written requests for single copies on a 3.5″ diskette of the guidance entitled ''Home Uterine Activity Monitors; Guidance for the Submission of 510(k) Premarket Notifications'' to the Division of Small Manufacturers Assistance (HFZ–220), Center for Devices and Radiological Health (CDRH), Food and Drug Administration, 1350 Piccard Dr., Rockville, MD 20850. Send one self-addressed adhesive label to assist that office in processing your request, or fax your request to 301–443–8818. See the **SUPPLEMENTARY INFORMATION** section for information on electronic access to the guidance.

Submit written comments on the ''Home Uterine Activity Monitors; Guidance for the Submission of 510(k) Premarket Notifications'' to the Dockets Management Branch (HFA–305), Food and Drug Administration, 5630 Fishers Lane, rm. 1061, Rockville, MD 20852.

FOR FURTHER INFORMATION CONTACT: Kathy Daws-Kopp, Center for Devices and Radiological Health (HFZ–470), Food and Drug Administration, 9200 Corporate Blvd., Rockville, MD 20850, 301–594–1180, ext. 132.

SUPPLEMENTARY INFORMATION:

I. Background

This guidance document describes a means by which HUAM's may comply with the requirement of special controls for class II devices. Designation of this guidance document as a special control means that manufacturers attempting to establish that their device is substantially equivalent to a predicate HUAM should demonstrate that the proposed device complies with either the specific recommendations of this guidance or some alternate control that provides equivalent assurances of safety and effectiveness.

The guidance document addresses such areas as: Intended use and indications for use; preclinical data including electrical safety testing, electromagnetic compatibility, software, material safety, and bench validation testing; clinical data; cleaning and disinfection; and labeling.

In addition to this guidance document, FDA is also proposing that patient registries be a special control for HUAM's.

II. Significance of Guidance

This guidance represents the agency's current thinking on premarket notifications for HUAM's. It does not create or confer any rights for or on any person and does not operate to bind FDA or the public. An alternative approach may be used if such approach satisfies the applicable statute, regulations, or both.

The agency has adopted good guidance practices (GGP's), which set forth the agency's policies and procedures for the development, issuance, and use of guidance documents (62 FR 8961, February 27, 1997). This guidance is issued as a Level 1 guidance consistent with GGP's.

III. Electronic Access

In order to receive ''Home Uterine Activity Monitors; Guidance for the Submission of 510(k) Premarket Notifications'' via your fax machine, call the CDRH Facts-On-Demand system at 800–899–0381 or 301–827–0111 from a touch-tone telephone. At the first voice prompt press 1 to access DSMA Facts, at second voice prompt press 2, and then enter the document number (820) followed by the pound sign (#). Then follow the remaining voice prompts to complete your request.

Persons interested in obtaining a copy of the guidance may also do so using the World Wide Web (WWW). CDRH maintains an entry on the WWW for easy access to information including text, graphics, and files that may be downloaded to a personal computer with access to the WWW. Updated on a regular basis, the CDRH home page includes ''Home Uterine Activity Monitors; Guidance for the Submission of 510(k) Premarket Notifications,'' device safety alerts, **Federal Register** reprints, information on premarket submissions (including lists of approved applications and manufacturers' addresses), small manufacturers' assistance, information on video conferencing and electronic submissions, mammography matters, and other device-oriented information. The CDRH home page may be accessed at ''http://www.fda.gov/cdrh''.

IV. Comments

Interested persons may, on or before October 28, 1999, submit to the Dockets Management Branch (address above) written comments regarding this draft guidance. Two copies of any comments are to be submitted, except that individuals may submit one copy. Comments are to be identified with the docket number found in brackets in the heading of this document. The guidance

document and received comments may be seen in the Dockets Management Branch between 9 a.m. and 4 p.m., Monday through Friday.

Dated: June 30, 1999.

Linda S. Kahan,

Deputy Director for Regulations Policy, Center for Devices and Radiological Health.

[FR Doc. 99–19531 Filed 7–29–99; 8:45 am]

BILLING CODE 4160–01–F

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

[Document Identifier: HCFA–0377/0378/R–0054]

Agency Information Collection Activities: Proposed Collection; Comment Request

AGENCY: Health Care Financing Administration.

In compliance with the requirement of section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, the Health Care Financing Administration (HCFA), Department of Health and Human Services, is publishing the following summary of proposed collections for public comment. Interested persons are invited to send comments regarding this burden estimate or any other aspect of this collection of information, including any of the following subjects: (1) The necessity and utility of the proposed information collection for the proper performance of the agency's functions; (2) the accuracy of the estimated burden; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) the use of automated collection techniques or other forms of information technology to minimize the information collection burden.

Type of Information Collection Request: Extension of a currently approved collection; *Title of Information Collection:* Request for Certification, HCFA–377 and the Ambulatory Surgical Center Survey Report Form, HCFA–378 and HCFA-R–0054 Supporting Regulations Contained in 42 CFR 416.1 thru 416.49; *Form No.*: HCFA–0377/0378/R–0054 (OMB# 0938–0200); *Use:* The ASC request for certification form is utilized as an application for facilities wishing to participate in the Medicare program as an ASC. This form initiates the process of obtaining a decision as to whether the conditions of coverage are met. It also promotes data retrieval from the Online Data Input Edit (ODIE system, a subsystem of the Online Survey Certification and Report (OSCAR) system by the Health Care Financing Administration's (HCFA) Regional Offices (RO)). The ASC report form is an instrument used by the State survey agency to record data collection in order to determine supplier compliance with individual conditions of coverage and to report it to the Federal government. The form is primarily a coding worksheet designed to facilitate data reduction and retrieval into the ODIE/OSCAR system at the HCFA ROs. This form includes basic information on compliance (i.e., met, not met and explanatory statements) and does not require any descriptive information regarding the survey activity itself.; *Frequency:* Annually; *Affected Public:* State, Local, or Tribal Government; *Number of Respondents:* 2,798; *Total Annual Responses:* 2,798; *Total Annual Hours:* 2,100.

To obtain copies of the supporting statement and any related forms for the proposed paperwork collections referenced above, access HCFA's Web Site address at http://www.hcfa.gov/regs/prdact95.htm, or E-mail your request, including your address, phone number, OMB number, and HCFA document identifier, to Paperwork@hcfa.gov, or call the Reports Clearance Office on (410) 786–1326. Written comments and recommendations for the proposed information collections must be mailed within 60 days of this notice directly to the HCFA Paperwork Clearance Officer designated at the following address: HCFA, Office of Information Services, Security and Standards Group, Division of HCFA Enterprise Standards, Attention: Louis Blank, Room N2–14–26, 7500 Security Boulevard, Baltimore, Maryland 21244–1850.

Dated: July 22, 1999.

John P. Burke III,

HCFA Reports Clearance Officer, HCFA Office of Information Services, Security and Standards Group, Division of HCFA Enterprise Standards.

[FR Doc. 99–19482 Filed 7–29–99; 8:45 am]

BILLING CODE 4120–03–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

[Document Identifier: HCFA–R–0106 and HCFA–R–0284]

Agency Information Collection Activities: Submission for OMB Review; Comment Request

AGENCY: Health Care Financing Administration.

In compliance with the requirement of section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, the Health Care Financing Administration (HCFA), Department of Health and Human Services, is publishing the following summary of proposed collections for public comment. Interested persons are invited to send comments regarding this burden estimate or any other aspect of this collection of information, including any of the following subjects: (1) The necessity and utility of the proposed information collection for the proper performance of the agency's functions; (2) the accuracy of the estimated burden; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) the use of automated collection techniques or other forms of information technology to minimize the information collection burden.

1. *Type of Information Collection Request:* Reinstatement, without change, of a previously approved collection for which approval has expired; *Title of Information Collection:* Criteria for Medicare Coverage of Heart Transplants; *Form No.:* HCFA–R–106 (OMB No 0938–0490); *Use:* Medicare participating hospitals must file an application to be approved for coverage and payment of heart transplants performed on Medicare beneficiaries. The application must include the following data: patient selection, patient management, commitment, facility plans, experience and survival rates, maintenance of data, organ procurement, laboratory procedures, and billing. *Frequency:* Annually; *Affected Public:* Business or other for-profit; *Number of Respondents:* 5; *Total Annual Responses:* 5; *Total Annual Hours Requested:* 500.

2. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* Medicaid Statistical Information System (MSIS); *Form No.:* HCFA–R–0284 (OMB# 0938–0345); *Use:* State data are reported by a Federally mandated process known as MSIS. These data are the basis for: Medicaid actuarial forecasts for service utilization and costs; Medicaid legislative analysis and cost savings estimates; and responding to requests for information from HCFA components, the Department, Congress, and other customers. The national MSIS database will contain details that will allow constructive or predictive analysis of today's Medicaid issues (e.g., pregnant women, and infants).; *Frequency:* Quarterly and Annually; *Affected Public:* State, Local, or Tribal

Government; *Number of Respondents:* 53; *Total Annual Responses:* 212; *Total Annual Hours:* 2,120.

To obtain copies of the supporting statement and any related forms for the proposed paperwork collections referenced above, access HCFA's Web Site address at http://www.hcfa.gov/regs/prdact95.htm, or E-mail your request, including your address, phone number, OMB number, and HCFA document identifier, to Paperwork@hcfa.gov, or call the Reports Clearance Office on (410) 786–1326. Written comments and recommendations for the proposed information collections must be mailed within 30 days of this notice directly to the OMB desk officer: OMB Human Resources and Housing Branch, Attention: Allison Eydt, New Executive Office Building, Room 10235, Washington, D.C. 20503.

Dated: July 22, 1999.

John P. Burke III,

HCFA Reports Clearance Officer, HCFA Office of Information Services, Security and Standards Group, Division of HCFA Enterprise Standards.

[FR Doc. 99–19481 Filed 7–29–99; 8:45 am]

BILLING CODE 4120–03–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

[Document Identifier: HCFA–R–0282]

Emergency Clearance: Public Information Collection Requirements Submitted to the Office of Management and Budget (OMB)

AGENCY: Health Care Financing Administration.

In compliance with the requirement of section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, the Health Care Financing Administration (HCFA), Department of Health and Human Services, is publishing the following summary of proposed collections for public comment. Interested persons are invited to send comments regarding this burden estimate or any other aspect of this collection of information, including any of the following subjects: (1) The necessity and utility of the proposed information collection for the proper performance of the agency's functions; (2) the accuracy of the estimated burden; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) the use of automated collection techniques or other forms of information technology to minimize the information collection burden.

We are, however, requesting an emergency review of the information collections referenced below. In compliance with the requirement of section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, we have submitted to the Office of Management and Budget (OMB) the following requirements for emergency review. We are requesting an emergency review because the collection of this information is needed before the expiration of the normal time limits under OMB's regulations at 5 CFR, Part 1320. This is necessary to ensure compliance with § 1852(c) of the Social Security Act and §§ 422.64, 422.111 and 422.560—422.622 of the CFR. We cannot reasonably comply with the normal clearance procedures because all beneficiaries who are eligible to elect M+C plans have had a legal right to receive appeals and grievance information from M+C organizations as of 1/1/99. If the agency does not provide formal guidance to M+C organizations, then it will be difficult for M+C organizations to operationalize the statutory and regulatory requirements. Furthermore, beneficiaries may be harmed by receiving inconsistent information across M+C organizations.

HCFA is requesting OMB review and approval of this collection by August 10, 1999, with a 180-day approval period. Written comments and recommendations will be accepted from the public if received by the individuals designated below by August 9, 1999. During this 180-day period, we will publish a separate **Federal Register** notice announcing the initiation of an extensive 60-day agency review and public comment period on these requirements. We will submit the requirements for OMB review and an extension of this emergency approval.

Type of Information Request: New collection.

Title of Information Collection: Medicare + Choice (M+C) Organization Appeals and Grievance Data Collection and Reporting Requirements and Supporting Regulations in 42 CFR 422.64, 422.111, and 422.560–422.622.

HCFA Form Number: HCFA–R–0282 (OMB approval #: 0938–NEW).

Use: These information collection pertains to the aggregate number and disposition of grievances and appeals by M+C organizations. Both the Balanced Budget Act (BBA) of 1997 and the Government Performance and Results Act (GPRA) of 1993 establish a need for HCFA to set and monitor performance standards in the area of appeals. The purpose is to hold M+C organizations accountable to regulators and consumers, as well as promote informed choice.

Frequency: Semi-annually.

Affected Public: Business or other for-profit and Individuals or Households.

Number of Respondents: 331.

Total Annual Responses: 662.

Total Annual Burden Hours: 662.

We have submitted a copy of this notice to OMB for its review of these information collections. A notice will be published in the **Federal Register** when approval is obtained.

To obtain copies of the supporting statement and any related forms for the proposed paperwork collections referenced above, E-mail your request, including your address, phone number, and HCFA form number(s) referenced above, to Paperwork@hcfa.gov, or call the Reports Clearance Office on (410) 786–1326.

Interested persons are invited to send comments regarding the burden or any other aspect of these collections of information requirements. However, as noted above, comments on these information collection and recordkeeping requirements must be mailed and/or faxed to the designees referenced below by August 9, 1999:

Health Care Financing Administration, Office of Information Services, Security and Standards Group, Division of HCFA Enterprise Standards, Room N2–14–26, 7500 Security Boulevard, Baltimore, MD 21244–1850. Fax Number: (410) 786–0262 Attn: Louis Blank HCFA–R–0282

and

Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503, Fax Number: (202) 395–6974 or (202) 395–5167. Attn: Allison Herron Eydt, HCFA Desk Officer.

Dated: July 22, 1999.

John P. Burke III,

HCFA Reports Clearance Officer, HCFA, Office of Information Services, Security and Standards Group, Division of HCFA Enterprise Standards.

[FR Doc. 99–19483 Filed 7–29–99; 8:45 am]

BILLING CODE 4120–03–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

Proposed Collection: Comment Request; Contraception and Infertility Research Loan Repayment Program

SUMMARY: In compliance with the requirement of section 3506(c)(2)(A) of

the Paperwork Reduction Act of 1995, for opportunity for public comment on proposed data collection projects, the National Institute of Child Health and Human Development (NICHD), the National Institutes of Health (NIH) will publish periodic summaries of proposed projects to be submitted to the Office of Management and Budget (OMB) for review and approval.

PROPOSED COLLECTION: Title: Contraception and Infertility Research Loan Repayment Program. Type of Request: Revision (OMB No. 0925–0440, Exp. 12/31/99). Form Number: NIH 2756–1, NIH 2756–2. Need and Use of Information Collection: The NICHD Contraception and Infertility Research Loan Repayment Program (CIR–LRP) intends to provide for the repayment of educational loan debt of health professionals (including graduate students) who agree to commit to a period of obligated service of not less than two years conducting research with respect to contraception and/or infertility. The CIR–LRP is designed to provide an incentive for health professionals to work in areas of reproductive research directly related to contraceptive development and/or infertility diagnosis and treatment by providing assistance in repaying educational loans for such individuals. The long-range objective of the CIR–LRP is to stimulate the commitment of researchers to sustaining a career focus on contraception and/or infertility research. The information proposed for collection will be used by the NICHD to determine an applicant's eligibility for participation in the CIR–LRP. It will enable the NICHD to select qualified individuals for participation in the program, and to deliver eligible benefits. The CIR–LRP application consists of two parts: Part I (Information About the Applicant) is completed by the applicant; Section A of Part II (Loan Information and Permission for Disclosure) is also completed by the applicant; and Section B, Part II (Lender's Verification) is completed by the Lending Institution. It may also be necessary for a State or other entity to verify an outstanding service obligation. In these instances, written verification of the service obligation will be requested from the State or other entity. Frequency of Response: On occasion. Affected Public: Individuals or households; Business or other for-profit; Not-for-profit institutions. Type of Respondents: Health professionals or those training in the health professions; Lenders. The annual reporting burden is as follows:

	Estimated number of respondents	Estimated number of responses per respondent	Average burden hours per response	Estimated total annual burden hours requested
Applicant	40	6	1.306	313.60
Lender	160	1	0.334	53.440
State/Other Entity	8	1	0.334	2.672
Total				369.712

There are no Capital Costs to report. There are no Operating or Maintenance Costs to report.

REQUEST FOR COMMENTS: Written comments and/or suggestions from the public and affected agencies are invited on one or more of the following points: (1) Whether the proposed collection of information is necessary for the proper performance of the function of the agency, including whether the information will have practical utility: (2) The accuracy of the agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used; (3) Ways to enhance the quality, utility, and clarity of the information collected; (4) Ways to minimize the burden of the collection of information on those who are to respond, including the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology.

FOR FURTHER INFORMATION: To request more information on the proposed project or to obtain a copy of the data collection plans and instruments, contact Dr. Louis DePaolo, Director, NICHD Contraception and Infertility Research Loan Repayment Program, CPR, NICHD, NIH, 6100 Executive Boulevard, Room 8B01, Bethesda, MD 20892, or call (301) 435–6970 or Email your request, including your address to: ld38p@nih.gov. Information can also be obtained via the World Wide Web at http://www.nih.gov/nichd/docs/research.html.

COMMENTS DUE DATE: Comments regarding this information collection are best assured of having their effect if received within 60-days of the date of publication.

Dated: July 22, 1999.

Michael Rosenthal,

Acting Executive Officer, NICHD.

[FR Doc. 99–19502 Filed 7–29–99; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Cancer Institute; Notice of Closed Meeting

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. Appendix 2), notice is hereby given of the following meeting.

The meeting will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personnel privacy.

Name of Committee: National Cancer Institute Special Emphasis Panel Director's Challenge—Molecular Classification of Tumors.

Date: August 16–18, 1999.

Time: 8:00 a.m. to 6:00 p.m.

Agenda: To review and evaluate grant applications.

Place: DoubleTree Hotel, 1750 Rockville Pike, Rockville, MD 20852.

Contact Person: Ray Bramhall, Scientific Review Administrator, Special Review, Referral and Resources Branch, Division of Extramural Activities, National Cancer Institute, National Institutes of Health, 6130 Executive Blvd, Rockville, MD 20892, (301) 496–3428.

(Catalogue of Federal Domestic Assistance Program Nos. 93.392, Cancer Construction; 93.393, Cancer Cause and Prevention Research; 93.394, Cancer Detection and Diagnosis Research; 93.395, Cancer

Treatment Research; 93.396, Cancer Biology Research; 93.397, Cancer Centers Support; 93.398, Cancer Research Manpower; 93.399, Cancer Control, National Institutes of Health, HHS)

Dated: July 21, 1999.

LaVerne Y. Stringfield,

Committee Management Officer, NIH.

[FR Doc. 99–19503 Filed 7–29–99; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Cancer Institute; Notice of Closed Meeting

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. Appendix 2), notice is hereby given of the following meeting.

The meeting will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: National Cancer Institute Initial Review Group Subcommittee D—Clinical Studies.

Date: August 2–3, 1999.

Time: 8:00 a.m. to 6:00 p.m.

Agenda: To review and evaluate grant applications.

Place: Holiday Inn, 8777 Georgia Avenue, Silver Spring, MD 20910.

Contact Person: Martin H. Goldrosen, MS, PhD, Scientific Review Administrator, Grants Review Branch, Division of Extramural Activities, National Cancer Institute, National Institutes of Health, 6130 Executive Boulevard, Room 635C, Rockville, MD 20852–7408, (301) 496–7930.

This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

(Catalogue of Federal Domestic Assistance Program Nos. 93.392, Cancer Construction; 93.393, Cancer Cause and Prevention Research; 93.394, Cancer Detection and Diagnosis Research; 93.395, Cancer Treatment Research; 93.396, Cancer Biology Research; 93.397, Cancer Centers Support; 93.398, Cancer Research Manpower, 93.399, Cancer Control, National Institutes of Health, HHS)

Dated: July 26, 1999.

LaVerne Y. Stringfield,

Committee Management Officer, NIH.

[FR Doc. 99–19506 Filed 7–29–99; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute of Mental Health; Notice of Closed Meetings

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. Appendix 2), notice is hereby given of the following meetings.

The meetings will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: National Institute of Mental Health Special Emphasis Panel.

Date: July 30, 1999.

Time: 2:00 p.m. to 3:30 p.m.

Agenda: To review and evaluate grant applications.

Place: Neuroscience Center, National Institutes of Health, 6001 Executive Blvd., Bethesda, MD 20892, (Telephone Conference Call).

Contact Person: Lawrence E. Chaitkin, PhD, Scientific Review Administrator, Division of Extramural Activities, National Institute of Mental Health, NIH, Neuroscience Center, 6001 Executive Blvd., Rm. 6138, MSC 9606, Bethesda, MD 20892–9606, 301–443–6470.

This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

Name of Committee: National Institute of Mental Health Special Emphasis Panel.

Date: August 12, 1999.

Time: 3:00 p.m. to 4:00 p.m.

Agenda: To review and evaluate grant applications.

Place: Neuroscience Center, National Institutes of Health, 6001 Executive Blvd., Bethesda, MD 20892, (Telephone Conference Call).

Contact Person: Jack D. Maser, PhD, Scientific Review Administrator, Division of Extramural Activities, National Institute of Mental Health, NIH, Neuroscience Center, 6001 Executive Blvd., Room 6150, MSC 9608, Bethesda, MD 20892–9608, 301–443–1340.

This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

(Catalogue of Federal Domestic Assistance Program Nos. 93.242, Mental Health Research Grants; 93.281, Scientist Development Award, Scientist Development Award for Clinicians, and Research Scientist Award; 93.282, Mental Health National Research Service Awards for Research Training, National Institutes of Health, HHS)

Dated: July 26, 1999.

LaVerne Y. Stringfield,

Committee Management Officer, NIH.

[FR Doc. 99–19504 Filed 7–29–99; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute on Drug Abuse; Notice of Closed Meeting

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. Appendix 2), notice is hereby given of the following meeting.

The meeting will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: National Institute on Drug Abuse Special Emphasis Panel National Drug Abuse Treatment Clinical Trials Network.

Date: August 4, 1999.

Time: 2:00 p.m. to 4:00 p.m.

Agenda: To review and evaluate grant applications.

Place: Neuroscience Center, National Institutes of Health, 6001 Executive Blvd., Bethesda, MD 20892 (Telephone Conference Call).

Contact Person: Susan L. Coyle, Phd, Chief, Clinical, Epidemiological and Applied Sciences Review Branch, Office of Extramural Program Review, National Institute on Drug Abuse, National Institutes of Health, DHHS, 6001 Executive Boulevard, Room 3158, MSC 9547, Bethesda, MD 20892–9547, (301) 443–2620.

This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

(Catalogue of Federal Domestic Assistance Program Nos. 93.277, Drug Abuse Scientist Development Award for Clinicians, Scientist Development Awards, and Research Scientist Awards; 93.278, Drug Abuse National

Research Service Awards for Research Training; 93.279, Drug Abuse Research Programs, National Institutes of Health, HHS)

Dated: July 26, 1999.

LaVerne Y. Stringfield,

Director, Office of Federal Advisory Committee Policy, NIH.

[FR Doc. 99–19505 Filed 7–29–99; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute of Allergy and Infectious Diseases; Notice of Closed Meeting

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. Appendix 2), notice is hereby given of the following meeting.

The meeting will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6). Title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: National institute of Allergy and infectious Diseases Special Emphasis Panel Review of Horga K08 Application.

Date: August 2, 1999.

Time: 1:30 p.m. to 2:30 p.m.

Agenda: To review and evaluate grant appications.

Place: NIAID, NIH, (Room 2148), 6700–B Rockledge Drive, MSC 7610, Bethesda, MD 20892–7610 (Telephone Conference Call).

Contact Person: Dianne E. Tingley, PhD, Scientific Review Administrator, Scientific Review Program, Division of Extramural Activities, NIAID, NIH, Room 2220, 6700–B Rockledge Drive, MSC 7610, Bethesda, MD 20892–7610, 301–496–2550.

This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

(Catalogue of Federal Domestic Assistance Program Nos. 93.855, Allergy, Immunology, and Transplantation Research; 93.856, Microbiology and Infectious Diseases Research, National Institutes of Health, HHS)

Dated: July 23, 1999.

LaVerne Y. Stringfield,

Director, Office of Federal Advisory Committee Policy, NIH.

[FR Doc. 99–19509 Filed 7–29–99; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute on Drug Abuse; Notice of Closed Meetings

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. Appendix 2), notice is hereby given of the following meetings.

The meetings will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The contract proposals and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the contract proposals, the disclosure of which constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: National Institute on Drug Abuse Special Emphasis Panel ''Clinical Trials Operations''.

Date: July 29, 1999.

Time: 9:00 a.m. to 4:00 p.m.

Agenda: To review and evaluate contract proposals.

Place: Bethesda Marriott Hotel, 5151 Pooks Hill Road, Bethesda, MD 20814.

Contact Person: Eric Zatman, Contract Review Specialist, Office of Extramural Program Review, National Institute on Drug Abuse, National Institutes of Health, DHHS, 6001 Executive Boulevard, Room 3158, MSC 9547, Bethesda, MD 20892–9547, (301) 435–1438.

This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

Name of Committee: National Institute on Drug Abuse Special Emphasis Panel ''Production, Analysis, and Distribution of Cannabis and Marijuana Cigarettes''.

Date: August 12, 1999.

Time: 9:00 a.m. to 1:00 p.m.

Agenda: To review and evaluate contract proposals.

Place: Bethesda Marriott Hotel, 5151 Pooks Hill Road, Bethesda, MD 20814.

Contact Person: Eric Zatman, Contract Review Specialist, Office of Extramural Program Review, National Institute on Drug Abuse, National Institutes of Health, DHHS, 6001 Executive Boulevard, Room 3158, MSC 9547, Bethesda, MD 20892–9547, (301) 435–1438.

(Catalogue of Federal Domestic Assistance Program Nos. 93.277, Drug Abuse Scientist Development Award for Clinicians, Scientist Development Awards, and Research Scientist Awards; 93.278, Drug Abuse National Research Service Awards for Research Training; 93.279, Drug Abuse Research Programs, National Institutes of Health, HHS)

Dated: July 23, 1999.

LaVerne Y. Stringfield,

Director, Office of Federal Advisory Committee Policy.

[FR Doc. 99–19510 Filed 7–29–99; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute of Mental Health; Notice of Closed Meeting

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. Appendix 2), notice is hereby given of the following meeting.

The meeting will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: National Institute of Mental Health Special Emphasis Panel.

Date: August 9, 1999.

Time: 8:00 a.m. to 5:00 p.m.

Agenda: To review and evaluate grant applications.

Place: The River Inn, 924 25th Street, Washington, DC 20037.

Contact Person: Russell E. Martenson, Ph.D., Scientific Review Administrator, Division of Extramural Activities, National Institute of Mental Health, NIH, Neuroscience Center, 6001 Executive Blvd., Rm. 6138, MSC 9606, Bethesda, MD 20892–9606, 301–443–7861.

This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

(Catalogue of Federal Domestic Assistance Program Nos. 93.242, Mental Health Research Grants; 93.281, Scientist Development Award, Scientist Development Awards for Clinicians, and Research Scientist Award; 93.282, Mental Health National Research Service Awards for Research Training, National Institutes of Health, HHS)

Dated: July 23, 1999.

LaVerne Y. Stringfield,

Committee Management Officer, NIH.

[FR Doc. 99–19511 Filed 7–29–99; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute of Neurological Disorders and Stroke; Notice of Closed Meetings

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. Appendix 2), notice is hereby given of the following meetings.

The meetings will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: National Institute of Neurological Disorders and Stroke Special Emphasis Panel.

Date: August 4, 1999.

Time: 8:30 a.m. to 5:00 p.m.

Agenda: To review and evaluate grant applications.

Place: Chevy Chase Holiday Inn, 5520 Wisconsin Avenue, Chevy Chase, MD 20815.

Contact Person: Alan L. Willard, PhD, Scientific Review Administrator, Scientific Review Branch, NINDS/NIH/DHHS, Neuroscience Center, 6001 Executive Blvd. Suite 3208, MSC 9529, Bethesda, MD 20892–9529, 301–469–9223.

This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

Name of Committee: National Institute of Neurological Disorders and Stroke Special Emphasis Panel.

Date: August 9, 1999.

Time: 8:00 a.m. to 7:00 p.m.

Agenda: To review and evaluate grant applications.

Place: Madison Hotel, Fifteenth & M Streets NW, Washington, DC 20005.

Contact Person: Alan L. Willard, PhD, Scientific Review Administrator, Scientific Review Branch, NINDS/NIH/DHHS, Neuroscience Center, 6001 Executive Blvd. Suite 3208, MSC 9529, Bethesda, MD 20892–9529, 301–469–9223.

This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

(Catalogue of Federal Domestic Assistance Program Nos. 93.853, Clinical Research Related to Neurological Disorders; 93.854, Biological Basis Research in the Neurosciences, National Institutes of Health, HHS)

Dated: July 22, 1999.

LaVerne Y. Stringfield,

Committee Management Officer, NIH.

[FR Doc. 99–19512 Filed 7–29–99; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute of General Medical Sciences; Notice of Closed Meeting

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. Appendix 2), notice is hereby given of the following meeting.

The meeting will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and the discussion could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: National Institute of General Medical Sciences Special Emphasis Panel Trauma and Burn.

Date: August 7, 1999.

Time: 8:00 a.m. to 11:00 a.m.

Agenda: To review and evaluate grant applications.

Place: Radisson Miyako Hotel, 1625 Post Street, San Francisco, CA 94115.

Contact Person: Bruce K. Wetzel, PhD, Scientific Review Administrator, Office of Scientific Review, NIGMS, Natcher Building, Room 1AS–19, Bethesda, MD 20892, (301) 594–3907.

This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

(Catalogue of Federal Domestic Assistance Program Nos. 93.375, Minority Biomedical Research Support; 93.821, Cell Biology and Biophysics Research; 93.859, Pharmacology, Physiology, and Biological Chemistry Research; 93.862, Genetics and Developmental Biology Research; 93.88, Minority Access to Research Careers; 93.96, Special Minority Initiatives, National Institutes of Health, HHS)

Dated: July 22, 1999.

LaVerne Y. Stringfield,

Director, Office of Federal Advisory Committee Policy, NIH.

[FR Doc. 99–19513 Filed 7–29–99; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute of General Medical Sciences; Notice of Closed Meeting

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. Appendix 2), notice is hereby given of the following meeting.

The meeting will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), title 5 U.S.C., as amended. the grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: National Institute of General Medical Sciences Special Emphasis Panel Trauma and Burn.

Date: August 4, 1999.

Time: 8:30 a.m. to 12:00 p.m.

Agenda: To review and evaluate grant applications.

Place: Harbor House, No. 28 at Pier 21, Galveston, TX 77550.

Contact Person: Bruce K. Wetzel, PhD, Scientific Review Administrator, Office of Scientific Review, NIGMS, Natcher Building, Room 1AS–19, Bethesda, MD 20892, (301) 594–3907.

This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

(Catalogue of Federal Domestic Assistance Program Nos. 93.375, Minority Biomedical Research Support; 93.821, Cell Biology and Biophysics Research; 93.859, Pharmacology, Physiology, and Biological Chemistry Research; 93.862, Genetics and Developmental Biology Research; 93.88, Minority Access to Research Careers; 93.96, Special Minority Initiatives, National Institutes of Health, HHS)

Dated: July 22, 1999.

LaVerne Y. Stringfield,

Director, Office of Federal Advisory Committee Policy, NIH.

[FR Doc. 99–19514 Filed 7–29–99; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

Center for Scientific Review; Notice of Closed Meetings

Pursuant to section 10(d) of the Federal Advisory Committee Act, as

amended (5 U.S.C. Appendix 2), notice is hereby given of the following meetings.

The meetings will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5, U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal property.

Name of Committee: Center for Scientific Review Special Emphasis Panel.
Date: July 26, 1999.
Time: 2:00 p.m. to 3:00 p.m.
Agenda: To review and evaluate grant applications.
Place: Hyatt Regency Hotel, One Bethesda Metro Center, Bethesda, MD 20814.
Contact Person: Mary Clare Walker, PhD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 5104, MSC 7852, Bethesda, MD 20892, (301) 435–1165.
This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

Name of Committee: Center for Scientific Review Special Emphasis Panel.
Date: July 30, 1999.
Time: 1:00 p.m. to 2:30 p.m.
Agenda: To review and evaluate grant applications.
Place: NIH, Rockledge 2, Bethesda, MD 20892, (Telephone Conference Call).
Contact Person: William C. Branche, PhD., Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 4182, MSC 7808, Bethesda, MD 20892, (301) 435–1148.
This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

Name of Committee: Center for Scientific Review Special Emphasis Panel.
Date: July 30, 1999.
Time: 1:00 p.m. to 2:00 p.m.
Agenda: To review and evaluate grant applications.
Place: NIH, Rockledge 2, Bethesda, MD 20892, (Telephone Conference Call).
Contact Person: Jean Hickman, Phd, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 4194, MSC 7808, Bethesda, MD 20892, (301) 435–1146.
This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

Name of Committee: Center for Scientific Review Special Emphasis Panel.
Date: July 30, 1999.
Time: 3:00 p.m. to 4:00 p.m.
Agenda: To review and evaluate grant applications.
Place: Ritz-Carlton Hotel at Pentagon City, 1250 South Hayes Street, Arlington, VA 22202.
Contact Person: Nancy Shinowara, PhD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 4208, MSC 7814, Bethesda, MD 20892–7814, (301) 435–1173, shinowan@drg.nih.gov.
This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

Name of Committee: Center for Scientific Review Special Emphasis Panel.
Date: August 2, 1999.
Time: 10:00 a.m. to 11:00 a.m.
Agenda: To review and evaluate grant applications.
Place: NIH, Rockledge 2, Bethesda, MD 20892, (Telephone Conference Call).
Contact Person: Edmund Copeland, PhD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 4142, MSC 7804, Bethesda, MD 20892, (301) 435–1715.
This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

Name of Committee: Center for Scientific Review Special Emphasis Panel.
Date: August 5–6, 1999.
Time: 8 a.m. to 2 p.m.
Agenda: To review and evaluate grant applications.
Place: Chevy Chase Holiday Inn, 5520 Wisconsin Ave., Chevy Chase, MD 20815.
Contact Person: Gloria B. Levin, PhD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 3166, MSC 7848, Bethesda, MD 20892, (301) 435–1017, leving@csr.nih.gov.
This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

Name of Committee: Center for Scientific Review Special Emphasis Panel.
Date: August 5, 1999.
Time: 8 a.m. to 5 p.m.
Agenda: To review and evaluate grant applications.
Place: Marriott Pooks Hill, 5151 Pooks Hill Road, Bethesda, MD 20814.
Contact Person: Joseph Kimm, PhD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 5178, MSC 7844, Bethesda, MD 20892, (301) 435–1249.
This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

Name of Committee: Center for Scientific Review Special Emphasis Panel r24s.
Date: August 5–6, 1999.
Time: 8 a.m. to 5 p.m.
Agenda: To review and evaluate grant applications.
Place: Georgetown Inn, 1310 Wisconsin Ave., NW., Washington, DC 20007.
Contact Person: Arnold Revzin, PhD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 4192, MSC 7806, Bethesda, MD 20892, (301) 435–1153.
This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

Name of Committee: Center for Scientific Review Special Emphasis Panel.
Date: August 5, 1999.
Time: 8:30 a.m. to 5:30 p.m.
Agenda: To review and evaluate grant applications.
Place: The Admiral Fell Inn, 888 South Broadway, Historic Fell's Point, Baltimore, MD 21231.
Contact Person: David L. Simpson, PhD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 5192, MSC 7846, Bethesda, MD 20892, (301) 435–1278.
This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

Name of Committee: Center for Scientific Review Special Emphasis Panel.
Date: August 5–6, 1999.
Time: 8:30 a.m. to 5 p.m.
Agenda: To review and evaluate grant applications.
Place: Georgetown Holiday Inn, 2101 Wisconsin Ave., NW., Washington, DC 20007.
Contact Person: Thomas A. Tatham, PhD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 3188, MSC 7848, Bethesda, MD 20892, (301) 435–0692.
This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

Name of Committee: Center for Scientific Review Special Emphasis Panel.
Date: August 5, 1999.
Time: 8:30 a.m. to 5 p.m.
Agenda: To review and evaluate grant applications.
Place: Georgetown Inn, 1310 Wisconsin Ave., NW., Washington, DC 20007.
Contact Person: Carole L. Jelsema, PhD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 5222, MSC 7850, Bethesda, MD 20892, (301) 435–1249, jelsemac@drg.nih.gov.
This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

Name of Committee: Center for Scientific Review Special Emphasis Panel ZRG1–1FCN8–03.
Date: August 5, 1999.
Time: 10:00 a.m. to 11:00 a.m.

Agenda: To review and evaluate grant applications.

Place: NIH, Rockledge 2, Bethesda, MD 20892, (Telephone Conference Call).

Contact Person: Samuel Rawlings, PhD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 5160, MSC 7844, Bethesda, MD 20892, (301) 435–1243.

This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

Name of Committee: Center for Scientific Review Special Emphasis Panel.

Date: August 5, 1999.

Time: 10:00 a.m. to 3:30 p.m.

Agenda: to review and evaluate grant applications.

Place: The River Inn, 924 25th Street, Washington, DC 20037.

Contact Person: J. Terrell Hoffeld, DDS, PhD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 4116, MSC 7816, Bethesda, MD 20892, (301) 435–1781.

This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

Name of Committee: Center for Scientific Review Special Emphasis Panel.

Date: August 5, 1999.

Time: 1:15 p.m. to 3:00 p.m.

Agenda: To review and evaluate grant applications.

Place: NIH, Rockledge 2, Bethesda, MD 20892, (Telephone Conference Call).

Contact Person: Robert Weller, PhD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 3160, MSC 7770, Bethesda, MD 20892, (301) 435–0694.

This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

Name of Committee: Center for Scientific Review Special Emphasis Panel.

Date: August 5, 1999.

Time: 2:00 p.m. to 4:00 p.m.

Agenda: To review and evaluate grant applications.

Place: NIH, Rockledge 2, Bethesda, MD 20892, (Telephone Conference Call).

Contact Person: Sami A. Mayyasi, PhD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 5112, MSC 7852, Bethesda, MD 20892, (301) 435–1169.

This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

Name of Committee: Center for Scientific Review Special Emphasis Panel.

Date: August 5, 1999.

Time: 2:00 p.m. to 3:00 p.m.

Agenda: To review and evaluate grant applications.

Place: NIH, Rockledge 2, Bethesda, MD 20892, (Telephone Conference Call).

Contact Person: Alexander D. Politis, PhD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 4204, MSC 7812, Bethesda, MD 20892, (301) 435–1225, politisa@csr.nih.gov

This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

Name of Committee: Center for Scientific Review Special Emphasis Panel ZRG1–IFCN8–02.

Date: August 5, 1999.

Time: 2:00 p.m. to 4:00 p.m.

Agenda: To review and evaluate grant applications.

Place: NIH, Rockledge 2, Bethesda, MD 20892, (Telephone Conference Call).

Contact Person: Samuel Rawlings, PhD, Scientific Review Administrator, Center for Scientific Review, National Institutes of health, 6701 Rockledge Drive, Room 5160, MSC 7844, Bethesda, MD 20892, (301) 435–1243.

This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

Name of Committee: Center for Scientific Review Special Emphasis Panel.

Date: August 5, 1999.

Time: 4:00 p.m. to 6:00 p.m.

Agenda: To review and evaluate grant applications.

Place: NIH, Rockledge 2, Bethesda, MD 20892 (Telephone Conference Call).

Contact Person: Timothy J. Henry, Ph.D., Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 4180, MSC 7808, Bethesda, MD 20892, (301) 435–1147.

This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review an funding cycle.

Name of Committee: Center for Scientific Review Special Emphasis Panel.

Date: August 5, 1999.

Time: 12:00 p.m. to 1:00 p.m.

Agenda: To review and evaluate grant applications.

Place: NIH, Rockledge 2, Bethesda, MD 20892 (Telephone Conference Call).

Contact Person: Edmund Copeland, Ph.D., Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 4142, MSC 7804, Bethesda, MD 20892, (301) 435–1715.

This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review an funding cycle.

Name of Committee: Center for Scientific Review Special Emphasis Panel.

Date: August 6, 1999.

Time: 2:00 p.m. to 4:30 p.m.

Agenda: To review and evaluate grant applications.

Place: NIH, Rockledge 2, Bethesda, MD 20892 (Telephone Conference Call).

Contact Person: John L. Bowers, Ph.D., Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 4168, MSC 7806, Bethesda, MD 20892, (301) 435–1725.

This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review an funding cycle.

Name of Committee: Center for Scientific Review Special Emphasis Panel zrg1-ifcn5–08.

Date: August 6, 1999.

Time: 10:00 a.m. to 11:30 a.m.

Agenda: To review and evaluate grant applications.

Place: NIH, Rockledge 2, Bethesda, MD 20892 (Telephone Conference Call).

Contact Person: John Bishop, Ph.D., Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 5180, MSC 7844, Bethesda, MD 20892, (301) 435–1250.

This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review an funding cycle.

Name of Committee: Center for Scientific Review Special Emphasis Panel.

Date: August 6, 1999.

Time: 11:00 a.m. to 1:00 p.m.

Agenda: To review and evaluate grant applications.

Place: NIH, Rockledge 2, Bethesda, MD 20892 (Telephone Conference Call).

Contact Person: Sami A. Mayyasi, Ph.D., Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 5112, MSC 7852, Bethesda, MD 20892, (301) 435–1169.

This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review an funding cycle.

(Catalogue of Federal Domestic Assistance Program Nos. 93.306, Comparative Medicine, 93.306; 93.333, Clinical Research, 93.333, 93.337, 93.393–93.396, 93.837–93.844, 93.846–93.878, 93.892, 93.893, National Institutes of Health, HHS)

Dated: July 23, 1999.

LaVerne Y. Stringfield,

Committee Management Officer, NIH.

[FR Doc. 99–19508 Filed 7–29–99; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

Clinical Center; Amended Notice of Meeting

Notice is hereby given of changes in the meeting of the Board of Governors of the Warren Grant Magnuson Clinical Center, Executive Committee, July 30, 1999, 9:00 a.m. to 10:00 a.m., which was published in the **Federal Register** on July 19, 1999, 64 FR 38685.

The meeting, which was advertized as closed, will be completely open to the public. The Board will approve the budget and discuss the Board oversight of clinical quality and expectations of Board members for the future.

The time of the meeting is changed to 10:30 a.m. to 11:45 a.m. As previously announced, the meeting will be held at the National Institutes of Health, Clinical Center Medical Board, Room 2C116, 9000 Rockville Pike, Bethesda, MD 20892.

Dated: July 23, 1999.

LaVerne Y. Stringfield,

Committee Management Officer, NIH.

[FR Doc. 99–19507 Filed 7–29–99; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

Prospective Grant of Exclusive License: Conjugate Vaccines to Prevent Disease Caused by Nontypeable Haemophilus influenzae and Moraxella catarrahalis, Particularly Otitis Media

AGENCY: National Institutes of Health, Public Health Service, DHHS.

ACTION: Notice.

SUMMARY: This is notice, in accordance with 35 U.S.C. 209(c)(1) and 37 CFR 404.7(a)(1)(I), that the National Institutes of Health (NIH), Department of Health and Human Services, is contemplating the grant of an exclusive license worldwide to practice the invention embodied in: US Patent Application Serial Number 08/842,409, entitled ''Conjugate Vaccine for Nontypeable *H. influenzae*'', filed April 23, 1997 and US Provisional Patent Application Serial Number 60/071,483 (now PCT/US99/00590), entitled ''Lipooligosaccharide-Based Vaccine for Prevention of *Moraxella (Branhamella) catarrhalis* Infections in Humans'', filed January 13, 1998, to Immune Complex Corporation, having a place of business in San Diego, CA. The patent rights in these inventions have been assigned to the United States of America.

DATES: Only written comments and/or application for a license which are received by the NIH Office of Technology Transfer on or before September 28, 1999 will be considered.

ADDRESSES: Requests for a copy of the patent applications, inquiries, comments and other materials relating to the contemplated license should be directed to: Robert Benson, Office of Technology Transfer, National Institutes of Health, 6011 Executive Boulevard, Suite 325, Rockville, MD 20852–3804; Telephone: (301) 496–7056, ext. 267; Facsimile: (301) 402–0220; e-mail: rb20m@nih.gov.

SUPPLEMENTARY INFORMATION: The two patent applications describe conjugates of detoxified lipooligosaccharide (dLOS), isolated from the cellular membrane of either nontypeable *H. influenzae* or *M. catarrhalis,* and a carrier. These conjugates have been shown to raise bactericidal antibodies against the bacterial strain from which the dLOS was isolated and are also cross-reactive with different strains.

The prospective exclusive license will be royalty-bearing and will comply with the terms and conditions of 35 U.S.C. 209 and 37 CFR 404.7. The prospective exclusive license may be granted unless, within 60 days from the date of this published Notice, NIH receives written evidence and argument that establishes that the grant of the license would not be consistent with the requirements of 35 U.S.C. 209 and 37 CFR 404.7.

The field of use may be limited to the development of conjugate vaccines for the prevention or treatment of diseases in humans caused by infection with nontypeable *H. influenzae* and *M. catarrhalis,* wherein the carrier is composed of Hepatitis B Virus core protein-based particles. Publication of this notice should be considered a modification of an earlier notice on this subject published in Vol. 64, No. 43, page 10671, on March 5, 1999.

Properly filed competing applications for a license filed in response to this notice will be treated as objections to the contemplated license. Comments and objections submitted in response to this notice will not be made available for public inspection, and, to the extent permitted by law, will not be released under the Freedom of Information Act, 5 U.S.C. 552.

Dated: July 22, 1999.

Jack Spiegel,

Director, Division of Technology Development and Transfer, Office of Technology Transfer, National Institutes of Health.

[FR Doc. 99–19501 Filed 7–29–99; 8:45 am]

BILLING CODE 4140–01–P

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

[Docket No. FR–4441–N–41]

Submission for OMB Review: Performance Funding System, Determination of Operating Subsidy for Vacancies

AGENCY: Office of the Assistant Secretary for Administration, HUD.

ACTION: Notice.

SUMMARY: Housing Agencies (HAs) report the information to HUD on the Form HUD–52728 in their operating subsidy submissions. The submissions are reviewed and approved by HUD Field Offices and serve as the basis for obligating operating subsidies.

DATES: *Comments Due Date:* August 30, 1999.

ADDRESSES: Interested persons are invited to submit comments regarding this proposal. Comments should refer to the proposal by name and/or OMB approval number (2577–0066) and should be sent to: Joseph F. Lackey, Jr., OMB Desk Officer, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503.

FOR FURTHER INFORMATION CONTACT: Wayne Eddins, Reports Management Officer, Department of Housing and Urban Development, 451 7th Street, Southwest, Washington, DC 20410, telephone (202) 708–2374. This is not a toll-free number. Copies of the proposed forms and other available documents submitted to OMB may be obtained from Mr. Eddins.

SUPPLEMENTARY INFORMATION: The Department has submitted the proposal for the collection of information, as described below, to OMB for review, as required by the Paperwork Reduction Act (44 U.S.C. Chapter 35). The Notice lists the following information: (1) The title of the information collection proposal; (2) the office of the agency to collect the information; (3) the OMB approval number, if applicable; (4) the description of the need for the information and its proposal use; (5) the agency form number, if applicable; (6) what members of the public will be affected by the proposal; (7) how frequently information submissions will be required; (8) an estimate of the total number of hours needed to prepare the information submission including number of respondents, frequency of response, and hours of response; (9) whether the proposal is new, an extension, reinstatement, or revision of an information collection requirement; and (10) the names and telephone

numbers of an agency official familiar with the proposal and of the OMB Desk Officer for the Department.

Authority: Section 3507 of the Paperwork Reduction Act of 1995, 44 U.S.C. 35, as amended.

Dated: July 23, 1999.

David S. Cristy,

Director, IRM Policy and Management Division.

Title of Proposal: Performance Funding System, Determination of Operating Subsidy for Vacancies.

Office: Public and Indian Housing.

OMB Approval Number: 2577–0066.

Description of the Need for the Information and its Proposed Use: Housing Agencies (HAs) report the information to HUD on the Form HUD–52728 in their operating subsidy submissions. The submissions are reviewed and approved by HUD Field Offices and serve as the basis for obligating operating subsidies.

Form Number: HUD–52728.

Respondents: State, Local or Tribal Government.

Frequency of Submission: Recordkeeping Report Annually.

Reporting Burden:

	Number of respondents	×	Frequency of response	×	Hours per response	=	Burden hours
HUD–52728	3,100		1		2		6,200

Total Estimated Burden Hours: 6,200.

Status: Reinstatement, without change.

Contact: Joan DeWitt, HUD, (202) 708–1872 ext. 4035, Joseph F. Lackey, Jr., OMB, (202) 395–7316.

[FR Doc. 99–19575 Filed 7–29–99; 8:45 am]

BILLING CODE 4210–01–M

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

[Docket No. FR–4441–N–42]

Submission for OMB Review: Interim Assessment of the HOPE VI Program: Survey Development, Data Collection, and Case Studies

AGENCY: Office of the Assistant Secretary for Administration, HUD.

ACTION: Notice.

SUMMARY: This study will continue the long-term assessment of the HOPE VI program and its effect on residents, neighborhoods,and cities. The study is looking at HOPE VI sites that have been re-occupied.

DATES: *Comments Due Date:* August 30, 1999.

ADDRESSES: Interested persons are invited to submit comments regarding this proposal. Comments should refer to the proposal by name and/or OMB proposal number and should be sent to: Joseph F. Lackey, Jr., OMB Desk Officer, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503.

FOR FURTHER INFORMATION CONTACT: Wayne Eddins, Reports Management Officer, Department of Housing and Urban Development, 451 7th Street, Southwest, Washington, DC 20410, telephone (202) 708–2374. This is not a toll-free number. Copies of the proposed forms and other available documents submitted to OMB may be obtained from Mr. Eddins.

SUPPLEMENTARY INFORMATION: The Department has submitted the proposal for the collection of information, as described below, to OMB for review, as required by the Paperwork Reduction Act (44 U.S.C. Chapter 35). The Notice lists the following information: (1) The title of the information collection proposal; (2) the Office of the agency to collect the information; (3) the OMB approval number, if applicable; (4) the description of the need for the information and its proposed use; (5) the agency form number, if applicable; (6) what members of the public will be affected by the proposal; (7) how frequently information submissions will be required; (8) an estimate of the total number of hours needed to prepare the information submission including number of respondents, frequency of response, and hours of response; (9) whether the proposal is new, an extension, reinstatement, or revision of an information collection requirement; and (10) the names and telephone numbers of an agency official familiar with the proposal and of the OMB Desk Officer for the Department.

Authority: Section 3507 of the Paperwork Reduction Act of 1995, 44 U.S.C. 35, as amended.

Dated: July 26, 1999.

David S. Cristy,

Director, IRM Policy and Management Division.

Title of Proposal: Interim Assessment of the HOPE VI Program: Survey Development, Data Collection, and Case Studies.

Office: Policy Development and Research.

OMB Approval Number: 2528–XXXX.

Description of the Need for the Information and Its Proposed Use: This study will continue the long-term assessment of the HOPE VI program and its effects on residents, neighborhoods, and cities. The study is looking at HOPE VI sites that have been re-occupied.

Form Number: None.

Respondents: Individuals or Households.

Frequency of Submission: On Occasion.

Reporting Burden:

	Number of respondents	×	Frequency of response	×	Hours of response	=	Burden hours
Information Collection	1,500		1		0.25		375

Total Estimated Burden Hours: 375.

Status: New.

Contract: Robert Leonard, HUD, (202) 708–3700 ext. 4027, Joseph F. Lackey, Jr., OMB, (202) 395–7316.

[FR Doc. 99–19576 Filed 7–29–99; 8:45 am]

BILLING CODE 4210–01–M

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

[Docket No. FR–4441–N43]

Submission for OMB Review: Case Study Section 8 Rental Voucher and Rental Voucher and Rental Certificate Programs in Alameda County, CA

AGENCY: Office of the Assistant Secretary for Administration, HUD.

ACTION: Notice.

SUMMARY: The purpose of the study is to trace the movement patterns of Section 8 families in the Oakland-Alameda County, California region and to determine the reasons for moving using the portability feature of the Section 8 programs.

DATES: *Comments Due Date:* August 30, 1999.

ADDRESSES: Interested persons are invited to submit comments regarding this proposal. Comments should refer to the proposal by name and/or OMB approval number and should be sent to: Joseph F. Lackey, Jr., OMB Desk Officer, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503.

FOR FURTHER INFORMATION CONTACT: Wayne Eddins, Reports Management Officer, Department of Housing and Urban Development, 451 7th Street, Southwest, Washington, DC 20410, telephone (202) 708–2374. This is not a toll-free number. Copies of the proposed forms and other available documents submitted to OMB may be obtained from Mr. Eddins.

SUPPLEMENTARY INFORMATION: The Department has submitted the proposal for the collection of information, as described below, to OMB for review, as required by the Paperwork Reduction Act (44 U.S.C. Chapter 35). The Notice lists the following information: (1) The title of the information collection proposal; (2) the office of the agency to collect the information; (3) the OMB approval number, if applicable; (4) the description of the need for the information and its proposed use; (5) the agency form number, if applicable; (6) what members of the public will be affected by the proposal; (7) how frequently information submissions will be required; (8) an estimate of the total number of hours needed to prepare the information submission including number of respondents, frequency of response, and hours of response; (9) whether the proposal is new, an extension, reinstatement, or revision of an information collection requirement; and (10) the names telephone numbers of an agency official familiar with the proposal and of the OMB Desk Officer for the Department.

Authority: Section 3507 of the Paperwork Reduction Act of 1995, 44 U.S.C. 35, as amended.

Dated: July 26, 1999.

David S. Cristy,

Director, Investment Strategies, Policy, and Management.

Title of Proposal: Case Study of Section 8 Rental Voucher and Rental Certificate Programs in Alameda, California.

Office: Policy Development and Research.

OMB Approval Number: 2528–XXXX.

Description of the Need for the Information and its Proposed Use: The purpose of the study is to trace the movement patterns of Section 8 families in the Oakland-Alameda County, California region and to determine the reasons for moving using the portability feature of the Section 8 programs.

Form Number: None.

Respondents: Individual or Households.

Frequency of Submission: On Time.

Reporting Burden:

	Number of respondents	x	Frequency of response	x	Hours per response	=	Burden hours
Information Collection	300		0		0.5		150

Total Estimated Burden Hours: 150.

Status: New.

Contact: Garland E. Allen, HUD, (202) 708–3700 ext. 57104027, Joseph F. Lackey, Jr., OMB, (202) 397–7316.

[FR Doc. 99–19577 Filed 7–29–99; 8:45 am]

BILLING CODE 4210–01–M

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

[Docket No. FR4485–N–02]

Submission for OMB Review: Public Housing Reform—Change in Admission and Occupancy Requirements

AGENCY: Office of the Assistant Secretary for Administration, HUD.

ACTION: Notice.

SUMMARY: PHAs will provide information required by statute on residency preferences, establishing individual savings accounts for residents, Community Services and Economic Self-Sufficiency Program, FSS Action Plan, over-income small PHAs as part of the admission and occupancy requirements for implementation of the Quality Housing and Work Responsibility Act of 1998.

DATES: *Comments Due Date:* August 30, 1999.

ADDRESSES: Interested persons are invited to submit comments regarding this proposal. Comments should refer to the proposal by name and/or OMB approval number and should be sent to: Joseph F. Lackey, Jr., OMB Desk Officer, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503.

FOR FURTHER INFORMATION CONTACT: Wayne Eddins, Reports Management Officer, Department of Housing and Urban Development, 451 7th Street, Southwest, Washington, DC 20410, telephone (202) 708–2374. This is not a toll-free number. Copies of the proposed forms and other available documents submitted to OMB may be obtained from Mr. Eddins.

SUPPLEMENTARY INFORMATION: The Department has submitted the proposal for the collection of information, as described below, to OMB for review, as required by the Paperwork Reduction Act (44 U.S.C. Chapter 35). The Notice lists the following information: (1) The title of the information collection proposal; (2) the office of the agency to collect the information; (3) the OMB approval number, if applicable; (4) the description of the need for the information and its proposed use; (5) the agency form number, if applicable; (6) what members of the public will be affected by the proposal; (7) how frequently information submissions will be required; (8) an estimate of the total number of hours needed to prepare the information submission including number of respondents, frequency of response, and hours of response; (9)

whether the proposal is new, an extension, reinstatement, or revision of an information collection requirement; and (10) the names and telephone numbers of an agency official familiar with the proposal and of the OMB Desk Officer for the Department.

Authority: Section 3507 of the Paperwork Reduction Act of 1995, 44 U.S.C. 35, as amended.

Dated: July 23, 1999.

David S. Cristy,

Director, IRM Policy and Management Division.

Title of Proposal: Public Housing Reform—Change in Admission and Occupancy Requirements.

Office: Public and Indian Housing.

OMB Approval Number: 2577–XXXX.

Description of the Need for the Information and its Proposed Use: PHAs will provide information required by statute on residency preferences, establishing individual savings accounts for residents, Community Services and Economic Self-Sufficiency Program, FSS Action Plan, over-income small PHAs as part of the admission and occupancy requirements for implementation of the Quality Housing and Work Responsibility Act of 1998.

Form Number: None.

Respondents: Individuals or Household, State, Local or Tribal Government.

Frequency of Submission: Report Annually.

Reporting Burden:

	Number of respondents	×	Frequency of response	×	Hours per response	=	Burden hours
Information Collection	3,400		1		50		169,300

Total Estimated Burden Hours: 169,300.

Status: New.

Contact: Patricia Arnaudo, HUD, (202) 708–10744 ext. 4250, Joseph F. Lackey, Jr., OMB, (202) 395–7316.

[FR Doc. 99–19578 Filed 7–29–99; 8:45 am]

BILLING CODE 4210–01–M

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

[Docket No. FR–4476–N–02]

Submission for OMB Review: Voluntary Conversion of Developments From Public Housing Stock: Assessments; Conversion Plan

AGENCY: Office of the Assistant Secretary for Administration, HUD.

ACTION: Notice.

SUMMARY: Public Housing Agencies can convert a development to tenant-based assistance voluntarily by removing the development or a portion of a development from its public housing inventory. PHAs will perform a conversion assessment first to support converting the units. Then, PHAs must develop and submit a conversion plan to HUD for approval.

DATES: *Comments Due Date:* August 29, 1999.

ADDRESSES: Interesed persons are invited to submit comments regarding this proposal. Comments should refer to the proposal by name and/or OMB approval number and should be sent to: Joseph F. Lackey, Jr., OMB Desk Officer, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503.

FOR FURTHER INFORMATION CONTACT: Wayne Eddins, Reports Management Officer, Department of Housing and Urban Development, 451 7th Street, Southwest, Washington, DC 20410, telephone (202) 708–2374. This is not a toll-free number. Copies of the proposed forms and other available documents submitted to OMB may be obtained from Mr. Eddins.

SUPPLEMENTARY INFORMATION: The Department has submitted the proposal for the collection of information, as described below, to OMB for review, as required by the Paperwork Reduction Act (44 U.S.C. Chapter 35). The Notice lists the following information: (1) The title of the information collection proposal; (2) the Office of the agency to collect the information; (3) the OMB approval number, if applicable; (4) the description of the need for the information and its proposed use; (5) the agency form number, if applicable; (6) what members of the public will be affected by the proposal; (7) how frequently information submissions will be required; (8) an estimate of the total number of hours needed to prepare the information submission including number of respondents, frequency of response, and hours of response; (9) whether the proposal is new, an extension, reinstatement, or revision of an information collection requirement; and (10) the names and telephone numbers of an agency official familiar with the proposal and of the OMB Desk Officer for the Department.

Authority: Section 3507 of the Paperwork Reduction Act of 1995, 44 U.S.C. 35, as amended.

Dated: July 23, 1999.

David S. Cristy,

Director, IRM Policy and Management Division.

Title of Proposal: Voluntary Conversion of Developments From Public Housing Stock: Assessment; Conversion Plan.

Office: Public and Indian Housing.

OMB Approval Number: 2577–XXXX.

Description of the Need for the Information and its Proposed Use: Public Housing Agencies can convert a development to tenant-based assistance voluntarily by removing the development or a portion of a development from its public housing inventory. PHAs will perform a conversion assessment first to support converting the units. Then, PHAs must develop and submit a conversion plan to HUD for approval.

Form Number: None.

Respondents: State, Local or Tribal Government.

Frequency of Submission: Report.

Reporting Burden:

	Number of respondents	×	Frequency of response	×	Hours per Response	=	Burden hours
Information Collection	680		1		30		20,400

Total Estimated Burden Hours: 20,400.

Status: New.

Contact: Jennifer Fogel, HUD, (202) 708–0713 ext. 4113

Joseph F. Lackey, Jr., OMB, (202) 395–7316

[FR Doc. 99–19579 Filed 7–29–99; 8:45 am]

BILLING CODE 4210–01–M

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

[Docket No. FR–4432–N–30]

Federal Property Suitable as Facilities To Assist the Homeless

AGENCY: Office of the Assistant Secretary for Community Planning and Development, HUD.

ACTION: Notice.

SUMMARY: This Notice identifies unutilized, underutilized, excess, and surplus Federal property reviewed by HUD for suitability for possible use to assist the homeless.

EFFECTIVE DATE: July 30, 1999.

FOR FURTHER INFORMATION CONTACT: Clifford Taffet, Department of Housing and Urban Development, Room 7262, 451 Seventh Street SW, Washington, DC 20410; telephone (202) 708–1234; TTY number for the hearing- and speech-impaired (202) 708–2565 (these telephone numbers are not toll-free), or call the toll-free Title V information line at 1–800–927–7588.

SUPPLEMENTARY INFORMATION: In accordance with the December 12, 1988 court order in *National Coalition for the Homeless* versus *Veterans Administration*, No. 88–2503–OG (D.D.C.), HUD publishes a Notice, on a weekly basis, identifying unutilized, underutilized, excess and surplus Federal buildings and real property that HUD has reviewed for suitability for use to assist the homeless. Today's Notice is for the purpose of announcing that no additional properties have been determined suitable or unsuitable this week.

Dated: July 23, 1999.

Fred Karnas, Jr.,

Deputy Assistant Secretary for Economic Development.

[FR Doc. 99–19346 Filed 7–29–99; 8:45 am]

BILLING CODE 4210–29–M

DEPARTMENT OF THE INTERIOR

Office of the Secretary

Allocation of Water Supply and Expected Long-Term Contract Execution, Central Arizona Project, Arizona

AGENCY: Office of the Secretary, Interior.

ACTION: Notice.

SUMMARY: The Department of the Interior, Bureau of Reclamation (Reclamation), announces its intention to prepare environmental documents under section 102(2)(C) of the National Environmental Policy Act (NEPA) of 1969, as amended, to assist in developing proposed modifications to previous Central Arizona Project (CAP) water allocations.

We anticipate that we will reallocate and offer contracts with certain quantities of CAP water in connection with (1) settlement discussions arising out of operation of the CAP; (2) settlement discussions arising out of legal claims involving the Gila River Indian Community and the San Carlos Indian Community, and (3) negotiations regarding implementation of the 1982 Southern Arizona Water Rights Settlement Act.

At present it is not clear whether the scope of the action and anticipated project impacts will require preparation of an environmental impact statement (EIS) or an environmental assessment (EA). However, to ensure a timely and appropriate level of NEPA compliance and to limit potential future delays to the proposed reallocation and contract actions, Reclamation is proceeding, at this time, as if the project impacts would require preparation of an EIS. Reclamation will reevaluate the need for an EIS after obtaining comments on the proposed action and analysis of alternatives and impacts during the NEPA process. Reclamation will publish a notice of cancellation if, as a result of additional information or analysis, a decision is made to prepare an EA rather than an EIS.

DATES: Comments must be received August 30, 1999.

ADDRESSES: Send written comments concerning the proposal to Mr. Bruce Ellis, Environmental Program Manager, Bureau of Reclamation, PO Box 81169, Phoenix, Arizona, 85069–1169. Written comments received by the Bureau of Reclamation become part of the public record associated with this action. Accordingly, such comments will be available to requestors of information associated with this Notice pursuant to the Freedom of Information Act.

FOR FURTHER INFORMATION CONTACT: Mr. Bruce Ellis, at (602) 216–3854.

SUPPLEMENTARY INFORMATION:

Background

We have been engaged in active negotiations with a variety of parties in Arizona that have an interest in the CAP, including the operator of the CAP (the Central Arizona Water Conservation District), the Arizona Department of Water Resources, Indian Tribes, and other water users. The current negotiations contemplate that the Secretary will undertake a reallocation of CAP water to assist in the resolution of outstanding Indian water rights claims, and to provide greater certainty to all users of CAP water. If the settlement goes forward, we anticipate that the proposed reallocation of CAP water would constitute a final allocation of water for the CAP system.

Purpose and Need for Action

The purpose and need of the proposed federal action is to implement settlement of ongoing litigation over the operation of the CAP, the status of CAP project water, and to assist in the resolution of outstanding Indian water rights claims. The United States intends that the final allocation of CAP water under the terms of the settlement will facilitate use of CAP water in satisfaction of the goals and purposes of the CAP authorizing legislation (*i.e.* the Colorado River Basin Project Act of 1968).

The Proposed Federal Action

Through the efforts of all parties to these negotiations, significant progress has been made on many matters involving operation and administration of the CAP and a general agreement on the details of the likely scenario regarding the reallocation of CAP water has emerged. Reclamation intends to undertake the environmental review that needs to be completed in order to facilitate the timely implementation of reallocations that are contemplated by the proposed settlement. Because of the lead time needed to complete the environmental review prior to reallocating, Reclamation is initiating the review at this time. In connection with the environmental analysis, Reclamation will analyze the proposed reallocation of CAP water that has been the subject of extensive discussion among the parties as the proposed federal action. This analysis does not preclude, of course, additional adjustments to the final reallocations depending upon the course of negotiations. Accordingly, pursuant to this notice, Reclamation is announcing its intention to undertake an environmental review of allocating and offering contracts for additional CAP water as follows:

1. Reallocation of an additional 200,000 acre feet of CAP water for Indian Water Rights Settlement Purposes. This water would retain its former priority status as ''Non-Indian Agricultural'' priority water. Of this amount, 102,000 acre feet of CAP water

would be allocated and contracted to the Gila River Indian Community; 28,200 acre feet of CAP water would be allocated and contracted to the Tohono O'odham Nation; and a residual amount of 69,800 would be available for allocation and contracting by the Secretary for use in facilitating additional, future Indian Water Rights Settlements.

2. 17,800 acre feet of the CAP water permanently relinquished by the Harquahala Valley Irrigation District (HVID) would be allocated and contracted to the Gila River Indian Community. This water has the priority of ''Indian'' priority CAP water.

3. All remaining, (approximately 18,600 acre feet) CAP water permanently relinquished by the Roosevelt Water Conservation District, would be allocated and contracted by the Gila River Indian Community. This water would retain its ''Non-Indian Agricultural'' CAP priority.

4. 17,000 AF of CAP water expected to be permanently relinquished by ASARCO Incorporated, would be allocated and contracted by the Gila River Indian Community. This water would retain its ''M&I'' CAP priority.

5. 65,647 acre feet of M&I priority water would be allocated and contracted to various municipalities and other entities within the CAP service area. This water would retain its ''M&I'' CAP priority. Identification of entities, and associated specific quantities for this water would be made after consultation between the Secretary and the State of Arizona (Arizona). It is anticipated that further, specific, NEPA compliance would be undertaken after Arizona has identified the entities it proposes should received allocations of this ''M&I'' priority CAP water, and completion of the consultation between the Secretary and Arizona on this matter.

As part of the proposed action Reclamation will consider all provisions of the settlements currently under negotiation, including provisions under consideration in the potential settlement of the *Central Arizona Water Conservation District* v. *United States* litigation, in which, as noted above, settlement discussions are currently in progress.

Range of Alternatives

In addition to the above-described proposed action (*i.e.* the settlement approach), Reclamation will implement NEPA requirements by identifying, reviewing and evaluating additional alternatives as part of its NEPA analysis. These alternative analyses will include alternatives that would address alternative allocation and contracting scenarios that could involve Non-Indian Agricultural priority water, Indian priority water, and M&I priority water. Reclamation will also include alternative allocation and contracting scenarios that could be undertaken in the absence of a settlement as part of its NEPA analysis.

Authority

The Secretary has the authority to contract for supplies of Central Arizona Project water under the Act of June 17, 1902, 32 Stat. 388, as amended and/or supplemented, including specifically the Colorado River Basin Project Act of September 30, 1968 (82 Stat. 885, 43 U.S.C. 1501 *et seq.*).

Prior Efforts

Allocation of CAP project water has been the subject of previous notices published in the **Federal Register** (See, *e.g.*, 37 FR 28082, December 20, 1972; 40 FR 17297, April 18, 1975; 41 FR 45883, October 18, 1976; 45 FR 52938, August 8, 1980; 45 FR 81265, December 10, 1980; 48 FR 12446, March 24, 1983; 56 FR 29704, June 28, 1991; 57 FR 4470, February 5, 1992; and 57 FR 483884, October 23, 1992).

Bruce Babbitt,

Secretary of the Interior.

[FR Doc. 99–19558 Filed 7–29–99; 8:45 am]

BILLING CODE 4310–10–M

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

[CA–360–2822–00–D680]

Closure and Restriction Orders

AGENCY: Bureau of Land Management (BLM), Interior.

ACTION: Temporary closure of certain public lands within Trinity County, California.

SUMMARY: The BLM is restricting camping and day uses on certain public lands located near the Trinity River at Bucktail Hole in Trinity County California. All public land within the NE¼ of Section 23 and the NW¼ of Section 24, Township 33 North, Range 8 West on the south side (left bank facing downstream) of the Trinity River is closed to camping and day uses, except those specifically authorized by BLM, until September 1, 1999.

The closure is meant to protect the public from activities within the Bucktail Hole area related to emergency rehabilitation of the Lowden wildfire area and the community of Lewiston, Trinity County, California. BLM contractors will be operating heavy equipment and camping within the Bucktail Hole area as part of the rehabilitation effort. Their activities could pose a threat to the safety of the public.

Background

The Lowden wildfire began on July 2, 1999 and resulted in the destruction of 23 homes and numerous outbuildings on private lands. The wildfire was due to the inadvertent escape of a BLM prescribed burn. Therefore, BLM is providing a contractor(s) to assist in the removal of debris from the private lands. Concrete and other masonry retrieved from ruins will be stored at an abandoned rock quarry on public land at Bucktail Hole. Water will also be drawn from the Trinity River within the Bucktail Hole area for use in abating fugitive dust on dirt or gravel access roads within the wildfire area during the implementation of the debris removal contract(s). Lastly, BLM is providing camping areas for contractors within the Bucktail Hole area due to the remote location of the project area and as a means to provide better security for contractor's equipment.

The authority for these closures and rule makings is 43 CFR 8364.1. Any person who fails to comply with a closure order or rule making is subject to arrest and fines of up to $100,000 and/or imprisonment not to exceed 12 months.

DATES: These restrictions take effect July 30, 1999.

FOR FURTHER INFORMATION CONTACT: Charles M. Schultz, Field Manager, Bureau of Land Management, 355 Hemsted Drive, Redding, CA 96002.

Francis Berg,

Acting Redding Field Manager.

[FR Doc. 99–19500 Filed 7–29–99; 8:45 am]

BILLING CODE 4310–40–P

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

[CO–500 1990–00]

Front Range Resource Advisory Council (Colorado) Open Houses and Comment Period

AGENCY: Bureau of Land Management, Interior.

ACTION: Notice of open houses and public comment period.

SUMMARY: Notice is hereby given that the Front Range Resource Advisory Council (Front Range RAC) will hold open houses for the purpose of gathering public comments and input

on Outdoor Recreation Management Guidelines. These will be recommended to the Bureau of Land Management in Colorado for consideration and use in day-to-day management of public lands in Colorado within the Front Range Center. The RAC will also accept written comments on the Outdoor Recreation Management Guidelines.

DATES: The open houses are scheduled for the following dates and times. Any changes to the time, date and/or location of the Open Houses will be publicized in the local media.

The open houses will be held at the Beidleman Environmental Center, 740 W. Caramillo Street, Colorado Springs, Colorado; at the Chaffee County Fairgrounds, 10165 County Road 120, Salida, Colorado. Unless otherwise indicated, all open houses will begin at 7 p.m. and end at approximately 9 p.m.

August 17, 1999 at the Beidleman Environmental Center.

August 31, 1999 at the Chaffee County Fairgrounds.

The written public comment period will begin with the publication of this notice and end September 15, 1999. Comments should be sent to Bureau of Land Management, Front Range Center, Attn: RAC, 3170 East Main Street, Canon City, Colorado 81212. Written comments and those given at the Open Houses will be equally considered. A copy of the Draft Outdoor Recreation Management Guidelines can be requested.

ADDRESSES: Bureau of Land Management (BLM), Front Range Center, 3170 East Main Street, Canon City Colorado 81212; Telephone (719) 269–8500.

FOR FURTHER INFORMATION CONTACT: Ken Smith at 719–269–8553.

SUPPLEMENTARY INFORMATION: The Front Range RAC, along with the other RACs in Colorado, intend to develop a joint set of outdoor recreation management guidelines to recommend to the BLM in Colorado for adoption and use in everyday management of the lands the agency administers. The open houses are intended as a means for the RACs to gather informal input and ideas on the proposed set of guidelines that all the RACs in Colorado have agreed with so far. After September 15, 1999, representatives from all RACs will jointly develop a set of final recommended guidelines to submit to the BLM for consideration. The guidelines will include recommendations dealing with the management of off-highway vehicle use.

Donnie R. Sparks,

Front Range Center Manager.

[FR Doc. 99–19484 Filed 7–29–99; 8:45 am]

BILLING CODE 4310–JB–P

INTERNATIONAL TRADE COMMISSION

[Investigation No. AA1921–129 (Review)]

Polychloroprene Rubber From Japan

Determination

On the basis of the record [1] developed in the subject five-year review, the United States International Trade Commission determines, pursuant to section 751(c) of the Tariff Act of 1930 (19 U.S.C. 1675(c)) (the Act), that revocation of the antidumping finding on melamine from Japan would be likely to lead to continuation or recurrence of material injury to an industry in the United States within a reasonably foreseeable time.[2]

Background

The Commission instituted this review on August 3, 1998 (63 FR 41282) and determined on November 5, 1998 that it would conduct a full review (63 FR 63748, November 16, 1998). Notice of the scheduling of the Commission's review and of a public hearing to be held in connection therewith was given by posting copies of the notice in the Office of the Secretary, U.S. International Trade Commission, Washington, DC, and by publishing the notice in the **Federal Register** on December 16, 1998 (63 FR 69306). The hearing was held in Washington, DC, on June 3, 1999, and all persons who requested the opportunity were permitted to appear in person or by counsel.

The Commission transmitted its determination in this investigation to the Secretary of Commerce on July 26, 1999. The views of the Commission are contained in USITC Publication 3212 (July 1999), entitled *Polychloroprene Rubber from Japan (Inv. No. AA1921–129 (Review).*

Issued: July 27, 1999.

By order of the Commission.

Donna R. Koehnke,

Secretary.

[FR Doc. 99–19582 Filed 7–29–99; 8:45 am]

BILLING CODE 7020–02–P

[1] The record is defined in § 207.2(f) of the Commission's rules of practice and procedure (19 CFR 207.2(f)).

[2] Commissioners Crawford and Askey dissenting.

INTERNATIONAL TRADE COMMISSION

[Investigations Nos. 701–TA–393–396 (Preliminary) and Investigations Nos. 731–TA–829–840 (Preliminary)]

Certain Cold-Rolled Steel Products From Argentina, Brazil, China, Indonesia, Japan, Russia, Slovakia, South Africa, Taiwan, Thailand, Turkey, and Venezuela

Determinations

On the basis of the record [1] developed in the subject investigations, the United States International Trade Commission determines, pursuant to section 703(a) of the Tariff Act of 1930 (19 U.S.C. 1671b(a)), that there is a reasonable indication that an industry in the United States is materially injured by reason of imports from Brazil of certain cold-rolled steel products, provided for in headings 7209, 7210, 7211, 7212, 7225, and 7226 of the Harmonized Tariff Schedule of the United States, that are alleged to be subsidized by the Government of Brazil. The Commission further determines, pursuant to 19 U.S.C. 1677(24)(A), that the subject imports from Indonesia, Thailand,[2] and Venezuela that are alleged to be subsidized are negligible and its investigations are thereby terminated pursuant to 19 U.S.C. 1671b(a)(1).[3] The Commission also determines, pursuant to section 733(a) of the Tariff Act of 1930 (19 U.S.C. 1673b(a)), that there is a reasonable indication that an industry in the United States is materially injured by reason of such imports from Argentina, Brazil, China, Indonesia, Japan, Russia, Slovakia, South Africa, Taiwan, Thailand, Turkey, and Venezuela that are alleged to be sold in the United States at less than fair value.

Commencement of Final Phase Investigations

Pursuant to § 207.18 of the Commission's rules, the Commission also gives notice of the commencement of the final phase of its investigations. The Commission will issue a final phase notice of scheduling which will be published in the **Federal Register** as provided in § 207.21 of the Commission's rules upon notice from the Department of Commerce

[1] The record is defined in § 207.2(f) of the Commission's rules of practice and procedure (19 CFR 207.2(f)).

[2] Commissioner Koplan dissenting with respect to allegedly subsidized imports from Thailand.

[3] Chairman Bragg, however, further finds that imports from Indonesia, Thailand, and Venezuela will imminently exceed the statutory negligibility threshold, and makes an affirmative threat determination with regard to such imports.

(Commerce) of affirmative preliminary determinations in these investigations under section 703(b) and section 733(b) of the Act, or, if the preliminary determinations are negative, upon notice of affirmative final determinations in the investigations under section 705(a) and section 735(a) of the Act. Parties that filed entries of appearance in the preliminary phase of the investigations need not enter a separate appearance for the final phase of the investigations. Industrial users, and, if the merchandise under investigation is sold at the retail level, representative consumer organizations have the right to appear as parties in Commission antidumping and countervailing duty investigations. The Secretary will prepare a public service list containing the names and addresses of all persons, or their representatives, who are parties to the investigation.

Background

On June 2, 1999, a petition was filed with the Commission and the Department of Commerce by Bethlehem Steel Corp., Bethlehem, PA; Gulf States Steel, Inc., Gadsden, AL; Ispat Inland, Inc., East Chicago, IN; LTV Steel Co., Inc., Cleveland, OH; National Steel Corp., Mishawaka, IN; Steel Dynamics, Inc., Fort Wayne, IN; U.S. Steel Corp.; a unit of USX Corp., Pittsburgh, PA; Weirton Steel Corp., Weirton, WV; the Independent Steelworkers Union; and United Steel Workers of America, Pittsburgh, PA, alleging that an industry in the United States is materially injured by reason of subsidized or LTFV imports of certain cold-rolled steel products from Argentina, Brazil, China, Indonesia, Japan, Russia, Slovakia, South Africa, Taiwan, Thailand, Turkey, and Venezuela. Accordingly, effective June 2, 1999, the Commission instituted antidumping investigations Nos. 701–TA–393–396 (Preliminary) and investigations Nos. 731–TA–829–840 (Preliminary).

Notice of the institution of the Commission's investigation and of a public conference to be held in connection therewith was given by posting copies of the notice in the Office of the Secretary, U.S. International Trade Commission, Washington, DC, and by publishing the notice in the **Federal Register** of June 9, 1999 (64 FR 31018). The conference was held in Washington, DC, on June 23, 1999, and all persons who requested the opportunity were permitted to appear in person or by counsel.

The Commission transmitted its determination in this investigation to the Secretary of Commerce on July 19, 1999. The views of the Commission are contained in USITC Publication 3214 (July 1999), entitled *Certain Cold-Rolled Steel Products from Argentina, Brazil, China, Indonesia, Japan, Russia, Slovakia, South Africa, Taiwan, Thailand, Turkey, and Venezuela: Investigations Nos. 701–TA–393–396 and 731–TA–829–840 (Preliminary).*

By order of the Commission.

Issued: July 23, 1999.

Donna R. Koehnke,

Secretary.

[FR Doc. 99–19583 Filed 7–29–99; 8:45 am]

BILLING CODE 7020–02–P

DEPARTMENT OF JUSTICE

Office of Community Oriented Policing Services

School-Based Partnership Grant Assessment Solicitation

AGENCY: Office of Community Oriented Policing Services, Department of Justice.

ACTION: Notice of availability.

SUMMARY: The Office of Community Oriented Policing Services (COPS) is seeking proposals to conduct an assessment of the School-Based Partnership (SBP) grant program. This notice provides background on the SBP program, outlines the purpose and needs sought from the assessment, and identifies questions to be addressed by applicants seeking to provide services under this cooperative agreement. The assessment is being announced as an open competition and requires a three-week turnaround. The selected awardee will be expected to begin work immediately upon selection.

DATES: Applications for the School-Based Partnerships Assessment Cooperative Agreement are due on August 17, 1999, by 5:00 p.m. EST. Please fax a short letter notifying the COPS Office of your intent to apply for the School-Based Partnerships Assessment Cooperative Agreement and identify the contact person, phone number, address, and fax number for receipt of SBP Background Materials. The letter should be faxed to the attention of COPS/PPSE c/o Stacy Curtis at (202) 633–1386 no later than August 3, 1999. The selected awardee will be notified by phone and fax and should plan to begin meeting with the COPS Office in September to begin planning the project.

REQUIREMENTS/LIMITATIONS: Package should include the original application and three copies. Applications should not exceed 15 double-spaced, 12-point typed pages. Budget materials, letters of support/cooperation, and time lines are considered acceptable appendices.

ADDRESSES: Please send application package to: Office of Community Oriented Policing Services Program/ Policy Support and Evaluation Division 1100 Vermont Ave, NW, Washington, DC 20530 (20005 for express services) Attn: Stacy Curtis.

FOR FURTHER INFORMATION CONTACT: Stacy Curtis at (202) 633–1297 or Karin Schmerler at (202) 633–1321 to obtain additional information about this solicitation. Additional information can also be obtained through the COPS Office Internet web site at *www.usdoj.gov/cops* or by calling the Department of Justice Response Center at 1–800–421–6770.

SUPPLEMENTARY INFORMATION:

Background

In 1998, the COPS Office announced the first round of School-Based Partnerships grantees to 155 law enforcement agencies. The COPS Office issued a second grant solicitation in early 1999, to fund additional policing agencies and their partners. Funding decisions for SBP '99 are forthcoming. Various components of this assessment will include grantees funded in 1998 while other tasks will focus on grantees funded in 1999. It is possible that some SBP grantees will receive grants in both 1998 and 1999 to problem solve on different crime and disorder problems. Applicants for the assessment should consider ways to best incorporate information from all grantees from the two years of funding and should not be limited in their proposals to the ideas and tasks included in this solicitation.

The SBP grant program is part of the COPS Office's commitment to advancing community policing through collaborative problem solving. The initiative seeks to facilitate a shift from traditional incident-driven policing to proactive problem-oriented policing that encourages community participation to keep children safe by reducing school-related violence, crime, and disorder. Rather than repeatedly responding to the same types of crimes after they have occurred, policing agencies that practice community policing and problem solving work with community members to identify persistent problems, learn more about why these problems occur, and address the underlying conditions that precipitate their occurrence.

The SBP program provides policing agencies with a unique opportunity to work with schools and community-based organizations to address persistent school-related crime problems. Grantees were required to

focus on one primary school-related crime or disorder problem occurring in or around an elementary or secondary school. Target problems include: drug dealing or use on school grounds, problems experienced by students on the way to and from school, assault/sexual assault, alcohol use or alcohol-related problems/DWI, bullying/threat/intimidation, vandalism/graffiti, loitering and disorderly conduct directly related to crime or student safety, disputes that pose a threat to student safety, or larceny. Successful applicants provided evidence of partnerships with schools or community-based agencies and with students to work cooperatively to analyze the targeted crime or public safety issue.

The School-Based Partnerships program emphasizes problem analysis, a key component of problem solving, to help develop effective responses, many of which include prevention and intervention efforts. Grantees use problem-solving methods to understand the causes of the problem, develop specific, tailor-made responses to that problem and assess the impact of those responses. In order to help communities use creative problem solving to address school-related problems, the program funded resources for purchasing computer technology, hiring crime analysis personnel, conducting student surveys and victim/offender interviews, utilizing community organizers, school personnel and/or students to analyze or coordinate the project, and procuring training and technical assistance in collaborative problem solving.

As part of a successful application, SBP grantees were required to allocate at least 5% of the total project cost to found a local-level evaluation. The COPS Office included this requirement to assure that the impacts of the SBP projects are well documented and to promote local-level practitioner-researcher partnerships. Policing agencies typically have partnered with universities or colleges, research agencies, or have accessed internal resources to conduct the evaluation. At a minimum, the local-level evaluations must include data on outcome measures to evaluate the project's impact on the target crime or disorder problem. Ideally, local level evaluators will also assess the implementation of the problem-solving process. The combination of process and outcome evaluations will provide the most thorough assessment of the SBP grant program. Grantees will be required to submit a final report detailing the implementation of the project, including hurdles and particular successes with the problem-solving model, as well as indicators of the impact of the problem-solving process on the targeted problem.

Information Assistance Needs

In recent years the number of departments across the country implementing problem-solving approaches has increased dramatically. In 1997, the COPS Office first facilitated collaborative problem-solving initiatives through the Problem-Solving Partnerships grant, which focuses on crime and disorder problems in communities across the country. The School-Based Partnerships program applies the same problem-solving model to crime and disorder experienced in and around schools. Anecdotal accounts of problem solving indicate that collaborative efforts to analyze crime and disorder problems prior to implementing a standard response have been very effective at enhancing quality of life and deceasing the targeted crime and disorder problems.

However, the field of policing continues to lack well-documented research on the use of problem-solving approaches to reducing crime and disorder.

The local-level evaluation of the SBP grant program provides the COPS Office an opportunity to understand the processes and outcomes associated with collaborative problem-solving involving police officers, schools, and community members. It will also allow the COPS Office to examine the factors that facilitate as well as impede the implementation of problem-solving approaches. Because the scope and intensity of local-level evaluations will vary across agencies, a national assessment of the SBP program will help provide a more comprehensive look at the COPS grant program's impact by documenting and assessing two rounds of grant funding.

The COPS Office is seeking to work with a provider to collect and analyze several project reports from all SBP '98 grantees. These reports will allow for systematic data collection from all grantees and will yield information on how departments operationalized the problem-solving model in the field. These reports will also provide in-depth information on lessons learned and the subsequent impact of problem solving in the targeted problems. Additionally, the COPS Office is interested in funding in-depth case studies of a subset of grantees awarded in fiscal year 1999. These case studies would use a quasi-experimental design to study the impact of problem solving in target schools compared to similar schools not participating in this school-based project but located in the same or similar jurisdiction as the policing agency and school participating in the SBP project. One of the primary goals of this solicitation is to provide information to law enforcement and educational agencies to stimulate the promotion of problem solving as a way to address crime and disorder problems in and around schools. In summary, the successful applicant will: (1) Develop (based on a previously used questionnaire), distribute, and synthesize findings from a progress report questionnaire on analysis activities undertaken by SBP '98 grantees; (2) review evaluation strategies provided by local-level evaluators and provide technical assistance when needed; (3) develop, distribute, and synthesize findings from a progress report questionnaire on the response activities of SBP '98 grantees; (4) develop, distribute, and synthesize findings from a survey of all SBP '98 grantees on their experiences implementing problem solving; (5) conduct case studies with a subset of SBP '99 grantees; and (6) prepare a final report of findings from SBP '98 and '99 grantees. Applicants should not be limited to these tasks as outlined below. Although the following deliverables are required, we are also seeking creative ideas on other problem-solving products relating to schools that would benefit the policing and education communities.

Scope of Work

For a period hereinafter set forth, the COPs Office and the Awardee will cooperatively furnish the necessary personnel, travel, supplies, and otherwise perform all things necessary for, or incident to, the performance of work (the accomplishment of functional objectives) as set forth below:

Specific Requirements

At a minimum, the following specific tasks are required.

Task 1

During the first quarter, the awardee will work collaboratively with the COPS Office to revise a progress report questionnaire developed previously to gather information on the analysis activities of grantees conducting projects under the Problem Solving partnerships grant (the questionnaire will be made available to the chosen provider). The awardee will distribute the progress report questionnaire to SBP '98 grantees and will collect and synthesize the data, culminating in the development of written reports on the major problem types. The awardee will

then distribute these reports to SBP '98 and '99 grantees. The purpose of this task is to provide all SBP grantees with important information regarding analysis findings and the ways their fellow grantees have addressed challenges in the analysis phase that may assist them in implementing their own grants. This tasks will also help the COPS Office anticipate challenges that may be faced by SBP '99 grantees, and help inform any future program design that may be necessary.

Throughout the course of this cooperative agreement, the awardee will provide information on the status of the project. A schedule for reporting will be established between the awardee and the COPS office.

Deliverables for Task 1

(1) The awardee will help the COPS Office refine the existing analysis phase progress report questionnaire, send it to the 155 SBP '98 grantees, collect responses, and synthesize data into at least four separate analysis reports covering the major problem types.

(2) The awardee will disseminate the reports to all SBP '98 and '99 grantees according to their focus problem.

(3) Throughout the course of the project, the awardee will submit progress reports on project activities according to an established schedule.

Task 2

During the first and second quarters of the cooperative agreement the awardee will review proposed local-level evaluation strategies submitted to COPS by SBP '98 grantees. Throughout the project, the awardee will assist local-level evaluators in refining these strategies when technical assistance appears to be required. It is estimated that providing technical assistance to local-level evaluators will make up approximately 10% of staff time on this project.

Deliverables for Task 2

(1) As necessary, the awardee will provide technical assistance to local level evaluators of SBP '98 grants.

(2) The awardee will develop a final report on the evaluation assistance provided to local level evaluators during the course of the cooperative agreement.

Task 3

During the second quarter, the awardee will work collaboratively with the COPS Office to revise a progress report questionnaire used previously to gather information on the responses utilized by Problem Solving Partnerships grantees to tackle the crime and disorder problems being addressed through the problem-solving model (the report will be made available to the awarded provider). The awardee will distribute the progress report questionnaire to SBP '98 grantees and will collect and synthesize the data, culminating in the development of written reports on the major problem types. The awardee will then distribute these reports to SBP '98 and '99 grantees. The purpose of this task is to provide SBP '98 and '99 grantees with important information regarding issues their fellow grantees have faced with respect to generating, selecting and implementing effective responses. This information may prove to be vital as SBP '99 grantees implement their own grant projects. This task will also help the COPS Office anticipate challenges that may be faced by SBP '99 grantees and will help inform future COPS program design.

Deliverables for Task 3

(1) The provider will help the COPS Office refine the existing response phase progress report questionnaire, send it to the 155 SBP '98 grantees, collect responses, and synthesize data into at least four separate reports covering the major problem types.

(2) The provider will disseminate the reports to all SBP '98 and '99 grantees according to their focus problem.

Task 4

During the third quarter, the awardee will develop a tool to collect project information that spans the life of the grant project from all SBP '98 grantees on their experiences implementing collaborative problem solving focused on problems in and around schools. The tool should include both process and outcome indicators and narrative descriptions provided by grantees outlining and processes and impacts of the grant projects. The awardee will work collaboratively with the COPS Office to assure that the instrument adequately addresses the goals of the SBP grant program. If necessary, in accordance with the Paperwork Reduction Act, the awardee will submit the instrument to the COPS Office to be cleared by the Office of Management and Budget (OMB). The awardee will be available to assist local level evaluators in completing this report. In addition, the awardee will identify a subset of grantees that implemented successful projects and will develop 10 short (3 to 5 page) case studies on these projects (an example, ''What Works: Promising Practices from the Field,'' will be provided to potential applicants pending submission of Notice of Intent to Apply, See SBP Background Materials). These case studies will include information generated by the information collection tools described previously and phone and other correspondence between the awardee and SBP '98 grantees. Given conditions at the local level and beyond the control of the COPS Office, this cooperative agreement may include a no-cost extension to incorporate additional time for the awardee to conduct case studies.

Deliverables for Task 4

(1) The awardee will develop an information collection instrument to collect final project information from all SBP '98 grantees on their experiences implementing collaborative problem solving focused on problems in and around schools. Prior to its administration, the awardee will submit the instrument to the COPS Office for review and approval.

(2) The awardee will produce a report to document survey findings.

(3) The awardee will produce 10 short case studies from the SBP '98 program.

Task 5

During the second and third quarters of the grant period, the awardee will select a subset of five SBP '99 grantees with which to conduct an in-depth case study of the processes and outcomes of their SBP grant projects. The awardee will identify promising projects through SBP '99 applications and follow-up contact with the grantees. Selected grantees should be able to implement a quasi-experimental design to compare a series of measures collected at the target schools and similar schools not participating in the School-Based Partnerships grant project. Technical assistance from the awardee is anticipated. Control schools should be located in the same or similar jurisdiction as the policing agency and school participating in the SBP grant project. Through subcontracts, the selected locales will be eligible for additional funding of up to $5,000 to collect information from control schools. Many control schools will already collect data on suspensions, attendance, calls for service, etc., and additional funding will allow grantees to conduct student/faculty surveys, environment surveys, etc., as deemed appropriate by the awardee in conjunction with the local level evaluator. The awardee will develop site selection criteria for review by the COPS Office and will submit a list of potential case study sites for final review and selection in collaboration with representatives of the COPS Office. It is anticipated that the awardee will travel to selected sites during the course of

these studies. The awardee will develop data collection instruments for use during site visits and will submit these to the COPS Office for review. The awardee will continue to be available to assist local-level evaluators. Given conditions at the local level and beyond the control of the COPS Office, this cooperative agreement may include a no-cost extension to incorporate additional time for the awardee to conduct all aspects of this cooperative agreement.

Deliverables for Task 5

(1) The awardee will develop a short proposal identifying potential case study sites selected from the pool of SBP '99 grantees. This proposal will include site selection criteria and justifications for including these grantees as potential case study candidates. Ultimately, five candidates will be selected in collaboration with the COPS Office to be included as case studies. Case studies will include the processes and outcomes of implementing collaborative problem solving, including a focus on the obstacles encountered and benefits of engaging in problem-solving partnerships with schools, community-based agencies (where applicable), and students. The awardee will provide oversight to ensure the integrity of the data and assessment process.

(2) The awardee will develop data collection instruments to document the experiences and outcomes of sites implementing the SBP grant program. The awardee will submit these for review by the COPS Office.

(3) The awardee will develop short reports (10 pages or fewer) that document the research methods and findings from each case study. These reports shall include a summary section and a description of each individual case study.

(4) The awardee will disseminate these case studies to all SBP '98 and '99 grantees and to other audiences as identified by the COPS Office and/or the provider.

Task 6

During the fourth quarter of the grant period, the awardee will write a report on the SBP grant program. The report will include an analysis of information collected from all SBP '98 grantees and in-depth information from the case study sites of SBP' 99 sites. This report should include an examination of the processes undertaken by SBP grantees, lessons learned, and recommendations to policing agencies and schools seeking to implement similar problem-solving partnerships. In addition, this report should include information on the impact of the projects and the methods and measures local-level evaluators used to assess the projects' impact. Given conditions at the local level and beyond the control of the COPS Office, this cooperative agreement may include a no-cost extension to incorporate additional time for the awardee to conduct all aspects of this cooperative agreement.

Deliverable for Task 6

(1) The awardee will develop a final report based on findings from an outcome evaluation of the SBP grant program.

(2) The awardee will disseminate widely copies of the report to SBP grantees and other policing agencies. The report must receive written approval from the COPS Office prior to dissemination.

Task 7 (Optional)

Applicants may propose additional problem-solving products that would make significant contributions to school safety.

1Applicant Criteria

Applicants should meet the following criteria:

1. Prossess expertise in the areas of community policing, collaborative problem-solving, and schools (or evidence of a partnership with a school organization/consultants with significant experience with school safety issues). Significant experience in the areas of community policing and general problem solving will be essential. In addition, prior experience working with schools or youth crime prevention issues is essential.

2. Posses significant experience coordinating assessments of efforts between policing agencies and other government agencies and/or community-based entities.

3. Possess significant experience providing technical assistance on evaluation to third-party evaluators, overseeing projects involving quasi-experimental designs, and conducting on-site interviews.

4. Possess experience administering federal grants or cooperative agreements of more than $300,000.

5. Have a person record of working collaboratively on projects with other organizations.

6. Possess experience working with local policing agencies in rural, suburban, and urban communities in jurisdictions ranging from 15,000 to over 1,000,000 persons.

Proposal Questions

Applicants competing for this cooperative agreement must submit a Notice of Intent to Apply (see **DATES** section). The COPS Office will provide potential applicants with required forms including, a background information form and budget worksheets (a full lists of forms is included in SBP Background materials). Applicants must complete these forms and provide a double-spaced narrative proposal to apply. The narrative should not exceed 15-pages; the required forms and budget do not count toward the page length. The proposal should address all of the following questions:

Capabilities

1. Describe your organization's previous experience working on assessments of community policing and collaborative problem-solving efforts. Describe your agency's background working with schools of youth crime prevention initiative. Please also describe your organization's experience providing technical assistance to third-party evaluators.

2. Discuss how you work on this project will enhance your organization's ability to be a long-term contributor to the assessment of innovative collaborative problem-solving strategies and community policing efforts. Please outline how your organization would build upon the efforts and infrasturture developed under this project to impact policing departments and communities over the next five years.

3. Discuss your management plan for implementing this project with respect to internal and external management of personnel and resources. Also address how you would facilitate and manage the operations of this project beyond the life of the Cooperative Agreement.

4. Describe a potential management plan for conducting the collection of information to best inform grantees of lessons learned? Provide research questions and topic areas for analysis.

Plan for Case Studies

5. Describe a potential management plan for conducting the five quasi-experimental case studies of SBP '99 grantees. Provide your plan for identifying potential sites, research questions and topic areas for analysis.

Plan for Final Report/Other Problem-Solving Products

6. Discuss how data collected from SBP '98 grantees and sites participating in the case studies could be analyzed, documented, reviewed, and disseminated to promote the ideal implementation of problem-solving

approaches in the future. Provide a description of any additional data collection efforts or other activities you would like to undertake and the deliverables that would result. Discuss how policing agencies and researchers could access the products developed out of this project.

Timeline

7. Provide a detailed timeline of the assessment activities described above. Although funds will be awarded for one calendar year, applicants may submit a timeline that exceeds 12 months in anticipation of a no-cost extension to allow for circumstances at the local level and beyond the control of the COPS Office or the awardee of this cooperative agreement.

Budget

Prepare a detailed budget for a one-year agreement. Applicants may apply for up to $350,000. The budget may include travel and per diem costs related to the case studies, mailing or telephone costs for data collection instruments, and production and dissemination costs of all deliverables.

SBP Background Materials

The following materials will be provided to potential applicants following their submission of a Notice of Intent to Apply (See DATES). Materials are also available from the COPS Office internet web site at *www.usdoj.gov/cops.*

—SF 424, Application for Federal Assistance
—Budget Detail Worksheet
—Certifications Regarding Lobbying; Debarment, Suspension and Other Responsibility Matters; Drug-Free Workplace Requirements; Coordination with Affected Agencies; Non-Supplanting; and Retention (one form)
—Assurances
—Disclosure of Lobbying Activities
—School-Based Partnerships Application Kit and Fact Sheet
—Problem-Solving Tips
—List of SBP grantees and problem types awarded in 1998; grantees awarded in 1999 will be available following the announcement of funding decisions (likely September 1999)
—Anticipated time line for SBP '98 and SBP '99 projects
—What Works: Promising Practices from the Field

The Catalog of Federal Domestic Assistance (CFDA) reference for this program is 16.710.

Dated: July 9, 1999.

Mary Lou Leary,

Interim Director.

[FR Doc. 99–18814 Filed 7–29–99; 8:45 am]

BILLING CODE 4410–AT–M

DEPARTMENT OF JUSTICE

Immigration and Naturalization Service

[INS No. 1953–99; AG Order No. 2236–99]

Termination of Designation of Liberia Under the Temporary Protected Status Program

AGENCY: Immigration and Naturalization Service, Justice.

ACTION: Notice.

SUMMARY: The Attorney General's most recent designation of Liberia under the Temporary Protected Status program (TPS) expires on September 28, 1999. After reviewing country conditions and consulting with the appropriate Government agencies, the Attorney General has determined that conditions in Liberia no longer support a TPS designation. Accordingly, the designation of Liberia for TPS is terminated effective September 28, 1999. After that date, aliens who are nationals of Liberia (and aliens having no nationality who last habitually resided in Liberia) who have had TPS under the Liberia program will no longer have such status. This notice contains information regarding the termination of the TPS designation for Liberia.

DATES: The termination of the TPS designation for Liberia is effective September 28, 1999.

FOR FURTHER INFORMATION CONTACT: Michael Valverde, Office of Adjudications, Residence and Status Branch, Immigration and Naturalization Service, Room 3040, 425 I Street, NW, Washington, DC 20536, telephone (202) 514–4754.

SUPPLEMENTARY INFORMATION:

What Is the Statutory Authority for the Designation and Termination of a TPS?

Under section 244 of the Immigration and Nationality Act (the Act), 8 U.S.C. 1254a, the Attorney General is authorized to designate a foreign state (or part of a state) for TPS. The Attorney General must then grant TPS to eligible nationals of that foreign state (or aliens having no nationality who last habitually resided in that state). Section 244(b)(3)(A) of the Act requires the Attorney General to review, at least 60 days before the end of the TPS designation, the conditions in a foreign state designated under section 244(b)(1) of the Act. 8 U.S.C. 1254a(b)(3)(A).

Section 244(b)(3) further requires the Attorney General to determine whether the conditions for such a designation continue to be met, and to terminate the state's designation when the Attorney General determines conditions are no longer met. 8 U.S.C. 1254a(b)(3)(B). The Attorney General must then publish a notice of termination in the **Federal Register**.

Why Did the Attorney General Decide To Terminate TPS for Liberia?

On September 29, 1998, the Attorney General published a notice re-designating Liberia for TPS for a period of one year, based upon conditions in Liberia at that time. 63 FR 51958 (Sept. 29, 1998). That TPS designation is scheduled to expire on September 28, 1999.

Based upon a more recent review of conditions within Liberia by the Departments of Justice and State, the Attorney General finds that conditions no longer support a TPS designation. A Department of State memorandum concerning Liberia states that ''[t]he divisive civil war in Liberia which began in 1990 ended with the Abuja Peace Accords in 1996. Since 1997, the country in general has not experienced ongoing armed conflict. In September 1998, violence erupted suddenly in Monrovia.* * * Since then, however, no further general conflict has occurred.'' The memorandum also states that ''Although conditions in Liberia remain difficult, the overall situation is not sufficiently adverse to prevent most Liberian nationals in the U.S. from returning to Liberia in safety.'' It concludes, ''The Department of State finds that sufficient grounds to recommend a further extension of TPS for Liberia do not exist. We therefore recommend that TPS for Liberia be terminated on its current expiration date of September 28, 1999.''

Based on these findings, the Attorney General has decided to terminate the designation of Liberia for TPS.

What Can I Do If I Feel That My Return To Liberia Is Unsafe?

This notice terminates the designation of Liberia under the TPS program. There may be avenues of immigration relief available to aliens who are nationals of Liberia (and aliens having no nationality who last habitually resided in Liberia) in the United States who believe that their particular circumstances make return to Liberia unsafe. Such avenues may include, but are not limited to, asylum or withholding of removal.

How Does The Termination of TPS Effect Former TPS Beneficiaries?

After the designation of Liberia for TPS is terminated on September 28, 1999, those aliens who are nationals of Liberia (and aliens having no nationality who last habitually resided in Liberia) will revert back to the immigration status they had prior to TPS, unless they have been granted another immigration status. They stay of removal and eligibility for employment authorization due to the designation of Liberia under the TPS program will no longer be avaiable. However, the termination of the TPS designation for Liberia will not affect any pending applications for other forms of immigration relief.

Those persons who received TPS under the Liberian designation may begin accruing unlawful presence as of September 29, 1999, if they have not been granted any other immigration benefit or have no application for such a benefit pending. Aliens who accrue certain periods of unlawful presence in the United States may be barred from admission to the United States under section 212(a)(9)(B)(i) of the Act. See 8 U.S.C. 1182(a)(9)(B)(i).

Notice of Termination of Designation of Liberia Under the TPS Program

By the authority vested in me as Attorney General under section 244(b)(3) of the Act, I have consulted with the appropriate agencies of Government concerning conflict and security conditions in Liberia. 8 U.S.C. 1254a(b)(3). Based on these consultations, I have determined that Liberia no longer meets the conditions for designation of TPS under section 244(b)(1) of the Act. See 8 U.S.C. 1254a(b)(1).

The civil war in Liberia ended in 1996, with the exception of some armed violence in September 1998. This eruption of violence resulted in the Department of State's September 1998 recommendation to extent TPS for an additional year. Since that time, however, no further general conflict has occurred. I also understand, that, even though the country has made little progress in recovering from the war, the return of persons to Liberia would not result in a danger to their personal safety. In view of the recommendations of the Departments of Justice and State for termination, I terminate the designation of Liberia under the TPS program.

Accordingly, I order as follows:

(1) The designation of Liberia for TPS under section 244(b) of the Act is terminated effective September 28, 1999.

(2) I estimate that there are no more than 10,000 nationals of Liberia (and aliens having no nationality who last habitually resided in Liberia) who have been previously granted TPS.

(3) Information concerning the termination of the TPS program for nationals of Liberia (and aliens having no nationality who last habitually resided in Liberia) will be available at local Service offices upon publication of this notice.

Dated: July 28, 1999.

Janet Reno,

Attorney General.

[FR Doc. 99–19700 Filed 7–28–99; 12:46 pm]

BILLING CODE 4410–10–M

DEPARTMENT OF JUSTICE

Federal Bureau of Prisons

Notice of Intent To Prepare a Draft Environmental Impact Statement (DEIS) for the Development of Either a High Security or Medium Security Federal Correctional Facility(ies) in South Carolina

AGENCY: U. S. Department of Justice Federal Bureau of Prisons.

ACTION: Notice of intent to prepare a Draft Environmental Impact Statement (DEIS).

SUMMARY:

Proposed Action

The United States Department of Justice, Federal Bureau of Prisons has determined that high-security and medium-security federal correctional facilities are needed in its system.

The Federal Bureau of Prisons has preliminarily evaluated several sites in three counties in South Carolina and determined that the DEIS will focus upon sites in the following areas:

Georgetown County 1 tract—1275 acres (apprx.) in Andrews
Marlboro County 1 tract—500 acres (apprx.) in Bennettsville
Williamsburg County 2 tracts—600 acres (apprx.) in Salters and 475 acres (apprx.) near Greeleyville

The Bureau of Prisons proposes to build and operate either a high-security or medium-security federal correctional facility, with an adjacent minimum-security satellite camp, in South Carolina. The main facility would provide habitation for approximately 1000–1200 inmates, and up to 300 inmates at the minimum-security camp. The Bureau of Prisons proposes to build the facility(ies) on portions of tracts near either:

Georgetown County in Andrews, South Carolina
Marlboro County in Bennettsville, South Carolina
Williamsburg County in Greeleyville, South Carolina
Williamsburg County in Salters, South Carolina

The sites appear to be of sufficient size to provide space for housing, programs, administrative services and other support areas such as staff training.

The Process

In the process of evaluating the sites, several aspects will receive detailed examination including: utilities, traffic patterns, noise levels, visual intrusion, threatened and endangered species, cultural resources and socio-economic impacts.

Alternatives

In developing the DEIS, the options of ''no action'' and ''alternative sites'' for the proposed facility(ies) will be fully and thoroughly examined.

Scoping Process

During the preparation of the DEIS, there will be opportunities for public involvement in order to determine the issues to be examined. Scoping Meetings will be held at 7:00 p.m. on the following dates and places:

August 23—Andrews, South Carolina (Georgetown County)—Andrews Elementary School, 13072 County Line Road
August 24—Greeleyville, South Carolina—(Williamsburg County)—C.E. Murray High School, State Highway 521
August 26—Bennettsville, South Carolina (Marlboro County)—Marlboro Civic Center, 106 Clyde Street

The meetings will be well publicized and will be held at times which will make it possible for the public and interested agencies or organizations to attend. In addition, numerous public information meetings have been held by representatives of the Bureau of Prisons with interested citizens, officials and community leaders.

DEIS Preparation

Public notice will be given concerning the availability of the DEIS for public review and comment.

Address

Questions concerning the proposed action and the DEIS may be directed to: David J. Dorworth, Chief, Site Selection and Environmental Review Branch, Federal Bureau of Prisons, 320 First

Street, NW., Washington, D.C. 20534. Telephone (202) 514–6470, Facsimile (202) 616–6024, e-mail *siteselection@bop.gov*.

Dated: July 22, 1999.

David J. Dorworth,

Chief, Site Selection and Environmental Review Branch.

[FR Doc. 99–19196 Filed 7–29–99; 8:45 am]

BILLING CODE 4410–05–P

DEPARTMENT OF LABOR

Office of the Secretary

Advisory Council on Employee Welfare and Pension Benefit Plans; Nominations for Vacancies

Section 512 of the Employee Retirement Income Security Act of 1974 (ERISA), 88 Stat. 895, 29 U.S.C. 1142, provides for the establishment of an ''Advisory Council on Employee Welfare and Pension Benefit Plans'' (the Council), which is to consist of 15 members to be appointed by the Secretary of Labor (the Secretary) as follows: Three representatives of employee organizations (at least one of whom shall be representative of an organization whose members are participants in a multiemployer plan); three representatives of employers (at least one of whom shall be representative of employers maintaining or contributing to multiemployer plans); one representative each from the fields of insurance, corporate trust, actuarial counseling, investment counseling, investment management and accounting; and three representatives from the general public (one of whom shall be a person representing those receiving benefits from a pension plan). No more than eight members of the Council shall be members of the same political party.

Members shall be persons qualified to appraise the programs instituted under ERISA. Appointments are for terms of three years. The prescribed duties of the Council are to advise the Secretary with respect to the carrying out of his or her functions under ERISA, and to submit to the Secretary, or his or her designee, recommendations with respect thereto. The Council will meet at least four times each year, and recommendations of the Council to the Secretary will be included in the Secretary's annual report to the Congress on ERISA.

The terms of five members of the Council expire on November 14, 1999. The groups or fields they represented are as follows: employee organizations, corporate trust, investment management, employers and the general public.

Accordingly, notice is hereby given that any person or organization desiring to recommend one or more individuals for appointment to the ERISA Advisory Council on Employee Welfare and Pension Benefit Plans to represent any of the groups or field specified in the preceding paragraph, may submit recommendations to Sharon Morrissey, Executive Secretary, ERISA Advisory Council, Frances Perkins Building, U.S. Department of Labor, 200 Constitution Avenue, NW, Suite N–5677, Washington, DC 20210. Recommendations must be delivered or mailed on or before October 1, 1999. Recommendations may be in the form of a letter, resolution or petition, signed by the person making the recommendation or, in the case of a recommendation by an organization, by an authorized representative of the organization. Each recommendation should contain a detailed statement of the nominee's background.

Signed at Washington, DC, this 26th day of July, 1999.

Richard McGahey,

Assistant Secretary of Labor, Pension and Welfare Benefits Administration.

[FR Doc. 99–19535 Filed 7–29–99; 8:45 am]

BILLING CODE 4510–29–M

DEPARTMENT OF LABOR

Employment and Training Administration

[NAFTA–03179]

Bend Wood Products, Incorporated, Bend, Oregon; Notice of Termination of Investigation

Pursuant to Title V of the North American Free Trade Agreement Implementation Act (Pub. L. 103–182) concerning transitional adjustment assistance, hereinafter called (NAFTA–TAA), and in accordance with Section 250(a), Subchapter D, Chapter 2, title II, of the Trade Act of 1974, as amended (19 U.S.C. 2273), an investigation was initiated on May 14, 1999 in response to a petition filed on behalf of workers at Bend Wood products, Incorporated, Bend, Oregon.

The worker group is currently covered by an existing determination (NAFTA—02841). Consequently, further investigation in this case would serve no purpose, and the investigation has been terminated.

Signed at Washington, DC, this 16th day of July 1999.

Grant D. Beale,

Program Manager, Office of Trade Adjustment Assistance.

[FR Doc. 99–19549 Filed 7–29–99; 8:45 am]

BILLING CODE 4510–30–M

DEPARTMENT OF LABOR

Employment and Training Administration

[NAFTA–02476]

Johnson & Johnson Medical, Inc. Including Leased Workers of Kelly Services, Incorporated Menlo Park, California; Amended Certification Regarding Eligibility To Apply for NAFTA-Transitional Adjustment Assistance

In accordance with section 250(A), subchapter D, chapter 2, Title II, of the Trade Act of 1974 (19 U.S.C. 2273), the Department of Labor issued a Certification for NAFTA Transitional Adjustment Assistance on August 31, 1998, applicable to all workers of Johnson & Johnson Medical, Inc., located in Menlo Park, California. The notice was published in the **Federal Register** on September 28, 1998 (63 FR 51605).

At the request of the State agency, the Department reviewed the certification for workers of the subject firm. The workers produce intravenous specialty catheters. New information provided by the State shows that some workers of Johnson & Johnson Medical, Inc. were leased from Kelly Services, Inc. to produce intravenous specialty catheters at the Menlo Park, California plant. Based on these findings, the Department is amending the certification to include leased workers from Kelly Services, Inc., Menlo Park, California.

Accordingly, the Department is amending the certification to reflect this matter.

The intent of the Department's certification is to include all workers of Johnson & Johnson Medical, Inc. adversely affected by imports from Mexico.

The amended notice applicable to NAFTA–02476 is hereby issued as follows:

All workers of Johnson & Johnson Medical, Inc., Menlo Park, California engaged in the production of intravenous specialty catheters and leased workers of Kelly Services, Inc., Menlo Park, California engaged in employment related to the production of intravenous specialty catheters for Johnson & Johnson Medical, Inc., Menlo Park, California who became totally or partially separated

from employment on or after July 3, 1997 through August 31, 2000 are eligible to apply for NAFTA–TAA under section 250 of the Trade Act of 1974.

Signed at Washington, D.C., this 19th day of July, 1999.

Grant D. Beale,

Program Manager, Office of Trade Adjustment Assistance.

[FR Doc 99–19541 Filed 7–29–99; 8:45 am]

BILLING CODE 4510–30–M

DEPARTMENT OF LABOR

Employment and Training Administration

[NAFTA–03111]

Seagull Energy Corporation, Corporate Office Houston , TX; Notice of Termination of Investigation

Pursuant to Title V of the North American Free Trade Agreement Implementation Act (P.L. 103–182) concerning transitional adjustment assistance, hereinafter called (NAFTA–TAA), and in accordance with section 250(a), subchapter D, chapter 2, title II, of the Trade Act of 1974, as amended (19 U.S.C. 2273), an investigation was initiated on April 14, 1999 in response to a petition filed on behalf of workers at Seagull Energy Corporation, Houston, Texas.

The petitioner was requested that the petition for NAFTA–TAA be withdrawn. Consequently, further investigation in this case would serve no purpose, and the investigation has been terminated.

Signed at Washington, D.C., this 20th day of July, 1999.

Grant D. Beale,

Program Manager, Office of Trade Adjustment Assistance.

[FR Doc. 99–19547 Filed 7–29–99; 8:45 am]

BILLING CODE 4510–30–M

DEPARTMENT OF LABOR

Employment and Training Administration

[NAFTA–02538 and NAFTA–02538A]

Whisper Knits, Inc./Jahmpasa USA, Inc., NC, Clinton, Vass, NC; Amended Certification Regarding Eligibility To Apply for NAFTA-Transitional Adjustment Assistance

In accordance with Section 250(A), Subchapter D, Chapter 2, Title II, of the Trade Act of 1974 (19 U.S.C. 2273), the Department of Labor issued a Certification for NAFTA Transitional Adjustment Assistance on September 15, 1998, applicable to workers of Whisper Knits, Inc., Clinton and Vass, North Carolina. The Notice was published in the **Federal Register** on September 28, 1998 (63 FR 51606).

At the request of the company, the Department reviewed the negative determination for workers of the subject firm. New findings show that the Department inadvertently failed to identify the subject firm title name in its entirety. The Department is amending the certification determination to correctly identify the subject firm title name to read ''Whisper Knits, Inc./Jahmpasa USA, Inc.''.

The amended notice applicable to NAFTA–02538 and NAFTA–2538A is hereby issued as follows:

''All workers of Whisper Knits, Inc./Jahmpasa USA, Inc., Clinton, North Carolina (NAFTA–02538) and Vass, North Carolina (NAFTA–02538A) who become totally or partially separated from employment on of after July 27 1997 through September 15, 2000 are eligible to apply for NAFTA–TAA under Section 250 of the Trade Act of 1974.''

Signed at Washington, DC this 23th day of July, 1999.

Grant D. Beale,

Program Manager, Office of Trade Adjustment Assistance.

[FR Doc. 99–19551 Filed 7–29–99; 8:45 am]

BILLING CODE 4510–30–M

DEPARTMENT OF LABOR

Employment and Training Administration

[TA–W–35,978

Acordis Cellulosic Fibers, Incorporated, Tencel Facility, Axis, Alabama; Termination of Investigation

Pursuant to section 221 of the Trade Act of 1974, an investigation was initiated on April 5, 1999 in response to a worker petition which was filed on behalf of all workers at the Tencel Facility of Acordis Cellulosic Fibers, Incorporated, located in Axis, Alabama (TA–W–35,978).

The petitioner has requested that the petition be withdrawn.

Consequently, further investigation in this case would serve no purpose, and the investigation has been terminated.

Signed at Washington, D.C., this 14th day of July 1999.

Grant D. Beale,

Program Manager, Office of Trade Adjustment Assistance.

[FR Doc. 99–19557 Filed 7–29–99; 8:45 am]

BILLING CODE 4510–30–M

DEPARTMENT OF LABOR

Employment and Training Administration

[TA–W–36,090]

Cliff's Drilling, Houston, Texas; Notice of Revised Determination on Reopening

In response to a letter of May 24, 1999, from a petitioner requesting administrative reconsideration of the Department's denial of TAA for workers of the subject firm, the Department reopened its investigation for the former workers of Cliff's Drilling, Houston, Texas.

The initial investigation resulted in a negative determination issued on April 28, 1999, because the workers were believed to be employed in oil exploration overseas. The denial notice was published in the **Federal Register** on May 21, 1999 (64 FR 27810).

By letter of May 24, 1999, a petitioner provided additional information to demonstrate that the workers were engaged in employment related to oil field drilling services and that revenues and employment declined at the subject firm during the relevant time period. Aggregate U.S. imports of crude oil and natural gas increased in the period March through February, 1998—1999, compared to the same time period one year earlier. The declines in revenues and employment resulted from a decreased demand for exploration and drilling activities from oil industry clients due to the increase in U.S. oil and gas imports.

Conclusion

After careful consideration of the new facts obtained on reopening, it is concluded that increased imports of articles like or directly competitive with crude oil produced by the subject firm contributed importantly to the decline in revenues and to the total or partial separation of workers of the subject firm. In accordance with the provisions of the Trade Act of 1974, I make the following revised determination:

All workers of Cliff's Drilling, Houston, Texas who became totally or partially separated from employment on or after March 22, 1998, are eligible to apply for adjustment assistance under Section 223 of the Trade Act of 1974.

Signed in Washington, D.C., this 6th day of July, 1999.

Grant D. Beale,

Acting Director, Office of Trade Adjustment Assistance.

[FR Doc. 99–19546 Filed 7–29–99; 8:45 am]

BILLING CODE 4510–30–M

DEPARTMENT OF LABOR

Employment and Training Administration

[TA–W–36,063]

Cobre Mining Company; Hanover, NM; Notice of Revised Determination on Reconsideration

On July 7, 1999, the Department issued a Notice of Affirmative Determination Regarding Application for Reconsideration regarding the petition for workers of the subject firm.

The initial investigation resulted in a negative determination issued on June 11, 1999, based on the finding that an unforeseen environmental mishap which rendered the continued mining and concentrating of copper impractical and unprofitable. Also, a survey conducted by the Department, revealed that major customers of the subject firm have not increased their purchases of imported copper concentrate, while reducing purchases from the subject firm. The denial notice was published in the **Federal Register** on June 30, 1999 (64 FR 35183).

On reconsideration, further information provided by the company revealed that the environmental mishap during March 1999, although a contributing factor, was not the only factor contributing to layoffs at the subject facility. The company during October 1998 revealed their intentions to close the Cobre mine by mid 1999. The investigation further revealed that the parent company increased their imports of copper concentrate during the relevant period. A group of workers at an affiliated mine of Phelps Dodge Corporation, located at Chino Mine, Santa Rita, New Mexico were certified on May 11, 1999 for Trade Adjustment Assistance under TA–W–35,806, based on increasing corporate imports of copper concentrate.

Conclusion

After careful review of the additional facts obtained on reconsideration, I conclude that increased imports of articles like or directly competitive with copper concentrate contributed importantly to the declines in sales or production and to the total or partial separation of workers of Cobre Mining Company, Hanover, New Mexico. In accordance with the provisions of the Act, I make the following certification:

All workers of Cobre Mining Company, Hanover, New Mexico who became totally or partially separated from employment on or after April 1, 1998 through two years from the date of this certification are eligible to apply for adjustment assistance under section 223 of the Trade Act of 1974.

Signed in Washington, D.C., this 20th day of July 1999.

Grant D. Beale,

Program Manager, Office of Trade Adjustment Assistance.

[FR Doc. 99–19545 Filed 7–29–99; 8:45 am]

BILLING CODE 4510–30–M

DEPARTMENT OF LABOR

Employment and Training Administration

[TA–W–36,494]

F.W.A.–J.S.M. Drilling Company, Midland, Texas; Termination of Investigation

Pursuant to Section 221 of the Trade Act of 1974, an investigation was initiated on June 28, 1999 in response to a worker petition which was filed on behalf of workers at F.W.A.–J.S.M. Drilling Company, Midland, Texas.

The investigation revealed that an active certification covering the petitioning group of workers remains in effect (TA–W–34,550). Consequently, further investigation in this case would serve no purpose, and the investigation has been terminated.

Signed at Washington, D.C., this 8th day of July, 1999.

Grant D. Beale,

Program Manager, Office of Trade Adjustment Assistance.

[FR Doc. 19555 Filed 7–29–99; 8:45 am]

BILLING CODE 4510–30–M

DEPARTMENT OF LABOR

Employment and Training Administration

[TA–W–36,222]

Fairfield Industries Incorporated, Sugar Land, Texas; Termination of Investigation

Pursuant to Section 221 of the Trade Act of 1974, an investigation was initiated on May 10, 1999 in response to a petition filed on April 27, 1999 on behalf of workers at Fairfield Industries Incorporated, Sugar Land, Texas.

The petitioner has requested that the petition be withdrawn. Consequently, further investigation in this case would serve no purpose, and the investigation has been terminated.

Signed in Washington, D.C., this 15th day of July, 1999.

Grant D. Beale,

Program Manager, Office of Trade Adjustment Assistance.

[FR Doc. 99–19543 Filed 7–29–99; 8:45 am]

BILLING CODE 4510–30–M

DEPARTMENT OF LABOR

Employment and Training Administration

[TA–W–36,431]

Fort James Corporation, Business Packaging Division, Portland, OR; Notice of Termination of Investigation

Pursuant to Section 221 of the Trade Act of 1974, an investigation was initiated on June 21, 1999, in response to a worker petition which was filed on behalf of workers at Fort James Corporation, Portland, Oregon.

The petitioning group of workers are subject to an ongoing investigation for which determinations have not yet been issued: Fort James Corporation, Portland, Oregon (TA–W–36,471). Consequently, further investigation in this case would serve no purpose; and the investigation has been terminated.

Signed in Washington, DC, this 9th day of July, 1999.

Grant D. Beale,

Program Manager, Office of Trade Adjustment Assistance.

[FR Doc. 99–19548 Filed 7–29–99; 8:45 am]

BILLING CODE 4510–30–M

DEPARTMENT OF LABOR

Employment and Training Administration

Investigations Regarding Certifications of Eligibility To Apply for Worker Adjustment Assistance

Petitions have been filed with the Secretary of Labor under Section 221(a) of the Trade Act of 1974 (''the Act'') and are identified in the Appendix to this notice. Upon receipt of these petitions, the Director of the Office of Trade Adjustment Assistance, Employment and Training Administration, has instituted investigations pursuant to Section 221(a) of the Act.

The purpose of each of the investigations is to determine whether the workers are eligible to apply for adjustment assistance under Title II, Chapter 2, of the Act. The investigations will further relate, as appropriate, to the determination of the date on which total or partial separations began or

threatened to begin and the subdivision of the firm involved.

The petitioners or any other persons showing a substantial interest in the subject matter of the investigations may request a public hearing, provided such request is filed in writing with the Director, Office of Trade Adjustment Assistance, at the address shown below, not later than August 9, 1999.

Interested persons are invited to submit written comments regarding the subject matter of the investigations to the Director, Office of Trade Adjustment Assistance, at the address shown below, not later than August 9, 1999.

The petitions filed in this case are available for inspection at the Office of the Director, Office of Trade Adjustment Assistance, Employment and Training Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, DC 20210.

Signed at Washington, DC this 6th day of July, 1999.

Grant D. Beale,

Program Manager, Office of Trade Adjustment Assistance.

Appendix—Petitions Instituted on 07/06/1999

TA–W	Subject firm (petitioners)	Location	Date of petition	Product(s)
36,500	Inspector's Corp—(TIC) (Wkrs)	Williston, ND	06/14/1999	Oilfield Inspection.
36,501	Becton Dickinson (Co.)	Hancock, NY	06/21/1999	Arterial Blood Gas Syringes.
36,502	Stuart Entertainment (Co.)	McAllen, TX	06/18/1999	Bingo Cards and Ink Dabbers.
36,503	Petron Industries, Inc. (Wkrs)	Houston, TX	06/18/1999	Computerized Drilling Instrumentation.
36,504	Galax Apparel Corp. (Co.)	Galax, VA	06/23/1999	Knit Shirts and Woven Bottoms.
36,505	American Industrial (Co.)	Breckenridge, TX	06/16/1999	Repair Engines & Compressors.
36,506	Fellowes Manufacturing (Wkrs)	Boone, NC	06/21/1999	Wood Racks for Cassette, Videos.
36,507	Alcatel Data Networks (Wkrs)	Mt. Laurel, NJ	06/21/1999	High Speed Switch for Telecommunications.
36,508	Trico International (Wkrs)	San Marcos, TX	06/22/1999	Oilfield Service Equipment.
36,509	Fabric Resources Int'l (Co.)	Mullins, SC	06/15/1999	Finished Fabrics and Ribbons.
36,510	Fairfield Apparel Corp. (Co.)	Fairfield, VA	06/14/1999	Medical Uniforms.
36,511	Willow Creek Apparel (Wkrs)	Jonesville, NC	06/28/1999	Ladies' Sleepwear.
36,512	L.W. Packard and Company (Wkrs)	Ashland, NH	06/26/1999	Woolen Fabric.
36,513	London International (Co.)	Dothan, AL	06/18/1999	Latex Gloves.
36,514	Sensus Tech (USWA)	Uniontown, PA	06/14/1999	Water Meters.
36,515	Strasburg Manufacturing (Wkrs)	Strasburg, VA	06/15/1999	Children's Sportswear & Dresses.
36,516	Jockey International (Wkrs)	Carlisle, KY	06/26/1999	Underwear.
36,517	Bandera Pipeline Service (Wkrs)	Houston, TX	06/23/1999	Repair Pipelines.
36,518	Turner and Seymour (UAW)	Torrington, CT	06/24/1999	Gray Iron Castings.
36,519	Kramer Steel, Inc (Co.)	Farmington Hill, MI	06/05/1999	Warehouses & Distributes Steel.
36,520	Carrier Corp. (SMWIA)	Syracuse, NY	06/25/1999	Industrial Air Conditioning Systems.
36,521	Permac, Inc (Wkrs)	Bluefield, VA	06/21/1999	Metallurgical Coal.
36,522	Inter-National Childrens (Co.)	Birmingham, AL	06/09/1999	Children's Apparel.
36,523	Bosch Automotive (UAW)	Hendersonville, TN	06/24/1999	Automotive Motors.
36,524	Dynamic Drilling Fluids (Co.)	Denver, CO	06/03/1999	Oil Drilling Chemicals.
36,525	Ponder Fishing Tools (Wkrs)	Healdton, OK	06/25/1999	Oilfield Services.
36,526	Pennzoil Energy Explor. (Wkrs)	Houston, TX	06/22/1999	Crude Oil, Natural Gas & Condensate.

[FR Doc. 99–19550 Filed 7–29–99; 8:45 am]

BILLING CODE 4510–30–M

DEPARTMENT OF LABOR

Employment and Training Administration

[TA–W–36,449]

International Mill Service, Beaumont, Texas; Termination of Investigation

Pursuant to Section 221 of the Trade Act of 1974, an investigation was initiated on June 21, 1999 in response to a worker petition which was filed on June 21, 1999 on behalf of workers at International Mill Service, located in Beaumont, Texas.

An active certification covering the petitioning group of workers remains in effect (TA–W–35,086). Consequently, further investigation in this case would serve no purpose, and the investigation has been terminated.

Signed in Washington, D.C., this 25th day of June, 1999.

Linda G. Poole,

Program Manager, Office of Trade Adjustment Assistance.

[FR Doc. 99–19542 Filed 7–29–99; 8:45 am]

BILLING CODE 4510–30–M

DEPARTMENT OF LABOR

Employment and Training Administration

[TA–W–34,749]

Johnson & Johnson Medical, Inc., Including Leased Workers of Kelly Services, Inc., Menlo Park, California; Amended Certification Regarding Eligibility To Apply for Worker Adjustment Assistance

In accordance with Section 223 of the Trade Act of 1974 (19 U.S.C. 2273) the Department of Labor issued a Certification of Eligibility to Apply for Worker Adjustment Assistance on August 31, 1998, applicable to all workers of Johnson & Johnson Medical, Inc., located in Menlo Park, California. The notice was published in the **Federal**

Register on September 28, 1998 (63 FR 51605).

At the request of the State agency, the Department reviewed the certification for workers of the subject firm. New information provided by the State shows that some workers of Johnson & Johnson Medical, Inc. were leased from Kelly Services, Inc. to produce intravenous specialty catheters at the Menlo Park, California plant. Based on these findings, the Department is amending the certification to include leased workers from Kelly Services, Inc., Menlo Park, California.

The intent of the Department's certification is to include all workers of Johnson & Johnson Medical, Inc. adversely affected by imports.

The amended notice applicable to TA–W–34,749 is hereby issued as follows:

All workers of Johnson & Johnson Medical, Inc., Menlo Park, California engaged in the production of intravenous specialty catheters and leased workers of Kelly Services, Inc., Menlo Park, California engaged in employment related to the production of intravenous specialty catheters for Johnson & Johnson Medical, Inc., Menlo Park, California who became totally or partially separated from employment on or after June 24, 1997 through August 31, 2000 are eligible to apply for adjustment assistance under Section 223 of the Trade Act of 1974.

Dated: July 22, 1999.

Signed at Washington, DC, this 19th day of July, 1999.

Grant D. Beale,

Program Manager, Office of Trade Adjustment Assistance.

[FR Doc. 99–19538 Filed 7–29–99; 8:45 am]

BILLING CODE 4510–30–M

DEPARTMENT OF LABOR

Employment and Training Administration

[TA–W–35,727]

Martin Marietta Magnesia specialties Inc. Manistee, MI; Revised Determination on Reopening

By letter of June 18 the company official presented evidence not previously considered in the Department's determination. Accordingly, the Department reopened the petition investigation applicable to workers of the subject firm.

The initial investigation resulted in a negative determination issued on April 20, 1999, based on the finding that during the time period relevant to the petition investigation, customers of Martin Marietta Magnesia Specialities, Inc. did not increase reliance on imports of articles like or directly competitive with refractory products produced at the Manistee, Michigan plant. Layoffs were attributable to the decline in demand for refractory products from the steel industry. The denial notice was published in the **Federal Register** on May 11, 1999 (64 FR 25371).

On reopening, further analysis was conducted regarding purchases of refractory products by the subject firm's major declining customers. New findings show that from 1997 to 1998 a major declining customer increased import purchases of refractory products while decreasing purchases from the Manistee, Michigan plant.

Sales, production and employment declined during the relevant period.

Conclusion

After careful review of the additional facts obtained on reopening, I conclude that increased imports of articles like or directly competitive with refractory products contributed importantly to the declines in sales or production and to the total or partial separation of workers of Martin Marietta Magnesia Specialties Inc., Michigan. In accordance with the provisions of the Act, I make the following certification:

All workers of Martin Marietta Magnesia Specialties Inc., Manistee, Michigan, who became totally or partially separated from employment on or after February 9, 1998, through two years from the date of this certification are eligible to apply for adjustment assistance under Section 223 of the Trade Act of 1974.

Dated: July 22, 1999.

Signed in Washington, D.C., this 20th day of July 1999.

Grant D. Beale,

Program Manager, Office of Trade Adjustment Assistance.

[FR Doc. 99–19544 Filed 7–29–99; 8:45 am]

BILLING CODE 4510–30–M

DEPARTMENT OF LABOR

[TA–W–35,980]

Morris Button Company, New York, New York; Dismissal of Application for Reconsideration

Pursuant to 29 CFR 90.18(C) an application for administrative reconsideration was filed with the Director of the Office of Trade Adjustment Assistance for workers at the Morris Button Company, New York, New York. The application contained no new substantial information which would bear importantly on the Department's determination. Therefore, dismissal of the application was issued.

TA–W–35,890; Morris Button Company, New York, New York (July 20, 1999)

Signed at Washington, D.C., this 20th day of July, 1999.

Grant D. Beale,

Program Manager, Office of Trade Adjustment Assistance.

[FR Doc. 99–19540 Filed 7–29–99; 8:45 am]

BILLING CODE 4510–30–M

DEPARTMENT OF LABOR

Employment and Training Administration

[TA–W–35, 909 and TA–W–35, 909A]

The O.S. Kelly Company; Springfield, Ohio and Jonesboro, Arkansas; Amended Certification Regarding Eligibility To Apply for Worker Adjustment Assistance

In accordance with Section 223 of the Trade Act of 1974 (19 U.S.C. 2273) the Department of Labor issued a Certification of Eligibility to Apply for Worker Adjustment Assistance on May 25, 1999, applicable to workers of the O.S. Kelly Company, Springfield, Ohio. The notice was published in the **Federal Register** on June 30, 1999 (64 FR 35184).

At the request of the company, the Department reviewed the certification for workers of the subject firm. New information provided by the company shows that worker separation occurred at the subject firm's Jonesboro, Arkansas facility when it closed in June, 1999. The workers were engaged in employment related to the production of piano plates. Accordingly, the Department is amending the certification to cover workers of The O.S. Kelly Company, Jonesboro, Arkansas.

The intent of the Department's certification is to include all workers of The O.S. Kelly Company adversely affected by increased imports.

The amended notice applicable to TA–W–35,909 is hereby issued as follows:

All workers of The O.S. Kelly Company, Springfield, Ohio (TA–W–35,909) and Jonesboro, Arkansas (TA–W–35,909A) who became totally or partially separated from employment on or after February 26, 1998 through March 25, 2001 are eligible to apply for adjustment assistance under Section 223 of the Trade Act of 1974.

Signed at Washington, DC, this 21st day of July, 1999.

Grant D. Beale,

Program Manager, Office of Trade Adjustment Assistance.

[FR Doc. 99–19537 Filed 7–29–99; 8:45 am]

BILLING CODE 4510–30–M

DEPARTMENT OF LABOR

Employment and Training Administration

[TA–W–35,599 and TA–W–35,599A]

Perfection Pad Co. Inc. A/K/A Consolidated Contractors A/K/A New York Pad Co. Buffalo, NY, Bronx, NY; Amended Certification Regarding Eligibility To Apply for Worker Adjustment Assistance

In accordance with Section 223 of the Trade Act of 1974 (19 U.S.C. 2273) the Labor Department issued a Notice of Revised Determination on Reopening on June 3, 1999, applicable to all workers of Perfection Pad Co., Inc., a/k/a Consolidated Contractors, a/k/a New York Pad Co. located in Buffalo, New York. The notice was published in the **Federal Register** on June 18, 1999 (64 FR 32895).

At the request of the company, the Department reviewed the certification for workers of the subject firm. New information received from the company shows that worker separations occurred at the Bronx, New York facility of Perfection Pad Co., Inc. when it closed in December, 1998. The workers were engaged in the production of shoulder pads and sleeveheads used by clothing manufacturers.

The intent of the Department's certification is to include all workers of Perfection Pad Co., Inc. who were adversely affected by increased imports of shoulder pads and sleeveheads.

Accordingly, the Department is amending the certification to cover the workers of Perfection Pad Co., Inc., also known as Consolidated Contractors, also known as New York Pad Co., Bronx, New York.

The amended notice applicable to TA–W–35,599 is hereby issued as follows:

All workers of Perfection Pad Co., Inc., also known as Consolidated Contractors, also known as New York Pad Co., Buffalo, New York (TA–W–35,999) and Bronx, New York (TA–W–35,999A) who became totally or partially separated from employment on or after January 7, 1998 through June 3, 2001 are eligible to apply for adjustment assistance under Section 223 of the Trade Act of 1974.

Signed at Washington D.C., this 14th day of July, 1999.

Grant D. Beale,

Program Manager, Office of Trade Adjustment Assistance.

[FR Doc. 99–19553 Filed 7–29–99; 8:45 am]

BILLING CODE 4510–30–M

DEPARTMENT OF LABOR

Employment and Training Administration

[TA–W–36,490]

Trans Texas Corporation, Laredo, Texas; Termination of Investigation

Pursuant to Section 221 of the Trade Act of 1974, an investigation was initiated on June 28, 1999 in response to a worker petition which was dated June 14, 1999, and filed on behalf of workers at Trans Texas Corporation; Laredo, Texas.

A negative determination applicable to the petitioning group of workers was issued on June 21, 1999 (TA–W–36,218). No new information is evident which would result in a reversal of the Department's previous determination. Consequently, further investigation in this case would serve no purpose, and the investigation has been terminated.

Signed in Washington, D.C., this 29th day of June, 1999.

Linda G. Poole,

Program Manager, Office of Trade Adjustment Assistance.

[FR Doc. 99–19556 Filed 7–29–99; 8:45 am]

BILLING CODE 4510–30–M

DEPARTMENT OF LABOR

Employment and Training Administration

[TA–W–36,313]

Watlow Controls, Watlow System Integrators, Decorah, Iowa; Termination of Investigation

Pursuant to Section 221 of the Trade Act of 1974, an investigation was initiated on June 1, 1999, in response to a worker petition which was filed by the company on behalf of its workers at Watlow Controls, Watlow System Integrators, Decorah, Iowa.

The petitioner has requested that the petition be withdrawn. Consequently, further investigation in this case would serve no purpose, and the investigation has been terminated.

Signed in Washington, D.C. this 13th day of July, 1999.

Grant D. Beale,

Program Manager, Office of Trade Adjustment Assistance.

[FR Doc. 99–19554 Filed 7–29–99; 8:45 am]

BILLING CODE 4510–30–M

DEPARTMENT OF LABOR

Employment and Training Administration

[TA–W–34,840 and TA–W–34,840A]

Whisper Knits, Inc./Jahmpasa USA, Inc., Clinton, NC; Vass, NC; Amended Certification Regarding Eligibility To Apply for Worker Adjustment Assistance

In accordance with Section 223 of the Trade Act of 1974 (19 U.S.C. 2273) the Department of Labor issued a Certification of Eligiblity to Apply for Worker Adjustment Assistance on September 15, 1998, applicable to workers of Whisper Knits, Inc., Clinton and Vass, North Carolina. The notice was published in the **Federal Register** on September 28, 1998 (63 FR 51605).

At the request of the company, the Department reviewed the certification for workers of the subject firm. New findings show that the Department inadvertently failed to identify the subject firm title name in its entirety. The Department is amending the certification determination to correctly identify the subject firm title name to read ''Whisper Knits, Inc./Jahmpasa USA, Inc.''.

The amended notice applicable to TA–W–34,840 and TA–W–34,840A is hereby issued as follows:

All workers of Whisper Knits, Inc./Jahmpasa USA, Inc., Clinton, North Carolina (TA–W–34,840) and Vass, North Carolina (TA–W–34,480A) who became totally or partially separated from employment on or after July 27, 1997 through September 27, 2000 are eligible to apply for adjustment assistance under Section 223 of the Trade Act of 1974.

Signed at Washington, D.C. this 23rd day of July, 1999.

Grant D. Beale,

Program Manager, Office of Trade Adjustment Assistance.

[FR Doc. 99–19552 Filed 7–29–99; 8:45 am]

BILLING CODE 4510–30–M

DEPARTMENT OF LABOR

Employment and Training Administration

Proposed Collection; Comment Request

ACTION: Notice.

SUMMARY: The Department of Labor, as part of its continuing effort to reduce paperwork and respondent burden conducts a preclearance consultation program to provide the general public and Federal agencies with an

opportunity to comment on proposed and/or continuing collections of information in accordance with the Paperwork Reduction Act of 1995 (PRA95) [44 U.S.C. 3506(c)(2)(A)]. This program helps to ensure that requested data can be provided in the desired format, reporting burden (time and financial resources) is minimized, collection instruments are clearly understood, and the impact of collection requirements on respondents can be properly assessed. Currently, the employment and Training Administration is soliciting comments concerning the proposed extension of the collection of Employment Rates for the Youth Opportunity Area Demonstration. A copy of the proposed information collection request (ICR) can be obtained by contacting the office listed below in the addressee section of this notice.

DATES: Written comments must be submitted to the office listed in the addressee's section below on or before September 28, 1999.

ADDRESSES: Greg Knorr, Employment and Training Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, room N–5637, Washington, DC 20210; 202–219–5782 ext. 120 (this is not a toll-free number); gknorr@doleta.gov; Fax: 202–219–5455 (this is not a toll-free number).

SUPPLEMENTARY INFORMATION:

I. Background

The Youth Opportunity Area Demonstration is an initiative designed to improve the labor market prospects of out-of-school youth in a small number of high poverty areas. Under this demonstration eleven Opportunity Areas have been created to expand employment, education, and training opportunities for out-of-school youth ages 16–24, with priority given to high school dropouts. Each Opportunity Area consists of an identified target area within a designated empowerment zone or enterprise community with a population of between 10,000 and 20,000 persons and a poverty rate among the highest in the community. The Opportunity Areas are in the cities of Chicago, Los Angeles, Houston, New York, Boston, Detroit, Denver, Baltimore, Oakland, San Diego, and in Kentucky's Lake County Area Development District.

An important part of determining whether these demonstrations are successful is to measure the youth employment rate in the subject areas before the program begins in each area and again after three years of operation. The extension of this collection will allow for the completion of these before and after comparisons. The OMB approved survey that is currently being used is strongly based on the Current Population Survey.

II. Review Focus

The Department of Labor is particularly interested in comments which:

- evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;
- evaluate the accuracy of the agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used;
- enhance the quality, utility, and clarity of the information to be collected; and
- minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, e.g., permitting electronic submissions of responses.

III. Current Actions

Continuing to collect the before and after youth employment rate measures will allow for an evaluation of the effectiveness of the demonstration's approach. Policy-makers in and out of government will be able to use results from this study to better understand what sorts of program initiatives are effective in increasing youth employment in poverty areas.

Type of Review: Extension.

Agency: Employment and Training Administration.

Title: Employment Rates for the Youth Opportunity Area Demonstrations.

OMB Number: 1205–0373.

Affected Public: Individuals or households.

Cite/Reference/Form/etc: Youth Employment Survey.

Total Respondents: 9,600.

Frequency: One-time.

Total Responses: 9,600.

Average Time per Response: 0.25 hours.

Estimated Total Burden Hours: 2,400.

Total Burden Cost (capital/startup): $0, extension of an ongoing project.

Total Burden Cost (operating/maintaining): $3,600,000 contractor support over three and one-half years

Comments submitted in response to this comment request will be summarized and/or included in the request for Office of Management and Budget approval of the information collection request; they will also become a matter of public record.

Dated: July 26, 1999.

Gerard F. Fiala,

Administrator, Office of Policy and Research.

[FR Doc. 99–19536 Filed 7–29–99; 8:45 am]

BILLING CODE 4510–30–M

DEPARTMENT OF LABOR

Employment and Training Administration

[NAFTA–03140]

Jahmpasa USA, Incorporated, Vass, North Carolina; Notice of Termination of Investigation

Pursuant to Title V of the North American Free Trade Agreement Implementation Act (Pub. L. 103–182) concerning transitional adjustment assistance, hereinafter called (NAFTA–TAA), and in accordance with section 250(a), subchapter D, chapter 2, title II, of the Trade Act of 1974, as ameded (19 U.S.C. 2273), an investigation was initiated on April 28, 1999 in response to a petition filed on behalf of workers at Jahmpasa USA, Incorporated, located in Vass, North Carolina (NAFTA–03158).

The Department of Labor has determined that the petitioning group of workers are covered by an existing certification, as amended (NAFTA–02538A). Consequently, further investigation in this case would serve no purpose, and the investigation has been terminated.

Signed at Washington, DC, this 23d day of July, 1999.

Grant D. Beale,

Program Manager, Office of Trade Adjustment Assistance.

[FR Doc. 99–19539 Filed 7–29–99; 8:45 am]

BILLING CODE 4510–30–M

DEPARTMENT OF LABOR

Employment Standards Administration, Wage and Hour Division

Minimum Wages for Federal and Federally Assisted Construction; General Wage Determination Decisions

General Wage determination decisions of the Secretary of Labor are issued in accordance with applicable law and are based on the information obtained by the Department of Labor from its study of local wage conditions and data made available from other sources. They

specify the basic hourly wage rates and fringe benefits which are determined to be prevailing for the described classes of laborers and mechanics employed on construction projects of a similar character and in the localities specified therein.

The determinations in these decisions of prevailing rates and fringe benefits have been made in accordance with 29 CFR Part 1, by authority of the Secretary of Labor pursuant to the provisions of the Davis-Bacon Act of March 3, 1931, as amended (46 Stat. 1494, as amended, 40 U.S.C. 276a) and of labor Federal status referred to in 29 CFR Part 1, Appendix, as well as such additional statutes as may from time to time be enacted containing provisions for the payment of wages determined to be prevailing by the Secretary of Labor in accordance with the Davis-Bacon Act. The prevailing rates and fringe benefits determined in these decisions shall, in accordance with the provisions of the foregoing statutes, constitute the minimum wages payable on Federal and federally assisted construction projects to laborers and mechanics of the specified classes engaged on contract work of the character and in the localities described therein.

Good cause is hereby found for not utilizing notice and public comment procedure thereon prior to the issuance of these determinations as prescribed in 5 U.S.C. 553 and not providing for delay in the effective date as prescribed in that section, because the necessity to issue current construction industry wage determinations frequently and in large volume causes procedures to be impractical and contrary to the public interest.

General wage determination decisions, and modifications and supersedes decisions thereto, contain no expiration dates and are effective from their date of notice in the **Federal Register**, or on the date written notice is received by the agency, whichever is earlier. These decisions are to be used in accordance with the provisions of 29 CFR Parts 1 and 5. Accordingly, the applicable decision, together with any modifications issued, must be made a part of every contract for performance of the described work within the geographic area indicated as required by an applicable Federal prevailing wage law and 29 CFR Part 5. The wage rates and fringe benefits, notice of which is published herein, and which are contained in the Government Printing Office (GPO) document entitled ''General Wage Determinations Issued Under the Davis-Bacon And Related Acts,'' shall be the minimum paid by contractors and subcontractors to laborers and mechanics.

Any person, organization, or governmental agency having an interest in the rates determined as prevailing is encouraged to submit wage rate and fringe benefit information for consideration by the Department. Further information and self-explanatory forms for the purpose of submitting this data may be obtained by writing to the U.S. Department of Labor, Employment Standards Administration, Wage and Hour Division, Division of Wage Determinations, 200 Constitution Avenue, N.W., Room S–3014, Washington, D.C. 20210.

New General Wage Determination Decisions

The number of the decisions added to the Government Printing Office document entitled ''General Wage Determinations Issued Under the Davis-Bacon and related Acts'' are listed by Volume and States:

Volume IV

Michigan
MI990085 (Jul. 30, 1999)
MI990086 (Jul. 30, 1999)
MI990087 (Jul. 30, 1999)
MI990088 (Jul. 30, 1999)

Modifications to General Wage Determination Decisions

The number of decisions listed in the Government Printing Office document entitled ''General Wage Determinations Issued Under the Davis-Bacon and related Acts'' being modified are listed by Volume and State. Dates of publication in the **Federal Register** are in parentheses following the decisions being modified.

Volume I

Connecticut
CT990001 (Mar. 12, 1999)
CT990002 (Mar. 12, 1999)
CT990003 (Mar. 12, 1999)
CT990004 (Mar. 12, 1999)
CT990005 (Mar. 12, 1999)

Massachusetts
MA990018 (Mar. 12, 1999)
MA990019 (Mar. 12, 1999)
NY990006 (Mar. 12, 1999)

New York
NY990002 (Mar. 12, 1999)
NY990003 (Mar. 12, 1999)
NY990006 (Mar. 12, 1999)
NY990007 (Mar. 12, 1999)
NY990010 (Mar. 12, 1999)
NY990011 (Mar. 12, 1999)
NY990013 (Mar. 12, 1999)
NY990015 (Mar. 12, 1999)
NY990016 (Mar. 12, 1999)
NY990017 (Mar. 12, 1999)
NY990021 (Mar. 12, 1999)
NY990022 (Mar. 12, 1999)
NY990025 (Mar. 12, 1999)
NY990026 (Mar. 12, 1999)
NY990031 (Mar. 12, 1999)
NY990032 (Mar. 12, 1999)
NY990034 (Mar. 12, 1999)
NY990036 (Mar. 12, 1999)
NY990037 (Mar. 12, 1999)
NY990038 (Mar. 12, 1999)
NY990039 (Mar. 12, 1999)
NY990040 (Mar. 12, 1999)
NY990041 (Mar. 12, 1999)
NY990042 (Mar. 12, 1999)
NY990043 (Mar. 12, 1999)
NY990045 (Mar. 12, 1999)
NY990046 (Mar. 12, 1999)
NY990049 (Mar. 12, 1999)
NY990050 (Mar. 12, 1999)
NY990060 (Mar. 12, 1999)
NY990074 (Mar. 12, 1999)
NY990076 (Mar. 12, 1999)

Volume II

Pennsylvania
PA990007 (Mar. 12, 1999)
PA990009 (Mar. 12, 1999)
PA990010 (Mar. 12, 1999)
PA990014 (Mar. 12, 1999)
PA990019 (Mar. 12, 1999)
PA990029 (Mar. 12, 1999)
PA990060 (Mar. 12, 1999)
PA990063 (Mar. 12, 1999)

Volume III

Kentucky
KY990025 (Mar. 12, 1999)
KY990027 (Mar. 12, 1999)
KY990028 (Mar. 12, 1999)

Volume IV

Michigan
MI990003 (Mar. 12, 1999)
MI990012 (Mar. 12, 1999)

Minnesota
MN990003 (Mar. 12, 1999)
MN990005 (Mar. 12, 1999)
MN990007 (Mar. 12, 1999)
MN990008 (Mar. 12, 1999)
MN990012 (Mar. 12, 1999)
MN990015 (Mar. 12, 1999)
MN990017 (Mar. 12, 1999)
MN990027 (Mar. 12, 1999)
MN990031 (Mar. 12, 1999)
MN990035 (Mar. 12, 1999)
MN990039 (Mar. 12, 1999)
MN990043 (Mar. 12, 1999)
MN990045 (Mar. 12, 1999)
MN990049 (Mar. 12, 1999)
MN990058 (Mar. 12, 1999)
MN990059 (Mar. 12, 1999)
MN990061 (Mar. 12, 1999)
MN990064 (Mar. 12, 1999)
MN990068 (Mar. 12, 1999)
MN990073 (Mar. 12, 1999)

Volume V

Iowa
IA990001 (Mar. 12, 1999)
IA990005 (Mar. 12, 1999)

Volume VI

Alaska
AK990001 (Mar. 12, 1999)
AK990006 (Mar. 12, 1999)

Oregon
OR990001 (Mar. 12, 1999)

Washington
WA990001 (Mar. 12, 1999)
WA990002 (Mar. 12, 1999)
WA990005 (Mar. 12, 1999)
WA990006 (Mar. 12, 1999)

WA990008 (Mar. 12, 1999)
WA990010 (Mar. 12, 1999)

Volume VII

None

General Wage Determination Publication

General wage determinations issued under the Davis-Bacon and related Acts, including those noted above, may be found in the Government Printing Office (GPO) document entitled ''General Wage Determinations Issued Under The Davis-Bacon and Related Acts.'' This publication is available at each of the 50 Regional Government Depository Libraries and many of the 1,400 Government Depository Libraries across the country.

The general wage determinations issued under the Davis-Bacon and related Acts are available electronically by subscription to the FedWorld Bulletin Board System of the National Technical Information Service (NTIS) of the U.S. Department of Commerce at 1–800–363–2068.

Hard-copy subscriptions may be purchased from: Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402, (202) 512–1800.

When ordering hard-copy subscription(s), be sure to specify the State(s) of interest, since subscriptions may be ordered for any or all of the seven separate volumes, arranged by State. Subscriptions include an annual edition (issued in January or February) which includes all current general wage determinations for the States covered by each volume. Throughout the remainder of the year, regular weekly updates are distributed to subscribers.

Signed at Washington, DC this 22nd day of July 1999.

Carl J. Poleskey,

Chief, Branch of Construction Wage Determinations.

[FR Doc. 99–19243 Filed 7–29–99; 8:45 am]

BILLING CODE 4510–27–M

LIBRARY OF CONGRESS

Copyright Office

[Docket No. 99–5 CARP CD 97]

Ascertainment of Controversy for 1997 Cable Royalty Funds

AGENCY: Copyright Office, Library of Congress.

ACTION: Notice with request for comments.

SUMMARY: The Copyright Office of the Library of Congress directs all claimants to royalty fees collected for secondary transmission by cable systems in 1997 to submit comments as to whether a Phase I or a Phase II controversy exists as to the distribution of these funds.

DATES: Comments are due September 28, 1999.

ADDRESSES: If sent by mail, an original and five copies of written comments and a Notice of Intent to Participate should be addressed to: Copyright Arbitration Royalty Panel (CARP), PO Box 70977, Southwest Station, Washington, DC 20024. If hand-delivered, an original and five copies of written comments and a Notice of Intent to Participate should be brought to: Office of the Copyright General Counsel, James Madison Memorial Building, LM–403, First and Independence Avenue, SE, Washington, D.C. 20559–6000.

FOR FURTHER INFORMATION CONTACT: David O. Carson, General Counsel, or Tanya M. Sandros, Attorney Advisor, Copyright Arbitration Royalty Panels, PO Box 70977, Southwest Station, Washington, DC 20024. Telephone: (202) 707–8380. Telefax: (202) 252–3423.

SUPPLEMENTARY INFORMATION: Each year, cable systems submit royalties to the U.S. Copyright Office under a statutory license which allows cable systems to retransmit broadcast signals to their subscribers. 17 U.S.C. 111. These royalties are distributed, in turn, in one of two ways to copyright owners whose works were included in a cable system's secondary transmission and who timely filed a claim with the Copyright Office.

These copyright owners may either negotiate a settlement agreement among themselves as to the distribution of the royalty fees, or the Librarian of Congress may convene an ad hoc Copyright Arbitration Royalty Panel (CARP) to determine the final distribution of the royalty fees which remain in controversy. *See* 17 U.S.C. chapter 8. The Copyright Act also allows the copyright owners to receive a partial distribution of the royalty fees prior to the final determination so long as sufficient funds are withheld from distribution ''to satisfy all claims with respect to which a controversy exists.'' 17 U.S.C. 111(d)(4)(C).

Each year since 1996, representatives of the Phase I claimant categories to which royalties have been allocated in prior distribution proceedings have filed with the Copyright Office a motion for partial distribution of the cable royalties collected two years prior to the requested distribution. However, before beginning a distribution proceeding or making a partial distribution, the Librarian of Congress must first ascertain whether a controversy exists as to the distribution of the funds. 17 U.S.C. 803(d).

In anticipation of a similar filing in 1999, the Office is requesting comment on the existence of any controversies as to the distribution of the 1997 cable royalties. The Office also requests that those claimants intending to participate in the 1997 distribution proceeding file a Notice of Intent to Participate, noting whether they anticipate participating in a Phase I proceeding, a Phase II proceeding, or both.

In a Phase I proceeding, the arbitrators ascertain the distribution of royalties among the categories of broadcast programming represented in the proceeding, and in a Phase II proceeding, the arbitrators settle disputes between claimants within a particular category concerning the distribution of royalty fees within the group. If a claimant anticipates a Phase II controversy, the claimant must state each program category in which he or she has an interest which by the end of the comment period has not yet been satisfied by private agreement.

Participants must advise the Office of the existence of all controversies, Phase I or Phase II, by the end of the comment period. The Office will not consider controversies which come to its attention after the close of the comment period. Failure to file a timely Notice of Intent to Participate shall also preclude a party from participating in this proceeding.

Dated: July 26, 1999.

Marybeth Peters,

Register of Copyrights.

[FR Doc. 99–19585 Filed 7–29–99; 8:45 am]

BILLING CODE 1410–33–P

NATIONAL COUNCIL ON DISABILITY

Sunshine Act Meeting

TYPE: Quarterly meeting.

AGENCY: National Council on Disability.

SUMMARY: This notice sets forth the schedule and proposed agenda of the forthcoming quarterly meeting of the National Council on Disability. Notice of this meeting is required under Section 552b(e)(1) of the Government in the Sunshine Act, (P.L. 94–409).

QUARTERLY MEETING DATES: September 23–24, 1999, 8:30 a.m. to 5:00 p.m.

LOCATION: Old Town Holiday Inn, 480 King Street, Old Town Alexandria, Virginia; 703–549–6080.

FOR INFORMATION, CONTACT: Mark S. Quigley, Public Affairs Specialist, National Council on Disability, 1331 F

Street NW, Suite 1050, Washington, DC 20004–1107; 202–272–2004 (Voice), 202–272–2074 (TTY), 202–272–2022 (Fax).

AGENCY MISSION: The National council on Disability is an independent federal agency composed of 15 members appointed by the President of the United States and confirmed by the U.S. Senate. Its overall purpose is to promote policies, programs, practices, and procedures that guarantee equal opportunity for all people with disabilities, regardless of the nature of severity of the disability; and to empower people with disabilities to achieve economic self-sufficiency, independent living, and inclusion and integration into all aspects of society.

ACCOMMODATIONS: Those needing interpreters or other accommodations should notify the National Council on Disability prior to this meeting.

ENVIRONMENTAL ILLNESS: People with environmental illness must reduce their exposure to volatile chemical substances in order to attend this meeting. In order to reduce such exposure, we ask that you not wear perfumes or scents at the meeting. We also ask that you smoke only in designated areas and the privacy of your room. Smoking is prohibited in the meeting room and surrounding area.

OPEN MEETING: This quarterly meeting of the National Council on Disability will be open to the public.

AGENDA: The proposed agenda includes.

Reports from the Chairperson and the Executive Director

Committee Meetings and Committee Reports

Executive Session (closed)

Unfinished Business

New Business

Announcements

Adjournment

Records will be kept of all National Council on Disability proceedings and will be available after the meeting for public inspection at the National Council on Disability.

Signed in Washington, DC, on July 27, 1999.

Ethel D. Briggs,

Executive Director.

[FR Doc. 99–19629 Filed 7–27–99; 4:02 pm]

BILLING CODE 6820–MA–M

NUCLEAR REGULATORY COMMISSION

[NUREG–1600, Revision 1]

Policy and Procedure for NRC Enforcement Actions; Interim Enforcement Policy Regarding Enforcement Discretion for Nuclear Power Plants During the Year 2000 Transition

AGENCY: Nuclear Regulatory Commission.

ACTION: Policy statement; amendment.

SUMMARY: The Nuclear Regulatory Commission (NRC) is amending its ''General Statement of Policy and Procedure for NRC Enforcement Actions,'' NUREG–1600, Revision 1 (Enforcement Policy), by adding Appendix E. This amendment adds an interim enforcement policy that the NRC will follow to exercise enforcement discretion for noncompliance with license conditions, including technical specifications (TSs), because of year 2000 (Y2K) related situations.

DATES: This action is effective August 30, 1999. Comments on this revision should be submitted within 30 days of publication in the **Federal Register** and will be considered by the NRC prior to the next Enforcement Policy revision.

ADDRESSES: Submit written comments to David L. Meyer, Chief, Rules and Directives Branch, Division of Administrative Services, Office of Administration, Mail Stop T–6 D59, U.S. Nuclear Regulatory Commission, Washington, DC 20555–0001. Hand deliver comments to 11555 Rockville Pike, Rockville, Maryland, between 7:30 a.m. and 4:15 p.m., Federal workdays. Copies of comments received may be examined at the NRC Public Document Room, 2120 L Street, NW, (Lower Level), Washington, DC.

FOR FURTHER INFORMATION CONTACT: Richard Wessman, Deputy Director, Division of Engineering, 301–415–3298, or Allen Hansen, Lead Project Manager, Division of Licensing, Project Management, 301–415–1390, Office of Nuclear Reactor Regulation, U.S. Nuclear Regulatory Commission, Washington, D.C. 20555–0001.

SUPPLEMENTARY INFORMATION:

Background

Y2K-related events arise from a date-related problem that is experienced by a software system, a software application, or a digital device at a key rollover date when the system, application, or device does not perform its intended function. The key rollover dates are January 1, 2000; February 29, 2000 (an uncommon leap day); and December 31, 2000 (the 366th day of an uncommon leap year). The nuclear utility industry is engaged in Y2K readiness programs at all nuclear power plant facilities to seek out and correct Y2K-related problems that have any potential to adversely affect facility operations.

Y2K concerns result from licensees' reliance upon:

(1) Software to schedule maintenance and technical specification surveillances;

(2) Programmable logic controllers and other commercial off-the-shelf software and hardware;

(3) Digital process control systems;

(4) Software to support facility operation;

(5) Digital systems for collection of operating data; and

(6) Digital systems to monitor post-accident plant conditions.

It is recognized that in spite of every reasonable effort by licensees to identify and correct Y2K computer system problems at their facilities, some software, applications, equipment, and systems may remain susceptible to the problem. Additionally, software, data, and systems external to the facility could adversely affect the facility (for example, interruption of communications or partial loss of offsite power).

The electricity production and delivery systems, as two of the more important elements of the North American economic and social infrastructure, must remain dependable during Y2K transition or rollover periods. Most other critical elements of the infrastructure depend on the availability of an interconnected, stable, and reliable supply of electrical power. There is no doubt that cascading or even localized outages of generators and transmission facilities could have serious short-term and long-term consequences.

Continued safe operation of nuclear power plants during Y2K transition or rollover periods will play a major role in maintaining stable and reliable electrical power supply systems, providing necessary reserve power if there are major losses at other generating facilities. The NRC staff is issuing interim guidance on the process for the NRC to exercise enforcement discretion in certain situations where power reactor licensees encounter Y2K-associated compliance problems in the Y2K transition period (December 31, 1999, through the first few days of 2000) or in other key rollover periods. The exercise of enforcement discretion may support a licensee decision to keep the

plant in operation, if the licensee has determined that safety will not be unacceptably affected, in order to help maintain electrical grid stability and reliability. The NRC Headquarters Operations Center and the NRC Region IV Incident Response Center will have staff augmented during the key transition from December 31, 1999, to January 1, 2000, to ensure that appropriate actions can be taken for any regulatory issues that arise.

Scope

This interim enforcement policy provides for the exercise of enforcement discretion to address noncompliance with license conditions, including TSs, because of Y2K transition or rollover issues. The interim enforcement policy applies to situations in which plant operation is needed to help maintain the stability and reliability of the electrical power supply system, even when license conditions, including TSs, would require a plant shutdown. If such situations occur, licensees are expected to follow the existing guidance in NRC Inspection Manual Part 9900 for Notices of Enforcement Discretion <http://www.nrc.gov/NRC/IM/noed.html> to the maximum extent practicable, particularly regarding a safety determination and notification of NRC. Licensees may decide to continue operations upon making a determination that it is safe and prudent to do so to help maintain electrical grid stability and reliability, and when certain criteria are met. This enforcement discretion does not extend to situations in which the licensee may be unable to communicate with the NRC. (The staff assessment of telecommunications capability indicates that a loss of all telecommunications between NRC and licensees is highly unlikely.)

To the extent noncompliance was involved, the NRC staff will normally take enforcement action for the root causes that led to the noncompliance for which enforcement discretion was used. Enforcement action will also be considered in those cases in which incorrect or incomplete information was provided to the NRC staff by a licensee in its justification. The NRC recognizes that a licensee will need to exercise judgement in making a determination under this discretion provision. Consistent with the NRC's position involving 10 CFR 50.54(x), enforcement action for a violation of a license condition, including a TS, will not be taken unless a licensee's action was clearly unreasonable considering all the relevant circumstances. Enforcement action could include the assessment of civil penalties and the issuance of orders.

Paperwork Reduction Act Statement

This interim policy statement does not contain a new or amended information collection requirement subject to the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*). Existing requirements were approved by the Office of Management and Budget, approval number 3150–0136.

Public Protection Notification

If a means used to impose an information collection does not display a currently valid OMB control number, the NRC may not conduct or sponsor, and a person is not required to respond to, the information collection.

The NRC is revising the NRC Enforcement Policy by adding Appendix E to read as follows:

General Statement of Policy and Procedure for NRC Enforcement Actions

* * * * *

Appendix E: Interim Enforcement Policy Regarding Enforcement Discretion for Nuclear Power Plants During the Year 2000 Transition

This appendix sets forth the interim enforcement policy that will govern the exercise of enforcement discretion by the NRC staff when licensees of operating nuclear power plants find it necessary to deviate from license conditions, including technical specifications (TSs), in those cases in which year 2000 (Y2K) related complications would otherwise require a plant shutdown that could adversely affect the stability and reliability of the electrical power grid. This policy does not extend to situations in which a licensee may be unable to communicate with the NRC.

The policy is effective August 30, 1999 and will remain in effect through January 1, 2001. This policy only applies during Y2K transition or rollover periods (December 31, 1999, through January 3, 2000; February 28, 2000, through March 1, 2000; and December 30, 2000, through January 1, 2001). During these periods, a licensee may contact the NRC Headquarters Operations Center and seek NRC enforcement discretion with regard to the potential noncompliance with license conditions, including TSs, if the licensee has determined that:

(a) Complying with license conditions, including TSs, in a Y2K-related situation would require a plant shutdown;

(b) Continued plant operation is needed to help maintain a reliable and stable grid; and

(c) Any decrease in safety as a result of continued plant operation is small (considering both risk and deterministic aspects), and reasonable assurance of public health and safety, the environment, and security is maintained with the enforcement discretion.

Licensees are expected to follow the existing guidance as stated in NRC Inspection Manual Part 9900 for Notices of Enforcement Discretion to the maximum extent practicable, particularly regarding a safety determination and notification of NRC. A licensee seeking NRC enforcement discretion must provide a written justification, or in circumstances in which good cause is shown, an oral justification followed as soon as possible by written justification. The justification must document the need and safety basis for the request and provide whatever other information the NRC staff needs to make a decision regarding whether the exercise of discretion is appropriate. The NRC staff may grant enforcement discretion on the basis of balancing the public health and safety or common defense and security of not operating against potential radiological or other hazards associated with continued operation, and a determination that safety will not be unacceptably affected by exercising the discretion. The Director of the Office of Nuclear Reactor Regulation, or designee, will advise the licensee whether the NRC has approved the licensee's request and, if so, will subsequently confirm the exercise of discretion in writing. Enforcement discretion will only be exercised if the NRC staff is clearly satisfied that the action is consistent with protecting public health and safety and is warranted in the circumstances presented by the licensee.

If the volume of requests to the NRC Headquarters Operations Center is such that the NRC staff cannot review and approve all licensee requests in a timely fashion, the NRC staff will obtain the safety-significant information from the licensee to enable the NRC staff to make a prompt initial assessment. Unless the assessment is unfavorable, the licensee would be permitted to proceed with its planned course of action. The NRC staff will complete these assessments as time permits and the licensee will be advised of the results orally, if possible, and then in writing. If the NRC staff's prompt initial assessment or subsequent assessment determines that a licensee's actions raise safety concerns, the licensee would be so informed. The licensee would then be required to follow its license conditions, including TSs.

If there are communications difficulties between the licensee and the NRC, the licensee is encouraged to interact with the NRC inspector onsite who will have a dedicated satellite telephone. The inspector should be able to facilitate communication with the NRC Headquarters Operations Center and/or the NRC Regional Incident Response Centers (IRCs). If communication with the NRC Headquarters Operations Center is not possible, then the licensee should contact the IRC in NRC Region IV to discuss enforcement discretion. Similarly, if the Region IV IRC cannot be reached, then the licensee should attempt to contact the Region I, II and III IRCs. Although it is considered highly unlikely, if communication with NRC is not possible, the licensee should follow the plant license conditions, including technical specifications.

In conducting its assessments, the licensee should follow, to the extent practicable, the guidance in NRC Inspection Manual Part 9900 for Notices of Enforcement Discretion.

Contrary to Part 9900 Section B.3 guidance, it is not necessary for an emergency to be declared by a government entity. Licensees are encouraged to contact NRC early in their evaluation process, particularly if time is of the essence, even though complete information as specified in Part 9900 may not be available.

The decision to exercise enforcement discretion does not change the fact that the licensee will be in noncompliance nor does it imply that enforcement discretion is being exercised for any noncompliance that may have led to the noncompliance at issue. To the extent noncompliance was involved, the NRC staff will normally take enforcement action for the root causes that led to the noncompliance for which enforcement discretion was granted. Enforcement action will also be considered in those cases in which incorrect or incomplete information was provided to the NRC staff by a licensee in its justification. The NRC recognizes that a licensee will need to exercise judgement in making a determination under this discretion provision. Consistent with the NRC's position involving 10 CFR 50.54(x), enforcement action for a violation of a license condition, including a TS, will not be taken unless a licensee's action was clearly unreasonable considering all the relevant circumstances. Enforcement action could include assessment of civil penalties and the issuance of orders.

Dated at Rockville, Maryland, this 26th day of July, 1999.

For the Nuclear Regulatory Commission.

Annette L. Vietti-Cook,

Secretary of the Commission.

[FR Doc. 99–19574 Filed 7–29–99; 8:45 am]

BILLING CODE 7590–01–P

POSTAL SERVICE

Privacy Act of 1974, System of Records

AGENCY: Postal Service.

ACTION: Notice of new system of records.

SUMMARY: This document publishes notice of a new Privacy Act system of records, USPS 050.070, Finance Records-Funds Transaction/Transfer Reports. The new system contains personal information about the purchaser and/or recipient of money orders, wire transfer, and/or stored value cards purchased in any combination totaling $3,000 or more during the same visit or multiple visits in 1 business day to the post office.

DATES: Any interested party may submit written comments on the proposed new system of records. This proposal will become effective without further notice on September 8, 1999, unless comments received on or before that date result in a contrary determination.

ADDRESSES: Written comments on this proposal should be mailed or delivered to Administration and FOIA, United States Postal Service, 475 L'Enfant Plaza SW, Washington, DC 20260–5202. Copies of all written comments will be available at the above address for public inspection and photocopying between 8 a.m. and 4:45 p.m., Monday through Friday.

FOR FURTHER INFORMATION CONTACT: Rubenia Carter (202) 268–4872.

SUPPLEMENTARY INFORMATION: The Postal Service will collect and maintain information about some of its customers to meet one of the requirements of the Bank Secrecy Act. That law is designed to detect and deter money laundering. The intent of the law is to require banks and money services businesses to obtain, maintain, and/or report to the Department of Treasury certain identifying information about individuals who purchase financial instruments at a certain dollar threshold. The Postal Service is named as an entity that must comply with that law (31 U.S.C. 5325 and 5330). The Postal Service will maintain information collected from the purchaser when the dollar amount of cash purchases totals $3,000 or more for money orders, wire transfers, and/or stored value cards. Multiple purchases during 1 business day totaling $3,000 or more must be treated as one purchase, and information about the purchaser must be obtained if a Postal Service employee knows or has reason to believe that multiple purchases are being made. The Postal Service is establishing this grouping of records as a system of records subject to the Privacy Act.

Maintenance of these records is not expected to have a significant impact on individual privacy rights. Information will be kept in a secured environment, with automated data processing physical and administrative security and technical software applied to information on computer media. Computer and hard copy records are maintained in a secured computer complex, with physical, administrative, and software controls. Access to areas within the complex where these records are maintained is restricted with card keys. Access within the area is further restricted to authorized personnel with an official need.

Pursuant to 5 U.S.C. 552a(e)(11), interested persons are invited to submit written data, views, or arguments on this proposal. A report of the following proposed system has been sent to Congress and to the Office of Management and Budget for their evaluation.

USPS 050.070

SYSTEM NAME:

Finance Records-Funds Transaction/Transfer Reports.

SYSTEM LOCATION:

Finance, Headquarters and St. Louis Accounting Service Center, St. Louis, Missouri.

CATEGORIES OF INDIVIDUALS COVERED BY THE SYSTEM:

Postal Service customers who purchase money orders, wire transfers, and/or stored value cards purchased in any combination totaling $3,000 or more during the same visit or multiple visits in 1 business day to the post office. Recipients of wire transfers and the beneficiary of funds from money orders totaling $10,000 or more during the same visit or multiple visits in 1 business day to the post office.

CATEGORIES OF RECORDS IN THE SYSTEM:

Name, address, social security number, date of birth, photo ID, type and amount of transactions, driver's license number (or other type of ID if driver's license is not available, such as Alien Registration Number, Passport Number, Military ID, Tax Identification Number), country code, date of issue, transaction number, place of issue, beginning and ending money order serial numbers, and wire transfer number or other transaction number.

AUTHORITY FOR MAINTENANCE OF THE SYSTEM:

31 U.S.C. 5325 and 5330.

PURPOSE(S):

The information will be used to obtain and maintain identifying information on Postal Service customers who purchase money orders, wire transfers, and/or stored value cards totaling $3,000 or more.

ROUTINE USES OF RECORDS MAINTAINED IN THE SYSTEM, INCLUDING CATEGORIES OF USERS AND THE PURPOSE OF SUCH USES:

General routine use statements a, b, c, d, e, f, g, h, and j listed in the prefatory statement at the beginning of the Postal Service's published system notices apply to this system. Other routine uses follow:

1. Information may be disclosed to the U.S. Department of Treasury, the U.S. Justice Department, and federal law enforcement agencies pursuant to the provisions of the Federal Bank Secrecy Act, as codified in section 5313 of Title 31 of the U.S. Code.

2. Information from this system may be disclosed to a foreign entity under agreement with the Postal Service to distribute money orders and transfer funds.

3. Information from this system may be disclosed to the purchaser or payee of a money order or money transfer in order to respond to an inquiry concerning the transaction.

POLICIES AND PRACTICES FOR STORING, RETRIEVING, ACCESSING, RETAINING, AND DISPOSING OF RECORDS IN THE SYSTEM:

STORAGE:

Paper and computer storage media.

RETRIEVABILITY:

By name and other unique identifier.

SAFEGUARDS:

Hard copy records and computers containing information within this system of records are maintained in a building with controlled access. To gain access to the building and access to controlled areas within the building, individuals must have authorized badges and/or card keys. Computer systems are protected within an installed security software package, the use of computer LOG-ON IDs, and operating system controls.

RETENTION AND DISPOSAL:

PS Form 8105–A will be destroyed either by shredding, burning, or other acceptable method of destruction 5 years from the end of accounting period in which they were created. Related automated information will be retained for the same period and purged from the system quarterly after the date of creation.

SYSTEM MANAGER(S) AND ADDRESS:

Chief Financial Officer, Finance, United States Postal Service, 475 L'Enfant Plaza SW, Washington DC 20260–5000.

NOTIFICATION PROCEDURE:

Individuals wanting to know whether information about them is maintained in this system of records must address inquiries in writing to the system manager. Inquiries must contain the name, address, and social security number or other identifying number (driver's license, Alien Registration Number, Passport Number, etc.) of purchaser; and the recipient's name and address of wire transfer transaction.

RECORD ACCESS PROCEDURES:

Requests for access must be made in accordance with the Notification Procedure above and the Privacy Act regulations regarding access to records and verification of identity under 39 CFR 266.6.

CONTESTING RECORD PROCEDURES:

See Notification Procedure and Record Access Procedures above.

RECORD SOURCE CATEGORIES:

Information is obtained from purchaser and, for wire transfer transaction information, is obtained from purchaser and recipient.

Stanley F. Mires,

Chief Counsel, Legislative.

[FR Doc. 99–19466 Filed 7–29–99; 8:45 am]

BILLING CODE 7710–12–P

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–41641; File No. SR–CBOE–99–31]

Self-Regulatory Organizations; Notice of Filing and Immediate Effectiveness of Proposed Rule Change and Amendment No. 1 Thereto by the Chicago Board Options Exchange, Incorporated Relating to the Administration of DBOE Rule 8.95(f)

July 22, 1999.

Pursuant to Section 19(b)(1) of the Securities Exchange Act of 1934 (''Act''),[1] and Rule 19b–4 thereunder,[2] notice is hereby given that on June 23, 1999, the Chicago Board Options Exchange, Incorporated (''CBOE'' or ''Exchange'') filed with the Securities and Exchange Commission (''Commission'') a proposed rule change. The Exchange submitted Amendment No. 1 to its proposed rule change on July 1, 1999.[3] The proposed rule change, as amended, is described in Items I, II, and III below, which Items have been prepared by the Exchange. The Commission is publishing this notice to solicit comments on the proposed rule change from interested persons.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

The Exchange proposes to adopt an Interpretation and Policy pertaining to the administration of DBOE Rule 8.95(f). The text of the proposed rule change is as follows. New text is italicized.

Allocation of Securities and Location of Trading Crowds and DPMs

Rule 8.95 No Change.

* * * *Interpretations and Policies:*

.01–.02 No change.

.03 trading crowd may indicate that it no longer wishes to trade an option class opened for trading prior to May 1, 1987, for purposes of paragraph (f) of Rule 8.95 by means of a voting procedure as described in this Interpretation and Policy. Members of a trading crowd eligible to participate in the vote shall include those market-makers and floor brokers who have transacted at least 80% of their market-maker contracts (in the case of market-makers) or orders (in the case of floor brokers) in each of the three immediately preceding calendar months in option classes traded in the trading crowd, and who continue to be present in the trading crowd in the capacity of a market maker or floor broker at the time of the vote. Eligible market-makers and floor brokers shall each have one vote, and shall vote together as a single class. A trading crowd shall be deemed to have indicated that it no longer wishes to trade a designated option class if a majority of the trading crowd participates in the vote and if a majority of the total votes cast are in favor of the proposition. Any member of a trading crowd eligible to vote on whether the crowd wishes to trade an option class may request that such a vote be held by submitting a written request to that effect to the Secretary of the Exchange. The Exchange shall post a notice at the trading station of the time and date of any vote to be taken for purposes of Rule 8.95(f) at least 24 hours prior to the time of the vote. The Allocation Committee or Special Product Assignment Committee, as applicable shall determine all other administrative procedures pertaining to the vote.

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, CBOE included statements concerning the purposes of, and basis for, the proposed rule change and discussed any comments it received on the proposed rule change. The text of these statements may be examined at the places specified in Item IV below. The CBOE has prepared summaries, set forth in Sections A, B, and C below, of the most significant aspects of such statements.

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[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

[3] In Amendment No. 1, the Exchange made two technical corrections to its proposed rule language to conform the text of the rule language to its current rule and clarified that the Allocation Committee or Special Product Assignment Committee, as applicable, administers CBOE Rule 8.95(f). *See* Letter from Arthur B. Reinstein, Assistant General Counsel, CBOE, to Terri Evans, Attorney, Division of Market Regulation, Commission, dated June 30, 1999 (''Amendment No. 1'').

A. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

1. Purpose

CBOE Rule 8.95(f) permits a trading crowd to indicate that it no longer wishes to trade an option class opened for trading prior to May 1, 1987, in which event the Exchange's Allocation Committee or Special Product Assignment Committee, as applicable,[4] may reallocate the class to another trading crowd or to a Designated Primary Market-Marker. The purpose of proposed Interpretation and Policy 8.95.03 is to adopt procedures for the administration of CBOE Rule 8.95(f) that specify how a trading crowd may manifest an indication that it no longer wishes to trade a class of options for purposes of that rule.

Two procedural aspects of the administration of CBOE Rule 8.95(f) are embodied in proposed Interpretation and Policy 8.95.03. The first is to define who constitutes a trading crowd for purposes of the rule, and the second is to adopt voting procedures to be used for purposes of determinations made under the rule. Proposed Interpretation and Policy 8.95.03 provides that members of a trading crowd for purposes of CBOE Rule 8.95(f) are those market-makers and floor brokers who have transacted at least 80% of their market-maker contracts (in the case of market-makers) or orders (in the case of floor brokers) in each of the three immediately preceding calendar months in option classes traded at that trading crowd's station, and who continue to be present in the trading crowd in the capacity of a market maker or floor broker at the time of the vote. These provisions are intended to ensure that determinations made under CBOE Rule 8.95(f) will be made by those members who are currently engaged as market-makers or floor brokers in the trading crowd, and who have concentrated their activity in the trading crowd over the last three months.

The proposed Interpretation and Policy also provides that a crowd will be deemed to have indicated that it no longer wishes to trade an option class only if (i) the question is put to a vote of the members of the trading crowd, (ii) a majority of the members of the trading crowd participate in the vote, and (iii) a majority of the votes cast are in favor of not wanting to continue to trade the class. At least 24 hours posted notice to the trading crowd of the time and date of the vote is required before a vote may take place. These voting procedures are substantially the same as those set forth in CBOE Rule 2.40(d) concerning recommendations of a market-maker surcharge under that rule, except that a specified quorum requirement and a longer (90-day) eligibility period for participation in the vote are provided under Interpretation and Policy 8.95.03 in light of the greater significance to a trading crowd of a determination not to continue to trade a class of options. In other respects, the Allocation Committee or Special Product Assignment Committee, as applicable, shall determine administrative procedures for conducting the vote.[5]

2. Statutory Basis

Proposed Interpretation and Policy 8.95.03 is consistent with and in furtherance of the objectives of Section 6(b)(5) of the Act[6] in that it is designed to promote just and equitable principles of trade and to remove impediments to and perfect the mechanisms of a free and open market, because it will provide fair and orderly procedures for the administration of CBOE Rule 8.95(f).

B. Self-Regulatory Organization's Statement on Burden on Competition

CBOE does not believe that the proposed rule change will impose any burden on competition not necessary or appropriate in furtherance of the purposes of the Act.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants or Others

The Exchange has neither solicited nor received written comments with respect to the proposed rule change.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

The foregoing rule change constitutes a stated policy, practice, or interpretation with respect to the meaning, administration, or enforcement of an existing rule of the Exchange, and therefore, has become effective pursuant to Section 19(b)(3)(A)(i) of the Act[7] and paragraph (f)(1) of Rule 19b–4.[8] At any time within 60 days of the filing of such proposed rule change, the Commission may summarily abrogate such rule change if it appears to the Commission that such action is necessary or appropriate in the public interest, for the protection of investors, or otherwise in furtherance of the purposes of the Act.

IV. Solicitation of Comments

Interested persons are invited to submit written data, views and arguments concerning the foregoing, including whether the proposed rule change is consistent with the Act. Persons making written submissions should file six copies thereof with the Secretary, Securities and Exchange Commission, 450 Fifth Street, N.W., Washington, D.C. 20549–0609. Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for inspection and copying in the Commission's Public Reference Room in Washington, D.C. Copies of such filing will also be available for inspection and copying at the principal office of the Exchange. All submissions should refer to File No. SR–CBOE–99–31 and should be submitted by August 20, 1999.

For the Commission, by the Division of Market Regulation, pursuant to delegated authority.[9]

Margaret H. McFarland,

Deputy Secretary.

[FR Doc. 99–19490 Filed 7–29–99; 8:45 am]

BILLING CODE 8010–01–M

[4] *Id.*

[5] *See* Amendment No. 1, *supra* note 3.

[6] 15 U.S.C. 78f(b(5).

[7] 15 U.S.C. 78s(b)(3)(A)(i).

[8] 17 CFR 240.19b–4(f)(1).

[9] 17 CFR 200.30–3(a)(12)

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–41647; File No. SR–NASD–98–61]

Self-Regulatory Organizations; National Association of Securities Dealers, Inc.; Order Granting Approval to Proposed Rule Change Relating to Reporting Transactions in Exchange-Listed Securities

July 23, 1999.

I. Introduction

On August 12, 1998, the National Association of Securities Dealers, Inc. (''NASD'' or ''Association''), through its wholly-owned subsidiary, Nasdaq Stock Market, Inc. (''Nasdaq''), filed with the Securities and Exchange Commission (''SEC'' or ''Commission''), pursuant to Section 19(b)(1) of the Securities Exchange Act of 1934 (''Exchange Act''

or ''Act'')[1] and Rule 19b–4 thereunder,[2] a proposed rule change to eliminate an unnecessary provision of an NASD rule relating to the reporting of transactions in exchange-listed securities traded in the third market.

The proposed rule change was published for comment in Exchange Act Release No. 40360 (August 25, 1998), 63 FR 46267 (August 31, 1998). No comments were received on the proposal.[3] This order approves the proposed rule change.

II. Description

The NASD proposes to eliminate an unnecessary provision of its rules applicable to the reporting of transactions in exchange-listed securities. Specifically, NASD Rule 6420(d)(3)(A), which is the general rule requiring NASD members to report all principal transactions in exchange-listed securities in the third market, currently contains language requiring members to report transactions in a manner ''reasonably related to the prevailing market taking into considerations all relevant circumstances * * *.'' Although this provision accompanied a change to the trade reporting rules approved in 1980 (which was intended to make comparable the reporting of third market trades with exchange transactions), Nasdaq believes that this particular language is superfluous in the context of exchange-listed securities and does not serve any meaningful purpose with respect to the trade reporting of these securities.

Nasdaq believes that the language has served only to promote the misperception that the rule provides flexibility in the manner in which NASD members may report third market transactions. The rule was intended to require third market trades to be reported on a ''gross'' basis, exclusive of any mark-up or mark-down charged to the customer.[4] Nasdaq believes that this has led to inaccurate trade reporting, and has been used by ITS Participants[5] as a reason for not extending the NASD's Intermarket Trading System/Computer Assisted Execution System (''ITS/CAES'') link to all exchange-listed securities. Accordingly, Nasdaq believes that the best practice would be to remove the unclear language from the rule.

III. Discussion

The Commission finds that the proposed rule change is consistent with the requirements of the Act and the rules and regulations thereunder applicable to the Association and, in particular, with the requirements of Section 15A(b)(6).[6] Section 15A(b) requires that the rules of the association be designed to prevent fraudulent and manipulative acts and practices, to promote just and equitable principles of trade, to foster cooperation and coordination with persons engaged in regulating, clearing, settling, processing information with respect to, and facilitating transactions in securities, to remove impediments to and perfect the mechanism of a free and open market and a national market system, and, in general, to protect investors and the public interest; and are not designed to permit unfair discrimination between customers, issuers, brokers, and dealers.[7]

The Commission also finds that the proposed rule change is consistent with Section 11A of the Act.[8] Specifically, the Commission finds that the proposed rule change should facilitate the further development of the National Market System by eliminating any confusion regarding the trade reporting responsibilities of third market makers.

Prior to July 1980, the NASD required that third market makers report transactions to the tape at the ''net'' price to the customer—that is, inclusive of mark-ups, mark-downs, commission equilavents, or service charges (collectively, ''charges''). In contrast, exchange rules have always required a trade to be reported to the tape at the ''gross'' transaction price—that is, exclusive of charges. In July 1980, the Commission approved an NASD rule change providing that members would be required to report transactions to the tape exclusive of charges. The NASD's rule also allowed members to report prices ''reasonably related to the market, taking into consideration all relevant circumstances. * * *''

The NASD's proposed rule change deletes the ''reasonably related to the market'' language. The Commission believes that the proposed rule change clarifies that third market makers will no longer have the perceived latitude to determine the price at which exchange-listed securities transactions are reported. The proposed rule change further promotes the comparability of transaction prices reported in the consolidated system and improves the manner in which transaction prices are disclosed to public investors.

The Commission notes that the ITS Participants have expressed concern that the perceived lack of comparability between the trade reporting requirements in the third market and those in the exchange markets results in disparate prices and obligations regarding the protection of quotations under the ITS Trade-Through Rule and Block Policy.[9] The Participants note that the

[1] 15 U.S.C. 78s (b)(1).

[2] 17 CFR 240.19b–4.

[3] Although the Commission did not receive any comments on this specific proposed rule change, the Chicago Stock Exchange (''CHX'') submitted a comment letter on the Commission's proposal to expand the Intermarket Trading System linkage to all listed securities. The CHX's letter questioned the practical effect of the NASD's proposed rule change. Specifically, CHX questioned whether the NASD's proposed rule change truly eliminated the discretionary nature of the current rule. *See* Letter to Jonathan G. Katz, Secretary, Commission, from Robert H. Forney, President and Chief Executive Officer, CHX, dated August 28, 1998. The NASD responded in December 1998. *See* Letter to Jonathan G. Katz, Secretary, Commission, from Richard G. Ketchum, President and Chief Operating Officer, NASD, dated December 17, 1998.

[4] *See* Exchange Act Release No. 16960 (July 7, 1980), 45 FR 47291 (July 14, 1980) (approving SR–NASD–80–03).

[5] ITS is a communications and order routing network linking eight national securities exchanges and the electronic over-the-counter market operated by the NASD. ITS was designated to facilitate intermarket trading in exchange-listed equity securities based on current quotation information emanating from the linked markets. The NASD's computer assisted execution system (''CAES'') enables participating firms to route their orders for listed securities through ITS to obtain executions against quotations of third market makers participating in Nasdaq. The ITS/CAES interface allows participant exchanges and Nasdaq market makers to route commitments to other participant exchange markets for execution.

Participants to the ITS Plan include the American Stock Exchange LLC, the Boston Stock Exchange, Inc., the Chicago Board Options Exchange, Inc., the CHX, the Cincinnati Stock Exchange, Inc., the NASD, the New York Stock Exchange, Inc. (''NYSE''), the Pacific Exchange, Inc., and the Philadelphia Stock Exchange, Inc. (collectively, ''Participants'').

[6] 15 U.S.C. 78o–3(b)(6).

[7] *See* 15 U.S.C. 78o–3. In approving this rule change, the Commission notes that it has considered the proposal's impact on efficiency, competition, and capital formation, consistent with Section 3 of the Act. *Id.* at 78c(f).

[8] 15 U.S.C. 78k–1.

[9] *See, e.g.,* CHX letter; Letter to Jonathan G. Katz, Secretary Commission, from James E. Buck, Senior Vice President and Secretary, NYSE, dated August 31, 1998 (comment letter to File No. 4–208, Exchange Act Release No. 40260 (July 24, 1998), 63 FR 40748 (July 30, 1998) nn.63, 67) (''NYSE letter'').

A ''trade-through'' occurs when a transaction is effected at a price below the best bid, or above the best prevailing offer. The ITS Trade-Through Rule requires that members of ITS Participant markets avoid initiating a trade-through when purchasing or selling, either as principal or agent, any ITS security on the Participant market or when sending a commitment to trade through ITS. The ITS Block Trade Policy provides that the member who represents a block-size order(s) shall, at the time of execution of the block trade, send, or cause to be sent, through ITS to each participating ITS market center displaying a bid (or offer) superior to the execution price, a commitment to trade at the execution price and for the number of shares displayed with that market center's better-priced bid (or offer). This policy is intended to enable

Continued

price at which a transaction is reported to the Consolidated Tape System determines whether or not a member in one Participant market who has displayed a better bid or offer within the linked ITS market is entitled to satisfaction as a consequence of an inferior priced transaction reported to the tape in another market. The ITS Participants believe that the current NASD trade reporting rule, containing the ''reasonably related to the market'' provision, provides latitude to NASD members to report a price to the tape different from the execution price confirmed to customers, thereby creating the potential to avoid the Trade-Through Rule.

In its letter to the Commission, CHX asserts that the NASD's proposed rule change does not address the discretionary nature of the NASD's current trade reporting rule because it ''would merely eliminate the standard articulating how to calculate the markup or markdown.'' The NASD responds that it ''fails to see the relevance of the argument that a third market maker could avoid a trade-through by reporting a price within the national best bid and offer while providing a different price to its customer, when that difference must be disclosed to the customer and assessed as a cost of trading on the same basis as any other charge or commission.'' [10] The NASD further disagrees with the CHX's assertion that the NASD's proposed rule change limits the value of a trade-through rule. CHX argues that a market maker's discretion to report a trade at a prevailing market price at the time of the trade, as long as the customer is made aware of the difference between the reported price and the net price (the markup), enables a market maker to avoid a trade-through. In response, the NASD states that its trade reporting rule emphasizes the value of a trade-through rule by encouraging market participants to provide an execution at a better price than the national best bid or offer. The NASD further believes that such an execution would be ''exactly comparable with orders executed on an exchange where the reported price does not include the broker's commission.'' [11]

The Commission finds that eliminating the ''reasonably related to the market'' language helps to clarify the NASD's trade reporting rule. As the NYSE stated, removal of the ''reasonably related to the prevailing market'' language would resolve its long-standing concern [12] with the trade reporting issue.[13] Furthermore, effective surveillance and confirmation disclosure of the charges to the customer should help to enforce these trade reporting obligations.[14] Specifically, in the event a broker-dealer is acting as principal in a transaction in a reporting security, the confirmation disclosure rule, Exchange Act Rule 10b–10, requires a broker-dealer to disclose to a customer the trade price reported to the Consolidated Tape, the net price to the customer in the transaction, and the difference, if any, between the reported price and the price to the customer. If a broker-dealer is acting as agent for a customer, the member must confirm to the customer the gross trade price (which is the price reported to the Consolidated Tape), and the commission equivalent as well as the net price to the customer.

IV. Conclusion

It is therefore ordered, pursuant to Section 19(b)(2) of the Act,[15] that the proposed rule change (SR–NASD–98–61) is approved.

For the Commission, by the Division of Market Regulation, pursuant to delegated authority.[16]

Margaret H. McFarland,

Deputy Secretary.

[FR Doc. 99–19488 Filed 7–29–99; 8:45 am]

BILLING CODE 8010–01–M

other markets to derive the benefit of the block without breaking it up.

[10] *See* NASD letter.

[11] *See* NASD letter.

[12] *See, e.g.,* Letter to Jonathan G. Katz, Secretary, Commission, from James E. Buck, Senior Vice President and Secretary, NYSE, dated June 25, 1997.

[13] *See* NYSE letter.

[14] *See* Exchange Act Release No. 18713 (May 6, 1982), 47 FR 20413, 20415 n.13 (May 12, 1982).

[15] 15 U.S.C. 78s(b)(2).

[16] 17 CFR 200.30–3(a)(12).

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–41646; File No. SR–Phlx–99–21]

Self-Regulatory Organizations; Notice of Filing and Immediate Effectiveness of Proposed Rule Change by the Philadelphia Stock Exchange, Inc. To Establish Fees for Transactions Executed Through the Volume Weighted Average Price (''VWAP'') Trading System (''VTS'')

July 23, 1999.

Pursuant to Section 19(b)(1) of the Securities Exchange Act of 1934 (''Act''),[1] and Rule 19b–4 thereunder,[2] notice is hereby given that on June 28, 1999, the Philadelphia Stock Exchange, Inc. (''Exchange'' or ''Phlx'') filed with the Securities and Exchange Commission (''Commission'') the proposed rule change as described in Items I, II, and III below, which Items have been prepared by the Exchange. The Commission is publishing this notice to solicit comments on the proposed rule change form interested persons.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

The Commission recently approved the Exchange's proposal to operate the Volume Weighted Average Price (''VWAP''®) Trading System (''VTS''™) [3] as a facility of the Exchange.[4] The VTS will provide a daily pre-opening order matching session for the execution of large stock orders at the VWAP. The Exchange now proposes to establish a fee schedule for trades executed through the VTS.

The text of the proposed rule change is available at the Office of the Secretary, the Exchange, and at the Commission.

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, the Exchange included statements concerning the purpose of and basis for the proposed rule change and discussed any comments it received on the proposed rule change. The text of these statements may be examined at the places specified in Item IV below. The Exchange has prepared summaries, set forth in sections A, B, and C below, of the most significant aspects of such statements.

A. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

1. Purpose

On March 24, 1999, the Exchange received Commission approval to operate the VTS as a facility of the Exchange. The VTS will provide a daily pre-opening order matching session for the execution of large stock orders at the VWAP. Approximately 300 of the most highly capitalized and highly liquid equity securities that are listed on the New York Stock Exchange will be

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

[3] VWAP is a registered trademark of the Universal Trading Technologies Corporation (''UTTC''). The VTS™ is the property of UTTC.

[4] *See* Securities Exchange Act Release No. 41210 (Mar. 24, 1999), 64 FR 15857 (Apr. 1, 1999) (''VTS Approval Order''). The approval is effective for a 1 year pilot period.

eligible for matching during the pre-opening session. During the pre-opening session, the VTS will electronically match orders for execution at the VWAP according to the algorithm developed by the Universal Trading Technologies Corporation. The matched and executed orders will be assigned a final VWAP after the close of regular trading.

As a facility of the Exchange, the VTS will operate using Exchange equipment and personnel, allow Exchange floor traders to participate, and rely upon the Stock Clearing Corporation of Philadelphia (''SCCP'') to process VTS trades.[5] Matches performed during the pre-opening session will be regulated and reported as Exchange trades. Further details regarding the operation of the VTS appear in the VTS Approval Order and Exchange Rule 237, ''The Universal Trading System Morning Session,'' which governs the operation of VTS.

The Exchange now proposes to adopt fees for trades executed through the VTS. Although trades executed on behalf of VTS users will result in transaction fees, it is only Exchange member firms and clearing firms that will be billed and held responsible for paying the fees. Thus, the transaction fees resulting from a VTS user's trading activity will be billed to the Exchange member or clearing firm through which the VTS orders were routed. Although the transaction fees vary primarily according to the ultimate user that receives trade execution through the VTS (*e.g*, retail customer, specialist, Exchange member), they also depend on the type of trade (*e.g.*, cross versus non-cross), and the annual volume of VTS trading activity. The proposed fee schedule is as follows:

- Institutional user and retail customer user (non-cross trades):

1 share to 10 million shares per year: $0.02 per share
>10 million to 20 million shares per year: $0.015 per share
>20 million shares per year: $0.01 per share

- Institutional user and retail customer user (cross trades):

Intra-firm: $0.005 per share[6]
Inter-firm: $0.01 per share

- Non-member/non-institutional user: $0.015 per share.
- Specialist or alternate specialist Committer: No charge.
- Member off-floor liquidity provider: $0.01 per share.
- Member user (not enrolled as Committer): $0.01 per share.

Under the proposal, the fees for non-cross trades executed on behalf of a institutional user[7] or retail customer user[8] will be predicated upon the aggregate number of shares that such institutional user or retail customer user trades annually through VTS. In calculating the number of shares that each user trades through the VTS, the Exchange shall always treat January 1 as the start of the year. For the first 10 million shares traded per year, the fee will be $.02 per share. For more than 10 million shares up to 20 million shares per year, the fee will be $.015 per share. For greater than 20 million shares per year, the fee be $.01 per share.[9] These volume discount thresholds will be prorated based upon a user's enrollment date.[10] The Exchange believes that reducing fees for increased trading volume should help attract order flow to the VTS.

With respect to cross orders[11] for institutional users and retail customer users, the Exchange proposes to charge $.005 per side, per share, for intra-firm crosses and $.01 per share for inter-firm crosses.[12] The trade volume of users' cross orders (inter-firm and intra-firm cross orders) will not be counted toward the volume aggregations applicable to non-cross orders.

Trades for non-member/non-institutional users[13] will be assessed fees of $.015 per share. Trades for specialist and alternate specialist Committers[14] will not be charged transaction fees for VTS trades. Trades for the other type of Committer—Exchange members who serve as off-floor liquidity providers—will be charged $.01 per share. Lastly, trades for member users who are not enrolled as Committers will be assessed fees of $.01 per share.

Although Exchange members will be billed for the VTS trades of their customer users, no other separate fee shall apply to members acting as brokers. This practice is similar to other fee arrangements currently employed by the Exchange, including the assessment of fees for equity option transactions.[15]

2. Statutory Basis

The Exchange believes that the proposed rule change is consistent with Section 6(b)(4) of the Act[16] in that it provides for the equitable allocation of reasonable fees and other charges among members using VTS. The Exchange further believes that the proposed fee schedule is reasonable and will help attract order flow to VTS.

B. Self-Regulatory Organization's Statement on Burden in Competition

The Exchange believes that the proposed rule change will not impose any inappropriate burden on competition.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants or Others

The Exchange did not solicit or receive written comments with respect to the proposed rule change.

[5] The SCCP has filed a separate proposal with the Commission to establish fees for the trade recording and confirmation services that SCCP will provide for VTS trades. *See* File No. SR–SCCP–99–02.

[6] Intra-firm cross trades refer to cross trades where the identified contra-sides are from the same firm. Because the same firm is on both sides of an intra-firm cross trade, the $.005 per share fee applies to each side, thus totaling $.01 per share.

[7] An institutional user is an entity not registered as a broker-dealer or doing business as a hedge fund (*i.e.*, private investment pool), but one that serves in a fiduciary capacity. Such entities include, but are not limited to: qualified pension plans, investment companies registered under the Investment company Act of 1940, bank trust departments, corporations that purchase securities for corporate purposes, and insurance companies. *See* Exchange Rule 237(c)(v).

[8] The level of fees will not affect the manner in which orders are matched pursuant to the UTTC matching algorithm. *See* Exchange Rule 237(e).

[9] The Exchange's billing system monitors users' VTS transaction volume on an aggregate and ongoing basis. Therefore, discounts are immediately applied toward any VTS transaction volume that exceeds the discount thresholds. Telephone conversation between Michael L. Loftus, Attorney, Division of Market Regulation, Commission, and Nandita Yagnik, Counsel, Exchange, on July 8, 1999.

[10] For example, if a new user enrolled on July 1, the volume discount thresholds would be reduced by 50% because 50% of the year would have expired. Thus, the user's trades would generate transaction fees of $.02 for the first five million shares matched, $.015 for matches greater than 5 million shares up to 10 million shares, and $.01 for matches over 10 million shares.

[11] A cross order is a two-sided order with both sides comprised of non-member interest, with instructions to match the identified buy-side with the identified sell-side. The two sides making up the cross can be entered separately, with the contra-side identified. *See* Exchange Rule 237(d)(i)(C).

[12] Inter-firm cross orders refer to cross orders where the identified contra-sides are from different firms.

[13] The non-member/non-institutional user category includes non-member broker-dealers.

[14] ''Committers'' are Exchange members who agree to provide contra-side liquidity on a proprietary basis. Committers are required to provide a minimum volume guarantee of 2,500 shares for each side of the market. Committer status is restricted to Exchange members that are: (i) Phlx floor traders, Phlx specialists, or Phlx alternate specialists; or (ii) off-floor liquidity providers. Specialists and alternate specialists may act as Committers only in their specialty issues. *See* Exchange Rule 237(c)(i). A more thorough description and discussion of order types, classes of users, and conditions to access appear in Exchange Rule 237 and the VTS Approval Order.

[15] *See* Securities Exchange Act Release No. 41317 (Apr. 21, 1999), 64 FR 23144 (Apr. 29, 1999).

[16] 15 U.S.C. 78f(b)(4).

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

Because the foregoing proposed rule change establishes a due, fee, or charge imposed by the Exchange, it has become effective upon filing pursuant to Section 19(b)(3)(A) of the Act[17] and Rule 19b–4(f)(2) thereunder.[18] At any time within 60 days of the filing of the proposed rule change, the Commission may summarily abrogate such rule change if it appears to the Commission that such action is necessary or appropriate in the public interest, for the protection of investors, or otherwise in furtherance of the purposes of the Act.[19]

IV. Solicitation of Comments

Interested persons are invited to submit written data, views, and arguments concerning the foregoing, including whether the proposed rule change is consistent with the Act. Persons making written submissions should file six copies thereof with the Secretary, Securities and Exchange Commission, 450 Fifth Street, N.W., Washington, D.C. 20549–0609. Copies of the submissions, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any persons, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for inspection and copying in the Commission's Public Reference Section, 450 Fifth Street, N.W., Washington, D.C. 20549. Copies of such filing will also be available for inspection and copying at the principal office of the Exchange. All submissions should refer to File No. SR–Phlx–99–21 and should be submitted by August 20, 1999.

For the Commission, by the Division of Market Regulation, pursuant to delegated authority.[20]

Margaret H. McFarland,

Deputy Secretary.

[FR Doc. 99–19489 Filed 7–29–99; 8:45 am]

BILLING CODE 8010–01–M

[17] 15 U.S.C. 78s(b)(3)(A).

[18] 17 CFR 240.19b–4(f)(2).

[19] In reviewing this proposed rule change, the Commission has considered the proposal's impact on efficiency, competition and capital formation. 15 U.S.C. 78c(f)

[20] 17 CFR 200.30–3(a)(12).

SMALL BUSINESS ADMINISTRATION

Reporting and Recordkeeping Requirements Under OMB Review

AGENCY: Small Business Administration.

ACTION: Notice of reporting requirements submitted for OMB review.

SUMMARY: Under the provisions of the Paperwork Reduction Act (44 U.S.C. Chapter 35), agencies are required to submit proposed reporting and recordkeeping requirements to OMB for review and approval, and to publish a notice in the **Federal Register** notifying the public that the agency has made such a submission.

DATES: Submit comments on or before August 30, 1999. If you intend to comment but cannot prepare comments promptly, please advise the OMB Reviewer and the Agency Clearance Officer before the deadline.

COPIES: Request for clearance (OMB 83–1), supporting statement, and other documents submitted to OMB for review may be obtained from the Agency Clearance Officer.

ADDRESSES: Address all comments concerning this notice to: Agency Clearance Officer, Jacqueline White, Small Business Administration, 409 3rd Street, SW, 5th Floor, Washington, DC 20416; and OMB Reviewer, Office of Information and Regulatory Affairs, Office of Management and Budget, New Executive Office Building, Washington, D.C. 20503.

FOR FURTHER INFORMATION CONTACT: Jacqueline White, Agency Clearance Officer, (202) 205–7044.

SUPPLEMENTARY INFORMATION:

Title: U.S. Small Business Administration's Application Survey.

Form No.: 1843.

Frequency: On Occasion.

Description of Respondents: Person's seeking employment with SBA.

Annual Responses: 75.

Annual Burden: 13.

Dated: July 22, 1999.

Jacqueline White,

Chief, Administrative Information Branch.

[FR Doc. 99–19480 Filed 7–29–99; 8:45 am]

BILLING CODE 8025–01–P

DEPARTMENT OF STATE

[Delegation of Authority No. 145–16]

Redelegation of Responsibilities and Functions of the U.S. Arms Control and Disarmament Agency to the Department of State

By virtue of the authority vested in me as Secretary of State, including section 1 of the State Department Basic Authorities Act, as amended (22 U.S.C. 2651), and the Chemical Weapons Convention Implementation Act of 1998 and the Foreign Affairs Reform and Restructuring Act of 1998 (as contained in Pub. L. 105–277), section 1(a) of State Department Delegation of Authority No. 145 of February 4, 1980 (45 FR 11655), as amended, is hereby further amended:

(1) By inserting at the end thereof the following new subsections:

''(13) The functions conferred on the Secretary by the Chemical Weapons Convention Implementation Act of 1998 (as contained in Pub. L. 105–277).

''(14) The functions that, before the effective date described in section 1201 of the Foreign Affairs Reform and Restructuring Act of 1998 (as contained in Pub. L. 105–277) were vested in the United States Arms Control and Disarmament Agency, including any functions conferred on the Director or any officer or employee of that agency, and that, pursuant to the provisions of the Act (including amendments made by that Act), are now conferred on the Secretary.''; and

(2) By striking the word ''Affairs'' following the phrase ''Under Secretary for Arms Control and International Security''.

This delegation shall be published in the **Federal Register.**

Dated: July 21, 1999.

Madeleine K. Albright,

Secretary of State.

[FR Doc. 99–19612 Filed 7–29–99; 8:45 am]

BILLING CODE 4710–10–M

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

Notice of Intent To Request Renewal From the Office of Management and Budget (OMB) of a Current Public Collection of Information

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Notice.

SUMMARY: In compliance with the Paperwork Reduction Act (44 U.S.C. 3501 *et seq.*), the FAA invites public comment on a currently approved public information collection which will be submitted to OMB for renewal.

DATES: Comments must be received on or before September 28, 1999.

ADDRESSES: Comments may be mailed or delivered to the FAA at the following address: Ms. Judith Street, Room 612, Federal Aviation Administration, Standards and Information Division, APF–100, 800 Independence Ave., SW., Washington, DC 20591.

FOR FURTHER INFORMATION CONTACT: Ms. Judith Street at the above address or on (202) 267–9895.

SUPPLEMENTARY INFORMATION: The FAA solicits comments on the following current collection of information in order to evaluate the necessity of the collection, the accuracy of the agency's estimate of the burden, the quality, utility, and clarity of the information to be collected, and possible ways to minimize the burden of the collection. Following is a short synopsis of the currently approved public information collection activity, which will be submitted to OMB for review and renewal: 2120–0007, Flight Engineers and Flight Navigators. This information collection is necessary to determine applicant eligibility for flight engineer or flight navigator certificates. The information is also to determine training course acceptability for those schools training flight engineers or navigators. The respondents are an approximate 2700 people applying for flight engineer or flight navigator certificates, and approximately 25 flight engineer schools.

Issued in Washington, DC, on July 23, 1999.

Patricia W. Carter,

Acting Manager, Standards and Information Division, APF–100.

[FR Doc. 99–19623 Filed 7–29–99; 8:45 am]

BILLING CODE 4910–13–M

DEPARTMENT OF TRANSPORTATION

Federal Highway Administration

Environmental Impact Statement: Lawrence County, Ohio and Greenup County, Kentucky

AGENCY: Federal Highway Administration (FHWA), DOT.

ACTION: Notice of intent.

SUMMARY: The FHWA is issuing this notice to advise the public that an Environmental Impact Statement will be prepared for transportation improvements proposed in Lawrence County, Ohio and Greenup County, Kentucky.

FOR FURTHER INFORMATION CONTACT: Scott McGuire, Field Operations Engineer, Federal Highway Administration, 200 North High Street, Room 328, Columbus, Ohio 43215, Telephone: (614) 280–6852.

SUPPLEMENTARY INFORMATION: The FHWA, in cooperation with the Ohio Department of Transportation, will prepare an Environmental Impact Statement (EIS) on a proposal to replace the Ironton-Russell Bridge (93C) across the Ohio River and connecting the two communities of Ironton, Ohio and Russell, Kentucky.

The purpose of the transportation improvement is to replace the structurally deficient and functionally obsolete bridge with a facility that meets current design standards while providing safe and efficient travel opportunity. Actions under consideration include (1) replacement of the existing facility on the existing alignment, (2) replacement on an adjacent location and (3) taking no action.

Letters describing the proposed action and soliciting comments will be sent to appropriate Federal, State and local agencies and to private organizations and citizens who have previously expressed or are known to have interest in this proposal. A series of public meetings will be held in the project area. On August 19, 1999 the preliminary corridors under consideration will be presented to the public and, in the year 2000, a public meeting will be held to obtain input on a preferred alignment. A Public Hearing will be held and may also take place in the year 2000. Public notice will be given of the exact time and place of the meetings and the hearing to be held for the project. The Draft EIS will be available for public and agency review and comment prior to the Public Hearing. No formal scoping meeting is planned at this time.

To ensure that the full range of issues related to this proposed action are addressed and all significant issues identified, comments, and suggestions are invited from all interested parties. Comments or questions concerning this proposed action or the EIS should be directed to the FHWA at the address provided above.

(Catalog of Federal Domestic Assistance Program Number 20.205, Highway Planning and Construction. The regulations implementing Executive Order 12372 regarding intergovernmental consultation on Federal programs and activities apply to this program.)

Issued on: July 26, 1999.

Scott A. McGuire,

Field Operations Engineer, Federal Highway Administration, Columbus, Ohio.

[FR Doc. 99–19581 Filed 7–29–99; 8:45 am]

BILLING CODE 4910–22–P

DEPARTMENT OF TRANSPORTATION

Federal Highway Administration

[FHWA Docket No. FHWA–99–5880]

Hours of Service of Drivers; Exemption Application From Hulcher Services, Inc.

AGENCY: Federal Highway Administration (FHWA), DOT.

ACTION: Notice of application for exemption and intent to deny exemption; request for comments.

SUMMARY: The FHWA is announcing its preliminary determination to deny the application of Hulcher Services, Inc. (Hulcher) for an exemption from the maximum driving time limitations in the Federal Motor Carrier Safety Regulations (FMCSRs). Hulcher requested an exemption because it believes the current requirements interfere with the efficiency and effectiveness of the company's core business, emergency and disaster response to railroad accidents. The FHWA intends to deny the exemption because Hulcher did not explain how it would ensure that it could achieve a level of safety that is equivalent to, or greater than, the level of safety that would be obtained by complying with the hours-of-service regulations. Also, Hulcher did not describe the impacts (e.g., inability to test innovative safety management control systems, etc.) it could experience if the exemption is not granted by the FHWA. The exemption, if granted, would preempt inconsistent State and local requirements applicable to interstate commerce.

DATES: Comments must be received on or before August 30, 1999.

ADDRESSES: Submit written, signed comments to FHWA Docket No. FHWA–99–5880, the Docket Clerk, U.S. DOT Dockets, Room PL–401, 400 Seventh Street, SW., Washington, DC 20590–0001. All comments received will be available for examination at the above address from 9 a.m. to 5 p.m., e.t., Monday through Friday, except Federal holidays. Those desiring notification of receipt of comments must include a self-addressed, stamped envelope or postcard.

FOR FURTHER INFORMATION CONTACT: Mr. Larry W. Minor, Office of Motor Carrier Research and Standards, HMCS–10, (202) 366–4009; or Mr. Charles E. Medalen, Office of the Chief Counsel, HCC–20, (202) 366–1354, Federal Highway Administration, 400 Seventh Street, SW., Washington, D.C. 20590–0001. Office hours are from 7:45 a.m. to 4:15 p.m., e.t., Monday through Friday, except Federal holidays.

SUPPLEMENTARY INFORMATION:

Electronic Access

Internet users may access all comments that were submitted to the Docket Clerk, U.S. DOT Dockets, Room PL–401, 400 Seventh Street, SW., Washington, DC 20590–0001, in response to previous rulemaking notices concerning the docket referenced at the beginning of this notice by using the universal resource locator (URL): *http://dms.dot.gov*. It is available 24 hours each day, 365 days each year. Please follow the instructions online for more information and help.

An electronic copy of this document may be downloaded using a modem and suitable communications software from the Government Printing Office's Electronic Bulletin Board Service at (202) 512–1661. Internet users may reach the Office of the Federal Register's home page at *http://www.nara.gov/fedreg* and the Government Printing Office's database at: *http://www.access.gpo.gov/nara*.

Background

On June 9, 1998, the President signed the Transportation Equity Act for the 21st Century (TEA–21) (Public Law 105–178, 112 Stat. 107). Section 4007 of TEA–21 amended 49 U.S.C. 31315 and 31136(e) concerning the Secretary of Transportation's (the Secretary's) authority to grant exemptions from the FMCSRs for a person(s) seeking regulatory relief from those requirements. An exemption may be granted for no longer than two years from its approval date, and may be renewed upon application to the Secretary. The Secretary must provide the public with an opportunity to comment on each exemption request prior to granting or denying the exemption.

The TEA–21 requires the FHWA to publish a notice in the **Federal Register** for each exemption requested, explaining that the request has been filed, and providing the public with an opportunity to inspect the safety analysis and any other relevant information known to the agency, and to comment on the request. Prior to granting a request for an exemption, the agency must publish a notice in the **Federal Register** identifying the person or class of persons who will receive the exemption, the provisions from which the person will be exempt, the effective period, and all terms and conditions of the exemption. The terms and conditions established by the FHWA must ensure that the exemption will likely achieve a level of safety that is equivalent to, or greater than, the level that would be achieved by complying with the regulation.

On December 8, 1998, the FHWA published an interim final rule implementing section 4007 of TEA–21 (63 FR 67600). The regulations at 49 CFR part 381 establish the procedures persons must follow to request waivers and to apply for exemptions from the FMCSRs, and the procedures the FHWA will use to process the requests for waivers and applications for exemptions.

Hulcher's Application for an Exemption

Hulcher applied for an exemption from 49 CFR 395.3, which provides requirements concerning the maximum driving time for drivers of commercial motor vehicles (CMVs). A copy of the application is in the docket identified at the beginning of this notice. Generally, under the current regulations drivers may not drive more than 10 hours following eight consecutive hours off duty, or for any period after being on duty (this includes all driving time, and all time spent working, but not driving) for 15 hours following eight consecutive hours off duty. In addition, drivers may not drive after being on duty 60 hours in any seven consecutive days if the employing motor carrier does not operate CMVs every day of the week (60-hour rule), or after being on duty 70 hours in any eight consecutive days if the employing motor carrier operates CMVs every day of the week (70-hour rule). Hulcher requested an exemption to all these requirements. If such an exemption is not possible, the company asked that the FHWA consider allowing its drivers a 24-hour restart for the 70-hour rule—after 24 consecutive hours off-duty, the driver would be allowed to drive a CMV irrespective of the number of days used to accumulate the previous 70-hours on-duty.

Hulcher is a business that provides assistance in restoring rail service after train accidents, including hazardous materials incidents. The company responds to emergencies, makes necessary repairs to tracks and switches, and lifts locomotives and rail cars back onto the tracks. Its equipment is maintained and staged strategically throughout the United States in order to respond quickly and efficiently to railroad emergencies. The company claims that its average movement of equipment and personnel is less than 200 miles. Hulcher states:

> The company's dilemma concerns, the interpretation by the company, of the requirement of [49 CFR 395.3]. The company's heavy equipment operators, and laborers, who are CDL qualified, and who would occasionally operate a CMV, maintain a daily record of duty status. These personnel are performing daily activities other than operating a CMV, and not necessarily associated with a CMV. The company's practice has been to record hours worked daily as, on duty not driving, in a driver's daily log. The duties being performed are no different from the duties of a heavy equipment mechanic. A mechanic whose daily job function, and classification, is to maintain the equipment at a company owned location and, on occasion, if CDL qualified, may be needed to operate a CMV. The mechanic would not be required to maintain a drivers daily log record, but would be accountable for seven days prior plus the day he would be operating a CMV. Because of this company's current practice to record a duty status of all hours of every day, available hours of service have been significantly reduced, when needed to respond to an emergency. These personnel may go for days or weeks, without operating a CMV, but may report daily to a company owned facility. These personnel are relieved from duty daily for at least fifteen hours while at these locations. In the event, our operators and laborers have been operating heavy equipment at an emergency scene, they are still showing a daily record of duty status as ''on duty not driving.'' Once the job is finished, and prior to transporting the equipment back to it's staged location, all heavy equipment operators, and laborers, who will be operating a CMV, for the return trip, will be housed at a motel or other accommodations in order that they be rested before operating the CMV. Several of these personnel may have exhausted all available hours of service during this job. In order to comply with the requirements of [49 CFR 395.3], they will need to stay off duty up to an additional two days before regaining available hours. These operators and laborers can not possibly be more rested after forty-eight or more hours off duty, and away from home, than after having been off duty for at least twenty-four hours and returning home, and being placed off duty. The company, and its Managers, will not allow a fatigued individual to operate any company owned vehicle, and or equipment.

Hulcher submitted information on its ''Safety Recognition Program'' which is intended to reward employees who have been successful in preventing both accidents and injuries. One point (each point has a cash value) is earned for each month that an employee works without having a ''chargeable'' accident or injury. If the employee has a chargeable accident or injury he or she loses points (two points per accident or injury). Bonus points may be earned based on the number of consecutive months or years the employee works without an incident, and based on the performance of the employee's division. The information provided does not show any discernible linkage between the recognition program and compliance with safety regulations or company guidelines.

Basis for Preliminary Determination to Deny the Exemption

The FHWA has carefully reviewed Hulcher's application for an exemption to the maximum driving time regulation and its alternate request for the use of a 24-hour restart to the 70-hour rule, and does not believe there is scientific or safety-performance data to support granting either request. Hulcher has failed to explain how it would ensure that it could achieve a level of safety that is equivalent to, or greater than, the level of safety that would be obtained by complying with the hours-of-service regulations. Also, Hulcher did not describe the impacts (e.g., inability to test innovative safety management control systems, etc.) it could experience if the exemption is not granted by the FHWA. Although Hulcher argues that regulatory relief is necessary to respond to disasters and emergencies, there is no discussion of specific disasters or emergencies the company has been unable to respond to because of compliance with the hours-of-service regulations. The FHWA does not believe that an exemption granted under the authority of section 4007 of the TEA–21 is necessary for motor carriers to obtain regulatory relief to respond to legitimate emergencies.

The FMCSRs include an emergency relief exemption (49 CFR 390.23) from almost all of the FMCSRs, including the hours-of-service requirements, for any motor carrier or driver operating a CMV to provide relief during an emergency (as defined [1] in 49 CFR 390.5) subject to certain limitations. For regional emergencies, the emergency relief exemption is effective when an emergency has been declared by the President, the governor of a State, or their authorized representatives having authority to declare emergencies; or certain officials in one of the FHWA's Resource Centers have declared that a regional emergency exists which justifies an exemption from parts 390 through 399. In the case of local emergencies, the exemption is effective when an emergency has been declared by a Federal, State or local government official having authority to declare an emergency; or certain officials in one of the FHWA's Resource Centers have declared that a local emergency exists which justifies an exemption from parts 390 through 399 of the FMCSRs.

The motor carrier or driver is subject to the requirements of parts 390 through 399 upon termination of direct assistance to the regional or local emergency relief effort. Direct assistance ends when a driver or CMV is used in interstate commerce to transport cargo not destined for the emergency relief effort, or when the motor carrier dispatches the driver or CMV to another location to begin operations in commerce. When the driver has been relieved of all duty and responsibilities after providing direct assistance to a regional or local emergency relief effort, the driver may not operate a CMV in commerce until all the requirements of § 395.3 are met and, the driver has had at least 24 consecutive hours off-duty when the driver has operated in excess of the 60-or 70-hour rules.

Hulcher has not explained why the current emergency relief exemption is not sufficient for the incidents to which they typically respond. Also, Hulcher has not provided an explanation of what it considers an emergency or disaster. The FHWA does not believe that the mere fact that a train accident occurs automatically constitutes an emergency necessitating regulatory relief from the hours-of-service rules. The exemption from all of the hours-of-service limits, as requested by Hulcher, provides no specific terms or conditions that could be evaluated by the agency beforehand to ensure that an acceptable level of safety would likely be achieved, nor does it offer a means to monitor the safety performance of Hulcher's drivers. Under these circumstances, it would be inappropriate to consider granting the request.

With regard to Hulcher's alternate request to use a 24-hour restart to the 70-hour rule, the FHWA is not aware of any research that would support such an exemption. The agency proposed allowing a 24-hour restart for all motor carriers in 1992 (57 FR 37504; August 19, 1992). Nearly 68,000 comments were received in response to the 1992 notice of proposed rulemaking. Virtually no substantive information was presented in these comments to support a change in the regulations. Except in very general terms, the FHWA received little discussion of potential impacts on highway safety that could result from increasing the available on-duty hours. The FHWA, therefore, declined to make the proposed changes to the rule and, on February 3, 1993 (58 FR 6937), withdrew the proposal and closed the docket.

On November 5, 1996 (61 FR 57252), the FHWA published an advance notice of proposed rulemaking (ANPRM) on all aspects of the hours-of-service regulations. The agency indicated that it was nearing the completion of several research projects and was seeking the results of other relevant research to consider in revising the hours-of-service regulations. To assist the FHWA in gathering all pertinent data to make informed decisions based upon scientific evidence, the FHWA requested assistance in locating any other relevant information, including research, operational tests, or pilot regulatory programs conducted anywhere in the world, that may be used by the agency in developing a revised regulatory scheme for CMV drivers' hours of service. The agency has reviewed all the research reports submitted by commenters to the rulemaking docket, and scientific information obtained through other sources, and is not aware of any data that would support granting an exemption to use a 24-hour restart. Copies of all known research reports, as well as all comments submitted in response to the ANRPM, are available in FHWA Docket No. FHWA–97–2350.

The FHWA recognizes that Hulcher provides an important service needed to restore rail service after an accident or incident, but does not believe it is necessary to grant either a blanket exemption to the hours-of-service regulations or allow a 24-hour restart to the 70-hour rule. There are no reported instances of the hours-of-service regulations preventing Hulcher from responding to a legitimate emergency or a disaster.

Moreover, the FHWA has considered Hulcher's safety recognition program and does not believe it is relevant to the application. Based on the information submitted by Hulcher, drivers are rewarded for not having ''chargeable'' accidents or injuries or penalized for having such occurrences. The FHWA does not consider this to be an acceptable alternative to complying with well-defined, enforceable terms and conditions that the agency could attempt to evaluate during the period of the exemption.

Request for Comments

In accordance with 49 U.S.C. 31315 and 31136(e), the FHWA is requesting public comment from all interested persons on the exemption application

[1] Emergency means any hurricane, tornado, storm (e.g., thunderstorm, snowstorm, icestorm, blizzard, sandstorm, etc.), high water, wind-driven water, tidal wave, tsunami, earthquake, volcanic eruption, mud slide, drought, forest fire, explosion, blackout or other occurrence, natural or man-made, which interrupts the delivery of essential services (such as, electricity, medical care, sewer, water, telecommunication transmissions) or essential supplies (such as, food and fuel) or otherwise immediately threatens human life or public welfare, provided such hurricane, tornado, or other event results in: a declaration of an emergency by the President, the governor of a State, or their authorized representatives; or by certain officials in one of the FHWA's resource centers near the location in which the emergency occurs; or by other Federal, State, or local government officials having authority to declare emergencies.

from Hulcher. All comments received before the close of business on the comment closing date indicated at the beginning of this notice will be considered and will be available for examination in the docket at the location listed under the address section of this notice. Comments received after the comment closing date will be filed in the public docket and will be considered to the extent practicable, but the FHWA may deny the exemption at any time after the close of the comment period. In addition to late comments, the FHWA will also continue to file, in the public docket, relevant information that becomes available after the comment closing date. Interested persons should continue to examine the public docket for new material.

Authority: 49 U.S.C. 31136 and 31315; and 49 CFR 1.48.

Issued on: July 22, 1999.

Kenneth R. Wykle,

Federal Highway Administrator.

[FR Doc. 99–19463 Filed 7–29–99; 8:45 am]

BILLING CODE 4910–22–P

DEPARTMENT OF TRANSPORTATION

Surface Transportation Board

[STB Finance Docket No. 33784]

Penn Virginia Corporation—Continuance in Control Exemption—Kanawha Rail Corp.

Penn Virginia Corporation (Penn Virginia) has filed a notice of exemption to continue in control of the Kanawha Rail Corp. (Kanawha),[1] upon Kanawha's becoming a Class III railroad.

The transaction is scheduled to be consummated on July 29, 1999, the effective date of the exemption (7 days after the notice of exemption was filed).

This transaction is related to STB Finance Docket No. 33783, *Kanawha Rail Corp.—Acquisition and Operation Exemption—Winifrede Railroad Company*, wherein Kanawha seeks to acquire and operate approximately 6.47 miles of rail line together with associated rail properties from the Winifrede Railroad Company.

Penn Virginia indirectly exercises control over the Powell River Railroad Company (PRR). PRR is wholly owned by the Powell River Railroad Corporation (PRCC). PRCC, in turn, is wholly owned by Penn Virginia.

Penn Virginia states that: (i) the rail line to be operated by Kanawha does not connect with the PRR (the only other railroad controlled by Penn Virginia); (ii) the transaction is not part of a series of anticipated transactions that would connect Kanawha with the PRR; and (iii) the transaction does not involve a Class I carrier. Therefore, the transaction is exempt from the prior approval requirements of 49 U.S.C. 11323. *See* 49 CFR 1180.2(d)(2).

Under 49 U.S.C. 10502(g), the Board may not use its exemption authority to relieve a rail carrier of its statutory obligation to protect the interests of its employees. Section 11326(c), however, does not provide for labor protection for transactions under sections 11324 and 11325 that involve only Class III rail carriers. Because this transaction involves Class III rail carriers only, the Board, under the statute, may not impose labor protective conditions for this transaction.

If the notice contains false or misleading information, the exemption is void *ab initio*. Petitions to revoke the exemption under 49 U.S.C. 10502(d) may be filed at any time. The filing of a petition to revoke will not automatically stay the transaction.

An original and 10 copies of all pleadings, referring to STB Finance Docket No. 33784, must be filed with the Surface Transportation Board, Office of the Secretary, Case Control Unit, 1925 K Street, N.W., Washington, DC 20423–0001. In addition, a copy of each pleading must be served on Kelvin J. Dowd, Esq., Slover & Loftus, 1224 Seventeenth Street, N.W., Washington, DC 20036.

Board decisions and notices are available on our website at ''WWW.STB.DOT.GOV.''

Decided: July 23, 1999.

By the Board, David M. Konschnik, Director, Office of Proceedings.

Vernon A. Williams,

Secretary.

[FR Doc. 99–19560 Filed 7–29–99; 8:45 am]

BILLING CODE 4915–00–P

[1] Kanawha was formerly known as Penn Virginia Resources Marketing Corporation.

DEPARTMENT OF TRANSPORTATION

Surface Transportation Board

[STB Finance Docket No. 33783]

Kanawha Rail Corp.—Acquisition and Operation Exemption—Winifrede Railroad Company

Kanawha Rail Corp. (Kanawha),[1] a noncarrier, has filed a verified notice of exemption under 49 CFR 1150.31 to acquire from Winifrede Railroad Company and operate approximately 6.47 miles of rail trackage in Kanawha County, WV (subject line), together with associated rail properties. The subject line extends from its northern terminus at an interchange with CSX Transportation, Inc., at CSX Station 670+30, south along Fields Creek, in Cabin Creek District, to its southern terminus.

Kanawha reports that it intends to consummate the transaction upon the effective date of the exemption. The earliest the transaction can be consummated is July 29, 1999 (7 days after the exemption was filed).

This transaction is related to STB Finance Docket No. 33784, *Penn Virginia Corporation—Continuance in Control Exemption—Kanawha Rail Corp.*, wherein Penn Virginia Corporation has concurrently filed a verified notice to continue in control of Kanawha upon its becoming a Class III rail carrier.

If the verified notice contains false or misleading information, the exemption is void *ab initio*. Petitions to reopen the proceeding to revoke the exemption under 49 U.S.C. 10502(d) may be filed at any time. The filing of a petition to revoke will not automatically stay the transaction.

An original and 10 copies of all pleadings, referring to STB Finance Docket No. 33783, must be filed with the Surface Transportation Board, Office of the Secretary, Case Control Unit, 1925 K Street, N.W., Washington, DC 20423–0001. In addition, a copy of each pleading must be served on Kelvin J. Dowd, Esq., Slover & Loftus, 1224 Seventeenth Street, N.W., Washington, DC 20036.

Board decisions and notices are available on our website at ''WWW.STB.DOT.GOV.''

Decided: July 23, 1999.

By the Board, David M. Konschnik, Director, Office of Proceedings.

Vernon A. Williams,

Secretary.

[FR Doc. 99–19559 Filed 7–29–99; 8:45 am]

BILLING CODE 4915–00–P

[1] Kanawha was formerly known as Penn Virginia Resources Marketing Corporation.

DEPARTMENT OF THE TREASURY

General Counsel Designation No. 241; Appointment of Members to the Legal Division Performance Review Board

Under the authority granted to me as General Counsel of the Department of the Treasury by 31 U.S.C. 301 and 26 U.S.C. 7801, Treasury Department Order No. 101–5 (Revised), and pursuant to the Civil Service Reform Act, I hereby appoint the following individuals to the Legal Division Performance Review Board:

(1) For the General Counsel Panel—
Kenneth R. Schmalzbach, Acting Deputy General Counsel, who shall serve as Chairperson
Roberta K. McInerney, Assistant General Counsel (Banking & Finance);
Stephen J. McHale, Assistant General Counsel (Enforcement);
Russell L. Munk, Assistant General Counsel (International Affairs);
Rochelle F. Granat, Acting Assistant General Counsel (General Law & Ethics);
Francine J. Kerner, Deputy Assistant General Counsel (Enforcement);
Marilyn L. Muench, Deputy Assistant General Counsel (International Affairs);
Eleni Constantine, Deputy Assistant General Counsel (Banking & Finance);
John J. Manfreda, Chief Counsel, Bureau of Alcohol, Tobacco & Firearms;
Elizabeth B. Anderson, Chief Counsel, United States Customs Service; and
Walter Eccard, Chief Counsel, Bureau of Public Debt.

(2) For the Internal Revenue Service Panel—
Chairperson, Deputy Chief Counsel, IRS;
Deputy General Counsel;
Two Associate Chief Counsel, IRS; and
Two Regional Counsel, IRS.

I hereby delegate to the Chief Counsel of the Internal Revenue Service the authority to make the appointments to the IRS Panel specified in this Designation and to make the publication of the IRS Panel as required by 5 U.S.C. 4314(c)(4).

Neal S. Wolin,

Acting General Counsel.

[FR Doc. 99–19485 Filed 7–29–99; 8:45 am]

BILLING CODE 4810–25–M

DEPARTMENT OF THE TREASURY

Bureau of Alcohol, Tobacco and Firearms

[Notice No. 878]

The Department of the Treasury's Odor Recognition Proficiency Standard for Explosives Detection Canines (99R–235P)

AGENCY: Bureau of Alcohol, Tobacco and Firearms (ATF), Department of the Treasury.

ACTION: Notice of availability.

SUMMARY: The Bureau of Alcohol, Tobacco and Firearms (ATF) is announcing the availability of the Department of the Treasury's Odor Recognition Proficiency Standard for Explosives Detection Canines. The standard has been revised using solicited input and recommendations from other Federal law enforcement agencies that use explosives detection canines. A copy of the standard is available to all interested persons.

ADDRESSES: To receive a copy of the Department of the Treasury's Odor Recognition Proficiency Standard, send a written request, on official law enforcement or government letterhead, to: Chief, Canine Operations Branch, Bureau of Alcohol, Tobacco and Firearms, 650 Massachusetts Avenue, NW., Room 5100, Washington, DC 20226.

FOR FURTHER INFORMATION CONTACT: Rhonda Bokorney, Chief, Canine Operations Branch, Bureau of Alcohol, Tobacco and Firearms, 650 Massachusetts Avenue, NW., Washington, DC 20226 (202–927–8680).

SUPPLEMENTARY INFORMATION:

Background

On September 30, 1996, the Omnibus Consolidated Appropriations Act of 1997, Public Law 104–208, authorized the Secretary of the Treasury to establish a standard for explosives detection canines. Section 653(a) of the Act provides the following:

> Authoritzation.—The Secretary of the Treasury is authorized to establish scientific certification standards for explosives detection canines, and shall provide, on a reimbursable basis, for the certification of explosives detection canines employed by Federal agencies, or other agencies providing explosives detection services at airports in the United States.

The Secretary of the Treasury requested the Bureau of Alcohol, Tobacco and Firearms (ATF) to develop the standard. On September 29, 1997, we published in the **Federal Register** a notice announcing the establishment of an odor recognition proficiency standard for explosives detection canines (Notice No. 97–101; 62 FR 50982). The standard included a minimum odor recognition proficiency test which could be used by agencies that use detection canines. Copies of the odor recognition proficiency standard were available to all interested persons.

In Notice No. 97–101, we also stated that the established odor recognition proficiency standard would be further tested and validated. Prior to its being scientifically validated, the standard was revised using solicited input and recommendations from other Federal law enforcement agencies that use explosives detection canines.

From May 28, 1998, through February 1999, the Oak Ridge National Laboratory, managed by Lockheed Martin Energy Research Corporation for the U.S. Department of Energy, conducted an independent assessment of the validity of the odor recognition proficiency standard. On march 10, 1999, the Laboratory issued a final report that concluded the standard and test are valid for the measure of the proficiency for detecting explosives odors at the recognition and alerting phase of training.

A copy of the revised Department of the Treasury's Odor Recognition Proficiency Standard is available to law enforcement and government agencies.

Authority and Issuance: This notice is issued under the authority in Sec. 653, Pub. L. 104–208, 110 Stat. 3009.

Signed: July 23, 1999.

John W. Magaw,

Director.

[FR Doc. 99–19520 Filed 7–29–99; 8:45 am]

BILLING CODE 4810–31–M

UNITED STATES INFORMATION AGENCY

Notice: Culturally Significant Objects Imported for Exhibition Determinations

AGENCY: United States Information Agency.

SUBJECT: Culturally significant objects imported for exhibition determinations.

ACTION: Notice.

SUMMARY: Notice is hereby given of the following determinations: Pursuant to the authority vested in me by the Act of October 19, 1965 (79 Stat. 985, 22 U.S.C. 2459), Executive Order 12047 of March 27, 1978 (43 FR 13359, March 29, 1978), and Delegation Order No. 85–5 of June 27, 1985 (50 FR 27393, July 2, 1985). I hereby determine that the objects to be included in the exhibit ''The Golden Age of Chinese Archaeology Celebrated Discoveries from the People's Republic of China'' imported from abroad for temporary exhibition without profit within the United States, is of cultural significance. These objects are imported from abroad for temporary exhibition without profit within the United States, is of cultural significance. These objects are imported pursuant to a loan agreement with the foreign lender. I also determine that the exhibition or display of the listed exhibit objects at the National Gallery of Art, Washington, DC from on or about September 19, 1999, to on or about January 2, 2000; at the Museum of Fine Arts, Houston TX, from on or about February 13, 2000 to May 7, 2000; and at the Asian Art Museum of San Francisco, San Francisco, CA, from on or about June 17, 2000, to on or about September 11, 2000, is in the national interest. Public Notice of these determinations is ordered to be published in the **Federal Register**.

FOR FURTHER INFORMATION CONTACT: Paul W. Manning, Assistant General Counsel, 202/619–5997, and the address is Room 700, U.S. Information Agency, 301 4th Street, SW, Washington, DC 20547–0001.

Dated: July 27, 1999.

Les Jin,

General Counsel.

[FR Doc. 99–19603 Filed 7–29–99; 8:45 am]

BILLING CODE 8230–01–M

UNITED STATES INFORMATION AGENCY

Culturally Significant Objects Imported for Exhibition Determination: ''Unseen Treasures: Imperial Russia and the New World''

AGENCY: United States Information Agency.

ACTION: Notice.

SUMMARY: Notice is hereby given of the following determinations: Pursuant to the authority vested in me by the Act of October 19, 1965 (79 Stat. 985, 22 U.S.C. 2459), Executive Order 12047 of March 27, 1978 (43 FR 13359, March 29, 1978), and Delegation Order No. 85–5 of June 27, 1985 (50 FR 27393, July 2, 1985), I hereby determine that the objects to be included in the exhibit, ''Unseen Treasures: Imperial Russia and the New World,'' imported from abroad for the temporary exhibition without profit within the United States, are of cultural significance. These objects are imported pursuant to a loan agreement with the foreign lender. I also determine that the exhibition or display of the listed objects at the New Jersey State Museum, Trenton, NJ, from on or about September 25, 1999, to on or about January 16, 2000, and the Missouri Historical Society, saint Louis, MO, from on or about May 15, 2000, to on or about August 15, 2000, and the Mint Museum of Art, Charlotte, NC, from on or about September 1, 2000, to on or about December 31, 2000, is in the national interest. Public Notice of these determinations is ordered to be published in the **Federal Register**.

FOR FURTHER INFORMATION CONTACT: For a copy of the list of exhibit objects and for further information, contact Ms. Neila Sheahan, Assistant General Counsel, Office of the General Counsel, 202/619–5030. The address is Room 700, U.S. Information Agency, 301 4th Street, SW, Washington, DC 20547–0001.

Dated: July 26, 1999.

Les Jin,

General Counsel.

[FR Doc. 99–19604 Filed 7–29–99; 8:45 am]

BILLING CODE 8230–01–M

federal register

Friday
July 30, 1999

Part II

Department of Health and Human Services

Health Care Financing Administration

42 CFR Parts 412, 413, 483, and 485

Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2000 Rates; Final Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 412, 413, 483, and 485

[HCFA–1053–F]

RIN 0938–AJ50

Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2000 Rates

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

ACTION: Final rule.

SUMMARY: We are revising the Medicare hospital inpatient prospective payment systems for operating costs and capital-related costs to implement changes arising from our continuing experience with the systems. In addition, in the addendum to this final rule, we describe changes in the amounts and factors necessary to determine rates for Medicare hospital inpatient services for operating costs and capital-related costs. These changes are applicable to discharges occurring on or after October 1, 1999. We also set forth rate-of-increase limits as well as policy changes for hospitals and hospital units excluded from the prospective payment systems. Finally, we are revising certain policies governing payment to hospitals for the direct costs of graduate medical education.

DATES: The provisions of this final rule are effective October 1, 1999. This rule is a major rule as defined in Title 5, United States Code, section 804(2). Pursuant to 5 U.S.C. section 801(a)(1)(A), we are submitting a report to Congress on this rule on July 30, 1999.

FOR FURTHER INFORMATION CONTACT:
Steve Phillips, (410) 786–4531, Operating Prospective Payment, Diagnosis-Related Group (DRG), and Wage Index Issues.
Tzvi Hefter, (410) 786–4487, Capital Prospective Payment, Excluded Hospitals, and Graduate Medical Education Issues.

SUPPLEMENTARY INFORMATION:

Availability of Copies and Electronic Access

To order copies of the **Federal Register** containing this document, send your request to: New Orders, Superintendent of Documents, P.O. Box 371954, Pittsburgh, PA 15250–7954. Specify the date of the issue requested and enclose a check or money order payable to the Superintendent of Documents, or enclose your Visa or Master Card number and expiration date. Credit card orders can also be placed by calling the order desk at (202) 512–1800 or by faxing to (202) 512–2250. The cost for each copy is $8.00. As an alternative, you can view and photocopy the **Federal Register** document at most libraries designated as Federal Depository Libraries and at many other public and academic libraries throughout the country that receive the **Federal Register**.

This **Federal Register** document is also available from the **Federal Register** online database through GPO Access, a service of the U.S. Government Printing Office. Free public access is available on a Wide Area Information Server (WAIS) through the Internet and via asynchronous dial-in. Internet users can access the database by using the World Wide Web; the Superintendent of Documents home page address is http://www.access.gpo.gov/nara__docs/, by using local WAIS client software, or by telnet to swais.access.gpo.gov, then login as guest (no password required). Dial-in users should use communications software and modem to call (202) 512–1661; type swais, then login as guest (no password required).

I. Background

A. Summary

Section 1886(d) of the Social Security Act (the Act) sets forth a system of payment for the operating costs of acute care hospital inpatient stays under Medicare Part A (Hospital Insurance) based on prospectively set rates. Section 1886(g) of the Act requires the Secretary to pay for the capital-related costs of hospital inpatient stays under a prospective payment system. Under these prospective payment systems, Medicare payment for hospital inpatient operating and capital-related costs is made at predetermined, specific rates for each hospital discharge. Discharges are classified according to a list of diagnosis-related groups (DRGs).

Certain specialty hospitals are excluded from the prospective payment systems. Under section 1886(d)(1)(B) of the Act, the following hospitals and hospital units are excluded from the prospective payment systems: psychiatric hospitals or units, rehabilitation hospitals or units, children's hospitals, long-term care hospitals, and cancer hospitals. For these hospitals and units, Medicare payment for operating costs is based on reasonable costs subject to a hospital-specific annual limit.

Under section 1886(a)(4) of the Act, costs incurred directly by a hospital in connection with approved graduate medical education (GME) programs are excluded from the operating costs of inpatient hospital services. Hospitals with approved GME programs are paid for the direct costs of GME in accordance with section 1886(h) of the Act; the amount of payment for direct GME costs for a cost reporting period is based on the hospital's number of residents in that period and the hospital's costs per resident in a base year.

The regulations governing the hospital inpatient prospective payment systems are located in 42 CFR part 412. The regulations governing excluded hospitals and hospital units are located in parts 412 and 413, and the GME regulations are located in part 413.

B. Summary of the Provisions of the May 7, 1999 Proposed Rule

On May 7, 1999, we published a proposed rule in the **Federal Register** (64 FR 24716) that set forth proposed changes to the Medicare hospital inpatient prospective payment systems for both operating costs and capital-related costs that would be effective for discharges occurring on or after October 1, 1999. We also proposed changes concerning GME costs and excluded hospitals and units, as well as critical access hospitals (CAHs). On June 15, 1999, we issued a correction notice (64 FR 31995) for the May 7, 1999 proposed rule. That notice corrected Table 3C of the Addendum (which lists each hospital's case-mix index and adjusted average hourly wage based on data on file at HCFA as of February 22, 1999) and made several other technical corrections.

In the proposed rule, we noted that the efforts that we were undertaking to make the Medicare computer systems compliant on January 1, 2000, would not delay our ability to make timely and updated payments to hospitals under the FY 2000 prospective payment systems final rule. This statement still applies and the changes and updated rates set forth in this final rule will be implemented on October 1, 1999.

The following is a summary of the contents of the proposed rule:

- In order to avoid compromising our ability to process and pay hospital claims during the period leading up to and immediately following January 1, 2000, we did not propose to implement any revisions to the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD–9–CM) coding system. We did propose to make some limited changes to certain DRG classifications for FY 2000 and described other proposed decisions

concerning DRGs. We also recalibrated the DRG relative weights based on the proposed DRG changes and updated Medicare claims data.

• We proposed an FY 2000 hospital wage index update, using FY 1996 wage data, and revisions to the wage index based on hospital redesignations. In addition, we proposed to begin excluding from the wage index Part A physician wage costs that are teaching-related, as well as resident and Part A certified registered nurse anesthetist (CRNA) costs.

• We proposed several policy changes in the regulations in 42 CFR parts 412 and 413 and proposed to continue existing policy concerning classifications of sole community hospitals; the indirect medical education adjustment; and Medicare Geographic Classification Review Board (MGCRB) decisions. In addition, we updated the qualifying criteria for rural referral centers and proposed several changes to the regulations governing payments for the direct costs of GME programs.

• We discussed the special exceptions process for certain eligible hospitals to receive additional payments for major construction or renovation projects that began soon after the start of the capital prospective payment system and proposals that we had received to change the eligibility criteria for these payments.

• We discussed a number of proposals concerning Medicare payments to excluded hospitals and hospital units and CAHs. These proposed changes related to limits on and adjustments to the proposed target amounts for FY 2000; changes in bed size or status of excluded hospitals or hospital units; payment for Medicare services furnished at satellite hospital locations; responsibility for care of patients in hospitals-within-hospitals; the allowable emergency response time for CAHs located in frontier or other specifically defined remote areas; and compliance with minimum data set requirements by CAHs with swing bed approval.

• In the addendum to the proposed rule, we set forth proposed changes to the amounts and factors for determining the FY 2000 prospective payment rates for operating costs and capital-related costs. We also addressed update factors for determining the rate-of-increase limits for cost reporting periods beginning in FY 2000 for hospitals and hospital units excluded from the prospective payment system.

• In Appendix A of the proposed rule, we set forth an analysis of the impact that the proposed changes would have on affected entities.

• In Appendix B of the proposed rule, we set forth the technical appendix on the proposed FY 2000 capital cost model.

• In Appendix C of the proposed rule, as required by section 1886(e)(3)(B) of the Act, we set forth our report to Congress on our initial estimate of a recommended update factor for FY 2000 for both hospitals included in and hospitals excluded from the prospective payment systems.

• In Appendix D of the proposed rule, as required by sections 1886(e)(4) and (e)(5) of the Act, we included our recommendation of the appropriate percentage change for FY 2000 for—

—Large urban area and other area average standardized amounts (and hospital-specific rates applicable to sole community hospitals and Medicare-dependent, small rural hospitals) for hospital inpatient services paid for under the prospective payment system for operating costs; and

—Target rate-of-increase limits to the allowable operating costs of hospital inpatient services furnished by hospitals and hospital units excluded from the prospective payment system.

• In the proposed rule, we discussed the recommendations concerning hospital inpatient payment policies made by the Medicare Payment Advisory Commission (MedPAC) and presented our responses to those recommendations. Under section 1805(b) of the Act, MedPAC is required to submit a report to Congress, not later than March 1 of each year, that reviews and makes recommendations on Medicare payment policies.

C. Public Comments Received in Response to the Proposed Rule

We received a total of 82 timely items of correspondence containing multiple comments on the proposed rule. The main areas of concern addressed by the commenters were removal of teaching-related and CRNA costs from the wage index, payments for services furnished at satellite hospital locations, and limits on the transfer of patients in hospitals-within-hospitals. We also received a number of comments relating to the eligibility criteria for hospitals to qualify for capital exceptions payments.

Summaries of the public comments received and our responses to those comments are set forth below under the appropriate section.

II. Changes to DRG Reclassifications and Recalibrations of Relative Weights

A. Background

Under the prospective payment system, we pay for inpatient hospital services on the basis of a rate per discharge that varies by the DRG to which a beneficiary's stay is assigned. The formula used to calculate payment for a specific case takes an individual hospital's payment rate per case and multiplies it by the weight of the DRG to which the case is assigned. Each DRG weight represents the average resources required to care for cases in that particular DRG relative to the average resources used to treat cases in all DRGs.

Congress recognized that it would be necessary to recalculate the DRG relative weights periodically to account for changes in resource consumption. Accordingly, section 1886(d)(4)(C) of the Act requires that the Secretary adjust the DRG classifications and relative weights at least annually. These adjustments are made to reflect changes in treatment patterns, technology, and any other factors that may change the relative use of hospital resources.

As discussed in more detail in section II.B.8 of this preamble, we are not implementing any revisions to the ICD–9–CM codes. We have undertaken, and continue to undertake, major efforts to ensure that all of the Medicare computer systems are ready to function on January 1, 2000. If we were to implement changes to the ICD–9–CM codes on October 1, 1999, we would endanger the functioning of the Medicare computer systems, and, specifically, we might compromise our ability to process hospital bills. We can, however, reclassify existing codes into different DRGs, if appropriate.

The changes to the DRG classification system, and the recalibration of the DRG weights for discharges occurring on or after October 1, 1999, are discussed below.

B. DRG Reclassification

1. General

Cases are classified into DRGs for payment under the prospective payment system based on the principal diagnosis, up to eight additional diagnoses, and up to six procedures performed during the stay, as well as age, sex, and discharge status of the patient. The diagnosis and procedure information is reported by the hospital using ICD–9–CM codes. The Medicare fiscal intermediary enters the information into its claims processing system and subjects it to a series of automated screens called the

Medicare Code Editor (MCE). These screens are designed to identify cases that require further review before classification into a DRG can be accomplished.

After screening through the MCE and any further development of the claims, cases are classified by the GROUPER software program into the appropriate DRG. The GROUPER program was developed as a means of classifying each case into a DRG on the basis of the diagnosis and procedure codes and demographic information (that is, sex, age, and discharge status). It is used both to classify past cases in order to measure relative hospital resource consumption to establish the DRG weights and to classify current cases for purposes of determining payment. The records for all Medicare hospital inpatient discharges are maintained in the Medicare Provider Analysis and Review (MedPAR) file. The data in this file are used to evaluate possible DRG classification changes and to recalibrate the DRG weights.

Currently, cases are assigned to one of 499 DRGs in 25 major diagnostic categories (MDCs). Most MDCs are based on a particular organ system of the body (for example, MDC 6, Diseases and Disorders of the Digestive System); however, some MDCs are not constructed on this basis since they involve multiple organ systems (for example, MDC 22, Burns).

In general, cases are assigned to an MDC based on the principal diagnosis before assignment to a DRG. However, there are five DRGs to which cases are directly assigned on the basis of procedure codes. These are the DRGs for liver, bone marrow, and lung transplants (DRGs 480, 481, and 495, respectively) and the two DRGs for tracheostomies (DRGs 482 and 483). Cases are assigned to these DRGs before classification to an MDC.

Within most MDCs, cases are then divided into surgical DRGs (based on a surgical hierarchy that orders individual procedures or groups of procedures by resource intensity) and medical DRGs. Medical DRGs generally are differentiated on the basis of diagnosis and age. Some surgical and medical DRGs are further differentiated based on the presence or absence of complications or comorbidities (CC).

Generally, GROUPER does not consider other procedures; that is, nonsurgical procedures or minor surgical procedures generally not performed in an operating room are not listed as operating room (OR) procedures in the GROUPER decision tables. However, there are a few non-OR procedures that do affect DRG assignment for certain principal diagnoses, such as extracorporeal shock wave lithotripsy for patients with a principal diagnosis of urinary stones.

We proposed several changes to the DRG classification system for FY 2000 and other decisions concerning DRGs. The proposed changes, the comments we received concerning them, and the final DRG changes are set forth below. Unless otherwise noted, our DRG analysis is based on the full (100 percent) FY 1998 MedPAR file, which contains data from bills received through March 31, 1999.

2. MDC 15 (Newborns and Other Neonates with Conditions Originating in the Perinatal Period)

In the May 7, 1999 proposed rule, we noted that the following codes in the newborn observation series are included in the allowable secondary diagnoses under DRG 391 (Normal Newborn):

V29.0, Observation for suspected infectious disease
V29.1, Observation for suspected neurological condition
V29.8, Observation for other specified suspected condition
V29.9, Observation for unspecified suspected condition

There are two related codes, however, that currently are not included as allowable secondary diagnoses under DRG 391: V29.2 (Observation for suspected respiratory condition) and V29.3 (Observation for suspected genetic or metabolic condition). (In the proposed rule, we incorrectly stated that V29.3 was titled ''Observation for other genetic problem.'') Diagnosis codes V29.2 and V29.3 (as well as the other V29.x codes noted above) are used to indicate that the newborn was suspected of having an abnormal condition resulting from exposure from the mother or the birth process, but is without signs or symptoms and, after examination and observation, no abnormal condition is found to exist. Currently, when either V29.2 or V29.3 is the only secondary diagnosis for an otherwise healthy newborn, the case is assigned to DRG 390 (Neonate with Other Significant Problems). Based on a belief that the presence of diagnosis code V29.2 or V29.3 should not exclude a newborn from being classified as normal, we proposed to include diagnosis codes V29.2 and V29.3 in the list of allowable secondary diagnoses under DRG 391 (Normal Newborn).

We received one comment on this proposal.

Comment: The commenter questioned whether any of the codes in the V29 series should be assigned to DRG 391. The commenter believes that the infants assigned to diagnosis code in the V29 series do not belong in the same clinical group as ''normal newborn.'' The commenter recommended that, before moving codes V29.2 and V29.3 to DRG 391, we should examine data such as the average length of stay for DRGs 390 and 391 and those cases coded with V29.x. Citing one hospital's experience, the commenter noted that 2.7 percent of the cases in DRG 391 were assigned a secondary diagnosis of V29.0 (Observation for suspected infectious disease). In addition, cases with secondary diagnosis codes V29.1, V29.8, and V29.9 represented less than 1 percent each of all cases in DRG 391. The commenter also reported that, for DRG 390, less than 1 percent of cases were assigned a secondary diagnosis code of V29.2 or V29.3. The commenter believes that the length of stay and resource consumption for these cases should be compared to other cases assigned to DRG 390 and DRG 391 to determine whether a separate DRG should be created to adequately categorize these infants.

Response: The experience of the hospital reported by the commenter indicates that newborn cases with a secondary diagnosis of V29.2 or V29.3 represent a small percentage of newborn cases. Medicare data do not contain enough data on newborns to verify this.

In the FY 1998 MedPAR file, there are only nine cases assigned to DRG 390 and none to DRG 391. In fact, in FY 1998, there were only 18 cases assigned to all of MDC 15. Because of the lack of data on newborns in the Medicare claims file, the relative weights and lengths of stay for the DRGs in MDC 15 are based on non-Medicare data collected from 19 States. (See the September 1, 1995 final rule (60 FR 45781) for a detailed discussion of this policy.) Therefore, we rely closely on experts outside of HCFA when we make any changes in MDC 15. We had received information before publication of the proposed rule suggesting that V29.2 and V29.3 should be included with the other V29.x codes in DRG 391. After verifying with our medical consultants that this information was clinically accurate, we proposed to make this DRG classification change. We do note that the average lengths of stay for DRG 390 and 391 do not differ dramatically (3.4 and 3.1 days, respectively). However, the relative weight for DRG 390 is significantly higher than that for DRG 391 (1.5908 and 0.1516, respectively). Thus, we believe the amount of resource use devoted to newborns in DRG 390 is not

connected to the amount of time spent in the hospital.

The commenter did not provide any length of stay or resource use data nor did the commenter provide any reason that codes V29.2 or V29.3 should be treated differently than the other codes in category V29.x. We believe that DRG 390, as its title indicates, should be used to classify newborns with significant problems. Newborns who exhibit no signs or symptoms and are merely evaluated or observed for a suspected condition that is ruled out should not be classified with newborns who have significant problems that require treatment.

We note that DRG 391 includes newborns who have minor problems or conditions that require treatment. For example, some newborns with jaundice, newborns with scalp injuries or mild birth asphyxia, and newborns with minor skin infections are all classified to DRG 391. Thus, that DRG does contain newborn cases for which some medical treatment must be provided. We believe that including newborns observed for suspected respiratory, genetic, or metabolic conditions in DRG 391 is clinically appropriate. Therefore, as proposed, we will include V29.2 and V29.3 as allowable secondary diagnoses under DRG 391, as are the rest of the codes in that category.

3. MDC 19 (Mental Diseases and Disorders)

We proposed to revise the title of DRG 425, ''Acute Adjustment Reaction and Disturbances of Psychosocial Dysfunction'' under MDC 19 to read ''Acute Adjustment Reaction and Psychosocial Dysfunction.'' Correspondents had stated that the terms ''disturbances'' and ''dysfunction'' were redundant since the terms have similar meanings.

We received one comment in support of this revision. Therefore, we are adopting this proposed revision as final.

4. MDC 22 (Burns)

In the July 31, 1998 final rule (63 FR 40957), we implemented an extensive redesign of the DRGs for burns to more appropriately capture the variation in resource use associated with different classes of burn patients. After these DRGs went into effect on October 1, 1998, we were contacted by several hospitals about our inclusion of the fifth digit ''0'' on codes 948.10 through 948.90 to capture cases of full-thickness burns. These hospitals stated that codes in category 948 with a fifth digit of ''0'' should not be assigned to DRGs 506 through 509 as full-thickness burns since not all of these cases will have a full-thickness (third degree) burn. The fifth digit ''0'' can capture cases in which there actually is no third degree burn. The hospitals requested that we consider removing from the full-thickness burn DRGs 506 through 509 all codes in the 948 category with a fifth digit of ''0'' as follows:

948.00 Body burn involving less than 10 percent of body surface, third degree less than 10 percent or unspecified

948.10 Body burn involving 10 to 19 percent of body surface, third degree less than 10 percent or unspecified

948.20 Body burn involving 20 to 29 percent of body surface, third degree less than 10 percent or unspecified

948.30 Body burn involving 30 to 39 percent of body surface, third degree less than 10 percent or unspecified

948.40 Body burn involving 40 to 49 percent of body surface, third degree less than 10 percent or unspecified

948.50 Body burn involving 50 to 59 percent of body surface, third degree less than 10 percent or unspecified

948.60 Body burn involving 60 to 69 percent of body surface, third degree less than 10 percent or unspecified

948.70 Body burn involving 70 to 79 percent of body surface, third degree less than 10 percent or unspecified

948.80 Body burn involving 80 to 89 percent of body surface, third degree less than 10 percent or unspecified

948.90 Body burn involving 90 percent or more of body surface, third degree less than 10 percent or unspecified.

We agreed with the hospitals and proposed that the codes listed above be removed from DRGs 506 through 509 and added to DRG 510 (Nonextensive Burns with CC or Significant Trauma) and DRG 511 (Nonextensive Burns without CC or Significant Trauma). Hospitals have been instructed in *Coding Clinic for ICD–9–CM*, Fourth Quarter, 1994 (pages 22 through 28) to code the site of the burn first (codes 940 through 947), when known. Codes from category 948 may be used as a principal diagnosis only when the site of the burn is not specified. Category 948 is used as an additional code to provide information on the percentage of total body that is burned or to show the percentage of burn that was third degree. When hospitals report codes properly, full-thickness burns would be assigned to a code for burn of the specific site (940 through 947). This site code also shows the degree of the burn. Furthermore, for those rare cases in which the site is not provided, but it is known that 10 percent or more of the body has a third degree burn, hospitals may report this information through the use of category 948 with a fifth digit of ''1'' through ''9.'' All of these cases would continue to be classified as full-thickness burns in DRGs 506 through 509. Therefore, the proposed removal of codes 948.1 through 948.9 with a fifth digit of ''0'' would not prevent cases from being assigned to one of the full-thickness DRGs when there is a third degree burn and the case is correctly coded.

Comment: One commenter stated that while it is true that codes in category 948 with a fifth digit of ''0'' may be assigned when there is no third degree burn, fifth digit ''0'' is also used to report cases that have a body surface of 1 to 9 percent involved in third degree burns. The commenter suggested that consideration be given to these cases as the presence of a third degree burn represents additional risk to the patient.

Response: We agree with the commenter that the presence of third degree burns represents additional risk to the patient and may result in a higher resource use. More accurately capturing this fact was one of the primary purposes in revising the burn DRGs in FY 1999. However, as the commenter noted, in category 948, the fifth digit of ''0'' includes cases with no third degree burns as well as third degree burns involving 1 to 9 percent of the body surface. It is precisely because many of the cases coded in 948 with a ''0'' fifth digit have no third degree burns that we believe it is not appropriate to include these codes in DRGs 506 through 509. As stated above, hospitals have been instructed to code the site of the burn first (codes 940 through 947), when known. These codes capture information on the site of the burn as well as whether the burn is a third degree burn. Therefore, by using the more precise codes in the 940 through 947 series, hospitals will be appropriately assigning cases with minor third degree burns to DRGs 506 through 509.

We are adopting as final our proposal to remove codes in the 948 category with a fifth digit of ''0'' from the list of full-thickness burns.

5. Surgical Hierarchies

Some inpatient stays entail multiple surgical procedures, each one of which, occurring by itself, could result in

assignment of the case to a different DRG within the MDC to which the principal diagnosis is assigned. It is, therefore, necessary to have a decision rule by which these cases are assigned to a single DRG. The surgical hierarchy, an ordering of surgical classes from most to least resource intensive, performs that function. Its application ensures that cases involving multiple surgical procedures are assigned to the DRG associated with the most resource-intensive surgical class.

Because the relative resource intensity of surgical classes can shift as a function of DRG reclassification and recalibration, we reviewed the surgical hierarchy of each MDC, as we have for previous reclassifications, to determine if the ordering of classes coincided with the intensity of resource utilization, as measured by the same billing data used to compute the DRG relative weights.

A surgical class can be composed of one or more DRGs. For example, in MDC 5, the surgical class ''heart transplant'' consists of a single DRG (DRG 103), and the class ''major cardiovascular procedures'' consists of two DRGs (DRGs 110 and 111). Consequently, in many cases, the surgical hierarchy has an impact on more than one DRG. The methodology for determining the most resource-intensive surgical class involves weighting each DRG for frequency to determine the average resources for each surgical class. For example, assume surgical class A includes DRGs 1 and 2 and surgical class B includes DRGs 3, 4, and 5. Assume also that the average charge of DRG 1 is higher than that of DRG 3, but the average charges of DRGs 4 and 5 are higher than the average charge of DRG 2. To determine whether surgical class A should be higher or lower than surgical class B in the surgical hierarchy, we would weight the average charge of each DRG by frequency (that is, by the number of cases in the DRG) to determine average resource consumption for the surgical class. The surgical classes would then be ordered from the class with the highest average resource utilization to that with the lowest, with the exception of ''other OR procedures'' as discussed below.

This methodology may occasionally result in a case involving multiple procedures being assigned to the lower-weighted DRG (in the highest, most resource-intensive surgical class) of the available alternatives. However, given that the logic underlying the surgical hierarchy provides that the GROUPER searches for the procedure in the most resource-intensive surgical class, this result is unavoidable.

We note that, notwithstanding the foregoing discussion, there are a few instances when a surgical class with a lower average relative weight is ordered above a surgical class with a higher average relative weight. For example, the ''other OR procedures'' surgical class is uniformly ordered last in the surgical hierarchy of each MDC in which it occurs, regardless of the fact that the relative weight for the DRG or DRGs in that surgical class may be higher than that for other surgical classes in the MDC. The ''other OR procedures'' class is a group of procedures that are least likely to be related to the diagnoses in the MDC but are occasionally performed on patients with these diagnoses. Therefore, these procedures should be considered only if no other procedure more closely related to the diagnoses in the MDC has been performed.

A second example occurs when the difference between the average weights for two surgical classes is very small. We have found that small differences generally do not warrant reordering of the hierarchy since, by virtue of the hierarchy change, the relative weights are likely to shift such that the higher-ordered surgical class has a lower average weight than the class ordered below it.

Based on the preliminary recalibration of the DRGs, we proposed to modify the surgical hierarchy as set forth below. However, in developing the proposed rule, we were unable to test the effects of proposed revisions to the surgical hierarchy and to reflect these changes in the proposed relative weights due to the unavailability of revised GROUPER software at the time the proposed rule was prepared. Rather, we simulated most major classification changes to approximate the placement of cases under the proposed reclassification and then determined the average charge for each DRG. These average charges then serve as our best estimate of relative resource use for each surgical class. We tested the proposed surgical hierarchy changes after the revised GROUPER was received. The final changes in the DRG relative weights are reflected in this final rule.

We proposed to revise the surgical hierarchy for the Pre-MDC DRGs and MDC 3 (Diseases and Disorders of the Ear, Nose, Mouth and Throat) as follows:

- In the Pre-MDC DRGs, we proposed to reorder Lung Transplant (DRG 495) above Bone Marrow Transplant (DRG 481).
- In MDC 3, we proposed to reorder Tonsil and Adenoid Procedure Except Tonsillectomy and/or Adenoidectomy Only (DRGs 57 and 58) above Cleft Lip and Palate Repair (DRG 52).

We received two comments in support of the two surgical hierarchy proposals. In addition, based on a test of the proposed revisions using the most recent MedPAR file and the revised GROUPER software, we have found that the revisions are still supported by the data and no additional changes are indicated. Therefore, we are incorporating the proposed revisions and reorders in this final rule.

6. Refinement of Complications and Comorbidities (CC) List

There is a standard list of diagnoses that are considered CCs. We developed this list using physician panels to include those diagnoses that, when present as a secondary condition, would be considered a substantial complication or comorbidity. In previous years, we have made changes to the standard list of CCs, either by adding new CCs or by deleting CCs already on the list. In the May 7, 1999 proposed rule, we did not propose to delete any of the diagnosis codes on the CC list.

In the September 1, 1987 final notice concerning changes to the DRG classification system (52 FR 33143), we modified the GROUPER logic so that certain diagnoses included on the standard list of CCs would not be considered a valid CC in combination with a particular principal diagnosis. Thus, we created the CC Exclusions List. We made these changes to preclude coding of CCs for closely related conditions, to preclude duplicative coding or inconsistent coding from being treated as CCs, and to ensure that cases are appropriately classified between the complicated and uncomplicated DRGs in a pair.

In the May 19, 1987 proposed notice concerning changes to the DRG classification system (52 FR 18877), we explained that the excluded secondary diagnoses were established using the following five principles:

- Chronic and acute manifestations of the same condition should not be considered CCs for one another (as subsequently corrected in the September 1, 1987 final notice (52 FR 33154)).
- Specific and nonspecific (that is, not otherwise specified (NOS)) diagnosis codes for a condition should not be considered CCs for one another.
- Conditions that may not co-exist, such as partial/total, unilateral/bilateral, obstructed/unobstructed, and benign/malignant, should not be considered CCs for one another.

• The same condition in anatomically proximal sites should not be considered CCs for one another.

• Closely related conditions should not be considered CCs for one another.

The creation of the CC Exclusions List was a major project involving hundreds of codes. The FY 1988 revisions were intended to be only a first step toward refinement of the CC list in that the criteria used for eliminating certain diagnoses from consideration as CCs were intended to identify only the most obvious diagnoses that should not be considered complications or comorbidities of another diagnosis. For that reason, and in light of comments and questions on the CC list, we have continued to review the remaining CCs to identify additional exclusions and to remove diagnoses from the master list that have been shown not to meet the definition of a CC. (See the September 30, 1988 final rule for the revision made for the discharges occurring in FY 1989 (53 FR 38485); the September 1, 1989 final rule for the FY 1990 revision (54 FR 36552); the September 4, 1990 final rule for the FY 1991 revision (55 FR 36126); the August 30, 1991 final rule for the FY 1992 revision (56 FR 43209); the September 1, 1992 final rule for the FY 1993 revision (57 FR 39753); the September 1, 1993 final rule for the FY 1994 revisions (58 FR 46278); the September 1, 1994 final rule for the FY 1995 revisions (59 FR 45334); the September 1, 1995 final rule for the FY 1996 revisions (60 FR 45782); the August 30, 1996 final rule for the FY 1997 revisions (61 FR 46171); the August 29, 1997 final rule for the FY 1998 revisions (62 FR 45966); and the July 31, 1998 final rule for the FY 1999 revisions (63 FR 40954).) In the May 7, 1999 proposed rule, we did not propose to add or delete any codes from the CC list.

In addition, because we are not making changes to the ICD–9–CM codes for FY 2000, we are not modifying the current list for new or deleted codes. Therefore, there are no revisions to the CC Exclusions List for FY 2000.

7. Review of Procedure Codes in DRGs 468, 476, and 477

Each year, we review cases assigned to DRG 468 (Extensive OR Procedure Unrelated to Principal Diagnosis), DRG 476 (Prostatic OR Procedure Unrelated to Principal Diagnosis), and DRG 477 (Nonextensive OR Procedure Unrelated to Principal Diagnosis) in order to determine whether it would be appropriate to change the procedures assigned among these DRGs.

DRGs 468, 476, and 477 are reserved for those cases in which none of the OR procedures performed is related to the principal diagnosis. These DRGs are intended to capture atypical cases, that is, those cases that do not occur with sufficient frequency to represent a distinct, recognizable clinical group. DRG 476 is assigned to those discharges in which one or more of the following prostatic procedures are performed and are unrelated to the principal diagnosis:

60.0 Incision of prostate
60.12 Open biopsy of prostate
60.15 Biopsy of periprostatic tissue
60.18 Other diagnostic procedures on prostate and periprostatic tissue
60.21 Transurethral prostatectomy
60.29 Other transurethral prostatectomy
60.61 Local excision of lesion of prostate
60.69 Prostatectomy NEC
60.81 Incision of periprostatic tissue
60.82 Excision of periprostatic tissue
60.93 Repair of prostate
60.94 Control of (postoperative) hemorrhage of prostate
60.95 Transurethral balloon dilation of the prostatic urethra
60.99 Other operations on prostate

All remaining OR procedures are assigned to DRGs 468 and 477, with DRG 477 assigned to those discharges in which the only procedures performed are nonextensive procedures that are unrelated to the principal diagnosis. The original list of the ICD–9–CM procedure codes for the procedures we consider nonextensive procedures, if performed with an unrelated principal diagnosis, was published in Table 6C in section IV of the Addendum to the September 30, 1988 final rule (53 FR 38591). As part of the final rules published on September 4, 1990, August 30, 1991, September 1, 1992, September 1, 1993, September 1, 1994, September 1, 1995, August 30, 1996, and August 29, 1997, we moved several other procedures from DRG 468 to 477, and some procedures from DRG 477 to 468. (See 55 FR 36135, 56 FR 43212, 57 FR 23625, 58 FR 46279, 59 FR 45336, 60 FR 45783, 61 FR 46173, and 62 FR 45981, respectively.) No procedures were moved in FY 1999, as noted in the July 31, 1998 final rule (63 FR 40962).

a. Adding Procedure Codes to MDCs

We annually conduct a review of procedures producing DRG 468 or 477 assignments on the basis of volume of cases in these DRGs with each procedure. Our medical consultants then identify those procedures occurring in conjunction with certain principal diagnoses with sufficient frequency to justify adding them to one of the surgical DRGs for the MDC in which the diagnosis falls. Based on this year's review, we identified several procedures that we proposed to move to surgical DRGs for additional MDCs so that they are not assigned to DRG 468. We did not identify any necessary changes in procedures under DRG 477 and, therefore, did not propose to move any procedures from DRG 477 to one of the surgical DRGs.

First, we proposed to move three codes from DRG 468 to MDC 1 (Diseases and Disorders of the Nervous System), all of which would be assigned to DRGs 7 and 8 (Peripheral and Cranial Nerve and Other Nervous System Procedure).[1] Procedure code 38.7 (Interruption of the vena cava) is sometimes performed in conjunction with treatment for the principal diagnosis 434.11 (Cerebral embolism with infarction), which is assigned to MDC 1. Our medical advisors believe that procedure code 38.7 is appropriately performed for some neurological conditions such as a cerebral embolism with infarction. Because the current DRG configuration does not allow this assignment, we proposed to add procedure code 38.7 to DRGs 7 and 8.

Second, we proposed that procedure codes 83.92 (Insertion or replacement of skeletal muscle stimulator) and 83.93 (Removal of skeletal muscle stimulator) both be categorized with other procedures on the nervous system. These procedures can be performed on patients with a principal diagnosis in MDC 1, such as 344.00 (Quadriplegia unspecified) or 344.31 (Monoplegia of lower limb, affecting dominant side). Therefore, these two codes would also be assigned to DRGs 7 and 8.

Third, procedure code 39.50 (Angioplasty or atherectomy of noncoronary vessel) is not currently assigned to MDC 4 (Diseases and Disorders of the Respiratory System). This procedure is performed for patients who develop pulmonary embolism. The principal diagnosis for pulmonary embolism is in MDC 4, and, to increase clinical coherence, we proposed to add procedure code 39.50 to that MDC in DRGs 76 and 77 (Other Respiratory System OR Procedures).

Fourth, insertion of totally implantable infusion pump (procedure code 86.06) is not assigned to MDC 5 (Diseases and Disorders of the Circulatory System) in the current DRG configuration. Infusion pumps should

[1] A single title combined with two DRG numbers is used to signify pairs. Generally, the first DRG is for cases with CC and the second DRG is for cases without CC. If a third number is included, it represents cases with patients who are age 0–17. Occasionally, a pair of DRGs is split between age >17 and age 0–17.

be assigned to all MDCs in which subcutaneous insertion of the pump is appropriate. Procedure code 86.06 may be performed on patients with a principal diagnosis in MDC 5 such as 451.83 (Phlebitis and thrombophlebitis of the deep veins of other extremities). Therefore, we proposed to add procedure code 86.06 to DRG 120 (Other Circulatory System OR Procedures) in MDC 5.

We received two comments on these MDC and DRG assignments, both of which concurred with our proposed changes. Therefore, we are adopting them as final.

b. Reassignment of Procedures Among DRGs 468, 476, and 477

We also reviewed the list of procedures that produce assignments to DRGs 468, 476, and 477 to ascertain if any of those procedures should be moved from one of these DRGs to another based on average charges and length of stay. Generally, we move only those procedures for which we have an adequate number of discharges to analyze the data. Based on our review this year, we did not propose to move any procedures from DRG 468 to DRGs 476 or 477, from DRG 476 to DRGs 468 or 477, or from DRG 477 to DRGS 468 or 476.

8. Changes to the ICD–9–CM Coding System

As described in section II.B.1 of this preamble, the ICD–9–CM is a coding system that is used for the reporting of diagnoses and procedures performed on a patient. In September 1985, the ICD–9–CM Coordination and Maintenance Committee was formed. This is a Federal interdepartmental committee, co-chaired by the National Center for Health Statistics (NCHS) and HCFA, that is charged with the mission of maintaining and updating the ICD–9–CM system. That mission includes approving coding changes, and developing errata, addenda, and other modifications to the ICD–9–CM to reflect newly developed procedures and technologies and newly identified diseases. The Committee is also responsible for promoting the use of Federal and non-Federal educational programs and other communication techniques with a view toward standardizing coding applications and upgrading the quality of the classification system.

The NCHS has lead responsibility for the ICD–9–CM diagnosis codes included in the *Tabular List* and *Alphabetic Index for Diseases,* while HCFA has lead responsibility for the ICD–9–CM procedure codes included in the *Tabular List* and *Alphabetic Index for Procedures.*

The Committee encourages participation in the above process by health-related organizations. In this regard, the Committee holds public meetings for discussion of educational issues and proposed coding changes. These meetings provide an opportunity for representatives of recognized organizations in the coding field, such as the American Health Information Management Association (AHIMA) (formerly American Medical Record Association (AMRA)), the American Hospital Association (AHA), and various physician specialty groups as well as physicians, medical record administrators, health information management professionals, and other members of the public, to contribute ideas on coding matters. After considering the opinions expressed at the public meetings and in writing, the Committee formulates recommendations, which then must be approved by the agencies.

The Committee presented proposals for coding changes for FY 2000 at public meetings held on June 4 and November 2, 1998. Even though the Committee conducted public meetings and considered approval of coding changes for FY 2000 implementation, we are not implementing any changes to ICD–9–CM codes for FE 2000. We have undertaken, and continue to undertake, major efforts to ensure that all of the Medicare computer systems are ready to function on January 1, 2000. If we were to make system changes to capture additions, deletions, and modifications to ICD–9–CM codes for FY 2000, we would endanger the functioning of the Medicare computer systems, and, specifically, we might compromise our ability to process hospital bills. Therefore, the code proposals presented at the public meetings held on June 4 and November 2, 1998, that (if approved) ordinarily would have been included as new codes for October 1, 1999, are not included in this final rule. These code changes to ICD–9–CM will be considered for inclusion in the annual update for FY 2001. The initial meeting for consideration of coding changes for implementation in FY 2001 was held on May 13, 1999.

Copies of the minutes of the 1998 meetings and the May 13, 1999 meeting can be obtained from the HCFA Home Page at http://www.hcfa.gov/medicare/icd9cm.htm or from http://www.hcfa.gov/events, click on ''meetings and workshops'' link, and then click on ''reports of the ICD–9–CM coordination and maintenance committee'' link. Paper copies of these minutes are no longer available and the mailing list has been discontinued. We encourage commenters to address suggestions on coding issues involving diagnosis codes to: Donna Pickett, Co-Chairperson; ICD–9–CM Coordination and Maintenance Committee; NCHS; Room 1100; 6525 Belcrest Road; Hyattsville, Maryland 20782. Comments may be sent by E-mail to dfp4@cdc.gov.

Questions and comments concerning the procedure codes should be addressed to: Patricia E. Brooks, Co-Chairperson; ICD–9–CM Coordination and Maintenance Committee; HCFA, Center for Health Plans and Providers, Plan and Provider Purchasing Policy Group, Division of Acute Care; C4–07–07; 7500 Security Boulevard; Baltimore, Maryland 21244–1850. Comments may be sent by E-mail to pbrooks@hcfa.gov.

We received one comment in support of our decision not to update ICD–9–CM codes given the magnitude of system changes needed during the period leading up to the year 2000.

9. Other Issues

a. Implantation of Muscle Stimulator

In the July 31, 1998 final rule, we responded to a comment on the DRG assignment for implantation of a muscle stimulator (63 FR 40964). In that document, we stated that we would readdress this issue after reviewing the FY 1998 MedPAR file.

There is concern in the manufacturing industry that the current DRG assignment for the implantation of a muscle stimulator and the associated tendon transfer for quadriplegics is inappropriate. When the procedures are performed during two separate admissions, the tendon transfer (procedure code 82.56 (Other hand tendon transfer or transplantation)) is assigned to DRGs 7 and 8, and the insertion of the muscle stimulator (procedure code 83.92 (Insertion or replacement of skeletal muscle stimulator)) is assigned to DRG 468. However, when both procedures are performed in the same admission, the case is assigned to DRGs 7 and 8.

As discussed in section II.B.7.a of this preamble, in the May 7, 1999 proposed rule, we proposed to assign code 83.92 to DRGs 7 and 8 in MDC 1. Therefore, if a case involves either procedure code 82.56 or 83.92, or both procedure codes, the case would be assigned to DRGs 7 and 8.

A presentation on one type of muscle stimulator was made by a device manufacturer before the ICD–9–CM Coordination and Maintenance Committee on November 2, 1998. The manufacturer strongly suggested that a

new code assignment be made for the procedure for insertion of this stimulator and that it be placed in category 04.9 (Other operations on cranial and peripheral nerves). However, based on comments received by the Committee, there was an overwhelming response from the coding community that a new code should not be created. The commenters believe that these codes (82.56 and 83.92) adequately described the procedures since the patient receives a tendon transfer in addition to the skeletal muscle stimulator insertion. This is done so that the quadriplegic patient can achieve some hand grasping ability where there was none before. Some quadriplegic patients receive the tendon transfer on one admission and the stimulator insertion on a subsequent admission. Others have both procedures performed on the same admission. Since the tendon transfer and stimulator insertion are being performed on quadriplegic patients, a condition found in MDC 1, we proposed to add procedure codes 82.56 and 83.92 to DRGs 7 and 8. We did not receive any comments on this proposal. Therefore, we are adopting it as final.

b. Pancreas Transplant

Through a Medicare Coverage Issues Manual revision (Transmittal No. 115, April 1999), HCFA announced that, effective July 1, 1999, Medicare covers whole organ pancreas transplantation (procedure codes 52.80 or 52.83) if it is performed simultaneous with or after a kidney transplant.

Pancreas transplantation is generally limited to those patients with severe secondary complications of diabetes, including kidney failure. However, pancreas transplantation is sometimes performed on patients with labile diabetes and hypoglycemic unawareness.

Pancreas transplantation for diabetic patients who have not experienced end-stage renal failure secondary to diabetes continue to be excluded from coverage. Medicare also excludes coverage of transplantation of partial pancreatic tissue or islet cells. Claims processing instructions to intermediaries were contained in Program Memorandum Transmittal No. A–99–16 (April 1999).

We received one comment regarding the coverage and claims processing instructions for pancreas transplants.

Comment: The commenter requested clarification on the date of coverage for services related to pancreas transplantation services furnished on or after July 1, 1999. Specifically, the commenter asked whether coverage is effective for admissions, discharges, or actual transplant surgery on or after that date. In addition, the commenter believes that if the resource use for a pancreas-kidney transplant is significantly greater than for a kidney transplant alone, then a new DRG should be created for the dual transplant. Finally, the commenter was unsure how hospitals should report the organ acquisition costs attributable to pancreas. Specifically, the commenter wanted to know if the costs should be included, on the hospital cost report with the kidney costs or whether a separate organ acquisition cost center will be established for pancreas acquisition costs.

Response: As stated in Transmittal No. 115, coverage is effective for dates of service on or after July 1, 1999. Therefore, any pancreas transplant performed on or after July 1, 1999 is covered by Medicare if all other qualifying criteria are met.

Under the current DRG classification, if a kidney transplant and a pancreas transplant are performed simultaneously on a patient with chronic renal failure secondary to diabetes with renal manifestations (diagnosis codes 250.40 through 250.43), the case is assigned to DRG 302 (Kidney Transplant) in MDC 11 (Disease and Disorders of the Kidney and Urinary Tract. If a pancreas transplant is performed following a kidney transplant (that is, in a different hospital admission) on a patient with chronic renal failure secondary to diabetes with renal manifestations, the case is assigned to DRG 468 (Major OR Procedure Unrelated to Principal Diagnosis) because pancreas transplant is not assigned to MDC 11, the MDC to which a principal diagnosis of chronic renal failure secondary to diabetes is assigned.

If a kidney and pancreas transplant are performed simultaneously or if a pancreas transplant is performed following a kidney transplant, on a patient with chronic renal failure secondary to diabetes with ketoacidosis (diagnosis codes 250.10 through 250.13), diabetes with hyperosmolarity (diagnosis codes 250.20 through 250.23), diabetes with other coma (diagnosis codes 250.30 through 250.33), diabetes with other specified manifestations (diagnosis codes 250.80 through 250.83), or diabetes with unspecified complication (diagnosis codes 250.90 through 250.93), the case would be assigned to DRG 292 or 293 (Other Endocrine, Nutritional and Metabolic OR Procedures) in MDC 10 (Endocrine, Nutritional, and Metabolic Diseases and Disorders). As the commenter notes, it is possible that the resource use for a pancreas-kidney transplant or a pancreas-only transplant might be significantly different from a kidney-only transplant. We intend to review the Medicare data in our FY 1999 MedPAR file in order to analyze whether we should either reassign these transplants to a different DRG or create a new DRG. We will announce any proposals on that issue in the FY 2001 proposed rule, which will be published in the Spring of 2000.

A separate organ acquisition cost center has been established for pancreas transplantation. The Medicare cost report will include a separate line to account for pancreas transplantation costs. In addition, in this final rule, we are making a conforming change to ' 412.2(e)(4) to include pancreas in the list of organ acquisition costs that are paid on a reasonable cost basis.

c. Immunotherapy

Effective October 1, 1994, procedure code 99.28 (Injection or infusion of biological response modifier [BRM] as an antineoplastic agent) was created. This procedure is also known as BRM therapy or immunotherapy. At that time, we designated the code as a Anon-OR@ code that does not affect DRG assignment.

Comment: One commenter, a manufacturer of a biologic response modifier, requested that we create a new DRG for BRM therapy or assign cases in which BRM therapy is performed to an existing DRG with a high relative weight. The commenter suggested that DRG 403 (Lymphoma and Non-Acute Leukemia with CC) would be an appropriate DRG. The manufacturer=s particular drug is used in the treatment of metastatic renal cell carcinoma and metastatic melanoma.

Response: Using the 100 percent FY 1998 MedPAR file that contains bills through December 31, 1998, we performed an analysis of the cases for which procedure code 99.28 was reported. Based on the commenter's request, for purposes of this analysis we examined cases only for hospitals that use the particular drug manufactured by the commenter. We identified 121 cases in 19 DRGs in 9 MDCs. No more than 31 cases were assigned to any one particular DRG. Of the 121 cases identified, 31 cases were assigned to DRG 318 (Kidney and Urinary Tract Neoplasms with CC) and 30 of the cases were assigned to DRG 82 (Respiratory Neoplasms). There was a wide range of charges (between approximately $1,300 and $125,000 per case) associated with this therapy. The average length of stay was approximately 5 days. Due to the limited number of cases that were

distributed throughout 19 DRGs and the variation of charges, we concluded that it would be inappropriate to classify these cases into a single DRG. Because of the numerous principal diagnoses reported with BRM therapy, a single DRG for procedure code 99.28 would need to be placed in the pre-MDC DRG category. Similarly, it would be impossible to classify these cases into DRG 403 because only a few cases were coded with a principal diagnosis assigned to MDC 17 (Myeloproliferative Diseases and Disorders, and Poorly Differentiated Neoplasms), the MDC that includes DRG 403. Finally, the variation in charges reflected in the 121 cases do not persuade us that there is an analytic basis for combining these cases into one DRG. Using the FY 1999 MedPAR, we intend to do a full analysis of these cases, which we will discuss in the FY 2001 proposed rule.

As a final note, any DRG classification change for procedure code 99.28 must be appropriate for all cases that receive BRM therapy, not just those that use the commenter's drug. Even if we might consider such an assignment appropriate, we have no way to distinguish between different drug therapies assigned to the same procedure code. The FY 1998 MedPAR file we analyzed contained 930 cases with procedure code 99.28. These 930 cases were assigned to 18 MDCs.

d. Heart Assist Devices

Effective May 5, 1997, we revised Medicare coverage of heart assist devices to allow coverage of a ventricular assist device used for support of blood circulation postcardiotomy if certain conditions were met. In the August 29, 1997 final rule (62 FR 45973), we moved procedure code 37.66 (Implant of an implantable pulsatile heart assist device) from DRGs 110 and 111 (Major Cardiovascular Procedures) to DRG 108 (Other Cardiothoracic Procedures) to improve payment for these procedures. In the July 31, 1998 final rule (63 FR 40956), in a further effort to improve payment for these cases, we moved procedure code 37.66 to DRGs 104 and 105 (Cardiac Valve and Other Major Cardiothoracic Procedures).

We received one comment regarding the DRG classification of procedure code 37.66.

Comment: The commenter recommended that we either reclassify heart assist device cases to DRG 103 (Heart Transplant) or create a new DRG specifically for this device and technology. The commenter cited a discrepancy between the cost of the device implantation and payment for DRGs 104 and 105 as the basis for these recommendations.

Response: We refer the reader to our response to a similar comment in the August 29, 1997 final rule (62 FR 45967). We note that the FY 1998 MedPAR file has 22 cases coded with procedure code 37.66. Of these 22 cases, 8 cases were assigned to DRG 103 (Heart Transplant) and 4 cases to DRG 483 (Tracheostomy Except for Face, Mouth, and Neck Diagnoses). The remaining 10 cases would have been assigned to DRGs 104 and 105 under the current classification.

C. Recalibration of DRG Weights

We proposed to use the same basic methodology for the FY 2000 recalibration as we did for FY 1999. (See the July 31, 1998 final rule (63 FR 40965).) That is, we recalibrated the weights based on charge data for Medicare discharges. However, we used the most current charge information available, the FY 1998 MedPAR file. (For the FY 1999 recalibration, we used the FY 1997 MedPAR file.) The MedPAR file is based on fully coded diagnostic and surgical procedure data for all Medicare inpatient hospital bills.

The final recalibrated DRG relative weights are constructed from FY 1998 MedPAR data, based on bills received by HCFA through March 1999, from all hospitals subject to the prospective payment system and short-term acute care hospitals in waiver States. The FY 1998 MedPAR file includes data for approximately 11.3 million Medicare discharges.

The methodology used to calculate the DRG relative weights from the FY 1998 MedPAR file is as follows:

- All the claims were regrouped using the DRG classification revisions discussed above in section II.B of this preamble.
- Charges were standardized to remove the effects of differences in area wage levels, indirect medical education (IME) and disproportionate share hospital (DSH) payments, and, for hospitals in Alaska and Hawaii, the applicable cost-of-living adjustment.
- The average standardized charge per DRG was calculated by summing the standardized charges for all cases in the DRG and dividing that amount by the number of cases classified in the DRG.
- We then eliminated statistical outliers, using the same criteria as were used in computing the current weights—that is, all cases that are outside of 3.0 standard deviations from the mean of the log distribution of both the charges per case and the charges per day for each DRG.
- The average charge for each DRG was then recomputed (excluding the statistical outliers) and divided by the national average standardized charge per case to determine the relative weight. A transfer case is counted as a fraction of a case based on the ratio of its length of stay to the geometric mean length of stay of the cases assigned to the DRG. That is, a 5-day length of stay transfer case assigned to a DRG with a geometric mean length of stay of 10 days is counted as 0.5 of a total case.
- We established the relative weight for heart and heart-lung, liver, and lung transplants (DRGs 103, 480, and 495) in a manner consistent with the methodology for all other DRGs except that the transplant cases that were used to establish the weights were limited to those Medicare-approved heart, heart-lung, liver, and lung transplant centers that have cases in the FY 1998 MedPAR file. (Medicare coverage for heart, heart-lung, liver, and lung transplants is limited to those facilities that have received approval from HCFA as transplant centers.)
- Acquisition costs for kidney, heart, heart-lung, liver, and lung transplants continue to be paid on a reasonable cost basis. Unlike other excluded costs, the acquisition costs are concentrated in specific DRGs (DRG 302 (Kidney Transplant); DRG 103 (Heart Transplant for Heart and Heart-Lung Transplants); DRG 480 (Liver Transplant); and DRG 495 (Lung Transplant)). Because these costs are paid separately from the prospective payment rate, it is necessary to make an adjustment to prevent the relative weights for these DRGs from including the effect of the acquisition costs. Therefore, we subtracted the acquisition charges from the total charges on each transplant bill that showed acquisition charges before computing the average charge for the DRG and before eliminating statistical outliers.

When we recalibrated the DRG weights for previous years, we set a threshold of 10 cases as the minimum number of cases required to compute a reasonable weight. We used that same case threshold in recalibrating the DRG weights for FY 2000. Using the FY 1998 MedPAR data set, there are 40 DRGs that contain fewer than 10 cases. We computed the weights for the 40 low-volume DRGs by adjusting the FY 1999 weights of these DRGs by the percentage change in the average weight of the cases in the other DRGs.

The weights developed according to the methodology described above, using the final DRG classification changes, result in an average case weight that is different from the average case weight

before recalibration. Therefore, the new weights are normalized by an adjustment factor, so that the average case weight after recalibration is equal to the average case weight before recalibration. This adjustment is intended to ensure that recalibration by itself neither increases nor decreases total payments under the prospective payment system.

Section 1886(d)(4)(C)(iii) of the Act requires that, beginning with FY 1991, reclassification and recalibration changes be made in a manner that ensures that the aggregate payments are neither greater than nor less than the aggregate payments that would have been made without the changes. Although normalization is intended to achieve this effect, equating the average case weight after recalibration to the average case weight before recalibration does not necessarily achieve budget neutrality with respect to aggregate payments to hospitals because payment to hospitals is affected by factors other than average case weight. Therefore, as we have done in past years and as discussed in section II.A.4.b of the Addendum to this final rule, we make a budget neutrality adjustment to ensure that the requirement of section 1886(d)(4)(C)(iii) of the Act is met.

D. Use of Non-MedPAR Data for Reclassification and Recalibration of the DRGs

1. Introduction

As in past years, in the DRG reclassification and recalibration process for the FY 2000 final rule, we used the MedPAR file, which consists of data for approximately 11.3 million Medicare discharges. In the FY 1999 final rulemaking process, we used the FY 1997 MedPAR file to recalibrate DRGs and evaluate possible changes to DRG classifications; for this FY 2000 final rule, we used the FY 1998 MedPAR file. The Conference Report that accompanied the Balanced Budget Act of 1997 stated that ''in order to ensure that Medicare beneficiaries have access to innovative new drug therapies, the conferees believe that HCFA should consider, to the extent feasible, reliable, validated data other than Medicare Provider Analysis and Review (MedPAR) data in annually recalibrating and reclassifying the DRGs'' (H.R. Conf. Rep. No. 105–217 at 734 (1997)).

Consistent with that language, we considered non-MedPAR data in the rulemaking process for FY 1999 and in developing the May 7, 1999 proposed rule for FY 2000. We received non-MedPAR data from entities on behalf of the manufacturer of a specific drug, platelet inhibitors. The manufacturer was seeking to obtain a new DRG assignment for cases involving platelet inhibitors. The non-MedPAR data purported to show cases involving platelet inhibitors. As discussed in the proposed rule, we concluded it was not feasible to use the non-MedPAR data submitted to us because, among other things, we did not have information to verify that the cases actually involved the drug, nor did we have information to verify that the cases reflected a representative sample (and did not simply reflect high cost cases).

Effective October 1, 1998, we implemented a code for platelet inhibitors, but until we receive bills for Medicare discharges occurring during FY 1999, the MedPAR data do not enable us to distinguish between cases with platelet inhibitors and cases without platelet inhibitors (63 FR 40963). Representatives of the pharmaceutical company first presented us with non-MedPAR data during the rulemaking process for FY 1999. The data were compiled by a health information company, and purported to show, for cases from a sample of hospitals, the average standardized charges (as calculated by the health information company) for different classes of patients.

In the FY 1999 final rule, we stated a number of reasons for rejecting the non-MedPAR data we had received. Basically, the data were unreliable and the data's use was not feasible—the data could not be validated or verified.

After publication of the July 31, 1998 final rule, we met and corresponded on several occasions with the manufacturers, vendors, and legal representatives of the pharmaceutical company in an effort to resolve data issues. We reiterated that, among other things, we needed to know for each case the hospital that furnished the services. Before the publication of the proposed rule, we had not received information necessary to validate the data or the data's representativeness.

We remain open to considering non-MedPAR data in the DRG reclassification and recalibration process, but, consistent with the Conference Report, as well as our longstanding policies, the data must be ''reliable'' and ''validated.'' The July 31, 1998 final rule reflected the major factors that we consider in evaluating whether data are feasible, reliable, and validated; however, because we believed it might be useful, we discussed these issues in much greater detail in the May 7, 1999 proposed rule.

2. The DRG Reclassification and Recalibration Process

In order to understand whether it is feasible to use non-MedPAR data, and whether the data are reliable and validated, it is critical to understand the DRG recalibration and reclassification process. As described earlier, one of the first steps in the annual DRG recalibration is that the Medicare hospital inpatient claims (in the MedPAR file) from the preceding Federal fiscal year are classified using the DRG classification system (proposed or final) for the upcoming year. Cases are classified into DRGs based on the principal diagnosis, up to eight additional diagnoses, and up to six procedures performed during the stay, as well as age, sex, and discharge status of the patient. Each case is classified into one and only one DRG.

As the term suggests, the relative weight for each DRG reflects *relative* resource use. The recalibration process requires data that enable us to compare resource use across DRGs. As explained earlier, as part of the recalibration process, we standardize the charges reflected on each Medicare claim to remove the effects of area wage differences, the IME adjustment, and the DSH adjustment; in order to standardize charges, we need to know which hospital furnished the service. For each DRG, we calculate the average of the standardized charges for the cases classified to the DRG. To calculate DRG relative weights, we compare average standardized charges across DRGs.

In evaluating whether it is appropriate to reclassify cases from one DRG to another, we examine the average standardized charges for those cases. The recalibration process and the reclassification process are integrally related; to evaluate whether cases involving a certain procedure should be reclassified, we need to have information that (1) enables us to identify cases that involve the procedure and cases that do not involve the procedure, and (2) enables us to determine appropriate DRG relative weights if certain cases are reclassified.

3. Feasible, Reliable, Validated Data

As indicated above, the Conference Report reflected the conferees' belief that, ''to the extent feasible,'' HCFA should consider ''reliable, validated data'' in recalibrating and reclassifying DRGs. The concepts of reliability and validation are closely related. In order for us to use non-MedPAR data, the non-MedPAR data must be independently validated. When an entity submits non-MedPAR data, we

must be able to independently review the medical records and verify that a particular procedure was performed for each of the cases that purportedly involved the procedure. This verification requires the identification of a particular Medicare beneficiary and the hospital where the beneficiary was treated, as well as the dates involved. Although it is unlikely that we would review 100 percent of thousands of cases submitted for review, at a minimum, we must be able to validate data through a random sampling methodology. We must also be able to verify the charges that are reflected in the data.

Independent validation is particularly critical in part because the non-MedPAR data might be submitted by (or on behalf of) entities that have a financial interest in obtaining a new DRG assignment and in obtaining the highest possible DRG relative weight. If we receive non-MedPAR data that purport to reflect cases involving a certain procedure and a certain level of charges, we must have some way to verify the data.

Even if non-MedPAR data are reliable and verifiable, that does not mean it is necessarily ''feasible'' to use the data for purposes of recalibration and reclassification. In order to be feasible for these purposes, the non-MedPAR data must enable us to appropriately measure relative resource use across DRGs. It is critical that cases are classified into one *and only one* DRG in the recalibration process, and that we have information that enables us to standardize charges for each case and determine appropriate DRG relative weights. Moreover, the data must reflect a complete set of cases or, at a minimum, a representative sample of hospitals and claims.

If cases are classified into more than one DRG (or into the incorrect DRG) in the recalibration process, or if the non-MedPAR data reflect an unrepresentative sample of cases, the measure of relative resources would be distorted. For example, cases of percutaneous transluminal coronary angioplasty (PTCA) treated with GPIIb/IIIa platelet inhibitors (procedure code 99.20) are currently classified to DRG 112. Prior to the publication of the proposed rule, the same drug manufacturer discussed above provided us with information on the average charges for a sample of cases that purportedly involve PTCA, for the purpose of evaluating whether these cases should be moved to the higher-weighted DRG 116. However, without adequate identification of the cases to allow us to specifically identify all of the cases treated with platelet inhibitors, the relative weight for DRG 112 would reflect the costs of platelet inhibitor cases. This distortion would result in excessive payments under DRG 112, and thus undermine the integrity of the recalibration process.

Therefore, in order for the use of non-MedPAR data to be feasible, generally we must be able to accurately and completely identify all of the cases to be reclassified from one DRG to another. At a minimum, we must have some mechanism for ensuring that DRG weights are not inappropriately inflated (or deflated) to the extent that a DRG weight reflects cases that would be reclassified to a different DRG.

In short, then, for use of non-MedPAR data to be feasible for purposes of DRG recalibration and reclassification, the data must, among other things (1) be independently verifiable, (2) reflect a complete set of cases (or a representative sample of cases), and (3) enable us to calculate appropriate DRG relative weights and ensure that cases are classified to the ''correct'' DRG, and to one DRG only, in the recalibration process.

4. Submission of Data

Finally, in order for use of non-MEDPAR data to be feasible, we must have sufficient time to evaluate and test the data. The time necessary to do so depends upon the nature and quality of the data submitted. Generally, however, a significant sample of the data should be submitted by August 1, approximately 8 months prior to the publication of the proposed rule, so that we can test the data and make a preliminary assessment as to the feasibility of the data's use. Subsequently, a complete database should be submitted no later than December 1 for consideration in conjunction with the next year's proposed rule.

5. How the Prospective Payment System Ensures Access to New Technologies

As noted at the outset of this discussion, the Conference Report that accompanied the BBA indicated that we should consider non-MEDPAR data, to the extent feasible, ''in order to ensure that Medicare beneficiaries have access to innovative new drug therapies'' (H.R. Conf. Rep. No. 105–217 at 734 (1997)). There seems to be a concern that, if a new technology is introduced, and if the new technology is costly, then Medicare would not make adequate payment if the new technology is not immediately placed in a new DRG. This concern is unfounded. As explained below, the Medicare hospital inpatient prospective payment does ensure access to new drug therapies, and to new technologies in general.

First, to the extent a case involving a new technology is extremely costly relative to the cases reflected in the DRG relative weight, the hospital might qualify for outlier payments, that is, additional payments over and above the standard prospective payment rate.

Second, Medicare promotes access to new technologies by making payments under the prospective payment system that are designed to ensure that Medicare payments for a hospital's cases *as a whole* are adequate. We establish DRGs based on factors such as clinical coherence and resource utilization. Each diagnosis-related group encompasses a variety of cases, reflecting a range of services and a range of resources. Generally, then, each DRG reflects some higher cost cases and some lower cost cases.

For some cases, the hospital's costs might be higher than the payment under the prospective payment system; this does not mean that the DRG classifications are ''inappropriate.'' For other cases, the hospital's costs will be lower than the payment under the prospective payment system. We believe that Medicare makes appropriate payments for a hospital's cases as a whole.

Each year we examine the best data available to assess whether DRG changes are appropriate and to recalibrate DRG relative weights. As we have indicated on numerous occasions, it usually takes 2 years from the time a procedure is assigned a code to collect the appropriate MedPAR data and then make an assessment as to whether a DRG change is appropriate. This timetable applies to reclassifications that would lead to decreased payment as well as those that would increase payment. In fact, the introduction of new technologies itself might lead to either higher than average costs or *lower* costs.

Our ability to evaluate and implement potential DRG changes depends on the availability of validated, representative data. We believe that our policies ensure access to new technologies and are critical to the integrity of the recalibration process. We still remain open to using non-MedPAR data if the data are reliable and validated and enable us to appropriately measure relative resource use.

We received a number of comments regarding this issue, including comments from MedPAC, pharmaceutical manufacturers (including two manufacturers of platelet inhibitor drugs), an industry manufacturers' association, and several

cardiologists. We received only one comment from a State hospital association; otherwise, hospital associations were silent on this issue.

Comment: MedPAC stated that HCFA's general criteria provide a valid basis for assessing the feasibility and appropriateness of using outside data to establish DRG assignments and relative weights for specific technologies. MedPAC believes that it would be helpful to entities that desire to submit useful data if HCFA would establish and publish explicit data standards to guide their efforts. MedPAC suggested the criteria might include the format and content of the patient care records; the minimum sample size; required documentation of sampling procedures; acceptable methods for ensuring that the sampled providers were representative of the relevant provider universe; and any other information that HCFA considered essential to establish the validity and reliability of the submitted data. MedPAC believes that the criteria would help to prevent misunderstandings and ensure HCFA's ability to assess whether the submitted data were adequate to serve as a basis for DRG assignment before actual MedPAR claims become available.

Response: We appreciate the Commission's support of our general criteria. We would prefer to gain further experience working with non-MedPAR data before we develop any specific criteria regarding sample sizes or methodologies. This will enable us to establish criteria that realistically reflect the availability of such data and the general suitability of the data for use in the DRG reclassification and recalibration process. Our intent at this time is to address some fundamental criteria that must be taken into consideration by outside parties interested in submitting non-MedPAR data.

We note that the timetable we set forth in the proposed rule is intended to provide adequate opportunity to permit outside parties to conform their data to our needs through testing and resubmission. This is the primary reason we believe it is generally necessary to have a sample of the data 8 months prior to the publication of the proposed rule. We are willing to meet with outside parties interested in submitting non-MedPAR data for consideration, and would suggest that those interested in submitting such data in the future should contact us to discuss the specific data they wish to submit and whether the data may be adequate.

Comment: One commenter, while supporting the idea that the data must be reliable and verifiable, indicated that HCFA should consider other means by which to accomplish this purpose. The commenter stated that many of the sources for data are restricted from releasing identifying elements of the data they collect. The commenter claimed, for example, that they could validate the method by which the data were assembled, thereby alleviating our concern that the cases may not represent Medicare beneficiaries or that the reported charges are inaccurate.

Response: We are open to considering any feasible method for validating non-MedPAR data, and that is why at this time we are not specifying explicit criteria for the types of data we will or will not consider. Instead, we have outlined general guidelines and fundamental objectives that must be met. One of those fundamental objectives is that we must be able to validate the data and to accurately identify cases to be reclassified during DRG recalibration.

In order to preserve the integrity of the DRG reclassification and recalibration process, we generally believe it is imperative that we are able to independently validate the data submitted. As noted previously, if we receive non-MedPAR data that purport to reflect cases involving a certain procedure and a certain level of charges, we must have some way to verify that data. In addition, it is not enough to simply decide that a particular diagnosis or procedure code should now be classified to a higher-weighted DRG. Cases in the MedPAR data used for recalibration with that diagnosis or procedure code should be reclassified accordingly. Otherwise, these cases will affect the calculation of the relative weights of other DRGs. Therefore, in order to allow us to ensure the accuracy of DRG recalibration, we must have some mechanism for ensuring that DRG weights are not inappropriately inflated.

Comment: Some commenters stated that the criteria regarding the feasibility of using the data are inconsistent with the intent of the Conference Report language. The commenters contend that there is no need to identify each case involving a new technology. Rather, the agency can extrapolate the findings from a representative sample of cases and estimate which cases must be moved from one DRG to another. Two of the commenters stated that this approach was used in reclassifying lithotripsy to an appropriate DRG, and that extrapolation is used to some degree in setting the physician fee schedule and was used in the proposed outpatient prospective payment system. One commenter wanted us to clarify that we would accept a representative, statistically valid sample of both non-HCFA and HCFA data that reflect cases for a period of less than a full year, as well as requesting that we specify the sources (for example, private payers, manufacturers of medical technologies, or suppliers) from which we are willing to accept such data.

Response: We did not rule out the use of extrapolation based on non-MedPAR data in the proposed rule. In fact, we stated that the data must reflect either a complete set of cases, or, at a minimum, a representative sample of hospitals and claims. However, as stated previously, the process of recalibrating the DRG weights requires that cases be moved consistent with the reclassification of diagnosis or procedure codes from one DRG to another. Failure to do so could lead to inflated or deflated relative weights, which, in turn, result in over or underpayments for cases in the affected DRGs.

We are attempting to accommodate the realities faced by outside parties as they attempt to collect and present non-MedPAR data for consideration. In addition, we will continue to explore our processes for ways to incorporate such data while preserving the empirical and clinical integrity of the recalibration process.

As noted by two commenters, in the September 3, 1986 final rule (51 FR 31486), we did, based on analysis by the Prospective Payment Assessment Commission (ProPAC), assign all cases involving a principal diagnosis of urinary stones treated by extracorporeal shock wave lithotripsy (ESWL) to DRG 323 (Urinary stones, age >69 and/or CC). Prior to this DRG change, ESWL cases were assigned to either DRG 323 or DRG 324, depending on the presence of a CC or based on the patients age (over 69). The Commission, an independent advisory body established by Congress (and MedPAC's predecessor organization), obtained information on ESWL procedure costs and other routine and ancillary hospital service charges from the American Heart Association (AHA), the American Urological Association, and seven hospitals that furnished ESWL. In addition, ProPAC obtained a preliminary summary of a study conducted by the Institute for Health Policy Analysis at Georgetown University Medical Center. This study included cost data from 16 hospitals that furnished lithotripsy. At the time of these studies, approximately 50 hospitals were furnishing ESWL. Because the ProPAC data were obtained directly from hospitals and were verified by the Commission at the

hospital level, we believed the data were reliable and used the data as a basis for reassigning ESWL cases to DRG 343 only. A full explanation of the study and ProPAC's analysis and recommendations can be found in the Technical Appendixes that accompanied ProPAC's April 1, 1986 Report to Congress.

We have not precluded using either external or internal data that represent less than a full year's worth of cases. For example, we could examine a partial year's worth of cases from the current Federal fiscal year rather than the preceding year's complete MedPAR. Once again, however, a feasible approach must be developed to enable the appropriate classification and recalibration of the DRG weights.

Finally, we do not believe it is necessary, or appropriate, to identify in advance the sources from which we are willing to accept data. At this time, we remain open to considering any data source that is reliable, verifiable, and feasible. We would note, however, that involving hospitals in any data collection would probably aid HCFA in any validation effort. Generally, if we receive non-MedPAR data, we will be contacting the hospitals that furnished the sources to verify some or all of the data.

Comment: Two commenters stated the timeframe for submission of the non-MedPAR data is unreasonable. They suggested that the submission of data 7 months before the updated DRGs take effect (March 1) in the case of internal HCFA data, and 8 months (February 1) in the case of external data, would more appropriately ensure beneficiary access.

Response: The length of time necessary to validate non-MedPAR data depends on the nature and quality of the data. In the proposed rule, we stated that a significant sample of the data should be submitted by August 1, approximately 8 months prior to the publication of the proposed rule, so that we can verify and test the data and make a preliminary assessment as to the feasibility of the data's use. Subsequently, a complete database should be submitted no later than December 1, approximately 4 months prior to the publication of the proposed rule.

We do not believe that this timeframe is unreasonable. If we were to adopt the commenter's suggestion, we would receive non-MedPAR data only 2 months before the proposed rule is scheduled to be published (April 1). This might not allow us sufficient time to ensure that the data are reliable or valid prior to their use in preparing the proposed rule.

We believe the timeframe we set forth is necessary to enable us to independently validate any non-MedPAR data submitted. In order to verify the data's reliability and validity, we believe we need to review a sufficient number of the medical records associated with the data. Expecting us to be able to accomplish this in a matter of weeks after receiving the data (which is all the time that would be available for data received in February due to the requirement to begin the process of reclassifying and recalibrating the proposed DRGs by the end of February in order for the proposed rule to be published by April 1) is unrealistic.

Comment: Many of the commenters, including the manufacturer of the platelet inhibitor drug, national associations representing device and drug manufacturers, and individual cardiologists, argued that our current process has inhibited the development of new medical technologies, and that the criteria for the use of non-MedPAR data are unworkable and would further slow the development of new technologies. Several commenters asserted that certain new technologies (including platelet inhibitors) are denied to Medicare beneficiaries due to insufficient payment.

Response: After 15 years of administering the prospective payment system, we do not have any independent evidence that Medicare beneficiaries are being denied access to new technologies by hospitals or physicians. Although we have always acknowledged that there is a time-lag between the time new technologies are introduced and the point at which we can begin to accurately identify their associated costs, we believe this has not hampered Medicare beneficiaries' access to these new technologies. The fact that under the prospective payment system a hospital might lose money on some cases but will gain money on other cases is well understood by hospitals. We received no comments from hospitals or beneficiary advocates complaining about access to new technologies in general or drug therapies in particular, and only a brief comment from a State hospital association that indicated that the use of non-MedPAR data should extend beyond drug therapies. Furthermore, as provided in § 489.53(a)(2), HCFA may terminate its participation agreement with any hospital if HCFA finds that the hospital places restrictions on the persons it will accept for treatment and it fails either to exempt Medicare beneficiaries from those restrictions or to apply them to Medicare beneficiaries the same as to all people seeking care.

Comment: Several commenters, including the manufacturer of a platelet inhibitor drug and individual cardiologists, specifically commented on our discussion in the proposed rule of the attempts by the manufacturer of the drug to introduce its data into the process, with the objective that cases in which platelet inhibitor therapy is administered should be reclassified from DRG 112 (Permanent Cardiovascular Procedures) to DRG 116 (Other Permanent Cardiac Pacemaker Implant or PTCA with Coronary Artery Stent Implant) for FY 2000. The commenters stated that HCFA has been unwilling to consider the data. One commenter stated that HCFA refused to accept these data when they were offered in December 1998.

Response: As discussed in great detail above, and also in the FY 1999 final rule, our review of the previous data submitted by the drug manufacturer found the data to be insufficient. Despite our consultation with the manufacturer's representatives in advance of their submission of data during the rulemaking process for FY 1999 (that is during the first half of calendar year 1998), in which we advised them that we must be able to identify individual hospitals and patients in order to utilize the data, this information was not included on over 90 percent of the cases submitted in May 1998. As noted in the May 7, 1999 proposed rule, we continued to meet and correspond with the manufacturers, contractors, and legal representatives of the pharmaceutical company in an effort to resolve data issues. At no time have we refused to consider any data offered by the company or its agents.

However, our discussions with these parties led us to the conclusion that it might be helpful to identify general criteria for submission of non-MedPAR data in the proposed rule. In particular, we were concerned that outside parties wishing to submit non-MedPAR data were unfamiliar with our current process and the importance of accurately reclassifying and recalibrating the DRGs. The DRG relative weights are the principle factor in adjusting the prospective payments for each of approximately 11 million Medicare discharges each year. In addition to the potential financial implications to the Medicare Trust Fund and to hospitals themselves if these weights are inaccurate, inappropriately assigning cases to higher-weighted DRGs may create incentives that are not in the best interest of Medicare beneficiaries.

We are hopeful that, by explaining the general criteria for submitting non-

MedPAR data and receiving public comments on those criteria, we can help to ensure that in the future those interested in submitting non-MedPAR data will be better informed regarding how the process can work. In particular, we believe the timeframe we set will enable us to work effectively with those interested in submitting non-MedPAR data to help them provide data that can be used.

Comment: A manufacturer of a platelet inhibitor drug expressed concern that HCFA may assign a special DRG classification for patients who receive coronary intervention with an angioplasty and treatment with platelet inhibitor therapy, but not for acute coronary syndrome patients who receive the same drugs without coronary intervention. These latter cases are assigned to DRG 124 (Circulatory Disorders Except Acute Myocardial Infarction, with Cardiac Catheterization and Complex Diagnoses) or DRG 140 (Angina Pectoris). The commenter stated that if we were to modify payment for one use and not the other, it would potentially create a financial incentive for expensive, risky, and invasive treatment. Making payment provisions for both indications at the same time, on the other hand, will give neither use an advantage over the other. We were asked by the commenter to evaluate platelet inhibitor therapy cases assigned to DRG 124 or DRG 140.

Response: Because this is the first comment we have received regarding the noncoronary intervention use of the therapy, an extensive study of DRGs 124 and 140 before publication of this final rule was not feasible. We will evaluate this issue as part of our annual update for FY 2001, when we will have MedPAR data capturing injection or infusion of platelet inhibitor (ICD–9–CM procedure code 99.20). This commenter's concern that increasing payment for one application of platelet inhibitors but not for others could actually create an inappropriate incentive in favor of a more invasive treatment, illustrates the importance of proceeding cautiously in the process of DRG reclassification and recalibration. We have a responsibility not to inadvertently create financial incentives that adversely affect clinical decisionmaking.

Comment: During the comment period, we received a revised set of data from the manufacturer seeking to have platelet inhibitor therapy cases receiving angioplasty reclassified from DRG 112 to DRG 116. The data contain 27,673 cases from 164 hospitals in which Medicare patients underwent an angioplasty. The commenter describes the data as Athe public MedPAR file with an additional field that identifies the MedPAR case as involving an angioplasty with or without platelet inhibitor therapy. Thus, HCFA can identify the patient and the hospital from these data such that they are reliable and verifiable. It also is a representative sample of claims and, therefore, it is feasible for the agency (HCFA) to use the data set. In light of the significant number of angioplasty cases contained in the data, HCFA should be able to utilize accepted statistical methods to extrapolate the results of these data and recalibrate the DRG weights.@ The manufacturer indicated that HCFA should reclassify angioplasty cases with platelet inhibitor therapy on the basis of these data.

Included with the comment are tables summarizing the results of the commenter's analysis of the data, showing that angioplasty cases receiving platelet inhibitor therapy are more expensive than those not receiving platelet inhibitors. According to the commenter, the approximate average standardized charges for the different classes of patients are as follows:

- No drug, no stent: $19,877.
- No drug, with stent: $22,968.
- Drug, no stent: $26,389.
- Drug, stent: $30,139.

Response: The submission of these data illustrates the problems of attempting to ensure that non-MedPAR data are reliable, validated, and feasible to use. Our greatest concern with respect to the data submitted by the commenter is that we must validate the data to assess whether they are reliable, and (as explained further below) this validation process would take significant time and resources because the data are not readily verifiable.

The data file submitted by the commenter is a MedPAR file with an additional field. The commenter has ''marked'' certain cases in the MedPAR file. The file contains variables named REO–FLAG and STENT–FLAG, which purportedly indicate the case received the platelet inhibitor or a coronary stent, respectively. However, the variables were placed in the file by the commenter, based on information that was not made available to HCFA; we did not receive any information to verify that the cases flagged by the commenter involved platelet inhibitors. Although we can use the FY 1998 MedPAR data to validate whether a case received a coronary stent (because the FY 1998 MedPAR data include the corresponding procedure code (36.06)), we cannot use the FY 1998 MedPAR file by itself to validate whether a case involved platelet inhibitors because the procedure code for the use of platelet inhibitors (procedure code 99.20) was not effective until October 1, 1998. Therefore, we cannot validate the data submitted to us without further investigation.

In order to do so, we believe it is necessary to review the medical records associated with the cases. Unless the entity submitting the non-MedPAR data includes medical records (or other information that would enable us to validate the data), the only method HCFA has to review medical records is through Peer Review Organization (PRO) review. Thus, we would need to request assistance in the PRO in each of the States represented in the submitted data. The PROs would then contact the hospitals involved to request copies of the medical records. Finally, based on reviewing those records, the PROs would notify HCFA whether the data can be validated.

Conducting a PRO independent validation would require a minimum of 2 to 3 months, and possibly much longer. Thus, there is not sufficient time available to conduct a review of the data submitted by the drug manufacturer. Since we cannot validate the data, it would compromise the integrity of the DRG recalibration process to use these data in the DRG reclassification and recalibration for FY 2000.

We note that the process used by the manufacturer to collect these data is not specified. Based upon our prior discussions with the manufacturer and its contractor that prepared the data, we believe the 164 hospitals represented in the sample have a contract for data analysis and review with the consultant. Although we would not rule out the possibility that this sample is statistically sufficient, we note that in general, random sampling is necessary for generalization beyond the sample itself.

The analysis submitted by the commenter is similar to that presented in last year's final rule. As we indicated at that time, our general process of waiting until we have identifiable MedPAR data applies to changes that would enhance payment as well as those that would decrease payment. Absent alternative data meeting the criteria otherwise described in the proposed rule and in this final rule, we cannot reclassify the administration of platelet inhibitors with angioplasty (procedure code 99.20) from DRG 112 to DRG 116.

Comment: Some commenters believed that the proposed weights for DRGs 112 and 116 are dramatically lower than they should be and the result will be a disincentive to use these technologies.

Another commenter stated that by not reclassifying cases receiving platelet inhibitors with angioplasty to DRG 116, we actually promote the inaccuracy of the DRG weights, by grouping these higher-cost cases with other lower-cost cases in DRG 112.

Response: With regard to the comment concerning the weights of DRGs 112 and 116, we refer the commenters to the discussion above in section II.C of this preamble concerning the steps we take in recalibrating the weights. Every year when the relative weights are recalibrated, we use charge information from the most recent Medicare data available. That is, we use the charges reported by hospitals for the cases under each DRG to establish the relative weights. Each DRG weight represents the average resources required to care for cases in that particular DRG relative to the average resources used to treat cases in all DRGs. We have not identified any problems or anomalies related to the cases in DRGs 112 and 116 and are confident that the relative weights are accurate.

With respect to the comment about our promoting the inaccuracy of the DRG weights by failing to reclassify platelet inhibitor cases, the commenter does not appear to understand the difference between reclassification and recalibration. That is, the commenter argues that the DRG relative weights are inaccurate because high-cost cases are not reclassified to a higher-weighted DRG. However, our point regarding the accuracy of the relative weights pertains to the necessity that, in the process of recalibration, cases are grouped in the DRG to be used for payment for similar cases during the upcoming year. Thus, the relative weights are accurate in the sense that they are calculated by grouping cases according to the DRG under which they would be paid.

Comment: One of the manufacturers of platelet inhibitor therapy disagreed with our statement in the proposed rule that the prospective payment system outlier policy would address the rationing of new technology to Medicare beneficiaries. The commenter argues that cases of platelet inhibitor therapy would not receive outlier payments because the cost of the drug, while it is several thousand dollars over the DRG payment, is not in excess of the fixed loss threshold ($14,575 over the DRG payment in the proposed rule for FY 2000).

Response: Section 1886(d)(5)(A) of the Act provides for payments in addition to the basic prospective payments for outlier cases, cases involving extraordinarily high costs. Our statement in the proposed rule was meant to apply to all new technologies, and not specifically to platelet inhibitor therapy. As stated previously, the prospective payment system reflects ''averaging principles,'' which means, among other things, that a hospital might lose money on some cases but will gain money on other cases; sometimes new technologies lead to lower costs and we might Aoverpay@ hospitals for those cases. If a case does not qualify for an outlier payment, then presumably the case falls within the ''typical'' range of costs for cases in the DRG. We believe that, as a whole, the prospective payment system does ensure access to new technologies, including platelet inhibitor therapy.

III. Changes to the Hospital Wage Index

A. Background

Section 1886(d)(3)(E) of the Act requires that, as part of the methodology for determining prospective payments to hospitals, the Secretary must adjust the standardized amounts ''for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level.'' In accordance with the broad discretion conferred under the Act, we currently define hospital labor market areas based on the definitions of Metropolitan Statistical Areas (MSAs), Primary MSAs (PMSAs), and New England County Metropolitan Areas (NECMAs) issued by the Office of Management and Budget (OMB). OMB also designates Consolidated MSAs (CMSAs). A CMSA is a metropolitan area with a population of one million or more, comprised of two or more PMSAs (identified by their separate economic and social character). For purposes of the hospital wage index, we use the PMSAs rather than CMSAs since they allow a more precise breakdown of labor costs. If a metropolitan area is not designated as part of a PMSA, we use the applicable MSA. Rural areas are areas outside a designated MSA, PMSA, or NECMA.

We note that effective April 1, 1990, the term Metropolitan Area (MA) replaced the term Metropolitan Statistical Area (MSA) (which had been used since June 30, 1983) to describe the set of metropolitan areas comprised of MSAs, PMSAs, and CMSAs. The terminology was changed by OMB in the March 30, 1990 **Federal Register** to distinguish between the individual metropolitan areas known as MSAs and the set of all metropolitan areas (MSAs, PMSAs, and CMSAs) (55 FR 12154). For purposes of the prospective payment system, we will continue to refer to these areas as MSAs.

Beginning October 1, 1993, section 1886(d)(3)(E) of the Act requires that we update the wage index annually. Furthermore, this section provides that the Secretary base the update on a survey of wages and wage-related costs of short-term, acute care hospitals. The survey should measure, to the extent feasible, the earnings and paid hours of employment by occupational category, and must exclude the wages and wage-related costs incurred in furnishing skilled nursing services. As discussed below in section III.F of this preamble, we also take into account the geographic reclassification of hospitals in accordance with sections 1886(d)(8)(B) and 1886(d)(10) of the Act when calculating the wage index.

B. FY 2000 Wage Index Update

The final FY 2000 wage index values in section VI of the Addendum to this rule (effective for hospital discharges occurring on or after October 1, 1999 and before October 1, 2000) are based on the data collected from the Medicare cost reports submitted by hospitals for cost reporting periods beginning in FY 1996 (the FY 1999 wage index was based on FY 1995 wage data).

The final FY 2000 wage index includes the following categories of data associated with costs paid under the hospital inpatient prospective payment system (as well as outpatient costs), which were also included in the FY 1999 wage index:

- Salaries and hours from short-term, acute care hospitals.
- Home office costs and hours.
- Certain contract labor costs and hours.
- Wage-related costs.

Consistent with the wage index methodology for FY 1999, the final wage index for FY 2000 also continues to exclude the direct and overhead salaries and hours for services not paid through the inpatient prospective payment system, such as skilled nursing facility services, home health services, or other subprovider components that are not subject to the prospective payment system. (As discussed in section III.C of this preamble, we are refining the methodology for calculating the wage index for FY 2000.)

We calculate a separate Puerto Rico-specific wage index and apply it to the Puerto Rico standardized amount. (See 62 FR 45984 and 46041.) This wage index is based solely on Puerto Rico's data. Finally, section 4410 of the BBA provides that, for discharges on or after October 1, 1997, the area wage index

applicable to any hospital that is not located in a rural area may not be less than the area wage index applicable to hospitals located in rural areas in that State.

Comment: In a general comment on the wage index, MedPac noted that new measures are needed to implement each new prospective payment system as well as for Medicare+Choice plans and suggested that we explore alternative strategies for obtaining labor prices that could be applied to each type of provider affected. MedPAC offers to assist us in examining this issue.

Response: We agree with MedPAC that this is an area warranting further attention to determine whether it is appropriate to continue to adjust payments for these other provider types based on the relative average hourly wages of hospital employees, and whether the collection of wage data for every type of Medicare provider is feasible or necessary. Currently, the data used to calculate the hospital wage index is used broadly in payment systems for other types of Medicare providers. New prospective systems for skilled nursing facilities, hospital outpatient services, and home health agencies will continue to use the hospital wage index data for the foreseeable future. We have collected data separately for skilled nursing facilities, but, pending further development and auditing of these data, we continue to use the hospital wage data (before reclassifications by the Medicare Geographic Classification Review Board) for adjusting skilled nursing facility payments at this time.

C. FY 2000 Wage Index Methodology Changes

In the July 31, 1998 final rule, we reiterated our position that, to the greatest degree possible, the hospital wage index should reflect the wage costs associated with the areas of the hospital included under the hospital inpatient prospective payment system (63 FR 40970). That final rule contained a detailed discussion concerning the costs related to teaching physicians, residents, and CRNAs, all of which are paid by Medicare separately from the prospective payment system. For reasons outlined in detail in that final rule, we decided not to remove those costs from the calculation of the FY 1999 wage index, but to review updated data and consider removing them in developing the FY 2000 wage index.

In response to concerns within the hospital industry related to the removal of these costs from the wage index calculation, the American Hospital Association (AHA) convened a workgroup to develop a consensus recommendation. The workgroup, which consisted of representatives from national and State hospital associations, recommended that costs related to teaching physicians, residents, and CRNAs should be phased-out of the wage index calculation over a 5-year period. Based upon our analysis of hospitals' FY 1996 wage data, and consistent with the AHA workgroup's recommendation, we proposed to phase-out these costs from the calculation of the wage index over a 5-year period. The proposed FY 2000 wage index was based on a blend of 80 percent of an average hourly wage including these costs, and 20 percent of an average hourly wage excluding these costs.

Comment: Commenters unanimously supported our proposal to remove teaching-related and CRNA costs from the wage index. Further, two commenters recommended that we emphasize that Medicare pays its share of teaching-related wage costs through direct graduate medical education (GME) payments and that these costs are being removed from the wage index only insofar as Medicare continues to pay the costs outside of the hospital prospective payment system. Additionally, commenters favored the proposed 5-year phase-out of these costs to reduce significant redistributive impacts.

MedPAC, however, recommended that, rather than reducing the weights for the old calculation and increasing the weights for the new calculation by the proposed 20 percent each year, we should apply smaller weights to the new wage index calculation for the first 2 years. Its rationale for this is its concern that inaccurate reporting of teaching physician data, and our methodology for removing costs for hospitals that fail to report these data, may inappropriately lower the wage index values for nonteaching hospitals in the same labor market areas.

Response: We are pleased to receive strong support for our efforts to remove from the hospital wage index, wage costs that are associated with areas of the hospital not included under the hospital prospective payment system. Therefore, beginning with the FY 2000 wage index, and over a 5-year period, we are phasing-out costs related to teaching physicians, residents, and CRNAs. As recommended, we emphasize that our rationale for removing these costs from the wage index calculation is that Medicare pays for these costs separately, and these costs will be excluded from the wage index as long as they are paid separately from the hospital prospective payment system.

With respect to MedPAC's recommendation that the weight given to the average hourly wage calculated after removing CRNAs, teaching physicians, and residents, should be less than 20 percent for FY 2000, we disagree. If we applied a percentage less than 20 percent for FY 2000 (and FY 2001), we then would have to apply a higher percentage phase-out in a later fiscal year (or years) and thus increase the redistributive impact for that year. We believe that applying 20 percent increments each year promotes the smoothest transition to total exclusion of the costs.

1. Teaching Physician Costs

As discussed in the FY 1999 final rule and the FY 2000 proposed rule, before FY 1999, we included direct physician Part A costs and excluded contract physician Part A costs from the wage index calculation. Since some States prohibit hospitals from directly employing physicians, hospitals in these States were unable to include physician Part A costs because they were incurred under contract rather than directly. Therefore, for cost reporting periods beginning in 1995, we began separately collecting physician Part A costs (both direct and contract) so we could evaluate how to best handle these costs in the wage index calculation. Based on our analysis of the 1995 wage data, we decided to include the contract physician salaries in the wage index beginning with FY 1999.

In the July 31, 1998 final rule, in response to comments regarding the inclusion in physician Part A costs of teaching physician costs for which teaching hospitals are already compensated through the Medicare GME payment, we stated that we would collect teaching physician data ''as expeditiously as possible in order to analyze whether it is feasible to separate teaching physician costs from other physician Part A costs'' (63 FR 40968). Excluding teaching physician costs from the wage index calculation is consistent with our general policy to exclude from that calculation those costs that are paid separately from the prospective payment system.

Because the FY 1996 cost reports did not identify teaching physician salaries and hours separately from physician Part A costs, we instructed our fiscal intermediaries to collect, through a survey, teaching physician costs and hours from the teaching hospitals they service. Specifically, we requested collection of data on the costs and hours related to teaching physicians that were

included in Line 4 (salaried), Line 10 (contracted), Line 12 (home office and related organizations), and Line 18 (wage-related costs) of the Worksheet S–3, Part II. In our instructions accompanying the survey, we indicated that these teaching-related costs are those payable under the per resident amounts (§ 413.86) and reported on Worksheet A, Line 23 of the hospital's cost report.

Survey data were received from approximately 59 percent of teaching hospitals reporting physician Part A costs on their Worksheet S–3, Part II (500 out of 845). Our fiscal intermediaries reviewed the survey data for consistency with the Supplemental Worksheet A–8–2 of the hospitals' cost reports. Supplemental Worksheet A–8–2 is used to apply the reasonable compensation equivalency limits to the costs of provider-based physicians, itemizing these costs by the corresponding line number on Worksheet A.

Hospitals were given until March 5, 1999 to request changes to the initial survey data. Fiscal intermediaries had until April 5, 1999 to submit the revised data to the Health Care Provider Cost Report Information system (HCRIS) for inclusion in the May 1999 final wage data file. Due to the extraordinary effort needed to collect these data and the importance of accurately removing teaching physician costs, we allowed hospitals to request revisions to their teaching survey data up until June 5, 1999.

The hospital industry workgroup also recommended that if the teaching data collected by the intermediaries are not accurate or reliable, HCFA should include only 20 percent of reported physician Part A costs in the calculation, based on the assumption that 80 percent of total physician Part A costs are related to teaching physicians. In developing the final FY 2000 wage index (as in the proposed), if we had complete survey data for a hospital, that amount was subtracted from the amount reported on the Worksheet S–3 for physician Part A costs. These data had been verified by the fiscal intermediary before submission to us. If we did not have survey data for a teaching hospital as of June 5, 1999, we removed 80 percent of the hospital's reported total physician Part A costs and hours for the wage index.

Although removing 80 percent from the amount reported on the Worksheet S–3 for physician Part A costs allows an estimate of teaching physician costs to be removed in the majority of cases in which survey data are not available, there are instances in which a teaching hospital did not report either survey data or any physician Part A costs on its Worksheet S–3. We identified 19 of these teaching hospitals in our final database (there were 72 of these hospitals identified in the proposed rule). For purposes of calculating the FY 2000 wage index for these 19 hospitals, we subtracted the costs reported on Line 23 of the Worksheet A, Column 1 (Resident and Other Program Costs) from Line 1 of the Worksheet S–3. These costs (from Line 23, Column 1 of Worksheet A) are included in Line 1 of the Worksheet S–3, which is the sum of Column 1, Worksheet A. They also represent costs for which the hospital is paid through the per resident amount under the direct GME payment.

We believe this approach is appropriate in situations in which hospitals have failed to otherwise identify their teaching physician costs. To determine the hours to be removed, we divided the costs reported on Line 23 of Worksheet A, Column 1 by the national average hourly wage for physician Part A costs based upon Line 4 of Worksheet S–3 (the national average hourly wage is $54.48). We indicate these 19 hospitals by an asterisk in Table 3C of this final rule.

In the proposed rule, we invited comments as to whether the proposed method to remove teaching-related costs based on the amount included in Line 23, Column 1 of Worksheet A would be an appropriate method for removing GME costs in the future (and perhaps other excluded area costs as well). We were especially concerned that the earliest cost report on which we would be able to make the necessary changes to capture the separate reporting of teaching physician Part A costs would be those submitted for cost reporting periods beginning during FY 1998. Therefore, we were considering subtracting the costs in Lines 20, 22, and 23 of Worksheet A from Line 1 of Worksheet S–3, Part II, in calculating the FY 2001 wage index. The current Worksheet S–3 is not designed to net out of Line 1 costs that are otherwise included in Column 1 of Worksheet A, but it would be possible to use data from the Worksheet A in a manner similar to that described above.

Comment: Two commenters disagreed with our decision to allow changes to the teaching survey data but not to corresponding lines on Worksheet S–3 during the final wage data correction period (June 5 deadline). They believed we should be willing to accept conforming wage data corrections, even during the final correction period, to achieve the goal of using the most accurate data available.

Response: If hospitals had miscategorized their teaching physician costs on their cost report in such a way that accurately completing the teaching survey would result in their teaching physician survey costs being removed twice, we did authorize corresponding revisions to Worksheet S–3. For example, some hospitals included teaching physician costs in Line 6 of their Worksheet S–3 (which is intended for reporting interns and residents' costs). Therefore, reporting these costs on their teaching physician survey, which would be subtracted from Line 4 for the salaries of teaching physicians directly employed by the hospital, would result in them being removed twice, once when the teaching physician data are subtracted from Line 1 of Worksheet S–3, and again when Line 6 of Worksheet S–3 is subtracted from Line 1.

Comment: We received several comments regarding our proposal to use the teaching survey data for teaching hospitals that submitted surveys but to remove 80 percent of the total physician Part A costs and hours for nonresponsive teaching hospitals. Most commenters supported our reliance on the teaching survey data for the FY 2000 wage index. One commenter added that we should be assertive in insisting that teaching survey data be reported accurately by hospitals and verified by fiscal intermediaries, holding hospitals to a level of accountability that is similar to the certification of a cost report at filing. Another commenter urged us to incorporate the separate collection of teaching physician Part A data into the cost report as soon as possible to ensure that the data submitted by hospitals is consistent.

Although most commenters agreed that we should reduce reported total physician Part A costs by 80 percent for teaching hospitals that do not submit the teaching survey, some took issue with this approach. One national and one State hospital association recommended we remove 100 percent of reported total physician Part A costs from nonresponsive teaching hospitals' total costs as a penalty for not reporting their data. The commenters believe that, for hospitals whose proportion of teaching physician Part A costs relative to total physician Part A costs is greater than 80 percent, there is no incentive to complete the teaching survey. On the other hand, MedPAC recommended that, since HCFA's preliminary teaching survey data indicate that teaching physician Part A costs are 68 percent of total physician Part A costs, we should have adjusted the hospital's data by that amount rather than the higher 80

percent figure. MedPAC comments that, although using the 80 percent figure may give hospitals the incentive to submit the requested survey data if their ratio of teaching physician Part A costs to total physician Part A costs is less than 80 percent, that amount could inappropriately lower the wage index values for other hospitals located in the same MSA as the nonresponsive teaching hospital. The comments do acknowledge, however, the policy dilemma in terms of the incentives not to report that may arise by setting the percentage too low.

Response: We appreciate the commenters' general support of using the survey data, as well as the efforts of hospitals and the fiscal intermediaries in this special data collection effort. We believe that, although the response rate is less than we would have preferred, the end result is a more accurate FY 2000 wage index.

Although Worksheet S–3 is being revised to provide for the separate reporting of teaching physician Part A costs, this change will not be incorporated until cost reporting periods beginning during FY 1998. Therefore, we will have to conduct another teaching physician cost survey corresponding with the FY 1997 wage data. We agree with the commenter's suggestion that the accuracy and completeness of the survey data should be certified by the hospital in the same manner as the accuracy and completeness of the cost report data must be certified.

In our calculation of the FY 2000 wage index, we removed 80 percent of physician Part A costs and hours for teaching hospitals that failed to report their teaching physician costs. We will consider the comment to remove 100 percent of these costs for nonresponsive hospitals in the future, however. Although the 80 percent figure was taken from the industry workgroup's recommendation, we believe it may be appropriate to consider raising this percentage to address the problem of hospitals failing to comply with Medicare instructions.

We appreciate MedPAC's concern that the estimation of teaching physician costs for hospitals that did not report should not disproportionately harm other hospitals in the same labor market area. Similarly, however, these hospitals should not benefit from noncompliance. Also, as noted previously, because the teaching physician costs are being removed gradually, with 80 percent of the FY 2000 wage index based on an average hourly wage that includes all of these costs, we do not believe it is necessary to reduce the 80 percent estimate to an amount based on the percentage of teaching physician Part A costs to all physician Part A costs for hospitals completing the survey to protect other hospitals in the labor market area. Any impact should be relatively minor for this first year.

Comment: Two commenters believed that hospitals that contract with physicians for Part A services are disadvantaged because the cost report and teaching survey instructions seem to be designed only for hospitals that employ physicians.

Response: The cost report and teaching survey do account for the costs of contract physicians. The first year contract physician Part A costs were included in the wage index was FY 1999. Beginning with the FY 1995 cost report, we revised Worksheet S–3 to allow a separate line item for reporting these costs. To improve the reporting for all physician-related wage costs, we made additional changes to the FY 1996 cost report. The teaching survey was patterned after the FY 1996 Worksheet S–3.

The salaries on the Worksheet S–3 for employed physicians derive from column 1 of Worksheet A. Hospitals should report the labor costs associated with contract physicians in column 2 of that same worksheet. If hospitals report their costs properly according to the cost report instructions, hospitals using contract physicians will not be disadvantaged by the way the costs are reported. We encourage hospitals to be diligent in working with their intermediaries if they have questions about reporting costs on the cost report.

Comment: We received four comments regarding the use of Worksheet A, Line 23, Column 1 as a proxy for teaching-related wage costs when a teaching hospital did not report either survey data or any physician Part A costs. One was favorable without qualifications. One commenter recommended that, beginning with the FY 2001 wage index, we should instruct hospitals to report on Worksheet S–3 the wage costs associated with teaching physicians directly from Worksheet A, Line 23 and the corresponding hours directly from hospitals' records. A national hospital association recommended that if we use Worksheet A, Line 23 for teaching salaries and a national average hourly wage for physicians to estimate the associated hours to be removed for nonreporting hospitals, then we should apply this approach to all hospitals. If we apply this method only to hospitals that do not respond to the teaching survey, the commenter believed that we should penalize nonresponsive hospitals by increasing the hourly rate by 25 percent to ensure they are not advantaged by not reporting their costs.

Several hospitals contacted us to report that, although they were listed as one of the 72 hospitals for whom we used Line 23 of Worksheet A to remove teaching physician costs, these costs were actually included in other lines of Worksheet S–3, such as Line 5, Physician Part B services, or Line 6, Interns and Residents. Therefore, since both of these lines are subtracted from Line 1 in our calculation, subtracting Line 23 from Worksheet A would remove these costs twice.

In opposing the use of Line 23 as a proxy for teaching-related costs, one commenter cautioned that, particularly for hospitals in States that are prohibited from employing physicians, Line 23, Column 1 may not include any teaching physician costs. MedPAC also stated concern with this approach, but did not cite any specific problems associated with it.

Response: For FY 2000, we are removing the amount reported on Worksheet A, Line 23, Column 1, only in the absence of teaching survey or Worksheet S–3 data for a hospital but we will continue to explore using this approach rather than the survey for identifying GME and CRNA costs to be removed in the FY 2001 wage index. The approach we adopted has the advantage of being straightforward and easy to apply. Line 1, Column 1 of Worksheet S–3 is equal to Line 101 of Column 1 of the Worksheet A. Line 23 of Column 1, which is for the reporting of nonresidents' costs related to GME that are paid separately from the prospective payment system, is included in Line 101. Therefore, one could argue that the simplest way to remove GME costs from the wage index calculation would be to subtract the costs from Line 1 of Worksheet S–3 that are attributable to the GME cost centers on Worksheet A (Lines 22 and 23).

In carving out an estimate of hours for the final 19 hospitals for which we subtracted Line 23 of Worksheet A from total salaries on Worksheet S–3, we removed an estimated amount of associated hours based on the average hourly wage of all physician Part A salaries. We did not increase this average hourly wage by 25 percent as a penalty for hospitals that did not otherwise report teaching physician costs. We do reserve the right to remove some or all of a hospital's wage data that cannot be appropriately supported by the hospital's records. We also reserve the right to pursue further action in the case of hospitals that intentionally withhold, conceal, or otherwise attempt

to circumvent the cost reporting requirements of their participation agreements.

If we were contacted timely by a hospital that reported its costs from Line 23 of Worksheet A somewhere other than Line 4 of the Worksheet S–3, we did accommodate the hospital's request to avoid removing the teaching physician Part A costs twice. We note that the majority of these situations involved hospitals that did not follow the cost reporting instructions for these costs. Despite MedPAC's general concerns about this approach to removing costs, we did not receive any comments that would cause us to rule out this seemingly straightforward approach for removing GME and CRNA costs from the FY 2001 wage index for all teaching hospitals. The biggest difficulty seems to be related to ensuring that the cost reporting instructions are uniformly followed.

Comment: Two commenters suggested using Worksheet A–8–2 of the cost report, ''Provider-Based Physicians Adjustments,'' to determine physician Part A costs, particularly for costs associated with teaching and contract physicians. The commenters reasoned that, because Worksheet A–8–2 is used to determine allowable cost and hours to be included in the Medicare cost report, HCFA should use Worksheet A–8–2 to determine physician Part A labor costs for wage index purposes. Use of the Worksheet A–8–2 would also ensure the wage index includes only those physician costs paid under Part A. One of the commenters commended us for requesting intermediaries to compare the teaching survey and Worksheet A–8–2 data, but suggested that we should also require intermediaries to use Worksheet A–8–2 data for determining teaching physician wage costs when the survey data are unacceptable.

Response: We agree that, if properly completed, Worksheet A–8–2 should be an acceptable source for teaching physician Part A data. In February, we instructed intermediaries to review hospitals' teaching survey data for consistency with Worksheet A–8–2, and when necessary, revise the data accordingly. One minor problem with relying solely on Worksheet A–8–2 is that it may include some wage-related costs that are excluded from the wage index calculation; however, these should be insignificant. We believe that Worksheet A–8–2 is an appropriate source for physician Part A costs. However, we need to examine Worksheet A–8–2 more closely before requiring that it be used to determine physician part A costs for future wage indexes.

Comment: We received two comments recommending that we remove overhead costs associated with the teaching physician, resident, and CRNA direct costs that are excluded from the wage index. The commenter compared this action to our current policy in which we remove the overhead costs associated with excluded providers such as skilled nursing facilities or rehabilitation units from the wage data. One commenter offered technical assistance to HCFA in this effort.

Response: We agree, in principle, that overhead costs associated with teaching-related and CRNA labor costs should be removed from the wage index calculation in the same way that we remove overhead costs associated with excluded areas of the hospital. However, we believe that the methodology we apply for specific patient care cost centers excluded from the wage data may not be appropriate for removing overhead related to CRNA and GME costs. Therefore, we are grateful for the commenter's offer of technical assistance to develop an appropriate methodology for allocating overhead costs related to CRNAs and GME. We anticipate that this issue will be discussed by HCFA's wage index workgroup later this year, and in next year's proposed rule for FY 2001.

2. Resident and CRNA Part A Costs

The wage index presently includes salaries and wage-related costs for residents in approved medical education programs and for CRNAs employed by hospitals under the rural pass-through provision (§ 412.113(c)). Because Medicare pays for these costs outside the prospective payment system, removing these costs from the wage index calculation would be consistent with our general policy to exclude costs that are not paid through the prospective payment system. However, because these costs were not separately identifiable on Worksheet S–3 before the FY 1995 wage data, we could not remove them.

We began collecting the resident and CRNA wage data separately on the FY 1995 cost report. However, there were data reporting problems associated with these costs. For example, the original FY 1995 cost report instructions for reporting resident costs on Line 6 of Worksheet S–3, Part III, erroneously included teaching physician salaries and other teaching program costs. Also, the FY 1995 Worksheet S–3 did not provide for separate reporting of CRNA wage-related costs. These problems were corrected in the reporting instructions for the FY 1996 cost report, and, therefore, we proposed and are now implementing the removal of CRNA and resident costs over a 5-year period, beginning with the FY 2000 wage index.

We received no comments related to this change.

3. Transition Period

The FY 2000 wage index is based on a blend of 80 percent of hospitals' average hourly wages without removing the costs and hours associated with teaching physician Part A, residents, and CRNAs, and 20 percent of the average hourly wage after removing these costs and hours from the wage index calculation. This methodology is consistent with the recommendation of the industry workgroup for a 5-year phase-out of these costs. The transition methodology is discussed in detail in section III.E of this preamble.

Comment: One hospital believed that it has been disadvantaged by HCFA's allowance of contract teaching physician Part A costs in the FY 1999 wage index, and that HCFA should disallow teaching physician costs entirely, beginning with FY 2000. The hospital stated that it is experiencing difficulty meeting the criteria for geographic reclassification for purposes of the wage index to another MSA that includes a teaching hospital that reports a large amount of contract teaching physician Part A costs.

Response: Our reasons for including contract physician Part A costs are discussed in detail in the July 31, 1998 **Federal Register** (63 FR 40967). In general, it was our belief that if contract physician Part A costs were reliably reported by hospitals, they should be included in the wage data along with the Part A costs of directly employed physicians. In that final rule, we also discussed our position that, to the greatest degree possible, the hospital wage index should reflect the wage costs associated with the areas of the hospital included under the hospital inpatient prospective payment system. Therefore, based on data we have collected since that final rule was published, and as discussed above, we are removing teaching physician costs (as well as CRNA and resident costs) for the wage data, over a 5-year period.

As is generally true with changes in the wage index, hospitals that may have once been eligible to reclassify to another MSA for purposes of the wage index may find that they no longer qualify after changes have been implemented. However, we believe that all our changes to the wage index are designed to more accurately reflect the wage costs incurred by hospitals. In the case of the teaching physician costs, we

believe that a 5-year phase out is appropriate to reduce significant redistribution impacts. With regard to the accuracy of the teaching hospital data, the intermediary verified the data and determined it is consistent with audit findings.

D. Verification of Wage Data from Medicare Cost Reports

The data for the FY 2000 wage index were obtained from Worksheet S–3, Parts II and III of the FY 1996 Medicare cost reports. The data file used to construct the final wage index includes FY 1996 data submitted to HCRIS as of early February 1999. As in past years, we performed an intensive review of the wage data, mostly through the use of edits designed to identify aberrant data. In the proposed rule, we discussed our review and methodology for resolving questionable elements in the hospital data (64 FR 24728). The revised data are reflected in this final rule. Since the proposed rule, we deleted data for four hospitals that reported aberrant and unverifiable wage data that would have significantly distorted the wage index values, and added data for seven hospitals that were not included in the proposed wage index but rather whose data have now been corrected and verified. The final FY 2000 wage index is calculated based on FY 1996 data for 5,038 hospitals.

Comment: One hospital association expressed concern that a number of hospitals might have failed to comply with the new cost reporting instructions for wage-related costs, causing an overreporting of these costs in the FY 2000 wage index. Prior to the FY 1996 cost report, the lines on Worksheet S–3 for core and other wage-related costs reflected a hospital's total costs for those categories. However, beginning with the FY 1996 cost report, core and other wage-related costs must be reported net of costs associated with excluded areas. The commenter stated that wage-related costs for a significant number of hospitals increased at least 10 percent this year and it believed that the increase is due to hospitals incorrectly reporting excluded area wage-related costs on Line 13. The commenter recommended that we develop a method to determine if a hospital misreports its wage-related costs, and that we should require correction of the data.

Response: We believe the new cost reporting instructions for wage-related costs, Lines 13 and 14 of Worksheet S–3, Part II, are clear regarding the exclusion of costs associated with excluded areas. Intermediaries were aware of the new cost reporting instructions and instructed their auditors to closely examine the costs reported in Lines 13 and 14 of Worksheet S–3, Part II for compliance. In addition, the intermediaries' FY 1996 wage data review program included an edit for hospitals having wage-related costs that increased 10 percent or more between FY 1995 and FY 1996. Furthermore, we contacted representatives of national hospital associations who agreed to alert their members of the reporting change. We are aware of numerous instances where intermediaries adjusted hospitals' wage-related costs after review. As part of the FY 1997 wage data desk review program (for the FY 2001 wage index), we will provide more specific instructions to the intermediaries to review the data reported for core and other wage-related costs to ensure no costs associated with excluded areas are included.

Comment: One commenter disagreed with the approach we used in the proposed rule to identify teaching hospitals to ensure that all of these hospitals had reported teaching physician survey data. We based our decision to remove either 80 percent of physician Part A costs and hours or the amount on Line 23, Column 1 of Worksheet A, based on whether the hospital had a resident-to-bed ratio greater than zero on the latest Provider-Specific File. The commenter suggested it would be more appropriate to base the identification of teaching hospitals on whether the hospital reported residents on its cost report for the period corresponding with the wage data.

Response: We agree with this comment. It is more appropriate to base the identification of teaching hospitals on data from the same year as the wage data we use. Therefore, we revised our method to identify teaching hospitals based on whether they reported residents during their cost reporting period beginning during FY 1996.

Comment: One State hospital association commented that the underrepresentation of physician Part A costs for hospitals in its State is due to the intermediary's exclusion of a majority of the costs reported by hospitals. The commenter believes there are inconsistencies between the two intermediaries that service hospitals in the State in their treatment of contract physician Part A costs. The commenter recommended that HCFA monitor intermediaries and enforce uniform application of Medicare principles and standards, particularly with regard to the determination of allowable physician costs on Worksheet A–8–2.

Response: For wage index purposes, contract physician costs are to be reported according to the instructions for Worksheet S–3 Part II, Line 10. The physician Part A costs reported on Worksheet S–3 may differ slightly from those reported on worksheet A–8–2 because there are minor differences in the types of wage-related costs that are allowed for each of the worksheets. The two forms serve different purposes. The wage index worksheet (S–3) may include, to a reasonable extent, the actual costs a hospital incurs. However, Worksheet A–8–2 is used to determine allowable costs for Medicare cost report purposes and includes cost limits. The commenter did not indicate exactly what inconsistencies it had found. If there are inconsistencies, we would like to address them as soon as possible for the FY 2001 wage index.

We note that, intermediaries have informed us that hours associated with contract physicians are often difficult to verify because hospitals have not developed reporting systems that accurately account for contract physician hours. Consistent with Medicare policy, intermediaries must exclude costs and other data that are insufficiently supported by a hospital's documentation.

Comment: One commenter noted several errors in the proposed rule and final wage data public use file. The commenter stated that Table 3C of the proposed rule included some hospitals with extremely low average hourly wages, and that the average hourly wages reported for some hospitals marked with an asterisk do not seem to incorporate the Worksheet A, Line 23 data as described in the footnote. Additionally, the commenter stated that the final wage data on the Internet includes two different date formats for fiscal year begin and end dates, an eight digit format and a seven digit format. The commenter asked that HCFA make the appropriate corrections in the final wage index calculation.

Response: We were informed shortly after publication of the proposed rule that there were several errors in Table 3C, including those noted by the commenter. As a result, we issued a revised Table 3C in a correction notice published in the **Federal Register** on June 15, 1999 (64 FR 31995). Although the extremely low average hourly wages still appear in Table 3C of the correction notice just as they were reported by the hospitals, the aberrant data were either corrected or deleted in the final wage index calculation. All other errors identified in Table 3C were corrected through the June 15 notice. Also, fiscal year beginning and ending dates that appear in a 7-digit date format in the final wage data public use file were

corrected to an 8-digit date format in the final calculation.

E. Computation of the Wage Index

The method used to compute the FY 2000 wage index is as follows:

Step 1—As noted above, we based the FY 2000 wage index on wage data reported on the FY 1996 Medicare cost reports. We gathered data from each of the non-Federal, short-term, acute care hospitals for which data were reported on the Worksheet S–3, Parts II and III of the Medicare cost report for the hospital's cost reporting period beginning on or after October 1, 1995 and before October 1, 1996. In addition, we included data from a few hospitals that had cost reporting periods beginning in September 1995 and reported a cost reporting period exceeding 52 weeks. These data were included because no other data from these hospitals would be available for the cost reporting period described above, and because particular labor market areas might be affected due to the omission of these hospitals. However, we generally describe these wage data as FY 1996 data.

Step 2—Salaries—The method used to compute a hospital's average hourly wage is a blend of 80 percent of the hospital's average hourly wage including all teaching physician Part A, resident, and CRNA costs, and 20 percent of the hospital's average hourly wage after eliminating all teaching physician, resident, and CRNA costs.

In calculating a hospital's average salaries plus wage-related costs, including all teaching physician Part A, resident, and CRNA costs, we subtracted from Line 1 (total salaries) the Part B salaries reported on Lines 3 and 5, home office salaries reported on Line 7, and excluded salaries reported on Lines 8 and 8.01 (that is, direct salaries attributable to skilled nursing facility services, home health services, and other subprovider components not subject to the prospective payment system). We also subtracted from Line 1 the salaries for which no hours were reported on Lines 2, 4, and 6. To determine total salaries plus wage-related costs, we added to the net hospital salaries the costs of contract labor for direct patient care, certain top management, and physician Part A services (Lines 9 and 10), home office salaries and wage-related costs reported by the hospital on Lines 11 and 12, and nonexcluded area wage-related costs (Lines 13, 14, 16, 18, and 20). We note that contract labor and home office salaries for which no corresponding hours are reported were not included.

We then calculated a hospital's salaries plus wage-related costs by subtracting from total salaries the salaries plus wage-related costs for teaching physicians (see section III.C.1 of this preamble for a detailed discussion of this policy), Part A CRNAs (Lines 2 and 16), and residents (Lines 6 and 20).

Step 3—Hours—With the exception of wage-related costs, for which there are no associated hours, we computed total hours using the same methods as described for salaries in Step 2.

Step 4—For each hospital reporting both total overhead salaries and total overhead hours greater than zero, we then allocated overhead costs. First, we determined the ratio of excluded area hours (sum of Lines 8 and 8.01 of Worksheet S–3, Part II) to revised total hours (Line 1 minus Lines 3, 5, and 7 of Worksheet S–3, Part II). We then computed the amounts of overhead salaries and hours to be allocated to excluded areas by multiplying the above ratio by the total overhead salaries and hours reported on Line 13 of Worksheet S–3, Part III. Finally, we subtracted the computed overhead salaries and hours associated with excluded areas from the total salaries and hours derived in Steps 2 and 3.

Step 5—For each hospital, we adjusted the total salaries plus wage-related costs to a common period to determine total adjusted salaries plus wage-related costs. To make the wage adjustment, we estimated the percentage change in the employment cost index (ECI) for compensation for each 30-day increment from October 14, 1995 through April 15, 1997 for private industry hospital workers from the Bureau of Labor Statistics' *Compensation and Working Conditions.* We use the ECI because it reflects the price increase associated with total compensation (salaries plus fringes) rather than just the increase in salaries. In addition, the ECI includes managers as well as other hospital workers. This methodology to compute the monthly update factors uses actual quarterly ECI data and ensures that the update factors match the actual quarterly and annual percent changes. The factors used to adjust the hospital's data were based on the midpoint of the cost reporting period, as indicated below.

MIDPOINT OF COST REPORTING PERIOD

After	Before	Adjustment factor
10/14/95	11/15/95	1.023163
11/14/95	12/15/95	1.021153

MIDPOINT OF COST REPORTING PERIOD—Continued

After	Before	Adjustment factor
12/14/95	01/15/96	1.019151
01/14/96	02/15/96	1.017157
02/14/96	03/15/96	1.015246
03/14/96	04/15/96	1.013489
04/14/96	05/15/96	1.011888
05/14/96	06/15/96	1.010428
06/14/96	07/15/96	1.009099
07/14/96	08/15/96	1.007900
08/14/96	09/15/96	1.006788
09/14/96	10/15/96	1.005719
10/14/96	11/15/96	1.004695
11/14/96	12/15/96	1.003653
12/14/96	01/15/97	1.002529
01/14/97	02/15/97	1.001325
02/14/97	03/15/97	1.000000
03/14/97	04/15/97	0.998514

For example, the midpoint of a cost reporting period beginning January 1, 1996 and ending December 31, 1996 is June 30, 1996. An adjustment factor of 1.009099 would be applied to the wages of a hospital with such a cost reporting period. In addition, for the data for any cost reporting period that began in FY 1996 and covers a period of less than 360 days or more than 370 days, we annualized the data to reflect a 1-year cost report. Annualization is accomplished by dividing the costs and hours by the number of days in the cost report and then multiplying the results by 365.

Step 6—Each hospital was assigned to its appropriate urban or rural labor market area before any reclassifications under sections 1886(d)(8)(B) or 1886(d)(10) of the Act. Within each urban or rural labor market area, we added the total adjusted salaries plus wage-related costs obtained in Step 5 for all hospitals in that area to determine the total adjusted salaries plus wage-related costs for the labor market area.

Step 7—We divided the total adjusted salaries plus wage-related costs obtained under both methods in Step 6 by the sum of the corresponding total hours (from Step 4) for all hospitals in each labor market area to determine an average hourly wage for the area.

Because the FY 2000 wage index is based on a blend of average hourly wages, we then added 80 percent of the average hourly wage calculated without removing teaching physician Part A, residents, and CRNA costs, and 20 percent of the average hourly wage calculated with these costs removed.

Step 8—We added the total adjusted salaries plus wage-related costs obtained in Step 5 for all hospitals in the nation and then divided the sum by the national sum of total hours from Step 4 to arrive at a national average hourly

wage (using the same blending methodology described in Step 7). Using the data as described above, the national average hourly wage is $21.1800.

Step 9—For each urban or rural labor market area, we calculated the hospital wage index value by dividing the area average hourly wage obtained in Step 7 by the national average hourly wage computed in Step 8. We note that on July 6, 1999, OMB announced the designations of two new MSAs: Auburn-Opelika, Alabama, comprising Lee County, and Corvallis, Oregon comprising Benton County.

Step 10—Following the process set forth above, we developed a separate Puerto Rico-specific wage index for purposes of adjusting the Puerto Rico standardized amounts. (The national Puerto Rico standardized amount is adjusted by a wage index calculated for all Puerto Rico labor market areas based on the national average hourly wage as described above.) We added the total adjusted salaries plus wage-related costs (as calculated in Step 5) for all hospitals in Puerto Rico and divided the sum by the total hours for Puerto Rico (as calculated in Step 4) to arrive at an overall average hourly wage of $9.86756 for Puerto Rico. For each labor market area in Puerto Rico, we calculated the hospital wage index value by dividing the area average hourly wage (as calculated in Step 7) by the overall Puerto Rico average hourly wage.

Step 11—Section 4410 of the BBA provides that, for discharges on or after October 1, 1997, the area wage index applicable to any hospital that is not located in a rural area may not be less than the area wage index applicable to hospitals located in rural areas in that State. Furthermore, this wage index floor is to be implemented in such a manner as to ensure that aggregate prospective payment system payments are not greater or less than those that would have been made in the year if this section did not apply. For FY 2000, this change affects 226 hospitals in 36 MSAs. The MSAs affected by this provision are identified in Table 4A by a footnote.

Comment: Two commenters suggested that, given the complexity of the FY 2000 wage index calculation, we should make our detailed calculation procedures and edits publicly available. This would enable hospitals and researchers to more easily replicate the wage index values. One of the commenters recommended that the detailed calculations and methods should be included in future proposed and final rules. In addition, they requested that we release the actual computer program used to calculate the wage index.

Response: We have fully explained the steps we take to calculate each hospital's average hourly wage and the wage index. In addition, we have worked with hospitals that contacted us after attempting to replicate our calculations, by reviewing their results and identifying discrepancies. In doing so, we have been able to identify certain anomalies in some of the proposed wage index values, which have been corrected in the final wage index. Therefore, we agree that it might be useful to provide more information to make it easier for the public to replicate our calculations, and we are exploring our options. However, we do not generally provide our computer programs that are used to perform the wage index calculations, or for that matter, the programs we use for all other calculations we perform.

Comment: One commenter recommended that, for leap years HCFA should use 366 days, rather than 365 days, when annualizing cost report data (see step 5 of the wage index calculation).

Response: We agree that the commenter's recommended method of annualization, which recognizes an additional day for leap years, is theoretically more accurate than our simple, across-the-board approach. However, due to the intense effort required to incorporate all of the wage data changes processed in conjunction with hospitals' final opportunity to request revisions, we were unable to evaluate and incorporate this change into our computer program in time to be reflected in the final FY 2000 wage index. Therefore, we are not adopting this recommendation for the FY 2000 wage index calculation. We would note that, as described in step 5 above, we annualize any cost reporting period that covers a period of fewer than 360 days or more than 370 days. The majority of cost reporting periods are not annualized. In those instances where annualization is done, we would further point out that it does not affect the hospital's average hourly wage calculation, since both the costs and hours are annualized by 365. The impact, therefore, of this commenter's suggestion is limited to the calculation of the labor market area average hourly wage. Furthermore, if we were to account for the additional day of a leap year in our annualization, the impact on any particular area's average hourly wage could be either positive or negative.

F. Revisions to the Wage Index Based on Hospital Redesignation

Under section 1886(d)(8)(B) of the Act, hospitals in certain rural counties adjacent to one or more MSAs are considered to be located in one of the adjacent MSAs if certain standards are met. Under section 1886(d)(10) of the Act, the Medicare Geographic Classification Review Board (MGCRB) considers applications by hospitals for geographic reclassification for purposes of payment under the prospective payment system.

The methodology for determining the wage index values for redesignated hospitals is applied jointly to the hospitals located in those rural counties that were deemed urban under section 1886(d)(8)(B) of the Act and those hospitals that were reclassified as a result of the MGCRB decisions under section 1886(d)(10) of the Act. Section 1886(d)(8)(C) of the Act provides that the application of the wage index to redesignated hospitals is dependent on the hypothetical impact that the wage data from these hospitals would have on the wage index value for the area to which they have been redesignated. Therefore, as provided in section 1886(d)(8)(C) of the Act, the wage index values were determined by considering the following:

- If including the wage data for the redesignated hospitals would reduce the wage index value for the area to which the hospitals are redesignated by 1 percentage point or less, the area wage index value determined exclusive of the wage data for the redesignated hospitals applies to the redesignated hospitals.
- If including the wage data for the redesignated hospitals reduces the wage index value for the area to which the hospitals are redesignated by more than 1 percentage point, the hospitals that are redesignated are subject to that combined wage index value.
- If including the wage data for the redesignated hospitals increases the wage index value for the area to which the hospitals are redesignated, both the area and the redesignated hospitals receive the combined wage index value.
- The wage index value for a redesignated urban or rural hospital cannot be reduced below the wage index value for the rural areas of the State in which the hospital is located.
- Rural areas whose wage index values would be reduced by excluding the wage data for hospitals that have been redesignated to another area continue to have their wage index values calculated as if no redesignation had occurred.
- Rural areas whose wage index values increase as a result of excluding

the wage data for the hospitals that have been redesignated to another area have their wage index values calculated exclusive of the wage data of the redesignated hospitals.

- The wage index value for an urban area is calculated exclusive of the wage data for hospitals that have been reclassified to another area. However, geographic reclassification may not reduce the wage index value for an urban area below the statewide rural wage index value.

We note that, except for those rural areas in which redesignation would reduce the rural wage index value, the wage index value for each area is computed exclusive of the wage data for hospitals that have been redesignated from the area for purposes of their wage index. As a result, several urban areas listed in Table 4A have no hospitals remaining in the area. This is because all the hospitals originally in these urban areas have been reclassified to another area by the MGCRB. These areas with no remaining hospitals receive the prereclassified wage index value. The prereclassified wage index value will apply as long as the area remains empty.

The final revised wage index values for FY 2000 are shown in Tables 4A, 4B, 4C, and 4F in the Addendum to this final rule. Hospitals that are redesignated should use the wage index values shown in Table 4C. Areas in Table 4C may have more than one wage index value because the wage index value for a redesignated urban or rural hospital cannot be reduced below the wage index value for the rural areas of the State in which the hospital is located. When the wage index value of the area to which a hospital is redesignated is lower than the wage index value for the rural areas of the State in which the hospital is located, the redesignated hospital receives the higher wage index value, that is, the wage index value for the rural areas of the State in which it is located, rather than the wage index value otherwise applicable to the redesignated hospitals.

Tables 4D and 4E list the average hourly wage for each labor market area, before the redesignation of hospitals, based on the FY 1996 wage data. In addition, Table 3C in the Addendum to this final rule includes the adjusted average hourly wage for each hospital based on the FY 1996 data (as calculated under Steps 4 and 5 above). The MGCRB will use the average hourly wage published in the final rule to evaluate a hospital's application for reclassification for FY 2001, unless that average hourly wage is later revised in accordance with the wage data correction policy described in § 412.63(w)(2). In these cases, the MGCRB will use the most recent revised data used for purposes of the hospital wage index. We note that, in adjudicating these wage index reclassification requests during FY 2000, the MGCRB will use the average hourly wages for each hospital and labor market area that are reflected in the final FY 2000 wage index.

At the time the proposed wage index was constructed, the MGCRB had completed its review of FY 2000 reclassification requests. Therefore, the proposed FY 2000 wage index values incorporated all 441 hospitals redesignated for purposes of the wage index (hospitals redesignated under section 1886(d)(8)(B) or 1886(d)(10) of the Act) for FY 2000. In this final rule, we have incorporated changes to the wage index that occurred after the proposed wage index was calculated and that resulted from withdrawals of requests for reclassification, wage index corrections, appeals, and the Administrator's review process. The changes may affect not only the wage index value for specific geographic areas, but also the wage index value redesignated hospitals receive, that is, whether they receive the wage index value for the area to which they are redesignated, or a wage index value that includes the data for both the hospitals already in the area and the redesignated hospitals. Further, the wage index value for the area from which the hospitals are redesignated may be affected.

Under § 412.273, hospitals that have been reclassified by the MGCRB are permitted to withdraw their applications within 45 days of the publication of the proposed rule. To be effective in FY 2000, the request for withdrawal of an application for reclassification had to be received by the MGCRB by June 21. A hospital that requests to withdraw its application may not later request that the MGCRB decision be reinstated.

G. Wage Data Corrections

In the proposed rule, we stated that, to allow hospitals time to evaluate the wage data used to construct the proposed FY 2000 hospital wage index, we would make available in May 1999 a final public data file containing the FY 1996 hospital wage data.

The final wage data file was released on May 7, 1999 (amended on May 14). As noted above in section III.C of this preamble, this file included hospitals' teaching survey data as well as cost report data. As with the file made available in February 1999, we made the final wage data file released in May 1999 available to hospital associations and the public (on the Internet). However, with the exception of the teaching survey data, this file was made available only for the limited purpose of identifying any potential errors made by HCFA or the intermediary in the entry of the final wage data that the hospital could not have known about before the release of the final wage data public use file, not for the initiation of new wage data correction requests.

If, after reviewing the May 1999 final data file, a hospital believed that its wage data were incorrect due to a fiscal intermediary or HCFA error in the entry or tabulation of the final wage data, it was provided an opportunity to send a letter to both its fiscal intermediary and HCFA, outlining why the hospital believed an error exists and provide all supporting information, including dates. These requests had to be *received* by us and the intermediaries no later than June 7, 1999.

Changes to the hospital wage data were made only in those very limited situations involving an error by the intermediary or HCFA that the hospital could not have known about before its review of the final wage data file. (As noted above, however, we also allowed hospitals to request changes to their teaching survey data. These requests had to comply with all of the documentation and deadline requirements specified in the May 7, 1999 proposed rule.) Specifically, neither the intermediary nor HCFA accepted the following types of requests at this stage of the process:

- Requests for wage data corrections that were submitted too late to be included in the data transmitted to HCRIS on or before April 5, 1999.
- Requests for correction of errors that were not, but could have been, identified during the hospital's review of the February 1999 wage data file.
- Requests to revisit factual determinations or policy interpretations made by the intermediary or HCFA during the wage data correction process.

Verified corrections to the wage index received timely (that is, by June 7, 1999) are incorporated into the final wage index in this final rule, to be effective October 1, 1999.

We believe the wage data correction process provides hospitals with sufficient opportunity to bring errors in their wage data to the intermediary's attention. Moreover, because hospitals had access to the final wage data by early May 1999, they had the opportunity to detect any data entry or tabulation errors made by the intermediary or HCFA before the development and publication of the FY 2000 wage index and its

implementation on October 1, 1999. If hospitals avail themselves of this opportunity, the FY 2000 wage index implemented on October 1 should be free of these errors. Nevertheless, in the unlikely event that errors should occur after that date, we retain the right to make midyear changes to the wage index under very limited circumstances.

Specifically, in accordance with § 412.63(w)(2), we may make midyear corrections to the wage index only in those limited circumstances in which a hospital can show (1) that the intermediary or HCFA made an error in tabulating its data; and (2) that the hospital could not have known about the error, or did not have an opportunity to correct the error, before the beginning of FY 2000 (that is, by the June 7, 1999 deadline). As indicated earlier, since a hospital had the opportunity to verify its data, and the intermediary notified the hospital of any changes, we do not foresee any specific circumstances under which midyear corrections would be made. However, should a midyear correction be necessary, the wage index change for the affected area will be effective prospectively from the date the correction is made.

In the September 1, 1994 **Federal Register**, we stated that we did not believe that a ''formal appeals process'' regarding intermediary decisions denying hospital requests for wage data revisions was necessary, given the numerous opportunities provided to hospitals to verify and revise their data (59 FR 45351). We continue to believe that the process described above provides hospitals more than adequate opportunity to ensure that their data are correct. Nevertheless, we wish to clarify that, while there is no formal appeals process that culminates before the publication of the final rule and that is described above, hospitals may later seek formal review of denials of requests for wage data revisions made as a result of that process.

Once the final wage index values are calculated and published in the **Federal Register**, the last opportunity for a hospital to seek to have its wage data revised is under the limited circumstances described in § 412.63(w)(2). As we noted in the September 1, 1995 **Federal Register**, however, hospitals are entitled to appeal any denial of a request for a wage data revision made as a result of HCFA's wage data correction process to the Provider Reimbursement Review Board (PRRB), consistent with the rules for PRRB appeals found at 42 CFR Part 405, Subpart R (60 FR 45795). As we also stated in the September 1, 1995 **Federal Register**, and as the regulation at § 412.63(w)(5) provides, any subsequent reversal of a denial of a wage revision request that results from a hospital's appeal to the PRRB or beyond will be given effect by paying the hospital under a revised wage index that reflects the revised wage data at issue. The revised wage data will not, however, be used for purposes of revisiting past adjudications of requests for geographic reclassification.

Comment: One commenter suggested that our notices of the wage index review process should be more explicit regarding dates, titles, and addresses, and should be presented in a format similar to the request for hearing language contained in most Notices of Program Reimbursements. The commenter believes this would avoid confusion and misunderstandings throughout the process.

Response: Although we believe that our notices of wage index file availability are already quite detailed, we agree they might be improved to minimize misunderstandings. For example, we intend to continue to work with our intermediaries to ensure that, in their correspondence with hospitals regarding the resolution of revision requests submitted by the hospitals, the intermediaries state more explicitly the criteria, procedures, and deadlines for requesting our intervention when a hospital disagrees with an intermediary's policy determination. We welcome any other specific recommendations.

Comment: One commenter requested that we consider providing a mid-year correction, as in the FY 1999 wage index, for those areas that are affected by a major change in the FY 2000 wage index. The commenter stated that further opportunity to review and adjust its wage data would provide a more meaningful wage index.

Response: As we stated in the February 25, 1999 final rule implementing changes resulting from the limited window of opportunity for hospitals to request revisions to their FY 1995 data used to calculate the FY 1999 wage index, we believe our usual procedures provide ample opportunity for diligent hospitals to ensure the accuracy of their wage data (64 FR 93781). The limited opportunity to request revisions to the data used to calculate the FY 1999 wage index was based on a combination of circumstances unique to that year, and hospitals should assume in the future that all requests to change their wage data must conform to the well-established guidelines discussed above. Therefore, we do not intend to again provide such a special opportunity for further revision requests.

IV. Other Decisions and Changes to the Prospective Payment System for Inpatient Operating Costs and Graduate Medical Education Costs

A. Sole Community Hospitals (SCHs) (§ 412.92)

If a hospital is classified as an SCH because, by reason of certain factors, it is the sole source of inpatient hospital services reasonably available to Medicare beneficiaries in a geographic area, the hospital is paid based on the highest of the following: the applicable adjusted Federal rate; the updated hospital-specific rate based on a 1982 base period; or the updated hospital-specific rate based on a 1987 base period. Under our existing rules, urban hospitals within 35 miles of another hospital cannot qualify as SCHs. Since 1983, we have consistently defined an ''urban'' area for purposes of determining if a hospital qualifies for SCH status as an MSA or NECMA as defined by OMB.

In the past, we have considered and rejected two alternatives to the MSA definitions of an urban area for SCH purposes. These alternatives were the urbanized areas as defined by the Census Bureau and the health facility planning areas (HFPAs) as used by the Health Resource Services Administration. We have concluded that the MSA definition continues to be the most appropriate geographic delimiter available at this time. Therefore, in the May 7, 1999 proposed rule, we proposed to continue to apply the MSA definition of an urban area for SCH status purposes.

We proposed to continue our current policy for several reasons. First, as we have previously noted, since OMB considers local commuting patterns in establishing urban definitions, we believe that residents in urban areas have access to hospital services either by living in close proximity to a hospital or by establishing a heavy commuting pattern to an area in which a hospital is located (48 FR 39780, September 1, 1983). We do not believe that either Census Bureau urbanized areas or HFPAs take commuting patterns into account in the way that OMB's MSAs do. We believe commuting patterns serve as an important indicator of whether a hospital is the sole hospital reasonably accessible by Medicare beneficiaries in an area.

In addition, we note that our use of MSAs to define urban areas for SCH status purposes has direct statutory support. Section 1886(d)(2)(D) of the

Act specifically authorizes us to use OMB's MSA definition of urban areas for purposes of calculating the prospective payment system standardized amounts. SCH status represents an adjustment to the usual prospective payment that a hospital would receive, and since that prospective payment is based on the standardized amount, among other factors, we believe it would be anomalous to employ one definition of urban area for purposes of calculating the standardized amount and another for purposes of determining if the hospital qualified as an SCH. To do so would be to use one set of geographic delimiters in applying the general rule (payment under the prospective payment system based on the standardized amount) but a different set in determining exceptions to the rule (payment under the prospective payment system adjusted to take into account SCH status). We do not think this would be appropriate. For this reason, also, we propose to continue to define ''urban'' for SCH purposes as meaning MSAs as defined by OMB, not as meaning either Census Bureau urbanized areas or HFPAs.

We received one comment on our proposed retention of this definition.

Comment: One commenter, which had been communicating with us before the issuance of the proposed rule, continued to express concern about our policy of defining urban areas for SCH purposes based on MSAs. The commenter raised several points. First, the commenter stated that our discussion in the proposed rule is ''misleading'' because it did not mention recent litigation on this issue. Second, the commenter argued that our proposal is flawed because it results in inequitable treatment of hospitals; that is, it renders a hospital's ability to qualify as an SCH dependent on OMB's reconfiguration of MSA boundaries, and patients' ability to access inpatient hospital services is not affected by those boundaries. Third, the commenter questioned two aspects of our rationale for retaining an MSA-based definition of the urban areas in the SCH context—that OMB considers commuting patterns when defining MSAs and that use of MSAs is consistent with the methodology we use for computing the standardized amounts. Finally, the commenter suggested that, if we decided to adopt our proposal to base the definition of urban areas for SCH purposes on MSAs, we should at least adopt an exception to that rule under which a hospital that is the only hospital in an MSA could still qualify as an SCH.

Response: We do not agree with the commenter that we should either abandon our longstanding policy of defining urban areas for SCH purposes based on MSAs or adopt the exception to that policy that the commenter suggests. Although the commenter is correct in pointing out that there has been recent litigation involving our definition of ''urban area'' for SCH purposes, we do not believe that our proposal was in any way misleading. Partly as a result of the litigation, we decided to reiterate and clarify our policy. Thus, we clearly stated in the proposed rule that we proposed to retain our longstanding definition in favor of other definitions based on the Census Bureau's urbanized areas or on HFPAs and explained the reasons for our proposal. We believe the proposed rule, therefore, gave interested parties more than adequate notice of the issue and afforded them the opportunity to comment.

We continue to believe that it is appropriate to adopt an MSA-based definition of urban areas for SCH purposes for the reasons stated in the proposed rule and in our earlier discussions of the MSA-based definition. The commenter gave an example of a situation in which an urban hospital is the nearest like hospital to a rural hospital, and the rural hospital is likewise the nearest hospital to the urban hospital. The commenter stated that the rural hospital could obtain SCH status, but the urban hospital could not, which, the commenter concluded, results in inequitable treatment of similarly situated hospitals.

We do not agree with this conclusion for several reasons. First, if the urban hospital was located more than 35 miles from the rural hospital, it could in fact qualify for SCH status under our rules. Moreover, the hospitals in this example are not similarly situated; one is urban and one is rural. As we have stated previously, urban areas generally have better roads, faster snow clearing, and more available hospitals, factors that affect access to inpatient hospital services. (See 56 FR 25483 (June 4, 1991).) Thus, even if the rural hospital in the commenter's example qualified as an SCH and the urban hospital did not, the difference in result is justified by the hospitals' different geographic circumstances.

The commenter's example does nothing to demonstrate that any other definition of an urban area for SCH purposes is preferable to an MSA-based definition. The somewhat unique situation the commenter described—an urban hospital that is closest to a rural hospital and vice versa—could arise no matter what definition of urban area we adopt.

Similarly, while the commenter objected to hospitals' ability to qualify for SCH status depending on possible shifting OMB definitions of MSAs, the same objection could be made of any definition of urban area that adopts geographic delimiters promulgated by another entity—including Census Bureau urbanized areas or HFPAs. In addition, we consider the fact that OMB occasionally revises the MSA boundaries to be a strength of that scheme. We think it is appropriate that any definition of urban areas for SCH purposes be reviewed periodically to take into account changes that have occurred in various areas' characteristics. Urban and rural areas do not remain static forever. Shifts in population and other changes can transform previously rural areas into urban ones, and vice versa. Because we believe the nature of an area as urban or rural is an important part of determining whether a hospital should qualify as an SCH, the mechanism for making those determinations should be able to account for changes in that nature.

As noted above and in our previous discussions of this issue, we believe that several factors make urban hospitals more accessible to patients than rural ones. Contrary to the commenter's statement that access is not affected by MSA boundaries, we proposed to adopt MSAs as the definition of urban areas for SCH purposes precisely because MSAs provided a good gauge of the presence of factors affecting access. The commenter's contentions fail to convince us that we should not adopt this proposal.

The commenter also argued that we have not properly considered reasonable alternatives to our proposed MSA-based definition of urban areas for SCH purposes. To the contrary, we specifically considered and proposed to reject two alternative definitions based on urbanized areas and HFPAs. The commenter offered no additional alternatives. Rather, the commenter questioned our reliance on OMB's use of commuting patterns in establishing MSAs, and stated that both urbanized areas and HFPAs also consider commuting patterns in the form of such factors as availability of roads and travel time and distance. Even if true, however, that means only that all three potential definitions consider commuting patterns in some form, and thus does not provide a basis for preferring a definition of urban areas other than one based on MSAs. The commenter pointed out that the

commuting patterns OMB analyzes pertain to commutes to workplaces, which, the commenter claimed, do not relate to access to hospital services. However, we have indicated that we deem commuting patterns important because they indicate access to areas in which hospitals are located. (See 48 FR 39780 (Sept. 1, 1983).) As such, they are a good indicator of access to hospital services.

The commenter questioned our reliance on the fact that MSAs are used as the basis for determining the standardized amounts that form the basis of prospective payment system payments. The MSAs also supply the definition of urban areas used for virtually every other purpose under the hospital inpatient prospective payment system, including other special status determinations, geographic reclassification, and calculation of the wage index. We continue to believe that it is appropriate to use a definition of urban areas for SCH purposes that is consistent with the definition used for almost all other components of the prospective payment rates.

In regard to the commenter's suggestion that, if we retain the MSA-based definition of urban areas for SCH purposes, we adopt an exception to that definition under which an urban hospital that is the only hospital in its MSA would qualify as an SCH if it would otherwise qualify absent its urban location. We note that, to a large extent, we already apply this rule. As noted above, an urban hospital that is more than 35 miles from the nearest like hospital may qualify as an SCH notwithstanding its urban location. Thus, urban hospitals, including those in a sole-hospital MSA, can in fact qualify as SCHs, provided they are not in close proximity to another like hospital.

We acknowledge that a small number of MSAs may contain only one hospital; however, we have stated that urban areas *generally* have more available hospitals (56 FR 25483 (June 4, 1991)). Again, urbanized areas, HFPAs, or an urban area defined under any other methodology might also contain only one hospital. As a result, there is nothing inherent in our adoption of an MSA-based definition that compels adoption of the exception the commenter has proposed. It continues to be our judgment that an urban hospital within 35 miles of another like hospital is not the ''sole'' source of inpatient hospital services in its community, given the close proximity of the other hospital and the other factors affecting increased access to inpatient hospital services that location in an urban area denotes. Thus, we have not adopted the commenter's proposed exception to the rule defining urban areas based on MSAs for SCH purposes.

B. Rural Referral Centers (§ 412.96)

Under the authority of section 1886(d)(5)(C)(i) of the Act, § 412.96 sets forth the criteria a hospital must meet in order to receive special treatment under the prospective payment system as a rural referral center. For discharges occurring before October 1, 1994, rural referral centers received the benefit of payment based on the other urban rather than the rural standardized amount. As of that date, the other urban and rural standardized amounts were the same. However, rural referral centers continue to receive special treatment under both the disproportionate share hospital (DSH) payment adjustment and the criteria for geographic reclassification.

One of the criteria under which a rural hospital may qualify as a rural referral center is to have 275 or more beds available for use. A rural hospital that does not meet the bed size criterion can qualify as a rural referral center if the hospital meets two mandatory criteria (specifying a minimum case-mix index and a minimum number of discharges) and at least one of the three optional criteria (relating to specialty composition of medical staff, source of inpatients, or volume of referrals). With respect to the two mandatory criteria, a hospital may be classified as a rural referral center if its—

- Case-mix index is at least equal to the lower of the median case-mix index for urban hospitals in its census region, excluding hospitals with approved teaching programs, or the median case-mix index for all urban hospitals nationally; and
- Number of discharges is at least 5,000 discharges per year or, if fewer, the median number of discharges for urban hospitals in the census region in which the hospital is located. (The number of discharges criterion for an osteopathic hospital is at least 3,000 discharges per year.)

1. Case-Mix Index

Section 412.96(c)(1) provides that HCFA will establish updated national and regional case-mix index values in each year's annual notice of prospective payment rates for purposes of determining rural referral center status. The methodology we use to determine the national and regional case-mix index values is set forth in regulations at § 412.96(c)(1)(ii). The proposed national case-mix index value in the May 7, 1999 proposed rule included all urban hospitals nationwide, and the proposed regional values were the median values of urban hospitals within each census region, excluding those with approved teaching programs (that is, those hospitals receiving indirect medical education payments as provided in § 412.105).

These values were based on discharges occurring during FY 1998 (October 1, 1997 through September 30, 1998) and include bills posted to HCFA's records through December 1998. Therefore, we proposed that, in addition to meeting other criteria, hospitals with fewer than 275 beds, if they are to qualify for initial rural referral center status for cost reporting periods beginning on or after October 1, 1999, must have a case-mix index value for FY 1998 that is at least—

- 1.3438; or
- The median case-mix index value for urban hospitals (excluding hospitals with approved teaching programs as identified in § 412.105) calculated by HCFA for the census region in which the hospital is located. (See the table set forth in the May 7, 1999 proposed rule at 64 FR 24732–24733.)

Based on the updated FY 1998 MedPAR file, which contains data from additional bills received through March 31, 1999, the final national case-mix value is 1.3438 and the median case-mix values by region are set forth in the following table:

Region	Case-mix index value
1. New England (CT, ME, MA, NH, RI, VT)	1.2498
2. Middle Atlantic (PA, NJ, NY)	1.2499
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	1.3306
4. East North Central (IL, IN, MI, OH, WI)	1.2577
5. East South Central (AL, KY, MS, TN)	1.2795
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	1.1877
7. West South Central (AR, LA, OK, TX)	1.2994
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	1.3438
9. Pacific (AK, CA, HI, OR, WA)	1.3231

For the benefit of hospitals seeking to qualify as referral centers or those wishing to know how their case-mix index value compares to the criteria, we are publishing each hospital's FY 1998 case-mix index value in Table 3C in section VI of the Addendum to this final rule. In keeping with our policy on discharges, these case-mix index values are computed based on all Medicare patient discharges subject to DRG-based payment.

2. Discharges

Section 412.96(c)(2)(i) provides that HCFA will set forth the national and regional numbers of discharges in each year's annual notice of prospective payment rates for purposes of determining referral center status. As specified in section 1886(d)(5)(C)(ii) of the Act, the national standard is set at 5,000 discharges. In the May 7, 1999 proposed rule, we proposed to update the regional standards. The proposed regional standards were based on discharges for urban hospitals' cost reporting periods that began during FY 1997 (that is, October 1, 1996 through September 30, 1997). That is the latest year for which we have complete discharge data available.

Therefore, we proposed that, in addition to meeting other criteria, a hospital, if it is to qualify for initial rural referral center status for cost reporting periods beginning on or after October 1, 1999, must have as the number of discharges for its cost reporting period that began during FY 1998 a figure that is at least—

- 5,000; or
- The median number of discharges for urban hospitals in the census region in which the hospital is located, as indicated in the following table. (See the table set forth in the May 7, 1999 proposed rule at 64 FR 24733.)

Based on the latest discharge data available for FY 1997, the final median number of discharges for urban hospitals by census region areas is as follows:

Region	Number of discharges
1. New England (CT, ME, MA, NH, RI, VT)	6733
2. Middle Atlantic (PA, NJ, NY)	8655
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	7845
4. East North Central (IL, IN, MI, OH, WI)	7499
5. East South Central (AL, KY, MS, TN)	6832
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	5346
7. West South Central (AR, LA, OK, TX)	5380
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	8026
9. Pacific (AK, CA, HI, OR, WA)	6151

We note that the number of discharges for hospitals in each census region is greater than the national standard of 5,000 discharges. Therefore, 5,000 discharges is the minimum criterion for all hospitals.

We reiterate that an osteopathic hospital, if it is to qualify for rural referral center status for cost reporting periods beginning on or after October 1, 1999, must have at least 3,000 discharges for its cost reporting period that began during FY 1997.

Comment: One commenter urged HCFA to reconsider its decision not to restore RRC status to those hospitals located in areas that have been redesignated as urban by the OMB. The commenter argued that the statute established only one qualification for having a hospital's RRC status restored; that is, a hospital must have been designated as an RRC in FY 1991. According to the commenter, the statute provides no other conditions, nor does it provide HCFA with the discretion to create other conditions. The commenter believes that our decision not to restore the RRC status of hospitals located in areas redesignated as urban by OMB effectively requires affected hospitals to satisfy an additional condition that they be located in a rural area.

Response: We responded to a comment raising the same issue in the May 12, 1998 final rule (63 FR 26326). We addressed our interpretation of section 4202(b)(1) of the BBA in the August 29, 1997 final rule with comment period (62 FR 45999 and 46000) as well as the May 12, 1998 final rule, and we refer the reader to those documents.

C. Changes to the Indirect Medical Education Adjustment (§ 412.105)

Section 1886(d)(5)(B) of the Act provides that prospective payment hospitals that have residents in an approved graduate medical education (GME) program receive an additional payment to reflect the higher indirect operating costs associated with GME. The regulations regarding the calculation of this additional payment, known as the indirect medical education (IME) adjustment, are located at § 412.105.

In the August 29, 1997 final rule (62 FR 46029), we redesignated the previous § 412.105(g) as § 412.105(f), and added a new paragraph (g) to implement section 1886(d)(5)(B) of the Act as revised by section 4621 of the BBA of 1997. However, when we redesignated paragraph (g) as paragraph (f), we inadvertently did not revise all of the relevant cross-references to reflect this redesignation. Specifically, at § 412.105(f)(1)(iii), there are three cross-references to paragraph (g)(1)(ii). These cross-references are incorrect in light of the redesignation of previous paragraph (g) as paragraph (f). We proposed to revise § 412.105(f)(1)(iii) to correct these cross-references.

We did not receive any comments on this proposal and are adopting it as final.

D. Medicare Geographic Classification Review Board: Conforming Changes §§ 412.256 and 412.276

In the May 12, 1998 final rule (63 FR 26321), we revised the regulations governing the timeframes for submittal of applications by hospitals to the MGCRB for geographic reclassifications and for MGCRB decisions to take into consideration the revised statutory publication schedule for the annual prospective payment policies and rates (that is, August 1 instead of September 1) implemented by the BBA. In making those changes, we inadvertently omitted conforming changes to two other sections of the regulations that also specify timeframes that are affected by the change to an August 1 publication date—§§ 412.256 and 412.276. We proposed to revise § 412.256(c)(2) to specify that at the request of the hospital, the MGCRB may, for good cause, grant a hospital that has submitted an application by September 1 (instead of October 1) an extension beyond September 1 (instead of October 1) to complete its application. In addition, we proposed to revise § 412.276(a) to specify that the MGCRB notifies the parties in writing, with a copy to HCFA, and issues a decision within 180 days after the ''first day of the 13-month period preceding the Federal fiscal year for which the hospital had filed a completed application'' for reclassification, to make the language consistent with the statute and the May 1998 changes made to the application deadline in § 412.256(a)(2).

We did not receive any comments on this proposal and are adopting it as final.

We note that the instructions for preparing applications for FY 2001 individual and group reclassifications, which are due to the MGCRB by September 1, 1999, are now available for downloading from the Internet at www.hcfa.gov/regs/appeals.

Comment: One commenter requested clarification about submitting an application for reclassification for the standardized amount when the payment rates had changed during the year for which the applicable cost report would be used. Specifically, the commenter was concerned that the revised average hourly wage data, wage index, and standardized amounts applicable for FY 1999 beginning on or after March 1, 1999 (see the final rule published on February 25, 1999 (64 FR 9378)) will require the MGCRB to determine which

wage index and standardized amount value to use when evaluating applications seeking standardized amount geographic reclassification. The commenter asserted that because the MGCRB must use historical national adjusted operating standardized amounts and wage indices, a problem potentially arises when HCFA calculates more than one standardized amount and wage index for an area in a year, as it did in FY 1999. The commenter suggested the MGCRB use prorated standardized amount and wage index values in evaluating applications.

Response: When the MGCRB evaluates an application for reclassification for the standardized amounts, it uses actual payment rates for actual periods. Therefore, if the payment rate changed during the year that applies to a hospital's application, those figures are incorporated into the calculation for the months during which they applied. The same policy holds true for wage data.

E. Payment for Direct Costs of Graduate Medical Education (§ 413.86)

Under section 1886(h) of the Act, Medicare pays hospitals for the direct costs of graduate medical education (GME). The payments are based on the number of residents trained by the hospital. The BBA revised section 1886(h) of the Act to cap the number of residents that hospitals may count for direct GME. We have issued rules to implement the caps for GME (62 FR 46002, August 29, 1997; 63 FR 26327, May 12, 1998; and 63 FR 40986, July 31, 1998). Since the publication of these rules we have received a number of questions relating to GME. In addition, we have received information related to other aspects of our GME policies. In response to these questions and information, in the proposed rule, we proposed to clarify certain GME policies and also make some technical changes to the regulations text. In addition, we proposed certain changes in GME policy.

1. Approved Geriatric Programs

Under sections 1886(h)(5)(F) and (G) of the Act and § 413.86(g), Medicare counts each resident within an initial residency period as a 1.0 full-time equivalent (FTE) for purposes of determining GME payments. Each resident beyond the initial residency period is counted as 0.5 full-time equivalent. Section 1886(h)(5)(F) of the Act extends the initial residency period by up to 2 years if an individual is in a geriatric or preventive medicine residency or fellowship. At § 413.86(b), we specify that an ''approved geriatric program'' is ''a fellowship program of one or more years in length that is approved by the Accreditation Council for Graduate Medical Education (ACGME) under the ACGME's criteria for geriatric fellowship programs.'' In recent years, geriatric programs have been approved by other national organizations. Consistent with the statute, we proposed to clarify the definition of approved geriatric programs at § 413.86(b) to include fellowship programs approved by the American Osteopathic Association, the Commission on Dental Accreditation, and the Council on Podiatric Medical Education. These organizations, in addition to ACGME, are recognized by HCFA as the accrediting bodies for determining approved educational activities. We also proposed to make a conforming change to § 413.86(g)(1)(iii) to recognize approved geriatric programs accredited by all national approving organizations.

We received one comment in support of our proposed revision to § 413.86(b). We are adopting the revision as final.

2. Hospital Payment For Resident Training in Nonhospital Settings

Under sections 1886(d)(5)(B)(iv) and 1886(h)(4)(E) of the Act, hospitals may count residents working in nonhospital sites for indirect and direct medical education respectively if the hospital incurs ''all or substantially all'' of these education costs. The requirements for counting the time residents spend training in nonhospital settings are addressed at § 413.86(f)(4). Currently, the requirements for hospital payment under this provision are that the resident spend his or her time in patient care activities and that a written agreement exist between the hospital and the nonhospital site. This written agreement must indicate that the hospital will incur the cost of the residents' salaries and fringe benefits while the residents are training in the nonhospital site and that the hospital is providing reasonable compensation to the nonhospital site for supervisory teaching activities. In addition, the written agreement must indicate the compensation the hospital is providing to the nonhospital site for supervisory teaching activities.

Under the statute, the time residents spend at nonhospital sites may be counted ''if the hospital incurs all, or substantially all, of the costs of the training program in that setting.'' The existing regulations text, however, is framed in terms of the hospital having an agreement that it ''will incur'' the costs in the nonhospital setting. We proposed to make a technical change to the regulations text by adding a new § 413.86(f)(4)(iii), to clarify that in order to count residents at a nonhospital site, the hospital must actually incur all or substantially all of the costs for the training program, as defined in § 413.86(b), in the nonhospital site. This definition of all or substantially all requires the hospital to incur the expenses of the residents' salaries and fringe benefits (including travel and lodging where applicable) and the portion of the cost of teaching physicians' salaries and fringe benefits attributable to direct GME.

Comment: Many commenters supported our technical change under the proposed § 413.86(f)(4)(iii), which provides that, in order to count residents training at a nonhospital site for purposes of direct and indirect GME payment, the hospital must actually incur all or substantially all of the costs for the training programs. However, we believe several commenters misunderstood our technical change. The commenters believed that the change was unnecessary because the existing regulations, which were issued in the July 31, 1998 final rule, provide adequate guidance for purposes of the hospital claiming direct and indirect GME for resident training in the nonhospital site.

Response: We proposed to make the technical change in § 413.86(f)(4)(iii) for two reasons. First, we stated in the preamble to the July 31, 1998 final rule that we are requiring the hospital to actually incur all or substantially all of the cost, but the regulation text only indicated that the hospital must have an agreement to incur the cost; that is, the regulation text did not include specific language requiring that the hospital actually incur the cost. Second, we defined the phrase ''all or substantially all'' in § 413.86(b) but inadvertently omitted using the phrase in the policy specified in § 413.86(f)(4).

Comment: In regard to our proposed technical change to the nonhospital payment policy as specified in § 413.86(f)(4)(iii), one commenter asked us to define the difference, if any, in our use of ''nonprovider'' entity and ''nonhospital'' entity. In addition, the commenter asked whether a skilled nursing facility or a unit excluded from the prospective payment system is considered to be a nonhospital setting.

Also, similar to the public comments addressed in the in July 31, 1998 final rule, several commenters asked us to clarify whether hospitals would still be eligible to receive payments in situations where the teaching faculty volunteers their services and neither the hospital nor the nonhospital entity

incurs costs for supervisory teaching physicians. The commenters asked us to continue to support the following statement that we included in the July 31, 1998 final rule (63 FR 40996) allowing hospitals to remain eligible for payment in such situations where supervisory physicians in the nonhospital site are volunteering their time: ''for the purposes of satisfying the requirement of a written agreement, the written agreement between a hospital and a nonhospital site may specify that there is no payment to the clinic for supervisory activities because the clinic does not have these costs.''

Response: For purposes of our nonhospital payment policy for GME in § 413.86(f)(4), we use the terms ''nonhospital'' and ''nonprovider'' interchangeably. A free-standing SNF (that is, a SNF that is not part of a hospital) is a nonhospital site. An excluded unit of a hospital is not a nonhospital site because an excluded unit is still part of a hospital.

We will continue a volunteer supervisory physician policy consistent with the policy stated in the July 31, 1998 final rule, as requested by the commenter. Hospitals may receive payment for the costs of training residents in the nonhospital site even though the hospital might not be incurring any costs for supervisory physician activities.

3. New Residency Programs

In the regulations we published on August 29, 1997 and May 12, 1998, we established special rules for adjusting the full-time equivalent (FTE) resident caps for indirect and direct GME for new medical residency programs. In general, the special rules allow for adjustments to the caps based on the number of residents participating in the program in its third year of existence. In §§ 413.86(g)(6)(i) and 413.86(g)(6)(ii), we set forth a methodology for adjusting hospital FTE caps for new medical residency training programs established on or after January 1, 1995. In the May 7, 1999 proposed rule, we proposed the following clarifications, technical changes, and policy changes:

a. In § 413.86(g)(6)(i), we specify that, if a hospital had no residents before January 1, 1995, the adjustments for new programs are based on the highest number of residents in any program year during the third year of the newly established program. However, § 413.86(g)(6)(ii) does not explicitly state the methodology for adjusting caps for hospitals that did have residents in the most recent cost reporting period ending before January 1, 1995. The adjustments of the caps for programs established on or after January 1, 1995 and on or before August 5, 1997, also are made based on the number of residents in the third year of the new program. We proposed to revise § 413.86(g)(6)(ii) to clarify that, for a hospital that did have residents in the most recent cost reporting period ending on or before December 31, 1996, the adjustment is based on the highest number of residents in any program year in the third year of the new program.

b. Sections 413.86(g)(6)(i) and 413.86(g)(6)(ii) specify that the adjustment to the cap is also based on the number of years in which residents are expected to complete each program based on the minimum accredited length for the type of program. We proposed to add language to clarify how to account for situations in which the residents spend an entire program year (or years) at one hospital and the remaining year (or years) of the program at another hospital. In this situation, the adjustment to the FTE cap is based on the number of years the residents are training at each hospital, not the minimum accredited length for the type of program. If we were to use the minimum accredited length for the program in this case, the total adjustment to the cap for both hospitals might exceed the total accredited slots available to the hospitals participating in the program. In the May 12, 1998 final rule (63 FR 26334), we specified that the adjustment to the FTE cap may not exceed the number of accredited resident slots available.

c. It was brought to our attention that the regulations do not explicitly address how to apply the cap during the first 3 years of a new program before the adjustments to the cap are established. In the May 7, 1999 proposed rule, we proposed to clarify our policy on new residency programs by adding language in §§ 413.86(g)(6)(i) and 413.86(g)(6)(ii) to specify how to determine the hospital's cap in the first 3 years of a new residency program, before the implementation of the hospital's permanent adjustment to its FTE cap effective beginning with the fourth year of the program. We proposed to specify that the cap may be adjusted during each year of the first 3 years of the hospital's new residency program, using the actual number of residents participating in the new program. The adjustment may not exceed the number of accredited slots available to the hospital for each program year.

d. As discussed above, on August 29, 1997, we implemented the hospital-specific caps on the number of residents that a hospital can count for purposes of GME payments in a final rule with comment period (62 FR 46002). In both the May 12, 1998 and July 31, 1998 final rules (63 FR 26327 and 63 FR 40954), we responded to comments we received on this provision. We did not receive any comments about hospitals that participated in residency training in the past, had terminated their participation before the hospitals' cost reporting period ending in calendar year 1996, and have now again begun a new residency program. After publication of the July 31, 1998 final rule, we were contacted by representatives of some hospitals that had a resident cap of zero because they had temporarily terminated their GME programs in the past and had no residents training during the cost reporting period ending in 1996. Based on the existing regulations, these hospitals have FTE caps of zero. There is no provision in the existing regulations for making adjustments to the cap to allow these hospitals to receive payment for indirect and direct GME for allopathic and osteopathic residents.

To address this issue, we proposed to revise § 413.86(g)(6)(i) to allow for an adjustment to a hospital's FTE cap if the hospital had no allopathic and osteopathic residents in its cost reporting period ending during calendar year 1996. This change would allow all hospitals that did not participate in allopathic and osteopathic resident training in the cost reporting period ending in calendar year 1996 to receive adjustments to the indirect and direct GME FTE caps for new residency programs. We believe it is appropriate to revise the regulations to allow for payment during the first 3 years of the new program and for an adjustment to the FTE cap 3 years after these hospitals restart participation in residency training, similar to the existing adjustment for hospitals that never participated in residency training. We proposed to revise § 413.86(g)(6)(i) to allow a hospital that has zero residents for the cost reporting period ending during the calendar year 1996 to receive an adjustment. This change would be effective for discharges occurring on or after October 1, 1999, for purposes of the IME adjustment and for cost reporting periods beginning on or after October 1, 1999, for purposes of direct GME.

In addition, we proposed to make a change in § 413.86(g)(6)(ii) to make the language similar to that in § 413.86(g)(6)(i) to specify that hospitals that did have residents in the cost reporting period ending on or before December 31, 1996, are allowed adjustments to the cap for new programs begun on or after January 1, 1995, and

on or before August 5, 1997. Existing § 413.86(g)(6)(ii) refers to a hospital that did have residents in its most recent cost reporting period ending on or before January 1, 1995. The regulation states that these hospitals also may qualify for an adjustment to the caps, but only for medical residency programs created on or after January 1, 1995, and on or before August 5, 1997. Since we proposed to revise § 413.86(g)(6)(i) to indicate that a hospital may qualify for an adjustment to the cap under that paragraph if it did not have residents in the cost reporting period ending during calendar year 1996, we proposed to make a similar change in § 413.86(g)(6)(ii) to indicate that this paragraph provides for an adjustment to the cap for hospitals that did have residents in its most recent reporting period ending on or before December 31, 1996. We proposed this revision to make the language of these two paragraphs consistent. Hospitals may qualify either under § 413.86(g)(6)(i) or § 413.86(g)(6)(ii). For hospitals that qualify under § 413.86(g)(6)(i), the FTE caps are established 3 years after the hospital either begins or restarts participation in residency training for programs that began on or after January 1, 1995. However, for hospitals that qualify under § 413.86(g)(6)(ii), adjustments to the cap are limited to those programs that began on or after January 1, 1995 and on or before August 5, 1997.

e. We proposed to make technical changes to §§ 413.86(g)(6)(i) and 413.86(g)(6)(ii), which refer to whether a hospital had residents in its most recent cost reporting period on or before December 31, 1996. Instead of simply specifying ''residents,'' we proposed to reference ''allopathic and osteopathic residents,'' because the FTE cap applies only to allopathic and osteopathy residents. There is no FTE cap on the number of podiatry and dentistry residents. Therefore, we proposed to add the words ''allopathic and osteopathic'' in §§ 413.86(g)(6)(i) and 413.86(g)(6)(ii) before the word ''resident.''

We received a number of comments on our proposals.

Comment: One commenter supported our technical changes to the new residency program adjustments under proposed §§ 413.86(g)(6)(i) and 413.86(g)(6)(ii). The commenter agreed with our technical change of referencing ''allopathic and osteopathic residents'' instead of simply ''residents.''

The proposed rule specified that the method for calculating the adjustment to the cap is based on the product of the highest number of residents in any program year during the third year of the newly established program and the number of years in which residents are expected to complete each year program based on the minimum accredited length for the type of program. One commenter requested an example of a calculation of this adjustment.

Response: In response to the commenter's request, we are providing the following example of how to calculate the new residency program adjustment under § 413.86(g)(6)(ii). This example was included in a Program Memorandum (Transmittal No. A–97–13 (p. 16), September 1997) that transmitted billing instructions to our fiscal intermediaries.

Example: Assume a hospital had an unweighted direct GME count of 100 FTE residents for its cost reporting period ending June 30, 1996 and the hospital, although it had 6 first year slots, began an internal medicine program on July 1, 1995 with 4 first year residents (who were included as part of the 100 FTE cap). On July 1, 1996, the program expands to 10 residents (6 first year and 4 second year residents.) On July 1, 1997, the program has 16 residents (6 first year residents, 6 second year residents, and 4 third year residents). Since the minimum accredited length for internal medicine program listed is 3 years, the hospital's unweighted FTE cap can be adjusted based on 18 residents in the internal medicine program (6 first year residents * 3 years). In the hospital's cost reporting period ending June 30, 1996, the hospital had a total of 100 FTE residents including 4 in internal medicine. The hospital's cap can be adjusted up to 14 residents (18 internal medicine residents less 4 already included in the fiscal year ending June 30, 1996 FTE count).

Comment: Several commenters expressed concern about our definition of ''new medical residency training program'' for purposes of determining the FTE cap adjustment under § 413.86(g). One commenter raised questions regarding the situation where the original sponsor of a residency program has been notified that it has lost its accreditation and a new sponsor assumes the training of all or most of the residents of an existing program. The commenter believed that the program under the new sponsor should be treated as ''new'' as well. Another commenter suggested we have interpreted ''new residency program'' to be simply a new site for a residency program that may have been in existence at other clinical sites in the past.

Response: Under the existing § 413.86(g)(7) (proposed to be redesignated as § 413.86(g)(9)), we define ''new medical residency training program'' to be a program ''that receives initial accreditation by the appropriate accrediting body or begins training residents on or after January 1, 1995.'' The language ''begins training residents on or after January 1, 1995'' means that the program may have been accredited by the appropriate accrediting body prior to January 1, 1995, but did not begin training in the program until on or after January 1, 1995. The language does not mean that it is the first time a particular hospital began training residents in a program on or after January 1, 1995, but the program was in existence at another hospital prior to January 1, 1995, as the commenter suggests.

We believe there may be some confusion on the part of the commenters as to how to determine when a hospital may receive an adjustment to its FTE cap for a new residency program. The definition can be more easily understood if we explain the application in two steps. First, determine if the hospital's residency program qualifies to be ''new'' under § 413.86(g)(9). Second, once the residency program is determined to meet the definition of ''new,'' apply the criteria under §§ 413.86(g)(6)(i) and 413.86(g)(6)(ii) to determine whether a hospital's new program qualifies for an adjustment to its FTE cap. A hospital's sponsorship of the program plays no role in determining whether a hospital qualifies to receive an adjustment under either § 413.86(g)(6)(i) or § 413.86(g)(6)(ii).

If two hospitals ''merge'' separate residency programs, the single residency program resulting from the merger would not be considered ''new'' for purposes of either hospital receiving an adjustment to its FTE cap. The programs have already been in existence and, presumably, the hospitals have been able to count the residents training in each individual program as part of the hospitals' respective FTE caps. If the hospital that is training the residents in the merged program would like to receive an adjustment to its FTE cap for the added residents it presumably now trains, that hospital may wish to affiliate for purposes of establishing an aggregate FTE cap.

Comment: We received several comments on our clarification on how to account for situations when residents spend an entire program year (or years) at one hospital and the remaining year (or years) of the program at another hospital (or hospitals) during the first 3

years of the new residency program. We stated that, in this situation, the adjustment to the FTE cap is based on the number of years the residents are training at each hospital, not the minimum accredited length of the program. One commenter asked us to clarify the adjustment to the cap in situations where the residents rotate to multiple sites in a single program year during the first 3 years of a new residency program—that is, the residents rotate to other hospitals for partial years. Another commenter requested that we give examples of how to calculate the FTE cap adjustment in these situations.

Response: In situations where residents spend an entire program year (or years) at one hospital and the remaining year (or years) of the program at another hospital during the first 3 years of the new residency program, each hospital that trains the residents receives an adjustment to its cap based on the product of the highest number of residents in any program years during the third year of the first program's existence and the number of years that the residents are training at each respective hospital. In situations where the residents spend partial years at different hospitals during the first 3 years of the new residency program, each hospital that trains the residents receives an adjustment to its cap based on product of the highest number of residents in any program year during the third year of the first program's existence and the minimum accredited length of the program.

In response to the second commenter's request, the following are some examples as to how to calculate the adjustment to the FTE cap for a new residency program in situations where residents spend an entire program year (or years) at one hospital and the remaining year (or years) at another hospital during the first 3 years of the program. In addition, we are including an example where residents spend partial years at different hospitals during the first 3 years of the new residency program:

Example 1

Assume Hospital A has 10 residents in a new internal medicine residency program. These 10 residents are trained at Hospital A for 2 years of the program. In the third year of the program, 5 of the 10 residents are rotated to Hospital B for training.

Hospital A would receive an adjustment to its cap of 10 FTE (5 residents * 2 years).

Hospital B would receive an adjustment to its cap of 5 FTE (5 residents * 1 year).

Example 2

Assume Hospital A has the following residents training in its new internal medicine residency program:

Year 1–10 new program year (PGY [1] 1) residents

Year 2—Hospital A rotates the 10 (now PGY 2) residents from Year 1 to Hospital B for training for 1 year and Hospital A also accepts 8 (PGY 1) new residents.

Year 3—The 10 (now PGY 3) residents who rotated to Hospital B in Year 2 return to Hospital A. Hospital A accepts 9 new (PGY 2) residents and also rotates the 8 (PGY 2) residents from Year 2 to Hospital B for training for 1 year. Thus, in the third year of the program, Hospital A has 10 (PGY 3) residents and 9 (PGY 1) residents and Hospital B has 8 (PGY 2) residents.

Hospital A would receive an FTE cap adjustment of 20 FTE (10 residents * 2 years).

Hospital B would receive an FTE cap adjustment of 8 FTE (8 residents * 1 year).

[1] PGY = Program Year

Example 3

Assume Hospital A has 10 residents in a new internal medicine program for one half of each of the three residency program years. Hospital B trains the 10 residents for the other half of each of the three residency years.

Hospital A would receive an FTE cap adjustment of 15 FTEs (10 residents * .5 FTE * 3 years).

Hospital B would receive an FTE cap adjustment of 15 FTEs (10 residents * .5 FTE * 3 years).

Both Hospital A and Hospital B train a total of 5 FTE residents each residency program year (.5 of 10 residents each year) and this number is multiplied by the minimum accredited length of the residency program (3 years for internal medicine).

Comment: One commenter suggested that only the hospital or hospitals that have received the accreditation for the new residency program should receive the adjustment to the FTE cap or caps.

Response: While Medicare will provide GME payment to a hospital for training a resident only if that resident is participating in an accredited program, it is irrelevant whether the accreditation for the program belongs to the hospital currently training the residents or some other entity. Thus, we disagree with the commenter's suggestion to allow only hospitals that received the new residency program accreditation to receive a new residency program adjustment.

Comment: Several commenters were concerned about our provision on the adjustment to the FTE cap during the first 3 years of a new residency program, as specified in proposed § 413.86(g)(6)(i)(B). One commenter stated that it seemed inconsistent to refer to ''adjusting the cap'' during these years when the cap is not actually adjusted until the third year. Another commenter suggested that, when looking at the number of residents training at the hospital during the first 3 years for purposes of deciding the cap adjustment in those 3 years, the FTE count for cost reporting purposes should be based on the number of residents for which the hospital has oversight and the time worked in locations within or outside the hospital complex to which they rotate.

Response: Section 413.86(g)(6)(i)(B) contains the provision that explains how a hospital is to adjust its FTE cap during the first 3 years of establishing a new residency program—the hospital's cap may be adjusted during each of the first 3 years using the actual number of residents participating in the new program. The ''number of residents participating in the new program'' means the number of residents actually training at that hospital. It does not mean the number of residents within the ''oversight'' of the hospital, which could include the time residents spend at other types of facilities during their training; it only includes the time the residents spend training at the actual hospital site.

When a hospital establishes a new residency program, the hospital's 1996 FTE cap for the first 3 years is adjusted. Thus, the 1996 FTE cap is also receiving an adjustment during those 3 years.

Comment: One commenter noted that while we made clarifications in our new residency program adjustment policy under §§ 413.86(g)(6)(i) and 413.86(g)(6)(ii), we failed to make consistent changes to § 413.86(g)(6)(iii).

Response: We agree that we inadvertently omitted the third change. We are revising § 413.86(g)(6)(iii) in this final rule.

Comment: One commenter suggested that our meaning is unclear concerning our provision in proposed redesignated § 413.86(g)(6)(i)(D) that allows a rural hospital that receives an adjustment to its FTE cap for establishing new residency programs to affiliate with other hospitals for the purpose of establishing an aggregate cap.

Response: We are revising the language in this section to state more clearly that, in the case of hospitals in urban areas, we limit the use of affiliations to provide for aggregate caps only to urban hospitals that did not receive a new residency program adjustment for a program begun on or after August 6, 1997 (the date after enactment of the BBA). Urban hospitals that had no program or programs reported for their most recent cost reporting period ending on or before December 31, 1996 and have received an FTE cap adjustment for a new program may not affiliate with other hospitals for purposes of establishing an aggregate FTE cap. However, rural hospitals that had no program or programs reported for the most recent cost reporting period ending on or before December 31, 1996 and have received an FTE cap adjustment for establishing a new program may affiliate with other hospitals for purposes of establishing an aggregate FTE cap.

4. Adjustment to GME Caps for Certain Hospitals to Account for Residents in New Medical Residency Training Programs

Section 4623 of the BBA amended section 1886(h) of the Act to provide for ''special rules'' in applying FTE caps for medical residency training programs established on or after January 1, 1995. In the August 29, 1997 and May 12, 1998 final rules (62 FR 46002 and 63 FR 26327), we implemented special rules to account for residents in new medical residency training programs. We proposed to implement another special rule to permit an adjustment to the FTE cap for a hospital if the entire facility was under construction prior to August 5, 1997 (the date of enactment of the BBA) and if the hospital sponsored a new medical residency training program but the residents were temporarily trained at another hospital.

Under current policies, if a new medical residency training program was established on or after January 1, 1995, a hospital may receive an adjustment to its FTE cap to account for residents in the new program. If the residents in the new program begin training in one hospital and are subsequently ''transferred'' to another hospital, the second hospital would *not* receive an adjustment to its FTE cap; if we made an adjustment for the second hospital, then two hospitals would receive an adjustment for the same resident.

We believe, however, that an adjustment for the second hospital might be appropriate in certain limited circumstances. If the second hospital sponsored a new medical residency training program but the residents in the new program temporarily trained at the first hospital because the second hospital was still being built, then we believe it would be appropriate to permit an adjustment for the second hospital. Otherwise, the second hospital's FTE cap would be zero, and the hospital would not receive any GME or IME payments.

We proposed to permit an adjustment under this policy only if the second hospital (the sponsor of the new program) began construction of its entire facility prior to the date of enactment of the BBA. Prior to August 5, 1997, a hospital would not have had knowledge of the provisions of the BBA and thus would not have known that a decision to temporarily train residents at another hospital might have resulted in the hospital being unable to receive GME and IME payments in the future. In contrast, a hospital that began construction of an entirely new facility after August 5, 1997, would have had notice of changes in the law prior to making a decision to temporarily train residents at another hospital.

Thus, we proposed to add a new § 413.86(g)(7) (existing § 413.86(g)(7) would be redesignated as § 413.86(g)(9)) to address application of the FTE caps with regard to a hospital that began construction of an entire facility prior to August 5, 1997, sponsored medical residency training programs, and temporarily trained those residents at another hospital(s) until the new facility was completed. For hospitals that meet these criteria, we proposed that the FTE caps will be determined in a manner similar to those hospitals that qualify for an adjustment to the FTE cap under § 413.86(g)(6)(i). That is, the hospital's cap would equal the lesser of (a) the product of the highest number of residents in any program year during the third year of the first program's existence for all new residency training programs at either the newly constructed facility or the temporary training site but sponsored by the newly constructed hospital and the number of years in which residents are expected to complete the programs based on the minimum accredited length for each type of program; or (b) the number of accredited slots available for each year of the program. If the medical residency training programs sponsored by the newly constructed hospital have been in existence for 3 years or more by the time the residents begin training at the newly constructed hospital, the newly constructed hospital's cap would be based on the number of residents training in the third year of the first of those programs begun at the temporary training site. If the medical residency training programs sponsored by the newly constructed hospital have been in existence for less than 3 years when the residents begin training at the newly constructed hospital, the hospital's cap would be based on the number of residents training at the newly constructed hospital in the third year of the first of those programs (including the years at the temporary training site). This provision would be effective for portions of cost reporting periods occurring on or after October 1, 1999.

Comment: With regard to our proposed change concerning our adjustment to the GME caps for newly constructed hospitals, one commenter suggested that while §§ 413.86(g)(7)(i)(A) and (B) appear to be clear and straightforward, §§ 413.86(g)(7)(ii) and (iii) are unclear and add confusion to the calculation of the newly constructed hospital's FTE cap. The commenter suggested that §§ 413.86(g)(7)(ii) and (iii) be removed.

Another commenter suggested that a newly constructed hospital under § 413.86(g)(7) should be able to affiliate with other hospitals for purposes of establishing an aggregate FTE cap.

Response: The purpose of both §§ 413.86(g)(7)(i)(B) and 413.86(g)(7)(ii)(B) is to clarify how to establish the newly constructed hospital's FTE cap in all possible situations. The regulation at ' 413.86(g)(7)(i)(B) addresses the calculation of the newly constructed hospital's FTE cap if the new program has been in existence for 3 or more years at the temporary training site by the time the residents begin training at the newly constructed hospital. The regulation at § 413.86(g)(7)(ii)(B) addresses the calculation of the cap if the new program has been in existence for 3 or fewer years at the temporary training site by the time the residents begin training at the newly constructed hospital.

We agree with the commenter's suggestion to allow a newly constructed hospital under § 413.86(g)(7) to affiliate for purposes of establishing an aggregate FTE cap. We currently allow teaching hospitals that receive a new residency program adjustment under § 413.86(g)(6)(ii) to affiliate with other hospitals if the teaching hospitals had established new programs prior to the enactment of the BBA. Teaching hospitals could not have known what policies would be enacted in the BBA. Therefore, they would not have had the opportunity to establish programs for purposes of affiliation in order to circumvent the FTE cap established by the BBA. The commenter notes that we used the same rationale when espousing

the policy on newly constructed hospitals in the proposed rule—we are allowing hospitals that began construction prior to August 5, 1997 to establish an FTE cap because the hospitals would not have had knowledge of the provisions of the BBA. For the same reason, we agree that the newly constructed hospital should be able to affiliate for purposes of establishing an aggregate cap because the hospital under construction would not have known the BBA restrictions. Therefore, we are revising the text of § 413.86(g)(7) to include this new policy.

In addition, consistent with this reasoning, we are allowing newly constructed hospitals under § 413.86(g)(7) to calculate their FTE cap using the same methodology as articulated in § 413.86(g)(6)(ii), the provision for teaching hospitals that establish new residency programs on or after January 1, 1995 and on or before August 5, 1997. We allow those teaching hospitals to receive a new residency program adjustment during that ''window'' because these hospitals could not have known what requirements would be enacted in the BBA if the teaching hospitals established new programs during that time. As stated above, we used the same rationale for allowing newly constructed hospitals to establish a cap—these hospitals could not have known about the BBA when the hospitals established residency programs. Therefore, we are adding language to § 413.86(g)(7) as follows: '' * * * a hospital that began construction of its facility on or before August 5, 1997, sponsored new medical residency training programs that were established on or after January 1, 1995 and on or before August 5, 1997, and either received initial accreditation by the appropriate accrediting body or temporarily trained those residents at another hospital(s) until the facility was completed, may receive an adjustment to its FTE cap.'' We note that we are clarifying the phrase ''prior to August 5, 1997'' to mean ''on or before August 5, 1997'' to make it consistent with this policy. We also are making conforming changes to §§ 413.86(g)(7)(i)(A) and (B) and 413.86(g)(7)(ii)(B) to allow the cap to be adjusted for each new program established within the ''window.'' Under the previous language, the adjustment was tied to the third year of the first new program. Under the new language, the adjustment is tied to each new program's establishment during the ''window.'' Therefore, for example, in a situation where a newly constructed hospital establishes a new residency program and the first new program began on July 1, 1995, and a second program began on July 1, 1997, the adjustment for the second program under the previous language would have been tied to the third year of the first new program (1997). However, under the new language, the adjustment for the second program is not established until the third year (1999) of the second program's existence.

Comment: Another commenter suggested that we include the word ''new'' when referring to medical residency training programs in § 413.86(g)(7)(ii) and (iii).

Response: We are making the revision as the commenter suggests. This revision will clarify that the provisions allowing an adjustment to the FTE cap for a facility constructed on or before August 5, 1997 applies to new residency programs.

5. Temporary Adjustments to FTE Cap to Reflect Residents Affected by Hospital Closure

In the May 12, 1998 prospective payment system final rule (63 FR 26330), we indicated that we would allow a temporary adjustment to a hospital's resident cap under limited circumstances and if certain criteria are met when a hospital assumes the training of additional residents because of another hospital's closure. The temporary adjustment to the FTE cap is available to the hospital only for the period of time necessary to train those displaced residents. Once the residents leave the hospital or complete their programs, the hospital cap would be based solely on the statutory base year (with any applicable adjustments for new medical residency training programs or affiliated group arrangements).

Under current policies, we permit a temporary adjustment to the FTE cap for a hospital only if it assumed additional medical residents from a hospital that closed in the July 1996–June 1997 residency training year. In the May 7, 1999 proposed rule, we proposed to allow adjustments to address hospital closures after this period. Thus, we would allow an adjustment for a hospital if it trains additional residents from a hospital that closes at any time, on or after July 1, 1996. This adjustment is intended to account for residents who may have partially completed a medical residency training program and would be unable to complete their training without a residency position at another hospital.

We proposed this change because hospitals have indicated a reluctance to accept additional residents from a closed hospital without a temporary adjustment to their caps. We proposed to add a new § 413.86(g)(8) to allow a temporary adjustment to a hospital's FTE cap to reflect residents added because of a hospital's closure at any time on or after July 1, 1996. We would allow an adjustment to a hospital's FTE cap if the hospital meets the following criteria: (a) the hospital is training additional residents from a hospital that closed on or after July 1, 1996; and (b) the hospital that is training the additional residents from the closed hospital submits a request to its fiscal intermediary at least 60 days before the beginning of training of the residents for a temporary adjustment to its FTE cap. The hospital must also document that it is eligible for this temporary adjustment to its FTE cap by identifying the residents who have come from the closed hospital and have caused the hospital to exceed its cap, and specify the length of time that the adjustment is needed. After the displaced residents leave the hospital's training program or complete their residency program, the hospital's cap would be based solely on the statutory base year (with any applicable adjustments for new medical residency training programs or affiliated group arrangements).

Comment: Many commenters were generally pleased with our proposed policy concerning the temporary adjustment to FTE caps to reflect residents affected by hospital closures specified under proposed § 413.86(g)(8). However, various commenters asked us to define what we meant by a ''closed'' hospital.

Response: Section 413.86(g)(8) provides that a hospital may receive a temporary adjustment to its FTE cap to reflect residents added because of another hospital's closure which occurs on or after July 1, 1996. By hospital ''closure,'' we mean the hospital terminates its Medicare participation agreement with HCFA under the provisions specified in § 489.52. To ''close,'' a hospital would have to comply with the requirements as specified in this section to terminate its agreement. We are making conforming changes in § 413.86(g)(8) on the temporary adjustment to reference § 489.52.

Comment: Many of the commenters suggested that we include bankruptcy of a hospital and lost accreditation of a program, both acts that displace residents, as applicable to the temporary adjustment policy.

Response: We do not agree with the commenters. We do not believe it is appropriate to expand our policy to cover any acts other than hospital

closure because, unless the hospital actually terminates its Medicare agreement, it will retain its statutory FTE cap. For example, in the case where a hospital files for bankruptcy, it continues to retain its FTE cap. While the bankruptcy action may displace the hospital's residents, the hospital continues to be subject to the statutorily mandated cap on FTEs. Therefore, it can still decide to train residents at the hospital or affiliate with other hospitals for purposes of establishing an aggregate cap. The hospital may, in fact, use its ability to affiliate in order to place its residents at a new hospital.

Comment: One commenter explained that there were hospitals that had plans to close their doors earlier this year and deliberately remained open for various reasons until the start of the July 1, 1999 residency year. This commenter suggested that because hospitals are training these displaced residents beginning on July 1, 1999, we should change the effective date of the temporary adjustment provision to coincide with the July 1, 1999 date. Similarly, another commenter was concerned about affiliated groups, suggesting that because final regulations on affiliated groups were not published until May 12, 1998, some hospitals that would have liked to have participated in affiliations prior to the FY 1998 were not able to because there were no implementing regulations before the May 12, 1998 date.

Response: The effective date of the temporary adjustment policy, like the effective date for all changes in this final rule, is October 1, 1999.

Similarly, hospitals that choose to affiliate cannot do so before the effective date of the May 12, 1998 regulation.

Comment: Under the temporary adjustment provision, § 413.86(g)(8)(ii) requires a hospital to submit a request for the temporary adjustment to its fiscal intermediary at least 60 days before the hospital begins to train the residents. One commenter suggested that it was not appropriate for the fiscal intermediary to be in the position of granting requests for adjustments. In addition, several commenters suggested that submitting a request at least 60 days before the hospital begins to train the residents is ''problematic,'' since it is not always easy to estimate exactly when a hospital will close and other hospitals can then continue training the residents.

Response: The fiscal intermediaries have been delegated the authority to calculate Medicare program payments for hospitals, including GME payments. HCFA is not in a position to be able to respond to every request for a temporary FTE cap adjustment. As long as hospitals that request the adjustments meet each condition in our regulations, the hospitals will receive the adjustments.

We agree with the commenters who suggested that requiring a hospital to submit a request for a temporary adjustment to an intermediary at least 60 days before the hospital begins to train the residents might be problematic for hospitals. Therefore, we are revising our regulations to require a hospital to submit a request for a temporary adjustment to an intermediary no later than 60 days after the hospital first begins training the displaced residents.

Comment: One commenter requested that we clarify the provision at ' 413.86(g)(8)(ii) that hospitals must identify residents that come from closed programs in order to receive a temporary adjustment to their FTE caps.

Response: In order to receive a temporary adjustment to their FTE caps, hospitals must provide the social security numbers of the residents coming from the closed hospital and documentation that proves that the residents were training at the hospital that closed.

6. Determining the Weighted Number of FTE Residents

Section 413.86(g)(1)(ii) states that for residency programs in osteopathy, dentistry, and podiatry, the minimum requirement for certification in a specialty or subspecialty is the minimum number of years of formal training necessary to satisfy the requirements of the appropriate approving body listed in § 415.200(a). This reference is incorrect. The correct section in which approving bodies for residency programs are listed is § 415.152. We proposed to make this correction.

Section 413.86(g)(1)(i) specifies that the initial residency period is the minimum number of years of formal training necessary to satisfy board eligibility in the particular specialty for which the resident is training, as specified in the 1985–1986 Directory of Residency Training Programs. Section 1886(h)(5)(G)(iii) of the Act allows the Secretary to increase or decrease the initial residency period if the minimum number of years of formal training specified in a later edition of the directory is different from the period specified in the 1985–1986 Directory of Residency Training Programs. We proposed to revise the regulations text to state that the initial residency period is determined using the most recently published edition of the Graduate Medical Education Directory, not the 1985–1986 Directory.

Comment: At § 413.86(g)(1), we proposed to update the provisions concerning what source to use when calculating the initial residency period for residencies. One commenter stated that one of the provisions that we updated, changing ''1985–1986 Directory of Residency Training'' to ''the most recently published edition of the Graduate Medical Education Directory,'' applies only when calculating the initial residency periods for allopathic residencies. The commenter suggests that initial residency periods for all residencies be published in the **Federal Register**. The commenter further suggested that, for determining the updates of initial residency periods for dental residencies, the most recent accreditation standards of the Commission on Dental Accreditation for advanced dental programs be used. Another commenter asked whether the most recently published edition of the Graduate Medical Education Directory or the initial residency periods is published in the **Federal Register** should be the guiding source when calculating the initial residency periods for residencies in the case where there is a discrepancy between the two.

Response: Generally, proposed redesignated § 413.86(g)(1)(i) defines the initial residency period as ''the minimum number of years of formal training necessary to satisfy the requirements for initial board eligibility in the particular specialty for which the resident is training, as specified in the most recently published edition of the Graduate Medical Education Directory.'' Proposed § 413.86(g)(1)(ii) provided that for residency programs in osteopathy, dentistry, and podiatry, ''the minimum number of years of formal training necessary to satisfy the requirements of the appropriate approving body listed in § 412.152 of this chapter.'' Section 412.152 lists all of the accreditation organizations for allopathy, osteopathy, podiatry, and dentistry, including the Commission on Dental Accreditation of the American Dental Association. In other words, while the Graduate Medical Education Directory only applies to allopathic residencies, as the first commenter suggests, the organization that the commenter encourages us to use as the accrediting organization for purposes of determining the initial residency period for dental residencies—the Commission on Dental Accreditation of the American Dental Association—is already used to determine the initial residency periods for dental residencies.

The first commenter also suggests that we publish the initial residency periods in the **Federal Register**. While we have already done so in the August 30, 1996 **Federal Register** (61 FR 46208), we plan to update the list of initial residency periods in upcoming regulations. The second commenter asked for guidance in the case where the initial residency periods listed in the August 30, 1996 (and in future regulations) differ from the information listed in the most recent edition of the Graduate Medical Directory. The information that we used to publish the initial residency periods in the August 30, 1996 **Federal Register** is based on the most recent edition of the Graduate Medical Directory. The Graduate Medical Directory is the most current and updated source of information on allopathic residencies. We agree that in some cases our latest listing in the **Federal Register** may not reflect the most recent update of the applicable directory. Thus, in the case where there is a discrepancy in the length of an initial residency period listed in what we publish in the **Federal Register** and what is published in the most recent edition of the Graduate Medical Education Directory (or other applicable publications for the other specialty areas), the Directory should be the guiding source.

7. Clarification of a Statement in the Preamble of the May 12, 1998 Final Rule Relating to Affiliated Groups

In the May 12, 1998 final rule (63 FR 26341), in the third column of page 26341, in the sentence prior to section ''O. Payment to Managed Care Plans for Graduate Medical Education,'' we stated, ''If the combined FTE counts for the individual hospitals that are members of the same affiliated group do not exceed the aggregate cap, we will pay each hospital based on its FTE cap as adjusted per agreements.'' The phrase ''do not exceed'' should have read ''exceed.'' Thus, the sentence should have read, ''If the combined FTE counts for individual hospitals that are members of the same affiliated group exceed the aggregate cap, we will pay each hospital based on its FTE cap as adjusted per agreements.'' We regret any confusion that resulted from this misstatement.

Comment: Several commenters requested that we clarify that a nonteaching hospital that participates in an affiliated group agreement as specified under § 413.86(g)(4) is not precluded from later seeking an adjustment to its FTE cap for establishing a new residency program.

Response: We agree with the commenters' request. Consistent with our regulations at § 413.86(g)(6)(i), a nonteaching hospital that participated (or participates) in an affiliated group for purposes of establishing an aggregate FTE cap does not forego its opportunities to later establish new residency programs and accordingly receive an adjustment to its individual FTE cap. The requirements under § 413.86(g)(6)(i) specify that a hospital may receive an adjustment to its FTE cap for establishing a new residency program if the hospital had no allopathic or osteopathic residents in its most recent cost reporting period ending on or before December 31, 1996. In other words, the hospital must have a zero FTE cap based on its number of residents in its most recent cost reporting period ending on or before December 31, 1996 in order to qualify to receive an adjustment under this provision. The fact that a nonteaching hospital has affiliated with other hospitals does not change the fact that in determining the aggregate cap for the affiliated group the nonteaching hospital still has an FTE cap of zero. Accordingly, consistent with our regulations, a nonteaching hospital that affiliates is not precluded from later seeking a new residency program adjustment.

Comment: The BBA specifically required the Secretary to give special consideration to facilities that meet the needs of underserved rural areas. With this mandate in mind, several commenters requested that we consider recognizing new family practice programs that are classified as rural by the Residency Review Committee for the purpose of establishing a cap and receiving GME payment under Medicare.

Response: We will consider the suggestion to apply our rules for rural hospitals to all hospitals with the new family practice programs for purposes of GME in developing future regulations.

Comment: We received several other comments suggesting GME policy changes concerning rural hospitals. One commenter suggested that we allow rural hospitals that received a new residency program adjustment under § 413.86(g)(6)(ii) to affiliate with other hospitals for purposes of establishing an aggregate FTE cap. Another commenter suggested that we allow rural hospitals a new residency program adjustment for expansions of already established residency programs at the rural hospitals.

Response: Any hospital, rural or urban, that receives a new residency program adjustment under § 413.86(g)(6)(ii) is permitted to affiliate for purposes of establishing an aggregate cap. As for allowing an FTE cap adjustment for expansions of already established residency programs at rural hospitals, we will take this policy suggestion into consideration in future regulations.

Comment: We received many comments on various other GME issues. One commenter asked what level of documentation is needed to demonstrate for purposes of our nonhospital payment policy that a particular hospital and nonhospital site are a single legal entity. Another commenter asked for a cost report change to account for situations when a hospital could have one FTE cap for one-half of the year and a different cap for the second half of the year. One commenter suggested that, in a situation when two hospitals affiliate for purposes of establishing an aggregate cap, the hospital that is the sponsor of the residency program should be given the ability to better control the limited number of training slots as established under the aggregate cap. Another commenter suggested that we consider allowing a new residency program adjustment for family practice programs beginning on or after July 1, 1994. Finally, one commenter made two suggestions: (1) that we increase a particular hospital's FTE count because when the cap was set, some of the hospital's residents were rotated out to other hospitals to meet a Residency Review Committee (RRC) program requirement, and are now brought back into the hospital after the BBA because the hospital can now meet the RRC requirement, and (2) that we allow payment to a hospital that had established an ambulatory care rotation prior to the BBA.

Response: We will consider all of these suggestions made by the commenters in future regulations.

Comment: One commenter suggested that we discuss what happens to hospitals' FTE caps in situations where there is a merger of two or more hospitals.

Response: We discussed the merger of hospitals and FTE caps in the May 12, 1998 **Federal Register** (63 FR 26329). Where two or more hospitals merge after each hospital's cost reporting period ending during FY 1996, the merged hospital's FTE cap will be an aggregation of the FTE cap for each hospital participating in the merger.

V. Changes to the Prospective Payment System for Capital-Related Costs: Special Exceptions Process

Section 1886(g) of the Act requires the Secretary to pay for hospital capital-related costs ''in accordance with a

prospective payment system established by the Secretary.'' Under the statute, the Secretary has broad authority in establishing and implementing the capital prospective payment system. We initially implemented the capital prospective payment system in the August 30, 1991 final rule (56 FR 43409), in which we established a 10-year transition period to change the payment methodology for Medicare inpatient capital-related costs from a reasonable cost-based methodology to a prospective methodology (based fully on the Federal rate).

Generally, during the transition period, inpatient capital-related costs are paid on a per discharge basis, and the amount of payment depends on the relationship between the hospital-specific rate and the Federal rate during the hospital's base year. A hospital with a base year hospital-specific rate lower than the Federal rate is paid under the fully prospective payment methodology during the transition period. This method is based on a dynamic blend percentage of the hospital's hospital-specific rate and the applicable Federal rate for each year during the transition period. A hospital with a base period hospital-specific rate greater than the Federal rate is paid under the hold harmless payment methodology during the transition period. A hospital paid under the hold harmless payment methodology receives the higher of (1) a blended payment of 85 percent of reasonable cost for old capital plus an amount for new capital based on a portion of the Federal rate or (2) a payment based on 100 percent of the adjusted Federal rate. The amount recognized as old capital is generally limited to the allowable Medicare capital-related costs that were in use for patient care as of December 31, 1990. Under limited circumstances, capital-related costs for assets obligated as of December 31, 1990, but put in use for patient care after December 31, 1990, also may be recognized as old capital if certain conditions are met. These costs are known as obligated capital costs. New capital costs are generally defined as allowable Medicare capital-related costs for assets put in use for patient care after December 31, 1990. Beginning in FY 2001, at the conclusion of the transition period for the capital prospective payment system, capital payments will be based solely on the Federal rate for the vast majority of hospitals.

In the August 30, 1991 final rule, we also established a capital exceptions policy, which provides for exceptions payments during the transition period (' 412.348). Section 412.348 provides that, during the transition period, a hospital may receive additional payment under an exceptions process when its regular payments are less than a minimum percentage, established by class of hospital, of the hospital's reasonable capital-related costs. The amount of the exceptions payment is the difference between the hospital's minimum payment level and the payments the hospital would receive under the capital prospective payment system in the absence of an exceptions payment. The comparison is made on a cumulative basis for all cost reporting periods during which the hospital is subject to the capital prospective payment transition rules. The minimum payment percentages for regular capital exceptions payments by class of hospitals for FY 2000 are:

- For sole community hospitals, 90 percent;
- For urban hospitals with at least 100 beds that have a disproportionate share patient percentage of at least 20.2 percent or that received more than 30 percent of their net inpatient care revenues from State or local governments for indigent care, 80 percent;
- For all other hospitals, 70 percent of the hospital's reasonable inpatient capital-related costs.

We indicated that we would carefully monitor the impact of the capital prospective payment system in order to determine whether some type of permanent exceptions process was necessary and the circumstances under which additional payments would be made.

Under the special exceptions provision at § 412.348(g), an additional payment may be made for up to 10 years beyond the end of the capital prospective payment system transition period for eligible hospitals that meet (1) a project need requirement as described at § 412.348(g)(2), which, in the case of certain urban hospitals, includes an excess capacity test; and (2) a project size requirement as described at § 412.348(g)(5). Eligible hospitals include sole community hospitals, urban hospitals with at least 100 beds that have a disproportionate share percentage of at least 20.2 percent, and hospitals with a combined Medicare and Medicaid inpatient utilization of at least 70 percent. In the September 1, 1994 final rule, we described the special exceptions process as ''* * * narrowly defined, focusing on a small group of hospitals who found themselves in a disadvantaged position. The target hospitals were those who had an immediate and imperative need to begin major renovations or replacements just after the beginning of the capital prospective payment system. These hospitals would not be eligible for protection under the old capital and obligated capital provisions, and would not have been allowed any time to accrue excess capital prospective payments to fund these projects'' (59 FR 45385).

For hospitals in States with certificate of need (CON) requirements, the project need requirement is satisfied by obtaining a CON approval. For other hospitals, the project need requirement is satisfied by meeting an age of assets test. The project size requirement is satisfied if the hospital completes the qualifying project between the period beginning on or after its first cost reporting period beginning on or after October 1, 1991, and the end of its last cost reporting period beginning before October 1, 2001, and the project costs are (1) at least $200 million or (2) at least 100 percent of the hospital's operating cost during the first 12-month cost reporting period beginning on or after October 1, 1991. The minimum payment level under special exceptions for all qualifying hospitals is 70 percent of allowable capital-related costs. Special exception payments are offset against positive Medicare capital and operating margins.

When we established the special exceptions process, we selected the hospital's cost reporting period beginning before October 1, 2001 as the project completion date in order to limit cost-based exceptions payments to a period of not more than 10 years beyond the end of the transition to the fully Federal capital prospective payment system. Because hospitals are eligible to receive special exceptions payments for up to 10 years from the year in which they complete their project (but for not more than 10 years after September 30, 2001, the end of the capital prospective payment transition), generally, if a project is completed by September 30, 2001, exceptions payments could continue up to September 30, 2011. In addition, we believe that for projects completed after the September 30, 2001 deadline, hospitals would have had the opportunity to reserve their prior years' capital prospective payment system payments for financing projects.

In the July 31, 1998 final rule (63 FR 40999), we stated that a few hospitals had expressed concern with the required completion date of October 1, 2001, and other qualifying criteria for the special exceptions payment. Therefore, we solicited certain information from hospitals on major capital construction projects that might qualify for the capital special exceptions

payments so we could determine if any changes in the special exceptions criteria or process were necessary.

In the May 7, 1999 proposed rule (64 FR 24736), we reported that four hospitals had responded timely to our solicitation with information on their major capital construction projects. The hospitals submitted information about their location, the cost of the project, the date that the CON approval was received, the start date of the project, and the anticipated completion date.

The hospitals suggested changing a number of the requirements of the special exception provision, including (1) changing the project completion date requirement; (2) revising the project size requirement; (3) lowering the DSH qualifying percentage from 20.2 percent to 15 percent; (4) changing the minimum payment level from 70 percent to 85 percent; and (5) revising the qualifying criteria so that only capital payment margins are considered instead of both capital payment margins and operating margins (as is now the case). In addition, hospitals suggested capping special exceptions payments that result from changes to the special exceptions process at $40 million annually.

When we issued the May 7, 1999 proposed rule, we had no specific proposal to revise the special exceptions process. However, we invited comments from hospitals and other interested parties on the suggestions and recommendations discussed above. We noted that, since the capital special exceptions process is budget neutral, any liberalization of the policy would require a commensurate reduction in the capital rate paid to all hospitals. That is, even after the end of the capital prospective payment system transition, we will continue to make an adjustment to the capital Federal rate in a budget neutral manner to pay for exceptions, as long as an exceptions policy is in force. Currently, the limited special exceptions policy will allow for exceptions payments through September 30, 2011. We also noted that, based on the comments we received, we may make changes to the special exceptions criteria in the final regulation or propose changes in the FY 2001 proposed rule.

In the May 7, 1999 proposed rule, we indicated that we had little information about the impact of any of the suggested changes discussed in the proposed rule, since no hospitals are currently being paid under the special exceptions process. Until FY 2001, the special exceptions provision currently pays either the same as the regular exceptions process or less for high DSH and sole community hospitals. We indicated that we would attempt to obtain information on projects that might qualify for special exceptions payments through our fiscal intermediaries during the comment period. However, we noted that we were reluctant to impose a burden on the fiscal intermediaries at this time, since it could interfere with our major efforts to make the Medicare computer systems Y2K compliant prior to January 1, 2000.

We received six comments on potential changes to the special exceptions process. Three were in favor of changing the process in various ways, and two were opposed to making any changes. In addition, MedPAC opposed expanding the process until we have a better estimate of the impact of any expansion.

Comments: Three commenters that supported changing the special exception process made various suggestions as to what those changes should be.

Two of the commenters believe that the way HCFA formulated the special exceptions process is inconsistent with Congressional intent because the Conference Report that accompanied the Omnibus Budget Reconciliation Act (OBRA) of 1993 (Public Law 103–66) indicated the conferees' expectation that HCFA would assess information and make appropriate changes to ''. . . address the problems of hospitals subject to lengthy CON review processes or subject to other circumstances which are not fully addressed in the current rules'' (H.R. Rep. No. 103–213, at 744 (1993)). The commenters noted that Congress used a separate sentence to state a belief that the Secretary should ''. . . evaluate whether current policies provide adequate protection to sole community hospitals and hospitals that serve a disproportionate share of low income patients.'' Thus, the commenters believe that Congress did not intend to limit the special exceptions process to any particular type of hospital and that Congress intended HCFA to deal separately with the problems of high DSH hospitals and to make the special exceptions process available to all hospitals.

One commenter stated that eligibility for special exceptions payments should be based solely on when a hospital had to begin a capital project and the size of the project, rather than ''noncapital-related'' tests such as the operating offset and the DSH requirement. The commenter argued that, if the purpose of the special exceptions process was to help hospitals that could not benefit from old and obligated capital provisions, then HCFA did not act consistently with that premise when it adopted criteria that limited qualifying hospitals. The commenter believes that HCFA may have adopted some criteria, such as the requirement that urban hospitals must have a DSH percentage of at least 20.2 and the offset of positive operating margins, to limit the cost of the special exceptions program. If that is the case, then the commenter suggested that a cap on total payments made under the special exceptions authority would accomplish the same result more fairly.

One commenter requested that the DSH percentage requirement for urban hospitals (20.2 percent) be lowered. The commenter believes that the current requirement is not a natural result of the rationale we used for limiting the special exceptions process, and that, if a hospital builds a project during the transition, it is disadvantaged relative to other hospitals regardless of its DSH percentage. This commenter suggested that, if we do decide to retain the DSH requirement, the requirement be lowered to 15 percent, and that we adopt a sliding scale payment floor of between 15 and 20.2 DSH percentages in which the minimum payment level at the 15 DSH percentage would be 70 percent and the maximum payment level at 20.2 DSH percentage would be 85 percent.

One commenter supported lowering the project size requirement from 100 percent of the hospital's FY 1992 operating costs to 45 percent of those costs.

All three commenters who advocated changes to the special exceptions process supported changing the offset provision so that eligibility for special exceptions does not take into account positive operating margins. They argued that the operating and capital payment methodologies were separately developed and that payments are separately calculated. If the offset against operating payments is not eliminated, they believe it should be modified to include outpatient margins as well. One of these commenters noted that a similar offset was not required for ''old capital.''

Two of the commenters recommended that, if a hospital had received CON approval by September 1, 1995 and expended $750,000 or 10 percent of total project cost, then the project completion date should be extended to December 31, 2003. They believe that a hospital could have started planning a major capital project early in the transition, but, because of events beyond the hospital's control, the completion date might extend beyond the end of the transition.

Two commenters suggested that we should establish a cap on special exceptions payments, and indicated that HCFA has the authority to set and implement such a cap because of the authority given the Secretary under section 1886(g) of the Act to implement the capital prospective payment system. The legislation provided for an exceptions process, as the Secretary determined to be appropriate. The commenter asserted that the ''regular'' capital exceptions process already includes a ''cap'' of 10 percent. The commenters recommended a cap of 1 percent of total capital prospective payments in a given fiscal year, and that, if aggregate eligibility for payments exceeds the cap, the payments would be reduced on a pro rata basis.

The commenters also recommended that any exception payments a hospital qualifies for but does not receive because of the cap should be rolled over into future years so that those payments could be made in later years. Without a rollover provision, the commenters advocate setting the cap at 1.5 percent. They believe that with the expiration of hold harmless provisions and the exceptions floors in FY 2001, the suggested cap would result in lower budget neutrality adjustments than is currently the case.

Using 1992 through 1996 cost report data, one of the commenters prepared an estimate of the number of hospitals it believes will be eligible for special exception payments if the criteria were changed as suggested by the commenter. Based on the commenter's estimate, aggregate eligibility for special exceptions payments would exceed the recommended 1 percent cap for approximately 5 years (FY 2002 through FY 2006). The commenter also suggested that hospitals that believe they are eligible for special exceptions be required to submit an application to their fiscal intermediary in January of each year, and to update their application by June of each year, so that an estimate could be prepared of the number of hospitals that will qualify for special exceptions. The data could also be used to estimate the amount of reductions that will be required to stay within the cap. The commenter suggests that hospitals that did not submit the information could be precluded from receiving special exceptions payments in the following fiscal year.

All three commenters who advocated changes to the special exceptions process supported raising the 70 percent minimum payment level to 85 percent. One commenter objected to the 70 percent minimum payment level, arguing that it offers little improvement over the Federal rate and guarantees that hospitals will take a 30-percent loss on their actual capital costs for each Medicare discharge. This commenter believes that special exceptions should be paid at the rate of 85 percent, which is what hospitals eligible for old capital hold harmless payment received.

In addition, two of the commenters supported finalizing changes to the special exceptions process in the FY 2000 final rule so that affected hospitals can plan more effectively.

Two national hospital associations were opposed to changing the special exceptions policy. They believe that the special exceptions process was intended to be limited in scope, and although some hospitals may be disadvantaged by some aspects of the fully Federal capital prospective payment system, they have had a number of years to plan for it. All other hospitals will be receiving payments based on the Federal rate beginning in FY 2002 and the commenters do not believe that the majority of hospitals should have their payments further reduced to expand the special exceptions process to a few hospitals. One of the commenters noted that Congress considered a similar proposal to expand the special exceptions process as part of the BBA deliberations and, ultimately, did not include the proposal. The commenter believes this failure to act was an indication of Congressional intent, and that HCFA has no authority to disregard it and adopt these changes by regulation. The other commenter stated that since HCFA has no reliable estimate of the number of hospitals that would be affected by changes to the special exceptions process, it would be capricious to make a change absent an impact analysis.

Response: When we proposed the special exceptions process in 1994 (May 27, 1994, **Federal Register** (59 FR 27746)), we stated ''* * * we are therefore proposing at § 412.348 to provide special protection for some hospitals that are undertaking major projects to renovate or replace aging plant during the transition period. This special protection, which will provide a 70 percent minimum payment level for up to 10 years beyond the transition period, will be available only to * * * [s]ole community hospitals * * *; [u]rban hospitals with at least 100 beds that either have a DSH percentage of 20.2 percent or receive at least 30 percent of their revenue from State or local funds for indigent care * * *; [h]ospitals with a combined inpatient Medicare and Medicaid utilization of at least 70 percent. * * *'' We believe this strict set of qualifying criteria makes it clear that we intended to make the special exception process limited in scope.

Since publication of the proposed rule, we have attempted to obtain information on hospital projects that might qualify for special exceptions payments in order to assess the impact of the recommended changes to the existing policy. Because of the impracticality of obtaining data timely from every State in the country, we focused our efforts on certain States. Using information obtained from the Department of Housing and Urban Development (HUD) and the Health Resources and Services Administration (HRSA), we developed a list of States in which a large concentration of hospital construction occurred during the capital transition period. For several States, we contacted the State Department of Health's Facility and Planning Staff, who provided us with information on the hospital construction projects in their State, including the name and location of the hospital, the cost of the construction project, the date of CON approval (if required), the start date of the project, and the completion or anticipated completion date of the project. In conjunction with the most recent cost report data readily available (FY 1996), we attempted to estimate which of the hospital construction projects might qualify for special exception payments under the existing policy and how that universe of hospitals might change as a result of the recommended revisions to the special exceptions criteria.

Because exception payments to a hospital for a given cost reporting period are based on a percentage of the hospital's capital costs incurred during the cost reporting period, we were unable to determine a precise estimate of the amount of payments to hospitals that might be eligible for special exceptions. In addition, hospitals are not eligible for special exception payments until the assets are put into use for patient care. Once eligibility for special exceptions payment has been demonstrated, it is some time before completed and settled cost reports are available to determine these payments. It is also difficult to predict whether particular hospitals will be able to meet all of the special exceptions eligibility criteria (DSH percentage, inpatient margins, completion date, project size, and project need requirements) in future years based on the earlier cost report data.

Based on our research, we were able to identify a universe of 266 possible hospital construction projects from two States (New York and Illinois) that

might possibly qualify for special exception payments. Our data largely understate the total number of eligible projects that may qualify for special exception payments nationally since our estimate is based on data from only 2 of the 50 States in the country. Our estimate includes all inpatient hospital construction projects in those two States, of which only a subset of projects will qualify for special exception payments. Extrapolating our estimate to the large numbers of hospital construction projects nationally, we believe that any changes to the special exceptions policy may affect a significant number of hospitals.

Based on our belief that these changes may have an impact on a significant number of hospitals and our evaluation of the comments and after careful consideration of all the issues, we have concluded, as suggested by one commenter, that the more appropriate forum for addressing the capital special exception is the legislative process in Congress rather than the regulation process.

Based on this conclusion, we are generally not addressing the specific changes recommended for the special exceptions process or eligibility criteria. However, there are some comments on the general policies of the special exception process that we would like to address individually. These include our efforts to address the OBRA 1993 Conference Report language concerning the obligated capital provisions of the capital prospective payment system, the rationale for the 70 percent minimum payment level for the special exceptions process, and the administrative feasibility of capping special exception payments and rolling over unfunded special exceptions to future years.

First, in the Conference Report that accompanied OBRA 1993, Congress addressed obligated capital criteria for hospitals in States with a lengthy CON process. The language states, ''The conferees note that in the proposed rule for fiscal year 1994, changes to the hospital inpatient prospective payment system, that was published in the **Federal Register** on May 26, 1993, the Secretary indicated that insufficient information was available to complete a systematic evaluation of the obligated capital criteria for hospitals in states with a lengthy Certificate-of-Need process in time to consider appropriate changes during the fiscal year 1994 rulemaking process. The conferees expect the Secretary to complete the assessment in time for consideration in the fiscal year 1995 rulemaking process and that appropriate changes in payment policy will be made to address the problems of hospitals subject to a lengthy Certificate-of-Need review process or subject to other circumstances which are not fully addressed in the current rules. In addition, the conferees believe the Secretary should evaluate whether current policies provide adequate protection to sole community hospitals and hospitals that serve a disproportionate share of low income patients'' (H.R. Conf. Rep. No. 103–66, at 744 (1993)).

In the May 27, 1994 proposed rule (59 FR 27744), we described our analysis of provisions related to obligated capital for hospitals subject to lengthy CON processes. We also proposed a change to the deadline for putting an asset into use for patient care (§ 412.302(c)(2)(i)(D)) and addressed recommendations that we had received from hospitals to change the capital exceptions policy, which would provide exceptions payments after the conclusion of the capital prospective payment transition period. These hospitals had asked that the minimum payment level for urban hospitals with at least 100 beds and a DSH percentage of at least 20.2 percent be guaranteed through the rest of the transition and extended for at least 10 years after the transition.

In the September 1, 1994 final rule (59 FR 45376), we adopted the proposed change to the deadline for putting an asset into use in the obligated capital regulations (§ 412.348) from ''the earlier of'' September 30, 1996, or 4 years from the date of CON approval to ''the later of'' September 30, 1996, or 4 years from the date of CON approval. We also implemented the capital special exceptions process and expanded the qualifying criteria for the classes of eligible hospitals to include sole community hospitals; urban hospitals with at least 100 beds that have a DSH percentage of at least 20.2 percent or that receive at least 30 percent of their revenue from State or local funds for indigent care; and hospitals with a combined inpatient Medicare and Medicaid utilization of at least 70 percent.

Because we adopted changes to both the obligated capital criteria and finalized the special exceptions process, we believe that we have appropriately addressed the issues raised in the Conference Report language concerning hospitals in States with a lengthy CON process as well as SCHs and hospitals that serve a disproportionate share of low-income patients.

Second, in response to the commenters' suggestion that the 70 percent minimum payment level for special exceptions be raised to 85 percent, we believe that this change would expand the special exceptions process beyond its original narrow focus. The commenters' comparison of the special exceptions process to hold harmless payments for old capital is not appropriate. Paying hospitals for 85 percent of the cost of old capital was reasonable to account for the change from a cost-based system to a prospective payment system for capital. Since hospitals had committed to these costs years prior to the implementation of the capital prospective payment system, it was reasonable to allow relief to hospitals for these costs. In addition, during the prospective payment system transition, all hospitals, based on their costs, were eligible for exception payments to account for high costs that exceed the prospective payment rate. Except for sole community hospitals and hospitals with a DSH percentage of at least 20.2, hospitals received exceptions payments at the 70-percent minimum payment level. A 70-percent minimum payment level for special exceptions continues exceptions payments for qualifying hospitals with high costs after the transition at the same level most hospitals received under the regular exceptions process during the transition.

Third, it would be extremely difficult administratively to implement a cap and roll-over provision such as the one advocated by the commenters. Hospitals are not eligible for special exception payments until assets are put into use for patient care. A lag time exists before completed and settled cost reports are available to determine special exception payments once eligibility has been demonstrated. Information taken from cost reports cannot be used to accurately determine whether a hospital meets all of the special exceptions eligibility criteria. Specifically, date of CON approval (if applicable) and DSH percent are not determined based on cost report information. Other criteria, such as project size and age of asset (if applicable) requirements, and their accuracy will need to be reported by the hospital and verified by the fiscal intermediaries.

Even when we have a more accurate assessment of qualifying special exception projects, we do not believe a cap and roll-over process such as the commenter suggests would be administratively feasible. We intend to administer the existing special exception process in the post-transition period in a manner similar to the regular exception process. Based on data received, we will make an estimate of special exception payments in the

coming year. If our model shows that special exception payments are projected to be more than 10 percent of total capital payments under the existing 70 percent payment level, we would reduce the minimum payment level to ensure that projected payments do not exceed the 10 percent threshold. If, however, when cost reports were settled for that fiscal year, payments for eligible projects were determined to be more or less than the amount estimated, they would still be eligible for special exception payments, even if actual payments exceeded the amount we initially estimated. Each year's exception payments are determined separately. It would be extremely difficult to maintain an estimate of actual qualifying projects, given varied dates on which hospitals' fiscal years end, and increase or decrease the exception payment amount each hospital was eligible to receive. We would not know whether the amount budgeted for a project was more or less than the amount the project actually qualified for until the cost report was settled. Since hospitals have different cost report ending dates, it would be some time before all the cost reports for a given fiscal year would be finalized. At that time, it would be necessary for each fiscal intermediary to determine how much was actually paid for special exception, and any carryover amount for each project to a future fiscal year. We believe that this process would be very cumbersome, if not impossible, to administer.

It is our intention in the FY 2001 proposed and final rules to discuss a data collection effort to assist us in modeling special exception payments for the FY 2002 proposed rule.

Comment: MedPAC commented that they share HCFA's desire to keep special exceptions narrowly targeted. The Commission stated that many of the suggestions for changing the special exception process and criteria would unnecessarily expand payments beyond clearly disadvantaged hospitals whose financial health is important to maintaining access to care for Medicare beneficiaries. MedPAC recommends that, since so few hospitals responded to our request for information on potentially qualifying projects, we should not change the current special exceptions policy until we receive more information about the extent of financial problems hospitals are having. However, MedPAC does believe that we should consider increasing the special exceptions payment for SCHs and urban hospitals with a DSH percentage of at least 20.2 percent to equal the amount they receive under the regular exceptions policy (that is, 90 and 80 percent, respectively). MedPAC suggests that these increases are necessary to continue to provide financial protection to institutions that safeguard access to care for Medicare beneficiaries.

MedPAC supports offsetting special exceptions payments against both capital and operating margins, because it is consistent with their belief that at the end of the transition the two payment systems should be combined.

Response: We agree with MedPAC that, in determining eligibility for special exception payments, it is appropriate to examine a hospital's operating margins as well as its capital margins. We believe it is reasonable to provide an additional limit on exceptions payments for the period 10 to 20 years after the beginning of capital prospective payments. In addition, we agree that since inpatient operating and capital costs are so inherently intertwined in providing inpatient care, it is appropriate to have an operating payment offset for the capital special exception. It is not appropriate to consider any outpatient services when determining eligibility for the inpatient special exception payment. Any outpatient capital-related costs are paid to hospitals under Medicare Part B.

VI. Changes for Hospitals and Hospital Units Excluded from the Prospective Payment System

A. Limits on and Adjustments to the Target Amounts for Excluded Hospitals and Units (§§ 413.40(b)(4), (c), (f), and (g))

1. Updated Caps

Section 1886(b)(3) of the Act (as amended by section 4414 of the BBA) establishes caps on the target amounts for certain excluded hospitals and units for cost reporting periods beginning on or after October 1, 1997 through September 30, 2002. The caps on the target amounts apply to the following three categories of excluded hospitals: psychiatric hospitals and units, rehabilitation hospitals and units, and long-term care hospitals.

A discussion of how the caps on the target amounts were calculated can be found in the August 29, 1997 final rule with comment period (62 FR 46018); the May 12, 1998 final rule (63 FR 26344); and the July 31, 1998 final rule (64 FR 41000). For purposes of calculating the caps on existing facilities, the statute requires us to calculate the 75th percentile of the target amounts for each class of hospital (psychiatric, rehabilitation, or long-term care) for cost reporting periods ending during FY 1996. Under section 1886(b)(3)(H)(iii) of the Act, the resulting amounts are updated by the market basket percentage increase applicable to the fiscal year.

In the May 7, 1999 proposed rule, we proposed the following caps on target amounts for cost reporting periods beginning in FY 2000:

- Psychiatric hospitals and units: $11,067
- Rehabilitation hospitals and units: $20,071
- Long-term care hospitals: $39,596

These proposed caps reflected an update of 2.6 percent, the projected market basket increase for excluded hospitals and units.

The final projection of the market basket percentage increase for excluded hospitals and units for FY 2000, based on the most recent data available, is 2.9 percent. Accordingly, the final caps on the target amounts for existing hospitals and units for cost reporting periods beginning during FY 2000 are as follows:

- Psychiatric hospitals and units: $11,100
- Rehabilitation hospitals and units: $20,129
- Long-term care hospitals: $39,712

2. New Excluded Hospitals and Units (§ 413.40(f))

a. Updated Caps for New Hospitals and Units

Section 1886(b)(7) of the Act establishes a payment methodology for new psychiatric hospitals and units, rehabilitation hospitals and units, and long-term care hospitals. Under the statutory methodology, for a hospital that is within a class of hospitals specified in the statute and that first receives payments as a hospital or unit excluded from the prospective payment system on or after October 1, 1997, the amount of payment will be determined as follows: for the first two 12-month cost reporting periods, the amount of payment is the lesser of (1) the operating costs per case, or (2) 110 percent of the national median of target amounts for the same class of hospitals for cost reporting periods ending during FY 1996, updated to the first cost reporting period in which the hospital receives payments and adjusted for differences in area wage levels.

The amounts included in the following table reflect the updated 110 percent of the wage neutral national median target amounts for each class of excluded hospitals and units for cost reporting periods beginning during FY 2000. These figures are based on the final FY 1999 figures updated by the projected market basket increase of 2.9

percent. (The proposed amounts were based on an estimated market basket increase of 2.6 percent.) For a new provider, the labor-related share of the target amount is multiplied by the appropriate geographic area wage index and added to the nonlabor-related share in order to determine the per case limit on payment under the statutory payment methodology for new providers.

Class of excluded hospital or unit	Labor-related share	Nonlabor-related share
Psychiatric	$ 6,394	$ 2,544
Rehabilitation	12,574	4,999
Long-term Care	16,206	6,443

As specified at § 413.40(c)(4), for purposes of determining the hospital's target amount for the hospital's third 12-month cost reporting period, the target amount for the preceding cost reporting period is equal to the payment amount in the second 12-month cost reporting period as determined in accordance with § 413.40(f)(2)(ii)(A). The payment amount is the lesser of (1) the operating costs per case, or (2) 110 percent of the national median of target amounts for the same class of hospitals for cost reporting periods ending during FY 1996, updated to the first cost reporting period in which the hospital receives payments and adjusted for differences in area wage levels. It has come to our attention that § 413.40(c)(4)(v) does not specify how to apply the update factors to the amount of payment for the second 12-month cost reporting period in order to calculate the target amount in subsequent cost reporting periods. Therefore, we are revising §§ 413.40(c)(4)(v) and 413.40(f)(2)(ii)(A) to clarify the application of the update factors and the base period for new psychiatric hospitals and units, rehabilitation hospitals and units, and long-term care hospitals.

b. Multicampus Excluded Hospitals

Section 1886(b) of the Act, as amended by the BBA, provides for caps on target amounts for certain classes of excluded hospitals, and also provides a statutory payment methodology for new excluded hospitals. A question has arisen regarding the appropriate target amount to be used for an excluded hospital or unit that was part of a multicampus hospital but alters its organizational structure so that it is no longer part of that multicampus hospital. The question was raised by long-term care hospitals that are seeking alternate structures due to the application of the cap on hospital-specific target amounts specified in § 413.40(c)(4)(iii).

In these cases, to determine the appropriate target amount, we must determine whether the excluded hospital or unit established under the organizational restructure is a new provider. Under § 413.40(f)(1), a new excluded hospital or unit is a provider of hospital inpatient services that (1) has operated as the type of hospital or unit for which HCFA granted it approval to participate in the Medicare program, under present or previous ownership (or both), for less than 1 full year; and (2) has provided the type of hospital inpatient services for which HCFA granted it approval to participate for less than 2 full years. If the new hospital is a children's hospital, a 2-year exemption from the application of the target amount is permitted (§ 413.40(f)(2)(i)). A new psychiatric or rehabilitation hospital or unit or a long-term care hospital receives, for the first two 12-month cost reporting periods, the lower of its new inpatient operating cost per case or 110 percent of a national median of target amounts for the class of hospital, updated and adjusted for area wages (§ 413.40(f)(2)(ii)).

If the entity that separated itself from the multicampus hospital provides inpatient services of a different type than it had when it was part of the multicampus hospital so that it qualifies as a different class of excluded hospital or unit (for example, from long-term care to rehabilitation), we would calculate a new target amount per discharge for the newly created hospital or unit. However, if the entity does not operate as a different class of hospital or unit, it does not meet the criteria at § 413.40(f)(1) to qualify as a new provider. Instead, if the entity replaces a hospital or unit that had been excluded from the prospective payment system (for example, the entity had previously been a long-term care hospital before becoming part of the multicampus hospital), the previously established hospital-specific target amount for the hospital, prior to its becoming part of the multicampus hospital, would again be applicable. This is consistent with our current policy for a hospital or unit that is excluded from the prospective payment system and that has periods in which the hospital or unit is not subject to the target amount, as specified at § 413.40(b)(1)(i). The target amount established earlier for the hospital or unit is again applicable despite intervening cost reporting periods during which the hospital or unit was not subject to that target amount due to other provisions of the law or regulations that applied while it was part of the multicampus hospital. We proposed to revise § 413.40(b)(1)(iii) to specify that if the entity continues to operate as the same class of hospital that is excluded from the prospective payment system, but does not replace a hospital or unit that existed prior to being part of a multicampus hospital (for example, a newly created long-term care hospital became part of a multicampus hospital and subsequently separates from the multicampus hospital to operate separately), the base period for calculating a hospital-specific target amount for the newly separated hospital is the first cost reporting period of at least 12 months effective with the revised Medicare certification.

We did not receive any comments on this proposed revision. Therefore, we are adopting the proposed change to § 413.40(b)(1)(iii) as final.

3. Exceptions

The August 29, 1997 final rule with comment period (62 FR 46018) specified that a hospital that has a hospital-specific target amount that is capped at the 75th percentile of target amounts for hospitals in the same class (psychiatric, rehabilitation, or long-term care) would not be granted an adjustment payment (also referred to as an exception payment) based solely on a comparison of its costs or patient mix in its base year to its costs or patient mix in the payment year. Since the hospital's target amount would not be determined based on its own experience in a base year, any comparison of costs or patient mix in its base year to costs or patient mix in the payment year would be irrelevant.

In addition, the July 31, 1998 final rule (63 FR 41001) revised § 413.40(g)(1) to specify, under paragraph (g)(1)(iv), that in the case of a psychiatric hospital or unit, rehabilitation hospital or unit, or long-term care hospital, the amount of the adjustment payment may not exceed the applicable limit amounts for hospitals of the same class.

Similarly, for hospitals and units with a FY 1998 hospital-specific revised target amount established under the rebasing provision at § 413.40(b)(1)(iv), in determining whether the hospital qualifies for an adjustment and the amount of the adjustment, we compare the hospital's operating costs to the average costs and statistics for the cost reporting periods used to determine the FY 1998 revised target amount. Since the rebased FY 1998 target amount is an average of three cost reporting periods, as described in § 413.40(b)(1)(iv), comparisons of costs from the cost year

to the FY 1998 cost period would be inaccurate. Therefore, as specified in the August 29, 1997 final rule with comment period (62 FR 46018), a determination of whether the hospital qualifies for an adjustment, and the amount of an adjustment, are based on a comparison of the hospital's operating costs and its costs used to calculate the FY 1998 rebased target amount. For hospitals that have been rebased under the provisions of § 413.40(b)(1)(iv) and qualify for an adjustment under the provisions of § 413.40(g), the base year figures used for such items as costs, utilization, and length-of-stay should be determined based on the average of the costs and utilization statistics from the same 3 cost reporting years used in calculating the FY 1998 rebased target amount.

In the proposed rule, we proposed to revise § 413.40(g)(1) to clarify these limitations on the adjustment payments.

We received no comments on this clarification and, therefore, are adopting it in this final rule.

4. Report on Adjustment Payments to the Ceiling (§ 413.40(g))

Changes in the types of patients served or inpatient care services that distort the comparability of a cost reporting period to the base year are grounds for requesting an adjustment payment in accordance with section 1886(b)(4) of the Act. Section 4419(b) of the BBA of 1997 requires the Secretary to publish annually in the **Federal Register** a report describing the total amount of adjustment (exception) payments made to excluded hospitals and units, by reason of section 1886(b)(4) of the Act, during the previous fiscal year. However, the data on adjustment payments made during the previous fiscal year are not available in time to publish a report describing the total amount of adjustment payments made to all excluded hospitals and units in the subsequent year's final rule published in the **Federal Register**.

The process of requesting, adjudicating, and awarding an adjustment payment for a given cost reporting period occurs over a 2-year period or longer. An excluded hospital or unit must first file its cost report for the previous fiscal year with its intermediary within 5 months after the close of the previous fiscal year. The fiscal intermediary then reviews the cost report and issues a Notice of Program Reimbursement (NPR) in approximately 2 months. If the hospital's operating costs are in excess of the ceiling, the hospital may file a request for an adjustment payment within 6 months from the date of the NPR. The intermediary, or HCFA, depending on the type of adjustment requested, then reviews the request and determines if an adjustment payment is warranted. Therefore, it is not possible to provide data in a final rule on adjustments granted for cost reports ending in the previous Federal fiscal year, since those adjustments have not even been requested by that time. However, in an attempt to provide interested parties at least some relevant data on adjustments, we are publishing data on requests for adjustments that were processed by the fiscal intermediaries or HCFA during the previous Federal fiscal year.

The table below includes the most recent data available from the fiscal intermediaries and HCFA on adjustment payments that were adjudicated during FY 1998. By definition these were for cost reporting periods ending in years prior to FY 1998. The total adjustment payments awarded to excluded hospitals and units during FY 1998 are $95,676,720. The table depicts for each class of hospital, in aggregate, the number of adjustment requests adjudicated, the excess operating cost over the ceiling, and the amount of the adjustment payment.

Class of hospital	Number	Excess cost over ceiling	Adjustment Payment
Psychiatric	235	$112,437,640	$55,784,497
Rehabilitation	93	67,353,452	26,487,095
Long-term care	7	10,326,069	6,085,941
Children's	7	6,893,393	2,898,679
Cancer	3	10,463,245	4,420,508

5. Development of Case-Mix Adjusted Prospective Payment System for Rehabilitation Hospitals and Units

Section 4421 of the BBA added a new section 1886(j) to the Act that mandates the phase-in of a case-mix adjusted prospective payment system for inpatient rehabilitation services (freestanding hospitals and units) for cost reporting periods beginning on or after October 1, 2000 and before October 1, 2002. The prospective payment system will be fully implemented for cost reporting periods beginning on or after October 1, 2002.

As provided in section 1886(j)(3)(A) of the Act, the prospective payment rates will be based on the inpatient operating and capital costs of rehabilitation facilities. Payments will be adjusted for case-mix using patient classification groups, area wages, inflation, and outlier and any other factors the Secretary determines necessary. We will set prospective payment amounts so that total payments under the system during FY 2001 and FY 2002 are projected to equal 98 percent of the amount of payments that would have been made under the current payment system. Outlier payments in a fiscal year may not be projected or estimated to exceed 5 percent of the total payments based on the rates for that fiscal year.

B. Changes in Bed Size or Status of Hospital Units Excluded under the Prospective Payment System

Existing regulations (§ 412.25(b) and (c)) specify that, for purposes of payment to a psychiatric or rehabilitation unit that is excluded from the prospective payment system, changes in the bed size or the status of excluded hospital units will be recognized only at the beginning of a cost reporting period. These regulations have been in effect since the inception of the hospital inpatient prospective payment system and were intended to simplify administration of the exclusion provisions of the prospective payment system by establishing clear rules for the timing of changes in these excluded units. The statutory basis and rationale for these rules are explained more fully in the preamble to the proposed rule (64 FR 24740).

To provide more flexibility to hospitals while not recognizing changes that undermine statutory requirements and principles, we proposed to revise § 412.25(b) and (c) to provide that, for purposes of exclusion from the prospective payment system, the number of beds and square footage of an excluded unit may be decreased, or an excluded unit may be closed in its entirety, at any time during a cost reporting period under certain conditions. The hospital would be

required to give the fiscal intermediary and the HCFA Regional Office a 30-day advance written notice of the intended change and to maintain all information needed to accurately determine costs attributable to the excluded unit and proper payments. However, any unit that is closed during a cost reporting period could not be paid again as a unit excluded from the prospective payment system until the start of the next cost reporting period. If the number of beds or square footage of a unit excluded from the prospective payment system is decreased during a cost reporting period, that decrease would remain in effect for the remainder of that period.

We noted that the number of beds and square footage of the part of the hospital paid under the prospective payment system may also be affected by a change in the size or status of a unit that is excluded from the prospective payment system. If the bed capacity and square footage were previously part of the excluded unit and are then included in the part of the hospital paid under the prospective payment system and are used to treat acute patients rather than excluded unit patients, the additional bed capacity and square footage would, starting with the effective date of the change, be counted as part of the hospital paid under the prospective payment system. We would count the bed capacity and square footage for purposes of calculating available bed days and the number of beds under §§ 412.105 and 412.106, relating to payments for the indirect costs of medical education and hospitals that serve a disproportionate share of low-income patients. On the other hand, if the bed capacity and square footage are taken out of service or added to another hospital-based provider, such as a distinct-part skilled nursing facility, they would not be counted as part of the hospital paid under the prospective payment system.

We received six comments on our proposal.

Comment: Several commenters expressed support for the proposed change and indicated that it would increase hospital flexibility. No commenters opposed the change. However, one commenter noted that some California hospitals may need to temporarily vacate certain facilities to allow renovation and construction necessary to comply with new State seismic code requirements, and stated that such a relocation of a facility may necessitate a change in its number of beds or square footage. The commenter recommended that our regulations be revised to account for this possibility or for relocations that are necessary due to catastrophic occurrences such as earthquakes, floods, tornadoes, or other natural disasters.

Response: We appreciate the commenters' support of our proposal and are adopting it as final with one change. To address the types of compliance or catastrophic situations described by one of the commenters, we are revising § 412.25(b) to allow reductions in the number of beds in an excluded unit, or increases or decreases in the square footage of the excluded unit, if these changes result from relocation of the unit made necessary because of construction or renovation needed to bring a facility into compliance with changes in Federal, State, or local law affecting the physical facility, or because of catastrophic events such as fires, floods, earthquakes, or tornadoes. We understand that these relocations may necessitate a change in the square footage of a unit, although it is not clear that any increase in bed size would be required. We also are allowing corresponding exceptions to the requirements that a grandfathered satellite facility be operated under the same terms and conditions in effect on September 30, 1999 under §§ 412.23(h)(3) and 412.25(e)(3)).

C. Payment for Services Furnished at Satellite Hospital Locations

Under Medicare, each hospital is treated, for purposes of certification, coverage, and payment, as a single institution. That is, each entity that is approved to participate in Medicare as a ''hospital'' must separately comply with applicable health and safety requirements as a condition of participation under regulations at part 482, with provider agreement requirements specified in regulations at part 489, and with requirements relating to the scope of benefits under Medicare Parts A and B specified in parts 409 and 410. Our policies that involve the movement of patients from one hospital to another, or from outpatient to inpatient status at the same hospital, are premised on the assumption that each hospital is organized and operated as a separate institution.

Section 412.22(e) of the regulations permits an entity that is located in the same building or in separate buildings on the same campus as another hospital to be treated, for purposes of exclusion under the prospective payment systems, as a ''hospital.'' This status is available, however, only when the entity meets specific, stringent criteria designed to ensure that the hospital-within-a-hospital is organized as a separate entity and operates as a separate entity.

We have received several requests for approval of ''satellite'' arrangements, under which an existing hospital that is excluded under the prospective payment system, and that is either a freestanding hospital or a hospital-within-a-hospital under § 412.22(e), wishes to lease space in a building or on a campus occupied by another hospital, and, in some cases, to have most or all services to patients furnished by the other hospital under contractual agreements, including arrangements permitted under section 1861(w)(1) of the Act. In most cases, a hospital intends to have several of these satellite locations so that the hospital would not exist at any single location, but only as an aggregation of beds located at several sites. Generally, the excluded hospital seeks to have the satellite facility treated as if the satellite facility were ''part of'' the excluded hospital.

In the preamble to the proposed rule, we explained in detail our reason for concern that satellite arrangements could lead to circumvention of several Medicare payment provisions. To prevent inappropriate Medicare payment for services furnished in satellite facilities, we proposed to revise §§ 412.22 and 412.25 to provide for payment to satellite facilities of hospitals and units that are excluded from the prospective payment system under specific rules. With respect to both hospitals and units, we proposed to define a ''satellite facility'' as a part of a hospital that provides inpatient services in a building also used by another hospital, or in one or more buildings on the same campus as buildings also used by another hospital but is not a ''hospital-within-a-hospital,'' since it is also part of another hospital. We proposed that, if the satellite facility is located in a hospital that is paid under the prospective payment system, Medicare would pay for services furnished at the satellite facility by using the same rates that apply to the prospective payment hospital within which the satellite is located. As explained in the proposed rule, we reasoned that, if the satellite facility is effectively ''part of'' the prospective payment system hospital, then it should be paid under the prospective payment system.

We proposed that if the satellite facility is located in a hospital excluded from the prospective payment system, then Medicare would pay for the services furnished in the satellite facility as follows: we proposed to examine the discharges of the satellite facility and to apply the target amount for the excluded hospital *in which the hospital is located,* subject to the

applicable cap for the hospital *of which the satellite is a part.* Also, when the satellite facility is established, we proposed to treat it as a new hospital for payment purposes. That is, for the satellite's first two 12-month cost reporting periods, the satellite would be subject to the cap that applies to new hospitals of the same class as the hospital of which the satellite is a part. We believed that the proposed application of the cap for new hospitals was appropriate because we believe that a number of hospitals are attempting to avoid the hospital caps by characterizing entities as satellites rather than new hospitals.

Under the proposed rule, satellite facilities excluded from the prospective payment system prior to the effective date of the revised regulations (October 1, 1999) would not be subject to those new regulations as long as they operate under the same terms and conditions in effect on September 30, 1999. We proposed to make this exception available only to those facilities that could document to the HCFA regional offices that they are operating as satellite facilities excluded from the prospective payment system as of that date. The exception would not be available to hospitals that might be excluded from the prospective payment system as of that date and at some later time enter into satellite arrangements. In addition, we proposed not to apply the rules for payments to satellite facilities to multicampus arrangements, that is, those in which a hospital has a facility at two or more locations but does not share a building or a campus with any other hospital at those locations.

We also solicited comments on a possible further exception. In section 4417 of the BBA, Congress extended the long-term care hospital exclusion to a hospital ''that first received payment under this subsection [subsection 1886(d)(1)(B)(iv) of the Act] in 1986 which has an average inpatient length of stay (as determined by the Secretary) of greater than 20 days and that has 80 percent or more of its annual Medicare inpatient discharges with a principal diagnosis of neoplastic disease in the 12-month cost reporting period ending in fiscal year 1997.'' In view of the specific provision made for a hospital meeting these requirements, we indicated that we were considering whether a satellite facility opened by such a hospital should be exempt from the proposed rules on satellites. We requested comment on this issue and on whether this exclusion could be implemented without compromising the effectiveness of the proposed changes.

We noted that there may be some operational difficulties differentiating services, costs, and discharges of the satellite facilities from those of the existing hospital that is excluded from the prospective payment system. We indicated that, if these operational problems cannot be overcome, we would consider revising the regulations to prohibit exclusion of any hospital or hospital unit from the prospective payment system that is structured, entirely or in part, as a satellite facility in a hospital paid under the prospective payment system.

We received 18 comments on this proposal.

Comment: Several commenters objected to the proposal to pay satellite facilities of excluded hospitals or units under a different methodology than that used for the excluded hospital or unit itself. These commenters argued that the potential abuses described in the preamble to the proposed rule are likely to occur rarely, if at all, and that differential payment for satellite facilities would interfere with hospitals' flexibility to use their facilities efficiently and to take advantage of economies of scale. Other commenters suggested that the proposal, if adopted, could lead to a shortage of crucial rehabilitation or long-term hospital services.

Most of the commenters suggested that the proposed changes be withdrawn and that no limitations be placed on the ability of excluded hospitals or units to establish satellite facilities and claim payment for their services on the same basis as services in the rest of the excluded hospital or unit. Other commenters suggested that we permit services in satellite facilities to be paid on the same basis as services in the remainder of the excluded hospital or unit only if satellite facilities were created and operated under certain rules. Some commenters, including a national health care association, suggested that our concerns could be addressed if we limit the number of satellite beds that an excluded hospital or unit could establish or require that the satellite independently meet exclusion criteria.

Response: We have reviewed these comments and concluded that we can address the concerns raised in the proposed rule, especially our concerns with the application of the appropriate BBA cap on the hospital target amount, without resorting to making payments for the services provided in the satellite under a different methodology than used for the original hospital or unit.

We have decided that, for purposes of payment, the satellite facility of an excluded hospital or unit may be treated as a part of the excluded hospital or unit and may receive payment on the same basis as the excluded hospital or unit, but only if the following specific criteria are met:

- In the case of a hospital (other than a children's hospital) or unit that was excluded from the prospective payment system before the effective date of section 4414 of the BBA (cost reporting periods beginning on or after October 1, 1997), the number of beds in the hospital or unit (including both the base hospital or unit and the satellite location) does not exceed the number of State-licensed and Medicare-certified beds in the hospital or unit on the last day of the hospital's or unit's last cost reporting period beginning before October 1, 1997. Thus, while an excluded hospital or unit can ''transfer'' bed capacity from a base facility to a satellite, it cannot, through the establishment of a satellite, increase total bed capacity beyond the level it had in the most recent cost reporting period prior to the effective date of section 4414.
- The satellite facility independently complies with selected prospective payment system exclusion requirements applicable to the type of hospital unit. Specifically, a satellite of a children's hospital must meet the requirement with respect to treatment of inpatients who are predominantly individuals under age 18, as stated in § 412.23(d)(2); a satellite of a long-term care hospital must meet the average length of stay requirement of § 412.23(e)(1) through (3)(i); a satellite of a rehabilitation hospital or unit must treat an inpatient population meeting the requirement in § 412.23(b)(2); and a satellite of a psychiatric unit must meet the requirement regarding admission of only psychiatric patients in § 412.27(a).
- The satellite facility complies with certain requirements designed to ensure that costs are reported accurately for both the hospital in which the satellite is located and the hospital of which the satellite is a part. Specifically, a satellite of an excluded hospital or unit must (1) have admission and discharge records that are separately identified from those of the hospital in which it is located and are readily available; (2) have beds that are physically separate from (that is, not commingled with) the beds of the hospital in which it is located; (3) be serviced by the same fiscal intermediary as the hospital of which it is a part; (4) be treated as a separate cost center of the hospital of which it is a part, for cost reporting and apportionment purposes; (5) use an accounting system that properly allocates costs; (6) maintain

adequate statistical data to support the basis of allocation; and (7) report its costs in the cost report of the hospital of which it is a part, covering the same fiscal period and using the same method of apportionment as the hospital of which it is a part.

If an excluded hospital or unit has a satellite location and fails to meet these requirements, the entire hospital or unit would lose its exclusion from the prospective payment system. Under §§ 412.22(d) and 412.25(c), the change in status from excluded to included in the prospective payment system would be effective at the start of the first cost reporting period after the cost reporting period in which the hospital or unit failed to meet the requirements. Loss of exclusion status means that payment to the entire hospital or unit would then be made under the prospective payment system.

Thus, under our policy, we permit a satellite facility to be excluded (and treated as part of an excluded hospital) if certain criteria are met, but deny excluded status to the entire hospital if the criteria are not met. We are adopting this policy primarily because of concerns about preventing inappropriate Medicare payments. As explained above and in the proposed rule, we believe that hospitals might be seeking satellite arrangements so that the services furnished in the satellite facility are paid on an excluded basis when they should be paid on a prospective payment basis. We also believe that hospitals are seeking satellite arrangements in order to avoid the effects of the payment caps that apply to new excluded hospitals under the BBA. Therefore, we believe it is necessary and appropriate to establish criteria for determining when a satellite facility may be treated as part of the excluded hospital and paid on an excluded basis, and to deny exclusion to the satellite facility if the satellite fails to meet those criteria.

Another significant concern underlying our policy is administratively feasibility. We believe it would be administrative cumbersome, if not infeasible, to pay a satellite facility on a different basis than the rest of the excluded hospital or unit. Therefore, we believe that, if the satellite does not qualify for exclusion, then it is necessary and appropriate to deny exclusion to the entire hospital. If a hospital is considering whether to establish a satellite facility, it should keep these payment rules in mind.

We note that these exclusion criteria would be administered in the same manner as the general rules for excluded hospitals and hospital units at § 412.22 and the common requirements for excluded hospital units at § 412.25. Specifically, the HCFA Regional Office will assess a hospital's or unit's compliance with the requirements before the start of a cost reporting period and will implement the decision at the start of the cost reporting period, effective for all of that period.

One of the major concerns we had with payments for services at satellites was the ability of a hospital to circumvent the intent of the BBA by applying the higher cap for existing hospitals and units to the beds in the new satellite. By requiring that the number of beds in the expanded hospital or unit (including both the base hospital or unit and the satellite location) cannot exceed the number of State-licensed and Medicare-certified beds in the excluded hospital or unit at the time the BBA was enacted, we ensure that the excluded hospital or unit does not inappropriately circumvent the payment caps for new hospitals enacted by the BBA. For hospitals and units first excluded from the prospective payment system after the enactment date of the BBA, we would not limit the number of beds in the hospital or unit, including all satellites, since all beds in the hospital or unit necessarily will be subject to the lower cap for new excluded hospitals and units. We are not applying this requirement to children's hospitals since those hospitals are not subject to caps established by the BBA.

Furthermore, by requiring that the satellite meet the prospective payment system exclusion requirements applicable to the type of hospital or unit, we are applying a policy to satellites that is similar to that currently applicable to a hospital-within-a-hospital. This policy, which is consistent with the suggestion of a national health care association, will ensure that the satellite retains the identity of the type of excluded hospital of which it is a part. For example, if we allowed the 25-day length of stay for long-term care hospital designation to be determined based on an examination of the base long-term care hospital including the satellite, the satellite could be excluded from the prospective payment system even if its patients all had short lengths of stay. By calculating the length of stay for patients exclusively at the satellite, we are ensuring that it is, in fact, a long-term care facility that warrants being excluded from the prospective payment system and receiving payment on a reasonable cost basis. Under this approach, if the satellite facility and the rest of the hospital or unit independently meet the applicable exclusion criteria, then the entire entity will be treated as one facility in making payments.

We also believe it is essential to be able to identify the costs of satellite facilities separately from the costs of the host hospitals in which they are located, so that services in both facilities are paid for accurately and Medicare does not pay two facilities for the same costs. To accomplish this, we will require the satellite to meet a number of requirements relating to separate identification of the beds, patients, and costs of the satellite. We note that these requirements closely parallel similar requirements applicable to all excluded units under § 412.25(a)(3) and (a)(7) through (12).

We are revising §§ 412.22(h) and 412.25(e) to implement this policy.

Comment: Some commenters argued that paying satellite facilities of excluded hospitals or units under a different methodology than that used for the excluded hospital or unit itself would be inconsistent with the Medicare law, in particular, sections 1886(b)(1) and (d)(1)(A) and (D) of the Act.

Response: We believe that our policies are consistent with the statutory scheme and the considerations underlying exclusions under the prospective payment system, as well as our rulemaking authority under section 1871 of the Act. Our policies addressing payments to satellite facilities are designed to prevent inappropriate payments to hospitals and to address potential fraud and abuse, and, at the same time, to permit exclusion from the prospective payment system when the circumstances warrant exclusion. As we discussed in the proposed rule, we believe that a number of excluded hospitals are seeking satellite arrangements so that the services furnished in the satellite facility are inappropriately paid on an excluded basis when they should be paid on a prospective payment basis; we also believe that a number of excluded hospitals are seeking satellite arrangements in order to avoid the effect of the payment caps that apply to new excluded hospitals. Even if hospitals are not *intentionally* trying to ''game'' the system, treating a satellite facility as ''part of'' the excluded hospital for payment purposes might lead to inappropriate payments in a number of ways.

We believe that Congress did not contemplate satellite arrangements when it enacted section 1886(d) of the Act. Section 1886(d) does not specifically address satellite

arrangements; also, section 1886(d) does not mandate that certification status equate to payment status. The statute does, however, establish a scheme under which entities may be excluded from the prospective payment system. The purpose of exclusions is to recognize situations in which the principles of the prospective payment system do not apply. As we explained in the proposed rule, the considerations underlying exclusions from the prospective payment system might not apply to satellite facilities, which might be ''part of'' excluded hospitals only ''on paper.'' Thus, we believe it is necessary and appropriate to address Medicare payment for services furnished in satellite facilities.

Comment: Several commenters approved of our proposal to grandfather excluded hospitals or units structured as satellite facilities on September 30, 1999, to the extent that they operate under the same terms and conditions in effect on that date.

Response: We agree that grandfathering these facilities is appropriate and are adopting this part of the proposed rule without change. However, we wish to emphasize that this policy does not extend to satellites established after September 30, 1999, even if they are established by an excluded hospital or unit that has another satellite that was grandfathered.

Comment: Two commenters expressed support for our proposal to not apply the new satellite rules to any hospital excluded from the prospective payment system by section 4417 of the BBA, as implemented under § 412.23(e)(2) (that is, a hospital that was first excluded in 1986, that had an average inpatient length of stay of greater than 20 days, and that demonstrated that at least 80 percent of its annual Medicare inpatient discharges in the 12-month cost reporting period ending in FY 1997 had a principal diagnosis that reflected a finding of neoplastic disease).

Response: We agree with the commenters that this is appropriate and are revising § 412.22(h)(3) to reflect this policy.

In addition, as discussed earlier under section VI.B of this preamble, we are including in §§ 412.22(h)(4) and 412.25(e) a corresponding exception to the requirement that a grandfathered satellite facility be operated under the terms and conditions in effect on September 30, 1999. The corresponding change would allow for increases or decreases in square footage, or decreases in the number of beds, of the satellite facility necessitated by changes for compliance with Federal, State, and local law affecting the physical facility or because of catastrophic events such as fires, floods, earthquakes, or tornadoes.

D. Responsibility for Care of Patients in Hospitals-within-Hospitals

Generally, hospitals that admit patients, including hospitals subject to the prospective payment system and ''hospitals-within-hospitals'' that are excluded from the prospective payment system, accept overall responsibility for the patients' care and furnish all services they require. In accordance with section 1886(d)(5)(I) of the Act and implementing regulations at § 412.4, for payment purposes, the prospective payment system distinguishes between ''discharges'' (situations in which a patient leaves an acute care hospital paid under the prospective payment system after receiving complete acute care treatment) and ''transfers'' (situations in which acute care treatment is not completed at the first hospital and the patient is transferred to another acute care hospital for continued, related care). The payment rules at § 413.30, which apply to hospitals excluded from the prospective payment system, also are premised on the assumption that discharges occur only when the excluded hospital's care of the patient is complete.

It has come to our attention that, given the co-location of prospective payment system facilities and facilities excluded from the prospective payment system in a hospital-within-a-hospital, and the absence of clinical constraints on the movement of patients, there may be situations in which, in these settings, patients appear to have been moved from one facility to another for financial rather than clinical reasons. The excluded hospital-within-a-hospital might have incentives to inappropriately discharge patients early (to the prospective payment system hospital within which it is located) in order to minimize its overall costs and, in turn, to minimize its cost per discharge. If the excluded hospital-within-a-hospital inappropriately discharges patients to the prospective payment system hospital without providing a complete episode of the type of care furnished by the excluded hospital, then Medicare would make inappropriate payments to the hospital-within-a-hospital. This is the case because payments made to an excluded hospital are made on a per-stay basis, up to the hospital's per discharge target amount, and any artificial decrease in the hospital's cost per stay could lead to the hospital inappropriately circumventing, through decreased length of stay, its target amount cap and receiving inappropriate bonus and relief payments under section 4415 of the BBA.

We believe it is important to address possible financial incentives for inappropriate early discharges from excluded hospitals-within-hospitals to prospective payment system hospitals. Therefore, in the proposed rule, we discussed several approaches for preventing inappropriate Medicare payments to an excluded hospital-within-a-hospital for inappropriate discharges to the prospective payment system hospital in which it is located. One approach was to provide that, if an excluded hospital-within-a-hospital transfers patients from its beds to beds of the prospective payment system hospital in which it is located, the hospital-within-a-hospital would not qualify for exclusion in the next cost reporting period. A second possible approach was to provide that the hospital-within-a-hospital would qualify for exclusion if it transfers patients to the prospective payment system hospital only when the services the patients require cannot be furnished by the hospital-within-a-hospital.

After considering these options, we decided to propose a third approach. We proposed to deny exclusion to a hospital-within-a-hospital for a cost reporting period if, during the most recent cost reporting period for which information is available, the excluded hospital-within-a-hospital transferred more than 5 percent of its inpatients to the prospective payment system hospital in which it is located. We stated that we believe that a 5-percent allowance of transfers under this approach would (1) avoid the need for administratively burdensome case review, (2) provide adequate flexibility for transfers in those cases in which the hospital-within-a-hospital is not equipped or staffed to provide the services required by the patient, and (3) limit the extent to which patients may be transferred inappropriately.

We solicited comments on our proposed approach as well as suggestions on other ways to address the possible incentives for inappropriate transfers in a manner that is administratively feasible.

We received 30 comments in response to our proposal and solicitation.

Comment: Several commenters argued that the choice of a 5-percent limit on discharges to the host prospective payment system hospital was arbitrary, and that we did not cite any study or other empirical evidence in support of it. Other commenters stated that the proposal could discourage excluded

hospitals-within-hospitals from admitting medically complex cases, thus contributing to a shortage of certain types of care. Other commenters, including a number of physicians, respiratory therapists, and other clinical personnel, expressed concern that the proposed rule could discourage medically appropriate transfers and thus limit patients' ability to receive needed care. One commenter indicated that the proposed rule was stated only in terms of transfers from the excluded hospital-within-a-hospital to the host prospective payment system hospital, while the problems described in the preamble involve transfers of patients from the excluded hospital-within-a-hospital to the host prospective payment system hospital, followed by readmission of the patient to the excluded hospital-within-a-hospital. Other commenters suggested that while these transfers might be abusive, the sanction identified in the proposed rule—loss of the exclusion from the prospective payment system of the hospital-within-a-hospital—is disproportionate to the problem.

Response: After review of all comments on this issue, we have decided to modify our approach. First, we agree with those commenters who stated that the primary focus of concern should not be discharges from the excluded hospital-within-a-hospital to the host prospective payment system hospital, but rather should include situations in which the discharges are then followed by readmissions to the excluded hospital-within-a-hospital, without any intervening movement of the patient from the host hospital to a skilled nursing facility, his or her home, or another hospital. Thus, we are revising the regulations to address only the latter situations.

We also agree that there is a better way to address inappropriate transfers and readmissions. When the level of inappropriate transfers exceeds the threshold level described below, we will, instead of terminating a hospital's exclusion, simply not consider the earlier discharge in these cases to have occurred, for purposes of calculating the payment to the hospital or unit. That is, if a patient is discharged from an excluded hospital-within-a-hospital to the host prospective payment system hospital and is then readmitted to the excluded hospital-within-a-hospital directly from the host hospital, the readmission would mean that the earlier discharge(s) from the excluded hospital will not be taken into account in calculating payments to the hospital-within-a-hospital under the excluded hospital payment provisions and their implementing regulations in § 413.40.

We also considered whether this policy should be applied in all cases or only if a specific threshold is exceeded. We continue to believe that the types of cases described (discharge of the patient to the host prospective payment system hospital, followed by readmission directly to the excluded hospital-within-a-hospital) are potentially vulnerable to abuse and that, in principle, we should adopt a policy of ''zero tolerance'' for these cases. At the same time, we are aware that this stringent approach might be difficult and controversial to implement and could have the unintended effect of discouraging some medically necessary or appropriate discharges to the host hospital. Therefore, we will allow a 5-percent margin to hospitals for these cases, in that we would not count the first discharge for purposes of payment as an excluded hospital only when the excluded hospital's number of these cases in a particular cost reporting year exceeded 5 percent of the total number of its discharges. If a hospital exceeds this 5-percent threshold, we would, with respect to these cases, not include any previous discharges to the host prospective payment system hospital in calculating the excluded hospital's cost per discharge. That is, the entire stay would be considered one ''discharge'' for purposes of payments to the hospital.

For example, assume that a patient was discharged from the excluded hospital-within-a-hospital to the prospective payment system hospital in which it is located and then was readmitted to the excluded hospital-within-a-hospital from the prospective payment system hospital (the ''host''). If the total number of discharges (to all locations) of the hospital-within-a-hospital in the cost reporting period is 100 and the number readmitted from the host after having been previously discharged to it is 3, the percentage would be 3 percent (3 divided by 100), and all of the discharges, including the previous discharge to the host, would be taken into account. However, if the total number of discharges had been only 50, and of those, 3 patients had been readmitted from the host after a previous discharge to it, the percentage would be 6 percent (3 divided by 50) and the first discharge of the patients readmitted to the host would not be counted. Therefore, payment would be based on 47 discharges. In determining whether a patient had previously been discharged and then readmitted, we would consider all prior discharges, even if the discharge occurred late in one cost reporting period and the readmission occurred in the next cost reporting period.

Thus, in the May 7, 1999 proposed rule, we proposed to deny exclusion to a hospital-within-a-hospital if, during the most recent cost reporting period for which information is available, the excluded hospital-within-a-hospital transferred more than 5 percent of its inpatients to the prospective payment system hospital in which it is located. After considering the public comments, in this final rule we are implementing a policy that differs from the proposed policy in two significant ways. First, rather than focusing solely on discharges to the host hospital, we are examining situations involving a discharge to the host hospital followed by a readmission to the excluded hospital. Second, if the 5-percent threshold is triggered, we would not deny exclusion to the hospital-within-a-hospital; instead, the hospital-within-a-hospital could continue to receive payment as an excluded hospital-within-a-hospital, but, for purposes of determining the amount of payment, we would not count the first discharge for those cases involving a discharge followed by readmission. (If the 5-percent threshold is not triggered, then all discharges would be counted.)

We continue to believe that the 5-percent threshold is appropriate to trigger special payment rules. We are trying to prevent inappropriate payments to hospitals for inappropriate transfers, and a 5-percent threshold reflects a balance of a number of considerations. As indicated in the proposed rule, a 5-percent threshold would (1) avoid the need for administratively burdensome case review (to determine whether discharges or readmissions were inappropriate), (2) provide adequate flexibility for transfers in those cases in which the hospital-within-a-hospital is not equipped or staffed to provide the services required by the patient, and (3) address possible incentives for hospitals to transfer patients inappropriately.

The rationale for this policy is largely conceptual in nature, and the 5-percent threshold is not based solely on any one source of statistics or data available to us. If we tried to set a threshold based solely on such statistics, it might be extremely difficult and time-consuming to distinguish between appropriate transfers and inappropriate transfers. Given the importance of preventing inappropriate payments, we believe it would not be prudent to delay implementing this policy. At this time, we believe that a 5-percent ''allowance'' reflects an appropriate balance of the considerations discussed above and is

consistent with information available to us. However, we will continue to monitor this issue and review data, and we might revise the threshold in a future rulemaking if information indicates that a revision is appropriate.

We are revising the definition of ''ceiling'' in § 413.40(a)(3) to implement our revised policy.

Comment: Some commenters asked whether the intent of the proposed rule was to exclude hospitals-within-hospitals described under § 412.22(f) from the provision on responsibility for care of patients, since the proposed rule would have added a new paragraph (e)(6), and existing § 412.22(f) states that the rules in paragraph (e) do not apply to hospitals described in paragraph (f).

Response: As discussed above, we are not proceeding with the proposed changes at § 412.22(e)(6) and are instead implementing our revised policy by amending the definition of ''ceiling'' in § 413.40(a)(3). The hospitals described in § 412.22(f) will be subject to the new policy on the same basis as other hospitals-within-hospitals.

E. Critical Access Hospitals (CAHs)

1. Emergency Response Time Requirements for CAHs in Frontier and Remote Areas

Because of the high cost of staffing rural hospital emergency rooms and the low volume of services in those facilities, we do not require CAHs to have emergency personnel on site at all times. Thus, for CAHs, the regulations at § 485.618(d) require a doctor of medicine or a doctor of osteopathy, a physician assistant, or a nurse practitioner with training and experience in emergency care to be on call and immediately available by telephone or radio contact, and available on site within 30 minutes, on a 24–hour basis. We included this requirement because we recognize the need of rural residents to have reasonable access to emergency care in their local communities.

Section 1820(h) of the Act, as added by section 4201 of the BBA, states that any medical assistance facility (MAF) in Montana shall be deemed to have been certified by the Secretary as a CAH if that facility is otherwise eligible to be designated by the State as a CAH. However, under the current requirements, following the initial transition of a MAF to CAH status, the former MAF would be subject to the CAH requirements during any subsequent review, one of which is the 30-minute emergency response time for emergency services currently required under § 485.518(d).

Some facilities have suggested that in many ''frontier'' areas (that is, those having fewer than six residents per square mile), the requirement of a 30-minute response might be too restrictive for CAHs, especially those MAFs transitioning to CAH status.

In order to recognize the special needs of sparsely populated rural areas in meeting beneficiaries' health needs, and at the same time to protect patients' health and safety, in the May 7, 1999 proposed rule, we proposed to revise § 485.618(d) to allow a response time of up to 60 minutes for a CAH if (1) it is located in an area of the State that is defined as a frontier area (that is, having fewer than six residents per square mile based on the latest population data published by the Bureau of the Census) or meets other criteria for a remote location adopted by the State and approved by HCFA under criteria specified in its rural health care plan under section 1820(b) of the Act; (2) the State determines that, under its rural health care plan, allowing the longer emergency response time is the only feasible method of providing emergency care to residents of the area; and (3) the State maintains documentation showing that a response time of up to 60 minutes at a particular CAH it designates is justified because other available alternatives would increase the time required to stabilize the patient in an emergency. The criteria for remote location would, like other parts of the rural health care plan, be subject to review and approval by the HCFA Regional Office, as would the State's documentation regarding the emergency response time.

We noted that, under the terms of the Montana State Code applicable to MAFs, at times when no emergency response person is available to come to the facility, a MAF's director of nursing is permitted to come to the facility and authorize the transfer of a patient seeking emergency services to another facility. Under one possible reading of the State requirement, this activity could be seen as an alternative way of complying with the emergency services requirement and the MAF's (and CAH's) responsibilities under section 1867 of the Act (the Emergency Medical Treatment and Active Labor Amendments Provision) to provide emergency medical screening and stabilization services to patients who come to the hospital seeking emergency treatment. We requested comments on whether the Medicare regulations in §§ 485.618(d) and 489.24 should be further revised to explicitly permit this practice to continue following the transition of a MAF to CAH status. We were particularly interested in obtaining comments from practitioners on the risks and benefits involved in adoption of this practice.

We received three comments on our proposal.

Comment: Two commenters supported our proposal to allow a 60-minute emergency response time for frontier areas.

Response: We appreciate the commenters' support and are adopting this proposal as final without change.

Comment: One commenter believed that the 60-minute response timeframe in the proposed rule is too long considering the importance of timely provision of emergency care even in remote areas. The commenter believes that if a facility wants to function as a CAH, it should have appropriate personnel onsite within 30 minutes to provide care.

Response: As we have indicated above, we believe that we must recognize the special needs of sparsely populated rural areas in meeting beneficiaries' health needs and at the same time protect patients' health and safety. We believe our proposed change accomplishes this goal.

2. Compliance with Minimum Data Set (MDS) Requirements by CAHs with Swing-Bed Approval

Existing regulations allow CAHs to obtain approval from HCFA to use their inpatient beds to provide posthospital SNF care (§ 485.645). To obtain this approval, however, the CAH must agree to meet specific requirements that also apply to SNFs, including the comprehensive assessment requirements at § 483.20(b) of the SNF conditions of participation.

Section 483.20(b)(1) specifies that a SNF must make a comprehensive assessment of a resident's needs, using the resident assessment instrument specified by the State. Section 483.20(b)(2) further specifies that, subject to the timeframes in § 413.343(b), the assessments must be conducted within 14 calendar days after the patient is admitted; within 14 days after the facility determines, or should have determined, that there is a significant change in the patient's physical or mental condition; and at least once every 12 months. Section 413.343(b) specifies that in accordance with the methodology in § 413.337(c) related to the adjustment of the Federal rates for case-mix (the SNF prospective payment system), patient assessments must be performed on the 5th, 14th, 30th, 60th, and 90th days following admission.

It is clear that the timeframes for patient assessments required under § 413.343(b) are linked to the prospective payment system for SNFs. The methodology specifically referenced in § 413.337(c) refers to the SNF prospective payment system. Therefore, it is apparent that the patient assessments and concomitant timeframes for performing such assessments are inextricably intertwined with the case-mix adjustment under the SNF prospective payment system. CAHs with swing-bed approval are not paid for their services to SNF-level patients under that SNF prospective payment system but are paid under the payment method described in § 413.114, which does not include a case-mix adjustment. Therefore, the timeframes for patient assessments as dictated by § 413.343(b) are not applicable to CAHs and are not required to be met by CAHs. Nevertheless, to make it explicit that the patient assessment timeframes required under § 413.343(b) do not apply, we proposed to revise § 485.645 to state that the requirements in § 413.343(b), and the timeframes specified in § 483.20, do not apply to CAHs.

Comments: We received three comments on this proposal. One commenter supported our proposal and stated that the clarification would help eliminate the confusion that has existed in the industry. Another commenter noted that we do not have a comparable requirement for screening patients in swing beds located in all other rural hospitals and therefore believes it is inappropriate to implement a standard for CAHs that exceed normal practice. Another commenter objected to the proposed clarification as inflexible and biased and urged us to defer implementing the screening policy for swing beds for CAHs until we have established overall policy for swing beds.

Response: We believe that the changes we have proposed have revised the rules to allow for flexibility for CAHs. As stated above, CAHs with swing-bed approval are not paid for their services to SNF-level patients under the SNF prospective payment system but are paid under the payment method described in § 413.114, which does not include a case-mix adjustment. However, swing beds in rural hospitals are paid under the SNF prospective payment system. As explained above, the changes proposed to the reporting requirements for CAHs are intended to allow the policy to be consistent with the payment policy for swing beds in CAHs. With the change, we are making it explicit that the patient assessment timeframes required under §§ 413.343(b) and 483.20 do not apply to CAHs.

3. Additional Comments Received on CAH Issues

We received comments on two separate issues regarding CAHs on which we did not propose policy changes.

Comment: One commenter believes that the definition of CAH is prohibitive in one State and recommended that we change the criteria for CAHs to allow a hospital that meets all the criteria except for being located in an urban (versus a rural) area to be considered a CAH.

Response: We would need a change in the statute to authorize a change in the requirements for CAH designation, as the commenter recommended. Section 1820(c)(2)(B)(i) of the Act provides that a State may designate a facility as a CAH only if the hospital is located in a rural area as defined in section 1886(d)(2)(D) of the Act. Thus, we did not revise our regulations to address this comment.

Comment: One commenter suggested that the reasonable cost payment methodology for CAHs should extend to ambulance services and requested that HCFA address this in the final rule.

Response: The provision of law governing payment for outpatient CAH services, section 1834(g) of the Act, states that reasonable cost payment is to be made for outpatient CAH services. These services are defined, at section 1861(mm)(3) of the Act, as medical and other health services furnished by a CAH on an outpatient basis. Consistent with our policy on ambulance services, these services are treated under a separate benefit and are covered and paid for under separate statutory authority and a separate payment method. Therefore, we have no basis on which to authorize reasonable cost payment for ambulance services .

VII. MedPAC Recommendations

As required by law, we reviewed the March 1, 1999 report submitted by MedPAC to the Congress and gave its recommendations careful consideration in conjunction with the proposals set forth in the May 7, 1999 proposed rule. We also responded to the individual recommendations in the proposed rule. The comments we received on the treatment of the MedPAC recommendations are set forth below, along with our responses to those comments. However, if we received no comments from the public concerning a MedPAC recommendation or our response to that recommendation, we have not repeated the recommendation. Recommendations concerning the update factors for inpatient operating cost and for hospitals and hospital distinct part units excluded from the prospective payment system are discussed in Appendix C of this final rule.

A. Excluded Hospitals and Hospital Units (Recommendations 4B and 4C)

Recommendation: The Congress should adjust the wage-related portion of the excluded hospital target amount caps (the 75th percentile of target amounts for hospitals in the same class (psychiatric hospital or unit, rehabilitation hospital or unit, or long-term care hospitals)) to account for geographic differences in labor costs. The Commission presumes legislation would be necessary to adjust the caps for wages.

Response in the Proposed Rule: We previously addressed this issue in the May 12, 1998 final rule (63 FR 26345). In that discussion, we explain why we believe the statutory language, the statutory scheme, and the legislative history, viewed together, strongly argue against making a wage adjustment in applying the target amount caps under the current statute.

Comment: We received two comments on our response to the MedPAC recommendation regarding the wage related portion of the excluded hospital target amount cap. Specifically, MedPAC commented that it would encourage HCFA to seek legislative authority to adjust the target amount caps for area wages. The other commenter asserted that such adjustments should be made since they are used for new facilities and because the exclusion of an adjustment is unfair to regions with higher labor costs.

Response: In the May 12, 1998 final rule, we explained our decision not to wage adjust the caps on the target amounts. The decision was based on our analysis of the statutory language, the statutory scheme, the legislative history, and policy considerations. First, we noted that section 4414 of the BBA, which provides that ''* * * in the case of a hospital or unit that is within a class of hospital described in clause (iv), the Secretary shall estimate the 75th percentile of the target amounts for such hospitals within such class for cost reporting periods ending during fiscal year 1996,'' directs the Secretary to examine target amounts and calculate a single number for each of three classes of hospitals. In addition, we stated that while the statutory language directs the Secretary to calculate the 75th percentile of target amounts, it does not explicitly direct or even authorize the Secretary to make adjustments to that

number after it is calculated. We agree that the absence of an explicit instruction, in and of itself, does not necessarily mean that the Secretary cannot implement a wage adjustment. However, Congressional ''silence'' on this issue must be construed in light of the statutory scheme and the legislative history, as well as policy considerations.

With regard to the statutory scheme, we stated that in requiring that we calculate a separate number for each class of hospitals, the Congress established a scheme that directs us to recognize differences across types of hospitals, but does not direct us to recognize differences in wages. In addition to the scheme of section 4414 itself, we considered this section in light of other statutory provisions. We concluded that, because the Congress explicitly requires wage adjustments in some contexts, failure to require a wage adjustment in this context reflects a judgement by the Congress that we should not make one under section 4414. In terms of the legislative history, we noted that there is no reference in the Conference Report to a wage adjustment to the TEFRA caps.

Finally, we asserted that while from a broad policy perspective a wage adjustment might be appropriate, policy considerations do not dictate a wage adjustment. A payment cap is different from a payment rate in that a cap only affects hospitals that are above the cap, while a payment rate affects all hospitals. Thus, we believe that while a wage adjustment might be preferable policy, the lack of a wage adjustment is not unreasonable. We stated that we would support a hospital-sponsored legislative change to permit wage adjustments and we will continue to do so; however, our decision, as expressed in the May 12, 1998 final rule, remains unchanged.

B. Disproportionate Share Hospitals (DSH) (Recommendations 3C, 3D, and 3E)

Recommendations: The Congress should require that disproportionate share payments be distributed according to each hospital's share of low-income patient costs, defined broadly to include all care to the poor. The measure of low-income costs should reflect: (1) Medicare patients eligible for Supplemental Security Income, Medicaid patients, patients sponsored by other indigent care programs, and uninsured and underinsured patients as represented by uncompensated care (both charity and bad debts); and (2) services provided in both inpatient and outpatient settings.

As under current policy, disproportionate share payment should be made in the form of an adjustment to the per-case payment rate. In this way, the total payment each hospital receives will reflect its volume of Medicare patients.

Through a minimum threshold for low-income share, the formula for distributing disproportionate share payments should concentrate payments among hospitals with the highest shares of poor patients. A reasonable range for this threshold would be levels that make between 50 percent and 60 percent of hospitals eligible for a payment. However, the size of the payment adjustment should increase gradually from zero at the threshold. The same distribution formula should apply to all hospitals covered by prospective payment.

The Secretary should collect the data necessary to revise the disproportionate share payment system from all hospitals paid under the prospective payment system.

Response in the Proposed Rule: We continue to give careful consideration to MedPAC's recommendations concerning the DSH adjustment made to operating payments under the prospective payment system.

We are in the process of preparing a report to the Congress on the Medicare DSH adjustment that includes several options for amending the statutory disproportionate share adjustment formula. We believe that any adjustment to the DSH formula or data sources should be directed and supported by the Congress.

The MedPAC option involves collecting data on uncompensated care, that is, charity and bad debts. Ideally, this would be a direct measure of a hospital's indigent care burden. However, there are problems associated with verification of such data and consistency of reporting nationally. We appreciate the Commission's recommendations about and assistance with the Medicare DSH adjustment as we formulate our legislative proposal and await Congressional action.

Comment: MedPAC commented that it does not believe that the verification process for uncompensated care (charity and bad debt) data needs to be burdensome. It recommends that HCFA keep reporting requirements to a minimum to limit data collection problems. Specifically, MedPAC recommends that HCFA collect only total uncompensated care data rather than separate data on the two components of uncompensated care—bad debts and charity care. HCFA should publish guidelines specifying the types of unpaid charges that can be included so that reporting problems are minimal.

Response: As we noted in our response to this recommendation in the proposed rule, we are preparing a Report to Congress on the revision of the DSH adjustment formula and have taken into consideration the inclusion of a recommendation to collect uncompensated care charge data by payer category (inpatient and outpatient) for our analysis. We believe it is important to promote the consistent reporting of data to the extent possible. We plan to minimize reporting problems by collecting only total uncompensated care data, thereby avoiding the problem of different definitions of bad debts, indigent care, and uncompensated care among States. However, we continue to anticipate other reporting problems such as hospital recordkeeping of these data.

VIII. Other Required Information

Requests for Data from the Public

In order to respond promptly to public requests for data related to the prospective payment system, we have set up a process under which commenters can gain access to the raw data on an expedited basis. Generally, the data are available in computer tape or cartridge format; however, some files are available on diskette as well as on the Internet at HTTP://WWW.HCFA.GOV/STATS/PUBFILES.HTML. In our May 7, 1999 proposed rule, we published a list of data files that are available for purchase (64 FR 24746 and 24747).

List of Subjects

42 CFR Part 412

Administrative practice and procedure, Health facilities, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

42 CFR Part 413

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

42 CFR Part 483

Grant programs-health, Health facilities, Health professions, Health records, Medicaid, Medicare, Nursing homes, Nutrition, Reporting and recordkeeping requirements, Safety.

42 CFR Part 485

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

42 CFR Chapter IV is amended as set forth below:

PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

A. Part 412 is amended as follows:

1. The authority citation for Part 412 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

2. In § 412.2, the introductory text of paragraph (e) is republished and paragraph (e)(4) is revised to read as follows:

§ 412.2 Basis of payment.

* * * * *

(e) *Excluded costs.* The following inpatient hospital costs are excluded from the prospective payment amounts and are paid on a reasonable cost basis:

* * * * *

(4) Heart, kidney, liver, lung, and pancreas acquisition costs incurred by approved transplantation centers.

* * * * *

3. Section 412.22 is amended by adding a new paragraph (h) to read as follows:

§ 412.22 Excluded hospitals and hospital units: General rules.

* * * * *

(h) *Satellite facilities.* (1) For purposes of paragraphs (h)(2) through (h)(4) of this section, a satellite facility is a part of a hospital that provides inpatient services in a building also used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital.

(2) Except as provided in paragraph (h)(3) of this section, effective for cost reporting periods beginning on or after October 1, 1999, a hospital that has a satellite facility must meet the following criteria in order to be excluded from the prospective payment systems for any period:

(i) In the case of a hospital (other than a children's hospital) that was excluded from the prospective payment systems for the most recent cost reporting period beginning before October 1, 1997, the hospital's number of State-licensed and Medicare-certified beds, including those at the satellite facilities, does not exceed the hospital's number of State-licensed and Medicare-certified beds on the last day of the hospital's last cost reporting period beginning before October 1, 1997.

(ii) The satellite facility independently complies with—

(A) For psychiatric hospitals, the requirements under § 412.23(a);

(B) For rehabilitation hospitals, the requirements under § 412.23(b)(2);

(C) For children's hospitals, the requirements under § 412.23(d)(2); or

(D) For long-term care hospitals, the requirements under §§ 412.23(e)(1) through (e)(3)(i).

(iii) The satellite facility meets all of the following requirements:

(A) It maintains admission and discharge records that are separately identified from those of the hospital in which it is located and are readily available.

(B) It has beds that are physically separate from (that is, not commingled with) the beds of the hospital in which it is located.

(C) It is serviced by the same fiscal intermediary as the hospital of which it is a part.

(D) It is treated as a separate cost center of the hospital of which it is a part.

(E) For cost reporting and apportionment purposes, it uses an accounting system that properly allocates costs and maintains adequate statistical data to support the basis of allocation.

(F) It reports its costs on the cost report of the hospital of which it is a part, covering the same fiscal period and using the same method of apportionment as the hospital of which it is a part.

(3) Except as provided in paragraph (h)(4) of this section, the provisions of paragraph (h)(2) of this section do not apply to—

(i) Any hospital structured as a satellite facility on September 30, 1999, and excluded from the prospective payment systems on that date, to the extent the hospital continues operating under the same terms and conditions, including the number of beds and square footage considered, for purposes of Medicare participation and payment, to be part of the hospital, in effect on September 30, 1999; or

(ii) Any hospital excluded from the prospective payment systems under § 412.23(e)(2).

(4) In applying the provisions of paragraph (h)(3) of this section, any hospital structured as a satellite facility on September 30, 1999, may increase or decrease the square footage of the satellite facility or may decrease the number of beds in the satellite facility if these changes are made necessary by relocation of a facility—

(i) To permit construction or renovation necessary for compliance with changes in Federal, State, or local law; or

(ii) Because of catastrophic events such as fires, floods, earthquakes, or tornadoes.

4. Section 412.25 is amended by revising paragraphs (b) and (c) and adding a new paragraph (e) to read as follows:

§ 412.25 Excluded hospital units: Common requirements.

* * * * *

(b) *Changes in the size of excluded units.* For purposes of exclusions from the prospective payment systems under this section, changes in the number of beds and square footage considered to be part of each excluded unit are allowed as specified in paragraphs (b)(1) through (b)(3) of this section.

(1) *Increase in size.* Except as described in paragraph (b)(3) of this section, the number of beds and square footage of an excluded unit may be increased only at the start of a cost reporting period.

(2) *Decrease in size.* Except as described in paragraph (b)(3) of this section, the number of beds and square footage of an excluded unit may be decreased at any time during a cost reporting period if the hospital notifies its fiscal intermediary and the HCFA Regional Office in writing of the planned decrease at least 30 days before the date of the decrease, and maintains the information needed to accurately determine costs that are attributable to the excluded unit. Any decrease in the number of beds or square footage considered to be part of an excluded unit made during a cost reporting period must remain in effect for the rest of that cost reporting period.

(3) *Exception to changes in square footage and bed size.* The number of beds in an excluded unit may be decreased, and the square footage considered to be part of the unit may be either increased or decreased, at any time, if these changes are made necessary by relocation of a unit—

(i) To permit construction or renovation necessary for compliance with changes in Federal, State, or local law affecting the physical facility; or

(ii) Because of catastrophic events such as fires, floods, earthquakes, or tornadoes.

(c) *Changes in the status of hospital units.* For purposes of exclusions from the prospective payment systems under this section, the status of each hospital unit (excluded or not excluded) is determined as specified in paragraphs (c)(1) and (c)(2) of this section.

(1) The status of a hospital unit may be changed from not excluded to excluded only at the start of the cost reporting period. If a unit is added to a

hospital after the start of a cost reporting period, it cannot be excluded from the prospective payment systems before the start of a hospital's next cost reporting period.

(2) The status of a hospital unit may be changed from excluded to not excluded at any time during a cost reporting period, but only if the hospital notifies the fiscal intermediary and the HCFA Regional Office in writing of the change at least 30 days before the date of the change, and maintains the information needed to accurately determine costs that are or are not attributable to the excluded unit. A change in the status of a unit from excluded to not excluded that is made during a cost reporting period must remain in effect for the rest of that cost reporting period.

* * * * *

(e) *Satellite facilities.* (1) For purposes of paragraphs (e)(2) through (e)(4) of this section, a satellite facility is a part of a hospital unit that provides inpatient services in a building also used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital.

(2) Except as provided in paragraph (e)(3) of this section, effective for cost reporting periods beginning on or after October 1, 1999, a hospital unit that establishes a satellite facility must meet the following requirements in order to be excluded from the prospective payment systems for any period:

(i) In the case of a unit excluded from the prospective payment systems for the most recent cost reporting period beginning before October 1, 1997, the unit's number of State-licensed and Medicare-certified beds, including those at the satellite facility, does not exceed the unit's number of State-licensed and Medicare-certified beds on the last day of the unit's last cost reporting period beginning before October 1, 1997.

(ii) The satellite facility independently complies with—

(A) For a rehabilitation unit, the requirements under § 412.23(b)(2); or

(B) For a psychiatric unit, the requirements under § 412.27(a).

(iii) The satellite facility meets all of the following requirements:

(A) It maintains admission and discharge records that are separately identified from those of the hospital in which it is located and are readily available.

(B) It has beds that are physically separate from (that is, not commingled with) the beds of the hospital in which it is located.

(C) It is serviced by the same fiscal intermediary as the hospital unit of which it is a part.

(D) It is treated as a separate cost center of the hospital unit of which it is a part.

(E) For cost reporting and apportionment purposes, it uses an accounting system that properly allocates costs and maintains adequate statistical data to support the basis of allocation.

(F) It reports its costs on the cost report of the hospital of which it is a part, covering the same fiscal period and using the same method of apportionment as the hospital of which it is a part.

(3) Except as specified in paragraph (e)(4) of this section, the provisions of paragraph (e)(2) of this section do not apply to any unit structured as a satellite facility on September 30, 1999, and excluded from the prospective payment systems on that date, to the extent the unit continues operating under the same terms and conditions, including the number of beds and square footage considered to be part of the unit, in effect on September 30, 1999.

(4) In applying the provisions of paragraph (h)(3) of this section, any unit structured as a satellite facility as of September 30, 1999, may increase or decrease the square footage of the satellite facility or may decrease the number of beds in the satellite facility at any time, if these changes are made necessary by relocation of the facility—

(i) To permit construction or renovation necessary for compliance with changes in Federal, State, or local law affecting the physical facility; or

(ii) Because of catastrophic events such as fires, floods, earthquakes, or tornadoes.

§ 412.105 [Amended]

5. Section 412.105 is amended by revising the cross reference ''paragraph (g)(1)(ii) of this section'' in paragraphs (f)(1)(iii) (three times) and (f)(2)(v) to read ''paragraph (f)(1)(ii) of this section''.

§ 412.256 [Amended]

6. In § 412.256, paragraph (c)(2), the date ''October 1'', appearing in two places, is revised to read ''September 1''.

7. Section 412.276 is amended by revising paragraph (a) to read as follows:

§ 412.276 Timing of MGCRB decision and its appeal.

(a) *Timing.* The MGCRB notifies the parties in writing, with a copy to HCFA, and issues a decision within 180 days after the first day of the 13-month period preceding the Federal fiscal year for which a hospital has filed a complete application. The hospital has 15 days from the date of the decision to request Administrator review.

* * * * *

PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES; OPTIONAL PROSPECTIVELY DETERMINED PAYMENT RATES FOR SKILLED NURSING FACILITIES

B. Part 413 is amended as follows:

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

Authority: Secs. 1102, 1812(d), 1814(b), 1815, 1833(a), (i), and (n), 1871, 1881, 1883, and 1886 of the Social Security Act (42 U.S.C. 1302, 1395f(b), 1395g, 1395l, 1395l(a), (i), and (n), 1395x(v), 1395hh, 1395rr, 1395tt, and 1395ww).

2. Section 413.40 is amended by adding a sentence containing paragraphs (A) and (B) at the end of the definition of ''ceiling'' in paragraph (a)(3) and revising paragraphs (b)(1)(iii), (c)(4)(v), (f)(2)(ii)(A), and (g)(1) to read as follows:

§ 413.40 Ceiling on the rate-of-increase in hospital inpatient costs.

(a) *Introduction.* * * *

(3) *Definitions.* * * *

Ceiling * * * For a hospital-within-a-hospital, as described in § 412.22(e) of this chapter, the number of Medicare discharges in a cost reporting period does not include discharges of a patient to another hospital in the same building on or on the same campus, if—

(A) The patient is subsequently readmitted to the hospital-within-a-hospital directly from the other hospital; and

(B) The hospital-within-a-hospital has discharged to the other hospital and subsequently readmitted more than 5 percent (that is, in excess of 5.0 percent) of the total number of inpatients discharged from the hospital-within-a-hospital in that cost reporting period.

* * * * *

(b) *Cost reporting periods subject to the rate-of-increase ceiling.* (1) *Base period.* * * *

(iii) When the operational structure of a hospital or unit changes (that is, a freestanding hospital becomes an excluded unit or an excluded unit becomes a freestanding hospital, or an entity of a multicampus hospital becomes a newly created hospital or unit or a hospital or unit becomes a part of a multicampus hospital), the base period for the hospital or unit that

changed its operational structure is the first cost reporting period of at least 12 months effective with the revised Medicare certification classification.

* * * * *

(c) *Cost subject to the ceiling.* * * *

(4) *Target amounts.* * * *

(v) In the case of a hospital that received payments under paragraph (f)(2)(ii) of this section as a newly created hospital or unit, to determine the hospital's target amount for the hospital's third 12-month cost reporting period, the payment amount determined under paragraph (f)(2)(ii) of this section for the preceding cost report period is updated to the third cost reporting period.

* * * * *

(f) *Comparison to the target amount for new hospitals and units.* * * *

(2) *Comparison.* * * *

(ii) *Median target amount.* (A) For cost reporting periods beginning on or after October 1, 1997, the amount of payment for a new psychiatric hospital or unit, a new rehabilitation hospital or unit, or a new long-term care hospital that was not paid as an excluded hospital prior to October 1, 1997, is the lower of the hospital's net inpatient operating cost per case or 110 percent of the national median of the target amounts for the class of excluded hospitals and units (psychiatric, rehabilitation, long-term care) as adjusted for differences in wage levels and updated to the first cost reporting period in which the hospital receives payment. The second cost reporting period is subject to the same target amount as the first cost reporting period.

* * * * *

(g) *Adjustment.* (1) *General rules.* (i) HCFA adjusts the amount of the operating costs considered in establishing the rate-of-increase ceiling for one or more cost reporting periods, including both periods subject to the ceiling and the hospital's base period, under the circumstances specified in paragraphs (g)(2), (g)(3), and (g)(4) of this section.

(ii) When the hospital requests an adjustment, HCFA makes an adjustment only to the extent that the hospital's operating costs are reasonable, attributable to the circumstances specified separately, identified by the hospital, and verified by the intermediary.

(iii) When the hospital requests an adjustment, HCFA makes an adjustment only if the hospital's operating costs exceed the rate-of-increase ceiling imposed under this section.

(iv) In the case of a psychiatric hospital or unit, rehabilitation hospital or unit, or long-term care hospital, the amount of payment under paragraph (g)(3) of this section may not exceed the payment amount based on the target amount determined under paragraph (c)(4)(iii) of this section.

(v) In the case of a hospital or unit that received a revised FY 1998 target amount under the rebasing provisions of paragraph (b)(1)(iv) of this section, the amount of an adjustment payment for a cost reporting period is based on a comparison of the hospital's operating costs for the cost reporting period to the average costs and statistics for the cost reporting periods used to determine the FY 1998 rebased target amount.

* * * * *

§ 413.86 [Amended]

3. Section 413.86 is amended as follows:

a. In paragraph (b), the definition of ''approved geriatric program'' is revised to read as set forth below.

b. In paragraph (b), under paragraph (1) of the definition of ''approved medical residency program'', the reference ''§ 415.200(a) of this chapter'' is revised to read ''§ 415.152 of this chapter''.

c. In paragraph (e)(1)(ii)(C), the reference ''paragraph (j)(2) of this section'' is revised to read ''paragraph (k)(1) of this section''.

d. In paragraph (e)(1)(iv), the reference, ''paragraph (j)(1) of this section'', is revised to read ''paragraph (k)(1) of this section''.

e. A new paragraph (f)(4)(iii) is added, paragraphs (g)(1)(i), (ii), and (iii), (g)(6) introductory text, (g)(6)(i) and (ii), and the first sentence of paragraph (g)(6)(iii) are revised, paragraph (g)(7) is redesignated as paragraph (g)(9), and new paragraphs (g)(7) and (g)(8) are added to read as follows:

§ 413.86 Direct graduate medical education payments.

* * * * *

(b) * * *

Approved geriatric program means a fellowship program of one or more years in length that is approved by one of the national organizations listed in § 415.152 of this chapter under that respective organization's criteria for geriatric fellowship programs.

* * * * *

(f) *Determining the total number of FTE residents.* * * *

(4) * * *

(iii) The hospital must incur all or substantially all of the costs for the training program in the nonhospital setting in accordance with the definition in paragraph (b) of this section.

(g) *Determining the weighted number of FTE residents.* * * *

(1) * * *

(i) For residency programs other than those specified in paragraphs (g)(1)(ii) and (g)(1)(iii) of this section, the initial residency period is the minimum number of years of formal training necessary to satisfy the requirements for initial board eligibility in the particular specialty for which the resident is training, as specified in the most recently published edition of the Graduate Medical Education Directory.

(ii) For residency programs in osteopathy, dentistry, and podiatry, the minimum requirement for certification in a specialty or subspecialty is the minimum number of years of formal training necessary to satisfy the requirements of the appropriate approving body listed in § 415.152 of this chapter.

(iii) For residency programs in geriatric medicine, accredited by the appropriate approving body listed in 415.152 of this chapter, these programs are considered approved programs on the later of—

(A) The starting date of the program within a hospital; or

(B) The hospital's cost reporting periods beginning on or after July 1, 1985.

* * * * *

(6) If a hospital establishes a new medical residency training program as defined in paragraph (g)(9) of this section on or after January 1, 1995, the hospital's FTE cap described under paragraph (g)(4) of this section may be adjusted as follows:

(i) If a hospital had no allopathic or osteopathic residents in its most recent cost reporting period ending on or before December 31, 1996, and it establishes a new medical residency training program on or after January 1, 1995, the hospital's unweighted FTE resident cap under paragraph (g)(4) of this section may be adjusted based on the product of the highest number of residents in any program year during the third year of the first program's existence for all new residency training programs and the number of years in which residents are expected to complete the program based on the minimum accredited length for the type of program. The adjustment to the cap may not exceed the number of accredited slots available to the hospital for the new program.

(A) If the residents are spending an entire program year (or years) at one hospital and the remainder of the program at another hospital, the adjustment to each respective hospital's

cap is equal to the product of the highest number of residents in any program year during the third year of the first program's existence and the number of years the residents are training at each respective hospital.

(B) Prior to the implementation of the hospital's adjustment to its FTE cap beginning with the fourth year of the hospital's residency program(s), the hospital's cap may be adjusted during each of the first 3 years of the hospital's new residency program using the actual number of residents participating in the new program. The adjustment may not exceed the number of accredited slots available to the hospital for each program year.

(C) Except for rural hospitals, the cap will not be adjusted for new programs established more than 3 years after the first program begins training residents.

(D) An urban hospital that qualifies for an adjustment to its FTE cap under paragraph (g)(6)(i) of this section is not permitted to be part of an affiliated group for purposes of establishing an aggregate FTE cap.

(E) A rural hospital that qualifies for an adjustment to its FTE cap under paragraph (g)(6)(i) of this section is permitted to be part of an affiliated group for purposes of establishing an aggregate FTE cap.

(ii) If a hospital had allopathic or osteopathic residents in its most recent cost reporting period ending on or before December 31, 1996, the hospital's unweighted FTE cap may be adjusted for new medical residency training programs established on or after January 1, 1995 and on or before August 5, 1997. The adjustment to the hospital's FTE resident limit for the new program is based on the product of the highest number of residents in any program year during the third year of the newly established program and the number of years in which residents are expected to complete each program based on the minimum accredited length for the type of program.

(A) If the residents are spending an entire program year (or years) at one hospital and the remainder of the program at another hospital, the adjustment to each respective hospital's cap is equal to the product of the highest number of residents in any program year during the third year of the first program's existence and the number of years the residents are training at each respective hospital.

(B) Prior to the implementation of the hospital's adjustment to its FTE cap beginning with the fourth year of the hospital's residency program, the hospital's cap may be adjusted during each of the first 3 years of the hospital's new residency program, using the actual number of residents in the new programs. The adjustment may not exceed the number of accredited slots available to the hospital for each program year.

(iii) If a hospital with allopathic or osteopathic residents in its most recent cost reporting period ending on or before December 31, 1996, is located in a rural area (or other hospitals located in rural areas that added residents under paragraph (g)(6)(i) of this section), the hospital's unweighted FTE limit may be adjusted in the same manner described in paragraph (g)(6)(ii) of this section to reflect the increase for residents in the new medical residency training programs established after August 5, 1997. * * *

(7) A hospital that began construction of its facility prior to August 5, 1997, and sponsored new medical residency training programs on or after January 1, 1995 and on or before August 5, 1997, that either received initial accreditation by the appropriate accrediting body or temporarily trained residents at another hospital(s) until the facility was completed, may receive an adjustment to its FTE cap.

(i) The newly constructed hospital's FTE cap is equal to the lesser of:

(A) The product of the highest number of residents in any program year during the third year of the newly established program and the number of years in which residents are expected to complete the programs based on the minimum accredited length for each type of program; or

(B) The number of accredited slots available to the hospital for each year of the programs.

(ii) If the new medical residency training programs sponsored by the newly constructed hospital have been in existence for 3 years or more by the time the residents begin training at the newly constructed hospital, the newly constructed hospital's cap will be based on the number of residents training in the third year of the programs begun at the temporary training site.

(iii) If the new medical residency training programs sponsored by the newly constructed hospital have been in existence for less than 3 years by the time the residents begin training at the newly constructed hospital, the newly constructed hospital's cap will be based on the number of residents training at the newly constructed hospital in the third year of the programs (including the years at the temporary training site).

(iv) A hospital that qualifies for an adjustment to its FTE cap under paragraph (g)(7) of this section may be part of an affiliated group for purposes of establishing an aggregate FTE cap.

(v) The provisions of this paragraph (g)(7) are applicable during portions of cost reporting periods occurring on or after October 1, 1999.

(8) A hospital may receive a temporary adjustment to its FTE cap to reflect residents added because of another hospital's closure if the hospital meets the following criteria:

(i) The hospital is training additional residents from a hospital that closed on or after July 1, 1996.

(ii) No later than 60 days after the hospital begins to train the residents, the hospital submits a request to its fiscal intermediary for a temporary adjustment to its FTE cap, documents that the hospital is eligible for this temporary adjustment by identifying the residents who have come from the closed hospital and have caused the hospital to exceed its cap, and specifies the length of time the adjustment is needed.

(iii) For purposes of paragraph (g)(8) of this section, ''closure'' means the hospital terminates its Medicare agreement under the provisions of § 489.52 of this chapter.

* * * * *

PART 483—REQUIREMENTS FOR STATES AND LONG-TERM CARE FACILITIES

C. Part 483 is amended as set forth below:

1. The authority citation for Part 483 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

2. In § 483.20, the introductory text of paragraph (b)(2) is revised to read as follows:

§ 483.20 Resident assessment.

* * * * *

(b) *Comprehensive assessments.* * * *

(2) *When required.* Subject to the timeframes prescribed in § 413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2) (i) through (iii) of this section. The timeframes prescribed in § 413.343(b) of this chapter do not apply to CAHs.

* * * * *

PART 485—CONDITIONS OF PARTICIPATION: SPECIALIZED PROVIDERS

D. Part 485 is amended as follows:

1. The authority citation for Part 485 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

2. Section 485.618 is amended by revising paragraph (d) to read as follows:

§ 485.618 Conditions of participation: Emergency services.

* * * * *

(d) *Standard: Personnel.* There must be a doctor of medicine or osteopathy, a physician assistant, or a nurse practitioner with training or experience in emergency care on call and immediately available by telephone or radio contact, and available on site within the following timeframes:

(1) Within 30 minutes, on a 24-hour a day basis, if the CAH is located in an area other than an area described in paragraph (d)(2) of this section; or

(2) Within 60 minutes, on a 24-hour a day basis, if all of the following requirements are met:

(i) The CAH is located in an area designated as a frontier area (that is, an area with fewer than six residents per square mile based on the latest population data published by the Bureau of the Census) or in an area that meets criteria for a remote location adopted by the State in its rural health care plan, and approved by HCFA, under section 1820(b) of the Act.

(ii) The State has determined under criteria in its rural health care plan that allowing an emergency response time longer than 30 minutes is the only feasible method of providing emergency care to residents of the area served by the CAH.

(iii) The State maintains documentation showing that the response time of up to 60 minutes at a particular CAH it designates is justified because other available alternatives would increase the time needed to stabilize a patient in an emergency.

* * * * *

3. In § 485.645, the introductory text of paragraph (d) is republished and paragraph (d)(6) is revised to read as follows:

§ 485.645 Special requirements for CAH providers of long-term care services (''swing beds'').

* * * * *

(d) *SNF services.* The CAH is substantially in compliance with the following SNF requirements contained in subpart B of part 483 of this chapter:

* * * * *

(6) Comprehensive assessment, comprehensive care plan, and discharge planning (§ 483.20 (b), (d), and (e) of this chapter, except that the CAH is not required to comply with the requirements for frequency, scope and number of assessments prescribed in § 413.343(b)).

* * * * *

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance)

Dated: July 21, 1999.

Michael M. Hash,

Deputy Administrator, Health Care Financing Administration.

Dated: July 22, 1999.

Donna E. Shalala,

Secretary.

Editorial Note: The following addendum and appendixes will not appear in the Code of Federal Regulations.

Addendum—Schedule of Standardized Amounts Effective with Discharges Occurring On or After October 1, 1999; Payment Amounts for Blood Clotting Factor Effective for Discharges Occurring On or After October 1, 1999; and Update Factors and Rate-of-Increase Percentages Effective With Cost Reporting Periods Beginning On or After October 1, 1999

I. Summary and Background

In this addendum, we are setting forth the amounts and factors for determining prospective payment rates for Medicare inpatient operating costs and Medicare inpatient capital-related costs. We are also setting forth rate-of-increase percentages for updating the target amounts for hospitals and hospital units excluded from the prospective payment system.

For discharges occurring on or after October 1, 1999, except for sole community hospitals, Medicare-dependent, small rural hospitals, and hospitals located in Puerto Rico, each hospital's payment per discharge under the prospective payment system will be based on 100 percent of the Federal national rate.

Sole community hospitals are paid based on whichever of the following rates yields the greatest aggregate payment: the Federal national rate, the updated hospital-specific rate based on FY 1982 cost per discharge, or the updated hospital-specific rate based on FY 1987 cost per discharge. Medicare-dependent, small rural hospitals are paid based on the Federal national rate or, if higher, the Federal national rate plus 50 percent of the difference between the Federal national rate and the updated hospital-specific rate based on FY 1982 or FY 1987 cost per discharge, whichever is higher. For hospitals in Puerto Rico, the payment per discharge is based on the sum of 50 percent of a Puerto Rico rate and 50 percent of a national rate.

As discussed below in section II, we are making changes in the determination of the prospective payment rates for Medicare inpatient operating costs for FY 2000. The changes, to be applied prospectively, affect the calculation of the Federal rates. In section III of this addendum, we are updating the payments per unit for blood clotting factor provided to hospital inpatients who have hemophilia. We are also adding another product (clotting factor, porcine (HCPCS code J7191)) to the list of clotting factors that are paid under this benefit.

In section IV of this addendum, we discuss our changes for determining the prospective payment rates for Medicare inpatient capital-related costs for FY 2000. Section V of this addendum sets forth our changes for determining the rate-of-increase limits for hospitals excluded from the prospective payment system for FY 2000. The tables to which we refer in the preamble to this final rule are presented at the end of this addendum in section VI.

II. Changes to Prospective Payment Rates For Inpatient Operating Costs for FY 2000

The basic methodology for determining prospective payment rates for inpatient operating costs is set forth at § 412.63 for hospitals located outside of Puerto Rico. The basic methodology for determining the prospective payment rates for inpatient operating costs for hospitals located in Puerto Rico is set forth at §§ 412.210 and 412.212. Below, we discuss the factors used for determining the prospective payment rates. The Federal and Puerto Rico rate changes, once issued as final, will be effective with discharges occurring on or after October 1, 1999. As required by section 1886(d)(4)(C) of the Act, we must also adjust the DRG classifications and weighting factors for discharges in FY 2000.

In summary, the standardized amounts set forth in Tables 1A and 1C of section VI of this addendum reflect—

- Updates of 1.1 percent for all areas (that is, the market basket percentage increase of 2.9 percent minus 1.8 percentage points);
- An adjustment to ensure budget neutrality as provided for in sections 1886 (d)(4)(C)(iii) and (d)(3)(E) of the Act by applying new budget neutrality adjustment factors to the large urban and other standardized amounts;
- An adjustment to ensure budget neutrality as provided for in section 1886(d)(8)(D) of the Act by removing the FY 1999 budget neutrality factor and applying a revised factor;

- An adjustment to apply the revised outlier offset by removing the FY 1999 outlier offsets and applying a new offset; and
- An adjustment in the Puerto Rico standardized amounts to reflect the application of a Puerto Rico-specific wage index.

A. Calculation of Adjusted Standardized Amounts

1. Standardization of Base-Year Costs or Target Amounts

Section 1886(d)(2)(A) of the Act required the establishment of base-year cost data containing allowable operating costs per discharge of inpatient hospital services for each hospital. The preamble to the September 1, 1983 interim final rule (48 FR 39763) contains a detailed explanation of how base-year cost data were established in the initial development of standardized amounts for the prospective payment system and how they are used in computing the Federal rates.

Section 1886(d)(9)(B)(i) of the Act required us to determine the Medicare target amounts for each hospital located in Puerto Rico for its cost reporting period beginning in FY 1987. The September 1, 1987 final rule contains a detailed explanation of how the target amounts were determined and how they are used in computing the Puerto Rico rates (52 FR 33043, 33066).

The standardized amounts are based on per discharge averages of adjusted hospital costs from a base period or, for Puerto Rico, adjusted target amounts from a base period, updated and otherwise adjusted in accordance with the provisions of section 1886(d) of the Act. Sections 1886(d)(2) (B) and (C) of the Act required us to update base-year per discharge costs for FY 1984 and then standardize the cost data in order to remove the effects of certain sources of variation in cost among hospitals. These effects include case mix, differences in area wage levels, cost-of-living adjustments for Alaska and Hawaii, indirect medical education costs, and payments to hospitals serving a disproportionate share of low-income patients.

Under sections 1886 (d)(2)(H) and (d)(3)(E) of the Act, in making payments under the prospective payment system, the Secretary estimates from time to time the proportion of costs that are wages and wage-related costs. Since October 1, 1997, when the market basket was last revised, we have considered 71.1 percent of costs to be labor-related for purposes of the prospective payment system. The average labor share in Puerto Rico is 71.3 percent. We are revising the discharge-weighted national standardized amount for Puerto Rico to reflect the proportion of discharges in large urban and other areas from the FY 1998 MedPAR file.

2. Computing Large Urban and Other Area Averages

Sections 1886(d) (2)(D) and (3) of the Act require the Secretary to compute two average standardized amounts for discharges occurring in a fiscal year: one for hospitals located in large urban areas and one for hospitals located in other areas. In addition, under sections 1886(d)(9) (B)(iii) and (C)(i) of the Act, the average standardized amount per discharge must be determined for hospitals located in urban and other areas in Puerto Rico. Hospitals in Puerto Rico are paid a blend of 50 percent of the applicable Puerto Rico standardized amount and 50 percent of a national standardized payment amount.

Section 1886(d)(2)(D) of the Act defines ''urban area'' as those areas within a Metropolitan Statistical Area (MSA). A ''large urban area'' is defined as an urban area with a population of more than 1,000,000. In addition, section 4009(i) of Public Law 100–203 provides that a New England County Metropolitan Area (NECMA) with a population of more than 970,000 is classified as a large urban area. As required by section 1886(d)(2)(D) of the Act, population size is determined by the Secretary based on the latest population data published by the Bureau of the Census. Urban areas that do not meet the definition of a ''large urban area'' are referred to as ''other urban areas.'' Areas that are not included in MSAs are considered ''rural areas'' under section 1886(d)(2)(D) of the Act. Payment for discharges from hospitals located in large urban areas will be based on the large urban standardized amount. Payment for discharges from hospitals located in other urban and rural areas will be based on the other standardized amount.

Based on 1997 population estimates published by the Bureau of the Census, 61 areas meet the criteria to be defined as large urban areas for FY 2000. These areas are identified by a footnote in Table 4A. We note that on July 6, 1999, the Office of Management and Budget announced the designation of the Corvallis, Oregon and the Auburn-Opelika, Alabama MSAs. We have incorporated these changes in this final rule.

3. Updating the Average Standardized Amounts

Under section 1886(d)(3)(A) of the Act, we update the area average standardized amounts each year. In accordance with section 1886(d)(3)(A)(iv) of the Act, we are updating the large urban areas' and the other areas' average standardized amounts for FY 2000 using the applicable percentage increases specified in section 1886(b)(3)(B)(i) of the Act. Section 1886(b)(3)(B)(i)(XV) of the Act specifies that, for hospitals in all areas, the update factor for the standardized amounts for FY 2000 is equal to the market basket percentage increase minus 1.8 percentage points.

The percentage change in the market basket reflects the average change in the price of goods and services purchased by hospitals to furnish inpatient care. The most recent forecast of the hospital market basket increase for FY 2000 is 2.9 percent. Thus, for FY 2000, the update to the average standardized amounts equals 1.1 percent.

As in the past, we are adjusting the FY 1999 standardized amounts to remove the effects of the FY 1999 geographic reclassifications and outlier payments before applying the FY 2000 updates. That is, we are increasing the standardized amounts to restore the reductions that were made for the effects of geographic reclassification and outliers. We then apply the new offsets to the standardized amounts for outliers and geographic reclassifications for FY 2000.

Although the update factor for FY 2000 is set by law, we are required by section 1886(e)(3) of the Act to report to the Congress on our final recommendation of update factors for FY 2000 for both prospective payment hospitals and hospitals excluded from the prospective payment system. We have included our final recommendations in Appendix C to this final rule.

4. Other Adjustments to the Average Standardized Amounts

a. Recalibration of DRG Weights and Updated Wage Index—Budget Neutrality Adjustment.

Section 1886(d)(4)(C)(iii) of the Act specifies that beginning in FY 1991, the annual DRG reclassification and recalibration of the relative weights must be made in a manner that ensures that aggregate payments to hospitals are not affected. As discussed in section II of the preamble, we normalized the recalibrated DRG weights by an adjustment factor, so that the average case weight after recalibration is equal

to the average case weight prior to recalibration.

Section 1886(d)(3)(E) of the Act requires us to update the hospital wage index on an annual basis beginning October 1, 1993. This provision also requires us to make any updates or adjustments to the wage index in a manner that ensures that aggregate payments to hospitals are not affected by the change in the wage index.

To comply with the requirement of section 1886(d)(4)(C)(iii) of the Act that DRG reclassification and recalibration of the relative weights be budget neutral, and the requirement in section 1886(d)(3)(E) of the Act that the updated wage index be budget neutral, we used historical discharge data to simulate payments and compared aggregate payments using the FY 1999 relative weights and wage index to aggregate payments using the FY 2000 relative weights and wage index. The same methodology was used for the FY 1999 budget neutrality adjustment. (See the discussion in the September 1, 1992 final rule (57 FR 39832).) Based on this comparison, we computed a budget neutrality adjustment factor equal to 0.997808. We also adjust the Puerto Rico-specific standardized amounts for the effect of DRG reclassification and recalibration. We computed a budget neutrality adjustment factor for Puerto Rico-specific standardized amounts equal to 0.999745. These budget neutrality adjustment factors are applied to the standardized amounts without removing the effects of the FY 1999 budget neutrality adjustments. We do not remove the prior budget neutrality adjustment because estimated aggregate payments after the changes in the DRG relative weights and wage index should equal estimated aggregate payments prior to the changes. If we removed the prior year adjustment, we would not satisfy this condition.

In addition, we will continue to apply these same adjustment factors to the hospital-specific rates that are effective for cost reporting periods beginning on or after October 1, 1999. (See the discussion in the September 4, 1990 final rule (55 FR 36073).)

b. Reclassified Hospitals—Budget Neutrality Adjustment.

Section 1886(d)(8)(B) of the Act provides that certain rural hospitals are deemed urban effective with discharges occurring on or after October 1, 1988. In addition, section 1886(d)(10) of the Act provides for the reclassification of hospitals based on determinations by the Medicare Geographic Classification Review Board (MGCRB). Under section 1886(d)(10) of the Act, a hospital may be reclassified for purposes of the standardized amount or the wage index, or both.

Under section 1886(d)(8)(D) of the Act, the Secretary is required to adjust the standardized amounts so as to ensure that total aggregate payments under the prospective payment system after implementation of the provisions of sections 1886(d)(8)(B) and (C) and 1886(d)(10) of the Act are equal to the aggregate prospective payments that would have been made absent these provisions. To calculate this budget neutrality factor, we used historical discharge data to simulate payments, and compared total prospective payments (including IME and DSH payments) prior to any reclassifications to total prospective payments after reclassifications. In the May 7, 1999 proposed rule, we applied an adjustment factor of 0.994453 to ensure that the effects of reclassification are budget neutral. The final budget neutrality adjustment factor is 0.993799.

The adjustment factor is applied to the standardized amounts after removing the effects of the FY 1999 budget neutrality adjustment factor. We note that the proposed FY 2000 adjustment reflects wage index and standardized amount reclassifications approved by the MGCRB or the Administrator as of February 26, 1999. The effects of any additional reclassification changes resulting from appeals and reviews of the MGCRB decisions for FY 2000 or from a hospital's request for the withdrawal of a reclassification request are reflected in the final budget neutrality adjustment required under section 1886(d)(8)(D) of the Act and published in this final rule.

c. Outliers.

Section 1886(d)(5)(A) of the Act provides for payments in addition to the basic prospective payments for ''outlier'' cases, cases involving extraordinarily high costs (cost outliers). Section 1886(d)(3)(B) of the Act requires the Secretary to adjust both the large urban and other area national standardized amounts by the same factor to account for the estimated proportion of total DRG payments made to outlier cases. Similarly, section 1886(d)(9)(B)(iv) of the Act requires the Secretary to adjust the large urban and other standardized amounts applicable to hospitals in Puerto Rico to account for the estimated proportion of total DRG payments made to outlier cases. Furthermore, under section 1886(d)(5)(A)(iv) of the Act, outlier payments for any year must be projected to be not less than 5 percent nor more than 6 percent of total payments based on DRG prospective payment rates.

i. FY 2000 outlier thresholds. For FY 1999, the fixed loss cost outlier threshold is equal to the prospective payment for the DRG plus $11,100 ($10,129 for hospitals that have not yet entered the prospective payment system for capital-related costs). The marginal cost factor for cost outliers (the percent of costs paid after costs for the case exceed the threshold) is 80 percent. We applied an outlier adjustment to the FY 1999 standardized amounts of 0.948740 for the large urban and other areas rates and 0.9392 for the capital Federal rate.

For FY 2000, we proposed to establish a fixed loss cost outlier threshold equal to the prospective payment rate for the DRG plus the IME and DSH payments plus $14,575 ($13,309 for hospitals that have not yet entered the prospective payment system for capital related costs). In addition, we proposed to maintain the marginal cost factor for cost outliers at 80 percent. In setting the final FY 2000 outlier thresholds, we used updated data. In this final rule, we are establishing a fixed loss cost outlier threshold for FY 2000 equal to the prospective payment rate for the DRG plus the IME and DSH payments plus $14,050 ($12,827 for hospitals that have not yet entered the prospective payment system for capital related costs). In addition, we are maintaining the marginal cost factor for cost outliers at 80 percent. As we have explained in the past, to calculate outlier thresholds we apply a cost inflation factor to update costs for the cases used to simulate payments. For FY 1998, we used a cost inflation factor of minus 2.005 percent (a cost per case decrease of 2.005 percent). For FY 1999, we used a cost inflation factor of minus 1.724 percent. To set the proposed FY 2000 outlier thresholds, we used a cost inflation factor (or cost adjustment factor) of zero percent. We are using a cost inflation factor of zero percent to set the final FY 2000 outlier thresholds. This factor reflects our analysis of the best available cost report data as well as calculations (using the best available data) indicating that the percentage of actual outlier payments for FY 1998 is higher than we projected before the beginning of FY 1998, and that the percentage of actual outlier payments for FY 1999 will likely be higher than we projected before the beginning of FY 1999. The calculations of ''actual'' outlier payments are discussed further below.

ii. Other changes concerning outliers. In accordance with section 1886(d)(5)(A)(iv) of the Act, we calculated outlier thresholds so that outlier payments are projected to equal 5.1 percent of total payments based on DRG prospective payment rates. In

accordance with section 1886(d)(3(E), we reduced the FY 2000 standardized amounts by the same percentage to account for the projected proportion of payments paid to outliers.

As stated in the September 1, 1993 final rule (58 FR 46348), we establish outlier thresholds that are applicable to both inpatient operating costs and inpatient capital-related costs. When we modeled the combined operating and capital outlier payments, we found that using a common set of thresholds resulted in a higher percentage of outlier payments for capital-related costs than for operating costs. We project that the thresholds for FY 2000 will result in outlier payments equal to 5.1 percent of operating DRG payments and 6.0 percent of capital payments based on the Federal rate.

The proposed outlier adjustment factors applied to the standardized amounts for FY 2000 were as follows:

	Operating standard-ized amounts	Capital federal rate
National	0.948934	0.9397
Puerto Rico	0.969184	0.9334

The final outlier adjustment factors applied to the standardized amounts for FY 2000 are as follows:

	Operating standard-ized amounts	Capital federal rate
National	0.948859	0.9402
Puerto Rico	0.968581	0.9331

As in the proposed rule, we apply the outlier adjustment factors after removing the effects of the FY 1999 outlier adjustment factors on the standardized amounts.

Table 8A in section VI of this addendum contains the updated Statewide average operating cost-to-charge ratios for urban hospitals and for rural hospitals to be used in calculating cost outlier payments for those hospitals for which the fiscal intermediary is unable to compute a reasonable hospital-specific cost-to-charge ratio. Effective October 1, 1999, these Statewide average ratios replace the ratios published in the July 31, 1998 final rule (63 FR 41099). Table 8B contains comparable Statewide average capital cost-to-charge ratios. These average ratios would be used to calculate cost outlier payments for those hospitals for which the fiscal intermediary computes operating cost-to-charge ratios lower than 0.209551 OR greater than 1.284349 and capital cost-to-charge ratios lower than 0.01290 or greater than 0.17205. This range represents 3.0 standard deviations (plus or minus) from the mean of the log distribution of cost-to-charge ratios for all hospitals. We note that the cost-to-charge ratios in Tables 8A and 8B will be used during FY 2000 when hospital-specific cost-to-charge ratios based on the latest settled cost report are either not available or outside the three standard deviations range.

iii. FY 1998 and FY 1999 outlier payments. In the July 31, 1998 final rule (63 FR 41009), we stated that, based on available data, we estimated that actual FY 1998 outlier payments would be approximately 5.4 percent of actual total DRG payments. This was computed by simulating payments using actual FY 1997 bill data available at the time. That is, the estimate of actual outlier payments did not reflect FY 1998 bills but instead reflected the application of FY 1998 rates and policies to available FY 1997 bills. Our current estimate, using available FY 1998 bills, is that actual outlier payments for FY 1998 were approximately 6.5 percent of actual total DRG payments. We note that the MedPAR file for FY 1998 discharges continues to be updated. Thus, the data indicate that, for FY 1998, the percentage of actual outlier payments relative to actual total payments is higher than we projected before FY 1998 (and thus exceeds the percentage by which we reduced the standardized amounts for FY 1998). In fact, the data indicate that the proportion of actual outlier payments for FY 1998 exceeds 6 percent. Nevertheless, consistent with the policy and statutory interpretation we have maintained since the inception of the prospective payment system, we do not plan to recoup money and make retroactive adjustments to outlier payments for FY 1998.

We currently estimate that actual outlier payments for FY 1999 will be approximately 6.3 percent of actual total DRG payments, higher than the 5.1 percent we projected in setting outlier policies for FY 1999. This estimate is based on simulations using the March 1999 update of the provider-specific file and the March 1999 update of the FY 1998 MedPAR file (discharge data for FY 1998 bills). We used these data to calculate an estimate of the actual outlier percentage for FY 1999 by applying FY 1999 rates and policies to available FY 1998 bills.

Comment: Several commenters indicated that the proposed 30-percent increase in the cost outlier threshold is too great and implementing that threshold will cause significant revenue losses for hospitals with large numbers of high-cost cases. They observed that the proposed increase in the fixed loss threshold may be reasonable to reach the 5.1 percent level of outlier payments, but suggested an increase in funding for outlier cases from the current level of 5.1 percent to 5.5 percent, or even 6.0 percent, with a corresponding reduction in the fixed loss threshold.

Response: Outlier payments are meant to protect hospitals against the financial effects of treating extraordinarily high-cost cases. Increasing the level of outlier payments to 5.5 percent would result in a corresponding offset to the standardized amounts, proportionally reducing payments for typical cases. We believe that it is in the best interest of hospitals and the program to maintain the level of outliers at 5.1 percent, thereby providing all hospitals with somewhat larger rates for typical cases.

We also note that we estimate that actual outlier payments for FY 1998 were equal to 6.5 percent of actual total DRG payments, and 6.3 percent for FY 1999. We believe that outlier payments are greater than expected for these years in part because actual hospital costs may be higher than reflected in the methodology used to set outlier thresholds for those years. While we are attempting to improve our estimate of payments for FY 2000 by using a cost inflation factor of zero percent rather than a negative inflation factor, we believe it would be imprudent to raise the estimated level of outlier payments at a time when actual outlier payments have exceeded our estimates by more than one percentage point for the past 2 years.

Comment: One commenter expressed concern that, in the proposed rule, we referenced our longstanding policy regarding overpayments and underpayments and retroactive adjustments to outlier payments. The commenter stated that this reference appears to be necessitated by a large number of hospital appeals and questioned whether we intend to provide a clarification instead of what appears to be a new interpretation.

Response: As we stated in the proposed rule, our statement that ''we do not plan to recoup money and make retroactive adjustments to outlier payments for FY 1998,'' because the actual outlier payments exceed 6 percent of total payments, is consistent with the policy and statutory interpretation we have maintained since the inception of the prospective payment system. We have publicly stated our policy on several occasions. For example, in the January 3, 1984 final rule (49 FR 234, 265), we stated:

''Using data we had available, we set the outlier criteria so that an estimated 6 percent of total payments would be made for outliers. Nevertheless, there is no necessary connection between the amount of estimated outlier payments and the actual payments made to hospitals for cases that actually meet the outlier criteria. While we expect that under these criteria, outlier payments will approximate 6 percent of total payments, we will pay for any outlier that meets the criteria, even if aggregate outlier payments result in more than 6 percent of total payments.'' Also, in the September 1, 1992 final rule (57 FR 39784), we stated that ''* * * in light of the nature of the prospective payment system, and our attempts to estimate outlier payments as accurately as possible, we believe that we have satisfied the statute and that no retroactive adjustment is warranted.'' In the same rule, we also stated that ''* * * retroactive adjustment of system wide elements would be contrary to the nature of the prospective payment system.'' Therefore, our comment in the proposed rule concerning the overpayment or underpayment of outliers was a restatement of our longstanding policy.

5. FY 2000 Standardized Amounts

The adjusted standardized amounts are divided into labor and nonlabor portions. Table 1A contains the two national standardized amounts that are applicable to all hospitals, except for hospitals in Puerto Rico. Under section 1886(d)(9)(A)(ii) of the Act, the Federal portion of the Puerto Rico payment rate is based on the discharge-weighted average of the national large urban standardized amount and the national other standardized amount (as set forth in Table 1A). The labor and nonlabor portions of the national average standardized amounts for Puerto Rico hospitals are set forth in Table 1C. This table also includes the Puerto Rico standardized amounts.

B. Adjustments for Area Wage Levels and Cost of Living

Tables 1A and 1C, as set forth in this addendum, contain the labor-related and nonlabor-related shares used to calculate the prospective payment rates for hospitals located in the 50 States, the District of Columbia, and Puerto Rico. This section addresses two types of adjustments to the standardized amounts that are made in determining the prospective payment rates as described in this addendum.

1. Adjustment for Area Wage Levels

Sections 1886(d)(3)(E) and 1886(d)(9)(C)(iv) of the Act requires that we make an adjustment to the labor-related portion of the prospective payment rates to account for area differences in hospital wage levels. This adjustment is made by multiplying the labor-related portion of the adjusted standardized amounts by the appropriate wage index for the area in which the hospital is located. In section III of this preamble, we discuss the data and methodology for the FY 2000 wage index. The wage index is set forth in Tables 4A through 4F of this addendum.

2. Adjustment for Cost of Living in Alaska and Hawaii

Section 1886(d)(5)(H) of the Act authorizes an adjustment to take into account the unique circumstances of hospitals in Alaska and Hawaii. Higher labor-related costs for these two States are taken into account in the adjustment for area wages described above. For FY 2000, we are adjusting the payments for hospitals in Alaska and Hawaii by multiplying the nonlabor portion of the standardized amounts by the appropriate adjustment factor contained in the table below.

TABLE OF COST-OF-LIVING ADJUSTMENT FACTORS, ALASKA AND HAWAII HOSPITALS

Alaska—All areas	1.25
Hawaii:	
County of Honolulu	1.25
County of Hawaii	1.15
County of Kauai	1.225
County of Maui	1.225
County of Kalawao	1.225

(The above factors are based on data obtained from the U.S. Office of Personnel Management.)

C. DRG Relative Weights

As discussed in section II of the preamble, we have developed a classification system for all hospital discharges, assigning them into DRGs, and have developed relative weights for each DRG that reflect the resource utilization of cases in each DRG relative to Medicare cases in other DRGs. Table 5 of section VI of this addendum contains the relative weights that we will use for discharges occurring in FY 2000. These factors have been recalibrated as explained in section II of the preamble.

D. Calculation of Prospective Payment Rates for FY 2000

General Formula for Calculation of Prospective Payment Rates for FY 2000

Prospective payment rate for all hospitals located outside of Puerto Rico except sole community hospitals and Medicare-dependent, small rural hospitals = Federal rate.

Prospective payment rate for sole community hospitals = Whichever of the following rates yields the greatest aggregate payment: 100 percent of the Federal rate, 100 percent of the updated FY 1982 hospital-specific rate, or 100 percent of the updated FY 1987 hospital-specific rate.

Prospective payment rate for Medicare-dependent, small rural hospitals = 100 percent of the Federal rate, or, if the greater of the updated FY 1982 hospital-specific rate or the updated FY 1987 hospital-specific rate is higher than the Federal rate, 100 percent of the Federal rate plus 50 percent of the difference between the applicable hospital-specific rate and the Federal rate.

Prospective payment rate for Puerto Rico = 50 percent of the Puerto Rico rate + 50 percent of a discharge-weighted average of the national large urban standardized amount and the national other standardized amount.

1. Federal Rate

For discharges occurring on or after October 1, 1999 and before October 1, 2000, except for sole community hospitals, Medicare-dependent, small rural hospitals, and hospitals in Puerto Rico, the hospital's payment is based exclusively on the Federal national rate.

The payment amount is determined as follows:

Step 1—Select the appropriate national standardized amount considering the type of hospital and designation of the hospital as large urban or other (see Table 1A in section VI of this addendum).

Step 2—Multiply the labor-related portion of the standardized amount by the applicable wage index for the geographic area in which the hospital is located (see Tables 4A, 4B, and 4C of section VI of this addendum).

Step 3—For hospitals in Alaska and Hawaii, multiply the nonlabor-related portion of the standardized amount by the appropriate cost-of-living adjustment factor.

Step 4—Add the amount from Step 2 and the nonlabor-related portion of the standardized amount (adjusted, if appropriate, under Step 3).

Step 5—Multiply the final amount from Step 4 by the relative weight

corresponding to the appropriate DRG (see Table 5 of section VI of this addendum).

2. Hospital-Specific Rate (Applicable Only to Sole Community Hospitals and Medicare-Dependent, Small Rural Hospitals)

Sections 1886(d)(5)(D)(i) and (b)(3)(C) of the Act provide that sole community hospitals are paid based on whichever of the following rates yields the greatest aggregate payment: the Federal rate, the updated hospital-specific rate based on FY 1982 cost per discharge, or the updated hospital-specific rate based on FY 1987 cost per discharge.

Sections 1886(d)(5)(G) and (b)(3)(D) of the Act provide that Medicare-dependent, small rural hospitals are paid based on whichever of the following rates yields the greatest aggregate payment: the Federal rate or the Federal rate plus 50 percent of the difference between the Federal rate and the greater of the updated hospital-specific rate based on FY 1982 and FY 1987 cost per discharge.

Hospital-specific rates have been determined for each of these hospitals based on both the FY 1982 cost per discharge and the FY 1987 cost per discharge. For a more detailed discussion of the calculation of the FY 1982 hospital-specific rate and the FY 1987 hospital-specific rate, we refer the reader to the September 1, 1983 interim final rule (48 FR 39772); the April 20, 1990 final rule with comment (55 FR 15150); and the September 4, 1990 final rule (55 FR 35994).

a. Updating the FY 1982 and FY 1987 Hospital-Specific Rates for FY 2000.

We are increasing the hospital-specific rates by 1.1 percent (the hospital market basket percentage increase of 2.9 percent minus 1.8 percentage points) for sole community hospitals and Medicare-dependent, small rural hospitals located in all areas for FY 2000. Section 1886(b)(3)(C)(iv) of the Act provides that the update factor applicable to the hospital-specific rates for sole community hospitals equals the update factor provided under section 1886(b)(3)(B)(iv) of the Act, which, for FY 2000, is the market basket rate of increase minus 1.8 percentage points. Section 1886(b)(3)(D) of the Act provides that the update factor applicable to the hospital-specific rates for Medicare-dependent, small rural hospitals equals the update factor provided under section 1886(b)(3)(B)(iv) of the Act, which, for FY 2000, is the market basket rate of increase minus 1.8 percentage points.

b. Calculation of Hospital-Specific Rate.

For sole community hospitals and Medicare-dependent, small rural hospitals, the applicable FY 2000 hospital-specific rate is calculated by increasing the hospital's hospital-specific rate for the preceding fiscal year by the applicable update factor (1.1 percent), which is the same as the update for all prospective payment hospitals. In addition, the hospital-specific rate is adjusted by the budget neutrality adjustment factor (that is, 0.997808) as discussed in section II.A.4.a of this Addendum. The resulting rate is used in determining under which rate a sole community hospital or Medicare-dependent, small rural hospital is paid for its discharges beginning on or after October 1, 1999, based on the formula set forth above.

3. General Formula for Calculation of Prospective Payment Rates for Hospitals Located in Puerto Rico Beginning On or After October 1, 1999 and Before October 1, 2000

a. Puerto Rico Rate. The Puerto Rico prospective payment rate is determined as follows:

Step 1—Select the appropriate adjusted average standardized amount considering the large urban or other designation of the hospital (see Table 1C of section VI of the addendum).

Step 2—Multiply the labor-related portion of the standardized amount by the appropriate Puerto Rico-specific wage index (see Table 4F of section VI of the addendum).

Step 3—Add the amount from Step 2 and the nonlabor-related portion of the standardized amount.

Step 4—Multiply the result in Step 3 by 50 percent.

Step 5—Multiply the amount from Step 4 by the appropriate DRG relative weight (see Table 5 of section VI of the addendum).

b. National Rate. The national prospective payment rate is determined as follows:

Step 1—Multiply the labor-related portion of the national average standardized amount (see Table 1C of section VI of the addendum) by the appropriate national wage index (see Tables 4A and 4B of section VI of the addendum).

Step 2—Add the amount from Step 1 and the nonlabor-related portion of the national average standardized amount.

Step 3—Multiply the result in Step 2 by 50 percent.

Step 4—Multiply the amount from Step 3 by the appropriate DRG relative weight (see Table 5 of section VI of the addendum).

The sum of the Puerto Rico rate and the national rate computed above equals the prospective payment for a given discharge for a hospital located in Puerto Rico.

Comment: One commenter asked if the temporary relief payment provision of the Balanced Budget Act of 1997 (BBA) would continue into FY 2000. The commenter suggested that, in light of reports that implementation of the hospital-related provisions of the BBA provided larger than expected savings, we consider extending the provision into next year and increasing the amount of relief.

Response: Under section 4401(b) of the BBA, the temporary special payment for certain hospitals that did not receive IME or DSH payments and that did not qualify as Medicare-dependent, small rural hospitals is limited to FY 1998 and FY 1999. The statute does not provide for the special payment in later fiscal years. We believe that the temporary special payment provided under section 4401(b) of the BBA was meant to partially protect qualifying hospitals from the initial effects of the reduced updates to hospital payment rates enacted by the BBA. We believe that two years of relief payments is adequate to allow hospitals to adjust to the reduced payment updates under the BBA.

III. Changes to the Payment Rates for Blood Clotting Factor for Hemophilia Inpatients

As discussed in our May 7, 1999 proposed rule (64 FR 24756), section 4452 of the BBA amended section 6011(d) of Public Law 101–239 to reinstate the add-on payment for the costs of administering blood clotting factor to Medicare beneficiaries who have hemophilia and who are hospital inpatients for discharges occurring on or after October 1, 1997. The add-on payment amount for each clotting factor, as described in HCFA's Common Procedure Coding System (HCPCS), is based on the median average wholesale price (AWP) of the several products available in that category of factor, discounted by 15 percent.

Also, we are adding HCPCS code J7191 (clotting factor, porcine) to the list of clotting factors that will be paid under this benefit. This code was recently reestablished in the HCPCS coding system because it represents a unique product that is different from the other clotting factors listed.

Based on the methodology described above, the prices per unit of factor for FY 2000 are as follows:

J7190 Factor VIII (antihemophilic factor, human) 0.79

J7191 Factor VIII (antihemophilic factor, porcine)	1.87
J7192 Factor VIII (antihemophilic factor, recombinant)	1.03
J7194 Factor IX (complex)	0.45
J7196 Other hemophilia clotting factors (for example, anti-inhibitors)	1.43
Q0160 Factor IX (antihemophilic factor, purified, nonrecombinant)	0.97
Q0161 Factor IX (antihemophilic factor, recombinant)	1.00

These prices for blood clotting factor administered to inpatients who have hemophilia will be effective for discharges beginning on or after October 1, 1999 through September 30, 2000. Payment will be made for the blood clotting factor only if there is an ICD–9–CM diagnosis code for hemophilia included on the bill.

We received one comment on this proposed provision.

Comment: One commenter indicated that there is a new clotting factor product, recombinant coagulation Factor VIIa, that is covered by this benefit, but was not mentioned in the proposed rule. Because this product is unique and packaged and dosed per microgram, and not per IU as the other clotting factor products listed in the HCPCS, the commenter requested a separate temporary code and price to be added to the final rule.

Response: We agree that recombinant coagulation Factor VIIa is covered by this benefit. We also agree that no appropriate HCPCS code exists for this product. Because of constraints on Year 2000 computer systems changes, we are not able to establish a new HCPCS code or a claims process to pay for this product at this time. Therefore, any providers furnishing recombinant coagulation Factor VIIa to hospital inpatients who have hemophilia should hold their billings for Factor VIIa until we announce by instructions to our fiscal intermediaries that a new code and claims process have been established. These hospitals should continue to submit claims for all other covered items and services furnished to these Medicare beneficiaries in accordance with established program procedures. The price for recombinant coagulation Factor VIIa for FY 2000 will be $1.19 per microgram.

IV. Changes to Payment Rates for Inpatient Capital-Related Costs for FY 2000

The prospective payment system for hospital inpatient capital-related costs was implemented for cost reporting periods beginning on or after October 1, 1991. Effective with that cost reporting period and during a 10-year transition period extending through FY 2001, hospital inpatient capital-related costs are paid on the basis of an increasing proportion of the capital prospective payment system Federal rate and a decreasing proportion of a hospital's historical costs for capital.

The basic methodology for determining Federal capital prospective rates is set forth at §§ 412.308 through 412.352. Below we discuss the factors that we used to determine the Federal rate and the hospital-specific rates for FY 2000. The rates would be effective for discharges occurring on or after October 1, 1999.

For FY 1992, we computed the standard Federal payment rate for capital-related costs under the prospective payment system by updating the FY 1989 Medicare inpatient capital cost per case by an actuarial estimate of the increase in Medicare inpatient capital costs per case. Each year after FY 1992, we update the standard Federal rate, as provided in § 412.308(c)(1), to account for capital input price increases and other factors. Also, § 412.308(c)(2) provides that the Federal rate is adjusted annually by a factor equal to the estimated proportion of outlier payments under the Federal rate to total capital payments under the Federal rate. In addition, § 412.308(c)(3) requires that the Federal rate be reduced by an adjustment factor equal to the estimated proportion of payments for exceptions under § 412.348. Furthermore, § 412.308(c)(4)(ii) requires that the Federal rate be adjusted so that the annual DRG reclassification and the recalibration of DRG weights and changes in the geographic adjustment factor are budget neutral. For FYs 1992 through 1995, § 412.352 required that the Federal rate also be adjusted by a budget neutrality factor so that aggregate payments for inpatient hospital capital costs were projected to equal 90 percent of the payments that would have been made for capital-related costs on a reasonable cost basis during the fiscal year. That provision expired in FY 1996. Section 412.308(b)(2) describes the 7.4 percent reduction to the rate that was made in FY 1994, and § 412.308(b)(3) describes the 0.28 percent reduction to the rate made in FY 1996 as a result of the revised policy of paying for transfers. In the FY 1998 final rule with comment period (62 FR 45966), we implemented section 4402 of the BBA, which requires that for discharges occurring on or after October 1, 1997, and before October 1, 2002, the unadjusted standard Federal rate is reduced by 17.78 percent. A small part of that reduction will be restored effective October 1, 2002. As a result of the February 25, 1999 final rule (64 FR 9378), the Federal rate changed effective March 1, 1999, because of revisions to the GAF.

For each hospital, the hospital-specific rate was calculated by dividing the hospital's Medicare inpatient capital-related costs for a specified base year by its Medicare discharges (adjusted for transfers), and dividing the result by the hospital's case-mix index (also adjusted for transfers). The resulting case-mix adjusted average cost per discharge was then updated to FY 1992 based on the national average increase in Medicare's inpatient capital cost per discharge and adjusted by the exceptions payment adjustment factor and the budget neutrality adjustment factor to yield the FY 1992 hospital-specific rate. Since FY 1992, the hospital-specific rate has been updated annually for inflation and for changes in the exceptions payment adjustment factor. For FYs 1992 through 1995, the hospital-specific rate was also adjusted by a budget neutrality adjustment factor. For discharges occurring on or after October 1, 1997, and before October 1, 2002, the unadjusted hospital-specific rate is reduced by 17.78 percent. A small part of this reduction will be restored effective October 1, 2002.

To determine the appropriate budget neutrality adjustment factor and the exceptions payment adjustment factor, we developed a dynamic model of Medicare inpatient capital-related costs, that is, a model that projects changes in Medicare inpatient capital-related costs over time. With the expiration of the budget neutrality provision, the model is still used to estimate the exceptions payment adjustment and other factors. The model and its application are described in greater detail in Appendix B of this final rule.

In accordance with section 1886(d)(9)(A) of the Act, under the prospective payment system for inpatient operating costs, hospitals located in Puerto Rico are paid for operating costs under a special payment formula. Prior to FY 1998, hospitals in Puerto Rico were paid a blended rate that consisted of 75 percent of the applicable standardized amount specific to Puerto Rico hospitals and 25 percent of the applicable national average standardized amount. However, effective October 1, 1998, as a result of enactment of section 4406 of the BBA, operating payments to hospitals in Puerto Rico are based on a blend of 50 percent of the applicable standardized amount specific to Puerto Rico hospitals and 50 percent of the applicable national average standardized amount. In conjunction with this change to the

operating blend percentage, effective with discharges on or after October 1, 1997, we compute capital payments to hospitals in Puerto Rico based on a blend of 50 percent of the Puerto Rico rate and 50 percent of the Federal rate. Section 412.374 provides for the use of this blended payment system for payments to Puerto Rico hospitals under the prospective payment system for inpatient capital-related costs. Accordingly, for capital-related costs we compute a separate payment rate specific to Puerto Rico hospitals using the same methodology used to compute the national Federal rate for capital.

A. Determination of Federal Inpatient Capital-Related Prospective Payment Rate Update

In the July 31, 1998 final rule (63 FR 41011), we established a capital Federal rate of $378.05 for FY 1999. As of the March 1, 1999 revision, the Federal rate for FY 1999 is $378.10. In the proposed rule, we stated that the proposed FY 2000 Federal rate was $374.31. In this final rule, we are establishing a FY 2000 Federal rate of $377.03.

In the discussion that follows, we explain the factors that were used to determine the FY 2000 capital Federal rate. In particular, we explain why the FY 2000 Federal rate has decreased 0.28 percent compared to the FY 1999 Federal rate. Even though the FY 2000 Federal capital rate is less than the FY 1999 Federal rate, we estimate aggregate capital payments will increase by 3.64 percent during this same period. This increase is primarily due to the increase in the Federal blend percentage from 80 to 90 percent for fully prospective payment hospitals.

Total payments to hospitals under the prospective payment system are relatively unaffected by changes in the capital prospective payments. Since capital payments constitute about 10 percent of hospital payments, a 1 percent change in the capital Federal rate yields only about 0.1 percent change in actual payments to hospitals. Aggregate payments under the capital prospective payment transition system are estimated to increase in FY 2000 compared to FY 1999.

1. Standard Federal Rate Update

a. Description of the Update Framework.

Under section 412.308(c)(1), the standard Federal rate is updated on the basis of an analytical framework that takes into account changes in a capital input price index and other factors. The update framework consists of a capital input price index (CIPI) and several policy adjustment factors. Specifically, we have adjusted the projected CIPI rate of increase as appropriate each year for case-mix index related changes, for intensity, and for errors in previous CIPI forecasts. The proposed rule reflected an update factor of −0.6 percent, based on the data available at that time. Under the update framework, the final update factor for FY 2000 is 0.3 percent. This update factor is based on a projected 0.6 percent increase in the CIPI, a 0.1 percent adjustment for the FY 1998 DRG reclassification and recalibration, and a forecast error correction of −0.4 percent. We explain the basis for the FY 2000 CIPI projection in section II.D of this addendum.

Below we describe the policy adjustments that have been applied to the FY 2000 capital payment rates update.

The case-mix index is the measure of the average DRG weight for cases paid under the prospective payment system. Because the DRG weight determines the prospective payment for each case, any percentage increase in the case-mix index corresponds to an equal percentage increase in hospital payments.

The case-mix index can change for any of several reasons:

- The average resource use of Medicare patients changes (''real'' case-mix change).
- Changes in hospital coding of patient records result in higher weight DRG assignments (''coding effects'').
- The annual DRG reclassification and recalibration changes may not be budget neutral (''reclassification effect'').

We define real case-mix change as actual changes in the mix (and resource requirements) of Medicare patients as opposed to changes in coding behavior that result in assignment of cases to higher-weighted DRGs but do not reflect higher resource requirements. In the update framework for the prospective payment system for operating costs, we adjust the update upwards to allow for real case-mix change, but remove the effects of coding changes on the case-mix index. We also remove the effect on total payments of prior changes to the DRG classifications and relative weights, in order to retain budget neutrality for all case-mix index-related changes other than patient severity. (For example, we adjusted for the effects of the FY 1998 DRG reclassification and recalibration as part of our FY 2000 update recommendation.) We have adopted this case-mix index adjustment in the capital update framework as well.

For FY 2000, we are projecting a 0.5 percent increase in the case-mix index. We estimate that real case-mix increase will equal 0.5 percent in FY 2000. Therefore, the net adjustment for case-mix change in FY 2000 is 0.0 percentage points.

We estimate that FY 1998 DRG reclassification and recalibration resulted in a −0.1 percent change in the case mix when compared with the case-mix index that would have resulted if we had not made the reclassification and recalibration changes to the DRGs. In the framework, we make an adjustment for DRG reclassification and recalibration to account for the 2-year lag on the available data used to estimate the effect of DRG changes. A DRG reclassification and recalibration adjustment of 0.1 percentage points was calculated for the FY 2000 update as the percent change in the case mix when compared with the case-mix index that would have resulted if we had not made the reclassification and recalibration changes to the DRGs based on FY 1998 data. That is, in determining the effect of DRG reclassification and recalibration using FY 1998 data, the actual effect of DRG reclassification and recalibration was understated by −0.1 percent. Therefore, we are making a 0.1 percent adjustment for DRG reclassification and recalibration in the update for FY 2000.

Comment: One commenter noted that the magnitude of the −0.7 adjustment for FY 1998 Reclassification and Recalibration (GROUPER Effect) in the proposed capital (and operating) update framework appears to be inconsistent with past numbers published by HCFA. Accordingly, the commenter requested that HCFA review the data and computation of that adjustment in the capital update framework.

Response: In the May 7, 1999 proposed rule (64 FR 24578), we estimated that FY 1998 DRG reclassification and recalibration resulted in a 0.7 percent change in the case-mix index when compared with the case-mix index that would have resulted if we had not made the reclassification and recalibration changes to the DRGs. Therefore, we proposed making a −0.7 percent adjustment for DRG reclassification and recalibration in the proposed capital update recommendation for FY 2000.

Upon review, we have discovered that incorrect data were used in estimating the proposed −0.7 adjustment for the effect of FY 1998 reclassification and recalibration. We have recalculated the adjustment based on correct and updated data and the revised adjustment for the effect of FY 1998 reclassification and recalibration for the FY 2000 capital update is +0.1.

The capital update framework contains an adjustment for forecast

error. The input price index forecast is based on historical trends and relationships ascertainable at the time the update factor is established for the upcoming year. In any given year, there may be unanticipated price fluctuations that may result in differences between the actual increase in prices and the forecast used in calculating the update factors. In setting a prospective payment rate under the framework, we make an adjustment for forecast error only if our estimate of the change in the capital input price index for any year is incorrect by 0.25 percentage points or more. There is a 2-year lag between the forecast and the measurement of the forecast error. A forecast error of −0.4 percentage points was calculated for the FY 1998 update. That is, current historical data indicate that the FY 1998 CIPI used in calculating the forecasted FY 1998 update factor overstated realized price increases by 0.4 percent. Therefore, we are making a −0.4 percent adjustment for forecast error in the update for FY 2000.

Under the capital prospective payment system update framework, we also make an adjustment for changes in intensity. We calculate this adjustment using the same methodology and data as in the framework for the operating prospective payment system. The intensity factor for the operating update framework reflects how hospital services are utilized to produce the final product, that is, the discharge. This component accounts for changes in the use of quality-enhancing services, changes in within-DRG severity, and expected modification of practice patterns to remove cost-ineffective services.

We calculate case-mix constant intensity as the change in total charges per admission, adjusted for price level changes (the CPI hospital component), and changes in real case mix. The use of total charges in the calculation of the intensity factor makes it a total intensity factor; that is, charges for capital services are already built into the calculation of the factor. Therefore, we have incorporated the intensity adjustment from the operating update framework into the capital update framework. Without reliable estimates of the proportions of the overall annual intensity increases that are due, respectively, to ineffective practice patterns and to the combination of quality-enhancing new technologies and within-DRG complexity, we assume, as in the revised operating update framework, that one-half of the annual increase is due to each of these factors. The capital update framework thus provides an add-on to the input price index rate of increase of one-half of the estimated annual increase in intensity to allow for within-DRG severity increases and the adoption of quality-enhancing technology.

For FY 2000, we have developed a Medicare-specific intensity measure based on a 5-year average using FY 1994 through FY 1998 data. In determining case-mix constant intensity, we found that observed case-mix increase was 0.8 percent in FY 1994, 1.7 percent in FY 1995, 1.6 percent in FY 1996, 0.3 percent in FY 1997, and −0.4 percent in FY 1998. For FY 1995 and FY 1996, we estimate that real case-mix increase was 1.0 to 1.4 percent each year. The estimate for those years is supported by past studies of case-mix change by the RAND Corporation. The most recent study was ''Has DRG Creep Crept Up? Decomposing the Case Mix Index Change Between 1987 and 1988'' by G.M. Carter, J.P. Newhouse, and D.A. Relles, R–4098–HCFA/ProPAC (1991). The study suggested that real case-mix change was not dependent on total change, but was usually a fairly steady 1.0 to 1.5 percent per year. We use 1.4 percent as the upper bound because the RAND study did not take into account that hospitals may have induced doctors to document medical records more completely in order to improve payment. Following that study, we consider up to 1.4 percent of observed case-mix change as real for FY 1994 through FY 1998. Based on this analysis, we believe that all of the observed case-mix increase for FY 1994, FY 1997, and FY 1998 is real. The increases for FY 1995 and FY 1996 were in excess of our estimate of real case-mix increase.

We calculate case-mix constant intensity as the change in total charges per admission, adjusted for price level changes (the CPI hospital component), and changes in real case-mix. Given estimates of real case mix of 0.8 percent for FY 1994, 1.0 percent for FY 1995, 1.0 percent for FY 1996, 0.3 percent for FY 1997, and −0.4 for FY 1998, we estimate that case-mix constant intensity declined by an average 1.3 percent during FYs 1994 through 1998, for a cumulative decrease of 6.3 percent. If we assume that real case-mix increase was 0.8 percent for FY 1994, 1.4 percent for FY 1995, 1.4 percent for FY 1996, 0.3 percent for FY 1997, and −0.4 for FY 1998, we estimate that case-mix constant intensity declined by an average 1.5 percent during FYs 1994 through 1998, for a cumulative decrease of 7.1 percent. Since we estimate that intensity has declined during that period, we are making a 0.0 percent intensity adjustment for FY 2000.

In summary, the FY 2000 final capital update under our framework is 0.3 percent. This update is based on a projected 0.6 increase in the CIPI, policy adjustment factors of 0.0, a 0.1 adjustment for the effect of FY 1998 reclassification and recalibration, and a forecast error correction of −0.4.

b. Comparison of HCFA and MedPAC Update Recommendations.

As discussed in the proposed rule, MedPAC recommended a −1.1 to 1.8 percent update to the standard capital Federal rate and we recommended a −0.6 percent update. (See the May 7, 1999 proposed rule for the differences between the MedPAC and HCFA update frameworks (64 FR 24758)). In this final rule, as discussed in the previous section, we are implementing a 0.3 percent update to the capital Federal rate.

Comment: MedPAC noted that our update recommendation of −0.6 percent was within the range of the −1.1 to 1.8 percent that they recommended. They also asserted that the distinction between inpatient operating and capital payment rates is arbitrary and does not foster efficient overall decision making about the allocation of resources. Accordingly, MedPAC recommended that once the transition to fully prospective capital payment is completed, a single prospective payment rate should be developed for hospital inpatient services to Medicare beneficiaries. MedPAC indicated that a single prospective payment rate for both operating and capital costs would be consistent with the way that hospitals purchase a majority of goods and services. MedPAC plans to investigate options for coordinating the capital and operating updates and would be pleased to work with HCFA on this effort.

Response: We responded to a similar comment in the May 7, 1999 proposed rule (64 FR 24759), the July 31, 1998 final rule (63 FR 41013), and in the September 1, 1995 final rule (60 FR 45816). In those rules, we stated that our long-term goal was to develop a single update framework for operating and capital prospective payments and that we would begin development of a unified framework. We indicated that, in the meantime, we would maintain as much consistency as possible between the current operating and capital frameworks in order to facilitate the eventual development of a unified framework. In addition, we stated that because of the similarity of the update frameworks, the update frameworks could be combined without too much difficulty. We maintain our goal of combining the update frameworks and

may examine combining the payment systems after the conclusion of the capital prospective payment transition period. While we welcome MedPAC's assistance in the eventual development of a unified operating and capital update framework, we believe that developing a unified operating and capital update framework would become a higher priority if the actual operating update was no longer determined by Congress through the statute and the unified update would be appropriately applied directly to a combined payment rate for operating and capital costs.

2. Outlier Payment Adjustment Factor

Section 412.312(c) establishes a unified outlier methodology for inpatient operating and inpatient capital-related costs. A single set of thresholds is used to identify outlier cases for both inpatient operating and inpatient capital-related payments. Outlier payments are made only on the portion of the Federal rate that is used to calculate the hospital's inpatient capital-related payments (for example, 90 percent for cost reporting periods beginning in FY 2000 for hospitals paid under the fully prospective payment methodology). Section 412.308(c)(2) provides that the standard Federal rate for inpatient capital-related costs be reduced by an adjustment factor equal to the estimated proportion of outlier payments under the Federal rate to total inpatient capital-related payments under the Federal rate. The outlier thresholds are set so that operating outlier payments are projected to be 5.1 percent of total operating DRG payments. The inpatient capital-related outlier reduction factor reflects the inpatient capital-related outlier payments that would be made if all hospitals were paid 100 percent of the Federal rate. For purposes of calculating the outlier thresholds and the outlier reduction factor, we model payments as if all hospitals were paid 100 percent of the Federal rate because, as explained above, outlier payments are made only on the portion of the Federal rate that is included in the hospital's inpatient capital-related payments.

In the July 31, 1998 final rule, we estimated that outlier payments for capital in FY 1999 would equal 6.08 percent of inpatient capital-related payments based on the Federal rate (63 FR 41013). Accordingly, we applied an outlier adjustment factor of 0.9392 to the Federal rate. For FY 2000, we estimate that outlier payments for capital will equal 5.98 percent of inpatient capital-related payments based on the Federal rate. Therefore, we are establishing an outlier adjustment factor of 0.9402 to the Federal rate. Thus, estimated capital outlier payments for FY 2000 represent a lower percentage of total capital standard payments than in FY 1999.

The outlier reduction factors are not built permanently into the rates; that is, they are not applied cumulatively in determining the Federal rate. Therefore, the net change in the outlier adjustment to the Federal rate for FY 2000 is 1.0011 (0.9402/0.9392). The outlier adjustment increases the FY 2000 Federal rate by 0.11 percent compared with the FY 1999 outlier adjustment.

3. Budget Neutrality Adjustment Factor for Changes in DRG Classifications and Weights and the Geographic Adjustment Factor

Section 412.308(c)(4)(ii) requires that the Federal rate be adjusted so that aggregate payments for the fiscal year based on the Federal rate after any changes resulting from the annual DRG reclassification and recalibration and changes in the GAF are projected to equal aggregate payments that would have been made on the basis of the Federal rate without such changes. We use the actuarial model, described in Appendix B, to estimate the aggregate payments that would have been made on the basis of the Federal rate without changes in the DRG classifications and weights and in the GAF. We also use the model to estimate aggregate payments that would be made on the basis of the Federal rate as a result of those changes. We then use these figures to compute the adjustment required to maintain budget neutrality for changes in DRG weights and in the GAF.

For FY 1999, we calculated a GAF/DRG budget neutrality factor of 1.0027. In the February 25, 1999 final rule (64 FR 9381), we adopted an incremental GAF/DRG budget neutrality factor of 1.0028 for discharges on or after March 1, 1999. In the proposed rule for FY 2000, we proposed a GAF/DRG budget neutrality factor of 0.9986. In this final rule, based on calculations using updated data, we are applying a factor of 0.9985. The GAF/DRG budget neutrality factors are built permanently into the rates; that is, they are applied cumulatively in determining the Federal rate. This follows from the requirement that estimated aggregate payments each year be no more than they would have been in the absence of the annual DRG reclassification and recalibration and changes in the GAF. The incremental change in the adjustment from FY 1999 to FY 2000 is 0.9985. The cumulative change in the rate due to this adjustment is 1.0014 (the product of the incremental factors for FY 1993, FY 1994, FY 1995, FY 1996, FY 1997, FY 1998, FY 1999, and FY 2000: $0.9980 \times 1.0053 \times 0.9998 \times 0.9994 \times 0.9987 \times 0.9989 \times 1.0028 \times 0.9985 = 1.0014$).

This factor accounts for DRG reclassifications and recalibration and for changes in the GAF. It also incorporates the effects on the GAF of FY 2000 geographic reclassification decisions made by the MGCRB compared to FY 1999 decisions. However, it does not account for changes in payments due to changes in the DSH and IME adjustment factors or in the large urban add-on.

4. Exceptions Payment Adjustment Factor

Section 412.308(c)(3) requires that the standard Federal rate for inpatient capital-related costs be reduced by an adjustment factor equal to the estimated proportion of additional payments for exceptions under § 412.348 relative to total payments under the hospital-specific rate and Federal rate. We use an actuarial model described in Appendix B to determine the exceptions payment adjustment factor.

For FY 1999, we estimated that exceptions payments would equal 2.17 percent of aggregate payments based on the Federal rate and the hospital-specific rate. Therefore, we applied an exceptions reduction factor of 0.9783 (1—0.0217) in determining the Federal rate. In the May 7, 1999 proposed rule, we estimated that exceptions payments for FY 2000 would equal 2.48 percent of aggregate payments based on the Federal rate and the hospital-specific rate. Therefore, we proposed an exceptions payment reduction factor of 0.9752 to the Federal rate for FY 2000. For this final rule, based on updated data, we estimate that exceptions payments for FY 2000 will equal 2.70 percent of aggregate payments based on the Federal rate and hospital-specific rate. We are, therefore, applying an exceptions payment reduction factor of 0.9730 (1—0.0270) to the Federal rate for FY 2000. The final exceptions reduction factor for FY 2000 is 0.54 percent lower than the factor for FY 1999 and 0.23 percent lower than the factor in the FY 2000 proposed rule.

The exceptions reduction factors are not built permanently into the rates; that is, the factors are not applied cumulatively in determining the Federal rate. Therefore, the net adjustment to the FY 2000 Federal rate is 0.9730/0.9783, or 0.9946.

5. Standard Capital Federal Rate for FY 2000

For FY 1999 (effective March 1, 1999), the capital Federal rate was $378.10. As a result of changes we proposed to the factors used to establish the Federal rate, we proposed that the FY 2000 Federal rate would be $374.31. In this final rule, we are establishing a FY 2000 Federal rate of $377.03. The Federal rate for FY 2000 was calculated as follows:

- The FY 2000 update factor is 1.0030; that is, the update is 0.30 percent.
- The FY 2000 budget neutrality adjustment factor that is applied to the standard Federal payment rate for changes in the DRG relative weights and in the GAF is 0.9985.
- The FY 2000 outlier adjustment factor is 0.9402.
- The FY 2000 exceptions payments adjustment factor is 0.9730.

Since the Federal rate has already been adjusted for differences in case mix, wages, cost of living, indirect medical education costs, and payments to hospitals serving a disproportionate share of low-income patients, we have made no additional adjustments in the standard Federal rate for these factors other than the budget neutrality factor for changes in the DRG relative weights and the GAF.

We are providing a chart that shows how each of the factors and adjustments for FY 2000 affected the computation of the FY 2000 Federal rate in comparison to the FY 1999 Federal rate. The FY 2000 update factor has the effect of increasing the Federal rate by 0.30 percent compared to the rate in FY 1999, while the final geographic and DRG budget neutrality factor has the effect of decreasing the Federal rate by 0.15 percent. The FY 2000 outlier adjustment factor has the effect of increasing the Federal rate by 0.11 percent compared to FY 1999. The FY 2000 exceptions reduction factor has the effect of decreasing the Federal rate by 0.54 percent compared to the exceptions reduction for FY 1999. The combined effect of all the changes is to decrease the Federal rate by 0.28 percent compared to the Federal rate for FY 1999.

COMPARISON OF FACTORS AND ADJUSTMENTS: FY 1999 FEDERAL RATE AND FY 2000 FEDERAL RATE

	FY 1999	FY 2000	Change	Percent change
Update Factor [1]	1.0010	1.0030	1.0030	0.30
GAF/DRG Adjustment Factor [1]	1.0028	0.9985	0.9985	−0.15
Outlier Adjustment Factor [2]	0.9392	0.9402	1.0011	0.11
Exceptions Adjustment Factor [2]	0.9783	0.9730	0.9946	−0.54
Federal Rate	$378.10	$377.03	0.9972	−0.28

[1] The update factor and the GAF/DRG budget neutrality factors are built permanently into the rates. Thus, for example, the incremental change from FY 1999 to FY 2000 resulting from the application of the 0.9985 GAF/DRG budget neutrality factor for FY 2000 is 0.9985.

[2] The outlier reduction factor and the exceptions reduction factor are not built permanently into the rates; that is, these factors are not applied cumulatively in determining the rates. Thus, for example, the net change resulting from the application of the FY 2000 outlier reduction factor is 0.9402/0.9392, or 1.0011.

As stated previously in this section, the FY 2000 Federal rate has decreased 0.28 percent compared to the FY 1999 Federal rate, even though the capital rate update factor has increased from 0.1 percent in FY 1999 to 0.3 percent in FY 2000. The 0.28 percent decrease in the Federal capital rate is a result of the combination of the FY 2000 factors and adjustments applied to the Federal rate. Specifically, the exceptions reduction factor decreased 0.54 percent from 0.9783 for FY 1999 to 0.9730 for FY 2000, which results in a larger reduction to the Federal capital rate for FY 2000 compared to FY 1999. Also, the GAF/DRG adjustment factor decreased 0.42 percent from 1.0027 for FY 1999 to 0.9985 for FY 2000, which results in a decrease the Federal capital rate for FY 2000 compared to FY 1999. The outlier adjustment factor increased 0.11 percent from 0.9392 for FY 1999 to 0.9402 for FY 2000, which results in an increase to the Federal capital rate for FY 2000 compared to FY 1999. The effect of all of these changes is a −0.28 percent decrease in the FY 2000 Federal rate compared to FY 1999.

Even though the FY 2000 Federal capital rate is less than the FY 1999 Federal rate, we estimate that aggregate capital payments will increase 3.64 percent during this same period, primarily due to the increase in the Federal blend percentage (from 80 to 90 percent) for fully prospective payment hospitals.

We are also providing a chart that shows how the final FY 2000 Federal rate differs from the proposed FY 2000 Federal rate.

COMPARISON OF FACTORS AND ADJUSTMENTS: FY 2000 PROPOSED FEDERAL RATE AND FY 2000 FINAL FEDERAL RATE

	Proposed FY 2000	Final FY 2000	Change	Percent change
Update Factor [1]	0.9940	1.0030	1.0091	0.91
GAF/DRG Adjustment Factor	0.9986	0.9985	0.9999	−0.01
Outlier Adjustment Factor	0.9397	0.9402	1.0005	0.05
Exceptions Adjustment Factor	0.9752	0.9730	0.9977	−0.23
Federal Rate	$374.31	$377.03	1.0073	0.73

[1] As noted previously in section IV.A.1.a of this addendum, upon review we discovered that incorrect data were used in estimating the proposed adjustment for the effect of FY 1998 reclassification and recalibration in the proposed rule. As a result, the revised adjustment for the effect of FY 1998 reclassification and recalibration for the capital update for FY 2000 is +0.1 (compared to the proposed −0.7). Accordingly, the FY 2000 final update is 0.30 (compared to the proposed −0.06), which accounts for the 0.73 increase in the Federal rate from the FY 2000 proposed to FY 2000 final rule.

6. Special Rate for Puerto Rico Hospitals

As explained above, hospitals in Puerto Rico are paid based on 50 percent of the Puerto Rico rate and 50 percent of the Federal rate. The Puerto Rico rate is derived from the costs of Puerto Rico hospitals only, while the Federal rate is derived from the costs of all acute care hospitals participating in the prospective payment system (including Puerto Rico). To adjust hospitals' capital payments for geographic variations in capital costs, we apply a geographic adjustment factor (GAF) to both portions of the blended rate. The GAF is calculated using the operating prospective payment system wage index and varies depending on the MSA or rural area in which the hospital is located. We use the Puerto Rico wage index to determine the GAF for the Puerto Rico part of the capital blended rate and the national wage index to determine the GAF for the national part of the blended rate. Since we implemented a separate GAF for Puerto Rico in 1998, we also applied separate budget neutrality adjustments for the national GAF and for the Puerto Rico GAF. We applied the same budget neutrality factor for DRG reclassifications and recalibration nationally and for Puerto Rico. The Puerto Rico GAF budget neutrality factor is 0.9991, while the DRG adjustment is 0.9999, for a combined cumulative adjustment of 0.9990.

In computing the payment for a particular Puerto Rico hospital, the Puerto Rico portion of the rate (50 percent) is multiplied by the Puerto Rico-specific GAF for the MSA in which the hospital is located, and the national portion of the rate (50 percent) is multiplied by the national GAF for the MSA in which the hospital is located (which is computed from national data for all hospitals in the United States and Puerto Rico). In FY 1998, we implemented a 17.78 percent reduction to the Puerto Rico rate as required by the BBA. For FY 1999, before application of the GAF, the special rate for Puerto Rico hospitals was $181.10. With the changes we proposed to the factors used to determine the rate, the proposed FY 2000 special rate for Puerto Rico was $174.15. In this final rule, the FY 2000 capital rate for Puerto Rico is $174.81.

B. Determination of Hospital-Specific Rate Update

Section 412.328(e) of the regulations provides that the hospital-specific rate for FY 2000 be determined by adjusting the FY 1999 hospital-specific rate by the following factors:

1. Hospital-Specific Rate Update Factor

The hospital-specific rate is updated in accordance with the update factor for the standard Federal rate determined under § 412.308(c)(1). For FY 2000, we are updating the hospital-specific rate by a factor of 1.0030.

2. Exceptions Payment Adjustment Factor

For FYs 1992 through FY 2001, the updated hospital-specific rate is multiplied by an adjustment factor to account for estimated exceptions payments for capital-related costs under § 412.348, determined as a proportion of the total amount of payments under the hospital-specific rate and the Federal rate. For FY 2000, we estimated in the proposed rule that exceptions payments would be 2.48 percent of aggregate payments based on the Federal rate and the hospital-specific rate. Therefore, we proposed that the updated hospital-specific rate be reduced by a factor of 0.9752. In this final rule, we estimate that exceptions payments will be 2.70 percent of aggregate payments based on the Federal rate and hospital-specific rate. Accordingly, for FY 2000, we are applying an exceptions reduction factor of 0.9730 to the hospital-specific rate. The exceptions reduction factors are not built permanently into the rates; that is, the factors are not applied cumulatively in determining the hospital-specific rate. The net adjustment to the FY 2000 hospital-specific rate is 0.9730/0.9783, or 0.9946.

3. Net Change to Hospital-Specific Rate

We are providing a chart to show the net change to the hospital-specific rate. The chart shows the factors for FY 1999 and FY 2000 and the net adjustment for each factor. It also shows that the cumulative net adjustment from FY 1999 to FY 2000 is 0.9976, which represents a decrease of 0.24 percent to the hospital-specific rate. For each hospital, the FY 2000 hospital-specific rate is determined by multiplying the FY 1999 hospital-specific rate by the cumulative net adjustment of 0.9976.

FY 2000 UPDATE AND ADJUSTMENTS TO HOSPITAL-SPECIFIC RATES

	FY 1999	Final FY 2000	Net adjustment	Percent change
Update Factor	1.0010	1.0030	1.0030	0.30
Exceptions Payment Adjustment Factor	0.9783	0.9730	0.9946	−0.54
Cumulative Adjustments	0.9793	0.9769	0.9976	−0.24

Note: The update factor for the hospital-specific rate is applied cumulatively in determining the rates. Thus, the incremental increase in the update factor from FY 1999 to FY 2000 is 1.0030. In contrast, the exceptions payment adjustment factor is not applied cumulatively. Thus, for example, the incremental increase in the exceptions reduction factor from FY 1999 to FY 2000 is 0.9730/0.9783, or 0.9946.

C. Calculation of Inpatient Capital-Related Prospective Payments for FY 2000

During the capital prospective payment system transition period, a hospital is paid for the inpatient capital-related costs under one of two payment methodologies—the fully prospective payment methodology or the hold-harmless methodology. The payment methodology applicable to a particular hospital is determined when a hospital comes under the prospective payment system for capital-related costs by comparing its hospital-specific rate to the Federal rate applicable to the hospital's first cost reporting period under the prospective payment system. The applicable Federal rate was determined by making adjustments as follows:

- For outliers by dividing the standard Federal rate by the outlier reduction factor for that fiscal year; and,
- For the payment adjustment factors applicable to the hospital (that is, the hospital's GAF, the disproportionate share hospital (DSH) adjustment factor, and the indirect medical education (IME) adjustment factor, when appropriate).

If the hospital-specific rate is higher than the applicable Federal rate, the hospital is paid under the hold-harmless methodology. If the hospital-specific rate is lower than the applicable Federal rate, the hospital is paid under the fully prospective methodology.

For purposes of calculating payments for each discharge under both the hold-harmless payment methodology and the fully prospective payment methodology,

the standard Federal rate is adjusted as follows: (Standard Federal Rate) × (DRG weight) × (GAF) × (Large Urban Add-on, if applicable) × (COLA adjustment for hospitals located in Alaska and Hawaii) × (1 + DSH Adjustment Factor + IME Adjustment Factor). The result is the adjusted Federal rate.

Payments under the hold-harmless methodology are determined under one of two formulas. A hold-harmless hospital is paid the higher of the following:

- 100 percent of the adjusted Federal rate for each discharge; or
- An old capital payment equal to 85 percent (100 percent for sole community hospitals) of the hospital's allowable Medicare inpatient old capital costs per discharge for the cost reporting period plus a new capital payment based on a percentage of the adjusted Federal rate for each discharge. The percentage of the adjusted Federal rate equals the ratio of the hospital's allowable Medicare new capital costs to its total Medicare inpatient capital-related costs in the cost reporting period.

Once a hospital receives payment based on 100 percent of the adjusted Federal rate in a cost reporting period beginning on or after October 1, 1994 (or the first cost reporting period after obligated capital that is recognized as old capital under § 412.302(c) is put in use for patient care, if later), the hospital continues to receive capital prospective payment system payments on that basis for the remainder of the transition period.

Payment for each discharge under the fully prospective methodology is the sum of the following:

- The hospital-specific rate multiplied by the DRG relative weight for the discharge and by the applicable hospital-specific transition blend percentage for the cost reporting period; and
- The adjusted Federal rate multiplied by the Federal transition blend percentage.

The blend percentages for cost reporting periods beginning in FY 2000 are 90 percent of the adjusted Federal rate and 10 percent of the hospital-specific rate.

Hospitals may also receive outlier payments for those cases that qualify under the thresholds established for each fiscal year. Section 412.312(c) provides for a single set of thresholds to identify outlier cases for both inpatient operating and inpatient capital-related payments. Outlier payments are made only on that portion of the Federal rate that is used to calculate the hospital's inpatient capital-related payments. For fully prospective hospitals, that portion is 90 percent of the Federal rate for discharges occurring in cost reporting periods beginning during FY 2000. Thus, a fully prospective hospital will receive 90 percent of the capital-related outlier payment calculated for the case for discharges occurring in cost reporting periods beginning in FY 2000. For hold-harmless hospitals paid 85 percent of their reasonable costs for old inpatient capital, the portion of the Federal rate that is included in the hospital's outlier payments is based on the hospital's ratio of Medicare inpatient costs for new capital to total Medicare inpatient capital costs. For hold-harmless hospitals that are paid 100 percent of the Federal rate, 100 percent of the Federal rate is included in the hospital's outlier payments.

The outlier thresholds for FY 2000 are in section II.A.4.c of this Addendum. For FY 2000, a case qualifies as a cost outlier if the cost for the case is greater than the prospective payment rate for the DRG (and any IME and DSH payments) plus $14,050.

During the capital prospective payment system transition period, a hospital may also receive an additional payment under an exceptions process if its total inpatient capital-related payments are less than a minimum percentage of its allowable Medicare inpatient capital-related costs. The minimum payment level is established by class of hospital under § 412.348. The minimum payment levels for portions of cost reporting periods occurring in FY 2000 are as follows:

- Sole community hospitals (located in either an urban or rural area), 90 percent.
- Urban hospitals with at least 100 beds and a disproportionate share patient percentage of at least 20.2 percent and urban hospitals with at least 100 beds that qualify for disproportionate share payments under § 412.106(c)(2), 80 percent.
- All other hospitals, 70 percent.

Under § 412.348(d), the amount of the exceptions payment is determined by comparing the cumulative payments made to the hospital under the capital prospective payment system to the cumulative minimum payment levels applicable to the hospital for each cost reporting period subject to that system. Any amount by which the hospital's cumulative payments exceed its cumulative minimum payment is deducted from the additional payment that would otherwise be payable for a cost reporting period.

New hospitals are exempted from the capital prospective payment system for their first 2 years of operation and are paid 85 percent of their reasonable costs during that period. A new hospital's old capital costs are its allowable costs for capital assets that were put in use for patient care on or before the later of December 31, 1990 or the last day of the hospital's base year cost reporting period, and are subject to the rules pertaining to old capital and obligated capital as of the applicable date. Effective with the third year of operation, we will pay the hospital under either the fully prospective methodology, using the appropriate transition blend in that Federal fiscal year, or the hold-harmless methodology. If the hold-harmless methodology is applicable, the hold-harmless payment for assets in use during the base period would extend for 8 years, even if the hold-harmless payments extend beyond the normal transition period.

D. Capital Input Price Index

1. Background

Like the operating input price index, the Capital Input Price Index (CIPI) is a fixed-weight price index that measures the price changes associated with costs during a given year. The CIPI differs from the operating input price index in one important aspect—the CIPI reflects the vintage nature of capital, which is the acquisition and use of capital over time. Capital expenses in any given year are determined by the stock of capital in that year (that is, capital that remains on hand from all current and prior capital acquisitions). An index measuring capital price changes needs to reflect this vintage nature of capital. Therefore, the CIPI was developed to capture the vintage nature of capital by using a weighted-average of past capital purchase prices up to and including the current year.

Using Medicare cost reports, American Hospital Association (AHA) data, and Securities Data Corporation data, a vintage-weighted price index was developed to measure price increases associated with capital expenses. We periodically update the base year for the operating and capital input prices to reflect the changing composition of inputs for operating and capital expenses. Currently, the CIPI is based to FY 1992 and was last rebased in 1997. The most recent explanation of the CIPI was discussed in the final rule with comment period for FY 1998 published on August 29, 1997 (62 FR 46050). The following **Federal Register** documents also describe development and revisions of the methodology involved with the construction of the CIPI: September 1, 1992 (57 FR 40016), May 26, 1993 (58 FR 30448), September 1, 1993 (58 FR 46490), May 27, 1994 (59

FR 27876), September 1, 1994 (59 FR 45517), June 2, 1995 (60 FR 29229), and September 1, 1995 (60 FR 45815), May 31, 1996 (61 FR 27466), August 30, 1996 (61 FR 46196), June 2, 1997 (62 FR 29953), August 29, 1997 (62 FR 46050), May 8, 1998 (63 FR 25619), July 31, 1998 (63 FR 41017), and May 7, 1999 (64 FR 24763).

2. Forecast of the CIPI for Federal Fiscal Year 2000

We are forecasting the CIPI to increase 0.6 percent for FY 2000. This reflects a projected 1.6 percent increase in vintage-weighted depreciation prices (building and fixed equipment, and movable equipment) and a 3.5 percent increase in other capital expense prices in FY 2000, partially offset by a 2.9 percent decline in vintage-weighted interest rates in FY 2000. The weighted average of these three factors produces the 0.6 percent increase for the CIPI as a whole.

V. Changes to Payment Rates for Excluded Hospitals and Hospital Units: Rate-of-Increase Percentages

The inpatient operating costs of hospitals and hospital units excluded from the prospective payment system are subject to rate-of-increase limits established under the authority of section 1886(b) of the Act, which is implemented in regulations at § 413.40. Under these limits, a hospital-specific target amount (expressed in terms of the inpatient operating cost per discharge) is set for each hospital, based on the hospital's own historical cost experience trended forward by the applicable rate-of-increase percentages (update factors). In the case of a psychiatric hospital or hospital unit, rehabilitation hospital or hospital unit, or long-term care hospital, the target amount may not exceed the updated figure for the 75th percentile of target amounts for hospitals and units in the same class (psychiatric, rehabilitation, and long-term care) for cost reporting periods ending during FY 1996. The target amount is multiplied by the number of Medicare discharges in a hospital's cost reporting period, yielding the ceiling on aggregate Medicare inpatient operating costs for the cost reporting period.

Each hospital-specific target amount is adjusted annually, at the beginning of each hospital's cost reporting period, by an applicable update factor.

Section 1886(b)(3)(B) of the Act, which is implemented in regulations at § 413.40(c)(3)(vii), provides that for cost reporting periods beginning on or after October 1, 1999 and before October 1, 2000, the update factor depends on the hospital's or hospital unit's costs in relation to the ceiling. For hospitals with costs exceeding the ceiling by 10 percent or more, the update factor is the market basket increase. For hospitals with costs exceeding the ceiling by less than 10 percent, the update factor is the market basket minus .25 percent for each percentage point by which costs are less than 10 percent over the ceiling. For hospitals with costs equal to or less than the ceiling but greater than 66.7 percent of the ceiling, the update factor is the greater of 0 percent or the market basket minus 2.5 percent. For hospitals with costs that do not exceed 66.7 percent of the ceiling, the update factor is 0.

The most recent forecast of the market basket increase for FY 2000 for hospitals and hospital units excluded from the prospective payment system is 2.9 percent. Therefore, the update to a hospital's target amount for its cost reporting period beginning in FY 2000 would be between 0.4 and 2.9 percent, or 0 percent.

In addition, § 413.40(c)(4)(iii) requires that for cost reporting periods beginning on or after October 1, 1999 and before October 1, 2000, the target amount for each psychiatric hospital or hospital unit, rehabilitation hospital or hospital unit, and long-term care hospital cannot exceed a cap on the target amounts for hospitals in the same class. In the May 7, 1999 proposed rule, based on available data, we estimated that, for cost reporting periods beginning in FY 2000, the caps on target amounts would be $11,067 for psychiatric hospitals and hospital units, $20,071 for rehabilitation hospitals and hospital units, and $39,596 for long-term care hospitals. In this final rule, based on updated data, we are establishing the caps as follows: $11,100 for psychiatric hospitals and hospital units, $20,129 for rehabilitation hospitals and hospital units, and $36,712 for long-term care hospitals. Regulations at § 413.40(d) specify the formulas for determining bonus and relief payments for excluded hospitals and specify established criteria for an additional bonus payment for continuous improvement. Regulations at § 413.40(f)(2)(ii) specify the payment methodology for new hospitals and hospital units (psychiatric, rehabilitation, and long-term care) effective October 1, 1997.

VI. Tables

This section contains the tables referred to throughout the preamble to this final rule and in this Addendum. For purposes of this final rule, and to avoid confusion, we have retained the designations of Tables 1 through 5 that were first used in the September 1, 1983 initial prospective payment final rule (48 FR 39844). Tables 1A, 1C, 1D, 3C, 4A, 4B, 4C, 4D, 4E, 4F, 5, 7A, 7B, 8A, 8B, and 10 are presented below. The tables presented below are as follows:

Table 1A—National Adjusted Operating Standardized Amounts, Labor/Nonlabor

Table 1C—Adjusted Operating Standardized Amounts for Puerto Rico, Labor/Nonlabor

Table 1D—Capital Standard Federal Payment Rate

Table 3C—Hospital Case-Mix Indexes for Discharges Occurring in Federal Fiscal Year 1998 and Hospital Average Hourly Wage for Federal Fiscal Year 2000 Wage Index

Table 4A—Wage Index and Capital Geographic Adjustment Factor (GAF) for Urban Areas

Table 4B—Wage Index and Capital Geographic Adjustment Factor (GAF) for Rural Areas

Table 4C—Wage Index and Capital Geographic Adjustment

Table 4D—Average Hourly Wage for Urban Areas

Table 4E—Average Hourly Wage for Rural Areas

Table 4F—Puerto Rico Wage Index and Capital Geographic Adjustment Factor (GAF)

Table 5—List of Diagnosis Related Groups (DRGs), Relative Weighting Factors, Geometric Mean Length of Stay, and Arithmetic Mean Length of Stay Points Used in the Prospective Payment System

Table 7A—Medicare Prospective Payment System Selected Percentile Lengths of Stay FY 98 MEDPAR Update 3/99 GROUPER V16.0

Table 7B—Medicare Prospective Payment System Selected Percentile Lengths of Stay FY 98 MEDPAR Update 3/99 GROUPER V17.0

Table 8A—Statewide Average Operating Cost-to-Charge Ratios for Urban and Rural Hospitals (Case Weighted) July 1999

Table 8B—Statewide Average Capital Cost-to-Charge Ratios (Case Weighted) July 1999

Table 10—Percentage Difference in Wage Indexes for Areas That Qualify for a Wage Index Exception for Excluded Hospitals and Units

TABLE 1A.—NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS, LABOR/NONLABOR

Large urban areas		Other areas	
Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
$2,809.18	$1,141.85	$2,764.70	$1,123.76

TABLE 1C.—ADJUSTED OPERATING STANDARDIZED AMOUNTS FOR PUERTO RICO, LABOR/NONLABOR

	Large urban areas		Other areas	
	Labor	Nonlabor	Labor	Nonlabor
National	$2,785.40	$1,132.18	$2,785.40	$1,132.18
Puerto Rico	1,336.54	538.00	1,315.38	529.48

TABLE 1D.—CAPITAL STANDARD FEDERAL PAYMENT RATE

	Rate
National	$377.03
Puerto Rico	174.81

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX

Prov.	Case mix index	Avg. hour wage
010001	1.4595	15.85
010004	0.9933	15.02
010005	1.1767	16.26
010006	1.4579	17.31
010007	1.1421	14.80
010008	1.1818	17.65
010009	1.0941	17.53
010010	1.0799	15.91
010011	1.5835	20.63
010012	1.2614	19.30
010015	1.0478	18.35
010016	1.2492	16.13
010018	0.9696	18.96
010019	1.2766	15.49
010021	1.2490	14.63
010022	0.9597	20.51
010023	1.6881	16.26
010024	1.4243	16.03
010025	1.3513	14.53
010027	0.8132	14.93
010029	1.6000	16.41
010031	1.4175	18.02
010032	0.8803	12.65
010033	1.9945	19.68
010034	1.0473	14.73
010035	1.2411	17.48
010036	1.0916	17.29
010038	1.2337	18.33
010039	1.6337	18.81
010040	1.4963	19.10
010043	1.0500	16.20
010044	1.0246	17.02
010045	1.1799	15.01
010046	1.4713	17.18
010047	0.9285	16.38
010049	1.1887	14.48
010050	1.0755	15.42
010051	0.8965	9.94

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
010052	1.0154	13.86
010053	1.0508	13.18
010054	1.1318	17.12
010055	1.4221	18.19
010056	1.3283	19.08
010058	1.0358	12.78
010059	1.0567	18.19
010061	1.1098	15.92
010062	1.0102	13.57
010064	1.7584	20.90
010065	1.3234	15.64
010066	0.9014	12.07
010068	1.3052	18.74
010069	1.1329	13.57
010072	1.0785	14.35
010073	0.8800	12.83
010078	1.2901	17.71
010079	1.1867	16.87
010080	.....	13.85
010081	1.6351	16.98
010083	1.0586	16.21
010084	1.5089	18.78
010085	1.3152	18.87
010086	1.0122	14.93
010087	1.7288	18.39
010089	1.1989	16.61
010090	1.6540	18.11
010091	0.9933	16.36
010092	1.4279	16.50
010094	1.1544	18.56
010095	1.0456	11.90
010097	0.8654	12.90
010098	0.9896	14.28
010099	1.1725	15.93
010100	1.2912	15.48
010101	1.0199	15.42
010102	0.9314	12.73
010103	1.8375	19.31

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
010104	1.6950	18.10
010108	1.1528	20.79
010109	1.0504	14.09
010110	0.9691	15.91
010112	1.1495	15.11
010113	1.6159	17.24
010114	1.2530	17.26
010115	0.8495	13.75
010118	1.2464	16.69
010119	0.8457	18.17
010120	0.9886	17.03
010121	1.2822	15.18
010123	1.1647	18.16
010124	1.2264	16.27
010125	1.0590	14.42
010126	1.1224	17.64
010127	1.3140	19.61
010128	0.9265	12.57
010129	1.0647	14.43
010130	1.0418	16.35
010131	1.3325	17.91
010134	0.8150	10.78
010137	1.3106	15.93
010138	0.9196	12.13
010139	1.6338	19.95
010143	1.2282	15.71
010144	1.4120	17.12
010145	1.3336	20.75
010146	1.1894	18.86
010148	0.9791	14.64
010149	1.2567	17.08
010150	1.0438	16.97
010152	1.2508	17.38
010155	1.0794	16.70
020001	1.5235	27.97
020002	1.0556	26.91
020004	1.1841	26.40
020005	0.8955	29.01

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
020006	1.1238	26.77
020007	0.8205	24.96
020008	1.0781	30.47
020009	0.8199	23.18
020010	0.9473	18.64
020011	0.9160	29.47
020012	1.2763	23.92
020013	0.9595	26.82
020014	1.1151	24.09
020017	1.4946	24.97
020018	0.8973	.....
020019	0.7991	.....
020021	0.8011	.....
020024	1.1106	22.73
020025	0.9156	27.15
020026	1.2660	.....
020027	0.9434	.....
030001	1.2614	19.87
030002	1.8069	21.63
030003	2.2742	23.67
030004	1.0231	17.73
030006	1.5269	17.64
030007	1.2538	18.56
030008	2.1843	.....
030009	1.2486	17.93
030010	1.3867	18.80
030011	1.4361	20.08
030012	1.2389	19.42
030013	1.2741	21.02
030014	1.5098	19.47
030016	1.2340	20.56
030017	1.4178	20.42
030018	1.8584	18.91
030019	1.2403	19.92
030022	1.4895	15.79
030023	1.4965	22.44
030024*	1.7469	21.67
030025	0.9555	17.67
030027	0.9624	17.58
030030	1.6450	21.62
030033	1.2353	16.84
030034	0.9867	19.09
030035	1.1548	19.72
030036	1.2810	18.94
030037	2.0844	21.44
030038	1.6163	22.08
030040	1.0766	17.97
030041	0.8880	17.44
030043	1.2200	20.77
030044	0.8787	16.47
030047	0.8899	19.69
030049	0.8711	19.09
030054	0.8646	14.49
030055	1.2312	18.28
030059	1.2853	21.71
030060	1.1435	16.77
030061	1.6875	17.35
030062	1.1800	17.48
030064	1.7662	18.54
030065	1.8097	19.93
030067	1.0273	15.62
030068	1.0246	17.35
030069	1.3639	19.00
030071	0.9602	.....

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
030072	0.8682	.....
030073	1.0290	.....
030074	0.8858	.....
030075	0.7952	.....
030076	0.8826	.....
030077	0.8563	.....
030078	1.1470	.....
030079	0.9065	.....
030080	1.3762	19.99
030083	1.2775	23.64
030084	1.1378	.....
030085	1.4648	17.84
030086	1.4452	18.50
030087	1.6802	20.05
030088	1.3656	19.58
030089	1.6781	19.90
030092	1.5831	21.56
030093	1.4204	19.47
030094	1.2697	19.48
030095	1.1371	14.25
030099	0.9411	18.07
030100	2.0364	.....
030101	1.4114	.....
030102	2.5824	.....
040001	1.0888	15.57
040002	1.1552	14.09
040003	1.1003	14.00
040004	1.6291	17.29
040005	1.0368	12.88
040007	1.6975	19.53
040008	1.0417	12.70
040010	1.3432	17.62
040011	0.9412	12.27
040014	1.3255	15.39
040015	1.2147	14.60
040016	1.6858	17.54
040017	1.1675	14.95
040018	1.2212	17.56
040019	1.0337	25.71
040020	1.6146	14.81
040021	1.1844	16.46
040022	1.4741	16.00
040024	0.9980	15.73
040025	0.9100	10.95
040026	1.5789	18.24
040027	1.2523	14.54
040028	1.0074	12.84
040029	1.2995	17.78
040030	0.8754	14.15
040032	0.9633	13.33
040035	0.9500	11.21
040036	1.4559	17.91
040037	1.0687	13.48
040039	1.2281	13.84
040040	0.9162	17.43
040041	1.2619	13.36
040042	1.2098	14.66
040044	1.0386	11.44
040045	1.0121	18.77
040047	1.0270	16.39
040048	.....	15.82
040050	1.1544	11.79
040051	1.0845	16.28
040053	1.0708	15.82

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
040054	0.9798	15.04
040055	1.4290	16.10
040058	1.0566	15.67
040060	0.9763	11.47
040062	1.6600	17.28
040064	1.0495	12.40
040066	1.0504	17.64
040067	1.0989	13.49
040069	1.0278	16.11
040070	0.9313	15.48
040071	1.6676	16.30
040072	1.0377	15.84
040074	1.2314	17.38
040075	1.0145	12.75
040076	1.0802	18.55
040077	1.0508	12.46
040078	1.5191	17.86
040080	1.0065	15.74
040081	0.8669	10.68
040082	1.0972	16.51
040084	1.1085	17.25
040085	1.1526	15.78
040088	1.3887	15.67
040090	0.8950	17.55
040091	1.1702	17.04
040093	0.9194	12.90
040100	1.1477	14.97
040105	0.9904	14.24
040106	0.9680	15.40
040107	1.0685	19.62
040109	1.1497	13.98
040114	1.8340	18.31
040116	1.1343	19.57
040118	1.4205	17.43
040119	1.1612	15.38
040124	1.0612	17.25
040126	0.9478	11.68
040132	.....	13.18
040134	2.7047	.....
040135	2.3711	.....
050002	1.4963	27.60
050006	1.4139	19.53
050007	1.4840	29.54
050008	1.4234	25.86
050009	1.6827	26.25
050013	1.9903	24.85
050014	1.2091	24.53
050015	1.4488	25.38
050016	1.1522	20.15
050017	2.0965	23.66
050018	1.3646	14.66
050021	.....	28.50
050022	1.6612	22.96
050024	1.3214	20.34
050025*	1.7668	22.00
050026	1.5146	28.69
050028	1.3702	16.45
050029	1.4013	23.29
050030	1.3135	21.01
050032	1.3391	22.59
050033	1.4640	24.56
050036	1.7264	20.47
050038	1.3454	27.83
050039	1.6288	22.25

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
050040	1.1955	30.67
050042	1.2702	22.23
050043	1.4927	33.23
050045	1.2716	20.73
050046	1.1729	31.38
050047	1.5619	29.44
050051	1.1199	17.84
050054	1.1899	19.37
050055	1.2399	29.09
050056	1.3404	23.85
050057	1.5981	21.76
050058	1.4969	25.73
050060	1.5506	20.92
050061	1.4125	23.74
050063	1.3477	23.07
050065	1.6835	21.18
050066	1.3006	21.42
050067	1.2503	21.30
050068	1.1029	28.48
050069	1.6082	29.30
050070	1.2340	32.60
050071	1.3229	33.14
050072	1.3883	32.97
050073	1.2621	34.61
050074	0.8073	.....
050075	1.3460	33.52
050076	2.0321	33.88
050077	1.5585	23.30
050078	1.2960	22.80
050079	1.4849	34.43
050082	1.6734	21.70
050084	1.6102	23.10
050088	0.9681	24.06
050089	1.3381	20.02
050090	1.2652	23.90
050091	1.0925	22.22
050092	0.8481	15.38
050093	1.5646	24.08
050095	.....	33.38
050096	1.1459	21.67
050097	1.5292	22.61
050099	1.4630	24.29
050100	1.6425	30.06
050101	1.3595	30.01
050102	1.3792	21.29
050103*	1.5724	25.34
050104	1.4491	25.44
050107	1.4640	21.76
050108	1.8389	25.21
050109	.....	26.48
050110	1.2148	20.18
050111	1.2943	21.74
050112	1.3851	26.29
050113	1.3172	27.78
050114	1.3842	25.91
050115	1.4915	21.05
050116	1.5226	25.59
050117	1.3979	20.44
050118	1.1870	24.00
050121	1.2882	18.88
050122	1.5694	.....
050124	1.2826	23.02
050125	1.3726	24.04
050126	1.4571	23.84
050127	1.2537	19.76
050128	1.6061	24.18
050129	1.7541	27.16
050131	1.2640	29.06
050132	1.3641	22.91
050133	1.2717	24.40
050135	1.4811	27.03
050136	1.3553	24.43
050137	1.3023	30.07
050138	2.0450	37.41
050139	1.2542	31.38
050140	1.3201	33.66
050144	1.4211	25.75
050145	1.3762	33.06
050146	1.5826	.....
050148	1.1126	21.06
050149	1.4979	23.38
050150	1.2673	23.48
050152	1.3291	27.75
050153	1.6393	29.59
050155	1.0972	22.94
050158	1.3019	27.98
050159	1.3226	25.21
050167	1.3813	21.68
050168	1.5382	25.25
050169	1.4765	24.64
050170	1.4490	22.20
050172	1.2543	17.70
050173	1.3755	23.33
050174	1.7008	31.21
050175	1.2707	27.79
050177	1.1869	20.25
050179	1.2337	19.29
050180	1.5831	32.19
050183	1.2743	19.98
050186	1.3443	21.91
050188	1.4374	27.44
050189	0.9674	23.24
050191	1.4686	26.73
050192	1.1474	17.81
050193	1.1575	23.73
050194	1.2304	28.27
050195	1.5638	34.78
050196	1.2799	16.69
050197	1.9550	31.45
050204	1.5274	24.39
050205	1.2839	21.15
050207	1.2607	20.86
050211	1.3187	31.22
050213	1.5919	20.73
050214	1.5454	20.87
050215	1.5686	28.41
050217	1.2859	19.89
050219	1.1417	25.47
050222	1.5169	27.07
050224	1.5831	23.79
050225	1.5688	20.80
050226	1.3277	26.93
050228	1.3226	30.38
050230	1.4125	25.36
050231	1.6438	25.58
050232	1.5691	23.38
050233	.....	31.40
050234	1.1501	28.52
050235	1.5560	25.86
050236	1.5100	26.27
050238	1.5300	24.00
050239	1.5979	20.41
050240	1.5284	25.25
050241	1.1379	27.22
050242	1.4436	30.14
050243	1.5323	22.91
050245	1.5075	24.40
050248	1.2025	27.42
050251	1.1079	18.50
050253	1.4192	20.07
050254	1.2000	19.69
050256	1.7675	23.53
050257	0.9509	19.59
050260	0.9690	23.52
050261	1.2104	20.45
050262	1.8179	29.01
050264	1.3472	29.45
050267	1.6945	24.75
050270	1.3631	23.73
050272	1.3984	21.44
050274	0.9467	21.19
050276	1.1734	28.51
050277	1.4821	22.31
050278	1.5187	23.84
050279	1.2881	21.06
050280	1.6532	24.43
050281	1.3916	18.59
050282	1.3212	24.46
050283	1.5054	27.88
050286	0.9172	17.80
050289	1.7326	26.72
050290	1.6720	26.37
050291	1.1953	26.49
050292	1.1088	22.49
050293	1.0656	19.18
050295	1.4570	20.74
050296	1.2166	25.32
050298	1.3348	20.52
050299	1.3248	25.77
050300	1.4160	22.74
050301	1.2329	26.03
050302	.....	29.20
050305	1.5886	32.71
050307	1.2758	27.98
050308	1.5082	28.40
050309	1.2826	24.40
050310	.....	20.62
050312	1.9732	23.79
050313	1.1561	23.10
050315	1.3435	21.92
050317	.....	19.45
050320	1.2358	30.60
050324	2.0041	26.27
050325	1.2290	23.24
050327	1.6638	22.85
050328	.....	23.19
050329	1.2988	21.41
050331	1.3506	25.53
050333	1.0612	20.15
050334	1.7488	32.02
050335	1.4579	20.20
050336	1.3568	20.10

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
050342	1.2515	19.35
050343	0.9701	17.34
050348	1.8021	20.75
050349	0.8875	15.05
050350	1.4042	25.07
050351	1.4941	24.69
050352	1.3148	23.59
050353	1.6191	23.25
050355	0.8391	17.16
050357	1.3422	23.64
050359	1.2474	20.40
050360	1.4310	31.76
050366	1.3326	21.34
050367	1.2594	29.48
050369	1.3034	24.26
050373	1.3971	26.65
050376	1.4232	25.30
050377	1.0200	25.64
050378	1.0934	22.24
050379	1.0197	15.50
050380	1.6047	30.58
050382	1.3597	26.15
050385	1.3419	25.92
050388	0.8725	13.79
050390	1.1965	22.57
050391	1.3438	22.49
050392	0.9370	21.93
050393	1.4352	23.14
050394	1.5741	22.24
050396	1.6444	23.63
050397	0.9367	20.77
050401	1.1055	17.78
050404	1.0664	19.28
050406	1.0245	16.89
050407	1.2842	30.12
050410	1.0668	16.47
050411	1.3582	32.24
050414	1.2992	24.42
050417	1.3197	21.89
050419	1.3788	23.12
050420	1.3062	22.68
050421	1.2343	.....
050423	1.0112	23.33
050424	1.8400	23.78
050425	1.2315	33.69
050426	1.3898	23.71
050427	0.9468	20.07
050430	1.0003	21.34
050432	1.5198	21.50
050433	0.9711	16.80
050434	1.0631	15.63
050435	1.1647	32.99
050436	1.0075	16.36
050438	1.7349	24.08
050440	1.2722	21.11
050441	1.9397	28.71
050443	0.8705	16.43
050444	1.3224	24.67
050446	0.8088	20.54
050447	1.0850	18.42
050448	1.1055	20.08
050449	1.2871	22.18
050454*	1.7729	28.69
050455	1.7949	19.92

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
050456	1.2213	17.62
050457	1.9129	31.25
050459	1.5220	37.09
050464	1.7089	22.31
050468	1.5589	23.17
050469	1.1499	23.44
050470	1.1391	17.03
050471	1.8969	24.29
050476	1.3686	23.14
050477	1.4367	27.78
050478	0.9911	23.05
050481	1.3949	26.83
050482	1.0569	16.93
050483	2.2575	21.60
050485	1.6066	23.19
050486	.....	24.50
050488	1.3257	32.86
050491	1.2006	25.10
050492	1.4183	21.42
050494	1.2386	25.41
050496	1.7595	33.02
050497	0.8258	.....
050498	1.2296	24.84
050502	1.7271	22.63
050503	1.3477	23.59
050506	1.3621	21.22
050510	1.2784	33.46
050512	1.4429	34.31
050515	1.3439	35.04
050516	1.5017	25.19
050517	1.2038	20.37
050522	1.1593	31.73
050523	1.2442	28.42
050526	1.2943	26.92
050528	1.1883	18.69
050531	1.1101	20.73
050534	1.2834	23.30
050535	1.5140	24.23
050537	1.3698	22.21
050539	1.3269	23.25
050541	1.5646	34.62
050542	0.9786	17.85
050543	0.8445	23.04
050545	0.7658	27.57
050546	0.6961	27.76
050547	0.9008	27.08
050548	.....	26.59
050549	1.6034	27.91
050550	1.3697	25.75
050551	1.3532	24.05
050552	1.2766	22.87
050557	1.5203	22.14
050559	1.2865	24.67
050561	1.2133	33.93
050564	1.3237	24.51
050565	1.3123	22.88
050566	0.9219	18.33
050567	1.5570	24.23
050568	1.3420	20.52
050569	1.2025	24.94
050570	1.6497	24.50
050571	1.3946	24.37
050573	1.5647	25.14
050575	1.1467	.....

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
050577	1.3600	20.52
050578	1.2666	28.91
050579	1.4322	30.07
050580	1.2849	23.92
050581	1.4507	23.57
050583	1.6163	23.36
050584	1.2401	23.16
050585	1.2561	26.50
050586	1.3532	23.84
050588	1.2801	30.39
050589	1.2395	24.35
050590	1.3227	.....
050591	1.3156	22.32
050592	1.2663	26.05
050594	1.6277	22.78
050597	1.2260	23.18
050598	1.3410	28.11
050599	1.5942	26.32
050601	1.6465	32.87
050603	1.4208	22.75
050604	1.4564	33.32
050607	.....	24.10
050608	1.2793	16.15
050609	1.4917	31.93
050613	1.1189	23.48
050615	1.5453	23.70
050616	1.3449	22.80
050618	1.0867	21.70
050623	1.5638	30.32
050624	1.3297	22.34
050625	1.6305	24.35
050630	1.2762	24.10
050633	1.2825	21.98
050635	.....	37.85
050636	1.4239	20.83
050638	1.1491	23.63
050641	1.2971	21.36
050643	0.9604	.....
050644	1.0737	23.12
050660	1.4966	.....
050661	.....	20.48
050662	0.8151	28.29
050663	1.1758	23.71
050667	1.0967	24.11
050668	1.0944	39.90
050670	0.7555	21.88
050674	1.2425	36.24
050675	2.2195	15.84
050676	1.0018	17.53
050677	1.3679	33.71
050678	1.2889	22.66
050680	1.1178	27.32
050682	0.9234	17.97
050684	1.2409	21.81
050685	1.1904	32.13
050686	1.2866	33.25
050688	1.1936	30.00
050689	1.4920	34.19
050690	1.4168	33.83
050693	1.3155	33.30
050694	1.3866	22.57
050695	1.0607	23.52
050696	2.1060	26.41
050697	1.3204	21.47

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
050699	0.5913	28.48
050700	.....	28.45
050701	1.3166	27.62
050702	.....	12.25
050704	1.0855	20.76
050707	0.9714	27.51
050708	1.4500	21.91
050709	1.2519	19.42
050710	1.3390	26.81
050713	0.7909	15.30
050714	1.3510	.....
050715	.....	19.12
050717	1.2647	.....
050718	0.7579	.....
050719	3.1984	.....
050720	0.9044	.....
060001	1.6835	20.59
060003	1.2708	19.32
060004	1.1987	21.79
060006	1.2571	17.86
060007	1.1650	16.38
060008	1.0843	17.09
060009	1.4985	21.18
060010	1.6674	22.72
060011	1.3925	21.97
060012	1.3814	19.77
060013	1.3217	19.14
060014	1.8153	20.53
060015	1.6320	23.57
060016	1.1638	15.96
060018	1.2867	21.86
060020	1.6130	17.73
060022	1.5677	19.65
060023	1.6323	19.65
060024	1.7015	22.83
060027	1.6925	21.67
060028	1.5331	22.25
060029	0.8925	21.41
060030	1.3542	20.03
060031	1.5383	19.40
060032	1.4782	22.37
060033	1.1398	13.82
060034	1.5846	21.41
060036	1.1376	19.24
060037	1.0079	14.05
060038	0.9440	14.31
060041	0.9246	14.83
060042	1.0356	20.08
060043	0.8801	13.05
060044	1.1681	22.53
060046	1.0302	20.44
060047	0.9655	15.12
060049	1.3171	20.64
060050	1.2512	16.80
060052	1.0404	12.55
060053	1.0148	14.94
060054	1.4104	19.39
060056	0.9051	17.05
060057	1.0273	23.38
060058	0.9425	16.91
060060	0.9200	14.89
060062	0.8628	14.94
060063	.....	15.09
060064	1.4833	20.93

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
060065	1.2913	24.30
060066	0.9930	14.07
060068	.....	19.64
060070	1.1250	16.58
060071	1.2078	16.95
060073	0.9583	15.84
060075	1.2425	22.85
060076	1.4325	19.29
060085	0.8869	13.48
060087	.....	21.03
060088	0.9983	16.67
060090	0.8997	14.51
060096	1.1067	23.12
060100	1.5321	22.00
060103	1.3211	22.34
060104	1.2351	22.30
060107	1.1955	13.64
060108	0.4789	.....
060109	1.1185	.....
070001	1.7614	26.51
070002	1.8336	25.46
070003	1.1215	26.09
070004	1.2043	23.27
070005	1.4436	25.57
070006	1.3881	28.71
070007	1.3524	27.19
070008	1.2506	26.03
070009	1.2685	23.47
070010	1.6992	25.94
070011	1.3820	23.96
070012	1.1724	25.10
070015	1.3890	25.33
070016	1.4259	26.30
070017	1.3718	24.80
070018	1.3684	28.88
070019	1.1838	24.70
070020	1.3222	23.72
070021	1.2362	26.52
070022	1.8643	25.08
070024	1.3255	25.15
070025	1.8686	25.41
070026	.....	18.79
070027	1.3113	23.64
070028	1.5522	24.69
070029	1.3352	22.75
070030	1.2883	24.97
070031	1.2420	21.66
070033	1.4115	28.81
070034	1.3893	29.12
070035	1.4205	23.06
070036	1.7251	28.95
070038	0.7729	.....
070039	0.9555	21.78
080001	1.7133	25.28
080002	.....	15.60
080003	1.3835	22.40
080004	1.2651	19.77
080005	.....	14.43
080006	1.3003	22.26
080007	1.4176	20.38
090001	1.6034	25.89
090002	1.3475	19.70
090003	1.3718	28.61
090004	1.7978	24.43

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
090005	1.3706	24.88
090006	1.3152	20.08
090007	1.3040	21.66
090008	1.5064	21.60
090010	1.0721	15.87
090011	2.1194	27.37
100001	1.5307	17.69
100002	1.4390	21.32
100004	1.0119	15.25
100006	1.6160	20.63
100007	1.8871	21.72
100008	1.5830	20.72
100009	1.4671	24.29
100010	1.4977	21.91
100012	1.6382	18.52
100014	1.4823	19.83
100015	1.4805	18.24
100017	1.5923	17.77
100018	1.5493	20.84
100019	1.5572	19.81
100020	1.3926	26.18
100022	1.7978	25.89
100023	1.3578	21.11
100024	1.3497	20.78
100025	1.7580	19.12
100026	1.5873	20.76
100027	1.0231	12.94
100028	1.2105	19.75
100029	1.3375	19.18
100030	1.2542	18.82
100032	1.8533	19.32
100034	1.7580	18.23
100035	1.5894	19.58
100038	1.6636	24.78
100039	1.5287	20.25
100040	1.7501	18.64
100043	1.3307	17.52
100044	1.3922	21.14
100045	1.3923	20.77
100046	1.4279	21.21
100047	1.8496	18.87
100048	0.9391	13.50
100049	1.2653	18.56
100050	1.1494	16.60
100051	1.2391	18.84
100052	1.3875	16.19
100053	1.2128	18.71
100054	1.2776	18.19
100055	1.3755	17.62
100056	1.4973	23.65
100057	1.3595	18.75
100060	1.8341	22.39
100061	1.4541	21.79
100062	1.7297	17.96
100063	1.1596	16.23
100067	1.3589	17.40
100068	1.3600	18.65
100069	1.2996	16.14
100070	1.4348	20.33
100071	1.2324	16.48
100072	1.2519	19.22
100073	1.7170	18.16
100075	1.5967	18.05
100076	1.2999	16.25

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
100077	1.3907	19.62
100078	1.0296	18.28
100079	1.3325	.....
100080	1.6004	21.16
100081	1.1059	13.96
100082	1.4981	19.80
100084	1.3484	20.40
100085	1.4397	21.08
100086	1.2337	21.16
100087	1.8332	23.12
100088	1.6560	20.06
100090	1.3796	17.88
100092	1.5762	18.19
100093	1.5951	16.63
100098	1.0984	19.03
100099	1.2207	15.30
100102	1.0153	19.33
100103	0.9374	18.10
100105	1.4538	21.50
100106	1.0262	19.31
100107	1.3128	18.01
100108	0.9979	11.47
100109	1.3846	22.17
100110	1.3687	19.64
100112	0.9703	9.77
100113	1.9526	22.26
100114	1.3378	23.45
100117	1.1904	18.86
100118	1.2978	19.76
100121	1.1778	19.34
100122	1.2065	18.06
100124	1.2961	19.05
100125	1.2709	17.33
100126	1.4682	18.09
100127	1.6587	19.87
100128	2.2076	21.37
100129	1.3074	18.57
100130	1.1759	19.10
100131	1.3440	22.17
100132	1.2920	16.90
100134	0.9738	13.47
100135	1.5672	17.48
100137	1.2758	19.05
100138	1.0055	11.01
100139	1.0894	15.64
100140	1.2173	17.35
100142	1.2261	18.68
100144	1.1622	15.02
100145	.....	19.11
100146	0.9697	17.87
100147	1.0080	14.68
100150	1.3244	21.02
100151	1.7687	19.40
100154	1.5832	19.85
100156	1.1101	17.13
100157	1.5609	21.03
100159	0.9570	16.38
100160	1.2026	21.63
100161	1.6995	21.50
100162	1.3955	19.87
100165	1.1535	18.57
100166	1.4349	20.42
100167	1.3548	21.81
100168	1.3372	20.13

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
100169	1.7623	20.78
100170	1.4159	15.12
100172	1.4335	15.18
100173	1.6528	17.34
100174	1.3768	20.51
100175	1.1543	17.82
100176	2.0764	24.70
100177	1.2977	22.00
100179	1.7103	20.91
100180	1.4415	18.48
100181	1.1065	24.57
100183	1.1888	20.86
100187	1.4299	20.69
100189	1.3286	21.01
100191	1.3182	18.47
100199	1.3519	23.37
100200	1.2409	22.26
100203	.....	18.86
100204	1.6272	20.20
100206	1.3739	20.35
100207	.....	15.92
100208	1.3673	20.83
100209	1.4791	19.73
100210	1.5718	19.18
100211	1.3991	25.53
100212	1.6224	25.34
100213	1.5100	19.12
100217	1.2751	19.87
100220	1.6355	19.91
100221	1.8110	22.25
100222	0.9440	22.19
100223	1.4651	18.76
100224	1.3349	24.70
100225	1.3371	20.64
100226	1.3508	24.86
100228	1.2825	23.70
100229	1.3326	18.21
100230	1.3523	20.60
100231	1.6815	17.40
100232	1.2511	17.32
100234	1.2587	21.58
100235	.....	17.66
100236	1.3925	21.81
100237	2.1893	22.93
100238	1.5454	17.63
100239	1.4287	19.76
100240	1.0888	17.93
100241	0.8994	13.83
100242	1.4298	17.12
100243	1.4071	20.38
100244	1.3741	17.41
100246	1.3686	21.22
100248	1.5873	21.54
100249	1.3084	19.02
100252	1.2005	17.87
100253	1.4323	20.60
100254	1.5401	20.91
100255	1.2559	21.02
100256	2.0104	23.56
100258	1.6901	21.88
100259	1.3409	19.86
100260	1.4570	21.22
100262	1.3448	19.59
100263	.....	16.90

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
100264	1.3620	17.61
100265	1.2932	19.86
100266	1.3567	17.73
100267	1.3056	17.10
100268	1.1952	23.59
100269	1.4345	21.20
100270	1.0181	19.86
100271	1.7715	19.92
100275	1.3944	21.33
100276	1.2371	21.98
100277	1.0333	16.14
100279	1.2721	23.02
100280	1.2951	16.58
100281	1.2795	22.02
100282	1.0837	19.77
100284	1.0855	.....
110001	1.2552	18.06
110002	1.2532	17.37
110003	1.3637	16.91
110004	1.3569	18.95
110005	1.1963	19.26
110006	1.4201	20.13
110007	1.6114	23.50
110008	1.2419	18.26
110009	1.1355	14.82
110010	2.1768	24.55
110011	1.1631	18.28
110013	1.0596	16.03
110014	0.9442	16.12
110015	1.1403	19.48
110016	1.2284	15.30
110017	0.9311	10.54
110018	1.1969	21.04
110020	1.1913	18.53
110023	1.3377	18.65
110024	1.3651	19.79
110025	1.3872	18.65
110026	1.1354	16.14
110027	1.1200	14.68
110028	1.7799	19.89
110029	1.3551	20.05
110030	1.2989	17.68
110031	1.2252	21.58
110032	1.2518	16.19
110033	1.4207	21.41
110034	1.5887	18.19
110035	1.3910	21.17
110036	1.8557	24.42
110038	1.4440	16.38
110039	1.4173	20.77
110040	1.0663	16.40
110041	1.1827	16.69
110042	1.1533	20.65
110043	1.8094	17.22
110044	1.1898	19.60
110045	1.1386	19.94
110046	1.2456	19.23
110048	1.2372	15.65
110049	1.0992	14.21
110050	1.1823	18.75
110051	1.0253	15.75
110052	.....	15.06
110054	1.3647	19.27
110056	1.0854	16.50

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
110059	1.2176	17.70
110061	1.0960	13.72
110062	0.9082	12.21
110063	1.0542	17.97
110064	1.4891	18.34
110065	1.0304	13.32
110066	1.4455	20.65
110069	1.2576	18.35
110070	1.1398	18.23
110071	1.0981	14.89
110072	0.9710	12.43
110073	1.1423	15.14
110074	1.5078	20.76
110075	1.3221	17.01
110076	1.4652	20.44
110078	1.7591	24.71
110079	1.4560	20.14
110080	1.3568	23.43
110082	2.0994	22.01
110083	1.7625	21.36
110086	1.2841	14.98
110087	1.3556	20.54
110089	1.2027	18.58
110091	1.2778	21.38
110092	1.0882	15.09
110093	0.9940	14.80
110094	0.9912	13.87
110095	1.3528	15.95
110096	1.0800	16.32
110097	1.0625	15.62
110098	0.9868	14.01
110100	1.0558	20.38
110101	1.1014	11.73
110103	0.9292	11.94
110104	1.0957	15.32
110105	1.3084	16.52
110107	1.8959	17.39
110108	0.9495	15.14
110109	1.1092	16.37
110111	1.2038	17.32
110112	0.9910	19.13
110113	1.0478	15.19
110114	1.0443	15.13
110115	1.7515	24.83
110118	1.1342	15.40
110120	1.0378	15.19
110121	1.2814	15.58
110122	1.3852	18.85
110124	1.2083	17.13
110125	1.2563	17.33
110127	0.8834	13.76
110128	1.1927	18.97
110129	1.6606	18.12
110130	1.0077	13.08
110132	1.1467	15.02
110134	0.9641	11.56
110135	1.3364	17.08
110136	1.1043	16.17
110140	1.0432	17.88
110141	0.9978	12.51
110142	0.9537	12.30
110143	1.4324	21.69
110144	1.0701	17.98
110146	1.0869	17.61

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
110149	1.1792	22.23
110150	1.4100	18.77
110152	1.0430	14.77
110153	1.0935	18.69
110154	0.9773	14.81
110155	1.1373	17.14
110156	1.0500	15.34
110161	1.3183	20.87
110162	0.7522	.....
110163	1.4626	18.20
110164	1.4197	19.49
110165	1.4296	19.00
110166	1.4485	19.85
110168	1.6662	19.82
110169	1.2028	18.72
110171	1.6129	20.09
110172	1.3551	25.44
110174	0.9161	14.30
110176	3.7291	22.40
110177	1.5099	19.59
110178	.....	16.85
110179	1.1506	20.52
110181	0.9051	13.72
110183	1.3138	21.18
110184	1.2424	20.95
110185	1.1859	16.25
110186	1.2579	17.34
110187	1.2755	21.45
110188	1.3546	20.05
110189	1.1719	18.86
110190	1.0646	19.43
110191	1.3087	19.11
110192	1.4455	20.77
110193	1.2441	18.78
110194	0.8928	15.09
110195	1.0992	10.52
110198	1.2874	26.19
110200	1.8858	17.21
110201	1.5098	19.24
110203	0.9319	20.30
110204	0.8239	20.57
110205	1.0578	26.12
110207	1.0141	12.87
110208	0.9593	14.89
110209	0.7100	20.46
110211	0.9611	21.82
110212	1.0031	12.66
110213	.....	13.20
110215	1.0915	.....
110216	2.1653	.....
110217	2.8336	.....
120001*	1.8210	26.71
120002	1.2129	24.38
120003	1.1495	23.85
120004	1.2588	24.05
120005	1.2449	20.54
120006	1.2730	23.72
120007	1.7318	23.27
120009	0.9876	19.02
120010*	1.8326	25.40
120011	1.3630	33.55
120012	0.8391	22.52
120014	1.2760	24.05
120015	1.0355	29.07

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
120016	1.0574	29.41
120018	1.2117	25.61
120019	1.3192	21.92
120021	0.8937	19.42
120022*	1.6843	17.93
120024	1.0727	22.28
120025	.....	19.02
120026	1.2648	23.22
120027	1.4048	24.55
120028	1.2481	23.49
130001	0.9681	24.95
130002	1.3266	16.19
130003	1.3394	19.95
130005	1.4416	20.17
130006	1.8354	18.87
130007	1.6730	19.84
130008	0.9590	12.92
130009	0.9302	18.30
130010	0.8926	21.43
130011	1.2859	19.08
130012	0.9911	22.62
130013	1.3306	19.22
130014	1.3247	17.98
130015	0.8768	15.27
130016	1.0211	17.00
130017	1.1066	16.88
130018	1.6255	17.97
130019	1.1213	17.23
130021	0.9692	12.26
130022	1.2150	19.50
130024	1.1595	18.38
130025	1.0955	15.27
130026	1.1725	20.55
130027	0.9334	20.70
130028	1.2849	18.21
130029	1.0697	20.32
130030	0.8448	18.40
130031	1.0229	17.65
130034	1.0325	18.82
130035	1.1048	20.47
130036	1.3938	13.79
130037	1.3059	17.74
130043	0.9589	16.07
130044	0.9748	13.18
130045	0.9802	16.47
130048	0.9813	15.09
130049	1.2324	20.39
130054	0.9573	17.78
130056	0.8508	15.66
130058	.....	17.75
130060	1.2887	20.85
130061	1.2950	16.78
130062	0.7200	15.11
130063	1.4979	.....
140001	1.2255	15.44
140002	1.2571	19.26
140003	1.0026	18.00
140004	1.1707	17.52
140005	0.9673	10.87
140007	1.4692	22.40
140008	1.4670	21.28
140010	1.3723	25.22
140011	1.2034	17.28
140012	1.2770	19.44

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
140013	1.5752	17.35
140014	1.1751	20.76
140015	1.2854	15.02
140016	1.0294	12.54
140018	1.2556	21.41
140019	1.1123	15.34
140024	0.9557	14.67
140025	1.0826	16.95
140026	1.2234	15.96
140027	1.2694	17.50
140029	1.3385	21.03
140030	1.8214	22.44
140031	1.2008	15.94
140032	1.3345	17.34
140033	1.2874	22.56
140034	1.1851	19.15
140035	1.0002	13.00
140036	1.2407	17.04
140037	1.0383	12.50
140038	1.1029	17.61
140040	1.2581	16.25
140041	1.1609	17.28
140042	1.0170	15.61
140043	1.1892	18.95
140045	1.0315	20.65
140046	1.3045	16.46
140047	1.0950	16.33
140048	1.3056	20.58
140049	1.6537	21.59
140051	1.5128	20.85
140052	1.3027	19.60
140053	2.0158	17.82
140054	1.3339	26.15
140055	1.0225	14.80
140058	1.2340	17.27
140059	1.1394	15.39
140061	1.0953	15.96
140062	1.2457	27.09
140063	1.4375	22.39
140064	1.3249	19.25
140065	1.4610	23.16
140066	1.1773	16.17
140067	1.8177	18.40
140068	1.2883	18.87
140069	1.0457	16.15
140070	1.2636	19.30
140074	1.0760	19.01
140075	1.3671	22.51
140077	1.2557	16.64
140079	1.2639	21.92
140080	1.5815	21.00
140081	1.0826	15.51
140082	1.3675	22.62
140083	1.2487	18.13
140084	1.2529	20.01
140086	1.1147	17.37
140087	1.3481	18.36
140088	1.7136	24.26
140089	1.2745	17.21
140090	1.5324	23.59
140091	1.9057	20.70
140093	1.1687	19.15
140094	1.3422	20.61
140095	1.4016	21.54

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
140097	0.9525	16.90
140100	1.3286	19.06
140101	1.2240	26.09
140102	1.0445	15.08
140103	1.4231	17.86
140105	1.2926	20.91
140107	1.0113	12.76
140108	1.3335	28.60
140109	1.1446	15.47
140110	1.2400	18.81
140112	1.1563	16.24
140113	1.5588	17.92
140114	1.3342	20.48
140115*	1.3041	20.09
140116	1.2341	21.83
140117	1.5614	19.64
140118	1.7249	23.08
140119	1.7816	26.50
140120	1.3740	14.84
140121	1.3607	9.53
140122	1.5542	23.75
140124	1.1024	26.97
140125	1.3478	17.10
140127	1.4164	19.42
140128	1.0296	17.67
140129	1.1659	15.25
140130	1.2488	23.77
140132	1.4905	23.04
140133	1.4025	19.91
140135	1.2759	17.69
140137	1.0383	16.51
140138	1.0650	14.59
140139	1.1039	16.58
140140	1.1395	15.30
140141	1.2644	15.18
140143	1.0957	18.76
140144	0.9933	19.79
140145	1.1514	16.61
140146	1.0740	23.74
140147	1.2519	24.82
140148	1.8274	19.50
140150	1.6434	27.85
140151	1.0618	19.30
140152	1.1951	22.43
140155	1.3310	17.31
140158	1.3594	22.27
140160	1.1737	17.88
140161	1.2224	19.04
140162	1.6988	18.42
140164	1.4390	18.61
140165	1.0866	15.42
140166	1.1670	17.54
140167	1.0995	16.57
140168	1.1303	16.46
140170	1.1327	14.14
140171	0.9915	14.73
140172	1.5915	20.80
140173	0.8685	18.48
140174	1.6130	19.92
140176	1.2480	21.41
140177	1.2010	18.17
140179	1.3630	22.70
140180	1.4469	23.25
140181	1.4232	20.55

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
140182	1.3607	20.70
140184	1.2116	14.98
140185	1.4938	17.36
140186	1.3429	18.99
140187	1.5865	17.69
140188	0.9985	14.84
140189	1.2534	19.08
140190	1.0757	15.88
140191	1.4399	24.74
140193	1.0289	15.52
140197	1.2537	17.98
140199	1.0816	18.83
140200	1.4773	21.65
140202	1.3290	22.18
140203	1.1563	20.78
140205	0.9296	17.24
140206	1.2023	20.51
140207	1.2939	20.20
140208	1.7156	23.94
140209	1.6271	17.79
140210	1.1138	12.66
140211	1.2095	20.96
140213	1.2790	26.20
140215	0.9874	14.45
140217	1.3233	23.32
140218	0.9871	15.08
140220	1.1223	16.73
140223	1.5508	21.47
140224	1.4309	22.99
140228	1.6773	18.67
140230	0.9381	16.60
140231	1.5608	21.61
140233	1.7813	18.37
140234	1.2225	18.72
140236	1.0843	13.13
140239	1.7318	18.88
140240	1.3948	24.21
140242	1.6371	22.67
140245	1.2029	15.56
140246	1.0621	12.82
140250	1.3281	23.41
140251	1.3069	20.58
140252	1.4989	24.49
140253	1.1634	16.74
140258	1.5765	21.13
140271	0.9795	15.36
140275	1.2739	17.96
140276	2.0654	23.72
140280	1.3786	18.84
140281	1.6496	23.34
140285	1.2739	14.71
140286	1.1863	19.95
140288	1.6193	21.82
140289	1.3459	16.45
140290	1.3383	21.24
140291	1.3339	22.44
140292	1.2911	22.71
140294	1.1347	17.52
140297	.....	21.47
140300	1.4559	23.26
150001	1.1041	21.70
150002	1.4489	18.76
150003	1.8053	19.31
150004	1.5183	19.70

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
150005	1.1499	19.00
150006	1.2599	20.04
150007	1.2063	19.53
150008	1.4364	20.97
150009	1.3649	18.22
150010	1.3600	18.48
150011	1.2166	19.19
150012	1.6210	20.52
150013	1.1027	16.00
150014	1.6030	21.28
150015	1.2975	22.05
150017	1.9021	18.89
150018	1.4575	19.56
150019	1.0931	15.29
150020	1.1536	14.46
150021	1.6905	19.02
150022	1.0882	17.92
150023	1.5779	18.66
150024	1.3427	17.83
150025	1.4440	18.15
150026	1.2077	20.51
150027	1.0057	16.48
150029	1.3399	21.74
150030	1.2418	17.33
150031	1.0791	18.01
150032	.....	20.64
150033	1.5759	21.69
150034	1.4830	21.29
150035	1.4915	19.82
150036	1.0011	20.38
150037	1.2875	17.79
150038	1.2923	20.25
150039	1.0012	17.49
150042	1.2828	17.12
150043	1.1061	17.98
150044	1.2617	17.64
150045	1.0943	17.04
150046	1.3952	17.32
150047	1.5995	24.88
150048	1.1920	16.96
150049	1.2163	16.85
150050	1.1659	17.14
150051	1.5091	18.20
150052	1.0896	15.36
150053	0.9867	18.75
150054	1.1338	17.33
150056	1.8954	23.30
150057	2.2387	16.86
150058	1.7048	20.95
150059	1.3598	20.80
150060	1.1844	16.01
150061	1.2118	17.21
150062	1.1077	18.41
150063	1.0850	21.09
150064	1.1848	17.03
150065	1.1695	19.01
150066	1.0217	14.60
150067	1.1259	17.08
150069	1.2229	17.39
150070	0.9568	17.20
150071	1.0951	14.73
150072	1.1985	16.11
150073	1.0647	19.03
150074	1.6339	18.86

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
150075	1.1208	14.98
150076	1.1839	22.34
150077	0.8124	17.58
150078	1.0539	19.01
150079	1.1723	15.45
150082	1.5245	17.88
150084	1.9902	22.92
150086	1.2532	17.34
150088	1.3451	19.45
150089	1.4582	22.94
150090	1.3308	19.06
150091	1.0358	19.89
150092	1.0090	15.92
150094	0.9814	18.34
150095	1.0848	17.12
150096	1.0067	20.03
150097	1.0940	18.31
150098	1.1571	14.30
150099	.....	18.97
150100	1.6554	17.48
150101	1.0910	17.56
150102	1.0778	11.50
150103	0.9707	17.31
150104	1.1260	17.26
150105	1.3381	19.17
150106	1.0525	18.91
150109	1.3958	18.23
150110	0.9834	18.58
150111	1.1588	16.17
150112	1.2455	19.82
150113	1.2372	19.20
150114	0.9743	16.96
150115	1.3404	17.06
150122	1.1625	19.35
150123	1.1180	15.16
150124	1.0843	15.07
150125	1.4619	20.32
150126	1.4866	20.30
150127	1.0396	22.81
150128	1.2478	19.92
150129	1.1853	23.47
150130	1.3391	16.41
150132	1.4200	19.48
150133	1.1910	16.49
150134	1.1949	17.06
150136	0.9556	19.28
160001	1.2585	19.03
160002	1.0936	15.37
160003	0.9994	15.77
160005	1.0825	15.23
160007	1.0218	15.66
160008	1.1402	14.97
160009	1.2212	16.09
160012	1.0500	16.54
160013	1.1368	17.06
160014	1.0250	15.09
160016	1.1678	18.37
160018	0.9630	14.16
160020	1.0690	14.41
160021	1.1123	15.49
160023	1.0852	14.20
160024	1.6086	18.95
160026	1.0312	18.66
160027	1.0851	15.74

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
160028	1.2328	20.54
160029	1.5330	20.40
160030	1.3897	17.99
160031	1.1173	15.28
160032	1.1540	16.18
160033	1.9249	18.37
160034	1.1538	14.51
160035	0.8486	15.92
160036	1.0544	19.20
160037	1.0575	18.40
160039	1.0380	17.63
160040	1.2725	16.83
160041	1.0640	15.47
160043	0.9958	15.63
160044	1.2165	16.04
160045	1.8190	20.12
160046	1.0270	14.77
160047	1.3715	16.69
160048	1.2473	13.14
160049	0.9271	13.36
160050	1.0702	16.42
160051	0.8978	14.27
160052	0.9917	17.55
160054	1.0301	15.71
160055	0.9883	14.06
160056	1.0674	15.38
160057	1.2430	17.41
160058	1.8366	20.34
160060	1.0432	15.95
160061	1.0830	17.57
160062	0.9941	14.44
160063	1.1620	16.30
160064	1.5338	19.91
160065	1.0522	16.51
160066	1.1019	16.26
160067	1.4239	17.85
160068	1.0224	15.85
160069	1.5367	18.49
160070	0.9958	15.66
160072	1.0345	14.19
160073	0.9972	15.05
160074	1.0388	16.48
160075	1.0778	17.89
160076	1.0989	17.31
160077	1.1087	11.40
160079	1.4119	17.71
160080	1.2114	17.81
160081	1.1520	16.51
160082	1.9236	18.76
160083	1.6706	18.41
160085	0.9972	18.55
160086	0.9601	16.46
160088	1.1561	17.53
160089	1.1911	16.74
160090	1.0139	16.60
160091	1.0383	12.19
160092	1.0120	15.80
160093	1.0155	15.95
160094	1.1043	16.56
160095	1.0299	14.26
160097	1.0774	15.21
160098	0.9466	15.54
160099	0.9654	13.79
160101	1.0851	17.87

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
160102	1.3432	18.36
160103	0.9416	17.15
160104	1.2969	19.74
160106	1.1113	16.66
160107	1.1505	16.56
160108	1.0215	15.42
160109	1.0167	16.49
160110	1.5105	18.81
160111	0.9969	13.17
160112	1.3695	16.28
160113	1.0947	14.58
160114	0.9776	15.58
160115	0.9770	15.76
160116	1.1196	16.69
160117	1.4111	17.29
160118	0.9954	15.84
160120	0.9721	12.56
160122	1.1137	18.52
160124	1.2998	17.16
160126	0.9700	17.74
160129	0.9742	15.89
160130	1.1286	15.45
160131	1.0437	14.69
160134	0.9459	13.32
160135	1.0163	16.33
160138	1.0146	15.71
160140	1.1321	18.80
160142	1.0188	16.14
160143	1.1242	15.92
160145	1.0697	15.17
160146	1.4411	16.35
160147	1.2764	18.39
160151	1.0545	15.74
160152	0.9425	15.22
160153	1.7595	19.69
170001	1.2073	17.44
170004	1.0739	13.06
170006	1.1966	19.31
170008	1.0034	13.90
170009	1.1479	19.59
170010	1.3585	17.90
170012	1.4135	16.79
170013	1.2818	17.89
170014	1.0342	17.34
170015	0.9809	15.89
170016	1.7098	19.64
170017	1.1985	17.87
170018	1.1014	14.28
170019	1.2400	16.66
170020	1.4076	16.15
170022	1.0506	17.94
170023	1.4694	19.36
170024	1.0663	13.06
170025	1.1917	16.37
170026	1.0821	13.31
170027	1.3182	16.39
170030	1.0600	15.24
170031	0.8926	13.47
170032	1.0154	14.48
170033	1.4154	16.05
170034	1.0335	14.63
170035	0.8974	15.62
170036	.....	14.17
170038	0.9007	14.21

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
170039	1.0924	14.30
170040	1.5839	20.14
170041	1.0515	11.47
170044	0.9951	14.78
170045	1.0889	12.11
170049	1.3513	18.58
170051	0.9883	14.16
170052	1.0435	14.62
170053	0.9379	9.04
170054	1.0385	12.77
170055	0.9812	14.99
170056	0.8854	14.87
170057	.....	15.09
170058	1.1560	18.34
170060	1.0207	17.23
170061	1.1617	14.14
170063	0.8974	11.33
170064	.....	12.42
170066	0.9451	14.48
170067	0.9987	12.78
170068	1.2647	15.82
170070	1.0611	12.82
170072	0.9119	13.34
170073	1.0417	16.47
170074	1.2029	14.40
170075	0.9266	11.26
170076	1.0180	13.58
170077	0.9138	12.72
170079	1.0029	14.29
170080	0.9644	12.20
170081	0.9118	12.51
170082	0.9387	12.39
170084	0.8978	12.16
170085	0.8894	14.51
170086	1.6767	19.85
170088	0.9319	11.75
170089	0.9744	18.08
170090	0.9652	11.27
170092	.....	12.85
170093	0.8902	12.78
170094	0.9571	17.71
170095	1.0123	15.75
170097	0.9087	15.85
170098	1.1360	14.10
170099	1.1529	13.55
170100	.....	14.47
170101	0.9694	12.88
170102	0.9678	13.24
170103	1.3272	16.66
170104	1.4805	19.76
170105	1.0590	15.93
170106	0.9336	14.68
170109	0.9346	16.94
170110	0.9857	15.55
170112	1.1452	13.39
170113	1.0746	13.39
170114	0.9511	14.51
170115	0.9977	12.68
170116	1.0599	15.76
170117	0.9782	15.28
170119	0.9657	13.97
170120	1.2725	16.21
170122	1.7569	20.13
170123	1.7222	21.42

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
170124	0.9948	10.21
170126	0.9316	12.13
170128	0.9613	14.99
170131	.....	13.10
170133	1.1278	17.11
170134	0.8746	14.23
170137	1.1825	17.42
170139	1.0034	13.39
170142	1.3143	17.32
170143	1.1142	15.88
170144	1.5081	16.09
170145	1.1137	16.75
170146	1.4464	19.97
170147	1.1950	16.28
170148	1.3683	17.25
170150	1.1491	15.43
170151	0.9386	13.37
170152	1.0039	13.68
170160	0.9948	13.31
170164	0.9849	15.56
170166	1.1213	17.57
170171	1.0545	13.81
170175	1.3044	17.88
170176	1.6757	20.32
170182	1.4288	14.20
170183	1.9802	19.09
170184	.....	27.01
180001	1.3845	19.52
180002	1.0807	18.13
180004	1.1145	15.99
180005	1.1967	20.63
180006	0.9088	11.23
180007	1.4605	17.20
180009	1.3630	20.81
180010	1.9352	17.55
180011	1.3149	16.93
180012	1.4399	18.74
180013	1.4516	17.45
180014	1.6962	20.80
180016	1.3326	18.84
180017	1.3055	15.17
180018	1.2972	18.90
180019	1.1916	16.76
180020	1.1096	17.78
180021	1.0498	15.16
180023	0.9502	15.22
180024	1.4071	15.33
180025	1.2007	17.17
180026	1.2061	14.16
180027	1.2508	14.89
180028	1.0896	19.35
180029	1.2291	18.02
180030	1.1690	17.02
180031	1.1171	13.79
180032	1.0592	16.09
180033	1.0969	13.77
180034	1.0876	17.32
180035	1.6449	19.45
180036	1.1569	19.19
180037	1.3120	18.81
180038	1.4617	17.16
180040	1.9294	19.44
180041	1.1888	15.17
180042	1.1678	16.29

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
180043	1.1248	16.61
180044	1.1967	17.82
180045	1.3993	17.73
180046	1.0431	17.91
180047	1.0016	15.04
180048	1.2482	19.57
180049	1.3489	16.08
180050	1.2187	18.48
180051	1.3876	15.68
180053	1.0545	14.63
180054	1.0894	16.39
180055	1.2204	14.64
180056	1.1028	16.62
180058	1.0446	14.36
180059	0.8725	14.26
180060	.....	7.21
180063	1.0690	11.91
180064	1.1791	14.49
180065	1.0777	20.03
180066	1.0801	18.56
180067	1.8973	18.53
180069	1.1243	17.30
180070	1.1056	13.84
180072	1.1200	17.85
180075	.....	15.07
180078	1.0782	19.16
180079	1.1816	13.41
180080	1.0820	15.83
180087	1.2278	14.97
180088	1.6070	22.53
180092	1.2232	16.31
180093	1.4180	16.83
180094	1.0265	12.51
180095	1.1312	13.40
180099	1.0423	13.70
180101	1.1766	19.56
180102	1.4368	17.88
180103	2.3182	19.22
180104	1.5485	18.87
180105	0.8828	14.08
180106	0.8754	13.61
180108	0.8268	14.62
180115	0.9601	17.11
180116	1.2335	16.94
180117	1.1154	18.38
180118	0.9648	12.15
180120	1.0190	17.81
180121	1.1698	14.51
180122	1.0646	16.97
180123	1.3537	19.00
180124	1.3291	18.41
180125	1.1248	19.73
180126	1.1140	12.40
180127	1.2901	17.35
180128	1.0665	17.05
180129	0.9823	17.86
180130	1.4358	19.01
180132	1.2696	17.26
180133	1.3414	22.23
180134	1.0880	13.63
180136	1.8166	17.71
180138	1.2012	18.61
180139	1.0562	18.77
180140	0.9802	20.40

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
180141	1.8686	20.01
180142	1.7788	.....
190001	0.8863	17.01
190002	1.6872	18.84
190003	1.3293	22.15
190004	1.4227	17.54
190005	1.5108	16.71
190006	1.4657	17.73
190007	1.0554	13.60
190008	1.6184	16.89
190009	1.2835	14.21
190010	1.2068	17.02
190011	1.1462	15.17
190013	1.3006	16.57
190014	1.1871	17.02
190015	1.2674	18.19
190017	1.3423	15.79
190018	1.1075	16.98
190019	1.7884	17.40
190020	1.1993	17.31
190025	1.3078	16.07
190026	1.5549	17.22
190027	1.5154	16.19
190029	1.1492	17.11
190033	0.9722	10.74
190034	1.1721	16.51
190036	1.6846	19.94
190037	0.9642	12.02
190039	1.4096	17.17
190040	1.3336	20.32
190041	1.6062	17.90
190043	1.0448	12.57
190044	1.1671	17.20
190045	1.4154	21.69
190046	1.4275	19.35
190048	1.2068	16.34
190049	0.9395	16.42
190050	1.0788	15.38
190053	1.1493	12.50
190054	1.2992	16.47
190059	0.8878	15.84
190060	1.3886	18.37
190064	1.5235	19.90
190065	1.4997	19.39
190071	0.8370	13.59
190077	0.8845	12.83
190078	1.1084	13.50
190079	1.3543	17.29
190081	0.8862	12.02
190083	1.0663	16.14
190086	1.3280	14.93
190088	1.2140	19.63
190089	1.1095	12.79
190090	1.0412	16.56
190092	.....	18.07
190095	0.9939	15.73
190098	1.5467	19.22
190099	1.1795	18.92
190102	1.6260	19.05
190103	0.9068	15.57
190106	1.1248	17.75
190109	1.2488	14.53
190110	0.9773	12.99
190111	1.5936	20.04

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
190112	1.6944	19.21
190113	1.3926	18.99
190114	1.0180	12.91
190115	1.2776	20.49
190116	1.1970	12.59
190118	0.9984	12.95
190120	0.9918	13.69
190122	1.2902	14.83
190124	1.6262	22.38
190125	1.4998	18.63
190128	1.1960	19.71
190130	1.0021	12.43
190131	1.2634	19.60
190133	1.0829	13.48
190134	1.0010	12.68
190135	1.4336	21.35
190136	0.9974	11.33
190138	.....	22.71
190140	0.9506	12.03
190142	0.9173	14.98
190144	1.1852	16.84
190145	0.9756	13.99
190146	1.5254	20.09
190147	0.9772	14.32
190148	0.9409	14.02
190149	0.9956	15.19
190151	1.0763	11.92
190152	1.5099	20.40
190155	.....	11.08
190156	0.9523	12.48
190158	1.2658	19.62
190160	1.2656	18.47
190161	1.0796	14.63
190162	1.2953	19.50
190164	1.1850	16.33
190167	1.1283	16.29
190170	0.9051	13.58
190173	1.3386	19.64
190175	1.4211	20.69
190176	1.6017	18.82
190177	1.7127	20.32
190178	0.9284	10.49
190182	1.3004	20.03
190183	1.1900	16.11
190184	0.9948	14.86
190185	1.3089	19.37
190186	0.9392	16.36
190189	.....	26.54
190190	0.9164	18.67
190191	1.1467	18.14
190196	0.9433	14.87
190197	1.1821	17.92
190199	1.1077	13.42
190200	1.4896	19.41
190201	1.0997	19.14
190202	1.1257	17.90
190203	1.4077	21.31
190204	1.4949	21.21
190205	1.9200	18.10
190206	1.6311	20.06
190207	1.2616	17.67
190208	0.8087	14.61
190218	1.0606	18.16
190223	.....	19.26

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
190227	1.0049	12.11
190231	1.5630	16.89
190235	.....	18.27
190236	1.4200	22.18
190237	2.6647	.....
190238	1.6631	.....
190239	1.1565	.....
190240	0.9574	.....
200001	1.3477	17.49
200002	1.1150	18.77
200003	1.0964	16.74
200006	1.0846	19.80
200007	1.0259	17.89
200008	1.2221	20.50
200009	1.8810	20.64
200012	1.1802	17.01
200013	1.1132	16.49
200015	.....	20.11
200016	1.0407	17.66
200017	.....	19.65
200018	1.2100	17.24
200019	1.2510	18.64
200020	1.1517	20.60
200021	1.1958	19.41
200023	0.8393	14.92
200024	1.4795	18.65
200025	1.2498	19.07
200026	0.9907	17.28
200027	1.2361	18.28
200028	0.9208	16.93
200031	1.2276	15.90
200032	1.3282	17.92
200033	1.7827	21.40
200034	1.2767	19.24
200037	1.2288	18.24
200038	1.1403	19.21
200039	1.2567	20.29
200040	1.1161	19.30
200041	1.1251	17.66
200043	0.8011	16.54
200050	1.2048	18.08
200051	0.9887	19.59
200052	0.9951	15.12
200055	1.0880	17.17
200062	0.9532	16.51
200063	1.2440	19.67
200066	1.1429	16.34
210001	1.4433	18.73
210002	2.0494	22.84
210003	1.6842	25.37
210004	1.3603	23.59
210005	1.2944	19.62
210006	1.1143	17.77
210007	1.8010	21.54
210008	1.3067	19.50
210009	1.8608	21.81
210010	1.1389	14.38
210011	1.3616	21.24
210012	1.6214	23.43
210013	1.3595	18.85
210015	1.3058	16.69
210016	1.8547	22.15
210017	1.2502	17.17
210018	1.2626	21.41

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
210019	1.6155	19.09
210022	1.4895	21.82
210023	1.4521	21.80
210024	1.6929	19.56
210025	1.3269	19.57
210026	1.3215	11.64
210027	1.2849	18.49
210028	1.1685	18.86
210029	1.2770	22.39
210030	1.2555	21.02
210031	1.3110	15.59
210032	1.1818	18.50
210033	1.2403	19.91
210034	1.3179	16.12
210035	1.3496	20.61
210037	1.2643	18.74
210038	1.4168	23.26
210039	1.1908	20.73
210040	1.3185	25.08
210043	1.2817	18.59
210044	1.3636	22.24
210045	1.0866	9.69
210048	1.2884	22.39
210049	1.1698	17.67
210051	1.4028	20.76
210054	1.3672	23.51
210055	1.3640	20.10
210056	1.3926	20.94
210057	1.3578	22.57
210058	1.5015	21.50
210059	1.1916	23.13
210060	1.2744	.....
210061	1.1312	20.02
220001	1.2885	26.32
220002	1.4675	22.58
220003	1.1126	19.14
220004	.....	20.01
220006	1.3858	22.12
220008	1.2978	21.89
220010	1.3476	21.92
220011	1.0966	28.57
220012	1.3138	29.51
220015	1.1694	21.78
220016	1.3440	23.14
220017	1.3512	25.26
220019	1.1553	19.13
220020	1.2443	19.99
220021	.....	23.63
220023	0.6351	18.76
220024	1.2152	21.59
220025	1.1428	19.94
220028	1.4561	22.07
220029	1.1597	21.87
220030	1.1060	14.54
220031	1.9047	28.16
220033	1.2607	20.41
220035	1.3065	22.00
220036	1.6250	24.16
220038	1.3105	22.35
220041	1.1892	23.15
220042	1.2714	25.28
220046	1.3199	22.47
220049	1.2818	23.03
220050	1.1650	20.83

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
220051	1.1795	20.48
220052	1.2991	23.14
220053	1.1633	21.27
220055	1.2850	21.57
220057	1.3594	23.00
220058	1.1555	20.19
220060	1.2301	26.17
220062	0.5637	20.06
220063	1.2667	20.95
220064	1.2836	22.18
220065	1.3716	20.20
220066	1.3505	20.46
220067	1.2871	25.74
220068	.....	6.45
220070	1.2178	19.77
220071	1.9238	24.65
220073	1.3020	25.87
220074	1.3357	24.05
220075	1.7963	21.54
220076	1.2498	24.78
220077	1.8273	24.80
220079	1.1002	21.01
220080	1.3051	20.50
220081	0.9211	25.34
220082	1.2653	20.02
220083	1.1883	23.08
220084	1.2499	24.66
220086	1.7929	30.46
220088	1.6454	23.38
220089	1.2586	21.79
220090	1.2248	21.64
220092	1.1846	17.04
220094	.....	21.99
220095	1.1895	21.45
220098	1.3182	20.86
220100	1.3672	25.35
220101	1.4445	24.33
220104	1.4751	27.53
220105	1.2705	21.69
220106	1.2167	24.55
220107	.....	20.27
220108	1.1918	22.64
220110	2.1062	29.19
220111	1.2452	23.05
220116	1.9074	24.97
220118	.....	30.52
220119	1.2606	22.86
220123	1.0333	27.31
220126	1.2501	20.96
220128	.....	20.56
220133	0.6976	35.27
220135	1.2820	25.08
220153	1.0071	23.90
220154	0.9026	22.13
220162	1.5209	.....
220163	2.0316	27.35
220171	1.6823	23.43
230001	1.1547	19.20
230002	1.2729	21.91
230003	1.1440	19.61
230004	1.6897	22.03
230005	1.2524	19.40
230006	1.0497	18.47
230007	.....	19.43

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
230012	0.9628	18.67
230013	1.3746	20.63
230015	1.1422	20.43
230017	1.6115	20.40
230019	1.5321	21.32
230020	1.7453	21.32
230021	1.5006	18.57
230022	1.2699	19.76
230024	1.4264	27.96
230027	1.0344	18.03
230029	1.5752	21.06
230030	1.3412	17.70
230031	1.4268	17.53
230032	1.7439	20.68
230034	1.2703	17.23
230035	1.0782	17.56
230036	1.2543	21.76
230037	1.1759	19.07
230038	1.7538	23.39
230040	1.1335	20.39
230041	1.2547	19.03
230042	1.2347	19.49
230046	1.9274	25.95
230047	1.3582	20.64
230053	1.5879	22.18
230054	1.8393	19.54
230055	1.1717	19.84
230056	0.9022	16.41
230058	1.1008	18.23
230059	1.4590	19.51
230060	1.3289	17.87
230062	0.9642	16.30
230063	1.2580	20.22
230065	1.3189	21.15
230066	1.3680	21.51
230069	1.1982	21.79
230070	1.6482	20.06
230071	1.1143	22.16
230072	1.2345	20.43
230075	1.5088	19.43
230076	1.4056	23.82
230077	2.0633	20.39
230078	1.1156	16.25
230080	1.2475	18.91
230081	1.2085	17.95
230082	1.1156	17.74
230085	1.2336	17.54
230086	0.9507	16.98
230087	1.0836	15.77
230089	1.2845	21.39
230092	1.3584	18.96
230093	1.2332	20.19
230095	1.1754	16.78
230096	1.1056	22.56
230097	1.6198	20.10
230099	1.1227	20.25
230100	1.1434	13.11
230101	1.0673	18.61
230103	1.0518	19.60
230104	1.5580	23.47
230105	1.8005	20.88
230106	1.1850	18.35
230107	0.9423	14.67
230108	1.2110	17.42

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
230110	1.3149	17.80
230113	0.8490	11.17
230115	1.0569	16.47
230116	0.8683	16.36
230117	1.9017	23.94
230118	1.1392	21.71
230119	1.3553	23.96
230120	1.1300	19.64
230121	1.2281	20.08
230122	1.3510	18.09
230124	1.1665	18.89
230125	.....	15.35
230128	1.4062	23.58
230130	1.6919	22.52
230132	1.3454	26.17
230133	1.2277	17.57
230134	.....	15.32
230135	1.2335	22.74
230137	.....	18.34
230141	1.6286	23.05
230142	1.2833	20.12
230143	1.2819	16.45
230144	1.1235	20.99
230145	1.1243	16.60
230146	1.2623	18.63
230147	1.4122	20.51
230149	1.1319	14.17
230151	1.4152	20.89
230153	1.0656	17.33
230154	0.8898	14.58
230155	1.0291	16.99
230156	1.7492	23.61
230157	1.1708	19.72
230159	1.0227	18.84
230162	0.9486	17.77
230165	1.9365	23.31
230167	1.7523	20.32
230169	1.3609	22.86
230171	1.0638	14.96
230172	1.1814	20.22
230174	1.3724	20.85
230175	2.3801	21.81
230176	1.2161	21.86
230178	0.9470	16.08
230180	1.1228	15.48
230184	1.2506	17.29
230186	1.1355	.....
230188	1.1192	15.56
230189	0.9459	15.91
230190	0.8855	23.71
230191	0.9307	17.12
230193	1.3034	20.18
230195	1.3593	22.37
230197	1.4069	21.62
230199	1.1010	18.40
230201	1.2559	15.32
230204	1.3711	22.95
230205	0.9890	13.89
230207	1.2528	20.35
230208	1.2993	17.15
230211	0.9109	17.51
230212	1.0548	22.14
230213	0.9300	15.32
230216	1.5720	19.59

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
230217	1.2676	20.95
230219	0.8629	20.70
230221*	.....	21.50
230222	1.3905	20.84
230223	1.2683	21.50
230227	1.4220	21.38
230230	1.5842	22.53
230232	.....	12.64
230235	1.0983	15.95
230236	1.3279	23.22
230239	1.1721	19.23
230241	1.1923	18.85
230244	1.4096	21.08
230253	0.9601	21.95
230254	1.2941	21.28
230257	0.9124	20.47
230259	1.1378	21.15
230264	1.6854	15.18
230269	1.3102	22.81
230270	1.2083	20.08
230273	1.5194	23.40
230275	0.5244	17.60
230276	0.5657	18.58
230277	1.2485	22.50
230278	.....	16.66
230279	0.6550	16.04
230280	1.0995	14.22
230283	2.2592	.....
240001	1.5332	22.85
240002	1.7586	23.02
240004	1.5987	23.92
240005	0.8865	16.98
240006	1.1679	27.11
240007	1.0673	16.98
240008	1.1473	21.81
240009	0.9476	16.69
240010	1.9899	23.63
240011	1.1456	18.96
240013	1.2868	18.97
240014	1.0965	21.86
240016	1.3894	19.86
240017	1.1545	17.23
240018	1.2702	19.07
240019	1.1855	20.99
240020	1.1176	19.57
240021	0.9884	17.40
240022	1.1043	19.16
240023	0.9797	20.39
240025	1.0961	17.25
240027	1.0734	16.25
240028	1.1427	19.38
240029	1.1507	17.99
240030	1.2812	18.44
240031	0.9279	18.07
240036	1.5882	20.33
240037	1.0148	18.46
240038	1.5017	26.35
240040	1.2710	19.90
240041	1.1727	19.21
240043	1.2209	17.31
240044	1.1345	18.92
240045	1.1610	20.99
240047*	1.5761	21.86
240048	.....	23.31

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
240049	.....	22.13
240050	1.2090	24.50
240051	0.9678	18.23
240052	1.3021	19.22
240053	1.4864	21.20
240056	1.2521	22.29
240057	1.8388	23.24
240058	0.9316	14.91
240059	1.0446	21.96
240061	1.7835	25.56
240063	1.4484	23.54
240064	1.3231	20.76
240065	1.1449	12.55
240066	1.3065	22.05
240069	1.1937	19.18
240071	1.1063	19.19
240072	1.0228	18.00
240073	0.8981	15.63
240075	1.2006	21.19
240076	1.0723	21.07
240077	0.8989	14.95
240078	1.5437	22.71
240079	0.9531	17.82
240080*	1.6136	23.73
240082	1.1218	18.03
240083	1.2912	19.29
240084	1.3307	19.61
240085	1.0393	18.02
240086	1.0475	15.33
240087	1.1670	17.06
240088	1.4004	21.02
240089	0.9225	18.42
240090	1.1253	18.05
240093	1.2993	18.68
240094	0.9638	20.57
240096	0.9927	18.34
240097	1.1145	23.62
240098	0.9306	20.60
240099	1.0713	14.38
240100	1.2877	19.19
240101	1.2098	17.75
240102	0.9288	15.56
240103	1.2084	16.88
240104	1.1678	24.02
240105	.....	14.79
240106	1.3974	23.78
240107	0.9782	19.03
240108	0.9821	16.46
240109	0.9815	13.15
240110	0.9379	17.28
240111	0.9930	17.04
240112	0.9784	15.32
240114	0.9362	15.49
240115	1.6103	22.16
240116	0.9259	15.18
240117	1.1442	17.57
240119	0.8629	22.50
240121	0.9090	21.37
240122	1.0827	18.04
240123	1.0155	15.60
240124	0.9602	19.05
240125	0.9736	13.15
240127	1.0148	14.77
240128	1.1120	16.08

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
240129	0.9953	15.42
240130	0.9313	15.65
240132	1.2720	24.50
240133	1.2168	18.52
240135	0.9183	13.60
240137	1.1747	19.18
240138	0.9423	13.74
240139	0.9616	17.02
240141	1.1570	21.99
240142	1.0110	20.61
240143	0.9629	14.28
240144	1.0633	15.87
240145	0.9100	15.00
240146*	0.9093	16.75
240148	1.0294	11.34
240150	0.8795	12.83
240152	1.0247	20.20
240153	1.0013	15.61
240154	1.0226	17.06
240155	0.9164	20.42
240157	1.0213	14.69
240160	1.0612	16.60
240161	1.0365	15.42
240162	1.0748	19.04
240163	0.9730	17.87
240166	1.1543	16.39
240169	0.9599	18.62
240170	1.1064	17.65
240171	1.0064	16.72
240172	0.9741	16.07
240173	0.9970	16.74
240179	1.0360	16.65
240184	0.9619	14.40
240187	1.2498	17.51
240193	1.0038	16.30
240196	0.6772	23.27
240200	0.9005	14.73
240205	0.9227	.....
240206	0.8330	.....
240207	1.2623	23.33
240210	1.2530	23.84
240211	0.9634	20.55
250001	1.6314	18.14
250002	0.8836	15.60
250003	0.9911	15.66
250004	1.5373	17.12
250005	0.9463	12.00
250006	0.9631	15.70
250007	1.2281	19.16
250008	1.0321	13.32
250009	1.2665	16.18
250010	1.0095	13.34
250012	0.9332	18.48
250015	1.0380	11.07
250017	1.0279	17.30
250018	0.9334	13.47
250019	1.4828	17.15
250020	0.9516	14.06
250021	0.8435	9.08
250023	0.8955	13.54
250024	0.8985	11.59
250025	1.1484	17.89
250027	0.9764	12.42
250029	0.8697	14.85

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
250030	0.9198	13.63
250031	1.2472	18.77
250032	1.2183	17.30
250033	1.0130	15.76
250034	1.5442	18.13
250035	0.8342	17.41
250036	0.9965	13.79
250037	0.8826	10.32
250038	0.9386	13.62
250039	0.9969	16.51
250040	1.3140	15.64
250042	1.2627	16.47
250043	0.9006	13.65
250044	0.9882	16.75
250045	1.2709	19.48
250047	0.9058	12.10
250048	1.5287	15.71
250049	0.8842	10.76
250050	1.2687	13.92
250051	0.9276	9.60
250057	1.1769	14.29
250058	1.1854	15.42
250059	1.0826	14.30
250060	0.7514	7.99
250061	0.8571	13.97
250063	0.8309	14.97
250065	0.8940	12.68
250066	0.9147	14.33
250067	1.1605	15.29
250068	0.8225	11.43
250069	1.2675	15.77
250071	0.9001	11.21
250072	1.4320	16.93
250077	0.9344	11.41
250078	1.5476	15.46
250079	0.8556	19.06
250081	1.2710	16.14
250082	1.4184	14.02
250083	0.9424	9.20
250084	1.0972	19.74
250085	0.9906	13.85
250088	0.9812	16.75
250089	1.0895	13.05
250093	1.1743	15.09
250094	1.3417	17.85
250095	0.9930	16.36
250096	1.2105	17.07
250097	1.2839	18.41
250098	0.9397	14.30
250099	1.2925	14.41
250100	1.2679	16.60
250101	0.8835	16.31
250102	1.5198	20.02
250104	1.4479	17.54
250105	0.9368	14.60
250107	0.8802	13.63
250109	0.8898	14.55
250112	0.9928	14.20
250117	1.0623	14.52
250119	1.0646	12.74
250120	1.0648	14.41
250122	1.1767	17.71
250123	1.2182	17.41
250124	0.9343	12.67

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
250125	1.2795	14.49
250126	0.9354	14.71
250127	0.9230	.....
250128	1.0364	13.00
250131	1.0826	10.28
250134	0.9628	17.98
250136	0.9183	18.05
250138	1.2050	17.60
250141	1.2056	17.12
250145	0.8696	11.40
250146	0.9386	13.28
250148	1.2354	14.82
250149	0.9692	12.98
250150	1.2560	.....
260001	1.6540	17.55
260002	1.4391	20.59
260003	1.1323	14.35
260004	0.9723	13.75
260005	1.6472	19.71
260006	1.5189	18.94
260008	1.0522	16.25
260009	1.2922	17.94
260011	1.5359	18.34
260012	1.0022	14.46
260013	1.1867	15.54
260015	1.1785	21.33
260017	1.1731	15.80
260018	0.8870	12.23
260019	1.1516	23.67
260020	1.8132	21.86
260021	1.4382	17.57
260022	1.2554	19.35
260023	1.4184	15.82
260024	0.9715	13.47
260025	1.3027	14.94
260027	1.6141	21.01
260029	1.1888	17.47
260030	1.1362	11.24
260031	1.5369	18.30
260032	1.7266	20.81
260034	1.0233	17.90
260035	1.0041	12.59
260036	1.0016	18.31
260039	1.0672	14.20
260040	1.6822	15.39
260042	1.2519	17.44
260044	1.0069	17.12
260047	1.6386	17.28
260048	1.2523	21.43
260050	1.0553	18.74
260052	1.3718	17.75
260053	1.1217	12.01
260054	1.3547	17.37
260055	0.9682	13.80
260057	1.0095	15.33
260059	1.2434	15.79
260061	1.1184	15.01
260062	1.1843	20.26
260063	1.0723	16.85
260064	1.3324	16.50
260065	1.7738	18.47
260066	1.0120	14.42
260067	0.8925	12.16
260068	1.6794	19.83

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
260070	1.0404	21.69
260073	1.0809	13.01
260074	1.2969	15.45
260077	1.7295	18.26
260078	1.1807	15.48
260079	1.0611	14.83
260080	0.9884	12.56
260081	1.6614	18.96
260082	1.1528	15.79
260085	1.5832	19.51
260086	0.9274	14.87
260091	1.6930	19.61
260094	1.1892	15.87
260095	1.3659	19.77
260096	1.5590	21.72
260097	1.1452	15.79
260100	1.0130	15.73
260102	1.0038	16.37
260103	1.3185	17.35
260104	1.7110	19.12
260105	1.8654	20.80
260107	1.4527	18.46
260108	1.8537	19.24
260109	0.9906	13.44
260110	1.6721	17.00
260113	1.2263	14.90
260115	1.2279	17.90
260116	1.1041	14.57
260119	1.2152	16.20
260120	1.1948	17.13
260122	1.0917	14.54
260123	1.0487	14.00
260127	1.0634	15.95
260128	1.0338	11.27
260129	.....	14.64
260131	1.2601	19.75
260134	1.1698	16.58
260137	1.7102	15.22
260138	1.9094	21.39
260141	2.0004	17.96
260142	1.1233	16.03
260143	1.0016	11.94
260147	0.9530	13.66
260148	0.9021	10.34
260158	1.0574	12.40
260159	1.0116	18.22
260160	1.1472	16.19
260162	1.5667	20.71
260163	1.2567	14.81
260164	0.9190	14.31
260166	1.2194	19.53
260172	0.9615	12.49
260173	1.0048	11.98
260175	1.1265	16.29
260176	1.7233	19.54
260177	1.3369	20.75
260178	1.4649	21.41
260179	1.6106	20.74
260180	1.6586	18.54
260183	1.6585	20.19
260186	1.5839	18.06
260188	1.2743	18.58
260189	0.9387	10.75
260190	1.1980	18.16

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
260191	1.2861	19.34
260193	1.2221	20.51
260195	1.2459	15.95
260197	1.0938	16.46
260198	1.2956	17.64
260200	1.2113	18.88
260205	1.1124	.....
260206	2.6705	.....
270002	1.2833	17.19
270003	1.2141	22.13
270004	1.6968	21.34
270006	0.8808	16.19
270007	1.0011	13.17
270009	1.0256	17.70
270011	1.0498	19.82
270012	1.6001	22.88
270013	.....	20.40
270014	1.8500	18.56
270016	0.9247	19.77
270017	1.2639	19.58
270019	1.0268	12.78
270021	1.1669	16.65
270023	1.2640	20.36
270026	0.9053	15.64
270027	1.0596	9.78
270028	1.1731	17.21
270029	0.9212	17.89
270032	1.1264	17.03
270033	0.8642	16.46
270035	1.0021	17.65
270036	0.9187	14.08
270039	1.0483	15.35
270040	1.1242	19.19
270041	1.0440	16.78
270044	1.1390	13.46
270046	.....	17.10
270048	1.0158	15.84
270049	1.7683	21.17
270050	0.9929	18.04
270051	1.3159	18.95
270052	1.0056	14.80
270057	1.3060	20.01
270058	0.9229	14.07
270059	0.7506	15.60
270060	0.9519	14.02
270063	0.9338	14.23
270073	1.0809	15.53
270074	0.8781	.....
270075	0.8274	.....
270079	0.9373	15.03
270080	1.1414	14.04
270081	0.9580	15.52
270082	1.1019	16.13
270083	1.0075	20.82
270084	0.9157	16.21
280001	1.0653	17.89
280003	2.1221	22.00
280005	1.3612	18.75
280009	1.7670	18.75
280010	0.8073	16.54
280011	0.8552	13.96
280012	.....	16.41
280013	1.7273	22.18
280014	0.9006	15.24

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
280015	1.0732	14.64
280017	1.0728	14.19
280018	1.0539	14.85
280020	1.8150	19.40
280021	1.1771	16.69
280022	0.9681	15.71
280023	1.3944	21.24
280024	0.9612	13.91
280025	0.9712	14.27
280026	1.0404	16.06
280028	1.0763	15.89
280029	1.2096	19.05
280030	1.7625	28.71
280031	0.9956	13.22
280032	1.3462	19.39
280033	1.0807	14.93
280034	.....	15.28
280035	0.9131	15.33
280037	1.0308	16.17
280038	1.0606	16.47
280039	1.0660	15.19
280040	1.7369	18.97
280041	0.9646	13.39
280042	1.0402	15.30
280043	0.9786	15.79
280045	1.0415	14.27
280046	1.0475	13.72
280047	1.1206	18.37
280048	1.1174	14.07
280049	1.0856	15.63
280050	0.8884	15.34
280051	1.1386	15.85
280052	1.0615	13.65
280054	1.2474	17.58
280055	0.9142	12.99
280056	0.9322	14.02
280057	0.9649	15.76
280058	1.2501	17.88
280060	1.6246	28.60
280061	1.4157	17.95
280062	1.1769	13.67
280064	1.0166	15.51
280065	1.2679	18.53
280066	1.0165	11.64
280068	0.9402	10.13
280070	0.9894	13.74
280073	0.9850	17.06
280074	0.9716	15.22
280075	1.1012	13.79
280076	1.0276	13.92
280077	1.2963	19.01
280079	1.0819	9.91
280080	1.0562	14.35
280081	1.7212	20.92
280082	1.0739	13.13
280083	1.0628	17.55
280084	0.9626	11.69
280085	0.8210	21.58
280088	1.2613	22.11
280089	0.8817	17.47
280090	0.8499	14.72
280091	1.0928	15.22
280092	0.9078	14.20
280094	0.9941	15.88

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
280097	1.0876	14.30
280098	0.8785	10.17
280101	1.0046	17.42
280102	.....	12.94
280104	0.9207	13.38
280105	1.2342	18.78
280106	1.0160	15.54
280107	1.1351	13.46
280108	1.0616	17.22
280109	0.9496	11.06
280110	0.9845	12.30
280111	1.2649	23.08
280114	0.9211	13.56
280115	0.9774	16.43
280117	1.0941	16.82
280118	0.9071	16.92
280119	0.9530	.....
280123	.....	20.77
280125	1.2264	.....
290001	1.6989	22.42
290002	0.9461	20.94
290003	1.6712	25.01
290005	1.3324	17.86
290006	1.2261	19.88
290007	1.6901	29.69
290008	1.2555	20.25
290009	1.6203	22.74
290010	1.1253	14.48
290011	1.0959	16.44
290012	1.3503	21.51
290013	0.9996	17.09
290014	1.0332	18.38
290015	0.9724	17.83
290016	1.1412	12.79
290019	1.3301	20.93
290020	0.9828	26.15
290021	1.6748	21.13
290022	1.5940	24.08
290027	0.8902	16.43
290029	0.9227	.....
290032	1.4060	22.79
290036	0.5760	18.61
290038	0.9361	23.14
290039	1.3330	25.80
290041	1.2649	.....
290043	1.5247	.....
300001	1.4811	21.42
300003	1.9992	23.38
300005	1.3421	19.99
300006	1.1762	18.93
300007	1.0898	19.34
300008	1.2459	16.46
300009	1.0636	20.01
300010	1.2614	19.38
300011	1.3223	21.24
300012	1.3247	23.89
300013	1.1162	18.97
300014	1.2417	19.80
300015	1.1328	19.93
300016	1.2146	18.50
300017	1.3266	22.34
300018	1.3652	20.89
300019	1.2381	20.61
300020	1.3828	21.97

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
300021	1.0721	17.35
300022	1.1269	17.19
300023	1.3992	20.39
300024	1.2667	17.95
300028	1.2841	18.05
300029	1.3193	20.90
300033	1.0937	19.85
300034	2.1599	23.52
310001	1.7867	27.60
310002	1.8508	27.87
310003	1.2979	27.42
310005	1.2978	23.05
310006	1.2138	21.56
310008	1.3295	24.95
310009	1.3238	23.19
310010	1.2493	21.11
310011	1.2567	23.40
310012	1.6481	26.32
310013	1.3716	22.11
310014	1.6717	28.70
310015	2.0397	26.76
310016	1.2889	26.05
310017	1.3516	26.07
310018	1.0776	24.53
310019	1.6759	23.09
310020	1.3978	19.27
310021	1.5405	22.65
310022	1.3233	20.73
310024	1.3299	22.78
310025	1.1918	22.81
310026	1.2343	23.87
310027	1.3202	21.77
310028	1.2507	23.52
310029	1.9457	23.38
310031	2.7809	25.18
310032	1.3227	23.30
310034	1.2856	21.69
310036	1.1393	19.82
310037	1.4029	27.44
310038	2.0126	25.38
310039	1.2557	22.03
310040	1.2028	23.99
310041	1.3458	23.78
310042	1.2925	24.33
310043	1.1863	22.09
310044	1.3355	20.43
310045	1.4863	28.16
310047	1.3368	24.52
310048	1.2892	23.33
310049	1.2327	24.76
310050	1.2135	22.59
310051	1.3946	25.28
310052	1.3043	22.58
310054	1.3470	24.74
310057	1.3024	20.45
310058	1.1475	26.22
310060	1.1966	19.11
310061	1.2040	20.80
310062	.....	19.27
310063*	1.3463	21.85
310064	1.3574	24.21
310067	1.3006	22.27
310069	1.2634	24.17
310070	1.4210	25.04

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
310072	1.3713	22.22
310073	1.6775	25.63
310074	1.3809	24.46
310075	1.4097	26.46
310076	1.4991	28.90
310077	1.6678	25.06
310078	1.4298	23.48
310081	1.3501	23.89
310083	1.2768	23.68
310084	1.3292	24.09
310086	1.2175	21.44
310087	1.3344	20.89
310088	1.2069	22.34
310090	1.3904	24.24
310091	1.2672	22.01
310092	1.3248	22.34
310093	1.2003	21.23
310096	1.9959	26.30
310105	1.2465	24.49
310108	1.4314	22.88
310110	1.2678	20.14
310111	1.2705	21.72
310112	1.3062	22.52
310113	1.2906	22.95
310115	1.3002	20.07
310116	1.2884	25.24
310118	1.2517	24.54
310119	1.7352	29.48
310120	1.2046	21.69
310121	.....	18.74
320001	1.5262	17.85
320002	1.3456	22.46
320003	1.0767	15.35
320004	1.2930	17.24
320005	1.3126	19.87
320006	1.3526	18.65
320009	1.5990	17.64
320011	1.1443	16.55
320012	1.0529	16.00
320013	1.1406	23.84
320014	1.0812	15.97
320016	1.1821	18.93
320017	1.1290	18.15
320018	1.5139	18.19
320019	1.5059	19.26
320021	1.8101	17.16
320022	1.2310	15.84
320023	1.0211	16.42
320030	1.1556	16.53
320031	0.9386	13.99
320032	0.8993	18.75
320033	1.1749	20.31
320035	1.0245	25.74
320037	1.1621	17.08
320038	1.2322	16.29
320046	1.4424	19.00
320048	1.4140	19.17
320056	1.1122	.....
320057	0.9720	.....
320058	0.8862	.....
320059	1.0597	.....
320060	0.9253	.....
320061	1.1311	.....
320062	0.8525	.....

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
320063	1.2513	19.83
320065	1.2154	16.10
320067	0.8614	57.48
320068	0.8969	18.18
320069	0.9807	11.31
320070	0.9556	.....
320074	1.0870	18.65
320079	1.2126	17.07
330001	1.1862	25.21
330002	1.4469	26.39
330003	1.3432	18.05
330004	1.3046	19.96
330005	1.6831	24.28
330006	1.3374	25.92
330007	1.3674	18.80
330008	1.1788	18.07
330009	1.3298	30.42
330010	1.2856	14.74
330011	1.3008	18.04
330012	1.7199	31.51
330013	2.0374	19.99
330014	1.3839	27.57
330016	0.9911	17.41
330019	1.3601	32.45
330020	1.0286	14.55
330023	1.3009	24.27
330024	1.8309	33.62
330025	1.1220	16.03
330027	1.4693	32.50
330028	1.4098	27.08
330029	1.1581	16.56
330030	1.4112	15.06
330033	1.3199	16.75
330034	0.5292	30.78
330036	1.2759	24.32
330037	1.2233	16.00
330038	1.1832	16.01
330039	.....	12.47
330041	1.2880	30.42
330043	1.3066	27.63
330044	1.2646	18.70
330045	1.3781	27.17
330046	1.4593	31.98
330047	1.1968	17.69
330048	1.2630	17.62
330049	1.2706	19.31
330053	1.2225	15.67
330055	1.5732	30.73
330056	1.4694	30.22
330057	1.6858	18.69
330058	1.3130	16.98
330059	1.6062	32.23
330061	1.2760	25.07
330062	1.0970	15.28
330064	1.4280	32.87
330065	1.2350	18.37
330066	1.2659	19.94
330067	1.3299	21.29
330072	1.4098	29.31
330073	1.1707	15.88
330074	1.2820	18.16
330075	1.0916	17.43
330078	1.4535	17.49
330079	1.2806	16.76

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
330080	1.2173	26.88
330084	1.0649	23.03
330085	1.2898	18.78
330086	1.2276	30.69
330088	1.0486	25.62
330090	1.5583	18.68
330091	1.3777	18.53
330092	1.0002	12.65
330094	1.2368	17.72
330095	1.3283	18.55
330096	1.1192	16.60
330097	1.2475	16.96
330100	0.9953	28.11
330101	1.7932	31.31
330102	1.3020	17.52
330103	1.2013	16.52
330104	1.4136	28.77
330106	1.7013	35.87
330107	1.2670	28.08
330108	1.2378	17.08
330111	1.0739	15.20
330114	0.9034	18.24
330115	1.1307	16.56
330116	0.8479	24.23
330118	1.6335	20.76
330119	1.7050	34.75
330121	1.0145	15.85
330122	1.0108	21.20
330125	1.8904	19.75
330126	1.1356	22.70
330127	1.3751	29.33
330128	1.3130	27.87
330132	1.2002	14.70
330133	1.3616	32.38
330135	1.1987	18.33
330136	1.3304	17.60
330140	1.8211	19.50
330141	1.3368	25.14
330144	0.9874	15.51
330148	1.0682	15.04
330151	1.0931	13.97
330152	1.4635	29.48
330153	1.7143	17.50
330154	1.7631	.....
330157	1.3782	20.82
330158	1.4535	26.05
330159	1.2598	18.02
330160	1.4258	30.57
330162	1.2112	27.72
330163	1.2668	20.46
330164	1.3673	19.48
330166	1.0666	14.18
330167	1.7231	31.18
330169	1.4422	33.45
330171	1.3081	25.43
330175	1.1866	16.69
330177	0.9536	14.54
330179	0.8480	12.69
330180	1.2149	15.53
330181	1.3246	32.47
330182	2.5278	30.93
330183	1.4710	20.00
330184	1.3687	27.49
330185	1.2683	26.95

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
330188	1.2749	18.72
330189	1.1706	17.66
330191	1.3142	18.86
330193	1.3094	29.80
330194	1.8144	35.57
330195	1.6168	31.39
330196	1.2584	28.45
330197	1.1217	17.00
330198	1.3910	23.81
330199	1.3867	27.66
330201	1.6595	30.33
330202	1.3321	30.79
330203*	1.3921	19.24
330204	1.3626	29.37
330205	1.2157	19.46
330208	1.2524	25.82
330209	1.2116	24.88
330211	1.1008	19.10
330212	1.1242	21.18
330213	1.1317	18.51
330214	1.8270	32.20
330215	1.2136	17.58
330218	1.0783	21.71
330219	1.6448	22.15
330221	1.2958	32.21
330222	1.2727	17.81
330223	1.0436	17.28
330224	1.2609	21.97
330225	1.1997	25.80
330226	1.2800	17.67
330229	1.3032	16.25
330230	1.3323	28.86
330231	1.0181	29.09
330232	1.2621	19.50
330233	1.4710	33.30
330234	2.3453	33.33
330235	1.1654	19.45
330236	1.3908	30.70
330238	1.2201	14.80
330239	1.2099	17.28
330240	1.3684	30.48
330241	2.0212	22.60
330242	1.2840	24.74
330245	1.4695	17.28
330246	1.3231	26.66
330247	0.8484	27.62
330249	1.1958	16.48
330250	1.2389	19.56
330252	.....	17.04
330254	1.1711	16.73
330258	1.2652	30.47
330259	1.4799	25.25
330261	1.3017	26.17
330263	1.0017	19.64
330264	1.1961	23.14
330265	1.3299	15.62
330267	1.3394	23.56
330268	0.9564	14.62
330270	2.0232	28.24
330273	1.2930	25.89
330275	1.3094	17.42
330276	1.1580	17.75
330277	1.1064	17.16
330279	1.2946	19.91

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
330285	1.8724	22.47
330286	1.3300	25.09
330290	1.7078	32.58
330293	1.1263	15.38
330304	1.2300	29.37
330306	1.3461	27.62
330307	1.3055	20.74
330308	.....	36.84
330314	1.3296	24.74
330316	1.2613	28.79
330327	0.8785	16.97
330331	1.3605	31.04
330332	1.2161	27.16
330333	1.2122	.....
330336	1.3033	30.17
330338	1.2486	23.01
330339	0.9024	19.67
330340	1.1804	26.92
330350	1.7352	30.38
330353	1.2745	33.55
330354	1.5861	.....
330357	1.3424	34.75
330359	.....	29.29
330372	1.2139	22.50
330381	1.2974	29.24
330385	1.1317	28.84
330386	1.1738	24.67
330387	0.7617	.....
330389	1.7654	32.42
330390	1.3622	29.79
330393	1.7228	27.99
330394	1.5602	18.77
330395	1.3551	37.68
330396	1.1225	30.72
330397	1.3731	31.00
330398	1.3883	30.32
330399	1.2650	35.52
330400	0.8755	.....
340001	1.4550	19.01
340002	1.8335	18.78
340003	1.1380	21.97
340004	1.5053	17.89
340005	1.1327	14.09
340006	1.0448	17.81
340007	1.1625	17.17
340008	1.1063	18.38
340009	.....	20.50
340010	1.3066	17.65
340011	1.1010	14.92
340012	1.1766	16.66
340013	1.2440	17.43
340014	1.5360	19.92
340015	1.2395	19.01
340016	1.1721	16.40
340017	1.2566	19.22
340018	1.1435	15.16
340019	0.9975	13.59
340020	1.2389	16.75
340021	1.2577	19.67
340022	1.1225	16.72
340023	1.3395	17.21
340024	1.1417	16.64
340025	1.2484	16.82
340027	1.2085	17.30

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
340028	1.5314	17.72
340030	2.0552	20.05
340031	0.9565	12.39
340032	1.3524	20.47
340035	1.0956	18.10
340036	1.1292	16.97
340037	1.0029	15.53
340038	1.1014	17.01
340039	1.2603	20.15
340040	1.7863	20.12
340041	1.2563	17.76
340042	1.1906	16.63
340044	1.1019	16.37
340045	1.0204	12.42
340047	1.8911	19.60
340048	0.6134	.....
340049	0.7590	16.50
340050	1.1658	18.56
340051	1.2890	18.60
340052	0.9879	21.37
340053	1.6306	19.49
340054	1.1743	14.47
340055	1.2601	18.18
340060	1.0858	17.92
340061	1.7102	20.85
340063	1.0122	16.92
340064	1.1554	17.26
340065	1.3341	18.32
340067	1.0091	18.61
340068	1.2353	16.70
340069	1.8140	19.99
340070	1.2558	18.63
340071	1.1412	16.37
340072	1.1342	15.60
340073	1.3877	20.69
340075	1.2374	18.21
340080	0.9827	16.85
340084	1.1280	21.78
340085	1.1684	16.24
340087	1.1121	16.70
340088	1.2483	19.83
340089	0.9798	13.86
340090	1.1715	17.85
340091	1.6767	19.40
340093	1.0384	15.16
340094	1.3871	15.96
340096	1.1735	17.98
340097	1.1300	21.37
340098	1.5807	20.17
340099	1.1289	15.09
340101	1.0689	15.36
340104	0.8681	15.87
340105	1.3487	18.90
340106	1.1391	18.08
340107	1.2312	16.95
340109	1.3520	17.96
340111	1.1185	14.92
340112	0.9997	14.60
340113	1.8588	20.88
340114	1.6123	20.82
340115	1.5468	18.67
340116	1.8562	19.48
340119	1.2136	16.85
340120	1.1373	14.38

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
340121	1.0483	15.97
340123	1.1257	16.22
340124	1.1103	14.05
340125	1.4571	19.63
340126	1.3214	17.72
340127	1.3040	17.38
340129	1.2333	19.73
340130	1.3605	19.44
340131	1.5410	18.94
340132	1.2906	16.94
340133	1.0718	14.35
340137	1.2697	.....
340138	1.0653	19.28
340141	1.7096	22.22
340142	1.1906	16.09
340143	1.4510	20.95
340144	1.2510	19.19
340145	1.3190	19.20
340146	1.0415	13.01
340147	1.2389	19.11
340148	1.3628	18.42
340151	1.2111	16.57
340153	1.8460	20.66
340155	1.3964	20.42
340156	0.7271	.....
340158	1.0716	17.26
340159	1.1780	16.80
340160	1.1654	15.53
340162	.....	16.64
340164	1.3637	19.68
340166	1.3042	19.17
340168	0.4833	14.75
340171	1.1348	20.05
340173	1.2020	20.21
350001	0.9646	11.73
350002	1.8448	17.28
350003	1.2042	17.43
350004	1.9290	17.90
350005	1.0889	16.03
350006	1.3866	16.62
350007	0.9036	13.28
350008	0.9709	21.70
350009	1.1851	18.28
350010	1.1308	15.28
350011	1.9286	18.49
350012	1.0793	12.73
350013	1.0590	16.68
350014	1.0326	15.79
350015	1.7240	15.87
350016	.....	11.63
350017	1.3378	17.78
350018	1.0325	13.64
350019	1.7209	19.40
350021	0.9859	12.69
350023	0.9505	12.80
350024	1.0053	14.37
350025	0.9820	16.24
350027	1.0099	17.12
350029	0.8409	12.80
350030	1.0653	17.35
350033	0.9296	14.90
350034	0.9296	18.32
350035	0.8734	10.16
350038	1.0783	18.74

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
350039	1.0442	17.31
350041	0.9447	14.68
350042	1.0586	16.75
350043	1.6076	17.16
350044	0.9014	10.53
350047	1.1414	17.93
350049	1.2037	14.53
350050	0.9242	10.57
350051	0.9872	17.53
350053	1.0048	13.94
350055	0.9884	12.37
350056	0.9227	14.74
350058	0.9550	14.35
350060	0.8626	9.60
350061	1.0451	14.59
350063	0.8913	.....
350064	0.8650	.....
350068	2.4777	.....
350069	1.2467	.....
360001	1.3010	17.39
360002	1.1805	17.40
360003	1.7521	22.03
360006	1.9102	22.09
360007	1.0878	17.10
360008	1.2553	17.82
360009	1.5416	17.53
360010	1.2807	18.09
360011	1.2954	18.95
360012	1.2982	19.22
360013	1.1484	20.81
360014	1.1318	19.88
360016	1.6655	18.77
360017	1.9312	22.50
360018	1.6955	21.34
360019	1.2255	20.17
360020	1.4599	22.95
360024	1.3135	18.54
360025	1.3536	19.29
360026	1.3128	17.04
360027	1.4745	20.36
360028	1.4934	17.27
360029	1.1928	18.22
360030	1.3464	15.35
360031	1.1973	19.90
360032	1.1566	17.93
360034	1.3261	15.56
360035*	1.6492	20.33
360036	1.3101	19.18
360037	2.1402	22.52
360038	1.6231	19.89
360039	1.2936	17.40
360040	1.2903	18.12
360041	1.2883	18.42
360042	1.1662	16.12
360044	1.1577	16.79
360045	1.4251	21.18
360046	1.1457	19.32
360047	1.1301	15.34
360048	1.8831	21.17
360049	1.2259	18.81
360050	1.2304	12.89
360051	1.6202	20.95
360052	1.6991	20.02
360054	1.2488	16.19

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
360055	1.3169	23.27
360056	1.3944	18.76
360057	1.0590	13.81
360058	1.1920	17.92
360059	1.6176	21.97
360062	1.4095	20.31
360063	1.1426	22.79
360064	1.6125	20.64
360065	1.2530	19.45
360066	1.6379	20.03
360067	1.1487	14.57
360068	1.7961	21.22
360069	1.1401	17.83
360070	1.7813	17.53
360071	1.4168	23.80
360072	1.2698	17.97
360074	1.2995	18.26
360075	1.3458	18.47
360076	1.3578	19.59
360077	1.6203	20.82
360078	1.2481	20.79
360079	1.8424	22.00
360080	1.1428	16.64
360081	1.3443	19.64
360082	1.2775	22.86
360083	.....	18.46
360084	1.6064	20.09
360085	1.8845	21.67
360086	1.4307	17.04
360087	1.4307	20.04
360088	1.3186	22.31
360089	1.1340	20.56
360090	1.2673	20.40
360091	1.3221	21.03
360092	1.1368	15.91
360093	1.1664	18.57
360094	1.3406	18.31
360095	1.2602	18.71
360096	1.0740	17.16
360098	1.4616	18.34
360099	1.0145	18.55
360100	1.2435	17.66
360101	1.3302	22.31
360102	1.2047	19.77
360103	.....	22.62
360104	1.1889	.....
360106	1.2012	16.18
360107	1.2436	18.62
360108	1.0496	16.51
360109	1.0898	19.52
360112	1.9109	22.57
360113	1.3312	22.46
360114	1.0862	16.33
360115	1.3561	18.19
360116	1.1098	18.08
360118	1.3482	18.61
360121	1.2089	21.10
360123	1.2389	19.13
360125	1.1466	18.17
360126	1.2114	20.46
360127	1.1478	16.92
360128	1.1562	15.58
360129	0.9412	15.52
360130	1.0130	15.34

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
360131	1.3306	18.29
360132	1.4151	18.27
360133	1.6452	19.03
360134	1.7555	20.24
360136	1.0165	17.85
360137	1.7409	20.26
360140	0.9460	19.13
360141	1.6436	22.85
360142	1.0518	17.32
360143	1.3319	20.44
360144	1.2938	21.92
360145	1.6950	19.39
360147	1.2418	16.59
360148	1.1492	18.89
360149	1.2611	18.79
360150	1.3013	20.63
360151	1.3912	17.49
360152	1.5355	22.00
360153	1.1316	14.89
360154	1.0439	13.78
360155	1.3700	20.90
360156	1.2856	17.92
360159	1.1775	20.71
360161	1.3543	19.41
360162	1.0718	18.61
360163	1.8529	20.38
360164	.....	16.16
360165	1.1711	19.48
360166	.....	16.98
360170	1.4463	17.18
360172	1.3447	18.47
360174	1.2444	19.09
360175	1.1884	20.41
360176	1.1409	15.47
360177	1.3262	19.41
360178	1.3137	17.40
360179	1.4139	19.14
360180	2.1661	22.09
360184	0.5560	19.35
360185	1.2339	18.67
360186	1.0606	20.86
360187	1.4030	18.02
360188	0.9307	17.53
360189	1.1003	17.37
360192	1.3355	21.00
360193	.....	17.69
360194	1.1609	17.69
360195	1.1446	19.02
360197	1.1573	19.42
360200	0.9129	17.76
360203	1.1658	15.62
360204	1.2012	19.35
360210	1.1911	20.28
360211	1.2583	19.58
360212	1.3505	20.23
360213	1.2574	18.33
360218	1.3249	18.41
360230	1.5283	21.44
360231	1.1689	13.56
360234	1.3667	22.43
360236	1.2668	19.49
360239	1.2640	19.86
360241	0.4070	22.08
360242	1.8361	.....

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
360243	0.6859	13.58
360244	.....	10.55
360245	0.7433	15.06
360247	0.4015	18.11
360248	.....	21.65
370001	1.7346	21.27
370002	1.2288	14.08
370004	1.1872	16.77
370005	0.9385	17.38
370006	1.1884	12.95
370007	1.1457	17.15
370008	1.3742	17.30
370011	1.0371	14.64
370012	0.8381	10.80
370013	1.8493	18.04
370014	1.1887	19.65
370015	1.1904	17.82
370016	1.3340	16.64
370017	1.1216	12.98
370018	1.3475	14.24
370019	1.3147	16.88
370020	1.2736	13.48
370021	0.8600	11.26
370022	1.3152	17.90
370023	1.2592	16.82
370025	1.3103	16.40
370026	1.4917	16.90
370028	1.8963	19.71
370029	1.1600	13.89
370030	1.1994	15.47
370032	1.6025	16.64
370033	1.0433	12.39
370034	1.2299	14.51
370035	1.7120	18.96
370036	1.0585	11.46
370037	1.7309	17.75
370038	0.9615	12.81
370039	1.1544	16.27
370040	1.0110	14.26
370041	0.9415	17.41
370042	0.8612	14.61
370043	0.9299	16.08
370045	1.0224	12.44
370046	0.9794	18.15
370047	1.4234	15.67
370048	1.2065	17.44
370049	1.3139	19.84
370051	0.9449	12.18
370054	1.3637	16.56
370056	1.5690	18.88
370057	1.0262	14.66
370059	1.1239	16.46
370060	1.0608	15.12
370063	1.1026	17.06
370064	0.9372	8.75
370065	0.9995	16.56
370071	1.0270	14.95
370072	0.8663	14.65
370076	1.2551	12.86
370077	.....	17.62
370078	1.6865	17.24
370079	0.9319	13.60
370080	0.9519	14.34
370082	0.8529	13.54

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
370083	0.9651	11.49
370084	1.0188	21.75
370085	0.8885	11.88
370086	1.1192	13.56
370089	1.2148	14.50
370091	1.6636	17.58
370092	0.9955	14.68
370093	1.7971	18.57
370094	1.4454	18.38
370095	0.9872	14.13
370097	1.3459	23.31
370099	1.1217	16.26
370100	0.9773	17.10
370103	0.9111	15.90
370105	1.9566	17.68
370106	1.5308	18.62
370108	0.9670	12.24
370112	1.0270	15.25
370113	1.2331	16.20
370114	1.6454	15.98
370121	1.0409	19.55
370122	1.0456	12.15
370123	1.4493	16.36
370125	0.8954	13.55
370126	0.9646	18.24
370131	0.9766	16.24
370133	1.0621	10.02
370138	1.0502	15.94
370139	1.0969	13.30
370140	1.0458	15.23
370141	1.3710	12.14
370146	1.0935	12.56
370148	1.4517	16.41
370149	1.3477	16.72
370153	1.1156	15.32
370154	1.0477	15.91
370156	1.1036	13.64
370158	1.0207	15.09
370159	1.2557	17.83
370163	0.9854	14.56
370165	1.2557	13.22
370166	1.0448	17.82
370169	1.0466	9.48
370170	1.0201	.....
370171	1.0333	.....
370172	0.8953	.....
370173	1.0677	.....
370174	0.7213	.....
370176	1.2191	16.03
370177	0.9826	11.88
370178	0.9826	11.64
370179	0.9491	19.27
370180	0.9918	.....
370183	1.0386	7.62
370186	0.9783	13.35
370190	1.4695	13.70
370192	1.4803	16.74
370196	0.8822	.....
370197	.....	21.57
370198	1.4366	.....
370199	1.0710	.....
370200	1.1757	.....
380001	1.3054	22.03
380002	1.2171	19.48

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
380003	1.1769	24.74
380004	1.7367	23.14
380005	1.1722	23.24
380006	1.2239	20.54
380007	1.6506	24.29
380008	1.0693	21.19
380009	1.7994	25.17
380010	1.0403	19.75
380011	1.1050	21.14
380013	1.1851	20.10
380014	1.6519	23.48
380017	1.9289	23.82
380018	1.8307	22.08
380019	1.2451	20.77
380020	1.4521	21.35
380021	1.2078	20.64
380022	1.1103	21.61
380023	1.1371	19.24
380025	1.2975	24.67
380026	1.1401	19.27
380027	1.2810	20.16
380029	1.1435	18.57
380031	0.9408	22.83
380033	1.7943	23.29
380035	1.3526	21.65
380036	1.0855	19.33
380037	1.2290	21.23
380038	1.2487	25.58
380039	1.2583	22.12
380040	1.2936	21.64
380042	1.0177	19.81
380047	1.6722	21.95
380048	1.0388	18.38
380050	1.4293	18.25
380051	1.6373	21.24
380052	1.2518	17.87
380055	.....	21.25
380056	1.1058	17.16
380060	1.4643	23.29
380061	1.5204	22.60
380062	1.2219	18.52
380063	.....	19.36
380064	1.3264	19.87
380065	1.3064	22.17
380066	1.3262	20.42
380068	.....	22.76
380069	1.0690	19.58
380070	1.3461	24.71
380071	1.2354	20.47
380072	0.9961	16.32
380075	1.4230	22.17
380078	1.1344	19.10
380081	1.0229	20.59
380082	1.2605	22.58
380083	1.1703	21.81
380084	1.2427	23.64
380087	1.2284	14.10
380088	1.0722	19.52
380089	1.2782	23.74
380090	1.2985	27.09
380091	1.2615	22.83
390001	1.5197	18.64
390002	1.3161	18.08
390003	1.2413	17.24

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
390004	1.3985	18.89
390005	1.0952	16.44
390006	1.8485	19.60
390007	1.2517	21.41
390008	1.1995	16.74
390009	1.7387	20.12
390010	1.2493	17.23
390011	1.2786	18.07
390012	1.2224	20.02
390013	1.2401	19.33
390015	1.1327	12.94
390016	1.2481	17.07
390017	1.1841	16.22
390018	1.2421	19.12
390019	1.0759	16.40
390022	1.3526	22.90
390023	1.2272	19.56
390024	1.1811	25.03
390025	0.4279	15.71
390026	1.2761	22.76
390027	1.8053	27.69
390028	1.8916	20.11
390029	2.0498	19.69
390030	1.2190	18.40
390031	1.2148	19.52
390032	1.2612	18.15
390035	1.2648	18.51
390036	1.5398	18.87
390037	1.3709	22.24
390039	1.1436	16.54
390040	0.9484	15.12
390041	1.2688	19.58
390042	1.5854	21.13
390043	1.1832	16.36
390044	1.6421	19.54
390045	1.7159	18.46
390046	1.6104	20.46
390047*	1.7392	24.58
390048	1.1549	18.38
390049	1.6110	21.13
390050	2.1144	20.92
390051	2.1338	26.05
390052	1.1515	17.10
390054	1.2341	17.44
390055	1.8882	25.90
390056	1.1205	17.17
390057	1.3152	19.75
390058	1.2858	19.25
390060	1.2088	13.63
390061	1.4942	20.48
390062	1.2444	16.45
390063	1.8378	19.64
390065	1.2322	20.00
390066	1.2608	18.71
390067	1.8018	20.65
390068	1.3033	17.55
390069	1.2663	19.28
390070	1.4159	20.19
390071	1.1073	16.23
390072	1.0501	15.56
390073	1.6671	20.69
390074	1.2469	16.60
390075	1.3924	17.27
390076	1.2799	21.43

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
390078	1.1498	18.23
390079	1.7562	18.20
390080	1.2916	19.52
390081	1.2972	23.99
390083	1.2031	20.59
390084	1.2677	16.35
390086	1.1360	17.25
390088	1.3689	23.49
390090	1.8001	20.65
390091	1.1280	18.37
390093	1.1551	16.63
390095	1.2033	13.05
390096	1.4914	19.31
390097	1.2750	21.41
390100	1.6552	20.30
390101	1.2029	17.05
390102	1.3959	19.49
390103	1.0911	17.71
390104	1.0664	15.96
390106	1.1156	16.28
390107	1.3308	19.18
390108	1.4026	21.29
390109	1.2009	14.66
390110	1.5954	21.32
390111	1.9491	28.79
390112	1.2904	14.04
390113	1.2508	17.94
390114	1.2348	22.97
390115	1.3965	24.72
390116	1.3025	20.60
390117	1.1716	16.90
390118	1.2155	16.90
390119*	1.3896	18.59
390121	1.3960	18.64
390122	1.0609	17.46
390123	1.2758	20.84
390125	1.2088	15.94
390126	1.2888	20.94
390127	1.2287	21.88
390128	1.2209	19.41
390130	1.1335	17.33
390131	1.3299	16.83
390132	1.2842	20.55
390133	1.7977	24.61
390135	1.2393	21.25
390136	1.1430	17.61
390137	1.5156	16.56
390138	1.3213	18.86
390139	1.5077	22.94
390142	1.6076	26.80
390145	1.3889	20.34
390146	1.2155	17.70
390147	1.2656	21.11
390150	1.1805	19.66
390151	1.2299	20.51
390152	1.1121	19.15
390153	1.2219	23.12
390154	1.2679	15.85
390156	1.4108	21.16
390157	1.3940	19.83
390158	.....	21.60
390160	1.2390	20.77
390161	1.1929	12.37
390162	1.5211	21.02

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
390163	1.2276	15.62
390164	2.1736	21.59
390166	1.1138	19.96
390167	.....	22.91
390168	1.2592	18.99
390169	1.3390	18.99
390170	1.8476	22.99
390173	1.2211	17.86
390174	1.6855	25.24
390176	1.1814	17.36
390178	1.3114	17.70
390179	1.3111	21.41
390180	1.4575	25.12
390181	1.0728	17.09
390183	1.1617	19.08
390184	1.1308	20.75
390185	1.2169	17.65
390189	1.1404	18.67
390191	1.1721	16.20
390192	1.1726	16.37
390193	1.1915	16.47
390194	1.1396	20.15
390195	1.8300	23.69
390196	1.5787	.....
390197	1.2829	18.99
390198	1.2778	15.45
390199	1.2683	16.66
390200	0.9687	13.59
390201	1.2641	20.50
390203	1.3610	21.19
390204	1.2735	20.85
390206	1.3965	18.57
390209	1.0811	16.96
390211	1.2188	17.91
390213	1.1371	17.44
390215	1.2554	21.43
390217	1.2220	19.29
390219	1.3081	21.63
390220	1.1645	18.52
390222	1.3169	20.91
390223	1.7259	22.65
390224	0.8838	15.91
390225	1.1965	18.17
390226	1.6019	23.16
390228	1.2988	19.81
390231	1.5687	24.49
390233	1.3518	18.77
390235	1.4228	24.60
390236	1.2240	17.03
390237	1.5705	21.75
390238	1.2725	.....
390242	.....	18.09
390244	0.9246	14.41
390245	1.3207	20.15
390246	1.1923	17.92
390247	1.0508	20.67
390249	0.9293	10.73
390256	1.8873	23.78
390258	1.4564	21.36
390260	1.0990	21.19
390262	1.9277	18.67
390263	1.4217	20.09
390265	1.2937	19.51
390266	1.2120	16.24

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
390267	1.2587	20.51
390268	1.3361	21.02
390270	1.3866	17.83
390272	0.4775	.....
390277	0.4015	27.10
390278	0.6656	19.20
390279	1.0539	13.70
390283	1.2887	.....
390284	1.2825	.....
400001	1.2244	9.86
400002	1.6964	9.31
400003	1.3598	9.99
400004	1.1415	8.48
400005	1.1222	7.85
400006	1.1587	10.53
400007	1.1989	7.86
400009	1.0514	8.37
400010	0.8930	11.66
400011	1.0733	5.68
400012	1.3553	7.81
400013	1.2614	8.21
400014	1.3933	9.54
400015	1.3572	10.33
400016	1.3661	12.07
400017	1.1566	8.57
400018	1.2826	9.45
400019	1.6564	10.15
400021	1.4420	9.91
400022	1.3356	11.12
400024	0.9529	7.56
400026	0.9627	7.12
400027	1.1026	8.49
400028	1.2378	8.40
400031	1.2515	9.78
400032	1.2192	9.73
400044	1.2602	11.75
400048	1.0437	8.92
400061	1.7071	12.28
400079	1.2218	7.08
400087	1.4146	10.40
400094	0.9953	7.82
400098	1.3997	7.21
400102	1.1587	7.73
400103	1.3967	10.73
400104	1.2587	9.94
400105	1.2156	10.17
400106	1.2572	8.51
400109	1.4778	10.18
400110	1.1266	10.53
400111	1.1973	9.56
400112	1.0576	12.85
400113	1.1558	9.48
400114	1.0813	6.41
400115	1.0388	9.13
400117	1.1552	10.04
400118	1.2390	8.70
400120	1.2553	9.74
400121	0.9964	7.11
400122	1.0235	8.48
400123	1.2032	9.02
400124	2.8388	11.48
400125	1.0258	.....
410001	1.3403	22.53
410004	1.2575	22.32

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
410005	1.3736	21.24
410006	1.3072	21.98
410007	1.6369	20.95
410008	1.2134	22.61
410009	1.2947	24.08
410010	1.1607	27.14
410011	1.2718	24.37
410012	1.9093	21.33
410013	1.2981	25.01
420002	1.5001	20.20
420004	1.8174	19.41
420005	1.1360	15.99
420006	1.2057	18.24
420007	1.5723	17.58
420009	1.1691	17.25
420010	1.1771	17.91
420011	1.2447	14.99
420014	1.0205	16.72
420015	1.3354	17.18
420016	0.9537	18.15
420018	1.8084	19.73
420019	1.2188	15.55
420020	1.1847	17.90
420023	1.4285	20.97
420026	1.8906	21.90
420027	1.3311	18.08
420029	.....	18.35
420030	1.2089	17.82
420031	0.8604	13.07
420033	1.1644	21.09
420036	1.2900	19.74
420037	1.1933	21.96
420038	1.3150	16.15
420039	1.0732	16.96
420042	.....	14.66
420043	1.1871	18.36
420048	1.2367	18.03
420049	1.1990	19.23
420051	1.6460	18.25
420053	1.1431	16.55
420054	1.2387	16.55
420055	1.0582	16.18
420056	1.1140	15.60
420057	1.1152	14.50
420059	0.9721	19.13
420061	1.1775	16.13
420062	1.1898	18.95
420064	1.1047	15.45
420065	1.3888	19.06
420066	0.9829	15.50
420067	1.2167	18.31
420068	1.3841	17.21
420069	1.0603	16.32
420070	1.2337	17.45
420071	1.3506	18.29
420072	0.9129	12.60
420073	1.2811	19.20
420074	1.0309	13.80
420075	0.9395	16.29
420078	1.8574	20.68
420079	1.5169	18.77
420080	1.3719	24.83
420081	.....	20.42
420082	1.5862	18.88

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
420083	1.3552	23.34
420085	1.4126	18.55
420086	1.4345	19.31
420087	1.5936	18.40
420088	1.0874	17.91
420089	1.2957	21.66
420091	1.2752	18.57
420093	1.0331	16.77
420094	.....	32.68
430004	0.9951	17.84
430005	1.3596	15.84
430007	1.0895	14.06
430008	1.0961	16.76
430010	1.1568	16.11
430011	1.2924	16.42
430012	1.3190	17.78
430013	1.2075	17.24
430014	1.3645	18.44
430015	1.2102	16.41
430016	1.8688	18.97
430018	0.8830	14.91
430022	0.8600	12.95
430023	0.8726	11.64
430024	0.9383	13.99
430026	.....	10.85
430027	1.7702	18.64
430028	1.0723	16.72
430029	0.9695	15.10
430031	0.9138	12.46
430033	0.9911	14.64
430034	0.9542	12.85
430036	0.9551	13.78
430037	0.9633	15.95
430038	1.0095	11.94
430040	1.0562	13.37
430041	0.9146	12.62
430043	1.1343	13.43
430044	0.9084	16.45
430047	1.0290	15.62
430048	1.2374	17.26
430049	0.8800	14.44
430051	0.9313	17.21
430054	0.9661	13.50
430056	0.8354	11.41
430057	0.8972	15.15
430060	1.0902	8.64
430062	.....	10.89
430064	1.0315	12.74
430065	.....	12.77
430066	0.9635	13.44
430073	1.0645	14.98
430076	0.9498	12.25
430077	1.6674	17.71
430079	0.9893	12.98
430081	0.8927	.....
430082	0.8557	.....
430083	0.9273	.....
430084	0.8292	.....
430085	0.7951	.....
430087	.....	10.45
430089	0.8333	17.01
430090	1.3132	.....
430091	1.4508	.....
430092	2.2027	.....

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
430093	0.9944	.....
440001	1.1723	15.31
440002	1.6655	18.54
440003	1.2107	17.47
440006	1.4049	20.66
440007	1.0023	7.76
440008	0.9789	15.47
440009	1.1546	15.46
440010	0.9316	13.51
440011	1.3825	17.16
440012	1.7212	19.06
440014	1.0054	14.61
440015	1.8026	21.09
440016	1.0329	14.94
440017	1.7407	21.13
440018	1.2959	18.21
440019	1.7380	28.22
440020	1.1314	15.59
440022	.....	19.02
440023	1.1026	14.14
440024	1.2941	18.10
440025	1.1546	15.28
440026	0.8073	22.92
440029	1.2571	18.52
440030	1.2081	15.57
440031	1.0313	14.30
440032	1.0042	13.60
440033	1.1597	14.04
440034	1.5624	17.93
440035	1.2300	18.16
440039	1.8880	19.37
440040	0.9695	17.50
440041	1.0284	13.63
440046	1.2340	16.88
440047	0.9232	17.00
440048	1.8759	18.14
440049	1.6647	16.71
440050	1.3886	16.76
440051	0.9140	14.91
440052	1.0635	16.27
440053	1.3256	17.69
440054	1.1374	12.31
440056	1.1442	14.25
440057	1.0332	12.72
440058	1.2111	18.74
440059	1.4218	17.53
440060	1.1643	15.86
440061	1.1488	16.84
440063	1.6723	18.29
440064	1.0849	17.62
440065	1.2815	18.69
440067	1.2417	22.07
440068	1.2254	17.45
440070	1.0048	15.04
440071	1.3484	16.27
440072	1.3554	16.77
440073	1.2784	18.56
440078	1.0266	13.09
440081	1.0930	17.97
440082	2.0510	23.08
440083	0.9673	35.10
440084	1.2069	13.37
440091	1.6378	19.73
440100	1.0065	13.95

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
440102	1.1291	13.96
440103	1.1144	19.21
440104	1.7467	22.39
440105	1.7762	16.03
440109	1.0850	14.25
440110	1.1007	15.92
440111	1.4511	21.07
440114	1.0554	13.61
440115	1.0675	12.97
440120	1.6383	18.30
440125	1.5580	16.11
440130	1.1358	16.67
440131	1.1191	14.68
440132	1.1320	15.91
440133	1.5497	21.51
440135	1.2187	20.90
440137	1.0853	14.70
440141	0.9707	12.48
440142	1.0003	13.01
440143	1.0458	17.84
440144	1.2153	16.67
440145	0.9558	13.66
440147	1.7028	22.01
440148	1.1231	17.64
440149	1.0963	17.15
440150	1.3332	13.08
440151	1.1150	15.43
440152	2.0217	17.84
440153	1.1545	16.10
440156	1.5019	19.61
440157	1.0816	11.40
440159	1.1206	17.62
440161	1.8695	20.76
440162	.....	14.41
440166	1.6850	18.14
440168	1.0595	15.95
440173	1.6016	18.47
440174	1.0343	17.01
440175	1.0711	17.61
440176	1.3789	18.75
440180	1.2237	17.34
440181	0.9669	11.85
440182	0.9559	20.32
440183	1.5916	19.44
440184	1.2535	18.06
440185	1.1857	18.73
440186	1.0484	18.53
440187	1.1034	16.25
440189	1.4919	16.19
440192	1.0808	19.97
440193	1.2258	18.40
440194	1.2517	20.33
440197	1.3608	23.11
440200	1.0409	16.06
440203	0.9731	16.61
440206	0.9468	15.55
440209	.....	14.75
440210	0.8584	12.33
440211	0.7028	.....
440212	1.3679	.....
440213	2.6309	.....
440214	1.3295	.....
440215	3.2594	.....
450002*	1.5331	19.92

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
450004	1.1460	15.28
450005	1.1874	15.59
450007	1.2676	15.75
450008	1.2574	15.75
450010	1.4353	16.08
450011	1.5196	18.01
450014	1.1164	18.22
450015	1.6333	18.44
450016	1.6642	17.31
450018	1.4440	20.41
450020	0.9574	16.97
450021	1.8603	22.69
450023	1.4538	16.64
450024	1.4522	16.56
450025	1.7316	16.44
450028	1.4999	18.43
450029	1.6790	17.69
450031	1.4813	20.90
450032	1.3572	15.24
450033	1.7147	20.86
450034	1.5646	18.91
450035	1.4767	16.81
450037	1.5593	18.65
450039	1.4220	22.08
450040	1.5467	17.52
450042	1.7755	17.59
450044	1.6190	21.04
450046	1.3229	17.09
450047	1.1484	13.90
450050	0.9409	13.00
450051	1.5732	20.08
450052	1.0005	13.53
450053	1.1017	17.31
450054	1.6336	21.98
450055	1.1134	14.81
450056	1.6266	20.00
450058	1.6320	16.98
450059	1.3025	14.21
450063	0.9080	13.81
450064	1.4194	16.42
450065	1.0265	19.61
450068	1.9340	22.69
450072	1.1756	17.38
450073	1.1201	16.62
450076	1.7324	.....
450078	0.8770	13.49
450079	1.5304	19.49
450080	1.1737	16.31
450081	1.0574	16.17
450082	0.9662	13.30
450083	1.8059	20.18
450085	1.0594	14.22
450087	1.4462	21.48
450090	1.1225	13.91
450092	1.2258	15.73
450094	1.3312	19.42
450096	1.4157	16.63
450097	1.3386	18.27
450098	1.0981	15.48
450099	1.1520	22.88
450101	1.4857	16.96
450102	1.7293	18.85
450104	1.1823	15.98
450107	1.5327	20.74

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
450108	1.0390	16.15
450109	0.9217	12.77
450110	.....	21.44
450111	1.2307	19.27
450112	1.2575	14.76
450113	1.3243	18.53
450118	1.6605	15.83
450119	1.4078	18.32
450121	1.5371	18.23
450123	1.1890	19.19
450124	1.6617	21.09
450126	1.3281	17.45
450128	1.1958	15.89
450130	1.5002	17.87
450131	1.2654	17.62
450132	1.6202	18.07
450133	1.6004	19.92
450135	1.6151	20.81
450137	1.5720	23.96
450140	0.9268	18.07
450143	1.0303	14.46
450144	1.1036	16.30
450145	0.8681	14.84
450146	0.9514	14.20
450147	1.3107	18.07
450148	1.2211	22.03
450149	1.4919	24.00
450150	0.9050	15.21
450151	1.1068	14.84
450152	1.2314	17.38
450153	1.5422	19.94
450154	1.1797	13.18
450155	1.0303	23.77
450157	1.0679	14.66
450160	0.9603	8.75
450162	1.2180	22.20
450163	1.0045	16.98
450164	1.1806	20.04
450165	1.0378	15.16
450166	0.9271	10.28
450169	.....	15.88
450170	0.9642	14.81
450176	1.2922	16.30
450177	1.2048	14.73
450178	1.0236	16.76
450181	1.0155	14.02
450184	1.4598	19.97
450185	1.0280	13.06
450187	1.1970	17.57
450188	0.9951	13.78
450191	1.0175	18.80
450192	1.1761	19.33
450193	2.0418	22.73
450194	1.3020	19.15
450196	1.4363	16.49
450200	1.4435	17.38
450201	1.0156	17.05
450203	1.1610	18.66
450209	1.5661	18.66
450210	1.0520	14.23
450211	1.3657	17.14
450213	1.7239	18.45
450214	1.3278	17.25
450217	0.9404	11.69

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
450219	1.0827	15.42
450221	1.1951	16.99
450222	1.4958	18.45
450224	1.3659	22.83
450229	1.5753	16.41
450231	1.6275	17.70
450234	1.0446	13.30
450235	1.0697	13.42
450236	1.1450	15.68
450237	1.5270	17.40
450239	1.0085	13.64
450241	0.9610	14.87
450243	0.9422	12.36
450246	1.0263	17.97
450249	1.0666	11.63
450250	0.9906	14.91
450253	1.1245	15.35
450258	1.0358	13.23
450259	.....	17.85
450264	0.8807	13.89
450269	0.9970	14.93
450270	1.0799	12.70
450271	1.2418	15.50
450272	1.2621	17.95
450276	1.0970	12.71
450278	0.8254	13.79
450280	1.5817	19.49
450283	1.0456	13.89
450286	.....	12.12
450288	1.1566	15.99
450289	1.4628	18.35
450292	1.1880	19.51
450293	0.9416	14.43
450296	1.3456	20.66
450299	1.5391	17.97
450303	0.9610	12.67
450306	1.0915	13.32
450307	0.8064	16.68
450309	1.0981	16.21
450315	0.9782	20.80
450320	1.2433	19.63
450321	0.9220	13.39
450322	0.5973	12.46
450324	1.5321	17.87
450327	0.9680	16.09
450330	1.1273	18.42
450334	0.9752	12.27
450337	0.9914	17.42
450340	1.4515	15.85
450341	1.0145	19.18
450346	1.4978	17.10
450347	1.2191	17.69
450348	1.1295	12.94
450351	1.2160	15.98
450352	1.1896	17.85
450353	1.1368	15.00
450355	1.0439	14.32
450358	2.0749	21.28
450362	1.0930	15.35
450369	1.0526	15.19
450370	1.2091	15.44
450371	1.2416	11.90
450372	1.2361	19.86
450373	1.1050	17.60

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
450374	0.8698	12.83
450378	1.2110	23.16
450379	1.5565	20.28
450381	0.9516	15.62
450388	1.7788	17.56
450389	1.2896	18.15
450393	1.2509	18.74
450395	1.0405	16.67
450399	0.9427	16.31
450400	1.3730	14.08
450403	1.2446	21.37
450411	0.9314	14.05
450417	1.0243	13.85
450418	1.3882	20.58
450419	1.2157	21.82
450422	1.0412	24.53
450423	1.5370	19.44
450424	1.2472	17.57
450429	1.1166	11.38
450431	1.5621	16.27
450438	1.1335	16.55
450446	0.7614	21.97
450447	1.3915	16.61
450451	1.1857	19.64
450457	1.8458	19.77
450460	1.0022	14.22
450462	1.7379	20.13
450464	0.9349	13.47
450465	1.3025	15.22
450467	1.0721	15.60
450469	1.3893	22.10
450473	1.0194	14.19
450475	1.0898	16.25
450484	1.4878	19.59
450488	1.3277	18.68
450489	0.9699	14.57
450497	1.1185	11.92
450498	0.9726	12.02
450508	1.3869	19.87
450514	1.0763	22.28
450517	0.9630	12.87
450518	1.5221	19.01
450523	1.4824	20.26
450530	1.1935	22.91
450534	0.9667	24.08
450535	1.2294	21.26
450537	1.3395	21.74
450538	.....	19.69
450539	1.2636	14.25
450544	1.1451	19.38
450545	1.3921	16.97
450547	1.0630	13.81
450551	1.1015	13.91
450558	1.7932	20.02
450559	.....	13.46
450561	.....	16.82
450563	1.2612	30.37
450565	1.2556	16.45
450570	1.1337	17.71
450571	1.4934	16.97
450573	0.9884	15.67
450574	0.9302	14.24
450575	1.1417	19.06
450578	0.9369	16.87

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
450580	1.1529	15.36
450583	1.0313	15.50
450584	1.1775	13.37
450586	1.0568	12.84
450587	1.1748	17.11
450591	1.1439	17.92
450596	1.2187	14.82
450597	0.9686	16.18
450603	0.7880	12.77
450604	1.3018	15.48
450605	1.1881	20.15
450609	0.8938	10.73
450610	1.4658	16.75
450614	0.9889	13.83
450615	1.0752	14.75
450617	1.3304	19.54
450620	1.1230	13.71
450623	1.1370	21.83
450626	1.0095	19.79
450628	1.0152	16.83
450630	1.5196	19.19
450631	1.6627	17.56
450632	0.9391	12.73
450633	1.5491	20.72
450634	1.6032	20.29
450638	1.5279	19.70
450639	1.4801	20.31
450641	1.0503	13.50
450643	1.2187	17.43
450644	1.4341	20.79
450646	1.4580	19.99
450647	1.8895	22.42
450648	1.0047	14.75
450649	1.0310	15.82
450651	1.6794	20.73
450652	0.9055	16.65
450653	1.0887	19.28
450654	0.9509	13.88
450656	1.3892	18.73
450658	0.9617	15.15
450659	1.4870	20.56
450661	1.1054	20.22
450662	1.4695	18.68
450665	0.8670	15.44
450666	1.3171	19.35
450668	1.6278	18.72
450669	1.3458	22.28
450670	1.3452	18.20
450672	1.5856	21.21
450673	1.0157	13.84
450674	1.1487	20.62
450675	1.3667	23.26
450677	1.3315	18.79
450678	1.4770	20.75
450681	1.3177	.....
450683	1.2748	21.17
450684	1.2383	22.85
450686	1.5942	15.01
450688	1.3164	20.90
450690	1.3880	22.41
450694	1.1399	18.49
450696	1.3358	17.57
450697	1.3675	15.93
450698	0.9133	14.40

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
450700	0.9460	15.12
450702	1.5056	21.01
450703	1.1321	18.80
450704	1.2429	21.62
450705	0.8800	22.32
450706	1.1954	21.38
450709	1.1866	19.77
450711	1.6330	18.24
450712	0.5453	16.89
450713	1.4858	23.60
450715	1.4308	19.77
450716	1.2691	19.99
450717	1.2889	19.45
450718	1.2002	19.07
450723	1.4188	19.70
450724	1.2574	20.07
450725	.....	19.56
450727	1.0500	17.75
450728	0.8255	12.93
450730	1.3987	20.91
450733	1.4696	20.37
450735	0.8297	8.00
450742	1.2714	20.78
450743	1.4590	15.95
450746	0.9207	20.75
450747	1.3342	17.38
450749	1.0361	12.95
450750	1.0162	14.72
450751	1.2134	22.25
450754	0.9408	14.89
450755	1.1073	14.71
450757	0.8766	13.96
450758	1.9447	18.65
450760	1.2078	18.07
450761	0.9462	11.14
450763	1.0029	17.56
450766	2.0818	21.81
450769	0.8516	13.62
450770	0.9940	16.83
450771	1.9082	21.58
450774	1.6697	16.52
450775	1.3660	19.97
450776	1.0045	10.20
450777	0.9770	19.59
450779	1.2931	22.97
450780	1.7380	15.28
450785	0.9897	18.55
450788	1.5021	20.98
450794	.....	18.40
450795	0.9879	14.17
450796	3.3883	17.45
450797	0.7701	18.59
450798	0.7662	9.22
450801	1.4581	16.61
450802	1.4444	18.90
450803	1.0992	16.20
450804	1.7531	20.22
450807	0.8919	13.23
450808	1.9250	45.47
450809	1.5460	19.03
450810	0.9739	.....
450811	2.3971	18.38
450812	.....	20.74
450813	0.9718	.....

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
450815	2.5623	.....
450817	0.6826	.....
450818	1.2025	.....
450819	1.5000	.....
450820	1.0411	.....
450822	1.2110	.....
460001	1.7793	20.63
460003	1.6046	20.60
460004	1.7755	20.82
460005	1.6581	17.58
460006	1.3373	19.65
460007	1.3076	20.57
460008	1.3677	21.03
460009	1.8478	21.11
460010	2.0972	21.25
460011	1.3205	16.71
460013	1.4303	20.33
460014	1.2254	19.55
460015	1.2396	20.10
460016	0.9953	18.08
460017	1.3888	26.03
460018	0.9230	16.86
460019	1.0510	17.37
460020	0.9556	17.03
460021	1.3848	20.26
460022	0.9569	18.21
460023	1.1785	21.33
460024	.....	13.03
460025	0.8243	12.51
460026	1.0605	17.34
460027	0.9545	20.83
460029	1.0958	17.25
460030	1.1918	17.22
460032	0.9792	19.55
460033	0.9753	15.72
460035	0.9477	14.28
460036	1.0005	22.38
460037	0.9080	18.77
460039	1.0603	24.48
460041	1.3072	21.69
460042	1.3714	17.85
460043	0.9896	23.90
460044	1.1363	20.69
460046	.....	17.11
460047	1.6723	21.38
460049	1.9825	18.82
460050	.....	26.25
460051	1.1552	20.98
460052	1.4619	.....
470001	1.3011	19.61
470003	1.8338	22.59
470004	1.0674	18.10
470005	1.2285	21.51
470006	1.2408	18.39
470008	1.2590	19.41
470010	1.0678	19.47
470011	1.1504	21.20
470012	1.2780	18.52
470015	1.1985	19.26
470018	1.2252	20.42
470020	0.9900	18.99
470023	1.3197	20.64
470024	1.1528	20.41
490001	1.1931	24.76

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
490002	1.0751	12.99
490003	0.6419	18.00
490004	1.2740	18.77
490005	1.5963	16.91
490006	1.2147	15.23
490007	2.0919	18.43
490009	1.9489	22.95
490010	1.0335	18.58
490011	1.4655	18.75
490012	1.1933	13.78
490013	1.2476	16.93
490014	1.5333	24.56
490015	1.5161	19.36
490017	1.3895	17.32
490018	1.3002	17.94
490019	1.1951	17.53
490020	1.2248	17.67
490021	1.3810	19.45
490022	1.5532	20.72
490023	1.2186	18.96
490024	1.6762	16.89
490027	1.1131	14.42
490030	1.1907	10.50
490031	1.0734	15.82
490032	1.7204	21.56
490033	1.1999	18.33
490037	1.1999	15.97
490038	1.2143	15.71
490040	1.4733	22.52
490041	1.2747	16.55
490042	1.2324	15.27
490043	1.3532	20.68
490044	1.3213	17.63
490045	1.2161	19.63
490046	1.5370	18.61
490047	1.1078	17.16
490048	1.5688	17.89
490050	1.4272	22.71
490052	1.6372	16.94
490053	1.3233	15.69
490054	1.0319	15.55
490057	1.5739	19.07
490059	1.5941	20.37
490060	1.0645	19.20
490063	1.7721	28.25
490066	1.3274	16.50
490067	1.2535	17.19
490069	1.4182	15.70
490071	1.4083	19.47
490073	1.5076	26.14
490074	.....	19.34
490075	1.3785	19.19
490077	1.2263	19.79
490079	1.3128	16.44
490083	.....	16.64
490084	1.1308	16.38
490085	1.1582	16.40
490088	1.1286	15.60
490089	1.0694	15.86
490090	1.1220	16.28
490091	1.2330	19.99
490092	1.2219	15.69
490093	1.4339	16.48
490094	1.0922	16.79

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
490095	.....	18.25
490097	1.2096	15.86
490098	1.2068	14.70
490099	0.9555	16.87
490100	.....	17.22
490101	1.2286	25.09
490104	0.7018	28.49
490105	0.5822	18.25
490106	0.8713	16.91
490107	1.3326	22.41
490108	0.8935	19.75
490109	0.8779	21.16
490110	1.2994	15.84
490111	1.2000	17.35
490112	1.6550	20.52
490113	1.3249	23.08
490114	1.1582	16.91
490115	1.1600	17.10
490116	1.1704	16.44
490117	1.1543	13.84
490118	1.7091	20.87
490119	1.3367	17.87
490120	1.3095	19.98
490122	1.3605	23.97
490123	1.1355	16.85
490124	1.0893	19.36
490126	1.3233	18.23
490127	1.0410	14.48
490129	1.0746	27.47
490130	1.3119	16.28
490132	1.0183	17.02
500001	1.4869	21.35
500002	1.4055	21.04
500003	1.4016	24.31
500005	1.7533	23.48
500007	1.3352	22.43
500008	1.9490	24.19
500011	1.3373	25.18
500012	1.5530	22.28
500014	1.5641	23.93
500015	1.3293	23.24
500016	1.4955	23.90
500019	1.3833	22.37
500021	1.4802	24.46
500023	1.2073	27.19
500024	1.6886	24.05
500025	1.9090	23.96
500026	1.4529	23.35
500027	1.6832	25.05
500028	1.0717	18.86
500029	0.9086	16.81
500030	1.4513	24.13
500031	1.2483	23.37
500033	1.3309	21.39
500036	1.3911	21.90
500037	1.1389	19.68
500039	1.3828	23.32
500041	1.3244	24.85
500042	1.4121	22.13
500043	1.0107	20.25
500044	1.9371	23.11
500045	1.0116	22.10
500048	0.9601	19.30
500049	1.4695	22.95

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
500050	1.3489	20.94
500051	1.6736	24.48
500052	1.1621	.....
500053	1.3284	22.05
500054	1.8781	22.90
500055	1.1284	22.88
500057	1.3026	18.04
500058	1.4834	23.40
500059	1.0767	22.54
500060	1.3712	23.54
500061	1.0000	20.40
500062	1.0655	19.46
500064	1.6382	24.53
500065	1.2532	21.42
500068	1.0543	18.70
500069	1.1155	20.63
500071	1.2837	19.38
500072	1.2021	24.46
500073	0.9531	21.43
500074	1.1055	18.65
500077	1.3298	23.21
500079	1.3220	22.98
500080	0.8180	13.80
500084	1.2784	22.22
500085	0.9302	28.61
500086	1.2601	22.31
500088	1.2967	23.70
500089	1.0515	17.94
500090	0.8380	16.33
500092	1.0165	17.29
500094	0.8803	18.11
500096	0.9394	20.96
500097	1.0798	20.80
500098	1.0464	12.99
500101	1.0108	19.45
500102	0.9022	20.33
500104	1.2616	22.58
500106	0.9351	18.71
500107	1.2053	17.30
500108	1.7383	27.21
500110	1.2107	21.41
500118	1.1490	22.92
500119	1.3555	21.57
500122	1.2755	21.91
500123	0.9495	19.58
500124	1.3681	24.15
500125	1.0521	16.63
500129	1.6409	23.60
500132	0.9686	19.36
500134	0.6491	20.96
500138	3.6799	.....
500139	1.4682	20.88
500141	1.3726	22.94
500143	0.5954	17.60
500146	.....	17.85
510001	1.9499	17.83
510002	1.2866	17.34
510005	1.0198	14.43
510006	1.2719	17.88
510007	1.5729	20.25
510008	1.2172	17.37
510012	1.0087	16.50
510013	1.1012	16.62
510015	0.9677	14.79

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
510016	.....	12.03
510018	1.0741	16.48
510020	1.0848	12.65
510022	1.8970	19.84
510023	1.2380	15.94
510024	1.5836	18.80
510026	1.0574	13.46
510027	0.9600	17.58
510028	1.0520	20.73
510029	1.2855	17.05
510030	1.0520	18.31
510031	1.4131	18.49
510033	1.2904	18.81
510035	1.2311	18.65
510036	0.9839	13.20
510038	1.0640	14.34
510039	1.3990	16.06
510043	0.9349	14.29
510046	1.2735	17.73
510047	1.2611	19.12
510048	1.1332	20.37
510050	1.7457	16.57
510053	1.0811	15.59
510055	1.2306	22.84
510058	1.2795	17.98
510059	2.0210	16.77
510060	1.0503	15.66
510061	1.0243	14.22
510062	1.2784	17.63
510065	.....	14.59
510066	.....	12.72
510067	1.2058	18.11
510068	1.2058	16.29
510070	1.2966	16.36
510071	1.3297	16.24
510072	1.0573	17.66
510077	1.1370	16.41
510080	1.1479	14.80
510081	1.0787	13.00
510082	1.1597	13.69
510084	1.0361	12.48
510085	1.2771	18.64
510086	1.1035	13.79
510088	1.0389	.....
520002	1.2721	18.35
520003	1.0869	16.43
520004	1.1778	18.17
520006	1.0164	20.44
520007	1.0508	13.11
520008	1.6392	22.80
520009	1.6949	18.51
520010	1.1559	20.34
520011	1.1930	20.38
520013	1.3680	21.63
520014	1.1066	16.40
520015	1.1978	18.32
520016	0.9703	13.29
520017	1.1930	19.32
520018	1.1211	18.64
520019	1.3095	18.31
520021	1.4596	20.03
520024	1.0420	14.61
520025	1.0654	18.11
520026	1.0296	19.81

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
520027	1.2626	18.91
520028	1.3294	19.14
520029	0.8917	16.75
520030	1.7395	20.00
520031	1.0756	18.71
520032	1.2622	17.90
520033	1.2388	18.89
520034	1.1058	16.69
520035	1.3246	17.10
520037	1.7026	20.05
520038	1.3352	17.71
520039	0.9990	19.60
520040	1.5261	20.74
520041	1.1567	15.37
520042	1.1256	17.66
520044	1.4143	17.79
520045	1.6556	19.67
520047	0.9397	17.87
520048	1.4958	19.17
520049	2.0506	19.57
520051	1.8466	19.74
520053	1.1884	16.49
520054	1.0542	15.99
520057	1.1944	18.32
520058	1.1077	18.13
520059	1.4368	19.85
520060	1.4770	17.17
520062	1.2487	17.80
520063	1.1864	20.77
520064	1.5707	21.46
520066	1.4671	22.44
520068	0.9618	18.08
520069	1.2293	17.91
520070	1.5249	17.82
520071	1.2525	18.79
520074	1.0559	18.69
520075	1.4866	19.09
520076	1.1796	16.51
520077	0.9312	15.54
520078	1.6373	20.56
520082	1.1943	16.74
520083	1.7219	22.57
520084	1.0804	18.95
520087	1.6992	19.39
520088	1.2752	20.15
520089	1.4733	20.61
520090	1.2604	18.00
520091	1.2778	20.07
520092	1.0845	17.56
520094	0.7818	19.78
520095	1.2908	18.51
520096	1.3848	19.30
520097	1.3197	19.65
520098	1.7723	20.03
520100	1.2561	18.38
520101	1.0650	17.85
520102	1.1753	19.83
520103	1.3285	21.23
520107	1.2649	20.54
520109	1.0080	18.63
520110	1.2429	20.03
520111	1.0771	17.24
520112	1.1382	18.18
520113	1.2755	20.59

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
520114	1.0706	17.38
520115	1.2453	17.38
520116	1.2751	18.57
520117	1.0083	17.42
520118	0.9267	12.44
520120	0.9639	15.62
520121	0.9801	17.58
520122	0.9988	16.76
520123	0.9687	17.41
520124	1.0567	16.39
520130	1.0645	15.16
520131	1.0215	18.80
520132	1.2140	17.28
520134	1.1056	17.61
520135	0.9686	14.47
520136*	1.5183	19.99
520138	1.8827	20.89
520139	1.2600	21.28
520140	1.6650	21.42
520141	.....	16.95
520142	0.8577	17.70
520144	1.0177	16.62
520145	0.9103	17.24
520146	1.0606	15.73
520148	1.1737	16.93
520149	0.8651	13.30
520151	1.0561	18.08
520152	1.1273	21.33
520153	0.9014	15.45
520154	1.1283	17.92
520156	1.1278	19.84
520157	1.1408	17.28
520159	0.9357	18.74
520160	1.7939	18.84
520161	0.9978	18.57
520170	1.1960	22.50
520171	0.9558	15.73
520173	1.1310	20.14
520177	1.7178	21.76
520178	1.0401	17.04
520187	0.6853	.....
520188	1.9479	.....
530002	1.1799	17.59
530003	0.8696	15.78
530004	0.9388	16.19
530005	1.1268	15.15
530006	1.1073	19.34
530007	1.0673	18.06
530008	1.2158	22.96
530009	0.9826	19.45
530010	1.2456	18.93
530011	1.1585	17.44
530012	1.6198	19.48
530014	1.4187	17.32
530015	1.2855	22.65
530016	1.2279	17.71
530017	0.9404	13.71
530018	0.9876	17.87
530019	0.9171	16.76
530022	1.1504	17.88
530023	0.8235	20.75
530025	1.3737	20.32
530026	1.1260	18.92
530027	0.8284	29.77

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hour wage
530029	0.9986	17.80
530031	0.8242	13.38
530032	1.1799	20.21

*Asterisk denotes teaching physician costs removed based on costs reported on Worksheet A, Col. 1, Line 23 of FY 1996 cost report.

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS

Urban area (constituent counties)	Wage index	GAF
0040 Abilene, TX	0.8179	0.8714
Taylor, TX		
0060 Aguadilla, PR [2]	0.4249	0.5565
Aguada, PR		
Aguadilla, PR		
Moca, PR		
0080 Akron, OH	1.0163	1.0111
Portage, OH		
Summit, OH		
0120 Albany, GA	1.0372	1.0253
Dougherty, GA		
Lee, GA		
0160 Albany-Schenectady-Troy, NY	0.8754	0.9129
Albany, NY		
Montgomery, NY		
Rensselaer, NY		
Saratoga, NY		
Schenectady, NY		
Schoharie, NY		
0200 Albuquerque, NM	0.8499	0.8946
Bernalillo, NM		
Sandoval, NM		
Valencia, NM		
0220 Alexandria, LA	0.7910	0.8517
Rapides, LA		
0240 Allentown-Bethlehem-Easton, PA	0.9550	o.9690
Carbon, PA		
LeHigh, PA		
Northampton, PA		
0280 Altoona, PA	0.9342	0.9545
Blair, PA		
0320 Amarillo, TX	0.8435	0.8900
Potter, TX		
Randall, TX		
0380 Anchorage, AK	1.3009	1.1974
Anchorage, AK		
0440 Ann Arbor, MI	1.1483	1.0993
Lenawee, MI		
Livingston, MI		
Washtenaw, MI		
0450 Anniston, AL	0.8462	0.8919
Calhoun, AL		
0460 Appleton-Oshkosh-Neenah, WI	0.8913	0.9242

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index	GAF
Calumet, WI		
Outagamie, WI		
Winnebago,WI		
0470 Arecibo, PR	0.4815	0.6062
Arecibo, PR		
Camuy, PR		
Hatillo, PR		
0480 Asheville, NC	0.8884	0.9222
Buncombe, NC		
Madison, NC		
0500 Athens, GA	0.9800	0.9863
Clarke, GA		
Madison, GA		
Oconee, GA		
0520 Atlanta, GA	1.0050	1.0034
Barrow, GA		
Bartow, GA		
Carroll, GA		
Cherokee, GA		
Clayton, GA		
Cobb, GA		
Coweta, GA		
DeKalb, GA		
Douglas, GA		
Fayette, GA		
Forsyth, GA		
Fulton, GA		
Gwinnett, GA		
Henry, GA		
Newton, GA		
Paulding, GA		
Pickens, GA		
Rockdale, GA		
Spalding, GA		
Walton GA		
0560 Atlantic-Cape May, NJ	1.1050	1.0708
Atlantic, NJ		
Cape May, NJ		
0580 Auburn-Opelika, AL	0.7748	0.8397
Lee, AL		
0600 Augusta-Aiken, GA–SC	0.9013	0.9313
Columbia, GA		
McDuffie, GA		
Richmond, GA		
Aiken, SC		
Edgefield, SC		
0640 Austin-San Marcos, TX [1]	0.9081	0.9361
Bastrop, TX		
Caldwell, TX		
Hays, TX		
Travis, TX		
Williamson, TX		
0680 Bakersfield, CA [2]	0.9951	0.9966
Kern, CA		
0720 Baltimore, MD [1]	0.9891	0.9925
Anne Arundel, MD		
Baltimore, MD		
Baltimore, City, MD		
Carroll, MD		
Harford, MD		
Howard, MD		
Queen Anne's, MD		
0733 Bangor, ME	0.9609	0.9731

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index	GAF
Penobscot, ME		
0743 Barnstable-Yarmouth, MA	1.3302	1.2158
Barnstable, MA		
0760 Baton Rouge, LA	0.8707	0.9095
Ascension, LA		
East Baton Rouge, LA		
Livingston, LA		
West Baton Rouge, LA		
0840 Beaumont-Port Arthur, TX	0.8624	0.9036
Hardin, TX		
Jefferson, TX		
Orange, TX		
0860 Bellingham, WA	1.1394	1.0935
Whatcom, WA		
0870 Benton Harbor, MI [2]	0.8831	0.9184
Berrien, MI		
0875 Bergen-Passaic, NJ [1]	1.1833	1.1222
Bergen, NJ		
Passaic, NJ		
0880 Billings, MT	1.0038	1.0026
Yellowstone, MT		
0920 Biloxi-Gulfport-Pascagoula, MS	0.7949	0.8545
Hancock, MS		
Harrison, MS		
Jackson, MS		
0960 Binghamton, NY	0.8750	0.9126
Broome, NY		
Tioga, NY		
1000 Birmingham, AL	0.8994	0.9300
Blount, AL		
Jefferson, AL		
St. Clair, AL		
Shelby, AL		
1010 Bismarck, ND	0.7893	0.8504
Burleigh, ND		
Morton, ND		
1020 Bloomington, IN	0.8593	0.9014
Monroe, IN		
1040 Bloomington-Normal, IL	0.8993	0.9299
McLean, IL		
1080 Boise City, ID	0.9086	0.9365
Ada, ID		
Canyon, ID		
1123 Boston-Worcester-Lawrence-Lowell-Brockton, MA–NH (MA Hospitals) [1 2]	1.1369	1.0918
Bristol, MA		
Essex, MA		
Middlesex, MA		
Norfolk, MA		
Plymouth, MA		
Suffolk, MA		
Worcester, MA		
Hillsborough, NH		
Merrimack, NH		
Rockingham, NH		
Strafford, NH		
1123 Boston-Worcester-Lawrence-Lowell-Brockton, MA–NH (NH Hospitals) [1]	1.1358	1.0911
Bristol, MA		
Essex, MA		
Middlesex, MA		
Norfolk, MA		
Plymouth, MA		
Suffolk, MA		
Worcester, MA		
Hillsborough, NH		
Merrimack, NH		
Rockingham, NH		
Strafford, NH		
1125 Boulder-Longmont, CO	0.9944	0.9962
Boulder, CO		
1145 Brazoria, TX	0.8516	0.8958
Brazoria, TX		
1150 Bremerton, WA	1.1011	1.0682
Kitsap, WA		
1240 Brownsville-Harlingen-San Benito, TX	0.9212	0.9453
Cameron, TX		
1260 Bryan-College Station, TX	0.8501	0.8947
Brazos, TX		
1280 [1] Buffalo-Niagara Falls, NY	0.9604	0.9727
Erie, NY		
Niagara, NY		
1303 Burlington, VT	1.0558	1.0379
Chittenden, VT		
Franklin, VT		
Grand Isle, VT		
1310 Caguas, PR	0.4561	0.5842
Caguas, PR		
Cayey, PR		
Cidra, PR		
Gurabo, PR		
San Lorenzo, PR		
1320 Canton-Massillon, OH [2]	0.8649	0.9054
Carrll, OH		
Stark, OH		
1350 Casper, WY	0.9199	0.9444
Natrona, WY		
1360 Cedar Rapids, IA	0.9018	0.9317
Linn, IA		
1400 Champaign-Urbana, IL	0.9163	0.9419
Champaign, IL		
1440 Charleston-North Charleston, SC	0.8988	0.9295
Berkeley, SC		
Charleston, SC		
Dorchester, SC		
1480 Charleston, WV	0.9095	0.9371
Kanawha, WV		
Putnam, WV		
1520 Charlotte-Gastonia-Rock Hill, NC–SC [1]	0.9433	0.9608
Cabarrus, NC		
Gaston, NC		
Lincoln, NC		
Mecklenburg, NC		
Rowan, NC		
Stanly, NC		
Union, NC		
York, SC		
1540 Charlottesville, VA	1.0573	1.0389
Albermarle, VA		
Charlottesville City, VA		
Fluvanna, VA		
Greene, VA		
1560 Chattanooga, TN–GA	0.9731	0.9815
Catoosa, GA		
Dade, GA		
Walker, GA		
Hamilton, TN		
Marion, TN		
1580 Cheyenne, WY [2]	0.8859	0.9204
Laramie, WY		
1600 Chicago, IL [1]	1.0872	1.0589
Cook, IL		
DeKalb, IL		
DuPage, IL		
Grundy, IL		
Kane, IL		
Kendall, IL		
Lake, IL		
McHenry, IL		
Will, IL		
1620 Chico-Paradise, CA	1.0390	1.0265
Butte, CA		
1640 Cincinnati, OH–KY–IN [1]	0.9434	0.9609
Dearborn, IN		
Ohio, IN		
Boone, KY		
Campbell, KY		
Gallatin, KY		
Grant, KY		
Kenton, KY		
Pendleton, KY		
Brown, OH		
Clermont, OH		
Hamilton, OH		
Warren, OH		
1660 Clarksville-Hopkinsville, TN–KY	0.8283	0.8790
Christian, KY		
Montgomery, TN		
1680 Cleveland-Lorain-Elyria, OH [1]	0.9688	0.9785

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index	GAF
Ashtabula, OH		
Cuyahoga, OH		
Geauga, OH		
Lake, OH		
Lorain, OH		
Medina, OH		
1720 Colorado Springs, CO	0.9218	0.9458
El Paso, CO		
1740 Columbia, MO	0.8904	0.9236
Boone, MO		
1760 Columbia, SC	0.9357	0.9555
Lexington, SC		
Richland, SC		
1800 Columbus, GA–AL	0.8510	0.8954
Russell, AL		
Chattahoochee, GA		
Harris, GA		
Muscogee, GA		
1840 Columbus, OH	0.9907	0.9936
Delaware, OH		
Fairfield, OH		
Franklin, OH		
Licking, OH		
Madison, OH		
Pickaway, OH		
1880 Corpus Christi, TX	0.8702	0.9092
Nueces, TX		
San Patricio, TX		
1890 Crovallis, OR	1.1087	1.0732
Benton, OR		
1900 Cumberland, MD–WV (Maryland Hospitals)	0.8801	0.9163
Allegany, MD		
Mineral, WV		
1920 Dallas, TX [1]	0.9589	0.9717
Collin, TX		
Dallas, TX		
Denton, TX		
Ellis, TX		
Henderson, TX		
Hunt, TX		
Kaufman, TX		
Rockwall, TX		
1950 Danville, VA	0.9061	0.9347
Danville City, VA		
Pittsylvania, VA		
1960 Davenport-Moline-Rock Island, IA–IL	0.8706	0.9095
Scott, IA		
Henry, IL		
Rock Island, IL		
2000 Dayton-Springfield, OH	0.9336	0.9540
Clark, OH		
Greene, OH		
Miami, OH		
Montgomery, OH		
2020 Daytona Beach, FL [2]	0.8986	0.9294
Flagler, FL		
Volusia, FL		
2030 Decatur, AL	0.8679	0.9075
Lawrence, AL		
Morgan, AL		
2040 Decatur, IL	0.8321	0.8817
Macon, IL		
2080 Danver, CO [1]	1.0197	1.0134
Adams, CO		
Arapahoe, CO		
Denver, CO		
Douglas, CO		
Jefferson, CO		
2120 Des Moines, IA	0.8754	0.9129
Dallas, IA		
Polk, IA		
Warren, IA		
2160 Detroit, MI [1]	1.0421	1.0286
Lapeer, MI		
Macomb, MI		
Monroe, MI		
Oakland, MI		
St. Clair, MI		
Wayne, MI		
2180 Dothan, AL	0.7836	0.8462
Dale, AL		
Houston, AL		
2190 Dover, DE	0.9335	0.9540
Kent, DE		
2200 Dubuque, IA	0.8520	0.8961
Dubuque, IA		
2240 Duluth-Superior, MN–WI	1.0165	1.0113
St. Louis, MN		
Douglas, WI		
2281 Dutchess County, NY	0.9872	0.9912
Dutchess, NY		
2290 Eau Claire, WI	0.8957	0.9273
Chippewa, WI		
Eau Claire, WI		
2320 El Paso, TX	0.8947	0.9266
El Paso, TX		
2330 Elkhart-Goshen, IN	0.9379	0.9570
Elkhart, IN		
2335 Elmira, NY [2]	0.8636	0.9045
Chemung, NY		
2340 Enid, OK	0.7953	0.8548
Garfield, OK		
2360 Erie, PA	0.9023	0.9320
Erie, PA		
2400 Eugene-Springfield, OR	1.0765	1.0518
Lane, OR		
2440 Evansville-Henderson, IN–KY (IN Hospitals) [2]	0.8396	0.8872
Posey, IN		
Vanderburgh, IN		
Warrick, IN		
Henderson, KY		
2440 Evansville-Henderson, IN–KY (KY Hospitals)	0.8303	0.8804
Posey, IN		
Vanderburgh, IN		
Warrick, IN		
Henderson, KY		
2520 Fargo-Moorhead, ND–MN	0.8620	0.9033
Clay, MN		
Cass, ND		
2560 Fayetteville, NC	0.8494	0.8942
Cumberland, NC		
2580 Fayetteville-Springdale-Rogers, AR	0.7773	0.8415
Benton, AR		
Washington, AR		
2620 Flagstaff, AZ–UT	1.0348	1.0237
Coconino, AZ		
Kane, UT		
2640 Flint, MI	1.1020	1.0688
Genesee, MI		
2650 Florence, AL	0.7927	0.8529
Colbert, AL		
Lauderdale, AL		
2655 Florence, SC	0.8618	0.9032
Florence, SC		
2670 Fort Collins-Loveland, CO	1.0302	1.0206
Larimer, CO		
2680 Ft. Lauderdale, FL [1]	1.0172	1.0117
Broward, FL		
2700 Fort Myers-Cape Coral, FL [2]	0.8986	0.9294
Lee, FL		
2710 Fort Pierce-Port St. Lucie, FL	1.0109	1.0075
Martin, FL		
St. Lucie, FL		
2720 Fort Smith, AR–OK	0.7844	0.8468
Crawford, AR		
Sebastian, AR		
Sequoyah, OK		
2750 Fort Walton Beach, FL [2]	0.8986	0.9294
Okaloosa, FL		
2760 Fort Wayne, IN	0.9096	0.9372
Adams, IN		
Allen, IN		
De Kalb, IN		
Huntington, IN		
Wells, IN		
Whitley, IN		
2800 Forth Worth-Arlington, TX [1]	0.9835	0.9887
Hood, TX		
Johnson, TX		
Parker, TX		
Tarrant, TX		
2840 Fresno, CA	1.0262	1.0179
Fresno, CA		
Madera, CA		
2880 Gadsden, AL	0.8754	0.9129
Etowah, AL		
2900 Gainesville, FL	1.0102	1.0070
Alachua, FL		
2920 Galveston-Texas City, TX	0.9732	0.9816
Galveston, TX		
2960 Gary, IN	0.9369	0.9563
Lake, IN		
Porter, IN		
2975 Glens Falls, NY [2]	0.8636	0.9045

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index	GAF
Warren, NY		
Washington, NY		
2980 Goldsboro, NC	0.8333	0.8826
Wayne, NC		
2985 Grand Forks, ND–MN	0.9097	0.9372
Polk, MN		
Grand Forks, ND		
2995 Grand Junction, CO	0.9188	0.9437
Mesa, CO		
3000 Grand Rapids-Muskegon-Holland, MI [1]	1.0135	1.0092
Allegan, MI		
Kent, MI		
Muskegon, MI		
Ottawa, MI		
3040 Great Falls, MT	1.0459	1.0312
Cascade, MT		
3060 Greeley, CO	0.9722	0.9809
Weld, CO		
3080 Green Bay, WI	0.9215	0.9456
Brown, WI		
3120 Greensboro-Winston-Salem-High Point, NC [1]	0.9037	0.9330
Alamance, NC		
Davidson, NC		
Davie, NC		
Forsyth, NC		
Guilford, NC		
Randolph, NC		
Stokes, NC		
Yadkin, NC		
3150 Greenville, NC	0.9500	0.9655
Pitt, NC		
3160 Greenville-Spartanburg-Anderson, SC	0.9188	0.9437
Anderson, SC		
Cherokee, SC		
Greenville, SC		
Pickens, SC		
Spartanburg, SC		
3180 Hagerstown, MD	0.8853	0.9200
Washington, MD		
3200 Hamilton-Middletown, OH	0.8989	0.9296
Butler, OH		
3240 Harrisburg-Lebanon-Carlisle, PA	0.9917	0.9943
Cumberland, PA		
Dauphin, PA		
Lebanon, PA		
Perry, PA		
3283 Hartford, CT [1 2]	1.2413	1.1595
Hartford, CT		
Litchfield, CT		
Middlesex, CT		
Tolland, CT		
3285 Hattiesburg, MS [2]	0.7306	0.806
Forrest, MS		
Lamar, MS		
3290 Hickory-Morganton-Lenoir, NC	0.9148	0.940
Alexander, NC		
Burke, NC		
Caldwell, NC		
Catawba, NC		
3320 Honolulu, HI	1.1479	1.099
Honolulu, HI		
3350 Houma, LA	0.7837	0.8463
Lafourche, LA		
Terrebonne, LA		
3360 Houston, TX [1]	0.9387	0.9576
Chambers, TX		
Fort Bend, TX		
Harris, TX		
Liberty, TX		
Montgomery, TX		
Waller, TX		
3400 Huntington-Ashland, WV–KY–OH	0.9757	0.9833
Boyd, KY		
Carter, KY		
Greenup, KY		
Lawrence, OH		
Cabell, WV		
Wayne, WV		
3440 Huntsville, AL	0.8822	0.9178
Limestone, AL		
Madison, AL		
3480 Indianapolis, IN [1]	0.9792	0.9857
Boone, IN		
Hamilton, IN		
Hancock, IN		
Hendricks, IN		
Johnson, IN		
Madison, IN		
Marion, IN		
Morgan, IN		
Shelby, IN		
3500 Iowa City, IA	0.9607	0.9729
Johnson, IA		
3520 Jackson, MI	0.8840	0.9190
Jackson, MI		
3560 Jackson, MS	0.8387	0.8865
Hinds, MS		
Madison, MS		
Rankin, MS		
3580 Jackson, TN	0.8600	0.9019
Madison, TN		
Chester, TN		
3600 Jacksonville, FL [1 2]	0.8986	0.9294
Clay, FL		
Duval, FL		
Nassau, FL		
St. Johns, FL		
3605 Jacksonville, NC [2]	0.8290	0.8795
Onslow, NC		
3610 Jamestown, NY [2]	0.8636	0.9045
Chautauqua, NY		
3620 Janesville-Beloit, WI	0.9656	0.9763
Rock, WI		
3640 Jersey City, NJ	1.1674	1.1118
Hudson, NJ		
3660 Johson City-Kingsport-Bristol, TN–VA	0.8894	0.9229
Carter, TN		
Hawkins, TN		
Sullivan, TN		
Unicoi, TN		
Washington, TN		
Bristol City, VA		
Scott, VA		
Washington, VA		
3680 Johnstown, PA [2]	0.8524	0.8964
Cambria, PA		
Somerset, PA		
3700 Jonesboro, AR	0.7251	0.8024
Craighead, AR		
3710 Joplin, MO [2]	0.7723	0.8378
Jasper, MO		
Newton, MO		
3720 Kalamazoo-Battlecreek, MI	0.9981	0.9987
Calhoun, MI		
Kalamazoo, MI		
Van Buren, MI		
3740 Kankakee, IL	0.8598	0.9017
Kankakee, IL		
3760 Kansas City, KS–MO [1]	0.9322	0.9531
Johnson, KS		
Leavenworth, KS		
Miami, KS		
Wyandotte, KS		
Cass, MO		
Clay, MO		
Clinton, MO		
Jackson, MO		
Lafayette, MO		
Platte, MO		
Ray, MO		
3800 Kenosha, WI	0.9033	0.9327
Kenosha, WI		
3810 Killeen-Temple, TX	0.9932	0.9953
Bell, TX		
Coryell, TX		
3840 Knoxville, TN	0.9199	0.9444
Anderson, TN		
Blount, TN		
Knox, TN		
Loudon, TN		
Sevier, TN		
Union, TN		
3850 Kokomo, IN	0.8984	0.9293
Howard, IN		
Tipton, IN		
3870 LaCrosse, WI–MN	0.8933	0.9256
Houston, MN		
La Crosse, WI		
3880 Lafayette, LA	0.8397	0.8872
Acadia, LA		
Lafayette, LA		
St. Landry, LA		
St. Martin, LA		
3920 Lafayette, IN	0.8809	0.9168
Clinton, IN		
Tippecanoa, IN		
3960 Lake Charles, LA	0.7966	0.8558

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index	GAF
Calcasieu, LA		
3980 Lakeland-Winter Haven, FL [2]	0.8986	0.9294
Polk, FL		
4000 Lancaster, PA	0.9255	0.9484
Lancaster, PA		
4040 Lansing-East Lansing, MI	0.9977	0.9984
Clinton, MI		
Eaton, MI		
Ingham, MI		
4080 Laredo, TX	0.8323	0.8819
Webb, TX		
4100 Las Cruces, NM	0.8590	0.9012
Dona Anam, NM		
4120 Las Vegas, NV–AZ [1]	1.1258	1.0845
Mohave, AZ		
Clark, NV		
Nye, NV		
4150 Lawrence, KS	0.8222	0.8745
Douglas, KS		
4200 Lawton, OK	0.9532	0.9677
Comanche, OK		
4243 Lewiston-Auburn, ME	0.8899	0.9232
Androscoggin, ME		
4280 Lexington, KY	0.8552	0.8984
Bourbon, KY		
Clark, KY		
Fayette, KY		
Jessamine, KY		
Madison, KY		
Scott, KY		
Woodford, KY		
4320 Lima, OH	0.9108	0.938
Allen, OH		
Auglaize, OH		
4360 Lincoln, NE	0.9670	0.977
Lancaster, NE		
4400 Little Rock-North Little Rock, AR	0.8614	0.9029
Faulkner, AR		
Lonoke, AR		
Pulaski, AR		
Saline, AR		
4420 Longview, Marshall, TX	0.8738	0.9118
Gregg, TX		
Harrison, TX		
Upshur, TX		
4480 Los Angeles-Long Beach, CA [1]	1.2085	1.1385
Los Angeles, CA		
4520 Louisville, KY–IN	0.9381	0.9572
Clark, IN		
Floyd, IN		
Harrison, IN		
Scott, IN		
Bullitt, KY		
Jefferson, KY		
Oldham, KY		
4600 Lubbock, TX	0.8411	0.8883
Lubbock, TX		
4640 Lynchburg, VA	0.8814	0.9172
Amherst, VA		
Bedford, VA		
Bedford City, VA		
Campbell, VA		
Lynchburg City, VA		
4680 Macon, GA	0.8530	0.8968
Bibb, GA		
Houston, GA		
Jones, GA		
Peach, GA		
Twiggs, GA		
4720 Madison, WI	0.9729	0.981
Dane, WI		
4800 Mansfield, OH [2]	0.8649	0.905
Crawford, OH		
Richland, OH		
4840 Mayaguez, PR	0.4674	0.5940
Anasco, PR		
Cabo Rojo, PR		
Hormigueros, PR		
Mayaguez, PR		
Sabana Grande, PR		
San German, PR		
4880 McAllen-Edinburg-Mission, TX	0.8120	0.8671
Hidalgo, TX		
4890 Medford-Ashland, OR	1.0492	1.0334
Jackson, OR		
4900 Melbourne-Titusville-Palm Bay, FL	0.9296	0.9512
Brevard, FL		
4920 Memphis, TN–AR–MS [1]	0.8244	0.8761
Crittenden, AR		
DeSoto, MS		
Fayette, TN		
Shelby, TN		
Tipton, TN		
4940 Merced, CA	1.0509	1.0346
Merced, CA		
5000 Miami, FL [1]	1.0233	1.0159
Dade, FL		
5015 Middlesex-Somerset-Hunterdon, NJ [1]	1.0876	1.0592
Hunterdon, NJ		
Middlesex, NJ		
Somerset, NJ		
5080 Milwaukee-Waukesha, WI [1]	0.9845	0.9894
Milwaukee, WI		
Ozaukee, WI		
Washington, WI		
Waukesha, WI		
5120 Minneapolis-St. Paul, MN–WI [1]	1.0929	1.0627
Anoka, MN		
Carver, MN		
Chisago, MN		
Dakota, MN		
Hennepin, MN		
Isanti, MN		
Ramsey, MN		
Scott, MN		
Sherburne, MN		
Washington, MN		
Wright, MN		
Pierce, WI		
St. Croix, WI		
5140 Missoula, MT	0.9085	0.9364
Missoula, MT		
5160 Mobile, AL	0.8267	0.8778
Baldwin, AL		
Mobile, AL		
5170 Modesto, CA	1.0111	1.0076
Stanislaus, CA		
5190 Monmouth-Ocean, NJ [1]	1.1258	1.0845
Monmouth, NJ		
Ocean, NJ		
5200 Monroe, LA	0.8221	0.8745
Quachita, LA		
5240 Montgomery, AL	0.7724	0.8379
Autauga, AL		
Elmore, AL		
Mongomery, AL		
5280 Muncie, IN	1.0834	1.0564
Delaware, IN		
5330 Myrtle Beach, SC	0.8529	0.8968
Horry, SC		
5345 Naples, FL	0.9839	0.9889
Collier, FL		
5360 Nashville, TN [1]	0.9449	0.9619
Cheatham, TN		
Davidson, TN		
Dickson, TN		
Robertson, TN		
Rutherford TN		
Sumner, TN		
Williamson, TN		
Wilson, TN		
5380 Nassau-Suffolk, NY [1]	1.4074	1.2637
Nassau, NY		
Suffolk, NY		
5483 New Haven-Bridgeport-Stamford-Waterbury-Danbury, CT [1]	1.2417	1.1598
Fairfield, CT		
New Haven, CT		
5523 New London-Norwich, CT	1.2428	1.1605
New London, CT		
5560 New Orleans, LA [1]	0.9089	0.9367

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index	GAF
Jefferson, LA		
Orleans, LA		
Plaquemines, LA		
St. Bernard, LA		
St. Charles, LA		
St. James, LA		
St. John The Baptist, LA		
St. Tammany, LA		
5600 New York, NY [1]	1.4517	1.2908
Bronx, NY		
Kings, NY		
New York, NY		
Putnam, NY		
Queens, NY		
Richmond, NY		
Rockland, NY		
Westchester, NY		
5640 Newark, NY [1]	1.0772	1.0522
Essex, NJ		
Morris, NJ		
Sussex, NJ		
Union, NJ		
Warren, NJ		
5660 Newburgh, NY–PA	1.0908	1.0613
Orange, NY		
Pike, PA		
5720 Norfolk-Virginia Beach-Newport News, VA–NC [1]	0.8442	0.8905
Currituck, NC		
Chesapeake City, VA		
Gloucester, VA		
Hampton City, VA		
Isle of Wight, VA		
James City, VA		
Mathews, VA		
Newport News City, VA		
Norfolk City, VA		
Poquoson City, VA		
Portsmouth City, VA		
Suffolk City, VA		
Virginia Beach City VA		
Williamsburg City, VA		
York, VA		
5775 Oakland, CA	1.5095	1.3258
Alameda, CA		
Contra Costa, CA		
5790 Ocala, FL	0.9615	0.9735
Marion, FL		
5800 Odessa-Midland, TX	0.8873	0.9214
Ector, TX		
Midland, TX		
5880 Oklahoma City, OK [1]	0.8589	0.9011
Candian, OK		
Cleveland, OK		
Logan, OK		
McClain, OK		
Oklahoma, OK		
Pottawatomie, OK		
5910 Olympia, WA	1.0932	1.0629
Thurston, WA		
5920 Omaha, NE–IA	1.0455	1.0309
Pottawattamie, IA		
Cass, NE		
Douglas, NE		
Sarpy, NE		
Washington, NE		
5945 Orange County, CA [1]	1.1592	1.1065
Orange, CA		
5660 Orlando, FL	0.9806	0.9867
Lake, FL		
Orange, FL		
Osceola, FL		
Seminole, FL		
5990 Owensboro, KY	0.8104	0.8659
Daviess, KY		
6015 Panama City, FL	0.9169	0.9423
6020 Parkersburg-Marietta, WV–OH (WV Hospitals)	0.8414	0.8885
Washington, OH		
Wood, WV		
6020 Parkersburg-Marietta, WV–OH (OH Hospitals) [2]	0.8649	0.9054
Washington, OH		
Wood, WV		
6080 Pensacola, FL [2]	0.8986	0.9294
Escambia, FL		
Santa Rosa, FL		
6120 Peoria-Perkin, IL	0.8399	0.8874
Peoria, IL		
Tazewell, IL		
Woodford, IL		
6160 Philadelphia, PA–NJ	1.1186	1.0798
Burlington, NJ		
Camden, NJ		
Gloucester, NJ		
Salem, NJ		
Bucks, PA		
Chester, PA		
Delaware, PA		
Montgomery, PA		
Philadelphia, PA		
6200 Phoenix-Messa, AZ [1]	0.9464	0.9630
Maricopa, AZ		
Pinal, AZ		
6240 Pine Bluff, AR	0.7697	0.8359
Jefferson, AR		
6280 Pittsburgh, PA [1]	0.9634	0.9748
Allegheny, PA		
Beaver, PA		
Butler, PA		
Fayette, PA		
Washington, PA		
Westmoreland, PA		
6323 Pittsfield, MA [2]	1.1369	1.0918
Berkshire, MA		
6340 Pocatello, ID	0.8973	0.9285
Bannock, ID		
6360 Ponce, PR	0.4971	0.6196
Guayanilla, PR		
Juana Diaz, PR		
Penuelas, PR		
Ponce, PR		
Villalba, PR		
Yauco, PR		
6403 Portland, ME	0.9487	0.9646
Cumberland, ME		
Sagadahoc, ME		
York, ME		
6440 Portland-Vancouver, OR–WA [1]	1.0996	1.0672
Clackamas, OR		
Columbia, OR		
Multnomah, OR		
Washington, OR		
Yamhill, OR		
Clark, WA		
6483 Providence-Warwick-Pawtucket, RI [1]	1.0690	1.0468
Bristol, RI		
Kent, RI		
Newport, RI		
Providence, RI		
Washington, RI		
6520 Provo-Orem, UT	0.9818	0.9875
Utah, UT		
6560 Pueblo, CO	0.8853	0.9200
Pueblo, CO		
6580 Punta Gorda, FL	0.9508	0.9660
Charalotte, FL		
6600 Racine, WI	0.9216	0.9456
Racine, WI		
6640 Raleigh-Durham-Chapel Hill, NC [1]	0.9544	0.9685
Chatham, NC		
Durham, NC		
Franklin, NC		
Johnston, NC		
Orange, NC		
Wake, NC		
6660 Rapid City, SD	0.8363	0.8848
Pennington, SD		
6680 Reading, PA	0.9436	0.9610
Berks, PA		
6690 Redding, CA	1.1263	1.0849
Shasta, CA		
6720 Reno, NV	1.0655	1.0444
Washoe, NV		
6740 Richland-Kennewick-Pasco, WA	1.1224	1.0823
Benton, WA		
Franklin, WA		
6760 Richmond-Petersburg, VA	0.9545	0.9686

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index	GAF
Charles City County, VA		
Chesterfield, VA		
Colonial Heights City, VA		
Dinwiddie, VA		
Goochland, VA		
Hanover, VA		
Henrico, VA		
Hopewell City, VA		
New Kent, VA		
Petersburg City, VA		
Powhatan, VA		
Prince George, VA		
Richmond City, VA		
6780 Riverside-San Bernardino, CA [1]	1.1061	1.0715
Riverside, CA		
San Bernardino, CA		
6800 Roanoke, VA	0.8142	0.8687
Botetourt, VA		
Roanoke, VA		
Roanoke City, VA		
Salem City, VA		
6820 Rochester, MN	1.1429	1.0958
Olmsted, MN		
6840 Rochester, NY [1]	0.9184	0.9434
Genesee, NY		
Livingston, NY		
Monroe, NY		
Ontario, NY		
Orleans, NY		
Wayne, NY		
6880 Rockford, IL	0.8783	0.9150
Boone, IL		
Ogle, IL		
Winnebago, IL		
6895 Rocky Mount, NC	0.8735	0.9115
Edgecombe, NC		
Nash, NC		
6920 Sacramento, CA [1]	1.2284	1.1513
El Dorado, CA		
Placer, CA		
Sacramento, CA		
6960 Saginaw-Bay City-Midland, MI	0.9294	0.9511
Bay, MI		
Midland, MI		
Saginaw, MI		
6980 St. Cloud, MN	0.9608	0.9730
Benton, MN		
Stearns, MN		
7000 St. Joseph, MO	0.8943	0.9264
Andrew, MO		
Buchanan, MO		
7040 St. Louis, MO–IL [1]	0.9052	0.9341
Clinton, IL		
Jersey, IL		
Madison, IL		
Monroe, IL		
St. Clair, IL		
Franklin, MO		
Jefferson, MO		
Lincoln, MO		
St. Charles, MO		
St. Louis, MO		
St. Louis City, MO		
Warren, MO		
7080 Salem, OR	0.9949	0.9965
Marion, OR		
Polk, OR		
7120 Salinas, CA	1.4710	1.3025
Monterey, CA		
7160 Salt Lake City-Ogden, UT [1]	0.9854	0.9900
Davis, UT		
Salt Lake, UT		
Weber, UT		
7200 San Angelo, TX	0.7845	0.8469
Tom Green, TX		
7240 San Antonio, TX [1]	0.8318	0.8815
Bexar, TX		
Comal, TX		
Guadalupe, TX		
Wilson, TX		
7320 San Diego, CA [1]	1.1955	1.1301
San Diego, CA		
7360 San Francisco, CA [1]	1.3784	1.2458
Marin, CA		
San Francisco, CA		
San Mateo, CA		
7400 San Jose, CA [1]	1.3492	1.2277
Santa Clara, CA		
7440 San Juan-Bayamon, PR [1]	0.4657	0.5925
Aguas Buenas, PR		
Barceloneta, PR		
Bayamon, PR		
Canovanas, PR		
Carolina, PR		
Catano, PR		
Ceiba, PR		
Comerio, PR		
Corozal, PR		
Dorado, PR		
Fajardo, PR		
Florida, PR		
Guaynabo, PR		
Humacao, PR		
Juncos, PR		
Los Piedras, PR		
Loiza, PR		
Luguillo, PR		
Manati, PR		
Morovis, PR		
Naguabo, PR		
Naranjito, PR		
Rio Grande, PR		
San Juan, PR		
Toa Alta, PR		
Toa Baja, PR		
Trujillo Alto, PR		
Vega Alta, PR		
Vega Baja, PR		
Yabucoa, PR		
7460 San Luis Obispo-Atascadero-Paso Robles, CA	1.0470	1.0320
San Luis Obispo, CA		
7480 Santa Barbara-Santa Maria-Lompoc, CA	1.0819	1.0554
Santa Barbara, CA		
7485 Santa Cruz-Watsonville, CA	1.3927	1.2546
Santa Cruz, CA		
7490 Santa Fe, NM	1.0437	1.0297
Los Alamos, NM		
Santa Fe, NM		
7500 Santa Rosa, CA	1.3000	1.1968
Sonoma, CA		
7510 Sarasota-Bradenton, FL	0.9905	0.9935
Manatee, FL		
Sarasota, FL		
7520 Savannah, GA	0.9953	0.9968
Bryan, GA		
Chatham, GA		
Effington, GA		
7560 Scranton—Wilkes-Barre—Hazleton, PA [2]	0.8524	0.8964
Columbia, PA		
Lackawanna, PA		
Luzerne, PA		
Wyoming, PA		
7600 Seattle-Bellevue-Everett, WA [1]	1.1289	1.0866
Island, WA		
King, WA		
Snohomish, WA		
7610 Sharon, PA [2]	0.8524	0.8964

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index	GAF
Mercer, PA		
7620 Sheboygan, WI [2]	0.8759	0.9133
Sheboygan, WI		
7640 Sherman-Denison, TX	0.9329	0.9535
Grayson, TX		
7680 Shreveport-Bossier City, LA	0.9049	0.9339
Bossier, LA		
Caddo, LA		
Webster, LA		
7720 Sioux City, IA–NE	0.8549	0.8982
Woodbury, IA		
Dakota, NE		
7760 Sioux Falls, SD	0.8776	0.9145
Lincoln, SD		
Minnehaha, SD		
7800 South Bend, IN	0.9793	0.9858
St. Joseph, IN		
7840 Spokane, WA	1.0799	1.0541
Spokane, WA		
7880 Springfield, IL	0.8684	0.9079
Menard, IL		
Sangamon, IL		
7920 Springfield, MO	0.7991	0.8576
Christian, MO		
Greene, MO		
Webster, MO		
8003 Springfield, MA [2]	1.1369	1.0918
Hampden, MA		
Hampshire, MA		
8050 State College, PA	0.9138	0.9401
Centre, PA		
8080 Steubenville-Weirton, OH–WV (OH Hospitals) [2]	0.8649	0.9054
Jefferson, OH		
Brooke, WV		
Hancock, WV		
8080 Steubenville-Weirton, OH–WV (OH Hospitals) [2]	0.8614	0.9029
Jefferson, OH		
Brooke, WV		
Hancock, WV		
8120 Stockton-Lodi, CA	1.0518	1.0352
San Joaquin, CA		
8140 Sumter, SC [2]	0.8264	0.8776
Sumter, SC		
8160 Syracuse, NY	0.9441	0.9614
Cayuga, NY		
Madison, NY		
Onondaga, NY		
Oswego, NY		
8200 Tacoma, WA	1.1631	1.1090
Pierce, WA		
8240 Tallahassee, FL [2]	0.8986	0.9294
Gadsden, FL		
Leon, FL		
8280 Tampa-St. Petersburg-Clearwater, FL [1]	0.9119	0.9388
Hernando, FL		
Hillsborough, FL		
Pasco, FL		
Pinellas, FL		
8320 Terre Haute, IN	0.8570	0.8997
Clay, IN		
Vermillion, IN		
Vigo, IN		
8360 Texarkana, AR-Texarkana, TX	0.8174	0.8710
Miller, AR		
Bowie, TX		
8400 Toledo, OH	0.9593	0.9719
Fulton, OH		
Lucas, OH		
Wood, OH		
8440 Topeka, KS	0.9326	0.9533
Shawnee, KS		
8480 Trenton, NJ	0.9955	0.9969
Mercer, NJ		
8520 Tucson, AZ	0.8742	0.9120
Pima, AZ		
8560 Tulsa, OK	0.8086	0.8646
Creek, OK		
Osage, OK		
Rogers, OK		
Tulsa, OK		
Wagoner, OK		
8600 Tuscaloosa, AL	0.8064	0.8630
Tuscaloosa, AL		
8640 Tyler, TX	0.9369	0.9563
Smith, TX		
8680 Utica-Rome, NY [2]	0.8636	0.9045
Herkimer, NY		
Oneida, NY		
8720 Vallejo-Fairfield-Napa, CA	1.2655	1.1750
Napa, CA		
Solano, CA		
8735 Ventura, CA	1.0952	1.0643
Ventura, CA		
8750 Victoria, TX	0.8378	0.8859
Victoria, TX		
8760 Vineland-Millville-Bridgeton, NJ	1.0517	1.0351
Cumberland, NJ		
8780 Visalia-Tulare-Porterville, CA	1.0411	1.0280
Tulare, CA		
8800 Waco, TX	0.8075	0.8638
McLennan, TX		
8840 Washington, DC–MD–VA–WV [1]	1.1053	1.0710
District of Columbia, DC		
Calvert, MD		
Charles, MD		
Frederick, MD		
Montgomery, MD		
Prince Georges, MD		
Alexandria City, VA		
Arlington, VA		
Clarke, VA		
Culpeper, VA		
Fairfax, VA		
Fairfax City, VA		
Falls Church City, VA		
Fauquier, VA		
Fredericksburg City, VA		
King George, VA		
Loudoun, VA		
Manassas City, VA		
Manassas Park City, VA		
Prince William, VA		
Spotsylvania, VA		
Stafford, VA		
Warren, VA		
Berkeley, WV		
Jefferson, WV		
8920 Waterloo-Cedar Falls, IA	0.8841	0.9191
Black Hawk, IA		
8940 Wausau, WI	0.9445	0.9617
Marathon, WI		
8960 West Palm Beach-Boca Raton, FL [1,2]	0.9951	0.9966
Palm Beach, FL		
9000 Wheeling, WV–OH (WV Hospitals) [2]	0.8068	0.8633
Belmont, OH		
Marshall, WV		
Ohio, WV		
9000 Wheeling, WV–OH (OH Hospitals) [2]	0.8649	0.9054
Belmont, OH		
Marshall, WV		
Ohio, WV		
9040 Wichita, KS	0.9421	0.09600
Butler, KS		
Harvey, KS		
Sedgwick, KS		
9080 Wichita Falls, TX	0.7652	0.8325
Archer, TX		
Wichita, TX		
9140 Williamsport, PA [2]	0.8524	0.8964
Lycoming, PA		
9160 Wilmington-Newark, DE–MD	1.1274	1.0856
New Castle, DE		
Cecil, MD		
9200 Wilmington, NC	0.9707	0.9798
New Hanover, NC		
Brunswick, NC		
9260 [2] Yakima, WA	1.0446	1.0303

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index	GAF
Yakima, WA		
9270 Yolo, CA	1.0485	1.0330
Yolo, CA		
9280 York, PA	0.9309	0.9521
York, PA		
9320 Youngstown-Warren, OH	0.9996	0.9997
Columbiana, OH		
Mahoning, OH		
Trumbull, OH		
9340 Yuba City, CA	1.0662	1.0449
Sutter, CA		
Yuba, CA		
9360 Yuma, AZ	0.9924	0.9948
Yuma, AZ		

[1] Large Urban Area.
[2] Hospitals geographically located in the area are assigned the statewide rural wage index for FY 2000.

TABLE 4B.—WAGE INDEX AND CAPITLA GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR RURAL AREAS

Nonurban area	Wage index	GAF
Alabama	0.7390	0.8129
Alaska	1.2057	1.1367
Arizona	0.8544	0.8978
Arkansas	0.7236	0.8013
California	0.9951	0.9966
Colorado	0.8813	0.9171
Connecticut	1.2413	1.1595
Delaware	0.9166	0.9421
Florida	0.8986	0.9294
Georgia	0.8094	0.8652
Hawaii	1.0726	1.0492
Idaho	0.8651	0.9055
Illinois	0.8047	0.8617
Indiana	0.8396	0.8872
Iowa	0.7926	0.8528
Kansas	0.7460	0.8182
Kentucky	0.8043	0.8615
Louisiana	0.7486	0.8201
Maine	0.8639	0.9047
Maryland	0.8631	0.9041
Massachusetts	1.1369	1.0918
Michigan	0.8831	0.9184
Minnesota	0.8669	0.9068
Mississippi	0.7306	0.8066
Missouri	0.7723	0.8378
Montana	0.8398	0.8873
Nebraska	0.8007	0.8588
Nevada	0.9097	0.9372
New Hampshire	0.9905	0.9935
New Jersey [1]	.....	.....
New Mexico	0.8378	0.8859
New York	0.8636	0.9045
North Carolina	0.8290	0.8795
North Dakota	0.7647	0.8322
Ohio	0.8649	0.9054
Oklahoma	0.7255	0.8027
Oregon	0.9873	0.9913
Pennsylvania	0.8524	0.8964
Puerto Rico	0.4249	0.5565

TABLE 4B.—WAGE INDEX AND CAPITLA GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR RURAL AREAS—Continued

Nonurban area	Wage index	GAF
Rhode Island [1]	.....	.....
South Carolina	0.8264	0.8776
South Dakota	0.7576	0.8269
Tennessee	0.7650	0.8324
Texas	0.7471	0.8190
Utah	0.8906	0.9237
Vermont	0.9427	0.9604
Virginia	0.7916	0.8521
Washington	1.0446	1.0303
West Virginia	0.8068	0.8633
Wisconsin	0.8759	0.9133
Wyoming	0.8859	0.9204

[1] All counties within the State are classified as urban.

TABLE 4C.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR HOSPITALS THAT ARE RECLASSIFIED

Area	Wage index	GAF
Abilene, TX	0.8179	0.8714
Akron, OH	0.9981	0.9987
Albany, GA	0.9544	0.9685
Alexandria, LA	0.7910	0.8517
Amarillo, TX	0.8435	0.8900
Anchorage, AK	1.3009	1.1974
Ann Arbor, MI	1.1343	1.0901
Atlanta, GA	1.0050	1.0034
Austin-San Marcos, TX	0.9081	0.9361
Baltimore, MD	0.9891	0.9925
Baton Rouge, LA	0.8707	0.9095
Beaumont-Port Arthur, TX	0.8624	0.9036
Benton Harbor, MI	0.8831	0.9184
Bergen-Passaic, NJ	1.1833	1.1222
Billings, MT	1.0038	1.0026
Biloxi-Gulfport-Pascagoula, MS	0.7949	0.8545
Binghamton, NY	0.8750	0.9126
Birmingham, AL	0.8994	0.9300
Bismarck, ND	0.7893	0.8504
Boise City, ID	0.9086	0.9365
Boston-Worcester-Lawrence-Lowell-Brockton, MA–NH	1.1358	1.0911
Burlington, VT	1.0122	1.0083
Caguas, PR	0.4561	0.5842
Champaign-Urbana, IL	0.9163	0.9419
Charleston-North Charleston, SC	0.8988	0.9295
Charleston, WV	0.8861	0.9205
Charlotte-Gastonia-Rock Hill, NC–SC	0.9433	0.9608
Chattanooga, TN–GA	0.9453	0.9622
Chicago, IL	1.0872	1.0589
Cincinnati, OH–KY–IN	0.9434	0.9609
Clarksville-Hopkinsville, TN–KY	0.8283	0.8790
Cleveland-Lorain-Elyria, OH	0.9688	0.9785
Columbia, MO	0.8736	0.9116
Columbia, SC	0.9215	0.9456
Columbus, GA–AL	0.8318	0.8815

TABLE 4C.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR HOSPITALS THAT ARE RECLASSIFIED—Continued

Area	Wage index	GAF
Columbus, OH	0.9728	0.9813
Corpus Christi, TX	0.8599	0.9018
Dallas, TX	0.9589	0.9717
Danville, VA	0.8706	0.9095
Davenport-Moline-Rock Island, IA–IL	0.8606	0.9023
Dayton-Springfield, OH	0.9231	0.9467
Denver, CO	1.0197	1.0134
Des Moines, IA	0.8754	0.9129
Dothan, AL	0.7836	0.8462
Dover, DE	1.0511	1.0347
Duluth-Superior, MN–WI	1.0165	1.0113
Elkhart-Goshen, IN	0.9379	0.9570
Eugene-Springfield, OR	1.0765	1.0518
Evansville-Henderson, IN–KY	0.8396	0.8872
Fargo-Moorhead, ND–MN (ND and SD Hospitals)	0.8620	0.9033
Fargo-Moorhead, ND–MN (MN Hospital)	0.8669	0.9068
Fayetteville, NC	0.8494	0.8942
Flagstaff, AZ–UT	0.9860	0.9904
Flint, MI	1.0918	1.0620
Fort Collins-Loveland, CO	1.0197	1.0134
Fort Pierce-Port St. Lucie, FL	1.0109	1.0075
Fort Smith, AR–OK	0.7696	0.8358
Fort Walton Beach, FL	0.8713	0.9100
Forth Worth-Arlington, TX	0.9835	0.9887
Fresno, CA	1.0262	1.0179
Gadsden, AL	0.8754	0.9129
Gainesville, FL	0.9963	0.9975
Goldsboro, NC	0.8333	0.8826
Grand Forks, ND–MN	0.9097	0.9372
Grand Rapids-Muskegon-Holland, MI	1.0017	1.0012
Great Falls, MT	1.0459	1.0312
Greeley, CO	0.9449	0.9619
Green Bay, WI	0.9215	0.9456
Greensboro-Winston-Salem-High Point, NC	0.9037	0.9330
Greenville, NC	0.9237	0.9471
Greenville-Spartanburg-Anderson, SC	0.9188	0.9437
Hagerstown, MD	0.8853	0.9200
Harrisburg-Lebanon-Carlisle, PA	0.9793	0.9858
Hartford, CT	1.1715	1.1145
Hickory-Morganton-Lenoir, NC	0.9148	0.9408
Honolulu, HI	1.1479	1.0991
Houston, TX	0.9387	0.9576
Huntington-Ashland, WV–KY–OH	0.9436	0.9610
Huntsville, AL	0.8608	0.9024
Indianapolis, IN	0.9792	0.9857
Iowa City, IA	0.9460	0.9627
Jackson, MS	0.8268	0.8779
Jackson, TN	0.8447	0.8909
Jacksonville, FL	0.8957	0.9273
Johnson City-Kingsport-Bristol, TN–VA	0.8894	0.9229
Jonesboro, AR	0.7251	0.8024
Joplin, MO	0.7678	0.8345

TABLE 4C.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR HOSPITALS THAT ARE RECLASSIFIED—Continued

Area	Wage index	GAF
Kalamazoo-Battlecreek, MI	0.9981	0.9987
Kansas City, KS–MO	0.9322	0.9531
Knoxville, TN	0.9199	0.9444
Kokomo, IN	0.8984	0.9293
Lafayette, LA	0.8397	0.8872
Lansing-East Lansing, MI	0.9834	0.9886
Las Vegas, NV–AZ	1.1258	1.0845
Lexington, KY	0.8552	0.8984
Lima, OH	0.9108	0.9380
Lincoln, NE	0.9451	0.9621
Little Rock-North Little Rock, AR	0.8432	0.8898
Longview-Marshall, TX	0.8541	0.8976
Los Angeles-Long Beach, CA	1.2085	1.1385
Louisville, KY–IN	0.9381	0.9572
Macon, GA	0.8530	0.8968
Madison, WI	0.9729	0.9814
Mansfield, OH	0.8649	0.9054
Memphis, TN–AR–MS	0.8244	0.8761
Merced, CA	1.0509	1.0346
Milwaukee-Waukesha, WI	0.9845	0.9894
Minneapolis-St. Paul, MN–WI	1.0929	1.0627
Missoula, MT	0.9085	0.9364
Monmouth-Ocean, NJ	1.1258	1.0845
Monroe, LA	0.8062	0.8628
Montgomery, AL	0.7724	0.8379
Myrtle Beach, SC	0.8357	0.8843
Nashville, TN	0.9254	0.9483
New Haven-Bridgeport-Stamford-Waterbury-Danbury, CT	1.2417	1.1598
New London-Norwich, CT	1.2328	1.1541
New Orleans, LA	0.9089	0.9367
New York, NY	1.4399	1.2836
Newark, NJ	1.0772	1.0522
Newburgh, NY–PA	1.0837	1.0566
Norfolk-Virginia Beach-Newport News, VA–NC	0.8442	0.8905
Oakland, CA	1.5095	1.3258
Oklahoma City, OK	0.8589	0.9011
Omaha, NE–IA	1.0455	1.0309
Orange County, CA	1.1592	1.1065
Orlando, FL	0.9806	0.9867
Peoria-Pekin, IL	0.8399	0.8874
Philadelphia, PA–NJ	1.1186	1.0798
Phoenix-Mesa, AZ	0.9464	0.9630
Pittsburgh, PA	0.9496	0.9652
Pocatello, ID	0.8651	0.9055
Portland, ME	0.9487	0.9646
Portland-Vancouver, OR–WA	1.0996	1.0672
Provo-Orem, UT	0.9818	0.9875
Raleigh-Durham-Chapel Hill, NC	0.9544	0.9685
Roanoke, VA	0.8142	0.8687
Rockford, IL	0.8783	0.9150
Sacramento, CA	1.2284	1.1513
Saginaw-Bay City-Midland, MI	0.9294	0.9511
St. Cloud, MN	0.9608	0.9730

TABLE 4C.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR HOSPITALS THAT ARE RECLASSIFIED—Continued

Area	Wage index	GAF
St. Louis, MO–IL	0.9052	0.9341
Salt Lake City-Ogden, UT	0.9854	0.9900
San Diego, CA	1.1955	1.1301
Santa Fe, NM	0.9911	0.9939
Santa Rosa, CA	1.3000	1.1968
Seattle-Bellevue-Everett, WA	1.1289	1.0866
Sharon, PA	0.8524	0.8964
Sherman-Denison, TX	0.8833	0.9185
Sioux City, IA–NE	0.8549	0.8982
South Bend, IN	0.9692	0.9788
Springfield, IL	0.8684	0.9079
Springfield, MO	0.7991	0.8576
Syracuse, NY	0.9441	0.9614
Tallahassee, FL	0.8274	0.8783
Tampa-St. Petersburg-Clearwater, FL	0.9119	0.9388
Texarkana, AR-Texarkana, TX	0.8174	0.8710
Toledo, OH	0.9593	0.9719
Topeka, KS	0.9326	0.9533
Tulsa, OK	0.7931	0.8532
Tuscaloosa, AL	0.8064	0.8630
Tyler, TX	0.9199	0.9444
Vallejo-Fairfield-Napa, CA	1.2167	1.1438
Victoria, TX	0.8378	0.8859
Waco, TX	0.8075	0.8638
Washington, DC–MD–VA–WV	1.1053	1.0710
Waterloo-Cedar Falls, IA	0.8841	0.9191
Wausau, WI	0.9445	0.9617
Wichita, KS	0.9082	0.9362
Rural Colorado	0.8813	0.9171
Rural Florida	0.8986	0.9294
Rural Illinois	0.8047	0.8617
Rural Louisiana	0.7486	0.8201
Rural Michigan	0.8831	0.9184
Rural Minnesota	0.8669	0.9068
Rural Missouri	0.7723	0.8378
Rural Montana	0.8398	0.8873
Rural Oregon	0.9873	0.9913
Rural Tennessee	0.7650	0.8324
Rural Texas	0.7471	0.8190
Rural Virginia (KY Hospital)	0.8043	0.8615
Rural Washington	1.0333	1.0227
Rural Wyoming	0.8859	0.9204

TABLE 4D.—AVERAGE HOURLY WAGE FOR URBAN AREAS

Urban area	Average hourly wage
Abilene, TX	17.3227
Aguadilla, PR	8.0776
Akron, OH	21.5248
Albany, GA	21.9678
Albany-Schenectady-Troy, NY	18.5415
Albuquerque, NM	18.0017
Alexandria, LA	16.6660
Allentown-Bethlehem-Easton, PA	21.6602
Altoona, PA	19.7859

TABLE 4D.—AVERAGE HOURLY WAGE FOR URBAN AREAS—Continued

Urban area	Average hourly wage
Amarillo, TX	17.7501
Anchorage, AK	27.2347
Ann Arbor, MI	24.3199
Anniston, AL	17.9235
Appleton-Oshkosh-Neenah, WI	18.8767
Arecibo, PR	10.1973
Asheville, NC	18.8155
Athens, GA	20.5536
Atlanta, GA	21.2868
Atlantic-Cape May, NJ	23.9544
Auburn-Opelika, AL	16.4103
Augusta-Aiken, GA–SC	19.0900
Austin-San Marcos, TX	19.2341
Bakersfield, CA	20.3699
Baltimore, MD	20.9485
Bangor, ME	20.3521
Barnstable-Yarmouth, MA	28.1731
Baton Rouge, LA	18.4424
Beaumont-Port Arthur, TX	18.2648
Bellingham, WA	24.1321
Benton Harbor, MI	17.9119
Bergen-Passaic, NJ	25.4749
Billings, MT	21.2596
Biloxi-Gulfport-Pascagoula, MS	16.6634
Binghamton, NY	18.5327
Birmingham, AL	19.0492
Bismarck, ND	16.4329
Bloomington,IN	18.1990
Bloomington-Normal, IL	19.0474
Boise City, ID	19.1895
Boston-Worcester-Lawrence-Lowell-Brockton, MA–NH	24.0562
Boulder-Longmont, CO	21.0610
Brazoria, TX	18.0362
Bremerton, WA	23.3211
Brownsville-Harlingen-San Benito, TX	19.5103
Bryan-College Station, TX	18.0042
Buffalo-Niagara Falls, NY	20.3404
Burlington, VT	22.3616
Caguas, PR	9.6595
Canton-Massillon, OH	18.5769
Casper, WY	19.4829
Cedar Rapids, IA	19.1010
Champaign-Urbana, IL	19.4065
Charleston-North Charleston, SC	19.0373
Charleston, WV	19.2624
Charlotte-Gastonia-Rock Hill, NC–SC	19.9800
Charlottesville, VA	22.3946
Chattanooga, TN–GA	20.6102
Cheyenne, WY	17.3158
Chicago, IL	23.0278
Chico-Paradise, CA	22.0066
Cincinnati, OH–KY–IN	19.9480
Clarksville-Hopkinsville, TN–KY	17.1337
Cleveland-Lorain-Elyria, OH	20.5190
Colorado Springs, CO	19.5228
Columbia, MO	18.8596
Columbia, SC	19.8182
Columbus, GA–AL	18.0250
Columbus, OH	20.9839
Corpus Christi, TX	18.4298
Corvallis, OR	23.4819
Cumberland, MD–WV	18.6405
Dallas, TX	20.3455
Danville, VA	19.1906
Davenport-Moline-Rock Island, IA–IL	18.4403

TABLE 4D.—AVERAGE HOURLY WAGE FOR URBAN AREAS—Continued

Urban area	Average hourly wage
Dayton-Springfield, OH	20.0366
Daytona Beach, FL	19.0345
Decatur, AL	18.3823
Decatur, IL	17.6232
Denver, CO	21.5811
Des Moines, IA	18.5408
Detroit, MI	22.0711
Dothan, AL	16.5159
Dover, DE	19.7725
Dubuque, IA	18.0451
Duluth-Superior, MN–WI	21.5294
Dutchess County, NY	22.3487
Eau Claire, WI	18.9711
El Paso, TX	18.9500
Elkhart-Goshen, IN	19.8656
Elmira, NY	18.0730
Enid, OK	16.8452
Erie, PA	19.1114
Eugene-Springfield, OR	22.4571
Evansville, Henderson, IN–KY	17.5854
Fargo-Moorhead, ND–MN	18.2572
Fayetteville, NC	17.9896
Fayetteville-Springdale-Rogers, AR	16.4641
Flagstaff, AZ–UT	21.9164
Flint, MI	23.3401
Florence, AL	16.7894
Florence, SC	18.2536
Fort Collins-Loveland, CO	21.8189
Fort Lauderdale, FL	21.5452
Fort Myers-Cape Coral, FL	18.9574
Fort Pierce-Port St. Lucie, FL	21.1766
Fort Smith, AR–OK	16.6129
Fort Walton Beach, FL	18.4550
Fort Wayne, IN	19.2662
Fort Worth-Arlington, TX	20.8308
Fresno, CA	21.7350
Gadsden, AL	18.4020
Gainesville, FL	21.3966
Galveston-Texas City, TX	20.6131
Gary, IN	19.8884
Glens Falls, NY	18.2277
Goldsboro, NC	17.6500
Grand Forks, ND–MN	19.2683
Grand Junction, CO	19.4593
Grand Rapids-Muskegon-Holland, MI	21.4652
Great Falls, MT	22.1512
Greeley, CO	20.5908
Green Bay, WI	19.3420
Greensboro-Winston-Salem-High Point, NC	19.1402
Greenville, NC	20.1214
Greenville-Spartanburg-Anderson, SC	19.4594
Hagerstown, MD	18.7266
Hamilton-Middletown, OH	18.9474
Harrisburg-Lebanon-Carlisle, PA	21.0037
Hartford, CT	24.8124
Hattiesburg, MS	16.1679
Hickory-Morganton-Lenoir, NC	19.2995
Honolulu, HI	24.3050
Houma, LA	16.5978
Houston, TX	19.8810
Huntington-Ashland, WV–KY–OH	20.6646
Huntsville, AL	18.6860
Indianapolis, IN	20.7402
Iowa City, IA	20.3481
Jackson, MI	18.7230

TABLE 4D.—AVERAGE HOURLY WAGE FOR URBAN AREAS—Continued

Urban area	Average hourly wage
Jackson, MS	17.7627
Jackson, TN	18.2151
Jacksonville, FL	18.9712
Jacksonville, NC	16.6300
Jamestown, NY	16.6418
Janesville-Beloit, WI	20.4504
Jersey City, NJ	24.7265
Johnson City-Kingsport-Bristol, TN–VA	18.7506
Johnstown, PA	18.2989
Jonesboro, AR	15.3149
Joplin, MO	16.2618
Kalamazoo-Battlecreek, MI	21.1395
Kankakee, IL	18.2109
Kansas City, KS–MO	19.7430
Kenosha, WI	19.1315
Killeen-Temple, TX	21.0356
Knoxville, TN	19.4838
Kokomo, IN	18.8885
La Crosse, WI–MN	18.9205
Lafayette, LA	17.6615
Lafayette, IN	18.6572
Lake Charles, LA	16.8715
Lakeland-Winter Haven, FL	18.6713
Lancaster, PA	19.6017
Lansing-East Lansing, MI	21.1315
Laredo, TX	17.6272
Las Cruces, NM	18.1944
Las Vegas, NV–AZ	23.8445
Lawrence, KS	17.4151
Lawton, OK	20.1897
Lewiston-Auburn, ME	18.8489
Lexington, KY	18.0690
Lima, OH	18.8613
Lincoln, NE	20.4820
Little Rock-North Little Rock, AR	18.2444
Longview-Marshall, TX	18.5072
Los Angeles-Long Beach, CA	25.5235
Louisville, KY–IN	19.8685
Lubbock, TX	17.8142
Lynchburg, VA	18.6683
Macon, GA	18.0675
Madison, WI	20.6054
Mansfield, OH	17.9510
Mayaguez, PR	9.9005
McAllen-Edinburg-Mission, TX	17.1975
Medford-Ashland, OR	22.2214
Melbourne-Titusville-Palm Bay, FL	19.6889
Memphis, TN–AR–MS	17.4610
Merced, CA	21.7673
Miami, FL	21.6737
Middlesex-Somerset-Hunterdon, NJ	23.5556
Milwaukee-Waukesha, WI	20.8513
Minneapolis-St. Paul, MN–WI	23.1482
Missoula, MT	19.2420
Mobile, AL	17.5090
Modesto, CA	21.4157
Monmouth-Ocean, NJ	23.8439
Monroe, LA	17.4115
Montgomery, AL	16.3157
Muncie, IN	22.9458
Myrtle Beach, SC	18.0643
Naples, FL	20.8392
Nashville, TN	20.0138
Nassau-Suffolk, NY	29.8096
New Haven-Bridgeport-Stamford-Waterbury-Danbury, CT	26.1700
New London-Norwich, CT	26.3222

TABLE 4D.—AVERAGE HOURLY WAGE FOR URBAN AREAS—Continued

Urban area	Average hourly wage
New Orleans, LA	19.2503
New York, NY	30.7475
Newark, NJ	24.6654
Newburgh, NY–PA	23.1041
Norfolk-Virginia Beach-Newport News, VA–NC	17.8754
Oakland, CA	31.8928
Ocala, FL	20.3639
Odessa-Midland, TX	18.7922
Oklahoma City, OK	18.1873
Olympia, WA	23.1536
Omaha, NE–IA	22.1432
Orange County, CA	24.5477
Orlando, FL	20.7465
Owensboro, KY	17.1643
Panama City, FL	19.4197
Parkersburg-Marietta, WV–OH	17.8217
Pensacola, FL	17.8801
Peoria-Pekin, IL	17.6840
Philadelphia, PA–NJ	23.6372
Phoenix-Mesa, AZ	20.0450
Pine Bluff, AR	16.3022
Pittsburgh, PA	20.4057
Pittsfield, MA	21.7194
Pocatello, ID	19.0047
Ponce, PR	10.5280
Portland, ME	20.0674
Portland-Vancouver, OR–WA	23.2438
Providence-Warwick, RI	22.6420
Provo-Orem, UT	20.7946
Pueblo, CO	18.7505
Punta Gorda, FL	20.1370
Racine, WI	19.5201
Raleigh-Durham-Chapel Hill, NC	20.2151
Rapid City, SD	17.7126
Reading, PA	19.9855
Redding, CA	23.8559
Reno, NV	22.5678
Richland-Kennewick-Pasco, WA	23.7721
Richmond-Petersburg, VA	20.2158
Riverside-San Bernardino, CA	23.7428
Roanoke, VA	17.2365
Rochester, MN	24.2072
Rochester, NY	19.4510
Rockford, IL	18.6017
Rocky Mount, NC	18.4997
Sacramento, CA	26.0168
Saginaw-Bay City-Midland, MI	19.6689
St. Cloud, MN	19.9529
St. Joseph, MO	18.9408
St. Louis, MO–IL	19.1725
Salem, OR	21.0721
Salinas, CA	31.1554
Salt Lake City-Ogden, UT	20.8711
San Angelo, TX	16.6166
San Antonio, TX	17.6168
San Diego, CA	25.2676
San Francisco, CA	29.6537
San Jose, CA	28.8225
San Juan-Bayamon, PR	9.8640
San Luis Obispo-Atascadero-Paso Robles, CA	22.1746
Santa Barbara-Santa Maria-Lompoc, CA	22.9137
Santa Cruz-Watsonville, CA	29.4979
Santa Fe, NM	22.1051
Santa Rosa, CA	27.5337
Sarasota-Bradenton, FL	20.9796
Savannah, GA	21.0803

TABLE 4D.—AVERAGE HOURLY WAGE FOR URBAN AREAS—Continued

Urban area	Average hourly wage
Scranton-Wilkes Barre-Hazleton, PA	17.7324
Seattle-Bellevue-Everett, WA	23.9115
Sharon, PA	17.5441
Sheboygan, WI	17.3719
Sherman-Denison, TX	19.7582
Shreveport-Bossier City, LA	19.1657
Sioux City, IA–NE	18.1059
Sioux Falls, SD	18.5874
South Bend, IN	20.7421
Spokane, WA	22.8719
Springfield, IL	18.3917
Springfield, MO	16.9245
Springfield, MA	22.6142
State College, PA	19.3540
Steubenville-Weirton, OH–WV	18.2449
Stockton-Lodi, CA	22.2772
Sumter, SC	17.4486
Syracuse, NY	19.9343
Tacoma, WA	24.3099
Tallahassee, FL	17.9690
Tampa-St. Petersburg-Clearwater, FL	19.1546
Terre Haute, IN	18.1515
Texarkana, AR-Texarkana, TX	17.2300
Toledo, OH	20.7884
Topeka, KS	19.7520
Trenton, NJ	21.3959
Tucson, AZ	18.5157
Tulsa, OK	17.1256
Tuscaloosa, AL	17.0793
Tyler, TX	19.8429
Utica-Rome, NY	17.5752
Vallejo-Fairfield-Napa, CA	28.2652
Ventura, CA	24.2606
Victoria, TX	17.7441
Vineland-Millville-Bridgeton, NJ	22.2740
Visalia-Tulare-Porterville, CA	22.0500
Waco, TX	17.1037
Washington, DC–MD–VA–WV	23.4111

TABLE 4D.—AVERAGE HOURLY WAGE FOR URBAN AREAS—Continued

Urban area	Average hourly wage
Waterloo-Cedar Falls, IA	18.0392
Wausau, WI	20.0043
West Palm Beach-Boca Raton, FL	21.2055
Wheeling, OH–WV	16.1892
Wichita, KS	19.9536
Wichita Falls, TX	16.2079
Williamsport, PA	17.8945
Wilmington-Newark, DE–MD	23.8786
Wilmington, NC	20.5594
Yakima, WA	21.8833
Yolo, CA	20.5840
York, PA	19.7168
Youngstown-Warren, OH	21.1707
Yuba City, CA	22.5818
Yuma, AZ	21.0182

TABLE 4E.—AVERAGE HOURLY WAGE FOR RURAL AREAS

Nonurban area	Average hourly wage
Alabama	15.6529
Alaska	25.5370
Arizona	18.0961
Arkansas	15.3250
California	21.0766
Colorado	18.6657
Connecticut	26.2903
Delaware	19.4135
Florida	19.0317
Georgia	17.1426
Hawaii	22.7187
Idaho	18.3238
Illinois	17.0445
Indiana	17.7834
Iowa	16.7882

TABLE 4E.—AVERAGE HOURLY WAGE FOR RURAL AREAS—Continued

Nonurban area	Average hourly wage
Kansas	15.8000
Kentucky	17.0342
Louisiana	15.6336
Maine	18.2971
Maryland	18.2815
Massachusetts	24.0785
Michigan	18.6693
Minnesota	18.3602
Mississippi	15.4749
Missouri	16.3576
Montana	17.7804
Nebraska	16.9591
Nevada	19.2681
New Hampshire	20.9790
New Jersey [1]	
New Mexico	17.7448
New York	18.2911
North Carolina	17.5573
North Dakota	16.1967
Ohio	18.3192
Oklahoma	15.3668
Oregon	20.8991
Pennsylvania	18.0541
Puerto Rico	8.9988
Rhode Island [1]	
South Carolina	17.5024
South Dakota	16.0465
Tennessee	16.2034
Texas	15.8229
Utah	18.8636
Vermont	19.9246
Virginia	16.7397
Washington	22.1244
West Virginia	17.0883
Wisconsin	18.5514
Wyoming	18.7641

[1] All counties within the State are classified as urban.

TABLE 4F.—PUERTO RICO WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF)

Area	Wage index	GAF	Wage index reclass. hospitals	GAF reclass. hospitals
Aguadilla, PR	0.9120	0.9389		
Arecibo, PR	1.0334	1.0228		
Caguas, PR	0.9789	0.9855	0.9789	0.9855
Mayaguez, PR	1.0033	1.0023		
Ponce, PR	1.0669	1.0453		
San Juan-Bayamon, PR	0.9996	0.9997		
Rural Puerto Rico	0.9120	0.9389		

TABLE 5.—LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY

				Relative weights	Geometric mean LOS	Arithmetic mean LOS
1	01	SURG	CRANIOTOMY AGE >17 EXCEPT FOR TRAUMA	3.0957	6.5	9.3
2	01	SURG	CRANIOTOMY FOR TRAUMA AGE >17	3.1047	7.4	9.9
3	01	SURG	*CRANIOTOMY AGE 0–17	1.9619	12.7	12.7
4	01	SURG	SPINAL PROCEDURES	2.3205	4.9	7.5
5	01	SURG	EXTRACRANIAL VASCULAR PROCEDURES	1.4466	2.5	3.4
6	01	SURG	CARPAL TUNNEL RELEASE	.8119	2.2	3.1
7	01	SURG	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W CC	2.4986	6.9	10.4

TABLE 5.—LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

				Relative weights	Geometric mean LOS	Arithmetic mean LOS
8	01	SURG	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W/O CC.	1.3426	2.2	3.1
9	01	MED	SPINAL DISORDERS & INJURIES	1.1917	4.6	6.3
10	01	MED	NERVOUS SYSTEM NEOPLASMS W CC	1.2036	4.9	6.6
11	01	MED	NERVOUS SYSTEM NEOPLASMS W/O CC	.8283	3.0	4.1
12	01	MED	DEGENERATIVE NERVOUS SYSTEM DISORDERS	.8904	4.6	6.3
13	01	MED	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA	.7599	4.2	5.2
14	01	MED	SPECIFIC CEREBROVASCULAR DISORDERS EXCEPT TIA	1.1914	4.7	6.1
15	01	MED	TRANSIENT ISCHEMIC ATTACK & PRECEREBRAL OCCLUSIONS	.7397	3.0	3.7
16	01	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W CC	1.0985	4.6	5.9
17	01	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W/O CC	.6399	2.6	3.4
18	01	MED	CRANIAL & PERIPHERAL NERVE DISORDERS W CC	.9353	4.2	5.5
19	01	MED	CRANIAL & PERIPHERAL NERVE DISORDERS W/O CC	.6503	3.0	3.8
20	01	MED	NERVOUS SYSTEM INFECTION EXCEPT VIRAL MENINGITIS	2.6125	7.7	10.2
21	01	MED	VIRAL MENINGITIS	1.5032	5.0	6.8
22	01	MED	HYPERTENSIVE ENCEPHALOPATHY	.9621	3.8	4.9
23	01	MED	NONTRAUMATIC STUPOR & COMA	.7746	3.1	4.2
24	01	MED	SEIZURE & HEADACHE AGE >17 W CC	.9770	3.7	5.0
25	01	MED	SEIZURE & HEADACHE AGE >17 W/O CC	.5911	2.6	3.4
26	01	MED	SEIZURE & HEADACHE AGE 0–17	.6337	2.8	3.6
27	01	MED	TRAUMATIC STUPOR & COMA, COMA >1 HR	1.3581	3.3	5.3
28	01	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W CC	1.2690	4.5	6.2
29	01	MED	TRAUMATIC STUPOR & COMA, COMA >1 HR AGE <17 W/O CC	.6859	2.8	3.6
30	01	MED	*TRAUMATIC STUPOR & COMA, COMA >1 HR AGE 0–17	.3318	2.0	2.0
31	01	MED	CONCUSSION AGE >17 W CC	.8497	3.2	4.3
32	01	MED	CONCUSSION AGE >17 W/O CC	.5295	2.1	2.7
33	01	MED	*CONCUSSION AGE 0–17	.2085	1.6	1.6
34	01	MED	OTHER DISORDERS OF NERVOUS SYSTEM W CC	1.0275	3.9	5.3
35	01	MED	OTHER DISORDERS OF NERVOUS SYSTEM W/O CC	.5937	2.7	3.5
36	02	SURG	RETINAL PROCEDURES	.6834	1.2	1.4
37	02	SURG	ORBITAL PROCEDURES	1.0318	2.6	3.8
38	02	SURG	PRIMARY IRIS PROCEDURES	.4875	1.9	2.6
39	02	SURG	LENS PROCEDURES WITH OR WITHOUT VITRECTOMY	.5704	1.4	1.9
40	02	SURG	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE >17	.8170	2.2	3.3
41	02	SURG	*EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE 0–17	.3378	1.6	1.6
42	02	SURG	INTRAOCULAR PROCEDURES EXCEPT RETINA, IRIS & LENS	.6236	1.6	2.1
43	02	MED	HYPHEMA	.4515	2.6	4.1
44	02	MED	ACUTE MAJOR EYE INFECTIONS	.6496	4.1	5.0
45	02	MED	NEUROLOGICAL EYE DISORDERS	.6941	2.7	3.4
46	02	MED	OTHER DISORDERS OF THE EYE AGE >17 W CC	.7525	3.5	4.6
47	02	MED	OTHER DISORDERS OF THE EYE AGE >17 W/O CC	.4784	2.5	3.2
48	02	MED	*OTHER DISORDERS OF THE EYE AGE 0–17	.2975	2.9	2.9
49	03	SURG	MAJOR HEAD & NECK PROCEDURES	1.8557	3.7	5.0
50	03	SURG	SIALOADENECTOMY	.8401	1.6	2.0
51	03	SURG	SALIVARY GLAND PROCEDURES EXCEPT SIALOADENECTOMY	.8504	1.9	2.9
52	03	SURG	CLEFT LIP & PALATE REPAIR	.7696	1.5	1.9
53	03	SURG	SINUS & MASTOID PROCEDURES AGE >17	1.1784	2.3	3.6
54	03	SURG	*SINUS & MASTOID PROCEDURES AGE 0–17	.4823	3.2	3.2
55	03	SURG	MISCELLANEOUS EAR, NOSE, MOUTH & THROAT PROCEDURES.	.8686	1.9	2.9
56	03	SURG	RHINOPLASTY	.8893	2.1	2.8
57	03	SURG	T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17.	1.1589	2.8	4.5
58	03	SURG	*T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0–17.	.2739	1.5	1.5
59	03	SURG	TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	.6720	1.9	2.5
60	03	SURG	*TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0–17	.2086	1.5	1.5
61	03	SURG	MYRINGOTOMY W TUBE INSERTION AGE >17	1.2597	2.9	4.8
62	03	SURG	*MYRINGOTOMY W TUBE INSERTION AGE 0–17	.2953	1.3	1.3
63	03	SURG	OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES	1.3136	3.0	4.5
64	03	MED	EAR, NOSE, MOUTH & THROAT MALIGNANCY	1.2464	4.3	6.6
65	03	MED	DYSEQUILIBRIUM	.5261	2.3	2.9
66	03	MED	EPISTAXIS	.5548	2.6	3.2
67	03	MED	EPIGLOTTITIS	.8031	2.9	3.7
68	03	MED	OTITIS MEDIA & URI AGE >17 W CC	.6758	3.4	4.2
69	03	MED	OTITIS MEDIA & URI AGE >17 W/O CC	.5191	2.7	3.3
70	03	MED	OTITIS MEDIA & URI AGE 0–17	.3985	2.3	2.7
71	03	MED	LARYNGOTRACHEITIS	.6136	2.7	3.4
72	03	MED	NASAL TRAUMA & DEFORMITY	.6462	2.6	3.4
73	03	MED	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE >17	.7667	3.3	4.3

TABLE 5.—LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

				Relative weights	Geometric mean LOS	Arithmetic mean LOS
74	03	MED	*OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE 0–17.	.3356	2.1	2.1
75	04	SURG	MAJOR CHEST PROCEDURES	3.1107	7.8	9.9
76	04	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W CC	2.7208	8.3	11.1
77	04	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W/O CC	1.2113	3.6	5.0
78	04	MED	PULMONARY EMBOLISM	1.3861	6.1	7.1
79	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W CC	1.6439	6.6	8.4
80	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W/O CC.	.8980	4.5	5.6
81	04	MED	*RESPIRATORY INFECTIONS & INFLAMMATIONS AGE 0–17	1.5196	6.1	6.1
82	04	MED	RESPIRATORY NEOPLASMS	1.3656	5.2	7.0
83	04	MED	MAJOR CHEST TRAUMA W CC	.9796	4.3	5.5
84	04	MED	MAJOR CHEST TRAUMA W/O CC	.5278	2.6	3.2
85	04	MED	PLEURAL EFFUSION W CC	1.2421	5.0	6.5
86	04	MED	PLEURAL EFFUSION W/O CC	.6724	2.9	3.8
87	04	MED	PULMONARY EDEMA & RESPIRATORY FAILURE	1.3694	4.8	6.3
88	04	MED	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	.9406	4.3	5.3
89	04	MED	SIMPLE PNEUMONIA & PLEURISY AGE >17 W CC	1.0855	5.1	6.1
90	04	MED	SIMPLE PNEUMONIA & PLEURISY AGE >17 W/O CC	.6734	3.7	4.3
91	04	MED	SIMPLE PNEUMONIA & PLEURISY AGE 0–17	.6334	3.3	4.0
92	04	MED	INTERSTITIAL LUNG DISEASE W CC	1.1786	5.0	6.3
93	04	MED	INTERSTITIAL LUNG DISEASE W/O CC	.7644	3.5	4.3
94	04	MED	PNEUMOTHORAX W CC	1.1910	4.8	6.4
95	04	MED	PNEUMOTHORAX W/O CC	.5944	2.9	3.6
96	04	MED	BRONCHITIS & ASTHMA AGE >17 W CC	.7943	3.9	4.8
97	04	MED	BRONCHITIS & ASTHMA AGE >17 W/O CC	.5954	3.1	3.7
98	04	MED	BRONCHITIS & ASTHMA AGE 0–17	.6859	3.3	4.5
99	04	MED	RESPIRATORY SIGNS & SYMPTOMS W CC	.6817	2.4	3.1
100 ...	04	MED	RESPIRATORY SIGNS & SYMPTOMS W/O CC	.5268	1.8	2.2
101 ...	04	MED	OTHER RESPIRATORY SYSTEM DIAGNOSES W CC	.8490	3.3	4.4
102 ...	04	MED	OTHER RESPIRATORY SYSTEM DIAGNOSES W/O CC	.5349	2.1	2.7
103 ...	05	SURG	HEART TRANSPLANT	19.5100	35.7	56.5
104 ...	05	SURG	CARDIAC VALVE & OTHER MAJOR CARDIOTHORACIC PROC W CARDIAC CATH.	7.2361	9.3	11.9
105 ...	05	SURG	CARDIAC VALVE & OTHER MAJOR CARDIOTHORACIC PROC W/O CARDIAC CATH.	5.6607	7.6	9.4
106 ...	05	SURG	CORONARY BYPASS W PTCA	7.3334	9.1	10.9
107 ...	05	SURG	CORONARY BYPASS W CARDIAC CATH	5.4639	9.3	10.5
108 ...	05	SURG	OTHER CARDIOTHORACIC PROCEDURES	5.7715	8.3	11.0
109 ...	05	SURG	CORONARY BYPASS W/O PTCA OR CARDIAC CATH	4.0403	6.9	7.8
110 ...	05	SURG	MAJOR CARDIOVASCULAR PROCEDURES W CC	4.1600	7.2	9.6
111 ...	05	SURG	MAJOR CARDIOVASCULAR PROCEDURES W/O CC	2.2267	4.9	5.7
112 ...	05	SURG	PERCUTANEOUS CARDIOVASCULAR PROCEDURES	1.9222	2.7	3.8
113 ...	05	SURG	AMPUTATION FOR CIRC SYSTEM DISORDERS EXCEPT UPPER LIMB & TOE.	2.7283	9.5	12.6
114 ...	05	SURG	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS.	1.5555	6.0	8.2
115 ...	05	SURG	PRM CARD PACEM IMPL W AMI, HRT FAIL OR SHK, OR AICD LEAD OR GNRTR PR.	3.4727	6.2	8.4
116 ...	05	SURG	OTH PERM CARD PACEMAK IMPL OR PTCA W CORONARY ARTERY STENT IMPLNT.	2.4651	2.8	3.9
117 ...	05	SURG	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT.	1.2931	2.7	4.1
118 ...	05	SURG	CARDIAC PACEMAKER DEVICE REPLACEMENT	1.5480	2.0	2.9
119 ...	05	SURG	VEIN LIGATION & STRIPPING	1.2297	3.0	4.9
120 ...	05	SURG	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	2.0136	5.0	8.2
121 ...	05	MED	CIRCULATORY DISORDERS W AMI & MAJOR COMP, DISCHARGED ALIVE.	1.6295	5.6	6.8
122 ...	05	MED	CIRCULATORY DISORDERS W AMI W/O MAJOR COMP, DISCHARGED ALIVE.	1.1063	3.4	4.2
123 ...	05	MED	CIRCULATORY DISORDERS W AMI, EXPIRED	1.5108	2.7	4.4
124 ...	05	MED	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH & COMPLEX DIAG.	1.4020	3.4	4.5
125 ...	05	MED	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O COMPLEX DIAG.	1.0436	2.2	2.8
126 ...	05	MED	ACUTE & SUBACUTE ENDOCARDITIS	2.5170	9.3	12.1
127 ...	05	MED	HEART FAILURE & SHOCK	1.0144	4.2	5.4
128 ...	05	MED	DEEP VEIN THROMBOPHLEBITIS	.7645	5.1	5.9
129 ...	05	MED	CARDIAC ARREST, UNEXPLAINED	1.0770	1.8	2.8
130 ...	05	MED	PERIPHERAL VASCULAR DISORDERS W CC	.9469	4.7	5.9

TABLE 5.—LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

				Relative weights	Geometric mean LOS	Arithmetic mean LOS
131 ...	05	MED	PERIPHERAL VASCULAR DISORDERS W/O CC	.6050	3.7	4.5
132 ...	05	MED	ATHEROSCLEROSIS W CC	.6713	2.5	3.1
133 ...	05	MED	ATHEROSCLEROSIS W/O CC	.5675	1.9	2.4
134 ...	05	MED	HYPERTENSION	.5846	2.6	3.3
135 ...	05	MED	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE ≤17 W CC.	.8704	3.3	4.4
136 ...	05	MED	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE ≤17 W/O CC.	.6004	2.3	2.9
137 ...	05	MED	*CARDIAC CONGENITAL & VALVULAR DISORDERS AGE 0–17	.8188	3.3	3.3
138 ...	05	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W CC	.8154	3.1	4.0
139 ...	05	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC	.5079	2.1	2.5
140 ...	05	MED	ANGINA PECTORIS	.5829	2.3	2.8
141 ...	05	MED	SYNCOPE & COLLAPSE W CC	.7091	2.9	3.7
142 ...	05	MED	SYNCOPE & COLLAPSE W/O CC	.5419	2.2	2.7
143 ...	05	MED	CHEST PAIN	.5342	1.8	2.2
144 ...	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W CC	1.1526	3.8	5.4
145 ...	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W/O CC	.6497	2.2	2.8
146 ...	06	SURG	RECTAL RESECTION W CC	2.7862	9.1	10.3
147 ...	06	SURG	RECTAL RESECTION W/O CC	1.6382	6.1	6.7
148 ...	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W CC	3.4289	10.1	12.1
149 ...	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC	1.5723	6.2	6.7
150 ...	06	SURG	PERITONEAL ADHESIOLYSIS W CC	2.8098	9.0	11.0
151 ...	06	SURG	PERITONEAL ADHESIOLYSIS W/O CC	1.3437	4.9	6.0
152 ...	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W CC	1.9606	6.9	8.3
153 ...	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC	1.2170	5.0	5.6
154 ...	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W CC.	4.1335	10.1	13.2
155 ...	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W/O CC.	1.3781	3.5	4.5
156 ...	06	SURG	*STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE 0–17.	.8432	6.0	6.0
157 ...	06	SURG	ANAL & STOMAL PROCEDURES W CC	1.2392	4.0	5.6
158 ...	06	SURG	ANAL & STOMAL PROCEDURES W/O CC	.6561	2.1	2.6
159 ...	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W CC.	1.3097	3.7	5.0
160 ...	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W/O CC.	.7801	2.2	2.7
161 ...	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W CC	1.0976	2.9	4.2
162 ...	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W/O CC	.6283	1.6	2.0
163 ...	06	SURG	*HERNIA PROCEDURES AGE 0–17	.8720	2.1	2.1
164 ...	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W CC	2.3463	7.3	8.5
165 ...	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W/O CC	1.2655	4.4	4.9
166 ...	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W CC	1.4788	4.1	5.1
167 ...	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC	.8995	2.4	2.8
168 ...	03	SURG	MOUTH PROCEDURES W CC	1.2039	3.3	4.6
169 ...	03	SURG	MOUTH PROCEDURES W/O CC	.7492	1.9	2.5
170 ...	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W CC	2.8435	7.8	11.3
171 ...	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC	1.2556	3.6	4.8
172 ...	06	MED	DIGESTIVE MALIGNANCY W CC	1.3144	5.1	6.9
173 ...	06	MED	DIGESTIVE MALIGNANCY W/O CC	.7123	2.7	3.8
174 ...	06	MED	G.I. HEMORRHAGE W CC	.9981	3.9	4.9
175 ...	06	MED	G.I. HEMORRHAGE W/O CC	.5456	2.5	2.9
176 ...	06	MED	COMPLICATED PEPTIC ULCER	1.0968	4.1	5.3
177 ...	06	MED	UNCOMPLICATED PEPTIC ULCER W CC	.8802	3.7	4.5
178 ...	06	MED	UNCOMPLICATED PEPTIC ULCER W/O CC	.6502	2.6	3.2
179 ...	06	MED	INFLAMMATORY BOWEL DISEASE	1.0869	4.8	6.2
180 ...	06	MED	G.I. OBSTRUCTION W CC	.9206	4.2	5.4
181 ...	06	MED	G.I. OBSTRUCTION W/O CC	.5277	2.8	3.4
182 ...	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST. DISORDERS AGE >17 W CC.	.7821	3.4	4.3
183 ...	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST. DISORDERS AGE >17 W/O CC.	.5710	2.4	3.0
184 ...	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST. DISORDERS AGE 0–17.	.5286	2.3	3.0
185 ...	03	MED	DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE >17.	.8593	3.3	4.5
186 ...	03	MED	*DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE 0–17.	.3214	2.9	2.9
187 ...	03	MED	DENTAL EXTRACTIONS & RESTORATIONS	.7790	2.9	3.9
188 ...	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W CC	1.0942	4.1	5.6

TABLE 5.—LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

				Relative weights	Geometric mean LOS	Arithmetic mean LOS
189 ...	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W/O CC	.5831	2.4	3.2
190 ...	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE 0–17	1.0011	3.9	5.6
191 ...	07	SURG	PANCREAS, LIVER & SHUNT PROCEDURES W CC	4.3837	10.6	14.2
192 ...	07	SURG	PANCREAS, LIVER & SHUNT PROCEDURES W/O CC	1.8454	5.7	7.0
193 ...	07	SURG	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W CC.	3.4161	10.3	12.6
194 ...	07	SURG	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W/O CC.	1.6401	5.4	6.6
195 ...	07	SURG	CHOLECYSTECTOMY W C.D.E. W CC	2.9359	8.4	10.0
196 ...	07	SURG	CHOLECYSTECTOMY W C.D.E. W/O CC	1.6554	4.9	5.7
197 ...	07	SURG	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W CC.	2.4183	7.1	8.6
198 ...	07	SURG	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W/O CC.	1.2324	3.9	4.5
199 ...	07	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR MALIGNANCY	2.3317	7.1	9.6
200 ...	07	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR NON–MALIGNANCY.	3.0708	7.2	11.1
201 ...	07	SURG	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES	3.5838	10.3	14.1
202 ...	07	MED	CIRRHOSIS & ALCOHOLIC HEPATITIS	1.3188	5.0	6.6
203 ...	07	MED	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS	1.3046	5.0	6.7
204 ...	07	MED	DISORDERS OF PANCREAS EXCEPT MALIGNANCY	1.2161	4.6	6.0
205 ...	07	MED	DISORDERS OF LIVER EXCEPT MALIG, CIRR, ALC HEPA W CC	1.1816	4.7	6.4
206 ...	07	MED	DISORDERS OF LIVER EXCEPT MALIG, CIRR, ALC HEPA W/O CC.	.7163	3.1	4.1
207 ...	07	MED	DISORDERS OF THE BILIARY TRACT W CC	1.1013	4.0	5.2
208 ...	07	MED	DISORDERS OF THE BILIARY TRACT W/O CC	.6455	2.3	2.9
209 ...	08	SURG	MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF LOWER EXTREMITY.	2.1175	4.6	5.2
210 ...	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W CC.	1.8028	5.9	6.8
211 ...	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W/O CC.	1.2609	4.5	4.9
212 ...	08	SURG	*HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 0–17	.8468	11.1	11.1
213 ...	08	SURG	AMPUTATION FOR MUSCULOSKELETAL SYSTEM & CONN TISSUE DISORDERS.	1.7130	6.1	8.3
214 ...	08	SURG	NO LONGER VALID	.0000	.0	.0
215 ...	08	SURG	NO LONGER VALID	.0000	.0	.0
216 ...	08	SURG	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE.	2.1400	6.9	9.6
217 ...	08	SURG	WND DEBRID & SKN GRFT EXCEPT HAND, FOR MUSCSKELET & CONN TISS DIS.	2.8006	8.6	12.6
218 ...	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE >17 W CC.	1.4900	4.2	5.3
219 ...	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE >17 W/O CC.	1.0117	2.7	3.2
220 ...	08	SURG	*LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE 0–17.	.5841	5.3	5.3
221 ...	08	SURG	NO LONGER VALID	.0000	.0	.0
222 ...	08	SURG	NO LONGER VALID	.0000	.0	.0
223 ...	08	SURG	MAJOR SHOULDER/ELBOW PROC, OR OTHER UPPER EXTREMITY PROC W CC.	.9378	2.0	2.6
224 ...	08	SURG	SHOULDER, ELBOW OR FOREARM PROC, EXC MAJOR JOINT PROC, W/O CC.	.8042	1.7	2.0
225 ...	08	SURG	FOOT PROCEDURES	1.0518	3.2	4.5
226 ...	08	SURG	SOFT TISSUE PROCEDURES W CC	1.4383	4.1	6.0
227 ...	08	SURG	SOFT TISSUE PROCEDURES W/O CC	.8181	2.1	2.8
228 ...	08	SURG	MAJOR THUMB OR JOINT PROC, OR OTH HAND OR WRIST PROC W CC.	1.0516	2.4	3.6
229 ...	08	SURG	HAND OR WRIST PROC, EXCEPT MAJOR JOINT PROC, W/O CC	.7348	1.9	2.4
230 ...	08	SURG	LOCAL EXCISION & REMOVAL OF INT FIX DEVICES OF HIP & FEMUR.	1.1722	3.2	4.8
231 ...	08	SURG	LOCAL EXCISION & REMOVAL OF INT FIX DEVICES EXCEPT HIP & FEMUR.	1.3623	3.1	4.6
232 ...	08	SURG	ARTHROSCOPY	1.1567	2.4	4.1
233 ...	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W CC	2.0424	5.3	7.5
234 ...	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC.	1.2450	2.7	3.5
235 ...	08	MED	FRACTURES OF FEMUR	.7479	3.8	5.1
236 ...	08	MED	FRACTURES OF HIP & PELVIS	.7157	3.9	5.0
237 ...	08	MED	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH	.5451	2.9	3.6

TABLE 5.—LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

				Relative weights	Geometric mean LOS	Arithmetic mean LOS
238 ...	08	MED	OSTEOMYELITIS	1.2831	6.4	8.4
239 ...	08	MED	PATHOLOGICAL FRACTURES & MUSCULOSKELETAL & CONN TISS MALIGNANCY.	.9660	4.9	6.3
240 ...	08	MED	CONNECTIVE TISSUE DISORDERS W CC	1.2328	5.0	6.7
241 ...	08	MED	CONNECTIVE TISSUE DISORDERS W/O CC	.6089	3.2	4.0
242 ...	08	MED	SEPTIC ARTHRITIS	1.0168	5.1	6.7
243 ...	08	MED	MEDICAL BACK PROBLEMS	.7164	3.7	4.7
244 ...	08	MED	BONE DISEASES & SPECIFIC ARTHROPATHIES W CC	.7024	3.8	4.8
245 ...	08	MED	BONE DISEASES & SPECIFIC ARTHROPATHIES W/O CC	.4801	2.8	3.6
246 ...	08	MED	NON-SPECIFIC ARTHROPATHIES	.5545	3.0	3.7
247 ...	08	MED	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE.	.5563	2.6	3.4
248 ...	08	MED	TENDONITIS, MYOSITIS & BURSITIS	.7554	3.6	4.6
249 ...	08	MED	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE.	.6504	2.5	3.5
250 ...	08	MED	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W CC.	.6700	3.2	4.1
251 ...	08	MED	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W/O CC.	.4608	2.3	2.9
252 ...	08	MED	*FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE 0–17	.2537	1.8	1.8
253 ...	08	MED	FX, SPRN, STRN & DISL OF UPARM, LOWLEG EX FOOT AGE >17 W CC.	.7261	3.7	4.8
254 ...	08	MED	FX, SPRN, STRN & DISL OF UPARM, LOWLEG EX FOOT AGE >17 W/O CC.	.4339	2.6	3.2
255 ...	08	MED	*FX, SPRN, STRN & DISL OF UPARM, LOWLEG EX FOOT AGE 0–17.	.2954	2.9	2.9
256 ...	08	MED	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES.	.7687	3.8	5.1
257 ...	09	SURG	TOTAL MASTECTOMY FOR MALIGNANCY W CC	.9134	2.3	2.9
258 ...	09	SURG	TOTAL MASTECTOMY FOR MALIGNANCY W/O CC	.7227	1.8	2.1
259 ...	09	SURG	SUBTOTAL MASTECTOMY FOR MALIGNANCY W CC	.8673	1.9	2.8
260 ...	09	SURG	SUBTOTAL MASTECTOMY FOR MALIGNANCY W/O CC	.6444	1.3	1.5
261 ...	09	SURG	BREAST PROC FOR NON-MALIGNANCY EXCEPT BIOPSY & LOCAL EXCISION.	.9188	1.7	2.2
262 ...	09	SURG	BREAST BIOPSY & LOCAL EXCISION FOR NON-MALIGNANCY	.8392	2.7	3.9
263 ...	09	SURG	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W CC.	2.0609	8.7	11.8
264 ...	09	SURG	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W/O CC.	1.1216	5.3	7.1
265 ...	09	SURG	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W CC.	1.5650	4.4	7.0
266 ...	09	SURG	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W/O CC.	.8495	2.4	3.3
267 ...	09	SURG	PERIANAL & PILONIDAL PROCEDURES	.9815	2.9	4.1
268 ...	09	SURG	SKIN, SUBCUTANEOUS TISSUE & BREAST PLASTIC PROCEDURES.	1.1979	2.4	3.8
269 ...	09	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROC W CC	1.6147	5.6	7.9
270 ...	09	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROC W/O CC	.7447	2.2	3.1
271 ...	09	MED	SKIN ULCERS	.9905	5.6	7.1
272 ...	09	MED	MAJOR SKIN DISORDERS W CC	1.0003	4.8	6.3
273 ...	09	MED	MAJOR SKIN DISORDERS W/O CC	.6275	3.3	4.4
274 ...	09	MED	MALIGNANT BREAST DISORDERS W CC	1.1335	4.7	6.6
275 ...	09	MED	MALIGNANT BREAST DISORDERS W/O CC	.6322	2.6	3.9
276 ...	09	MED	NON-MALIGANT BREAST DISORDERS	.6529	3.5	4.4
277 ...	09	MED	CELLULITIS AGE >17 W CC	.8312	4.7	5.8
278 ...	09	MED	CELLULITIS AGE >17 W/O CC	.5621	3.7	4.4
279 ...	09	MED	CELLULITIS AGE 0–17	.6641	4.1	5.1
280 ...	09	MED	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W CC	.6736	3.3	4.2
281 ...	09	MED	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W/O CC.	.4596	2.4	3.1
282 ...	09	MED	*TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE 0–17	.2569	2.2	2.2
283 ...	09	MED	MINOR SKIN DISORDERS W CC	.7129	3.6	4.7
284 ...	09	MED	MINOR SKIN DISORDERS W/O CC	.4373	2.5	3.2
285 ...	10	SURG	AMPUTAT OF LOWER LIMB FOR ENDOCRINE, NUTRIT, & METABOL DISORDERS.	2.0217	7.7	10.6
286 ...	10	SURG	ADRENAL & PITUITARY PROCEDURES	2.2287	5.2	6.6
287 ...	10	SURG	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DISORDERS.	1.8045	7.4	10.4
288 ...	10	SURG	O.R. PROCEDURES FOR OBESITY	2.0665	4.6	5.7
289 ...	10	SURG	PARATHYROID PROCEDURES	.9756	2.1	3.0

TABLE 5.—LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

				Relative weights	Geometric mean LOS	Arithmetic mean LOS
290 ...	10	SURG	THYROID PROCEDURES	.9174	1.9	2.4
291 ...	10	SURG	THYROGLOSSAL PROCEDURES	.6732	1.6	2.0
292 ...	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W CC	2.4719	7.1	10.4
293 ...	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC	1.1942	3.5	5.0
294 ...	10	MED	DIABETES AGE >35	.7518	3.7	4.7
295 ...	10	MED	DIABETES AGE 0–35	.7464	3.0	3.9
296 ...	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W CC	.8556	4.0	5.3
297 ...	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W/O CC.	.5204	2.8	3.5
298 ...	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS AGE 0–17	.4954	2.4	3.5
299 ...	10	MED	INBORN ERRORS OF METABOLISM	.9475	3.8	5.4
300 ...	10	MED	ENDOCRINE DISORDERS W CC	1.0779	4.8	6.2
301 ...	10	MED	ENDOCRINE DISORDERS W/O CC	.5889	2.8	3.6
302 ...	11	SURG	KIDNEY TRANSPLANT	3.5669	8.2	9.7
303 ...	11	SURG	KIDNEY, URETER & MAJOR BLADDER PROCEDURES FOR NEOPLASM.	2.5401	7.2	8.8
304 ...	11	SURG	KIDNEY, URETER & MAJOR BLADDER PROC FOR NON-NEOPL W CC.	2.3458	6.5	8.9
305 ...	11	SURG	KIDNEY, URETER & MAJOR BLADDER PROC FOR NON-NEOPL W/O CC.	1.1857	3.2	3.9
306 ...	11	SURG	PROSTATECTOMY W CC	1.2448	3.7	5.4
307 ...	11	SURG	PROSTATECTOMY W/O CC	.6588	2.0	2.4
308 ...	11	SURG	MINOR BLADDER PROCEDURES W CC	1.5907	4.1	6.1
309 ...	11	SURG	MINOR BLADDER PROCEDURES W/O CC	.9442	2.0	2.5
310 ...	11	SURG	TRANSURETHRAL PROCEDURES W CC	1.0869	3.0	4.3
311 ...	11	SURG	TRANSURETHRAL PROCEDURES W/O CC	.6126	1.6	1.9
312 ...	11	SURG	URETHRAL PROCEDURES, AGE >17 W CC	1.0270	3.1	4.6
313 ...	11	SURG	URETHRAL PROCEDURES, AGE >17 W/O CC	.6640	1.8	2.4
314 ...	11	SURG	*URETHRAL PROCEDURES, AGE 0–17	.4950	2.3	2.3
315 ...	11	SURG	OTHER KIDNEY & URINARY TRACT O.R. PROCEDURES	2.0660	4.5	7.8
316 ...	11	MED	RENAL FAILURE	1.3380	4.9	6.7
317 ...	11	MED	ADMIT FOR RENAL DIALYSIS	.6965	2.1	3.2
318 ...	11	MED	KIDNEY & URINARY TRACT NEOPLASMS W CC	1.1413	4.4	6.0
319 ...	11	MED	KIDNEY & URINARY TRACT NEOPLASMS W/O CC	.6187	2.1	2.9
320 ...	11	MED	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W CC	.8647	4.4	5.4
321 ...	11	MED	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W/O CC	.5785	3.3	3.9
322 ...	11	MED	KIDNEY & URINARY TRACT INFECTIONS AGE 0–17	.5606	3.0	3.7
323 ...	11	MED	URINARY STONES W CC, &/OR ESW LITHOTRIPSY	.7816	2.4	3.2
324 ...	11	MED	URINARY STONES W/O CC	.4475	1.6	1.9
325 ...	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W CC.	.6287	3.0	3.9
326 ...	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W/O CC.	.4203	2.2	2.7
327 ...	11	MED	*KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE 0–17	.3541	3.1	3.1
328 ...	11	MED	URETHRAL STRICTURE AGE >17 W CC	.7024	2.7	3.7
329 ...	11	MED	URETHRAL STRICTURE AGE >17 W/O CC	.5172	1.7	2.4
330 ...	11	MED	*URETHRAL STRICTURE AGE 0–17	.3189	1.6	1.6
331 ...	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W CC	1.0157	4.1	5.5
332 ...	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W/O CC.	.6104	2.6	3.4
333 ...	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE 0–17	.7642	3.3	4.4
334 ...	12	SURG	MAJOR MALE PELVIC PROCEDURES W CC	1.5864	4.3	5.0
335 ...	12	SURG	MAJOR MALE PELVIC PROCEDURES W/O CC	1.1911	3.3	3.5
336 ...	12	SURG	TRANSURETHRAL PROSTATECTOMY W CC	.8965	2.8	3.6
337 ...	12	SURG	TRANSURETHRAL PROSTATECTOMY W/O CC	.6229	2.0	2.2
338 ...	12	SURG	TESTES PROCEDURES, FOR MALIGNANCY	1.1552	3.3	5.1
339 ...	12	SURG	TESTES PROCEDURES, NON-MALIGNANCY AGE >17	1.0600	2.9	4.5
340 ...	12	SURG	*TESTES PROCEDURES, NON-MALIGNANCY AGE 0–17	.2834	2.4	2.4
341 ...	12	SURG	PENIS PROCEDURES	1.1141	2.1	3.2
342 ...	12	SURG	CIRCUMCISION AGE >17	.8601	2.6	3.5
343 ...	12	SURG	*CIRCUMCISION AGE 0–17	.1540	1.7	1.7
344 ...	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROCEDURES FOR MALIGNANCY.	1.1025	1.6	2.4
345 ...	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXCEPT FOR MALIGNANCY.	.8816	2.5	3.7
346 ...	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W CC	.9645	4.2	5.7
347 ...	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W/O CC	.5828	2.3	3.1
348 ...	12	MED	BENIGN PROSTATIC HYPERTROPHY W CC	.6983	3.2	4.2
349 ...	12	MED	BENIGN PROSTATIC HYPERTROPHY W/O CC	.4345	2.0	2.5
350 ...	12	MED	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM	.6957	3.6	4.4

TABLE 5.—LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

				Relative weights	Geometric mean LOS	Arithmetic mean LOS
351 ...	12	MED	*STERILIZATION, MALE	.2363	1.3	1.3
352 ...	12	MED	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES	.6769	2.7	3.9
353 ...	13	SURG	PELVIC EVISCERATION, RADICAL HYSTERECTOMY & RADICAL VULVECTOMY.	1.9721	5.4	7.1
354 ...	13	SURG	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W CC.	1.5134	4.8	5.8
355 ...	13	SURG	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W/O CC.	.9477	3.2	3.4
356 ...	13	SURG	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES.	.7916	2.2	2.6
357 ...	13	SURG	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY.	2.3699	7.0	8.7
358 ...	13	SURG	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W CC	1.2357	3.7	4.4
359 ...	13	SURG	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC	.8699	2.7	2.9
360 ...	13	SURG	VAGINA, CERVIX & VULVA PROCEDURES	.8823	2.5	3.0
361 ...	13	SURG	LAPAROSCOPY & INCISIONAL TUBAL INTERRUPTION	1.1894	2.4	3.4
362 ...	13	SURG	*ENDOSCOPIC TUBAL INTERRUPTION	.3020	1.4	1.4
363 ...	13	SURG	D&C, CONIZATION & RADIO-IMPLANT, FOR MALIGNANCY	.7807	2.5	3.3
364 ...	13	SURG	D&C, CONIZATION EXCEPT FOR MALIGNANCY	.7601	2.6	3.5
365 ...	13	SURG	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES	1.8299	4.9	7.1
366 ...	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W CC	1.2474	4.7	6.8
367 ...	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/O CC	.5509	2.2	3.0
368 ...	13	MED	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM	1.0499	4.8	6.2
369 ...	13	MED	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS.	.5526	2.4	3.2
370 ...	14	SURG	CESAREAN SECTION W CC	1.0974	4.4	5.9
371 ...	14	SURG	CESAREAN SECTION W/O CC	.7212	3.3	3.6
372 ...	14	MED	VAGINAL DELIVERY W COMPLICATING DIAGNOSES	.5920	2.6	3.5
373 ...	14	MED	VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	.4020	1.9	2.1
374 ...	14	SURG	VAGINAL DELIVERY W STERILIZATION &/OR D&C	.7081	2.5	3.2
375 ...	14	SURG	*VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C	.6856	4.4	4.4
376 ...	14	MED	POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE.	.5342	2.4	3.4
377 ...	14	SURG	POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE.	1.3506	3.1	5.4
378 ...	14	MED	ECTOPIC PREGNANCY	.9394	2.2	2.8
379 ...	14	MED	THREATENED ABORTION	.4424	2.1	3.1
380 ...	14	MED	ABORTION W/O D&C	.3404	1.6	1.9
381 ...	14	SURG	ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY.	.6002	1.7	2.3
382 ...	14	MED	FALSE LABOR	.2045	1.2	1.3
383 ...	14	MED	OTHER ANTEPARTUM DIAGNOSES W MEDICAL COMPLICATIONS.	.5334	2.8	4.0
384 ...	14	MED	OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS.	.3437	1.8	2.4
385 ...	15		*NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY.	1.3760	1.8	1.8
386 ...	15		*EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE.	4.5376	17.9	17.9
387 ...	15		*PREMATURITY W MAJOR PROBLEMS	3.0991	13.3	13.3
388 ...	15		*PREMATURITY W/O MAJOR PROBLEMS	1.8699	8.6	8.6
389 ...	15		*FULL TERM NEONATE W MAJOR PROBLEMS	1.8398	4.7	4.7
390 ...	15		*NEONATE W OTHER SIGNIFICANT PROBLEMS	1.6011	3.4	3.4
391 ...	15		*NORMAL NEWBORN	.1526	3.1	3.1
392 ...	16	SURG	SPLENECTOMY AGE >17	3.1411	7.2	9.7
393 ...	16	SURG	*SPLENECTOMY AGE 0–17	1.3479	9.1	9.1
394 ...	16	SURG	OTHER O.R. PROCEDURES OF THE BLOOD AND BLOOD FORMING ORGANS.	1.6806	4.1	6.8
395 ...	16	MED	RED BLOOD CELL DISORDERS AGE >17	.8168	3.3	4.6
396 ...	16	MED	RED BLOOD CELL DISORDERS AGE 0–17	1.0917	2.1	3.2
397 ...	16	MED	COAGULATION DISORDERS	1.2154	3.9	5.4
398 ...	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W CC	1.2507	4.7	6.0
399 ...	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W/O CC	.7085	3.0	3.7
400 ...	17	SURG	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE	2.6610	5.9	9.1
401 ...	17	SURG	LYMPHOMA & NON–ACUTE LEUKEMIA W OTHER O.R. PROC W CC.	2.6191	7.8	11.1
402 ...	17	SURG	LYMPHOMA & NON–ACUTE LEUKEMIA W OTHER O.R. PROC W/O CC.	1.0641	2.8	4.2
403 ...	17	MED	LYMPHOMA & NON–ACUTE LEUKEMIA W CC	1.7181	5.7	8.1
404 ...	17	MED	LYMPHOMA & NON–ACUTE LEUKEMIA W/O CC	.8549	3.2	4.3

TABLE 5.—LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

				Relative weights	Geometric mean LOS	Arithmetic mean LOS
405 ...	17		*ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE 0–17 ...	1.9110	4.9	4.9
406 ...	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W CC.	2.7833	7.5	10.1
407 ...	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W/O CC.	1.2463	3.4	4.2
408 ...	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R.PROC.	1.9990	4.7	7.7
409 ...	17	MED	RADIOTHERAPY	1.0631	4.5	6.1
410 ...	17	MED	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS.	.9015	2.8	3.6
411 ...	17	MED	HISTORY OF MALIGNANCY W/O ENDOSCOPY	.4335	1.9	2.4
412 ...	17	MED	HISTORY OF MALIGNANCY W ENDOSCOPY	.4070	1.5	2.0
413 ...	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W CC.	1.3925	5.5	7.5
414 ...	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W/O CC.	.7824	3.1	4.2
415 ...	18	SURG	O.R. PROCEDURE FOR INFECTIOUS & PARASITIC DISEASES	3.5541	10.3	14.1
416 ...	18	MED	SEPTICEMIA AGE >17	1.4988	5.6	7.3
417 ...	18	MED	SEPTICEMIA AGE 0–17	.8695	3.5	4.8
418 ...	18	MED	POSTOPERATIVE & POST–TRAUMATIC INFECTIONS	.9931	4.8	6.1
419 ...	18	MED	FEVER OF UNKNOWN ORIGIN AGE >17 W CC	.8885	3.9	4.9
420 ...	18	MED	FEVER OF UNKNOWN ORIGIN AGE >17 W/O CC	.6136	3.0	3.7
421 ...	18	MED	VIRAL ILLNESS AGE >17	.6663	3.1	3.9
422 ...	18	MED	VIRAL ILLNESS & FEVER OF UNKNOWN ORIGIN AGE 0–17	.4792	2.4	3.0
423 ...	18	MED	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES	1.6019	5.7	7.7
424 ...	19	SURG	O.R. PROCEDURE W PRINCIPAL DIAGNOSES OF MENTAL ILLNESS.	2.3706	8.7	14.1
425 ...	19	MED	ACUTE ADJUSTMENT REACTION & PSYCHOLOGICAL DYSFUNCTION.	.6805	3.0	4.1
426 ...	19	MED	DEPRESSIVE NEUROSES	.5363	3.4	4.7
427 ...	19	MED	NEUROSES EXCEPT DEPRESSIVE	.5714	3.4	4.9
428 ...	19	MED	DISORDERS OF PERSONALITY & IMPULSE CONTROL	.6982	4.4	6.9
429 ...	19	MED	ORGANIC DISTURBANCES & MENTAL RETARDATION	.8448	4.9	6.7
430 ...	19	MED	PSYCHOSES	.7881	6.0	8.4
431 ...	19	MED	CHILDHOOD MENTAL DISORDERS	.7532	4.7	7.1
432 ...	19	MED	OTHER MENTAL DISORDER DIAGNOSES	.7083	3.3	5.2
433 ...	20		ALCOHOL/DRUG ABUSE OR DEPENDENCE, LEFT AMA	.2961	2.3	3.1
434 ...	20		ALC/DRUG ABUSE OR DEPEND, DETOX OR OTH SYMPT TREAT W CC.	.7296	3.9	5.2
435 ...	20		ALC/DRUG ABUSE OR DEPEND, DETOX OR OTH SYMPT TREAT W/O CC.	.4275	3.4	4.4
436 ...	20		ALC/DRUG DEPENDENCE W REHABILITATION THERAPY	.7850	10.7	13.6
437 ...	20		ALC/DRUG DEPENDENCE, COMBINED REHAB & DETOX THERAPY.	.6864	7.5	9.0
438 ...			NO LONGER VALID	.0000	.0	.0
439 ...	21	SURG	SKIN GRAFTS FOR INJURIES	1.6571	5.0	7.5
440 ...	21	SURG	WOUND DEBRIDEMENTS FOR INJURIES	1.9354	5.7	9.0
441 ...	21	SURG	HAND PROCEDURES FOR INJURIES	.9179	2.2	3.1
442 ...	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W CC	2.2454	5.2	7.9
443 ...	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W/O CC	.9614	2.5	3.3
444 ...	21	MED	TRAUMATIC INJURY AGE >17 W CC	.7087	3.3	4.3
445 ...	21	MED	TRAUMATIC INJURY AGE >17 W/O CC	.4800	2.4	3.0
446 ...	21	MED	*TRAUMATIC INJURY AGE 0–17	.2962	2.4	2.4

TABLE 5.—LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

				Relative weights	Geometric mean LOS	Arithmetic mean LOS
447 ...	21	MED	ALLERGIC REACTIONS AGE >17	.5220	1.9	2.5
448 ...	21	MED	*ALLERGIC REACTIONS AGE 0–17	.0974	2.9	2.9
449 ...	21	MED	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W CC	.8149	2.6	3.7
450 ...	21	MED	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W/O CC	.4352	1.6	2.0
451 ...	21	MED	*POISONING & TOXIC EFFECTS OF DRUGS AGE 0–17	.2631	2.1	2.1
452 ...	21	MED	COMPLICATIONS OF TREATMENT W CC	.9920	3.5	4.9
453 ...	21	MED	COMPLICATIONS OF TREATMENT W/O CC	.5060	2.2	2.9
454 ...	21	MED	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W CC	.8152	3.2	4.5
455 ...	21	MED	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W/O CC	.4663	1.9	2.6
456 ...			NO LONGER VALID	.0000	.0	.0
457 ...			NO LONGER VALID	.0000	.0	.0
458 ...			NO LONGER VALID	.0000	.0	.0
459 ...			NO LONGER VALID	.0000	.0	.0
460 ...			NO LONGER VALID	.0000	.0	.0
461 ...	23	SURG	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES.	1.1309	2.4	4.5
462 ...	23	MED	REHABILITATION	1.3599	9.9	12.4
463 ...	23	MED	SIGNS & SYMPTOMS W CC	.6811	3.3	4.3
464 ...	23	MED	SIGNS & SYMPTOMS W/O CC	.4942	2.5	3.2
465 ...	23	MED	AFTERCARE W HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS.	.6720	2.0	3.6
466 ...	23	MED	AFTERCARE W/O HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS.	.7129	2.3	4.0
467 ...	23	MED	OTHER FACTORS INFLUENCING HEALTH STATUS	.4986	2.1	3.3
468 ...			EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS.	3.6400	9.3	13.2
469 ...			**PRINCIPAL DIAGNOSIS INVALID AS DISCHARGE DIAGNOSIS	.0000	.0	.0
470 ...			**UNGROUPABLE	.0000	.0	.0
471 ...	08	SURG	BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY.	3.2205	4.9	5.6
472 ...			NO LONGER VALID	.0000	.0	.0
473 ...	17		ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE >17	3.7200	7.8	13.4
474 ...			NO LONGER VALID	.0000	.0	.0
475 ...	04	MED	RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT.	3.7065	8.0	11.2
476 ...	.....	SURG	PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS.	2.2633	8.6	11.7
477 ...		SURG	NON–EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS.	1.7696	5.3	8.1
478 ...	05	SURG	OTHER VASCULAR PROCEDURES W CC	2.3515	5.0	7.3
479 ...	05	SURG	OTHER VASCULAR PROCEDURES W/O CC	1.4618	2.9	3.8
480 ...		SURG LIVER TRANS PLANT	10.7834	17.5	23.1	
481 ...		SURG	BONE MARROW TRANSPLANT	8.7285	21.9	24.9
482 ...		SURG	TRACHEOSTOMY FOR FACE, MOUTH & NECK DIAGNOSES	3.6454	9.9	12.9
483 ...		SURG	TRACHEOSTOMY EXCEPT FOR FACE, MOUTH & NECK DIAGNOSES.	16.1211	33.0	40.9
484 ...	24	SURG	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA	5.5421	8.9	13.3
485 ...	24	SURG	LIMB REATTACHMENT, HIP AND FEMUR PROC FOR MULTIPLE SIGNIFICANT TRA.	3.0757	7.4	9.2

TABLE 5.—LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

				Relative weights	Geometric mean LOS	Arithmetic mean LOS
486 ...	24	SURG	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA.	4.8962	8.4	12.3
487 ...	24	MED	OTHER MULTIPLE SIGNIFICANT TRAUMA	1.9536	5.3	7.4
488 ...	25	SURG	HIV W EXTENSIVE O.R. PROCEDURE	4.7891	12.0	18.1
489 ...	25	MED	HIV W MAJOR RELATED CONDITION	1.7913	6.1	8.8
490 ...	25	MED	HIV W OR W/O OTHER RELATED CONDITION	.9651	3.8	5.3
491 ...	08	SURG	MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF UPPER EXTREMITY.	1.6673	3.0	3.5
492 ...	17	MED	CHEMOTHERAPY W ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS.	4.4470	11.4	16.8
493 ...	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC	1.8290	4.3	5.7
494 ...	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC	1.0246	2.0	2.5
495 ...		SURG	LUNG TRANSPLANT	8.8332	12.9	15.6
496 ...	08	SURG	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION	5.6871	8.4	10.8
497 ...	08	SURG	SPINAL FUSION W CC	2.8441	4.9	6.3
498 ...	08	SURG	SPINAL FUSION W/O CC	1.7952	2.8	3.4
499 ...	08	SURG	BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W CC	1.4487	3.6	4.8
500 ...	08	SURG	BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W/O CC	.9836	2.3	2.8
501 ...	08	SURG	KNEE PROCEDURES W PDX OF INFECTION W CC	2.5305	8.0	10.0
502 ...	08	SURG	KNEE PROCEDURES W PDX OF INFECTION W/O CC	1.5559	5.2	6.3
503 ...	08	SURG	KNEE PROCEDURES W/O PDX OF INFECTION	1.2029	3.1	4.0
504 ...	22	SURG	EXTENSIVE 3RD DEGREE BURNS W SKIN GRAFT	13.2930	24.0	31.6
505 ...	22		EXTENSIVE 3RD DEGREE BURNS W/O SKIN GRAFT	2.2593	2.6	5.2
506 ...	22		FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W CC OR SIG TRAUMA.	4.2007	12.5	16.8
507 ...	22		FULL THICKNESS BURN W SKIN GRFT OR INHAL INJ W/O CC OR SIG TRAUMA.	1.8942	6.8	9.5
508 ...	22		FULL THICKNESS BURN W/O SKIN GRFT OR INHAL INJ W CC OR SIG TRAUMA.	1.5971	5.8	8.6
509 ...	22		FULL THICKNESS BURN W/O SKIN GRFT OR INH INJ W/O CC OR SIG TRAUMA.	.8554	3.9	5.4
510 ...	22		NON–EXTENSIVE BURNS W CC OR SIGNIFICANT TRAUMA	1.3335	5.1	7.3
511 ...	22		NON–EXTENSIVE BURNS W/O CC OR SIGNIFICANT TRAUMA	.8312	3.6	5.2

*MEDICARE DATA HAVE BEEN SUPPLEMENTED BY DATA FROM 19 STATES FOR LOW VOLUME DRGS.
*DRGS 469 AND 470 CONTAIN CASES WHICH COULD NOT BE ASSIGNED TO VALID DRGS.
***NOTE:** GEOMETRIC MEAN IS USED ONLY TO DETERMINE PAYMENT FOR TRANSFER CASES
***NOTE:** ARITHMETIC MEAN IS PRESENTED FOR INFORMATIONAL PURPOSES ONLY.
NOTE: RELATIVE WEIGHTS ARE BASED ON MEDICARE PATIENT DATA AND MAY NOT

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY

[FY98 MEDPAR Update 03/99 Grouper V16.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
1	36836	9.2593	2	4	7	12	19
2	7214	9.8343	3	5	7	12	19
3	7	10.5714	1	4	12	12	14
4	6080	7.4523	1	3	5	9	16
5	99334	3.4177	1	1	2	4	7
6	378	3.1138	1	1	2	4	7
7	11825	9.7856	2	4	7	12	19
8	3419	3.1120	1	1	2	4	7
9	1714	6.1190	1	3	5	8	12
10	19310	6.5665	2	3	5	8	13
11	3187	4.0446	1	2	3	5	8
12	44543	6.2764	2	3	4	7	12
13	6583	5.1621	2	3	4	6	9
14	356495	6.0058	2	3	5	7	11
15	144927	3.7348	1	2	3	5	7
16	12107	5.9202	2	3	5	7	11
17	3316	3.3685	1	2	3	4	6
18	27243	5.4721	2	3	4	7	10
19	7972	3.7881	1	2	3	5	7
20	6169	9.9651	2	5	8	13	19
21	1426	6.8079	2	3	5	9	13
22	2583	4.9001	2	2	4	6	9
23	7700	4.1762	1	2	3	5	8
24	54812	5.0310	1	2	4	6	10

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY98 MEDPAR Update 03/99 Grouper V16.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
25	24401	3.3481	1	2	3	4	6
26	29	3.5862	1	1	3	4	6
27	3652	5.2916	1	1	3	7	12
28	11240	6.0932	1	3	5	8	12
29	3756	3.6140	1	2	3	5	7
30	1	13.0000	13	13	13	13	13
31	3208	4.3332	1	2	3	5	8
32	1420	2.6901	1	1	2	3	5
34	20085	5.3312	1	2	4	6	10
35	4903	3.4852	1	2	3	4	7
36	4666	1.4256	1	1	1	1	2
37	1560	3.8372	1	1	3	4	8
38	107	2.6355	1	1	2	3	5
39	1469	1.8693	1	1	1	2	4
40	1988	3.3441	1	1	2	4	7
42	3314	2.1177	1	1	1	2	4
43	85	4.0471	1	2	2	4	7
44	1360	4.9669	2	3	4	6	9
45	2503	3.4259	1	2	3	4	6
46	3061	4.5541	1	2	3	6	9
47	1208	3.1283	1	1	2	4	6
48	1	6.0000	6	6	6	6	6
49	2282	5.0206	1	2	4	6	10
50	2831	1.9947	1	1	1	2	3
51	278	2.8921	1	1	1	3	7
52	243	1.9506	1	1	1	2	3
53	2719	3.6348	1	1	2	4	8
54	1	1.0000	1	1	1	1	1
55	1561	2.8482	1	1	2	3	6
56	587	2.8399	1	1	2	3	6
57	501	4.7665	1	1	3	5	12
59	79	2.5316	1	1	2	3	6
60	4	1.2500	1	1	1	1	2
61	239	4.8075	1	1	3	6	10
62	2	2.5000	2	2	3	3	3
63	3306	4.4574	1	2	3	5	9
64	3302	6.6087	1	2	4	8	14
65	31897	2.9095	1	1	2	4	5
66	7003	3.2128	1	2	3	4	6
67	512	3.7051	1	2	3	4	7
68	13164	4.1907	2	2	3	5	7
69	4092	3.3140	1	2	3	4	6
70	38	2.7368	1	2	2	3	5
71	109	3.4037	1	2	3	4	6
72	804	3.5162	1	2	3	4	7
73	6475	4.3396	1	2	3	5	8
74	1	2.0000	2	2	2	2	2
75	40541	9.9139	3	5	7	12	19
76	40510	11.0970	3	5	9	14	21
77	2204	5.1134	1	2	4	7	10
78	30089	7.0769	3	5	6	9	12
79	204223	8.4303	3	4	7	10	16
80	8430	5.5426	2	3	5	7	10
81	9	6.1111	1	4	6	7	9
82	67992	6.9678	2	3	5	9	14
83	6986	5.4814	2	3	4	7	10
84	1530	3.2170	1	2	3	4	6
85	21593	6.5211	2	3	5	8	13
86	1741	3.7731	1	2	3	5	7
87	67713	6.2694	1	3	5	8	12
88	398220	5.2575	2	3	4	7	9
89	510879	6.1132	2	3	5	8	11
90	46381	4.3406	2	3	4	5	7
91	64	3.9531	1	2	3	5	7
92	14187	6.2415	2	3	5	8	12
93	1438	4.2976	1	2	4	6	8
94	13076	6.3852	2	3	5	8	12
95	1514	3.6242	1	2	3	4	7
96	63671	4.7632	2	3	4	6	8
97	28420	3.7362	1	2	3	5	7

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY98 MEDPAR Update 03/99 Grouper V16.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
98	18	4.5000	2	2	3	4	5
99	19449	3.1467	1	1	2	4	6
100	7748	2.1705	1	1	2	3	4
101	20140	4.4049	1	2	3	6	8
102	4778	2.6877	1	1	2	3	5
103	547	56.5466	9	15	39	81	126
104	32842	11.8946	3	6	10	15	22
105	28697	9.4228	4	5	7	11	17
106	3906	10.9158	5	7	9	13	18
107	97459	10.4755	5	7	9	12	17
108	5282	10.9737	3	6	9	14	21
109	66660	7.8095	4	5	7	9	13
110	59376	9.5303	2	5	8	11	18
111	6606	5.6197	2	4	6	7	8
112	80818	3.8201	1	1	3	5	8
113	46280	11.9185	3	5	9	15	23
114	8726	8.1877	2	4	7	10	16
115	14436	8.4070	2	4	7	11	16
116	272446	3.9260	1	1	3	5	8
117	3511	4.1398	1	1	3	5	9
118	6439	2.8987	1	1	2	4	6
119	1554	4.8932	1	1	3	6	11
120	36832	8.2211	1	2	5	11	18
121	169544	6.5073	2	4	5	8	12
122	83742	3.9783	1	2	4	5	7
123	42140	4.4070	1	1	2	6	10
124	145335	4.4326	1	2	3	6	8
125	69830	2.8428	1	1	2	4	6
126	5297	11.8577	3	6	9	15	23
127	725354	5.3846	2	3	4	7	10
128	13964	5.8876	3	4	5	7	9
129	4522	2.8074	1	1	1	3	7
130	93798	5.8395	2	3	5	7	10
131	26368	4.4800	1	3	4	6	7
132	167891	3.0914	1	2	2	4	6
133	7132	2.3751	1	1	2	3	4
134	32871	3.3420	1	2	3	4	6
135	7556	4.3634	1	2	3	5	8
136	1151	2.9427	1	1	2	4	6
138	204380	3.9935	1	2	3	5	8
139	74952	2.5369	1	1	2	3	5
140	90171	2.8048	1	1	2	3	5
141	85551	3.7306	1	2	3	5	7
142	40836	2.7078	1	1	2	3	5
143	174426	2.1903	1	1	2	3	4
144	77995	5.3213	1	2	4	7	11
145	6796	2.8261	1	1	2	4	5
146	12246	10.3034	5	7	9	12	17
147	2305	6.7080	3	5	7	8	10
148	143500	12.1060	5	7	10	14	21
149	16362	6.7222	4	5	6	8	10
150	22214	11.0307	4	6	9	14	19
151	4386	5.9758	2	3	6	8	11
152	4778	8.3024	3	5	7	10	14
153	1793	5.6168	3	4	5	7	8
154	32409	13.1933	4	7	10	16	25
155	5603	4.5138	1	2	4	6	8
156	5	10.6000	2	2	11	13	22
157	8595	5.5779	1	2	4	7	11
158	4411	2.6384	1	1	2	3	5
159	17429	4.9651	1	2	4	6	10
160	10531	2.7382	1	1	2	4	5
161	12611	4.1561	1	2	3	5	9
162	6778	2.0031	1	1	1	2	4
163	6	3.3333	1	3	3	5	5
164	5103	8.5348	4	5	7	10	14
165	1821	4.9368	2	3	5	6	8
166	3423	5.1440	2	3	4	6	10
167	2688	2.7742	1	2	2	3	5
168	1682	4.6843	1	2	3	6	10

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY98 MEDPAR Update 03/99 Grouper V16.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
169	866	2.5208	1	1	2	3	5
170	12216	11.2317	2	5	8	14	22
171	1060	4.7679	1	2	4	6	9
172	32209	6.9183	2	3	5	9	14
173	2318	3.8007	1	1	3	5	8
174	250706	4.8426	2	3	4	6	9
175	25360	2.9403	1	2	3	4	5
176	17698	5.2788	2	3	4	6	10
177	10596	4.4886	2	2	4	6	8
178	3611	3.1742	1	2	3	4	6
179	12438	6.1530	2	3	5	8	12
180	90784	5.3432	2	3	4	7	10
181	24531	3.4095	1	2	3	4	6
182	236683	4.3360	1	2	3	5	8
183	77376	2.9902	1	1	2	4	6
184	89	3.0225	1	1	2	3	7
185	4281	4.5359	1	2	3	6	9
186	7	3.2857	1	2	3	4	4
187	865	3.9052	1	2	3	5	8
188	76094	5.5497	1	2	4	7	11
189	9709	3.2163	1	1	2	4	6
190	69	5.6087	1	2	4	7	9
191	9760	14.1831	4	7	10	17	28
192	838	7.0251	2	4	6	9	11
193	6564	12.6140	5	7	10	15	23
194	743	6.5639	2	4	6	8	11
195	5935	9.9928	4	6	8	12	17
196	1267	5.6780	2	4	5	7	9
197	23028	8.6261	3	5	7	10	15
198	6393	4.5098	2	3	4	6	8
199	1894	9.6172	2	4	7	13	19
200	1196	10.9983	2	4	8	14	22
201	1515	14.0614	4	6	11	18	28
202	27560	6.5773	2	3	5	8	13
203	30112	6.7066	2	3	5	9	13
204	55486	5.9715	2	3	5	7	11
205	23295	6.3206	2	3	5	8	12
206	1730	4.0694	1	2	3	5	8
207	32811	5.1164	1	2	4	6	10
208	9895	2.9051	1	1	2	4	6
209	355057	5.1351	3	3	4	6	8
210	134595	6.7578	3	4	6	8	11
211	29234	4.9046	3	3	4	6	7
212	8	3.6250	1	2	4	5	5
213	7936	8.3266	2	4	6	10	17
216	6080	9.5355	2	4	7	12	19
217	19791	12.6226	3	5	9	15	27
218	22787	5.2827	2	3	4	6	10
219	19533	3.1973	1	2	3	4	5
220	4	9.2500	1	1	6	12	18
223	17962	2.5659	1	1	2	3	5
224	8009	2.0411	1	1	2	3	4
225	5837	4.4655	1	2	3	6	9
226	5298	5.9932	1	2	4	8	12
227	4340	2.7548	1	1	2	3	5
228	2585	3.5791	1	1	2	4	8
229	1157	2.4408	1	1	2	3	4
230	2300	4.7948	1	2	3	6	10
231	11018	4.6331	1	2	3	6	10
232	535	4.0748	1	1	2	5	9
233	4876	7.5070	2	3	5	9	16
234	2587	3.4519	1	2	3	4	7
235	5406	5.0218	1	2	4	6	9
236	39509	4.9105	1	3	4	6	9
237	1711	3.5634	1	2	3	4	6
238	7793	8.3853	3	4	6	10	16
239	55949	6.2607	2	3	5	8	12
240	12987	6.6413	2	3	5	8	13
241	3039	4.0234	1	2	3	5	7
242	2683	6.6347	2	3	5	8	13

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY98 MEDPAR Update 03/99 Grouper V16.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
243	84670	4.7255	1	3	4	6	9
244	12703	4.8316	1	3	4	6	9
245	4970	3.5777	1	2	3	4	7
246	1351	3.7187	1	2	3	5	7
247	14132	3.4177	1	2	3	4	7
248	9001	4.6185	1	2	4	6	9
249	10992	3.5375	1	1	2	4	7
250	3653	4.1237	1	2	3	5	8
251	2300	2.8961	1	1	2	4	5
253	19185	4.7469	1	3	4	6	9
254	10028	3.2017	1	2	3	4	6
256	5967	5.1324	1	2	4	6	10
257	19522	2.9195	1	2	2	3	5
258	16906	2.0608	1	1	2	2	3
259	3748	2.7620	1	1	2	3	6
260	4729	1.4743	1	1	1	2	2
261	1803	2.1780	1	1	1	3	4
262	653	3.9326	1	1	3	5	8
263	26034	11.3386	3	5	8	14	22
264	3840	6.9898	2	3	5	8	13
265	4133	6.9557	1	2	4	8	14
266	2546	3.3496	1	1	2	4	7
267	241	4.0788	1	1	3	5	9
268	897	3.8060	1	1	2	4	8
269	8851	7.8528	2	3	6	10	16
270	2749	3.1364	1	1	2	4	7
271	22655	7.0989	3	4	6	8	13
272	5664	6.2920	2	3	5	7	12
273	1357	4.3839	1	2	3	5	8
274	2464	6.5345	1	3	5	8	13
275	208	3.8894	1	1	2	5	8
276	1001	4.3906	1	2	4	5	8
277	84629	5.7563	2	3	5	7	10
278	27776	4.4282	2	3	4	5	8
279	11	5.0909	1	3	4	5	8
280	15056	4.2132	1	2	3	5	8
281	6510	3.0602	1	1	3	4	6
282	1	3.0000	3	3	3	3	3
283	5366	4.7128	1	2	4	6	9
284	1799	3.1957	1	1	3	4	6
285	6035	10.5781	3	5	8	13	21
286	2166	6.6307	2	3	5	8	13
287	6069	10.3935	3	5	7	12	20
288	2020	5.7025	3	3	4	6	9
289	4812	3.0247	1	1	2	3	6
290	8605	2.4284	1	1	2	3	4
291	76	2.0132	1	1	1	2	3
292	4847	10.4246	2	4	8	13	21
293	323	4.9567	1	2	4	6	11
294	84534	4.7447	1	2	4	6	9
295	3469	3.8665	1	2	3	5	7
296	234511	5.2830	2	3	4	6	10
297	36737	3.5367	1	2	3	4	6
298	90	3.4889	1	1	2	4	7
299	1124	5.3932	1	2	4	7	11
300	16177	6.2295	2	3	5	8	12
301	2822	3.5666	1	2	3	4	7
302	8038	9.6920	5	6	7	11	17
303	20077	8.7449	4	5	7	10	15
304	12388	8.8926	2	4	7	11	18
305	2795	3.9030	1	2	3	5	7
306	9132	5.4262	1	2	3	7	12
307	2186	2.3605	1	1	2	3	4
308	8285	6.1389	1	2	4	8	13
309	4064	2.5226	1	1	2	3	5
310	25390	4.3348	1	2	3	5	9
311	7973	1.9387	1	1	1	2	4
312	1665	4.5808	1	1	3	6	10
313	643	2.3919	1	1	2	3	5
314	1	2.0000	2	2	2	2	2

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY98 MEDPAR Update 03/99 Grouper V16.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
315	28422	7.8309	1	2	5	10	17
316	94820	6.6602	2	3	5	8	13
317	801	3.1898	1	1	2	3	6
318	6098	5.9802	1	3	4	8	12
319	457	2.8665	1	1	2	4	6
320	183745	5.4047	2	3	4	7	10
321	26994	3.8755	2	2	3	5	7
322	68	3.6618	1	2	3	4	6
323	16793	3.2042	1	1	2	4	6
324	7668	1.9287	1	1	1	2	4
325	7806	3.8663	1	2	3	5	7
326	2390	2.7046	1	1	2	3	5
327	9	3.4444	1	2	3	6	6
328	691	3.7019	1	2	3	5	7
329	108	2.4259	1	1	1	3	5
331	45316	5.5090	1	3	4	7	11
332	4707	3.4391	1	1	3	4	7
333	267	4.4082	1	2	3	5	10
334	14231	4.9975	3	3	4	6	8
335	10417	3.5491	2	3	3	4	5
336	46652	3.6099	1	2	3	4	7
337	31028	2.2136	1	1	2	3	3
338	2147	5.1202	1	2	3	7	12
339	1813	4.4865	1	1	3	6	10
340	2	1.0000	1	1	1	1	1
341	4093	3.2057	1	1	2	3	6
342	880	3.4966	1	2	2	4	7
344	4123	2.3546	1	1	1	2	5
345	1236	3.7055	1	1	2	4	8
346	4984	5.7153	1	3	4	7	11
347	376	3.1303	1	1	2	4	7
348	3100	4.1839	1	2	3	5	8
349	600	2.5250	1	1	2	3	5
350	6572	4.3821	2	2	4	5	8
352	698	3.9169	1	1	3	5	7
353	2712	7.0749	3	4	5	8	13
354	9042	5.7710	3	3	4	6	10
355	5962	3.4074	2	3	3	4	5
356	28380	2.5532	1	2	2	3	4
357	6098	8.6471	3	5	7	10	16
358	25005	4.4148	2	3	3	5	7
359	29669	2.8899	2	2	3	3	4
360	17416	3.0307	1	2	3	3	5
361	478	3.3703	1	1	2	4	7
362	1	1.0000	1	1	1	1	1
363	3606	3.2887	1	2	2	3	7
364	1831	3.5281	1	1	2	4	7
365	2018	7.0927	2	3	5	9	15
366	4378	6.7106	1	3	5	8	14
367	476	2.9853	1	1	2	3	6
368	2781	6.2312	2	3	5	8	12
369	2776	3.2248	1	1	2	4	6
370	1166	5.9185	3	3	4	5	9
371	1248	3.6330	2	3	3	4	5
372	888	3.4651	1	2	2	3	5
373	3969	2.1464	1	2	2	2	3
374	140	3.1714	1	2	2	3	4
375	6	3.8333	1	1	2	5	5
376	205	3.4439	1	1	2	3	7
377	35	5.4000	1	1	3	5	13
378	177	2.7514	1	2	2	3	4
379	359	3.0836	1	1	2	3	6
380	91	1.8571	1	1	1	2	3
381	185	2.3297	1	1	1	3	5
382	56	1.2857	1	1	1	1	2
383	1526	4.0216	1	2	3	5	8
384	123	2.4065	1	1	2	2	5
385	1	2.0000	2	2	2	2	2
389	8	6.7500	1	5	5	7	12
390	9	3.3333	1	1	4	4	5

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY98 MEDPAR Update 03/99 Grouper V16.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
392	2665	9.6432	3	4	7	12	20
394	1796	6.8135	1	2	4	8	15
395	77862	4.5487	1	2	3	6	9
396	17	3.1765	1	1	2	4	6
397	19299	5.3534	1	2	4	7	11
398	18648	5.9575	2	3	5	7	11
399	1513	3.7198	1	2	3	5	7
400	7367	9.1258	2	3	6	11	20
401	6271	11.0518	2	5	8	14	22
402	1464	4.1735	1	1	3	5	9
403	36559	8.0187	2	3	6	10	16
404	4130	4.3341	1	2	3	6	9
406	2851	10.1371	3	5	8	13	21
407	677	4.1773	1	2	3	5	7
408	2412	7.7363	1	2	5	10	18
409	3775	6.1094	2	3	4	6	12
410	50278	3.5715	1	2	3	4	6
411	20	2.3500	1	1	2	3	4
412	28	2.0000	1	1	1	2	4
413	7463	7.4528	2	3	6	10	15
414	693	4.1616	1	2	3	5	9
415	42974	14.0677	4	6	11	17	28
416	215135	7.3072	2	4	6	9	14
417	42	4.6905	1	2	3	6	10
418	22536	6.0572	2	3	5	7	11
419	15983	4.9037	2	2	4	6	9
420	3053	3.6495	1	2	3	5	7
421	13182	3.9219	1	2	3	5	7
422	93	2.9785	1	1	2	4	6
423	9177	7.6953	2	3	6	9	16
424	1398	14.0250	2	5	10	17	27
425	15652	4.0606	1	2	3	5	8
426	4620	4.6361	1	2	3	6	9
427	1678	4.9362	1	2	3	6	11
428	871	6.8726	1	2	4	8	15
429	29605	6.5253	2	3	5	8	13
430	59517	8.3640	2	3	6	11	17
431	313	7.1374	1	3	5	8	13
432	442	5.1833	1	2	3	5	10
433	6368	3.0974	1	1	2	4	6
434	21885	5.1509	1	2	4	6	10
435	14675	4.3381	1	2	4	5	8
436	3324	13.5096	4	7	12	21	27
437	11674	8.9895	3	5	8	11	15
439	1202	7.5166	1	3	5	9	15
440	5340	8.9891	2	3	6	11	19
441	571	3.0490	1	1	2	4	7
442	15865	7.8969	1	3	6	10	16
443	3389	3.2762	1	1	2	4	7
444	5071	4.2901	1	2	3	5	8
445	2242	2.9942	1	1	2	4	6
447	4724	2.5356	1	1	2	3	5
448	2	1.5000	1	1	2	2	2
449	26249	3.7076	1	1	3	4	7
450	6361	2.0483	1	1	1	2	4
451	4	3.7500	1	1	2	4	8
452	22505	4.9207	1	2	3	6	10
453	4265	2.8802	1	1	2	4	5
454	6007	4.4748	1	2	3	5	9
455	994	2.5905	1	1	2	3	5
461	3500	4.5026	1	1	2	5	11
462	11041	12.2571	4	6	10	16	23
463	16720	4.2907	1	2	3	5	8
464	4504	3.1854	1	2	3	4	6
465	204	3.6029	1	1	1	4	7
466	1771	4.0011	1	1	2	4	8
467	1238	3.2504	1	1	2	4	6
468	60480	13.2738	3	6	10	17	26
471	11960	5.6279	3	3	5	6	9
473	8085	13.1116	2	3	7	19	33

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY98 MEDPAR Update 03/99 Grouper V16.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
475	110336	11.1055	2	5	9	15	22
476	5200	11.6544	2	6	10	15	21
477	27191	8.0489	1	3	6	10	17
478	119489	7.2839	1	3	5	9	15
479	21407	3.7730	1	2	3	5	7
480	459	23.1046	7	11	16	28	48
481	274	24.8759	10	19	23	30	40
482	6476	12.8700	4	7	10	15	23
483	43362	38.9597	14	21	32	48	71
484	416	13.1466	1	5	10	18	27
485	3232	9.1894	4	5	7	11	17
486	2171	12.1935	1	5	10	16	24
487	3766	7.3221	1	3	6	9	15
488	794	18.0416	3	7	13	23	37
489	14199	8.7326	2	3	6	11	18
490	4835	5.2709	1	2	4	7	10
491	11661	3.5467	2	2	3	4	6
492	2597	16.8063	4	5	11	27	35
493	55406	5.7168	1	3	5	7	11
494	26219	2.5095	1	1	2	3	5
495	143	15.6434	6	8	12	22	29
496	1111	10.7885	4	5	8	13	21
497	23280	6.2649	2	3	5	7	11
498	16782	3.4122	1	2	3	4	6
499	33561	4.8046	1	2	4	6	9
500	40918	2.7633	1	1	2	3	5
501	1994	10.0035	4	5	8	12	19
502	554	6.2708	3	4	5	7	11
503	5907	3.9661	1	2	3	5	7
504	123	31.6260	9	15	26	40	63
505	158	5.2405	1	1	2	6	13
506	1117	16.4270	4	7	13	22	33
507	415	9.5133	2	4	8	13	20
508	1111	7.3987	2	3	5	9	14
509	504	4.9187	1	2	3	6	11
510	1026	6.9688	2	3	5	8	15
511	307	4.8143	1	2	3	6	9
	11262531						

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY

[FY98 MEDPAR Update 03/99 Grouper V17.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
1	36836	9.2593	2	4	7	12	19
2	7214	9.8343	3	5	7	12	19
3	7	10.5714	1	4	12	12	14
4	6080	7.4523	1	3	5	9	16
5	99334	3.4177	1	1	2	4	7
6	378	3.1138	1	1	2	4	7
7	12698	10.3438	2	4	7	13	21
8	3450	3.1467	1	1	2	4	7
9	1714	6.1190	1	3	5	8	12
10	19309	6.5667	2	3	5	8	13
11	3187	4.0446	1	2	3	5	8
12	44543	6.2764	2	3	4	7	12
13	6583	5.1621	2	3	4	6	9
14	356487	6.0057	2	3	5	7	11
15	144920	3.7348	1	2	3	5	7
16	12105	5.9197	2	3	5	7	11
17	3316	3.3685	1	2	3	4	6
18	27243	5.4721	2	3	4	7	10
19	7971	3.7885	1	2	3	5	7
20	6169	9.9651	2	5	8	13	19
21	1426	6.8079	2	3	5	9	13
22	2583	4.9001	2	2	4	6	9
23	7698	4.1758	1	2	3	5	8

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY98 MEDPAR Update 03/99 Grouper V17.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
24	54812	5.0310	1	2	4	6	10
25	24400	3.3482	1	2	3	4	6
26	29	3.5862	1	1	3	4	6
27	3652	5.2916	1	1	3	7	12
28	11239	6.0937	1	3	5	8	12
29	3756	3.6140	1	2	3	5	7
30	1	13.0000	13	13	13	13	13
31	3208	4.3332	1	2	3	5	8
32	1420	2.6901	1	1	2	3	5
34	20085	5.3312	1	2	4	6	10
35	4903	3.4852	1	2	3	4	7
36	4666	1.4256	1	1	1	1	2
37	1560	3.8372	1	1	3	4	8
38	107	2.6355	1	1	2	3	5
39	1469	1.8693	1	1	1	2	4
40	1988	3.3441	1	1	2	4	7
42	3314	2.1177	1	1	1	2	4
43	85	4.0471	1	2	2	4	7
44	1360	4.9669	2	3	4	6	9
45	2503	3.4259	1	2	3	4	6
46	3061	4.5541	1	2	3	6	9
47	1208	3.1283	1	1	2	4	6
48	1	6.0000	6	6	6	6	6
49	2282	5.0206	1	2	4	6	10
50	2831	1.9947	1	1	1	2	3
51	278	2.8921	1	1	1	3	7
52	159	1.8868	1	1	1	2	3
53	2719	3.6348	1	1	2	4	8
54	1	1.0000	1	1	1	1	1
55	1561	2.8482	1	1	2	3	6
56	587	2.8399	1	1	2	3	6
57	680	4.4588	1	1	2	5	11
59	79	2.5316	1	1	2	3	6
60	4	1.2500	1	1	1	1	2
61	239	4.8075	1	1	3	6	10
62	2	2.5000	2	2	3	3	3
63	3306	4.4574	1	2	3	5	9
64	3302	6.6087	1	2	4	8	14
65	31895	2.9094	1	1	2	4	5
66	7002	3.2129	1	2	3	4	6
67	512	3.7051	1	2	3	4	7
68	13163	4.1908	2	2	3	5	7
69	4092	3.3140	1	2	3	4	6
70	38	2.7368	1	2	2	3	5
71	109	3.4037	1	2	3	4	6
72	804	3.5162	1	2	3	4	7
73	6475	4.3396	1	2	3	5	8
74	1	2.0000	2	2	2	2	2
75	40541	9.9139	3	5	7	12	19
76	41055	11.1287	3	5	9	14	21
77	2213	5.1148	1	2	4	7	10
78	30088	7.0769	3	5	6	9	12
79	204216	8.4304	3	4	7	10	16
80	8429	5.5429	2	3	5	7	10
81	9	6.1111	1	4	6	7	9
82	67991	6.9678	2	3	5	9	14
83	6985	5.4805	2	3	4	7	10
84	1530	3.2170	1	2	3	4	6
85	21592	6.5212	2	3	5	8	13
86	1741	3.7731	1	2	3	5	7
87	67711	6.2696	1	3	5	8	12
88	398204	5.2576	2	3	4	7	9
89	510853	6.1132	2	3	5	8	11
90	46380	4.3406	2	3	4	5	7
91	64	3.9531	1	2	3	5	7
92	14187	6.2415	2	3	5	8	12
93	1438	4.2976	1	2	4	6	8
94	13076	6.3852	2	3	5	8	12
95	1514	3.6242	1	2	3	4	7
96	63669	4.7632	2	3	4	6	8

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY98 MEDPAR Update 03/99 Grouper V17.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
97	28418	3.7363	1	2	3	5	7
98	18	4.5000	2	2	3	4	5
99	19447	3.1469	1	1	2	4	6
100	7748	2.1705	1	1	2	3	4
101	20139	4.4047	1	2	3	6	8
102	4778	2.6877	1	1	2	3	5
103	547	56.5466	9	15	39	81	126
104	32842	11.8946	3	6	10	15	22
105	28697	9.4228	4	5	7	11	17
106	3906	10.9158	5	7	9	13	18
107	97459	10.4755	5	7	9	12	17
108	5282	10.9737	3	6	9	14	21
109	66660	7.8095	4	5	7	9	13
110	59376	9.5303	2	5	8	11	18
111	6606	5.6197	2	4	6	7	8
112	80818	3.8201	1	1	3	5	8
113	46280	11.9185	3	5	9	15	23
114	8726	8.1877	2	4	7	10	16
115	14436	8.4070	2	4	7	11	16
116	272446	3.9260	1	1	3	5	8
117	3511	4.1398	1	1	3	5	9
118	6439	2.8987	1	1	2	4	6
119	1554	4.8932	1	1	3	6	11
120	36921	8.2184	1	2	5	11	18
121	169542	6.5073	2	4	5	8	12
122	83737	3.9785	1	2	4	5	7
123	42138	4.4072	1	1	2	6	10
124	145335	4.4326	1	2	3	6	8
125	69830	2.8428	1	1	2	4	6
126	5297	11.8577	3	6	9	15	23
127	725343	5.3846	2	3	4	7	10
128	13957	5.8882	3	4	5	7	9
129	4522	2.8074	1	1	1	3	7
130	93795	5.8394	2	3	5	7	10
131	26365	4.4803	1	3	4	6	7
132	167887	3.0915	1	2	2	4	6
133	7131	2.3751	1	1	2	3	4
134	32871	3.3420	1	2	3	4	6
135	7556	4.3634	1	2	3	5	8
136	1151	2.9427	1	1	2	4	6
138	204377	3.9935	1	2	3	5	8
139	74949	2.5370	1	1	2	3	5
140	90166	2.8049	1	1	2	3	5
141	85549	3.7307	1	2	3	5	7
142	40835	2.7078	1	1	2	3	5
143	174420	2.1903	1	1	2	3	4
144	77994	5.3212	1	2	4	7	11
145	6796	2.8261	1	1	2	4	5
146	12246	10.3034	5	7	9	12	17
147	2305	6.7080	3	5	7	8	10
148	143500	12.1060	5	7	10	14	21
149	16362	6.7222	4	5	6	8	10
150	22213	11.0306	4	6	9	14	19
151	4386	5.9758	2	3	6	8	11
152	4778	8.3024	3	5	7	10	14
153	1793	5.6168	3	4	5	7	8
154	32408	13.1935	4	7	10	16	25
155	5602	4.5059	1	2	4	6	8
156	5	10.6000	2	2	11	13	22
157	8593	5.5783	1	2	4	7	11
158	4411	2.6384	1	1	2	3	5
159	17429	4.9651	1	2	4	6	10
160	10531	2.7382	1	1	2	4	5
161	12610	4.1558	1	2	3	5	9
162	6778	2.0031	1	1	1	2	4
163	6	3.3333	1	3	3	5	5
164	5103	8.5348	4	5	7	10	14
165	1821	4.9368	2	3	5	6	8
166	3422	5.1441	2	3	4	6	10
167	2688	2.7742	1	2	2	3	5

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY98 MEDPAR Update 03/99 Grouper V17.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
168	1624	4.6188	1	2	3	6	9
169	829	2.5223	1	1	2	3	5
170	12216	11.2317	2	5	8	14	22
171	1060	4.7679	1	2	4	6	9
172	32207	6.9186	2	3	5	9	14
173	2318	3.8007	1	1	3	5	8
174	250699	4.8426	2	3	4	6	9
175	25358	2.9404	1	2	3	4	5
176	17698	5.2788	2	3	4	6	10
177	10595	4.4886	2	2	4	6	8
178	3611	3.1742	1	2	3	4	6
179	12437	6.1533	2	3	5	8	12
180	90780	5.3431	2	3	4	7	10
181	24531	3.4095	1	2	3	4	6
182	236680	4.3360	1	2	3	5	8
183	77375	2.9902	1	1	2	4	6
184	89	3.0225	1	1	2	3	7
185	4281	4.5359	1	2	3	6	9
186	7	3.2857	1	2	3	4	4
187	865	3.9052	1	2	3	5	8
188	76090	5.5497	1	2	4	7	11
189	9709	3.2163	1	1	2	4	6
190	69	5.6087	1	2	4	7	9
191	9760	14.1831	4	7	10	17	28
192	838	7.0251	2	4	6	9	11
193	6564	12.6140	5	7	10	15	23
194	743	6.5639	2	4	6	8	11
195	5935	9.9928	4	6	8	12	17
196	1267	5.6780	2	4	5	7	9
197	23028	8.6261	3	5	7	10	15
198	6393	4.5098	2	3	4	6	8
199	1894	9.6172	2	4	7	13	19
200	1196	10.9983	2	4	8	14	22
201	1515	14.0614	4	6	11	18	28
202	27560	6.5773	2	3	5	8	13
203	30111	6.7062	2	3	5	9	13
204	55485	5.9715	2	3	5	7	11
205	23295	6.3206	2	3	5	8	12
206	1730	4.0694	1	2	3	5	8
207	32809	5.1165	1	2	4	6	10
208	9894	2.9049	1	1	2	4	6
209	355054	5.1351	3	3	4	6	8
210	134594	6.7578	3	4	6	8	11
211	29233	4.9046	3	3	4	6	7
212	8	3.6250	1	2	4	5	5
213	7936	8.3266	2	4	6	10	17
216	6080	9.5355	2	4	7	12	19
217	19791	12.6226	3	5	9	15	27
218	22787	5.2827	2	3	4	6	10
219	19533	3.1973	1	2	3	4	5
220	4	9.2500	1	1	6	12	18
223	17960	2.5661	1	1	2	3	5
224	8009	2.0411	1	1	2	3	4
225	5837	4.4655	1	2	3	6	9
226	5297	5.9941	1	2	4	8	12
227	4340	2.7548	1	1	2	3	5
228	2585	3.5791	1	1	2	4	8
229	1157	2.4408	1	1	2	3	4
230	2300	4.7948	1	2	3	6	10
231	11018	4.6331	1	2	3	6	10
232	535	4.0748	1	1	2	5	9
233	4876	7.5070	2	3	5	9	16
234	2587	3.4519	1	2	3	4	7
235	5406	5.0218	1	2	4	6	9
236	39504	4.9102	1	3	4	6	9
237	1711	3.5634	1	2	3	4	6
238	7793	8.3853	3	4	6	10	16
239	55949	6.2607	2	3	5	8	12
240	12987	6.6413	2	3	5	8	13
241	3039	4.0234	1	2	3	5	7

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY98 MEDPAR Update 03/99 Grouper V17.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
242	2683	6.6347	2	3	5	8	13
243	84667	4.7255	1	3	4	6	9
244	12703	4.8316	1	3	4	6	9
245	4969	3.5768	1	2	3	4	7
246	1351	3.7187	1	2	3	5	7
247	14131	3.4179	1	2	3	4	7
248	9001	4.6185	1	2	4	6	9
249	10990	3.5379	1	1	2	4	7
250	3653	4.1237	1	2	3	5	8
251	2300	2.8961	1	1	2	4	5
253	19183	4.7470	1	3	4	6	9
254	10028	3.2017	1	2	3	4	6
256	5967	5.1324	1	2	4	6	10
257	19521	2.9195	1	2	2	3	5
258	16906	2.0608	1	1	2	2	3
259	3748	2.7620	1	1	2	3	6
260	4729	1.4743	1	1	1	2	2
261	1803	2.1780	1	1	1	3	4
262	653	3.9326	1	1	3	5	8
263	26033	11.3385	3	5	8	14	22
264	3840	6.9898	2	3	5	8	13
265	4133	6.9557	1	2	4	8	14
266	2546	3.3496	1	1	2	4	7
267	241	4.0788	1	1	3	5	9
268	897	3.8060	1	1	2	4	8
269	8851	7.8528	2	3	6	10	16
270	2749	3.1364	1	1	2	4	7
271	22654	7.0990	3	4	6	8	13
272	5663	6.2930	2	3	5	7	12
273	1357	4.3839	1	2	3	5	8
274	2464	6.5345	1	3	5	8	13
275	208	3.8894	1	1	2	5	8
276	1001	4.3906	1	2	4	5	8
277	84624	5.7564	2	3	5	7	10
278	27774	4.4283	2	3	4	5	8
279	11	5.0909	1	3	4	5	8
280	15054	4.2136	1	2	3	5	8
281	6510	3.0602	1	1	3	4	6
282	1	3.0000	3	3	3	3	3
283	5366	4.7128	1	2	4	6	9
284	1799	3.1957	1	1	3	4	6
285	6035	10.5781	3	5	8	13	21
286	2166	6.6307	2	3	5	8	13
287	6069	10.3935	3	5	7	12	20
288	2020	5.7025	3	3	4	6	9
289	4812	3.0247	1	1	2	3	6
290	8605	2.4284	1	1	2	3	4
291	76	2.0132	1	1	1	2	3
292	4847	10.4246	2	4	8	13	21
293	323	4.9567	1	2	4	6	11
294	84531	4.7447	1	2	4	6	9
295	3469	3.8665	1	2	3	5	7
296	234504	5.2830	2	3	4	6	10
297	36736	3.5367	1	2	3	4	6
298	90	3.4889	1	1	2	4	7
299	1124	5.3932	1	2	4	7	11
300	16177	6.2295	2	3	5	8	12
301	2822	3.5666	1	2	3	4	7
302	8038	9.6920	5	6	7	11	17
303	20077	8.7449	4	5	7	10	15
304	12388	8.8926	2	4	7	11	18
305	2795	3.9030	1	2	3	5	7
306	9132	5.4262	1	2	3	7	12
307	2186	2.3605	1	1	2	3	4
308	8285	6.1389	1	2	4	8	13
309	4064	2.5226	1	1	2	3	5
310	25390	4.3348	1	2	3	5	9
311	7973	1.9387	1	1	1	2	4
312	1665	4.5808	1	1	3	6	10
313	643	2.3919	1	1	2	3	5

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY98 MEDPAR Update 03/99 Grouper V17.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
314	1	2.0000	2	2	2	2	2
315	28422	7.8309	1	2	5	10	17
316	94819	6.6602	2	3	5	8	13
317	801	3.1898	1	1	2	3	6
318	6096	5.9810	1	3	4	8	12
319	457	2.8665	1	1	2	4	6
320	183743	5.4047	2	3	4	7	10
321	26994	3.8755	2	2	3	5	7
322	68	3.6618	1	2	3	4	6
323	16792	3.2039	1	1	2	4	6
324	7668	1.9287	1	1	1	2	4
325	7806	3.8663	1	2	3	5	7
326	2390	2.7046	1	1	2	3	5
327	9	3.4444	1	2	3	6	6
328	691	3.7019	1	2	3	5	7
329	108	2.4259	1	1	1	3	5
331	45315	5.5089	1	3	4	7	11
332	4707	3.4391	1	1	3	4	7
333	267	4.4082	1	2	3	5	10
334	14231	4.9975	3	3	4	6	8
335	10417	3.5491	2	3	3	4	5
336	46652	3.6099	1	2	3	4	7
337	31028	2.2136	1	1	2	3	3
338	2147	5.1202	1	2	3	7	12
339	1813	4.4865	1	1	3	6	10
340	2	1.0000	1	1	1	1	1
341	4093	3.2057	1	1	2	3	6
342	880	3.4966	1	2	2	4	7
344	4123	2.3546	1	1	1	2	5
345	1236	3.7055	1	1	2	4	8
346	4983	5.7154	1	3	4	7	11
347	376	3.1303	1	1	2	4	7
348	3100	4.1839	1	2	3	5	8
349	600	2.5250	1	1	2	3	5
350	6571	4.3821	2	2	4	5	8
352	698	3.9169	1	1	3	5	7
353	2712	7.0749	3	4	5	8	13
354	9042	5.7710	3	3	4	6	10
355	5962	3.4074	2	3	3	4	5
356	28378	2.5532	1	2	2	3	4
357	6098	8.6471	3	5	7	10	16
358	25005	4.4148	2	3	3	5	7
359	29668	2.8899	2	2	3	3	4
360	17416	3.0307	1	2	3	3	5
361	478	3.3703	1	1	2	4	7
362	1	1.0000	1	1	1	1	1
363	3606	3.2887	1	2	2	3	7
364	1831	3.5281	1	1	2	4	7
365	2018	7.0927	2	3	5	9	15
366	4378	6.7106	1	3	5	8	14
367	476	2.9853	1	1	2	3	6
368	2781	6.2312	2	3	5	8	12
369	2776	3.2248	1	1	2	4	6
370	1166	5.9185	3	3	4	5	9
371	1248	3.6330	2	3	3	4	5
372	888	3.4651	1	2	2	3	5
373	3968	2.1467	1	2	2	2	3
374	140	3.1714	1	2	2	3	4
375	6	3.8333	1	1	2	5	5
376	205	3.4439	1	1	2	3	7
377	35	5.4000	1	1	3	5	13
378	177	2.7514	1	2	2	3	4
379	359	3.0836	1	1	2	3	6
380	91	1.8571	1	1	1	2	3
381	185	2.3297	1	1	1	3	5
382	56	1.2857	1	1	1	1	2
383	1526	4.0216	1	2	3	5	8
384	123	2.4065	1	1	2	2	5
385	1	2.0000	2	2	2	2	2
389	8	6.7500	1	5	5	7	12

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY98 MEDPAR Update 03/99 Grouper V17.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
390	9	3.3333	1	1	4	4	5
392	2665	9.6432	3	4	7	12	20
394	1796	6.8135	1	2	4	8	15
395	77861	4.5487	1	2	3	6	9
396	17	3.1765	1	1	2	4	6
397	19299	5.3534	1	2	4	7	11
398	18648	5.9575	2	3	5	7	11
399	1513	3.7198	1	2	3	5	7
400	7367	9.1258	2	3	6	11	20
401	6271	11.0518	2	5	8	14	22
402	1464	4.1735	1	1	3	5	9
403	36557	8.0188	2	3	6	10	16
404	4130	4.3341	1	2	3	6	9
406	2851	10.1371	3	5	8	13	21
407	677	4.1773	1	2	3	5	7
408	2412	7.7363	1	2	5	10	18
409	3775	6.1094	2	3	4	6	12
410	50278	3.5715	1	2	3	4	6
411	20	2.3500	1	1	2	3	4
412	28	2.0000	1	1	1	2	4
413	7463	7.4528	2	3	6	10	15
414	693	4.1616	1	2	3	5	9
415	42974	14.0677	4	6	11	17	28
416	215132	7.3072	2	4	6	9	14
417	42	4.6905	1	2	3	6	10
418	22536	6.0572	2	3	5	7	11
419	15983	4.9037	2	2	4	6	9
420	3053	3.6495	1	2	3	5	7
421	13182	3.9219	1	2	3	5	7
422	93	2.9785	1	1	2	4	6
423	9177	7.6953	2	3	6	9	16
424	1398	14.0250	2	5	10	17	27
425	15651	4.0608	1	2	3	5	8
426	4620	4.6361	1	2	3	6	9
427	1678	4.9362	1	2	3	6	11
428	871	6.8726	1	2	4	8	15
429	29599	6.5256	2	3	5	8	13
430	59517	8.3640	2	3	6	11	17
431	313	7.1374	1	3	5	8	13
432	442	5.1833	1	2	3	5	10
433	6368	3.0974	1	1	2	4	6
434	21885	5.1509	1	2	4	6	10
435	14675	4.3381	1	2	4	5	8
436	3324	13.5096	4	7	12	21	27
437	11674	8.9895	3	5	8	11	15
439	1202	7.5166	1	3	5	9	15
440	5340	8.9891	2	3	6	11	19
441	571	3.0490	1	1	2	4	7
442	15864	7.8964	1	3	6	10	16
443	3388	3.2760	1	1	2	4	7
444	5071	4.2901	1	2	3	5	8
445	2242	2.9942	1	1	2	4	6
447	4724	2.5356	1	1	2	3	5
448	2	1.5000	1	1	2	2	2
449	26247	3.7078	1	1	3	4	7
450	6361	2.0483	1	1	1	2	4
451	4	3.7500	1	1	2	4	8
452	22505	4.9207	1	2	3	6	10
453	4265	2.8802	1	1	2	4	5
454	6006	4.4745	1	2	3	5	9
455	994	2.5905	1	1	2	3	5
461	3500	4.5026	1	1	2	5	11
462	11041	12.2571	4	6	10	16	23
463	16720	4.2907	1	2	3	5	8
464	4503	3.1857	1	2	3	4	6
465	204	3.6029	1	1	1	4	7
466	1771	4.0011	1	1	2	4	8
467	1238	3.2504	1	1	2	4	6
468	58933	13.2171	3	6	10	17	26
471	11960	5.6279	3	3	5	6	9

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY98 MEDPAR Update 03/99 Grouper V17.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
473	8085	13.1116	2	3	7	19	33
475	110336	11.1055	2	5	9	15	22
476	5200	11.6544	2	6	10	15	21
477	27190	8.0489	1	3	6	10	17
478	119489	7.2839	1	3	5	9	15
479	21407	3.7730	1	2	3	5	7
480	459	23.1046	7	11	16	28	48
481	274	24.8759	10	19	23	30	40
482	6476	12.8700	4	7	10	15	23
483	43362	38.9597	14	21	32	48	71
484	416	13.1466	1	5	10	18	27
485	3232	9.1894	4	5	7	11	17
486	2171	12.1935	1	5	10	16	24
487	3766	7.3221	1	3	6	9	15
488	794	18.0416	3	7	13	23	37
489	14199	8.7326	2	3	6	11	18
490	4835	5.2709	1	2	4	7	10
491	11661	3.5467	2	2	3	4	6
492	2597	16.8063	4	5	11	27	35
493	55404	5.7170	1	3	5	7	11
494	26218	2.5095	1	1	2	3	5
495	143	15.6434	6	8	12	22	29
496	1111	10.7885	4	5	8	13	21
497	23280	6.2649	2	3	5	7	11
498	16782	3.4122	1	2	3	4	6
499	33561	4.8046	1	2	4	6	9
500	40918	2.7633	1	1	2	3	5
501	1994	10.0035	4	5	8	12	19
502	554	6.2708	3	4	5	7	11
503	5907	3.9661	1	2	3	5	7
504	123	31.6260	9	15	26	40	63
505	158	5.2405	1	1	2	6	13
506	974	16.7454	4	8	13	22	33
507	354	9.4831	2	4	8	13	19
508	602	8.5166	2	3	6	10	17
509	214	5.2991	1	2	4	7	10
510	1678	7.3194	2	3	5	9	16
511	658	5.1884	1	2	3	6	11
	11262262						

TABLE 8A.—STATEWIDE AVERAGE OPERATING COST-TO-CHARGE RATIOS FOR URBAN AND RURAL HOSPITALS (CASE WEIGHTED) JULY 1999

State	Urban	Rural
ALABAMA	0.379	0.377
ALASKA	0.507	0.732
ARIZONA	0.368	0.532
ARKANSAS	0.478	0.454
CALIFORNIA	0.361	0.457
COLORADO	0.440	0.571
CONNECTICUT	0.500	0.506
DELAWARE	0.495	0.453
DISTRICT OF COLUMBIA	0.519	.....
FLORIDA	0.372	0.386
GEORGIA	0.486	0.487
HAWAII	0.492	0.556
IDAHO	0.549	0.576
ILLINOIS	0.441	0.531
INDIANA	0.559	0.596
IOWA	0.498	0.626
KANSAS	0.425	0.631
KENTUCKY	0.483	0.513
LOUISIANA	0.417	0.489

TABLE 8A.—STATEWIDE AVERAGE OPERATING COST-TO-CHARGE RATIOS FOR URBAN AND RURAL HOSPITALS (CASE WEIGHTED) JULY 1999—Continued

State	Urban	Rural
MAINE	0.615	0.566
MARYLAND	0.764	0.821
MASSACHUSETTS	0.528	0.559
MICHIGAN	0.474	0.580
MINNESOTA	0.524	0.594
MISSISSIPPI	0.469	0.471
MISSOURI	0.423	0.512
MONTANA	0.501	0.568
NEBRASKA	0.488	0.625
NEVADA	0.288	0.492
NEW HAMPSHIRE	0.569	0.592
NEW JERSEY	0.412	.....
NEW MEXICO	0.476	0.511
NEW YORK	0.542	0.620
NORTH CAROLINA	0.537	0.506
NORTH DAKOTA	0.616	0.662
OHIO	0.520	0.564
OKLAHOMA	0.436	0.539
OREGON	0.547	0.594

TABLE 8A.—STATEWIDE AVERAGE OPERATING COST-TO-CHARGE RATIOS FOR URBAN AND RURAL HOSPITALS (CASE WEIGHTED) JULY 1999—Continued

State	Urban	Rural
PENNSYLVANIA	0.403	0.531
PUERTO RICO	0.488	0.591
RHODE ISLAND	0.590	.....
SOUTH CAROLINA	0.453	0.455
SOUTH DAKOTA	0.522	0.617
TENNESSEE	0.465	0.490
TEXAS	0.416	0.519
UTAH	0.514	0.663
VERMONT	0.645	0.608
VIRGINIA	0.472	0.494
WASHINGTON	0.590	0.661
WEST VIRGINIA	0.592	0.571
WISCONSIN	0.562	0.634
WYOMING	0.475	0.681

TABLE 8B.—STATEWIDE AVERAGE CAPITAL COST-TO-CHARGE RATIOS (CASE WEIGHTED) JULY 1999

State	Ratio
ALABAMA	0.047
ALASKA	0.066
ARIZONA	0.042
ARKANSAS	0.050
CALIFORNIA	0.039
COLORADO	0.049
CONNECTICUT	0.037
DELAWARE	0.055
DISTRICT OF COLUMBIA	0.039
FLORIDA	0.046
GEORGIA	0.056
HAWAII	0.046
IDAHO	0.060
ILLINOIS	0.042
INDIANA	0.059
IOWA	0.054
KANSAS	0.049
KENTUCKY	0.050
LOUISIANA	0.050

TABLE 8B.—STATEWIDE AVERAGE CAPITAL COST-TO-CHARGE RATIOS (CASE WEIGHTED) JULY 1999—Continued

State	Ratio
MAINE	0.040
MARYLAND	0.013
MASSACHUSETTS	0.056
MICHIGAN	0.045
MINNESOTA	0.050
MISSISSIPPI	0.047
MISSOURI	0.049
MONTANA	0.051
NEBRASKA	0.057
NEVADA	0.029
NEW HAMPSHIRE	0.067
NEW JERSEY	0.037
NEW MEXICO	0.044
NEW YORK	0.052
NORTH CAROLINA	0.050
NORTH DAKOTA	0.075
OHIO	0.052

TABLE 8B.—STATEWIDE AVERAGE CAPITAL COST-TO-CHARGE RATIOS (CASE WEIGHTED) JULY 1999—Continued

State	Ratio
OKLAHOMA	0.051
OREGON	0.049
PENNSYLVANIA	0.042
PUERTO RICO	0.049
RHODE ISLAND	0.035
SOUTH CAROLINA	0.047
SOUTH DAKOTA	0.069
TENNESSEE	0.055
TEXAS	0.051
UTAH	0.050
VERMONT	0.051
VIRGINIA	0.060
WASHINGTON	0.066
WEST VIRGINIA	0.056
WISCONSIN	0.056
WYOMING	0.053

TABLE 10.—PERCENTAGE DIFFERENCE IN WAGE INDEXES FOR AREAS THAT QUALIFY FOR A WAGE INDEX EXCEPTION FOR EXCLUDED HOSPITALS AND UNITS

Area	1982–1996 difference	1984–1996 difference	1988–1996 difference	1990–1996 difference	1991–1996 difference	1992–1996 difference	1993–1996 difference	1994–1996 difference
Colorado					10.4524		8.1881	
Connecticut	19.6203	21.9951						
Delaware		10.0096						
Florida		10.2983						
Georgia		8.7027						
Hawaii		21.3348	11.4158		12.6562	8.9266		
Illinois				9.5874	8.7873			
Indiana				9.2802				
Iowa				8.2639	9.0834			
Maryland		8.3480						
Massachusetts	8.6383	12.1756						
Mississippi				9.6174	9.9473	8.1089		
Nebraska			14.3694	11.6425	9.9561	10.9156	10.9771	
New Hampshire		11.6434						
New Mexico				11.9006				
North Carolina		8.5221						
South Carolina		14.2383						
South Dakota				8.9288	9.0543	8.3679		
Tennessee		8.6185						
Vermont		11.9881						
Washington			8.3161	12.0455	8.3048			
Wyoming				12.9830	11.6587	10.5578	8.3272	
Akron, OH				9.7516				
Albany, GA	27.7655	33.1280	28.7328	21.9948	17.5830	20.4926	20.6327	
Anniston, Al		10.2828						
Arecibo, PR		10.1831	21.6831	29.8544	26.7773		9.4816	
Athens, GA	19.5810	25.7158	18.1110	18.0248	9.5754			
Atlanta, GA		8.1459		6.4055				
Atlantic-Cape May, NJ		14.8340						
Bellingham, WA			8.4523					
Bergen-Passaic, NJ	12.8013	14.7272	16.7200					
Billings, MT	16.1065	19.1965	26.2081	30.8632	35.1113	35.3130	29.6247	
Bremerton, WA	13.0957	15.0214	15.3709	15.4435	13.8559			
Brownsville-Harlingen-San Benito, TX				8.5425	12.0954			
Bryan-College, Station, TX								
Burlington, VT		12.4268	12.7269	10.3355		13.9804		
Caquas, PR		14.7999						
Casper, WY				9.2907	9.6686	9.1351		
Cedar Rapids, IA				10.3119				
Charlotte-Gastonia-Rock Hill, NC–SC		12.6597						
Charlottesville, VA	14.0438	19.5365	9.8608	11.4472	12.9594	15.1868	15.4762	
Chattanooga, TN–GA		13.4017			8.8235		9.9797	
Cheyenne, WY						8.3488	9.3340	
Clarksville-Hopkinsville, TN–KY		11.2945	10.4286	18.4133				
Columbia, SC		10.8124						
Columbus, GA–AL	8.1734	15.8296	13.6333	12.7302	9.6367	9.7215	9.3830	
Cumberland, MD–MVA				8.5070	9.0177			
Danville, VA	12.9378	18.7705	20.6043	14.8561	11.9610			
Decatur, AL			17.3472	15.8281	8.4468			
Dubuque, IA					9.1888			

TABLE 10.—PERCENTAGE DIFFERENCE IN WAGE INDEXES FOR AREAS THAT QUALIFY FOR A WAGE INDEX EXCEPTION FOR EXCLUDED HOSPITALS AND UNITS—Continued

Area	1982–1996 difference	1984–1996 difference	1988–1996 difference	1990–1996 difference	1991–1996 difference	1992–1996 difference	1993–1996 difference	1994–1996 difference
Duluth-Superior, MN–WI				10.7902	10.0227			
Dutchess County, NY		8,4704						
Elkhart-Goshen, IN				9.4527				
Eugene-Springfield, OR				11.7281				
Flagstaff, AZ–UT								
Florence, AL		11.8054						
Florence, SC	13.0320	11.8640						
Gadsen, AL				12.1611				
Gainsville, FL		15.7424	14.7172	13.7100	14.4832	12.2944		
Grand Junction, CO								
Great Falls, MT				18.0341	21.0392	17.3455	20.4676	
Greeley, CO				11.4525				
Hickory-Morganton-Lenoir, NC		10.9461						
Houma, LA			9.0896					
Huntington-Ashland, WV–KY–OH				8.6526	8.6163	8.4473		
Jackson, MS			8.3592	12.0957	12.2607	11.1892		
Jackson, TN	9.5132	13.7566	8.6270					
Jacksonville, NC		8.7685	8.6495	8.9799	9.1010	13.3699	11.2812	
Janesville-Beliot, WI			13.9620	14.6249	13.0547	9.9021	11.6946	
Jersey City, NJ		8.7268	10.8011					
Killeen-Temple, TX	13.1336							
Knoxville, TN		12.1556				8.5300	8.5044	
Laredo, TX		13.0842	14.2641	26.7784	19.4632	23.3037	17.6562	
Las Cruse, NM			8.5144					
Lawton, OK		11.8386	13.5303	12.6581	12.2204	10.9146	13.9374	
Lima, OH			10.3470					
Lynchburg, VA							8.5602	
Macon, GA			9.3169					
Mayaguez, PR							10.8634	
Medford-Ashland, OR		8.6916		12.5510	8.3660			
Middlesex-Somerset-Hunterdon, NJ	8.3277	12.0153						
Monmouth-Ocean, NJ	14.3408	19.9318	13.6139	9.5243				
Muncie, IN	8.4919	12.2462	34.1672	26.6394	14.0301	18.7288	11.5183	
Nassau-Suffolk, NY		16.2468	8.6879					
New Haven-Bridgeport-Stamford-Waterbury-Danbury, CT	10.4496	14.7474						
New London-Norwich, CT	12.8280	16.4870						
New York, NY		10.1191						
Newburgh, NY–PA	18.2439	22.5618	12.9076					
Ocala, FL	10.9508	18.0769	11.5170	13.1443	9.4978			
Omaha, NEIA			16.2054				10.2732	
Owensboro, KY						8.0822		
Panama City, FL	10.6298	16.0633		9.5853	21.6370	12.0631	13.7311	
Parkersburg-Marietta, WV–OH				8.4838		8.5537		
Ponce, PR					9.0132			
Providence-Warwick-Pawtucket, RI		9.8100						
Pueblo, CO					10.4692			
Redding, CA		13.7562						
Richland-Kennewick-Pasco, WA	10.3096	15.4733	19.2774	21.6958	16.3350	12.1167	12.5664	
Richmond-Pertersburg, VA				8.3428				
Riverside-San Bernardino, CA								
Rochester, MN	12.0161			13.2930	8.6820		9.5886	
Salinas, CA	17.9442	16.9131	12.7030	11.4394				
San Angelo, TX					9.9972			
Santa Cruz-Watsonville, CA	12.9155	12.9980	8.8387	9.1800				
Santa Fe, NM		10.0021	14.1030					
Savannah, GA	12.5014	18.2769	19.4121	14.6131		10.9835		
Sherman-Denison, TX							8.3004	
Tacoma, WA		12.0133	11.1455	12.9502	10.2700			
Vallejo-Fairfield-Napa, CA		8.7346						
Wilmington-Newark, DE–MD		9.6799						
Wilmington, NC		18.6820	11.3188					
Yakima, WA				9.5536	8.2905			
Yuma, AZ			11.5934		14.3977			

Appendix A : Regulatory Impact Analysis

I. Introduction

Section 804(2) of title 5, United States Code (as added by section 251 of Public Law 104–121), specifies that a ''major rule'' is any rule that the Office of Management and Budget finds is likely to result in—

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

We estimate that the impact of this final rule will be to reduce payments to hospitals by approximately $125 million in FY 2000. Therefore, this rule is a major rule as defined in Title 5, United States Code, section 804(2).

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 final rule will not have a significant economic impact on a substantial number of small entities. For purposes of the RFA, we consider all hospitals to be small entities.

Also, section 1102(b) of the Act requires us to prepare a regulatory impact analysis for any rule that may have a significant impact on the operations of a substantial number of small rural hospitals. Such an analysis must conform to the provisions of section 604 of the RFA. With the exception of hospitals located in certain New England counties, for purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital with fewer than 100 beds that is located outside of a Metropolitan Statistical Area (MSA) or New England County Metropolitan Area (NECMA). Section 601(g) of the Social Security Amendments of 1983 (Public Law 98–21) designated hospitals in certain New England counties as belonging to the adjacent NECMA. Thus, for purposes of the hospital inpatient prospective payment system, we classify these hospitals as urban hospitals.

It is clear that the changes being made in this document would affect both a substantial number of small rural hospitals as well as other classes of hospitals, and the effects on some may be significant. Therefore, the discussion below, in combination with the rest of this final rule, constitutes a combined regulatory impact analysis and regulatory flexibility analysis.

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

II. Changes in the Final Rule

Since we published the proposed rule, the market basket estimates for hospitals subject to the prospective payment system and hospitals and units excluded from the system have risen by 0.2 and 0.3 percentage points, respectively. As a result, the updates are 0.2 percent higher than the updates reflected in the impact analysis for the proposed rule.

Since the May 7, 1999 proposed rule, we have discovered that incorrect data were used in the capital (and operating) update framework in estimating the proposed adjustment for the effect of FY 1998 Reclassification and Recalibration. The revised adjustment resulted in a 0.91 percent increase in the capital rate update factor in this final rule.

With the exception of these changes, we are generally implementing the policy and statutory provisions discussed in the proposed rule.

III. Limitations of Our Analysis

As has been the case in our previously published regulatory impact analyses, the following quantitative analysis presents the projected effects of our policy changes, as well as statutory changes effective for FY 2000, on various hospital groups. We estimate the effects of individual policy changes by estimating payments per case while holding all other payment policies constant. We use the best data available, but we do not attempt to predict behavioral responses to our policy changes, and we do not make adjustments for future changes in such variables as admissions, lengths of stay, or case mix.

We received no comments on the methodology used for the impact analysis in the proposed rule.

IV. Hospitals Included in and Excluded From the Prospective Payment System

The prospective payment systems for hospital inpatient operating and capital-related costs encompass nearly all general, short-term, acute care hospitals that participate in the Medicare program. There were 44 Indian Health Service hospitals in our database, which we excluded from the analysis due to the special characteristics of the prospective payment method for these hospitals. Among other short-term, acute care hospitals, only the 50 such hospitals in Maryland remain excluded from the prospective payment system under the waiver at section 1814(b)(3) of the Act. Thus, as of July 1999, we have included 4,922 hospitals in our analysis. This represents about 82 percent of all Medicare-participating hospitals. The majority of this impact analysis focuses on this set of hospitals.

The remaining 18 percent are specialty hospitals that are excluded from the prospective payment system and continue to be paid on the basis of their reasonable costs (subject to a rate-of-increase ceiling on their inpatient operating costs per discharge). These hospitals include psychiatric, rehabilitation, long-term care, children's, and cancer hospitals. The impacts of our final policy changes on these hospitals are discussed below.

V. Impact on Excluded Hospitals and Units

As of July 1999, there were 1,112 specialty hospitals excluded from the prospective payment system and instead paid on a reasonable cost basis subject to the rate-of-increase ceiling under § 413.40. Broken down by specialty, there were 586 psychiatric, 200 rehabilitation, 225 long-term care, 71 children's, 20 Christian Science Sanatoria, and 10 cancer hospitals. In addition, there were 1,497 psychiatric and 942 rehabilitation units in hospitals otherwise subject to the prospective payment system. These excluded units are also paid in accordance with § 413.40. Under § 413.40(a)(2)(i)(A), the target rate-of-increase ceiling is not applicable to the 20 specialty hospitals and units in Maryland that are paid in accordance with the waiver at section 1814(b)(3) of the Act.

As required by section 1886(b)(3)(B) of the Act, the update factor applicable to the rate-of-increase limit for excluded hospitals and units for FY 2000 will be between 0 and 2.9 percent, depending on the hospital's or unit's costs in relation to its limit for the most recent cost reporting period for which information is available.

The impact on excluded hospitals and units of the update in the rate-of-increase limit depends on the cumulative cost increases experienced by each excluded hospital or unit since its applicable base period. For excluded hospitals and units that have maintained their cost increases at a level below the percentage increases in the rate-of-increase limits since their base period, the major effect will be on the level of incentive payments these hospitals and units receive. Conversely, for excluded hospitals and units with per case cost increases above the cumulative update in their rate-of-increase limits, the major effect will be the amount of excess costs that would not be reimbursed.

We note that, under § 413.40(d)(3), an excluded hospital or unit whose costs exceed 110 percent of its rate-of-increase limit receives its rate-of-increase limit *plus* the lesser of 50 percent of the difference between its reasonable costs and 110 percent of the limit, or 10 percent of the limit. In no case would the payment exceed 110 percent of the limit. In addition, under the various provisions set forth in § 413.40, certain excluded hospitals and units can obtain payment adjustments for justifiable increases in operating costs that exceed the limit. At the same time, however, by generally limiting payment increases, we continue to provide an incentive for excluded hospitals and units to restrain the growth in their spending for patient services.

VI. Quantitative Impact Analysis of the Policy Changes Under the Prospective Payment System for Operating Costs

A. Basis and Methodology of Estimates

In this final rule, we are announcing policy changes and payment rate updates for the prospective payment systems for operating and capital-related costs. We have prepared separate impact analyses of the changes to each system. This section deals with changes to the operating prospective payment system.

The data used in developing the quantitative analyses presented below are taken from the FY 1998 MedPAR file and the most current Provider-Specific File that is used for payment purposes. Although the analyses of the changes to the operating prospective payment system do not incorporate cost data, the most recently available hospital cost report data were used to categorize hospitals. Our analysis has several qualifications. First, we do not make adjustments for behavioral changes that hospitals may adopt in response to these policy changes. Second, due to the interdependent nature of the prospective payment system, it is very difficult to precisely quantify the impact associated with each change. Third, we draw upon various sources for the data used to categorize hospitals in the tables. In some cases, particularly the number of beds, there is a fair degree of variation in the data from different sources. We have attempted to construct these variables with the best available source overall. For individual hospitals, however, some miscategorizations are possible.

Using cases in the FY 1998 MedPAR file, we simulated payments under the operating prospective payment system given various combinations of payment parameters. Any short-term, acute care hospitals not paid under the general prospective payment systems (Indian Health Service hospitals and hospitals in Maryland) are excluded from the simulations. Payments under the capital prospective payment system, or payments for costs other than inpatient operating costs, are

not analyzed here. Estimated payment impacts of final FY 2000 changes to the capital prospective payment system are discussed below in section VII of this Appendix.

The final changes discussed separately below are the following:

- The effects of the annual reclassification of diagnoses and procedures and the recalibration of the DRG relative weights required by section 1886(d)(4)(C) of the Act.
- The effects of the floor on the wage index established by section 4410(a) of the BBA of 1997, which provided that the wage index for urban hospitals may not be less than the area wage index applicable to hospitals in rural areas of the State in which the hospital is located.
- The effects of changes in hospitals' wage index values reflecting the wage index update (FY 1996 data).
- The effects of fully removing from the wage index the costs and hours associated with teaching physicians Part A, residents, and CRNAs; and the effects of our policy to implement the first year of a 5-year phase-out of these costs, by calculating a wage index based on 20 percent of hospitals' average hourly wages after removing the costs and hours associated with teaching physicians, residents, and CRNAs, and 80 percent of hospitals' average hourly wages with these costs included.
- The effects of geographic reclassifications by the MGCRB that will be effective in FY 2000.
- The total change in payments based on FY 2000 policies relative to payments based on FY 1999 policies.

To illustrate the impacts of the FY 2000 final changes, our analysis begins with a FY 2000 baseline simulation model using: the FY 1999 GROUPER (version 16.0); the FY 1999 wage index without applying the rural floor; and no MGCRB reclassifications. Outlier payments are set at 5.1 percent of total DRG plus outlier payments.

Each final and statutory policy change is then added incrementally to this baseline model, finally arriving at an FY 2000 model incorporating all of the changes. This allows us to isolate the effects of each change.

Our final comparison illustrates the percent change in payments per case from FY 1999 to FY 2000. Four factors have significant impacts here. The first is the update to the standardized amounts. In accordance with section 1886(d)(3)(A)(iv) of the Act, we are updating the large urban and the other areas' average standardized amounts for FY 2000 using the most recently forecasted hospital market basket increase for FY 2000 of 2.9 percent minus 1.8 percentage points. Similarly, section 1886(b)(3)(C)(ii) of the Act provides that the update factor applicable to the hospital-specific rates for sole community hospitals (SCHs), essential access community hospitals (EACHs) (which are treated as SCHs for payment purposes), and Medicare-dependent, small rural hospitals (MDHs) is equal to the market basket increase of 2.9 percent minus 1.8 percentage points (for an update of 1.1 percent).

A second significant factor that impacts changes in hospitals' payments per case from FY 1999 to FY 2000 is a change in MGCRB reclassification status from one year to the next. That is, hospitals reclassified in FY 1999 that are no longer reclassified in FY 2000 may have a negative payment impact going from FY 1999 to FY 2000; conversely, hospitals not reclassified in FY 1999 that are reclassified in FY 2000 may have a positive impact. In some cases, these impacts can be quite substantial, so if a relatively small number of hospitals in a particular category lose their reclassification status, the percentage increase in payments for the category may be below the national mean.

A third significant factor is that we currently estimate that actual outlier payments during FY 1999 will be 6.3 percent of actual total DRG payments. When the FY 1999 final rule was published, we projected FY 1999 outlier payments would be 5.1 percent of total DRG plus outlier payments, and the standardized amounts were reduced correspondingly. The effects of the higher than expected outlier payments during FY 1999 (as discussed in the Addendum to this final rule) are reflected in the analyses below comparing our current estimates of FY 1999 payments per case to estimated FY 2000 payments per case.

Fourth, payment adjustments for indirect medical education (IME) and disproportionate share (DSH) are lower in FY 2000 relative to FY 1999. Section 1886(d)(5)(B)(ii) of the Act provides that the IME adjustment is reduced from approximately a 6.5 percent increase for every 10 percent increase in a hospital's resident-to-bed ratio in FY 1999, to a 6.0 percent increase in FY 2000. Similarly, in accordance with section 1886(d)(5)(F)(ix) of the Act, the DSH adjustment for FY 2000 is reduced by 3 percent from what would otherwise have been paid, compared to a 2 percent reduction for FY 1999.

Table I demonstrates the results of our analysis. The table categorizes hospitals by various geographic and special payment consideration groups to illustrate the varying impacts on different types of hospitals. The top row of the table shows the overall impact on the 4,922 hospitals included in the analysis. This figure represents 53 fewer hospitals than were included in the impact analysis in the FY 1999 final rule (63 FR 41106).

The next four rows of Table I contain hospitals categorized according to their geographic location (all urban, which is further divided into large urban and other urban, or rural). There are 2,782 hospitals located in urban areas (MSAs or NECMAs) included in our analysis. Among these, there are 1,584 hospitals located in large urban areas (populations over 1 million), and 1,198 hospitals in other urban areas (populations of 1 million or fewer). In addition, there are 2,140 hospitals in rural areas. The next two groupings are by bed-size categories, shown separately for urban and rural hospitals. The final groupings by geographic location are by census divisions, also shown separately for urban and rural hospitals.

The second part of Table I shows hospital groups based on hospitals' FY 2000 payment classifications, including any reclassifications under section 1886(d)(10) of the Act. For example, the rows labeled urban, large urban, other urban, and rural show that the number of hospitals paid based on these categorizations (after consideration of geographic reclassifications) are 2,858, 1,662, 1,197, and 2,064, respectively.

The next three groupings examine the impacts of the final changes on hospitals grouped by whether or not they have residency programs (teaching hospitals that receive an IME adjustment) or receive DSH payments, or some combination of these two adjustments. There are 3,809 nonteaching hospitals in our analysis, 871 teaching hospitals with fewer than 100 residents, and 242 teaching hospitals with 100 or more residents.

In the DSH categories, hospitals are grouped according to their DSH payment status, and whether they are considered urban or rural after MGCRB reclassifications. Hospitals in the rural DSH categories, therefore, represent hospitals that were not reclassified for purposes of the standardized amount or for purposes of the DSH adjustment. (They may, however, have been reclassified for purposes of the wage index.) The next category groups hospitals considered urban after geographic reclassification, in terms of whether they receive the IME adjustment, the DSH adjustment, both, or neither.

The next five rows examine the impacts of the final changes on rural hospitals by special payment groups (SCHs, rural referral centers (RRCs), and MDHs), as well as rural hospitals not receiving a special payment designation. The RRCs (154), SCHs (647), MDHs (355), and SCH and RRCs (57) shown here were not reclassified for purposes of the standardized amount. There are 15 RRCs, 3 SCHs, and 2 SCH and RRCs that will be reclassified for the standardized amount in FY 2000 that, therefore, are not included in these rows.

The next two groupings are based on type of ownership and the hospital's Medicare utilization expressed as a percent of total patient days. These data are taken primarily from the FY 1997 Medicare cost report files, if available (otherwise FY 1996 data are used). Data needed to determine ownership status or Medicare utilization percentages were unavailable for some hospitals (80 and 82, respectively). For the most part, these are new hospitals.

The next series of groupings concern the geographic reclassification status of hospitals. The first three groupings display hospitals that were reclassified by the MGCRB for both FY 1999 and FY 2000, or for either of those 2 years, by urban and rural status. The next rows illustrate the overall number of FY 2000 reclassifications, as well as the numbers of reclassified hospitals grouped by urban and rural location. The final row in Table I contains hospitals located in rural counties but deemed to be urban under section 1886(d)(8)(B) of the Act.

Table I—Impact Analysis of Changes For FY 2000 Operating Prospective Payment System
[PERCENT CHANGES IN PAYMENTS PER CASE]

	Number of hospitals[1]	DRG recalib.[2]	Wage index floor[3]	New wage data[4]	Remove GME and CRNA costs[5]	Blended wage index costs[6]	DRG & WI changes[7]	MGCRB reclassification[8]	All FY 2000 changes[9]
	(0)	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
(BY GEOGRAPHIC LOCATION)									
ALL HOSPITALS	4,922	0.0	0.1	0.1	0.4	0.1	0.0	0.0	−0.5
URBAN HOSPITALS	2,782	0.0	0.1	0.0	0.3	0.1	−0.1	−0.4	−0.7
LARGE URBAN	1,584	0.0	0.0	0.0	0.1	0.0	−0.1	−0.4	−0.8
OTHER URBAN	1,198	0.0	0.2	0.0	0.6	0.1	0.1	−0.4	−0.5
RURAL HOSPITALS	2,140	0.2	0.0	0.4	0.6	0.5	0.5	2.6	1.0
BED SIZE (URBAN):									
0–99 BEDS	727	0.1	0.3	−0.2	0.4	−0.2	0.1	−0.5	−0.2
100–199 BEDS	938	0.1	0.2	0.1	0.4	0.1	0.2	−0.5	−0.1
200–299 BEDS	553	0.0	0.1	0.1	0.4	0.1	0.0	−0.4	−0.5
300–499 BEDS	422	0.0	0.1	0.0	0.4	0.1	−0.1	−0.3	−0.7
500 OR MORE BEDS	142	−0.1	0.0	0.0	0.0	0.0	−0.2	−0.4	−1.6
BED SIZE (RURAL):									
0–49 BEDS	1,194	0.3	0.0	0.4	0.5	0.5	0.6	0.2	1.4
50–99 BEDS	571	0.2	0.0	0.4	0.5	0.5	0.5	1.0	1.2
100–149 BEDS	223	0.2	0.0	0.4	0.7	0.5	0.5	3.8	1.2
150–199 BEDS	87	0.1	0.0	0.5	0.6	0.6	0.5	4.5	1.2
200 OR MORE BEDS	65	0.1	0.0	0.4	0.5	0.5	0.4	4.8	0.3
URBAN BY CENSUS DIVISION:									
NEW ENGLAND	149	0.0	0.2	0.6	0.8	0.7	0.6	−0.2	−0.2
MIDDLE ATLANTIC	421	0.0	0.1	−0.2	−0.5	−0.2	−0.3	−0.3	−1.4
SOUTH ATLANTIC	407	0.0	0.2	0.1	0.9	0.3	0.2	−0.4	−0.2
EAST NORTH CENTRAL	467	0.0	0.1	0.4	0.0	0.4	0.3	−0.4	−0.4
EAST SOUTH CENTRAL	165	0.0	0.1	0.5	0.3	0.6	0.4	−0.4	0.0
WEST NORTH CENTRAL	190	−0.1	0.0	−0.1	0.1	0.0	−0.3	−0.5	−0.8
WEST SOUTH CENTRAL	353	0.0	0.0	−0.6	0.4	−0.5	−0.7	−0.5	−1.1
MOUNTAIN	134	−0.1	0.0	−0.1	0.2	0.0	−0.3	−0.5	−0.5
PACIFIC	449	0.0	0.1	−0.3	0.9	−0.2	−0.3	−0.4	−0.8
PUERTO RICO	47	0.1	0.0	0.4	0.3	0.4	0.4	−0.5	0.2
RURAL BY CENSUS DIVISION:									
NEW ENGLAND	52	0.1	0.0	−0.2	0.1	−0.1	−0.3	2.5	0.5
MIDDLE ATLANTIC	79	0.1	0.0	−0.4	0.0	−0.4	−0.4	2.2	0.7
SOUTH ATLANTIC	280	0.2	0.0	1.0	0.7	1.1	1.1	3.0	0.9
EAST NORTH CENTRAL	283	0.1	0.0	0.3	0.6	0.4	0.3	2.3	1.0
EAST SOUTH CENTRAL	267	0.3	0.0	0.7	0.8	0.8	0.9	2.7	1.6
WEST NORTH CENTRAL	492	0.1	0.0	0.8	0.4	0.9	0.8	2.3	1.5
WEST SOUTH CENTRAL	341	0.3	0.0	−0.3	0.7	−0.2	−0.1	3.5	0.9
MOUNTAIN	201	0.2	0.0	0.5	0.4	0.5	0.5	1.8	1.3
PACIFIC	140	0.1	0.0	−0.4	0.7	−0.2	−0.3	1.9	0.0
PUERTO RICO	5	0.1	0.0	1.8	0.6	1.9	1.9	1.6	2.4
(BY PAYMENT CATEGORIES)									
URBAN HOSPITALS	2,858	0.0	0.1	0.0	0.3	0.1	0.0	−0.3	−0.7
LARGE URBAN	1,662	0.0	0.0	0.0	0.1	0.0	−0.1	−0.3	−0.9
OTHER URBAN	1,197	0.0	0.2	0.1	0.6	0.2	0.1	−0.3	−0.4
RURAL HOSPITALS	2,064	0.2	0.0	0.4	0.6	0.5	0.5	2.3	1.1
TEACHING STATUS:									
NON-TEACHING	3,809	0.1	0.1	0.1	0.5	0.2	0.2	0.3	0.2
LESS THAN 100 RESIDENTS	871	0.0	0.1	0.0	0.4	0.1	−0.1	−0.3	−0.6
100+ RESIDENTS	242	0.0	0.0	0.1	−0.1	0.1	−0.1	−0.2	−1.5
DISPROPORTIONATE SHARE HOSPITALS (DSH):									
NON-DSH	3,069	0.0	0.1	0.1	0.4	0.1	0.0	0.3	−0.2
URBAN DSH 100 BEDS OR MORE	1,387	0.0	0.1	0.0	0.3	0.1	0.0	−0.4	−0.8
FEWER THAN 100 BEDS	89	0.2	0.1	−0.2	0.6	0.0	0.1	−0.5	0.1
RURAL DSH SOLE COMMUNITY (SCH)	158	0.3	0.0	0.4	0.6	0.6	0.6	0.3	2.1
REFERRAL CENTERS (RRC)	60	0.2	0.0	0.7	0.7	0.8	0.8	5.0	1.2
OTHER RURAL DSH HOSPITALS 100 BEDS OR MORE	49	0.2	0.0	0.7	0.8	0.8	0.9	1.0	1.1
FEWER THAN 100 BEDS	110	0.4	0.0	0.7	0.8	0.9	1.0	0.2	2.0
URBAN TEACHING AND DSH:									
BOTH TEACHING AND DSH	716	0.0	0.0	0.0	0.2	0.1	−0.1	−0.4	−1.1
TEACHING AND NO DSH	331	−0.1	0.1	0.0	0.2	0.1	−0.2	−0.1	−0.8
NO TEACHING AND DSH	760	0.1	0.2	0.0	0.6	0.1	0.1	−0.2	0.0
NO TEACHING AND NO DSH	1,052	0.0	0.2	0.0	0.4	0.1	0.1	−0.4	−0.3
RURAL HOSPITAL TYPES:									
NONSPECIAL STATUS HOSPITALS	851	0.3	0.0	0.5	0.7	0.7	0.7	1.1	1.2
RRC	154	0.1	0.0	0.4	0.7	0.6	0.4	5.7	0.6
SCH	647	0.2	0.0	0.2	0.3	0.3	0.3	0.3	1.4
MDH	355	0.3	0.0	0.4	0.5	0.5	0.6	0.3	1.2
SCH AND RRC	57	0.1	0.0	0.2	0.3	0.2	0.1	2.2	1.4
TYPE OF OWNERSHIP:									
VOLUNTARY	2,831	0.0	0.1	0.1	0.3	0.1	0.0	−0.1	−0.5
PROPRIETARY	752	0.1	0.1	0.0	0.6	0.1	0.0	0.0	−0.2
GOVERNMENT	1,259	0.1	0.1	0.2	0.6	0.3	0.2	0.3	−0.3
UNKNOWN	80	0.0	0.0	0.3	−0.8	0.1	0.0	−0.5	−1.4

Table I—Impact Analysis of Changes For FY 2000 Operating Prospective Payment System—Continued

[PERCENT CHANGES IN PAYMENTS PER CASE]

	Number of hospitals[1] (0)	DRG recalib.[2] (1)	Wage index floor[3] (2)	New wage data[4] (3)	Remove GME and CRNA costs[5] (4)	Blended wage index costs[6] (5)	DRG & WI changes[7] (6)	MGCRB reclassification[8] (7)	All FY 2000 changes[9] (8)
MEDICARE UTILIZATION AS A PERCENT OF INPATIENT DAYS:									
0–25	386	0.1	0.0	−0.3	0.6	−0.1	−0.3	−0.1	−1.3
25–50	1,775	0.0	0.0	0.0	0.3	0.1	−0.1	−0.3	−0.8
50–65	1,893	0.0	0.1	0.1	0.4	0.2	0.1	0.2	−0.1
OVER 65	786	0.1	0.2	0.3	0.4	0.3	0.4	0.3	0.1
UNKNOWN	82	0.0	0.0	0.3	−0.8	0.1	0.0	−0.5	−1.4
HOSPITALS RECLASSIFIED BY THE MEDICARE GEOGRAPHIC REVIEW BOARD									
RECLASSIFICATION STATUS DURING FY 1999 AND FY 2000:									
RECLASSIFIED DURING BOTH FY 1999 AND FY 2000	370	0.1	0.0	0.3	0.7	0.4	0.3	5.9	0.0
URBAN	57	0.0	0.0	0.0	0.9	0.1	0.0	4.4	−1.4
RURAL	313	0.1	0.0	0.4	0.6	0.5	0.4	6.6	0.7
RECLASSIFIED DURING FY 2000 ONLY	127	0.1	0.0	0.2	0.5	0.3	0.2	4.4	4.7
URBAN	26	0.0	0.1	−0.1	0.4	0.0	−0.2	3.3	2.7
RURAL	101	0.2	0.0	0.6	0.6	0.7	0.7	5.7	7.0
RECLASSIFIED DURING FY 1999 ONLY	188	0.1	1.1	−0.2	0.6	−0.1	0.8	−0.5	−3.9
URBAN	100	0.0	1.7	−0.6	0.6	−0.4	1.0	−0.5	−3.7
RURAL	88	0.2	0.0	0.4	0.6	0.5	0.5	−0.5	−4.2
FY 2000 RECLASSIFICATIONS:									
ALL RECLASSIFIED HOSPITALS	498	0.1	0.0	0.3	0.6	0.4	0.3	5.6	0.9
STANDARDIZED AMOUNT ONLY	66	0.2	0.0	0.3	0.8	0.4	0.4	2.6	−1.4
WAGE INDEX ONLY	386	0.1	0.0	0.3	0.6	0.4	0.3	6.0	1.3
BOTH	46	0.1	0.0	−0.1	0.7	0.0	−0.1	4.8	−0.5
NONRECLASSIFIED	4,398	0.0	0.1	0.1	0.3	0.1	0.0	−0.6	−0.6
ALL URBAN RECLASSIFIED	83	0.0	0.0	−0.1	0.7	0.1	−0.1	4.1	−0.2
STANDARDIZED AMOUNT ONLY	13	0.1	0.1	−0.4	0.9	−0.2	−0.2	0.8	−4.4
WAGE INDEX ONLY	47	0.0	0.1	0.2	0.7	0.3	0.1	5.4	0.6
BOTH	23	0.2	0.0	−0.8	0.7	−0.6	−0.7	0.7	−1.1
NONRECLASSIFIED	2,673	0.0	0.1	0.0	0.3	0.1	−0.1	−0.6	−0.7
ALL RURAL RECLASSIFIED	416	0.1	0.0	0.5	0.6	0.6	0.5	6.5	1.5
STANDARDIZED AMOUNT ONLY	53	0.2	0.0	0.7	0.8	0.9	0.9	3.9	0.6
WAGE INDEX ONLY	339	0.1	0.0	0.4	0.6	0.5	0.4	6.3	1.7
BOTH	23	0.1	0.0	1.0	0.6	1.1	1.0	11.6	0.5
NONRECLASSIFIED	1,725	0.2	0.0	0.4	0.5	0.5	0.5	−0.4	0.6
OTHER RECLASSIFIED HOSPITALS (SECTION 1886(d)(8)(B))	26	0.1	8.7	−0.4	0.3	−0.3	8.3	1.5	3.2

[1] Because data necessary to classify some hospitals by category were missing, the total number of hospitals in each category may not equal the national total. Discharge data are from FY 1998, and hospital cost report data are from reporting periods beginning in FY 1996 and FY 1997.

[2] This column displays the payment impact of the recalibration of the DRG weights based on FY 1998 MedPAR data and the DRG reclassification changes, in accordance with section 1886(d)(4)(C) of the Act.

[3] This column shows the impacts of implementing the rural wage index floor for urban hospitals in an area that otherwise would have a wage index below the Statewide rural wage index. This was established by section 4410(a) of the BBA of 1997.

[4] This column shows the payment effects of updating the data used to calculate the wage index with data from the FY 1996 cost reports.

[5] This column displays the impact of completely removing the costs and hours associated with teaching physicians Part A, residents, and CRNAs from the wage index calculation.

[6] This column illustrates the payment impact of phasing out the costs and hours associated with teaching physicians Part A, residents, and CRNAs, by calculating the wage index based on a blend of 20 percent of an average hourly wage after removing these costs and 80 percent of an average hourly wage without removing these costs.

[7] This column displays the combined impact of the reclassification and recalibration of the DRGs, the updated and revised wage data used to calculate the wage index, and the budget neutrality adjustment factor for these two changes, in accordance with sections 1886(d)(4)(C)(iii) and 1886(d)(3)(E) of the Act. Thus, it represents the combined impacts shown in columns 1, 2, 3, 4, and 5, and the FY 2000 budget neutrality factor of 0.997808.

[8] Shown here are the effects of geographic reclassifications by the Medicare Geographic Classification Review Board (MGCRB). The effects demonstrate the FY 2000 payment impact of going from no reclassifications to the reclassifications scheduled to be in effect for FY 2000. Reclassification for prior years has no bearing on the payment impacts shown here.

[9] This column shows changes in payments from FY 1999 to FY 2000. It incorporates all of the changes displayed in columns 6 and 7 (the changes displayed in columns 1, 2 and 5 are included in column 6). It also displays the impact of the FY 2000 update, changes in hospitals' reclassification status in FY 2000 compared to FY 1999, the difference in outlier payments from FY 1999 to FY 2000, and the reductions to payments through the IME and DSH adjustments taking effect during FY 2000. The sum of these columns may be different from the percentage changes shown here due to rounding and interactive effects.

B. Impact of the Changes to the DRG Reclassifications and Recalibration of Relative Weights (Column 1)

In column 1 of Table I, we present the combined effects of the DRG reclassifications and recalibration, as discussed in section II of the preamble to this final rule. Section 1886(d)(4)(C)(i) of the Act requires us to annually make appropriate classification changes and to recalibrate the DRG weights in order to reflect changes in treatment patterns, technology, and any other factors that may change the relative use of hospital resources.

We compared aggregate payments using the FY 1999 DRG relative weights (GROUPER version 16) to aggregate payments using the FY 2000 DRG relative weights (GROUPER version 17). Overall payments per case are unchanged due to the DRG reclassifications and recalibration. Consistent with the minor

changes we made in the FY 2000 GROUPER, the redistributional impacts of DRG reclassifications and recalibration across hospital groups are very small (no change for large and other urban hospitals; a 0.2 percent increase for rural hospitals). Within hospital categories, the net effects for urban hospitals are small positive changes for small hospitals (a 0.1 percent increase for hospitals with fewer than 200 beds), and small decreases for larger hospitals (a 0.1 percent decrease for hospitals with more than 500 beds). Among rural hospitals, small hospital categories experience the largest increases, a 0.3 percent increase for hospitals with fewer than 50 beds.

The breakdown by urban census division shows either no impact or a small decrease (0.1 percent), except that payments to urban hospitals in Puerto Rico increase by 0.1 percent. All rural hospital census divisions experience payment increases, which range from 0.1 percent to 0.3 percent for hospitals in the East South Central and West South Central census divisions.

This pattern of payment increases for small hospitals and decreases for larger hospitals persists among other categories. Declines in the relative weights of several specific DRGs likely contribute to this trend. Among these DRGs, the relative weight for DRG 108 (Other Cardiothoracic Procedures), declined from 5.9764 in FY 1999 to 5.7715 in this final rule for FY 2000. Also, the relative weight for DRG 112 (Percutaneous Cardiovascular Procedures) declined from 1.9893 in FY 1999 to 1.9217 in this final rule for FY 2000. Although these cardiovascular procedures are not necessarily limited to very large hospitals, we would expect they are more likely to occur in larger hospitals. As the relative weights of DRGs predominantly occurring in large hospitals decline, the relative weights of other DRGs rise, leading to the small payment increases in hospitals less likely to be affected by the declines in the DRGs noted above.

C. Impact of the Wage Index Floor for Urban Areas (Column 2)

Section 4410(a) of the BBA of 1997 required that the wage indexes for urban hospitals may not be below the Statewide rural wage index for the State in which the urban hospitals are located. The section went on to state that this floor must be implemented in a budget neutral manner, so that total payments after establishing the floor are equal to what they were prior to establishing the floor. We include this impact when we calculate the wage and recalibration budget neutrality factor, as noted in the Addendum to this final rule.

There are 36 MSAs (and 226 hospitals) affected by this provision for FY 2000. The MSAs affected are identified in Table 4A, as indicated in the footnote. The largest impacts among census divisions are increases of 0.2 percent for urban hospitals in New England and the South Atlantic. In New England, several Massachusetts MSAs (including the 63 hospitals in the Boston MSA) receive the rural Massachusetts wage index. Similarly, in the South Atlantic, seven Florida MSAs receive the rural Florida wage index.

D. Impact of Updating the Wage Data (Column 3)

Section 1886(d)(3)(E) of the Act requires that, beginning October 1, 1993, we annually update the wage data used to calculate the wage index. In accordance with this requirement, the wage index for FY 2000 is based on data submitted for hospital cost reporting periods beginning on or after October 1, 1995 and before October 1, 1996. As with the previous column, the impact of the new data on hospital payments is isolated by holding the other payment parameters constant in the two simulations. That is, column 3 shows the percentage changes in payments when going from a model using the FY 1999 wage index (effective for discharges on or after March 1, 1999 (64 FR 9378)) based on FY 1995 wage data before geographic reclassifications including the application of the rural floor to a model using the FY 2000 prereclassification wage index based on FY 1996 wage data.

The wage data collected on the FY 1996 cost reports are similar to the data used in the calculation of the FY 1999 wage index. For example, the wage index values used here include all physician Part A costs (direct and contracted), resident costs, and CRNA costs. Also, as in the calculation for the FY 1999 wage index, contract labor costs and hours for top management positions are included, and the overhead costs allocated to patient care areas excluded from the calculation of the wage index are excluded as well.

The results indicate that the new wage data have an overall impact of a 0.1 percent increase in hospital payments (prior to applying the budget neutrality factor, see column 6). Rural hospitals especially appear to benefit from the update. Their payments increase by 0.4 percent. Rural Arizona experiences an increase of nearly 7 percent in the prereclassification wage index values due to new data.

Urban hospitals as a group are not significantly affected by the updated wage data. Urban West South Central hospitals experience a 0.6 percent decrease. Meanwhile, the urban New England census division experiences a 0.6 percent increase, and urban East South Central payments per case increase 0.5 percent due to the update to the wage data.

The largest increases are seen in the rural census divisions. Rural Puerto Rico experiences the greatest positive impact, 1.8 percent. Hospitals in three other rural census divisions receive relatively large positive impacts: South Atlantic at 1.0 percent, East South Central at 0.7 percent, and West North Central at 0.8 percent.

E. Impact of Removing Teaching Physicians' Part A, Residents', and CRNAs' Costs (Column 4)

As discussed in section III.C of the preamble, we are revising the calculation of the wage index by phasing out the costs and hours associated with teaching physicians Part A, residents, and CRNAs. Although the FY 2000 wage index is based upon a blend of 20 percent of hospitals' average hourly wages after removing these costs and 80 percent of average hourly wages calculated without removing these costs, this column displays the impacts on payments per case of completely removing these costs from the wage index calculation.

As described above in section III.C.1 of the preamble, we determined teaching physician costs by first subtracting the costs and hours attributable to teaching physicians based upon the special survey data we collected for this purpose. If these data were not available from the survey for a particular teaching hospital, 80 percent of the total physician Part A costs and hours for that hospital were removed, consistent with the recommendation of the hospital industry (see discussion in section III.C.1 of the preamble). If a teaching hospital did not separately report its physician Part A costs on the cost report, the amount reported on Line 23, Column 1, of the Worksheet A was removed from the total wage data (as was an associated amount for hours). Resident and CRNA costs and hours were removed in their entirety, based upon the data separately attributed to these employees on the Worksheet S–3.

Column 4 shows the payment impacts of completely removing these costs, relative to wage index values calculated based on the FY 1996 wage data without removing these costs. The overall payment impact of completely removing these costs and hours from the wage index calculation would be a 0.4 percent increase in total payments (prior to applying budget neutrality). The FY 2000 wage index is, however, based on a blended average hourly wage. The impacts of this blended approach are shown in column 5.

The impacts of removing these costs from the wage index calculation are generally positive across the majority of hospital categories, with negative impacts concentrated in particular groups. Examining the impacts across urban and rural census divisions indicate that urban Middle Atlantic hospitals experience a 0.5 percent decrease. This effect is attributable to the concentration of teaching hospitals in this census division. The largest positive impacts occur in the urban South Atlantic and the Pacific census divisions, with 0.9 percent payment increases.

F. Impact of 5-Year Phase-Out of Teaching Physicians', Residents', and CRNAs' Costs (Column 5)

As described above in section III.E of this final rule, the FY 2000 wage index is calculated by blending 80 percent of hospitals' average hourly wages calculated without removing teaching physician Part A, residents, or CRNA costs (and hours), and 20 percent of average hourly wages calculated after removing these costs (and hours). This constitutes the first year of a 5-year phase-out of these costs, where the proportion of the calculation based upon average hourly wages after removing these costs increases by 20 percentage points per year.

This column shows the impact of the blended wage index relative to a wage index using FY 1996 wage data without removing costs or hours of Part A teaching physicians, residents, or CRNAs. As expected, the hospital categories experiencing significant payment impacts in column 4 are mitigated

considerably by the blend. The impact is 0.1 percent for all hospitals and for urban hospitals as a category, while for rural hospitals it is 0.5 percent.

The impacts in this column illustrate that, for the FY 2000 wage index, replacing hospitals' FY 1995 wage data with FY 1996 wage data has a much greater impact on the final wage indexes than the removal of GME and CRNA costs. The urban West South Central census division loses 0.6 percent from the new wage data, and gains 0.4 percent from the removal of GME and CRNA costs, but the impact of the blended wage index is a 0.5 decrease relative to last year's wage index.

The following chart compares the shifts in wage index values for labor market areas for FY 2000 relative to FY 1999. This chart demonstrates the impact of the changes for the FY 2000 wage index relative to the FY 1999 wage index. The majority of labor market areas (318) experience less than a 5-percent change. A total of 30 labor market areas experience an increase of more than 5 percent, with 8 having an increase greater than 10 percent. A total of 22 areas experience decreases of more than 5 percent. Of those, 5 decline by 10 percent or more.

Percentage change in area wage index values	Number of labor market areas	
	FY 1999	FY 2000
Increase more than 10 percent	9	8
Increase more than 5 percent and less than 10 percent	29	22
Increase or decrease less than 5 percent	305	318
Decrease more than 5 percent and less than 10 percent	28	17
Decrease more than 10 percent	0	5

Among urban hospitals, 112 would experience an increase of between 5 and 10 percent and 21 more than 10 percent. A total of 13 rural hospitals have increases greater than 5 percent, but none greater than 10 percent. On the negative side, 121 urban hospitals but no rural hospitals have decreases in their wage index values of at least 5 percent but less than 10 percent. There also are no rural hospitals with decreases greater than 10 percent. However, there are 18 urban hospitals in this category. The following chart shows the projected impact for urban and rural hospitals.

Percentage change in area wage index values	Number of hospitals	
	Urban	Rural
Increase more than 10 percent	21	0
Increase more than 5 percent and less than 10 percent	112	13
Increase or decrease less than 5 percent	2587	2051
Decrease more than 5 percent and less than 10 percent	121	0
Decrease more than 10 percent	18	0

G. Combined Impact of DRG and Wage Index Changes—Including Budget Neutrality Adjustment (Column 6)

The impact of DRG reclassifications and recalibration on aggregate payments is required by section 1886(d)(4)(C)(iii) of the Act to be budget neutral. In addition, section 1886(d)(3)(E) of the Act specifies that any updates or adjustments to the wage index are to be budget neutral. As noted in the Addendum to this final rule, we compared simulated aggregate payments using the FY 1999 DRG relative weights and wage index (prior to application of the rural floor) to simulated aggregate payments using the FY 2000 DRG relative weights and blended wage index, after applying the rural floor. Based on this comparison, we computed a wage and recalibration budget neutrality factor of 0.997808. In Table I, the combined overall impacts of the effects of both the DRG reclassifications and recalibration and the updated wage index are shown in column 6. The 0.0 percent impact for All Hospitals demonstrates that these changes, in combination with the budget neutrality factor, are budget neutral.

For the most part, the changes in this column are the sum of the changes in columns 1, 2, and 5, minus approximately 0.2 percent attributable to the budget neutrality factor. There may be some variation of plus or minus 0.1 percent due to rounding.

H. Impact of MGCRB Reclassifications (Column 7)

Our impact analysis to this point has assumed hospitals are paid on the basis of their actual geographic location (with the exception of ongoing policies that provide that certain hospitals receive payments on bases other than where they are geographically located, such as hospitals in rural counties that are deemed urban under section 1886(d)(8)(B) of the Act). The changes in column 7 reflect the per case payment impact of moving from this baseline to a simulation incorporating the MGCRB decisions for FY 2000. As noted below, these decisions affect hospitals' standardized amount and wage index area assignments. In addition, rural hospitals reclassified for purposes of the standardized amount qualify to be treated as urban for purposes of the DSH adjustment.

Beginning in 1998, by February 28 of each year, the MGCRB makes reclassification determinations that will be effective for the next fiscal year, which begins on October 1. (In previous years, these determinations were made by March 30.) The MGCRB may approve a hospital's reclassification request for the purpose of using the other area's standardized amount, wage index value, or both, or for FYs 1999 through 2001, for purposes of qualifying for a DSH adjustment or to receive a higher DSH payment.

The FY 2000 wage index values incorporate all of the MGCRB's reclassification decisions for FY 2000. The wage index values also reflect any decisions made by the HCFA Administrator through the appeals and review process. Additional changes that resulted from the Administrator's review of MGCRB decisions or a request by a hospital to withdraw its application are reflected in this final rule.

The overall effect of geographic reclassification is required by section 1886(d)(8)(D) of the Act to be budget neutral. Therefore, we applied an adjustment of 0.993799 to ensure that the effects of reclassification are budget neutral. (See section II.A.4.b. of the Addendum to this final rule.)

As a group, rural hospitals benefit from geographic reclassification. Their payments rise 2.6 percent, while payments to urban hospitals decline 0.4 percent. Among urban hospital groups (that is, bed size, census division, and special payment status), payments generally decline.

A positive impact is evident among all rural hospital groups. The smallest increases among the rural census divisions is 1.6 percent for Puerto Rico and 1.8 percent for Mountain. The largest increase is in rural West South Central, with an increase of 3.5 percent.

Among rural hospitals designated as RRCs, 128 hospitals are reclassified for purposes of the wage index only, leading to the 5.7 percent increase in payments among RRCs overall. This positive impact on RRCs is also reflected in the category of rural hospitals with 200 or more beds, which has a 4.8 percent increase in payments.

Rural hospitals reclassified for FY 1999 and FY 2000 experience a 6.6 percent increase in payments. This may be due to the fact that these hospitals have the most to gain from reclassification and have been reclassified for a period of years. Rural hospitals reclassified for FY 2000 but not FY 1999 experience a 5.7 percent increase in payments, while rural hospitals reclassified for FY 1999 but not FY 2000 experience a 0.5 percent decrease in payments. Urban hospitals reclassified for FY 1999 but not FY 2000 experience a 0.5 percent decline in payments overall. Urban hospitals reclassified for FY 2000 but not for FY 1999 experience a 3.3 percent increase in payments.

The FY 2000 Reclassification rows of Table I show the changes in payments per case for all FY 2000 reclassified and nonreclassified hospitals in urban and rural locations for each of the three reclassification categories (standardized amount only, wage index only, or both). The table illustrates that the largest impact for reclassified rural hospitals is for those hospitals reclassified for both the standardized amount and the wage index. These hospitals receive an 11.6 percent increase in payments. In addition, rural hospitals reclassified just for the wage index receive a 6.3 percent payment increase. The overall impact on reclassified hospitals is to increase their payments per case by an average of 5.6 percent for FY 2000.

The reclassification of hospitals primarily affects payment to nonreclassified hospitals through changes in the wage index and the geographic reclassification budget neutrality adjustment required by section 1886(d)(8)(D) of the Act. Among hospitals that are not reclassified, the overall impact of hospital reclassifications is an average decrease in payments per case of about 0.6 percent. Rural nonreclassified hospitals decrease by 0.4 percent, and urban nonreclassified hospitals lose 0.6 percent (the amount of the budget neutrality offset).

I. All Changes (Column 8)

Column 8 compares our estimate of payments per case, incorporating all changes reflected in this final rule for FY 2000 (including statutory changes), to our estimate of payments per case in FY 1999. It includes the effects of the 1.1 percent update to the standardized amounts and the hospital-specific rates for SCHs and MDHs. It also reflects the 1.2 percentage point difference between the projected outlier payments in FY 2000 (5.1 percent of total DRG payments) and the current estimate of the percentage of actual outlier payments in FY 1999 (6.3 percent), as described in the introduction to this Appendix and the Addendum to this final rule.

Additional changes affecting the difference between FY 1999 and FY 2000 payments are the reductions to the IME and DSH adjustments enacted by the BBA of 1997. These changes initially went into effect during FY 1998 and include additional decreases in payment for each of several succeeding years. As noted in the introduction to this impact analysis, for FY 2000, IME is reduced to approximately a 6.0 percent rate of increase, and DSH is reduced by 3 percent from what hospitals otherwise would have received. We estimate the overall effect of these statutory changes to be a 0.5 percent reduction in FY 2000 payments. For hospitals receiving both IME and DSH, the impact is estimated to be a 0.8 percent reduction in payments per case.

We also note that column 8 includes the impacts of FY 2000 MGCRB reclassifications compared to the payment impacts of FY 1999 reclassifications. Therefore, when comparing FY 2000 payments to FY 1999, the percent changes due to FY 2000 reclassifications shown in column 7 need to be offset by the effects of reclassification on hospitals' FY 1999 payments (column 7 of Table 1, July 31, 1998 final rule (63 FR 41106)). For example, the impact of MGCRB reclassifications on rural hospitals' FY 1999 payments was approximately a 2.7 percent increase, more than offsetting the 2.6 percent increase in column 7 for FY 2000. Therefore, the net change in FY 2000 payments due to reclassification for rural hospitals is actually a decrease of 0.1 percent relative to FY 1999. However, last year's analysis contained a somewhat different set of hospitals, so this might affect the numbers slightly.

There might also be interactive effects among the various factors comprising the payment system that we are not able to isolate. For these reasons, the values in column 8 may not equal the sum of the changes in columns 6 and 7, plus the other impacts that we are able to identify.

The overall payment change from FY 1999 to FY 2000 for all hospitals is a 0.5 percent decrease. This reflects the 1.1 percent update for FY 2000, the 1.2 percent lower outlier payments in FY 2000 compared to FY 1999 (5.1 percent compared to 6.3 percent); and the 0.5 percent reduction due to lower IME and DSH payments.

Hospitals in urban areas experience a 0.7 percent drop in payments per case compared to FY 1999. The 0.4 percent negative impact due to reclassification is offset by an identical negative impact for FY 1999. The impact of reducing IME and DSH is a 0.6 percent reduction in FY 2000 payments per case. Payment to hospitals in large urban areas are expected to fall 0.8 percent per case compared to 0.5 percent per case for hospitals in other urban areas.

Hospitals in rural areas, meanwhile, experience a 1.0 percent payment increase. As discussed above, this is primarily due to the positive effect of the wage index and DRG changes (0.5 percent increase).

Among census divisions, urban Middle Atlantic displays the largest negative impact (−1.4 percent), followed by the West South Central (−1.1 percent decrease in payments). In the case of hospitals in the urban Middle Atlantic census division, these decreases are related to changes to the wage index, plus a greater impact of the IME and DSH payment reductions and the decline in estimated outlier payments. In the case of the urban West South Central census division, the decline is largely related to changes in the wage index. East South Central and Puerto Rico are the only urban categories grouped by census division not exhibiting decreases in payments per case for FY 2000.

No rural census division experiences a negative payment impact, although payments to rural hospitals in the Pacific census division are unchanged from FY 1999. The largest increases by rural hospitals are in Puerto Rico at 2.4 percent. Among rural census divisions, the largest increases are in the East South Central and West North Central, with 1.6 percent and 1.5 percent increases in their FY 2000 payments per case, respectively. As with the other impacts discussed above, this is generally due to updating the wage data. One rural census division that did not experience an increase in payments as large as suggested by the positive impact of updating the wage data was the South Atlantic. This census division experienced a 3.8 percent payment increase due to geographic reclassification in FY 1999, but the effect of geographic reclassification in FY 2000 was only 3.0 percent.

Among special categories of rural hospitals, those hospitals receiving payment under the hospital-specific methodology (SCHs, MDHs, and SCH/RRCs) experience payment increases of 1.4 percent, 1.2 percent, and 1.4 percent, respectively. This outcome is primarily related to the fact that, for hospitals receiving payments under the hospital-specific methodology, there are no outlier payments. Therefore, these hospitals do not experience negative payment impacts from the decline in outlier payments from FY 1999 to FY 2000 (from 6.3 of total DRG plus outlier payments to the projected 5.1 percent) as do hospitals paid based on the national standardized amounts.

The largest negative payment impacts from FY 1999 to FY 2000 are among hospitals that were reclassified for FY 1999 and are not reclassified for FY 2000. Overall, these hospitals lose 3.9 percent. The urban hospitals in this category lose 3.7 percent, while the rural hospitals lose 4.2 percent. On the other hand, hospitals reclassified for FY 2000 that were not reclassified for FY 1999 would experience the greatest payment increases: 4.7 percent overall; 7.0 percent for 101 rural hospitals in this category and 2.7 percent for 26 urban hospitals.

TABLE II.—IMPACT ANALYSIS OF CHANGES FOR FY 2000 OPERATING PROSPECTIVE PAYMENT SYSTEM

[Payments per case]

	Number of hospitals (1)	Average FY 1999 payment per case (2) [1]	Average FY 2000 payment per case (3) [1]	All changes (4)
(BY GEOGRAPHIC LOCATION)				
ALL HOSPITALS	4,922	6,779	6,747	−0.5
URBAN HOSPITALS	2,782	7,344	7,293	−0.7
LARGE URBAN AREAS	1,584	7,881	7,815	−0.8
OTHER URBAN AREAS	1,198	6,620	6,590	−0.5
RURAL HOSPITALS	2,140	4,493	4,540	1.0
BED SIZE (URBAN):				
0–99 BEDS	727	4,969	4,958	−0.2
100–199 BEDS	938	6,150	6,141	−0.1
200–299 BEDS	553	7,012	6,977	−0.5
300–499 BEDS	422	7,819	7,764	−0.7
500 OR MORE BEDS	142	9,882	9,726	−1.6
BED SIZE (RURAL):				
0–49 BEDS	1,194	3,720	3,771	1.4
50–99 BEDS	570	4,225	4,274	1.2
100–149 BEDS	223	4,584	4,638	1.2
150–199 BEDS	87	4,962	5,019	1.2
200 OR MORE BEDS	65	5,734	5,749	0.3
URBAN BY CENSUS DIVISION:				
NEW ENGLAND	149	7,757	7,739	−0.2
MIDDLE ATLANTIC	421	8,278	8,162	−1.4
SOUTH ATLANTIC	407	6,970	6,954	−0.2
EAST NORTH CENTRAL	467	6,991	6,960	−0.4
EAST SOUTH CENTRAL	165	6,574	6,572	0.0
WEST NORTH CENTRAL	190	7,099	7,043	−0.8
WEST SOUTH CENTRAL	353	6,785	6,709	−1.1
MOUNTAIN	134	7,014	6,983	−0.5
PACIFIC	449	8,451	8,382	−0.8
PUERTO RICO	47	3,115	3,120	0.2
RURAL BY CENSUS DIVISION:				
NEW ENGLAND	52	5,354	5,383	0.5
MIDDLE ATLANTIC	79	4,858	4,892	0.7
SOUTH ATLANTIC	280	4,660	4,702	0.9
EAST NORTH CENTRAL	283	4,562	4,608	1.0
EAST SOUTH CENTRAL	267	4,138	4,203	1.6
WEST NORTH CENTRAL	492	4,282	4,348	1.5
WEST SOUTH CENTRAL	341	3,997	4,031	0.9
MOUNTAIN	201	4,763	4,825	1.3
PACIFIC	140	5,566	5,567	0.0
PUERTO RICO	5	2,327	2,383	2.4
(BY PAYMENT CATEGORIES)				
URBAN HOSPITALS	2,858	7,309	7,259	−0.7
LARGE URBAN	1,662	7,807	7,740	−0.9
OTHER URBAN	1,197	6,609	6,582	−0.4
RURAL HOSPITALS	2,064	4,468	4,516	1.1
TEACHING STATUS:				
NON-TEACHING	3,809	5,462	5,471	0.2
FEWER THAN 100 RESIDENTS	871	7,173	7,130	−0.6
100 OR MORE RESIDENTS	242	10,898	10,737	−1.5
DISPROPORTIONATE SHARE HOSPITALS (DSH):				
NON-DSH	3,069	5,800	5,787	−0.2
URBAN DSH:				
100 BEDS OR MORE	1,387	7,959	7,899	−0.8
FEWER THAN 100 BEDS	89	5,099	5,105	0.1
RURAL DSH:				
SOLE COMMUNITY (SCH)	158	4,190	4,277	2.1
REFERRAL CENTERS (RRC)	60	5,310	5,371	1.2
OTHER RURAL DSH HOSPITALS:				
100 BEDS OR MORE	49	4,051	4,094	1.1
FEWER THAN 100 BEDS	110	3,589	3,660	2.0
URBAN TEACHING AND DSH:				
BOTH TEACHING AND DSH	716	8,922	8,827	−1.1
TEACHING AND NO DSH	331	7,318	7,256	−0.8
NO TEACHING AND DSH	760	6,331	6,329	0.0
NO TEACHING AND NO DSH	1,052	5,641	5,624	−0.3

TABLE II.—IMPACT ANALYSIS OF CHANGES FOR FY 2000 OPERATING PROSPECTIVE PAYMENT SYSTEM—Continued

[Payments per case]

	Number of hospitals (1)	Average FY 1999 payment per case (2) [1]	Average FY 2000 payment per case (3) [1]	All changes (4)
RURAL HOSPITAL TYPES:				
NONSPECIAL STATUS HOSPITALS	851	3,911	3,956	1.2
RRC	154	5,198	5,230	0.6
SCH	647	4,462	4,523	1.4
MDH	355	3,758	3,803	1.2
SCH AND RRC	57	5,374	5,446	1.4
TYPE OF OWNERSHIP:				
VOLUNTARY	2,831	6,957	6,920	−0.5
PROPRIETARY	752	6,187	6,171	−0.2
GOVERNMENT	1,259	6,295	6,279	−0.3
UNKNOWN	80	9,713	9,575	−1.4
MEDICARE UTILIZATION AS A PERCENT OF INPATIENT DAYS:				
0–25	386	8,790	8,678	−1.3
25–50	1,775	7,908	7,845	−0.8
50–65	1,893	5,998	5,992	−0.1
OVER 65	786	5,273	5,276	0.1
UNKNOWN	82	9,711	9,573	−1.4
HOSPITALS RECLASSIFIED BY THE MEDICARE GEOGRAPHIC REVIEW BOARD				
RECLASSIFICATION STATUS DURING FY 1999 AND FY 2000:				
RECLASSIFIED DURING BOTH FY 1999 AND FY 2000	370	5,823	5,826	0.0
URBAN	57	7,961	7,853	−1.4
RURAL	313	5,185	5,220	0.7
RECLASSIFIED DURING FY 2000 ONLY	127	5,580	5,840	4.7
URBAN	26	7,182	7,377	2.7
RURAL	101	4,385	4,693	7.0
RECLASSIFIED DURING FY 1999 ONLY	188	5,597	5,378	−3.9
URBAN	100	6,389	6,151	−3.7
RURAL	88	4,574	4,382	−4.2
FY 2000 RECLASSIFICATIONS:				
ALL RECLASSIFIED HOSPITALS	498	5,776	5,828	0.9
STANDARDIZED AMOUNT ONLY	66	4,768	4,701	−1.4
WAGE INDEX ONLY	386	5,822	5,900	1.3
BOTH	46	6,255	6,223	−0.5
NONRECLASSIFIED	4,398	6,910	6,867	−0.6
ALL URBAN RECLASSIFIED	83	7,717	7,704	−0.2
STANDARDIZED AMOUNT ONLY	13	5,279	5,047	−4.4
WAGE INDEX ONLY	47	8,415	8,464	0.6
BOTH	23	6,992	6,912	−1.1
NONRECLASSIFIED	2,673	7,342	7,289	−0.7
ALL RURAL RECLASSIFIED	416	5,062	5,139	1.5
STANDARDIZED AMOUNT ONLY	53	4,473	4,501	0.6
WAGE INDEX ONLY	339	5,089	5,175	1.7
BOTH	23	5,384	5,409	0.5
NONRECLASSIFIED	1,725	4,113	4,140	0.6
OTHER RECLASSIFIED HOSPITALS (SECTION 1886(d)(8)(B))	26	4,663	4,813	3.2

[1] These payment amounts per case do not reflect any estimates of annual case-mix increase.

Table II presents the projected impact of the changes for FY 2000 for urban and rural hospitals and for the different categories of hospitals shown in Table I. It compares the projected payments per case for FY 2000 with the average estimated per case payments for FY 1999, as calculated under our models. Thus, this table presents, in terms of the average dollar amounts paid per discharge, the combined effects of the changes presented in Table I. The percentage changes shown in the last column of Table II equal the percentage changes in average payments from column 8 of Table I.

VII. Impact of Changes in the Capital Prospective Payment System

A. General Considerations

We now have cost report data for the 6th year of the capital prospective payment system (cost reports beginning in FY 1997) available through the March 1999 update of the Health Care Provider Cost Report Information System (HCRIS). We also have updated information on the projected aggregate amount of obligated capital approved by the fiscal intermediaries. However, our impact analysis of payment changes for capital-related costs is still limited by the lack of hospital-specific data on several items: the hospital's projected new capital costs for each year, its projected old capital costs for each year, and the actual amounts of obligated capital that will be put in use for patient care and recognized as Medicare old capital costs in each year. The lack of this information affects our impact analysis in the following ways:

- Major investment in hospital capital assets (for example, in building and major fixed equipment) occurs at irregular intervals. As a result, there can be significant variation in the growth rates of Medicare capital-related costs per case among hospitals. We do not have the necessary hospital-specific budget data to project the

hospital capital growth rate for individual hospitals.

• Our policy of recognizing certain obligated capital as old capital makes it difficult to project future capital-related costs for individual hospitals. Under § 412.302(c), a hospital is required to notify its fiscal intermediary that it has obligated capital by the later of October 1, 1992, or 90 days after the beginning of the hospital's first cost reporting period under the capital prospective payment system. The fiscal intermediary must then notify the hospital of its determination whether the criteria for recognition of obligated capital have been met by the later of the end of the hospital's first cost reporting period subject to the capital prospective payment system or 9 months after the receipt of the hospital's notification. The amount that is recognized as old capital is limited to the lesser of the actual allowable costs when the asset is put in use for patient care or the estimated costs of the capital expenditure at the time it was obligated. We have substantial information regarding fiscal intermediary determinations of projected aggregate obligated capital amounts. We still do not know, however, when these projects will actually be put into use for patient care, the actual amount that will be recognized as obligated capital when the project is put into use, or the Medicare share of the recognized costs. Therefore, we do not know actual obligated capital commitments for purposes of the FY 2000 capital cost projections. In Appendix B of this final rule, we discuss the assumptions and computations that we employ to generate the amount of obligated capital commitments for use in the FY 2000 capital cost projections.

In Table III of this section, we present the redistributive effects that are expected to occur between ''hold-harmless'' hospitals and ''fully prospective'' hospitals in FY 2000. In addition, we have integrated sufficient hospital-specific information into our actuarial model to project the impact of the FY 2000 capital payment policies by the standard prospective payment system hospital groupings. While we now have actual information on the effects of the transition payment methodology and interim payments under the capital prospective payment system and cost report data for most hospitals, we still need to randomly generate numbers for the change in old capital costs, new capital costs for each year, and obligated amounts that will be put in use for patient care services and recognized as old capital each year. We are unable to predict accurately FY 2000 capital costs for individual hospitals but, with the most recent data hospitals' experience under the capital prospective payment system, there is adequate information to estimate the aggregate impact on most hospital groupings.

B. Projected Impact Based on the FY 2000 Actuarial Model

1. Assumptions

In this impact analysis, we model dynamically the impact of the capital prospective payment system from FY 1999 to FY 2000 using a capital cost model. The FY 2000 model, as described in Appendix B of this final rule, integrates actual data from individual hospitals with randomly generated capital cost amounts. We have capital cost data from cost reports beginning in FY 1989 through FY 1997 as reported on the March 1999 update of HCRIS, interim payment data for hospitals already receiving capital prospective payments through PRICER, and data reported by the intermediaries that include the hospital-specific rate determinations that have been made through April 1, 1999 in the provider-specific file. We used these data to determine the FY 2000 capital rates. However, we do not have individual hospital data on old capital changes, new capital formation, and actual obligated capital costs. We have data on costs for capital in use in FY 1997, and we age that capital by a formula described in Appendix B. Therefore, we need to randomly generate only new capital acquisitions for any year after FY 1997. All Federal rate payment parameters are assigned to the applicable hospital.

For purposes of this impact analysis, the FY 2000 actuarial model includes the following assumptions:

• Medicare inpatient capital costs per discharge will change at the following rates during these periods:

AVERAGE PERCENTAGE CHANGE IN CAPITAL COSTS PER DISCHARGE

Fiscal year	Percentage change
1998	0.37
1999	1.00
2000	1.00

• The Medicare case-mix index will decrease by 0.5 percent in FY 1999 and increase by 0.5 percent in FY 2000.

• The Federal capital rate and hospital-specific rate were updated in FY 1996 by an analytical framework that considers changes in the prices associated with capital-related costs, and adjustments to account for forecast error, changes in the case-mix index, allowable changes in intensity, and other factors. The FY 2000 update is 0.3 percent (see section IV of the Addendum to this final rule).

2. Results

We have used the actuarial model to estimate the change in payment for capital-related costs from FY 1999 to FY 2000. Table III shows the effect of the capital prospective payment system on low capital cost hospitals and high capital cost hospitals. We consider a hospital to be a low capital cost hospital if, based on a comparison of its initial hospital-specific rate and the applicable Federal rate, it will be paid under the fully prospective payment methodology. A high capital cost hospital is a hospital that, based on its initial hospital-specific rate and the applicable Federal rate, will be paid under the hold-harmless payment methodology. Based on our actuarial model, the breakdown of hospitals is as follows:

CAPITAL TRANSITION PAYMENT METHODOLOGY FOR FY 2000

Type of hospital	Percent of hospitals	Percent of discharges	Percent of capital costs	Percent of capital payments
Low Cost Hospital	66	61	53	59
High Cost Hospital	34	39	47	41

A low capital cost hospital may request to have its hospital-specific rate redetermined based on old capital costs in the current year, through the later of the hospital's cost reporting period beginning in FY 1994 or the first cost reporting period beginning after obligated capital comes into use (within the limits established in § 412.302(e) for putting obligated capital into use for patient care). If the redetermined hospital-specific rate is greater than the adjusted Federal rate, these hospitals will be paid under the hold-harmless payment methodology. Regardless of whether the hospital became a hold-harmless payment hospital as a result of a redetermination, we continue to show these hospitals as low capital cost hospitals in Table III.

Assuming no behavioral changes in capital expenditures, Table III displays the percentage change in payments from FY 1999 to FY 2000 using the above described actuarial model. With the Federal rate, we estimate aggregate Medicare capital payments will increase by 3.64 percent in FY 2000.

TABLE III.—IMPACT OF FINAL CHANGES FOR FY 2000 ON PAYMENTS PER DISCHARGE

	Number of hospitals	Discharges	Adjusted federal payment	Average federal percent	Hospital specific payment	Hold harmless payment	Exceptions payment	Total payment	Percent change over FY 1999
FY 1999 Payments per Discharge:									
Low Cost Hospitals	3,203	6,746,008	$518.19	81.46	$59.00	$3.39	$8.65	$589.23	.....
Fully Prospective	2,983	16,158,921	507.63	80.00	64.62	.....	7.26	579.51	.....
100% Federal Rate	185	517,623	652.10	100.00	.....	.....	5.01	657.11	.....
Hold Harmless	35	69,464	456.70	69.51	.....	329.49	158.88	945.07	.....
High Cost Hospitals	1,640	4,259,861	649.03	97.08	.....	27.20	15.52	691.75	.....
100% Federal Rate	1,425	3,846,137	664.09	100.00	.....	.....	9.25	673.35	.....
Hold Harmless	215	413,723	508.96	71.69	.....	280.11	73.75	862.82	.....
Total Hospitals	4,843	11,005,868	568.83	87.69	36.16	12.61	11.31	628.91	.....
FY 2000 Payments per Discharge:									
Low Cost Hospitals	3,203	6,814,738	$573.54	90.68	$29.43	$2.32	$11.72	$617.01	4.71
Fully Prospective	2,983	6,221,683	568.06	90.00	32.23	.....	8.39	608.68	5.03
100% Federal Rate	190	542,491	643.37	100.00	.....	.....	17.97	661.34	0.64
Hold Harmless	30	50,564	499.44	74.17	.....	312.08	354.68	1,166.20	23.40
High Cost Hospitals	1,640	4,303,107	641.55	97.57	.....	22.65	25.76	689.96	−0.26
100% Federal Rate	1,432	3,901,155	653.77	100.00	.....	.....	15.41	669.18	−0.62
Hold Harmless	208	401,953	522.90	75.31	.....	242.47	126.27	891.65	3.34
Total Hospitals	4,843	11,117,846	599.86	93.41	18.04	10.19	17.16	645.25	2.60

We project that low capital cost hospitals paid under the fully prospective payment methodology will experience an average increase in payments per case of 5.03 percent, and high capital cost hospitals will experience an average decrease of 0.26 percent. These results are due to the change in the blended percentages to the payment system to 90 percent adjusted Federal rate and 10 percent hospital-specific rate.

We project that low capital cost hospitals paid under the hold-harmless payment methodology will experience an average increase in payments per case of 23.40 percent over FY 1999. Because this group of hospitals consists of such a small number of hospitals, when determining the percentage change over FY 2000, a slight change in the number of hospitals in that group (35 hospitals in FY 1999 compared to 30 hospitals in FY 2000) results in a large percentage change. That is, the five hospitals that left this group from FY 1999 to FY 2000 were lower cost hospitals, so that there are fewer hospitals in this group over which to distribute their total capital payments. As a result, the remaining hospitals in this group are projected to receive a larger increase in payments over FY 1999.

For hospitals paid under the fully prospective payment methodology, the Federal rate payment percentage will increase from 80 percent to 90 percent and the hospital-specific rate payment percentage will decrease from 20 to 10 percent in FY 2000. The Federal rate payment percentage for hospitals paid under the hold-harmless payment methodology is based on the hospital's ratio of new capital costs to total capital costs. The average Federal rate payment percentage for high cost hospitals receiving a hold-harmless payment for old capital will increase from 71.69 percent to 75.31 percent. We estimate the percentage of hold-harmless hospitals paid based on 100 percent of the Federal rate will increase from 86.9 percent to 87.3 percent. We estimate that the few remaining high cost hold-harmless hospitals (208) will experience an increase in payments of 3.34 percent from FY 1999 to FY 2000. This estimate differs from our projection (8.38 percent) in the proposed rule; in the proposed rule, we estimated a larger increase in exception payments for these hospitals between FY 1999 and FY 2000 than we are now projecting in this final rule.

We expect that the average hospital-specific rate payment per discharge will decrease from $64.62 in FY 1999 to $32.23 in FY 2000. This is mostly due to the decrease in the hospital-specific rate payment percentage from 20 percent in FY 1999 to 10 percent in FY 2000.

We have made no changes in our exceptions policies for FY 2000. As a result, the minimum payment levels are—

- 90 percent for sole community hospitals;
- 80 percent for urban hospitals with 100 or more beds and a disproportionate share patient percentage of 20.2 percent or more; or
- 70 percent for all other hospitals.

We estimate that exceptions payments will increase from 1.80 percent of total capital payments in FY 1999 to 2.66 percent of payments in FY 2000. The projected distribution of the exception payments is shown in the chart below:

Estimated FY 2000 Exceptions Payments

Type of hospital	Number of hospitals	Percent of exceptions payments
Low Capital Cost	171	42
High Capital Cost	216	58
Total	387	100

C. Cross-Sectional Comparison of Capital Prospective Payment Methodologies.

Table IV presents a cross-sectional summary of hospital groupings by capital prospective payment methodology. This distribution is generated by our actuarial model.

TABLE IV.—DISTRIBUTION BY METHOD OF PAYMENT (HOLD-HARMLESS/FULLY PROSPECTIVE) OF HOSPITALS RECEIVING CAPITAL PAYMENTS (ESTIMATED FOR FY 2000)

	(1) Total No. of hospitals	(2) Hold-harmless		(3) Percentage paid fully prospective rate
		Percentage paid hold-harmless (A)	Percentage paid fully federal (B)	
By Geographic Location:				
All hospitals	4,843	4.9	33.5	61.6
Large urban areas (populations over 1 million)	1,546	5.2	41.1	53.6
Other urban areas (populations of 1 million or fewer)	1,167	6.5	41.0	52.4
Rural areas	2,130	3.8	23.8	72.4
Urban hospitals	2,713	5.8	41.1	53.1

TABLE IV.—DISTRIBUTION BY METHOD OF PAYMENT (HOLD-HARMLESS/FULLY PROSPECTIVE) OF HOSPITALS RECEIVING CAPITAL PAYMENTS (ESTIMATED FOR FY 2000)—Continued

	(1) Total No. of hospitals	(2) Hold-harmless		(3) Percentage paid fully prospective rate
		Percentage paid hold-harmless (A)	Percentage paid fully federal (B)	
0–99 beds	670	7.2	33.3	59.6
100–199 beds	927	7.9	47.6	44.6
200–299 beds	552	4.7	41.8	53.4
300–499 beds	422	1.2	39.3	59.5
500 or more beds	142	3.5	38.0	58.5
Rural hospitals	2,130	3.8	23.8	72.4
0–49 beds	1,187	3.1	17.2	79.7
50–99 beds	568	5.1	28.7	66.2
100–149 beds	223	6.3	36.3	57.4
150–199 beds	87	0.0	32.2	67.8
200 or more beds	65	1.5	47.7	50.8
By Region:				
Urban by Region	2,713	5.8	41.1	53.1
New England	148	1.4	27.7	70.9
Middle Atlantic	415	4.1	34.9	61.0
South Atlantic	402	5.7	52.5	41.8
East North Central	463	5.4	31.5	63.1
East South Central	158	9.5	48.1	42.4
West North Central	181	4.4	39.2	56.4
West South Central	332	11.7	58.1	30.1
Mountain	124	2.4	53.2	44.4
Pacific	443	5.2	34.8	60.0
Puerto Rico	47	4.3	25.5	70.2
Rural by Region	2,130	3.8	23.8	72.4
New England	52	1.9	23.1	75.0
Middle Atlantic	77	6.5	19.5	74.0
South Atlantic	279	1.4	34.4	64.2
East North Central	282	2.1	20.2	77.7
East South Central	267	3.0	32.6	64.4
West North Central	491	3.3	16.3	80.4
West South Central	338	5.0	26.6	68.3
Mountain	200	8.0	17.5	74.5
Pacific	139	5.8	24.5	69.8
Large urban areas (populations over 1 million)	1,624	5.0	41.1	53.8
Other urban areas (populations of 1 million or fewer)	1,165	6.5	40.6	52.9
Rural areas	2,054	3.9	23.4	72.7
Teaching Status:				
Non-teaching	3,731	5.1	32.9	61.9
Fewer than 100 Residents	870	4.7	36.2	59.1
100 or more Residents	242	2.5	32.2	65.3
Disproportionate share hospitals (DSH):				
Non-DSH	2,997	4.9	29.3	65.8
Urban DSH:				
100 or more beds	1,383	5.0	44.1	50.9
Less than 100 beds	87	8.0	23.0	69.0
Rural DSH:				
Sole Community (SCH/EACH)	158	5.1	22.8	72.2
Referral Center (RRC/EACH)	60	3.3	48.3	48.3
Other Rural:				
100 or more beds	49	4.1	40.8	55.1
Less than 100 beds	109	2.8	25.7	71.6
Urban teaching and DSH:				
Both teaching and DSH	715	3.8	36.9	59.3
Teaching and no DSH	331	5.7	32.3	61.9
No teaching and DSH	755	6.5	48.5	45.0
No teaching and no DSH	988	6.4	40.9	52.7
Rural Hospital Types:				
Non special status hospitals	842	1.9	24.3	73.8
RRC/EACH	154	1.9	42.2	55.8
SCH/EACH	647	7.6	21.0	71.4
Medicare-dependent hospitals (MDH)	354	1.7	16.9	81.4
SCH, RRC and EACH	57	10.5	26.3	63.2
Type of Ownership:				
Voluntary	2,821	4.5	32.9	62.6
Proprietary	732	8.5	57.8	33.7

TABLE IV.—DISTRIBUTION BY METHOD OF PAYMENT (HOLD-HARMLESS/FULLY PROSPECTIVE) OF HOSPITALS RECEIVING CAPITAL PAYMENTS (ESTIMATED FOR FY 2000)—Continued

	(1) Total No. of hospitals	(2) Hold-harmless		(3) Percentage paid fully prospective rate
		Percentage paid hold-harmless (A)	Percentage paid fully federal (B)	
Government	1,257	3.7	21.0	75.3
Medicare Utilization as a Percent of Inpatient Days:				
0–25	375	5.3	28.5	66.1
25–50	1,770	5.2	35.9	58.9
50–65	1,885	4.8	32.6	62.6
Over 65	779	4.4	33.0	62.6

As we explain in Appendix B of this final rule, we were not able to determine a hospital-specific rate for 79 of the 4,922 hospitals in our database. Consequently, the payment methodology distribution is based on 4,843 hospitals. These data should be fully representative of the payment methodologies that will be applicable to hospitals.

The cross-sectional distribution of hospital by payment methodology is presented by: (1) geographic location; (2) region; and (3) payment classification. This provides an indication of the percentage of hospitals within a particular hospital grouping that will be paid under the fully prospective payment methodology and the hold-harmless payment methodology.

The percentage of hospitals paid fully Federal (100 percent of the Federal rate) as hold-harmless hospitals is expected to increase to 33.5 percent in FY 2000.

Table IV indicates that 61.6 percent of hospitals will be paid under the fully prospective payment methodology. (This figure, unlike the figure of 66 percent for low cost capital hospitals in the chart ''Capital Transition Payment Methodology for FY 2000,'' shown previously in section VII.B.2 of this impact analysis, takes into account the effects of redeterminations. In other words, this figure does not include low cost hospitals that, following a hospital-specific rate redetermination, are now paid under the hold-harmless methodology.) As expected, a relatively higher percentage of rural and governmental hospitals (72.4 percent and 75.3 percent, respectively by payment classification) are being paid under the fully prospective payment methodology. This is a reflection of their lower than average capital costs per case. In contrast, only 33.7 percent of proprietary hospitals are being paid under the fully prospective methodology. This is a reflection of their higher than average capital costs per case. (We found, at the time of the August 30, 1991 final rule (56 FR 43430), that 62.7 percent of proprietary hospitals had a capital cost per case above the national average cost per case.)

D. Cross-Sectional Analysis of Changes in Aggregate Payments

We used our FY 2000 actuarial model to estimate the potential impact of our changes for FY 2000 on total capital payments per case, using a universe of 4,843 hospitals. The individual hospital payment parameters are taken from the best available data, including: the April 1, 1999 update to the provider-specific file, cost report data, and audit information supplied by intermediaries. In Table V we present the results of the cross-sectional analysis using the results of our actuarial model and the aggregate impact of the FY 2000 payment policies. Columns 3 and 4 show estimates of payments per case under our model for FY 1999 and FY 2000. Column 5 shows the total percentage change in payments from FY 1999 to FY 2000. Column 6 presents the percentage change in payments that can be attributed to Federal rate changes alone.

Federal rate changes represented in Column 6 include the 0.28 percent decrease in the Federal rate, a 0.5 percent increase in case mix, changes in the adjustments to the Federal rate (for example, the effect of the new hospital wage index on the geographic adjustment factor), and reclassifications by the MGCRB. Column 5 includes the effects of the Federal rate changes represented in Column 6. Column 5 also reflects the effects of all other changes, including the change from 80 percent to 90 percent in the portion of the Federal rate for fully prospective hospitals, the hospital-specific rate update, changes in the proportion of new to total capital for hold-harmless hospitals, changes in old capital (for example, obligated capital put in use), hospital-specific rate redeterminations, and exceptions. The comparisons are provided by: (1) geographic location, (2) region, and (3) payment classification.

The simulation results show that, on average, capital payments per case can be expected to increase 2.6 percent in FY 2000, despite the effect of the 0.9 percent decrease attributable to the reduction in the Federal rate and other factors (which include changes in the adjustment to the Federal rate, the increase in case mix, and the other components of column 6 of table V).

Our comparison by geographic location shows that urban and rural hospitals will experience slightly different rates of increase in capital payments per case (2.5 percent and 3.2 percent, respectively). This is due to the differing impact on urban hospitals relative to rural hospitals (-1.1 percent and 0.2 percent, respectively) from Federal rate changes alone. Urban hospitals will gain approximately the same as rural hospitals (3.6 percent and 3.0 percent, respectively) from the effects of all other changes.

Most regions are estimated to receive increases in total capital payments per case, partly due to the increased share of payments that are based on the Federal rate (from 80 to 90 percent). Changes by region vary from a low of 0.4 percent decrease (West South Central urban region) to a high of 5.2 percent increase (West North Central rural region).

By type of ownership, government hospitals are projected to have the largest rate of increase of total payment changes (3.7 percent, a 4.2 percent increase from the effects of all other changes and a 0.5 percent decrease due to Federal rate changes). Payments to voluntary hospitals will increase 2.7 percent (a 3.6 percent increase from the effects of all other changes and a 0.9 percent decrease due to Federal rate changes), and payments to proprietary hospitals will increase 0.7 percent (a 2.2 percent increase from the effects of all other changes and a 1.5 percent decrease due to Federal rate changes).

Section 1886(d)(10) of the Act established the MGCRB. Hospitals may apply for reclassification for purposes of the standardized amount, wage index, or both, and for purposes of DSH for FYs 1999 through 2001. Although the Federal capital rate is not affected, a hospital's geographic classification for purposes of the operating standardized amount does affect a hospital's capital payments as a result of the large urban adjustment factor and the disproportionate share adjustment for urban hospitals with 100 or more beds. Reclassification for wage index purposes affects the geographic adjustment factor, since that factor is constructed from the hospital wage index.

To present the effects of the hospitals being reclassified for FY 2000 compared to the effects of reclassification for FY 1999, we show the average payment percentage increase for hospitals reclassified in each fiscal year and in total. For FY 2000 reclassifications, we indicate those hospitals reclassified for standardized amount purposes only, for wage index purposes only, and for both purposes. The reclassified groups are compared to all other nonreclassified hospitals. These categories are further identified by urban and rural designation.

Hospitals reclassified for FY 2000 as a whole are projected to experience a 3.7 percent increase in payments (a 3.5 percent increase attributable to the effects of all other changes and a 0.2 percent increase attributable to Federal rate changes). Payments to nonreclassified hospitals will increase less (2.5 percent) than reclassified hospitals (3.7 percent) overall. While payments to reclassified hospitals will increase (0.2 percent) from the Federal rate changes, payments to nonreclassified hospitals will decrease by 1.1 percent from the Federal rate changes. However, they will both gain about the same from the effects of all other changes (3.5 percent compared to 3.6 percent).

TABLE V.—COMPARISON OF TOTAL PAYMENTS PER CASE

[FY 1999 Payments Compared to FY 2000 Payments]

	Number of hospitals	Average FY 1999 Payments/case	Average FY 2000 Payments/case	All changes	Portion attributable to federal rate change
By Geographic Location:					
All hospitals	4,843	629	645	2.6	−0.9
Large urban areas (populations over 1 million)	1,546	729	745	2.2	−1.1
Other urban areas (populations of 1 million or fewer)	1,167	616	634	3.0	−1.0
Rural areas	2,130	418	432	3.2	0.2
Urban hospitals	2,713	681	698	2.5	−1.1
0–99 beds	670	499	506	1.4	−1.0
100–199 beds	927	597	613	2.8	−1.0
200–299 beds	552	649	663	2.2	−1.0
300–499 beds	422	701	723	3.1	−1.0
500 or more beds	142	899	917	2.0	−1.4
Rural hospitals	2,130	418	432	3.2	0.2
0–49 beds	1,187	343	358	4.6	0.6
50–99 beds	568	391	409	4.5	0.3
100–149 beds	223	436	448	2.8	0.3
150–199 beds	87	451	464	2.9	0.0
200 or more beds	65	535	539	0.8	−0.4
By Region:					
Urban by Region	2,713	681	698	2.5	−1.1
New England	148	691	721	4.3	−0.2
Middle Atlantic	415	752	766	1.8	−1.3
South Atlantic	402	665	690	3.8	−0.9
East North Central	463	638	659	3.3	−0.5
East South Central	158	629	643	2.2	−1.1
West North Central	181	669	691	3.4	−1.2
West South Central	332	669	672	0.4	−2.0
Mountain	124	648	660	1.8	−0.8
Pacific	443	755	768	1.7	−1.4
Puerto Rico	47	293	296	1.0	−1.6
Rural by Region	2,130	418	432	3.2	0.2
New England	52	499	516	3.5	0.0
Middle Atlantic	77	441	455	3.1	−0.2
South Atlantic	279	435	445	2.5	−0.1
East North Central	282	427	438	2.6	0.2
East South Central	267	385	398	3.5	0.6
West North Central	491	405	427	5.2	0.8
West South Central	338	375	385	2.5	−0.1
Mountain	200	439	454	3.4	0.4
Pacific	139	495	513	3.6	−0.8
By Payment Classification:					
All hospitals	4,843	629	645	2.6	−0.9
Large urban areas (populations over 1 million)	1,624	722	738	2.2	−1.1
Other urban areas (populations of 1 million or fewer)	1,165	614	633	3.0	−1.0
Rural areas	2,054	415	429	3.3	0.2
Teaching Status:.					
Non-teaching	3,731	524	538	2.7	−0.7
Fewer than 100 Residents	870	661	676	2.3	−1.1
100 or more Residents	242	951	978	2.8	−1.1
Urban DSH:					
100 or more beds	1,383	721	739	2.5	−1.1
Less than 100 beds	87	503	503	0.1	−0.4
Rural DSH:					
Sole Community (SCH/EACH)	158	371	385	3.7	0.8
Referral Center (RRC/EACH)	60	474	484	2.1	0.0
Other Rural:					
100 or more beds	49	378	386	2.1	0.2
Less than 100 beds	109	327	342	4.8	1.2
Urban teaching and DSH:					
Both teaching and DSH	715	794	813	2.4	−1.2
Teaching and no DSH	331	680	699	2.8	−1.1
No teaching and DSH	755	596	613	2.8	−1.0

TABLE V.—COMPARISON OF TOTAL PAYMENTS PER CASE—Continued

[FY 1999 Payments Compared to FY 2000 Payments]

	Number of hospitals	Average FY 1999 Payments/case	Average FY 2000 Payments/case	All changes	Portion attributable to federal rate change
No teaching and no DSH	988	564	577	2.2	−1.0
Rural Hospital Types:					
Non special status hospitals	842	369	382	3.5	0.4
RRC/EACH	154	484	496	2.5	−0.3
SCH/EACH	647	410	427	4.0	0.3
Medicare-dependent hospitals (MDH)	354	344	360	4.6	0.4
SCH, RRC and EACH	57	489	502	2.6	0.5
Hospitals Reclassified by the Medicare Geographic Classification Review Board:					
Reclassification Status During FY99 and FY00:					
Reclassified During Both FY99 and FY00	370	546	563	3.0	−0.7
Reclassified During FY00 Only	127	528	563	6.7	3.6
Reclassified During FY99 Only	146	518	508	−2.0	−4.3
FY00 Reclassifications:					
All Reclassified Hospitals	498	543	563	3.7	0.2
All Nonreclassified Hospitals	4,319	640	656	2.5	−1.1
All Urban Reclassified Hospitals	83	715	745	4.1	−0.7
Urban Nonreclassified Hospitals	2,604	680	697	2.4	−1.1
All Reclassified Rural Hospitals	415	479	496	3.5	0.6
Rural Nonreclassified Hospitals	1,715	377	388	3.0	−0.3
Other Reclassified Hospitals (Section 1886(D)(8)(B))	26	456	470	3.0	1.8
Type of Ownership:					
Voluntary	2,821	643	661	2.7	−0.9
Proprietary	732	625	630	0.7	−1.5
Government	1,257	552	572	3.7	−0.5
Medicare Utilization as a Percent of Inpatient Days:					
0–25	375	762	781	2.4	−1.5
25–50	1,770	724	740	2.2	−1.1
50–65	1,885	567	585	3.1	−0.8

Appendix B: Technical Appendix on the Capital Cost Model and Required Adjustments

Under section 1886(g)(1)(A) of the Act, we set capital prospective payment rates for FY 1992 through FY 1995 so that aggregate prospective payments for capital costs were projected to be 10 percent lower than the amount that would have been payable on a reasonable cost basis for capital-related costs in that year. To implement this requirement, we developed the capital acquisition model to determine the budget neutrality adjustment factor. Even though the budget neutrality requirement expired effective with FY 1996, we must continue to determine the recalibration and geographic reclassification budget neutrality adjustment factor and the reduction in the Federal and hospital-specific rates for exceptions payments. To determine these factors, we must continue to project capital costs and payments.

We used the capital acquisition model from the start of prospective payments for capital costs through FY 1997. We now have 6 years of cost reports under the capital prospective payment system. For FY 1998, we developed a new capital cost model to replace the capital acquisition model. This revised model makes use of the data from these cost reports.

The following cost reports are used in the capital cost model for this final rule: the March 31, 1999 update of the cost reports for PPS–IX (cost reporting periods beginning in FY 1992), PPS–X (cost reporting periods beginning in FY 1993), PPS–XI (cost reporting periods beginning in FY 1994), PPS–XII (cost reporting periods beginning in FY 1995), PPS–XIII (cost reporting periods beginning in FY 1996), and PPS–XIV (cost reporting periods beginning in FY 1997). In addition to model payments, we use the April 1, 1999 update of the provider-specific file and the March 1994 update of the intermediary audit file.

Since hospitals under alternative payment system waivers (that is, hospitals in Maryland) are currently excluded from the capital prospective payment system, we excluded these hospitals from our model.

We developed FY 1992 through FY 1999 hospital-specific rates using the provider-specific file and the intermediary audit file. (We used the cumulative provider-specific file, which includes all updates to each hospital's records, and chose the latest record for each fiscal year.) We checked the consistency between the provider-specific file and the intermediary audit file. We ensured that increases in the hospital-specific rates were at least as large as the published updates (increases) for the hospital-specific rates each year. We were able to match hospitals to the files as shown in the following table:

Source	Number of hospitals
Provider-Specific File Only	145
Provider-Specific and Audit File	4,777
Total	4,922

Of the 4,922 hospitals, 105 had unusable or missing data or had no cost reports available. For 23 of the 105 hospitals, we were unable to determine a hospital-specific rate from the available cost reports. However, there was adequate cost information to determine that these hospitals were paid under the hold-harmless methodology. Since the hospital-specific rate is not used to determine payments for hospitals paid under the hold-harmless methodology, there was sufficient cost report information available to include these 21 hospitals in the analysis. We were able to estimate hospital specific amounts from the PPS–IX cost report data for an additional two hospitals and from the PPS–X cost report data for one more hospital. Hence, we were able to use 26 of the 105 hospitals. We used 4,843 hospitals for the analysis. Seventy-nine hospitals could not be used in the analysis because of insufficient information. These hospitals account for less than 0.3 percent of admissions. Therefore, any effects from the elimination of their cost report data should be minimal.

We analyzed changes in capital-related costs (depreciation, interest, rent, leases, insurance, and taxes) reported in the cost reports. We found a wide variance among

hospitals in the growth of these costs. For hospitals with more than 100 beds, the distribution and mean of these cost increases were different for large changes in bed-size (greater than ±20 percent). We also analyzed changes in the growth in old capital and new capital for cost reports that provided this information. For old capital, we limited the analysis to decreases in old capital. We did this since the opportunity for most hospitals to treat ''obligated'' capital put into service as old capital has expired. Old capital costs should decrease as assets become fully depreciated and as interest costs decrease as the loan is amortized.

The new capital cost model separates the hospitals into three mutually exclusive groups. Hold-harmless hospitals with data on old capital were placed in the first group. Of the remaining hospitals, those hospitals with fewer than 100 beds comprise the second group. The third group consists of all hospitals that did not fit into either of the first two groups. Each of these groups displayed unique patterns of growth in capital costs. We found that the gamma distribution is useful in explaining and describing the patterns of increase in capital costs. A gamma distribution is a statistical distribution that can be used to describe patterns of growth rates, with the greatest proportion of rates being at the low end. We use the gamma distribution to estimate individual hospital rates of increase as follows:

(1) For hold-harmless hospitals, old capital cost changes were fitted to a truncated gamma distribution, that is, a gamma distribution covering only the distribution of cost decreases. New capital cost changes were fitted to the entire gamma distribution, allowing for both decreases and increases.

(2) For hospitals with fewer than 100 beds (small), total capital cost changes were fitted to the gamma distribution, allowing for both decreases and increases.

(3) Other (large) hospitals were further separated into three groups:

- Bed-size decreases over 20 percent (decrease).
- Bed-size increases over 20 percent (increase).
- Other (no change).

Capital cost changes for large hospitals were fitted to gamma distributions for each bed-size change group, allowing for both decreases and increases in capital costs. We analyzed the probability distribution of increases and decreases in bed size for large hospitals. We found the probability somewhat dependent on the prior year change in bed size and factored this dependence into the analysis. Probabilities of bed-size change were determined. Separate sets of probability factors were calculated to reflect the dependence on prior year change in bed size (increase, decrease, and no change).

The gamma distributions were fitted to changes in aggregate capital costs for the entire hospital. We checked the relationship between aggregate costs and Medicare per discharge costs. For large hospitals, there was a small variance, but the variance was larger for small hospitals. Since costs are used only for the hold-harmless methodology and to determine exceptions, we decided to use the gamma distributions fitted to aggregate cost increases for estimating distributions of cost per discharge increases.

Capital costs per discharge calculated from the cost reports were increased by random numbers drawn from the gamma distribution to project costs in future years. Old and new capital were projected separately for hold-harmless hospitals. Aggregate capital per discharge costs were projected for all other hospitals. Because the distribution of increases in capital costs varies with changes in bed size for large hospitals, we first projected changes in bed size for large hospitals before drawing random numbers from the gamma distribution. Bed-size changes were drawn from the uniform distribution with the probabilities dependent on the previous year bed-size change. The gamma distribution has a shape parameter and a scaling parameter. (We used different parameters for each hospital group and for old and new capital.)

We used discharge counts from the cost reports to calculate capital cost per discharge. To estimate total capital costs for FY 1998 (the MedPAR data year) and later, we use the number of discharges from the MEDPAR data. Some hospitals had considerably more discharges in FY 1998 than in the years for which we calculated cost per discharge from the cost report data. Consequently, a hospital with few cost report discharges would have a high capital cost per discharge, since fixed costs would be allocated over only a few discharges. If discharges increase substantially, the cost per discharge would decrease because fixed costs would be allocated over more discharges. If the projection of capital cost per discharge is not adjusted for increases in discharges, the projection of exceptions would be overstated. We address this situation by recalculating the cost per discharge with the MedPAR discharges if the MedPAR discharges exceed the cost report discharges by more than 20 percent. We do not adjust for increases of less than 20 percent because we have not received all of the FY 1998 discharges, and we have removed some discharges from the analysis because they are statistical outliers. This adjustment reduces our estimate of exceptions payments, and consequently, the reduction to the Federal rate for exceptions is smaller. We will continue to monitor our modeling of exceptions payments and make adjustments as needed.

The average national capital cost per discharge generated by this model is the combined average of many randomly generated increases. This average must equal the projected average national capital cost per discharge, which we projected separately (outside this model). We adjusted the shape parameter of the gamma distributions so that the modeled average capital cost per discharge matches our projected capital cost per discharge. The shape parameter for old capital was not adjusted since we are modeling the aging of ''existing'' assets. This model provides a distribution of capital costs among hospitals that is consistent with our aggregate capital projections.

Once each hospital's capital-related costs are generated, the model projects capital payments. We use the actual payment parameters (for example, the case-mix index and the geographic adjustment factor) that are applicable to the specific hospital.

To project capital payments, the model first assigns the applicable payment methodology (fully prospective or hold-harmless) to the hospital as determined from the provider-specific file and the cost reports. The model simulates Federal rate payments using the assigned payment parameters and hospital-specific estimated outlier payments. The case-mix index for a hospital is derived from the FY 1998 MedPAR file using the FY 2000 DRG relative weights included in section VI. of the Addendum to this final rule. The case-mix index is increased each year after FY 1998 based on analysis of past experiences in case-mix increases. Based on analysis of recent case-mix increases, we estimate that case-mix will decrease 0.5 percent in FY 1999. We project that case-mix will increase 0.5 percent in FY 2000. (Since we are using FY 1998 cases for our analysis, the FY 1998 increase in case mix has no effect on projected capital payments.)

Changes in geographic classification and revisions to the hospital wage data used to establish the hospital wage index affect the geographic adjustment factor. Changes in the DRG classification system and the relative weights affect the case-mix index.

Section 412.308(c)(4)(ii) requires that the estimated aggregate payments for the fiscal year, based on the Federal rate after any changes resulting from DRG reclassifications and recalibration and the geographic adjustment factor, equal the estimated aggregate payments based on the Federal rate that would have been made without such changes. For FY 1999, the budget neutrality adjustment factors were 1.00294 for the national rate and 1.00233 for the Puerto Rico rate.

Since we implemented a separate geographic adjustment factor for Puerto Rico, we applied separate budget neutrality adjustments for the national geographic adjustment factor and the Puerto Rico geographic adjustment factor. We applied the same budget neutrality factor for DRG reclassifications and recalibration nationally and for Puerto Rico. Separate adjustments were unnecessary for FY 1998 and earlier since the geographic adjustment factor for Puerto Rico was implemented in 1998.

To determine the factors for FY 2000, we first determined the portions of the Federal national and Puerto Rico rates that would be paid for each hospital in FY 2000 based on its applicable payment methodology. Using our model, we then compared, separately for the national rate and the Puerto Rico rate, estimated aggregate Federal rate payments based on the FY 1999 DRG relative weights and the FY 1999 geographic adjustment factor to estimated aggregate Federal rate payments based on the FY 1999 relative weights and the FY 2000 geographic adjustment factor. In making the comparison, we held the FY 2000 Federal rate portion constant and set the other budget neutrality adjustment factor and the exceptions reduction factor to 1.00. We determined that, to achieve budget neutrality for the changes in the national geographic adjustment factor,

an incremental budget neutrality adjustment of 0.99857 for FY 2000 should be applied to the previous cumulative FY 1999 adjustment of 1.00294, yielding a cumulative adjustment of 1.00151 through FY 2000. For the Puerto Rico geographic adjustment factor, an incremental budget neutrality adjustment of 0.99910 for FY 2000 should be applied to the previous cumulative FY 1999 adjustment of 1.00233, yielding a cumulative adjustment of 1.00143 through FY 2000. We apply these new adjustments, then compare estimated aggregate Federal rate payments based on the FY 1999 DRG relative weights and the FY 2000 geographic adjustment factors to estimated aggregate Federal rate payments based on the FY 2000 DRG relative weights and the FY 2000 geographic adjustment factors. The incremental adjustment for DRG classifications and changes in relative weights would be 0.99991 nationally and for Puerto Rico. The cumulative adjustments for DRG classifications and changes in relative weights and for changes in the geographic adjustment factors through FY 2000 would be 1.00142 nationally, and 1.00134 for Puerto Rico. The following table summarizes the adjustment factors for each fiscal year:

BUDGET NEUTRALITY ADJUSTMENT FOR DRG RECLASSIFICATIONS AND RECALIBRATION AND THE GEOGRAPHIC ADJUSTMENT FACTORS

Fiscal year	National				Puerto Rico			
	Incremental adjustment			Cumulative	Incremental adjustment			Cumulative
	Geographic adjustment factor	DRG reclassifications and recalibration	Combined		Geographic adjustment factor	DRG reclassifications and recalibration	Combined	
1992	.....	.....	.....	1.00000	.....	.....	.....	.....
1993	.....	.....	0.99800	0.99800	.....	.....	.....	.....
1994	.....	.....	1.00531	1.00330	.....	.....	.....	.....
1995	.....	.....	0.99980	1.00310	.....	.....	.....	.....
1996	.....	.....	0.99940	1.00250	.....	.....	.....	.....
1997	.....	.....	0.99873	1.00123	.....	.....	.....	.....
1998	.....	.....	0.99892	1.00015	.....	.....	.....	1.00000
1999	0.99944	1.00335	1.00279	1.00294	0.99898	1.00335	1.00233	1.00233
2000	0.99857	0.99991	0.99848	1.00142	0.99910	0.99991	0.99901	1.00134

The methodology used to determine the recalibration and geographic (DRG/GAF) budget neutrality adjustment factor is similar to that used in establishing budget neutrality adjustments under the prospective payment system for operating costs. One difference is that, under the operating prospective payment system, the budget neutrality adjustments for the effect of geographic reclassifications are determined separately from the effects of other changes in the hospital wage index and the DRG relative weights. Under the capital prospective payment system, there is a single DRG/GAF budget neutrality adjustment factor (the national rate and the Puerto Rico rate are determined separately) for changes in the geographic adjustment factor (including geographic reclassification) and the DRG relative weights. In addition, there is no adjustment for the effects that geographic reclassification has on the other payment parameters, such as the payments for serving low-income patients or the large urban addon payments.

In addition to computing the DRG/GAF budget neutrality adjustment factor, we used the model to simulate total payments under the prospective payment system.

Additional payments under the exceptions process are accounted for through a reduction in the Federal and hospital-specific rates. Therefore, we used the model to calculate the exceptions reduction factor. This exceptions reduction factor ensures that aggregate payments under the capital prospective payment system, including exceptions payments, are projected to equal the aggregate payments that would have been made under the capital prospective payment system without an exceptions process. Since changes in the level of the payment rates change the level of payments under the exceptions process, the exceptions reduction factor must be determined through iteration.

In the August 30, 1991 final rule (56 FR 43517), we indicated that we would publish each year the estimated payment factors generated by the model to determine payments for the next 5 years. The table below provides the actual factors for FYs 1992 through 1999, the final factors for FY 2000, and the estimated factors that would be applicable through FY 2004. We caution that these are estimates for FYs 2001 and later, and are subject to revisions resulting from continued methodological refinements, receipt of additional data, and changes in payment policy. We note that in making these projections, we have assumed that the cumulative national DRG/GAF budget neutrality adjustment factor will remain at 1.00142 (1.00134 for Puerto Rico) for FY 2000 and later because we do not have sufficient information to estimate the change that will occur in the factor for years after FY 2000.

The projections are as follows:

Fiscal year	Update factor	Exceptions reduction factor	Budget neutrality factor	DRG/GAF adjustment factor [1]	Outlier adjustment factor	Federal rate adjustment	Federal rate (after outlier) reduction)
1992	N/A	0.9813	0.9602	.....	.9497	.....	415.59
1993	6.07	.9756	.9162	.9980	.9496	.....	417.29
1994	3.04	.9485	.8947	1.0053	.9454	[2] .9260	378.34
1995	3.44	.9734	.8432	.9998	.9414	.....	376.83
1996	1.20	.9849	N/A	.9994	.9536	[3] .9972	461.96
1997	0.70	.9358	N/A	.9987	.9481	.....	438.92
1998	0.90	.9659	N/A	.9989	.9382	[4] .8222	371.51
1999	0.10	.9783	N/A	1.0028	.9392	.....	378.10
2000	0.30	.9730	N/A	.9985	.9402	.....	377.03
2001	0.50	.9636	N/A	[5] 1.0000	[5] .9402	.....	375.26
2002	0.50	[6] 1.0000	N/A	1.0000	.9402	.....	391.38
2003	0.50	[6] 1.0000	N/A	1.0000	.9402	[4] 1.0255	403.38

Fiscal year	Update factor	Exceptions reduction factor	Budget neutrality factor	DRG/GAF adjustment factor [1]	Outlier adjustment factor	Federal rate adjustment	Federal rate (after outlier) reduction)
2004	0.50	[6] 1.0000	N/A	1.0000	.9402		405.40

[1] Note: The incremental change over the previous year.
[2] Note: OBRA 1993 adjustment.
[3] Note: Adjustment for change in the transfer policy.
[4] Note: Balanced Budget Act of 1997 adjustment.
[5] Note: Future adjustments are, for purposes of this projection, assumed to remain at the same level.
[6] Note: We are unable to estimate exceptions payments for the year under the special exceptions provision (§ 412.348(g) of the regulations) because the regular exceptions provision (§ 412.348(e)) expires.

Appendix C: Recommendation of Update Factors for Operating Cost Rates of Payment for Inpatient Hospital Services

I. Background

Several provisions of the Act address the setting of update factors for inpatient services furnished in FY 2000 by hospitals subject to the prospective payment system and those excluded from the prospective payment system. Section 1886(b)(3)(B)(i)(XV) of the Act sets the FY 2000 percentage increase in the operating cost standardized amounts equal to the rate of increase in the hospital market basket minus 1.8 percent for prospective payment hospitals in all areas. Section 1886(b)(3)(B)(iv) of the Act sets the FY 2000 percentage increase in the hospital-specific rates applicable to sole community and Medicare-dependent, small rural hospitals equal to the rate set forth in section 1886(b)(3)(B)(i) of the Act, that is, the same update factor as all other hospitals subject to the prospective payment system, or the rate of increase in the market basket minus 1.8 percentage points. Under section 1886(b)(3)(B)(ii) of the Act, the FY 2000 percentage increase in the rate of increase limits for hospitals excluded from the prospective payment system ranges from the percentage increase in the excluded hospital market basket to 0 percent, depending on the hospital's costs in relation to its limit for the most recent cost reporting period for which information is available.

In accordance with section 1886(d)(3)(A) of the Act, we are updating the standardized amounts, the hospital-specific rates, and the rate-of-increase limits for hospitals excluded from the prospective payment system as provided in section 1886(b)(3)(B) of the Act. Based on the second quarter 1999 forecast of the FY 2000 market basket increase of 2.9 percent for hospitals subject to the prospective payment system, the updates in the standardized amounts are 1.1 percent for hospitals in both large urban and other areas. The update in the hospital-specific rate applicable to sole community and Medicare-dependent, small rural hospitals is also 1.1 percent. The update for hospitals excluded from the prospective payment system can be as high as the percentage increase in the excluded hospital market basket (currently estimated at 2.9 percent) or as low as zero, depending on the hospital's costs in relation to its rate-of-increase limit. (See Section V of the Addendum to this final rule.)

Section 1886(e)(4) of the Act requires that the Secretary, taking into consideration the recommendations of the Medicare Payment Advisory Commission (MedPAC), recommend update factors for each fiscal year that take into account the amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality. In its March 1, 1999 report, MedPAC stated that the legislated update of market basket increase minus 1.8 percentage points would provide a reasonable level of payment to hospitals. Although MedPAC suggests that a somewhat lower update could be justified in light of changes in the utilization and provision of hospital inpatient care, the Commission does not believe it is necessary to recommend a lower update for FY 2000. MedPAC did not make a separate recommendation for the hospital-specific rates applicable to sole community and Medicare-dependent, small rural hospitals.

Under section 1886(e)(5) of the Act, we are required to publish the update factors recommended under section 1886(e)(4) of the Act. Accordingly, we published the FY 2000 update factors recommended by the Secretary as Appendix D of the May 7, 1999 proposed rule (64 FR 24852).

Under section 1886(e)(4) of the Act, we recommended that an appropriate update factor for the standardized amounts was 0.0 percentage points for hospitals located in large urban and other areas. We also recommended an update of 0.0 percentage points to the hospital-specific rate for sole community hospitals and Medicare-dependent, small rural hospitals. These figures are consistent with the President's FY 2000 budget recommendations. We stated that we believe our recommended update factors would ensure that Medicare acts as a prudent purchaser and provide incentives to hospitals for increased efficiency, thereby contributing to the solvency of the Medicare Part A Trust Fund.

In the proposed rule, we recommended that hospitals excluded from the prospective payment system receive an update of between 0 and 2.6 percentage points. The recommended update for excluded hospitals and units was equal to the increase in the excluded hospital operating market basket less a percentage between 0 and 2.5 percentage points, or 0 percentage points, depending on the hospital's or unit's costs in relation to its rate-of-increase limit. For the proposed rule, the market basket rate of increase was forecast at 2.6 percent. This recommendation was consistent with the President's FY 2000 budget, although we noted that the market basket rate of increase was forecast at 2.7 percent when the budget was submitted.

II. Secretary's Final Recommendations for Updating the Prospective Payment System Standardized Amounts

We received seven comments concerning our proposed recommendations, two of which commented directly on the update recommendation. Our final recommendations for the operating update for both prospective and excluded hospitals do not differ from the proposed. However, the second quarter forecast of the market basket percentage increase is 2.9 for prospective payment hospitals (up from 2.7 estimated in the proposed rule) and 2.9 for excluded hospitals and units (up from 2.6 estimated in the proposed rule).

Comment: Several commenters expressed support for our proposal to update hospital payment rates on October 1, 1999, rather than delaying the update because of concerns about ''Year 2000'' (Y2K) systems issues. One commenter, while acknowledging that we are required to use the factors set in current law to update payment rates, expressed concern that an update to the rates less than the full market basket rate of increase is inadequate, forcing hospitals to forego technological advances that may improve quality and patient outcomes. Another commenter believes that the proposed updates would place more financial hardship on hospitals, in particular teaching hospitals, by freezing or reducing payment rates.

Response: We appreciate the support from commenters. As the one commenter noted, we are required by section 1886(b)(3) of the Act, as amended by the Balanced Budget Act of 1997 (BBA), to update rates for FY 2000 by the estimated increase in the hospital market basket minus 1.8 percentage points. Our latest available data show that hospital costs per case are continuing to decline while payments per case are increasing, resulting in high average Medicare profit margins across all hospitals. Therefore, we believe that the update to payment rates specified by law for FY 2000 is sufficient to allow hospitals to continue providing Medicare beneficiaries with efficient care of high quality. We will continue to monitor the financial performance of hospitals as newer data become available and will adjust our future update recommendations to Congress as appropriate.

Comment: MedPAC stated that while HCFA's proposed update recommendation of zero percentage points is within the range that MedPAC adopted in its own recommendation, the Commission believes

that the update specified in law is appropriate because the effects of the BBA are not yet fully evident. Reducing payments below the level prescribed by law would not be prudent, at least for FY 2000. MedPAC further stated that it will monitor the financial performance of hospitals under BBA during the coming year.

Response: As we stated in the proposed rule, we believe that our recommendation (an update of zero percentage points) is an appropriate response to current trends in health care delivery, including the recent decreases in the use of hospital inpatient services and the corresponding increase in the use of hospital outpatient and postacute care services. Furthermore, as a prudent purchaser of health care for Medicare beneficiaries, we believe it is important that we maintain incentives to hospitals to provide high quality care efficiently. Like MedPAC, we, too, will continue to monitor the financial performance of hospitals and adjust future update recommendations as appropriate.

III. Secretary's Final Recommendation for Updating the Rate-of-Increase Limits for Excluded Hospitals

We received one comment concerning our proposed recommendation for updating the rate-of-increase limits for excluded hospitals.

Comment: MedPAC recommended adding 0.4 percentage points to the market basket forecast before applying the update formula to account for technical improvements that hospitals must make related to Y2K-related computer problems. MedPAC believes Y2K-related computer malfunctions could potentially compromise patient care by interrupting service continuity, thereby creating substantial liability exposure for hospitals. Therefore, HCFA should increase the market basket forecast to account for the additional costs hospitals will incur in making computer system improvements to avoid Y2K problems.

Response: Our final recommendation is that hospitals and hospital units excluded from the prospective payment system receive an update using a market basket increase estimate of 2.9 percentage points. This update is consistent with the updates provided to the prospective payment hospitals. We note that under our update framework for excluded hospitals and units, the analysis indicates identical findings to those for prospective payment system hospitals regarding changes in productivity, scientific and technological advances, practice patterns, and case-mix for FY 2000. We believe these updates will ensure that Medicare acts as a prudent purchaser and will provide incentives to hospitals for increased efficiency. Thus, using the statutory target amount update formula, the update factor for an excluded hospital or unit will be between 0.4 percent and 2.9 percent, or 0.

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federal register

Friday
July 30, 1999

Part III

Department of Health and Human Services

Health Care Financing Administration

42 CFR Parts 409, 411, 413, and 489

Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities—Update; Final Rule and Notice

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 409, 411, 413, and 489

[HCFA–1913–F]

RIN 0938–AI47

Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities

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

ACTION: Final rule.

SUMMARY: This final rule responds to comments submitted by the public on our May 12, 1998 interim final rule, that implemented provisions in section 4432 of the Balanced Budget Act of 1997 regarding Medicare payment for skilled nursing facility services. This legislation established a prospective payment system, a consolidated billing provision, and a number of related changes.

EFFECTIVE DATE: These regulations are effective on September 28, 1999.

FOR FURTHER INFORMATION CONTACT:

Dana Burley, (410) 786–4547 (for information related to the case-mix classification methodology).

John Davis, (410) 786–0008 (for information related to the Federal rates).

Jackie Gordon, (410) 786–4517 (for information related to consolidated billing).

Steve Raitzyk, (410) 786–4599 (for information related to the facility-specific transition payment rates).

Bill Ullman, (410) 786–5667 (for information related to coverage and level of care determinations).

Laurence Wilson, (410) 786–4603 (for general information).

SUPPLEMENTARY INFORMATION: To assist readers in referencing sections contained in this preamble, we are providing the following table of contents.

Table of Contents

I. Background
- A. Payment Provisions—Federal Rate
- B. Payment Provisions—Transition Period
- C. Payment Provisions—Facility-Specific Rate
- D. Consolidated Billing for Skilled Nursing Facilities

II. Provisions of the Interim Final Rule

III. Analysis of and Responses to Public Comments
- A. Federal Rates—Outliers/Non-therapy ancillaries (NTAs)
- B. Federal Rate Calculation
- C. Federal Rates—Part B Add-on
- D. Facility-specific Rates-Transition
- E. Minimum Data Set (MDS) Assessments
  - 1. Billing Issues
  - 2. Corrections
  - 3. Other Medicare Required Assessment (OMRA)
- F. Certification and Recertification
- G. MDS Scheduling Requirements
  - 1. Grace Days
  - 2. Completion and Locking
  - 3. Discharge and Leave of Absence
- H. Other Medicare MDS Requirements
- I. Medical Review
- J. Rehabilitation Therapy Services and PPS
- K. RUG–III Groups
- L. Nurse Staffing and the Staff Time Measurement Studies
- M. SNF Coverage and Level of Care Determinations
- N. SNF Consolidated Billing
- O. Scope of Extended Care Benefits
- P. Impact Analysis

IV. Provisions of the Final Regulations

V. Collection of Information Requirements

VI. Impact Analysis
- A. Background
- B. Impact of this Final Rule
- C. Rural Hospital Impact Statement
- D. Unfunded Mandates

In addition, because of the many terms to which we refer by acronym in this rule, we are listing these acronyms and their corresponding terms in alphabetical order below:

ADLs Activities of daily living
ASC Ambulatory Surgical Center
BBA Balanced Budget Act of 1997
CAH Critical access hospital
CBO Congressional Budget Office
CFR Code of Federal Regulations
CORF Comprehensive Outpatient Rehabilitation Facility
CPI Consumer Price Index
CPI–U Consumer Price Index for All Urban Consumers
CPT [Physicians'] Current Procedural Terminology
DME Durable medical equipment
ESRD End stage renal disease
FI Fiscal intermediary
GAO General Accounting Office
HCFA Health Care Financing Administration
HCPCS HCFA Common Procedure Coding System
HIPPS Health Insurance Prospective Payment System
ICD–9–CM International Classification of Diseases, Ninth Edition, Clinical Modification
MDS Minimum Data Set
MEDPAR Medicare Provider Analysis and Review File
MGCRB Medicare Geographic Classification Review Board
MIM–3 Medicare Intermediary Manual, Part 3
MRI Magnetic Resonance Imaging
MSA Metropolitan Statistical Area
NHCMQD [Multistate] Nursing Home Case-mix and Quality Demonstration
OBRA 87 Omnibus Budget Reconciliation Act of 1987
OIG Office of the Inspector General
OMRA Other Medicare Required Assessment
PM Program Memorandum
PPS Prospective payment system
PRM Provider Reimbursement Manual
PRO Peer Review Organization
RAI Resident Assessment Instrument
RAPs Resident Assessment Protocols
RUG–III Resource Utilization Groups, version III
SNF Skilled nursing facility
SOM State Operations Manual
STM Staff time measure

I. Background

Section 4432 of the Balanced Budget Act of 1997 (BBA) (Public Law 105–33) mandated the implementation of a per diem prospective payment system (PPS) for skilled nursing facilities (SNFs), covering all costs (routine, ancillary, and capital) of covered SNF services furnished to beneficiaries under Part A of the Medicare program, effective for cost reporting periods beginning on or after July 1, 1998. Major elements of the system include:

- *Rates:* Per diem Federal rates are established for urban and rural areas using allowable costs from fiscal year (FY) 1995 cost reports. These rates also include an estimate of the cost of services that, before July 1, 1998, had been paid under Part B but furnished to SNF residents during a Part A covered stay. Rates are case-mix adjusted using a resident classification system (Resource Utilization Groups, version III (RUG–III)) based on resident assessments (using the Minimum Data Set (MDS) 2.0). In addition, the Federal rates are adjusted by a wage index to account for geographic variation in wages. Finally, the rates will be adjusted annually using an SNF market basket index.
- *Transition:* The SNF PPS includes a 3-year transition that blends a facility-specific payment rate with the Federal case-mix adjusted rate. The blend that is used changes each cost reporting period after a facility migrates to the new system. For most facilities, the facility-specific rate is based on allowable costs from FY 1995.
- *Coverage:* The PPS legislation did not change Medicare's fundamental statutory requirements for SNF coverage. However, because RUG–III classification is based, in part, on the resident's need for skilled nursing care and therapy, we have attempted where possible to adapt the existing claims review procedures to coordinate them with the outputs of resident assessment and RUG–III classifying activities, as discussed later in this preamble.

• *Consolidated Billing:* The statute includes a billing provision that requires an SNF to submit consolidated Medicare bills for its residents for virtually all services that are covered under either Part A or Part B. The statute excludes a small list of services (primarily those of physicians and certain other types of practitioners). A related statutory provision requires SNFs to use HCFA Common Procedure Coding System (HCPCS) coding on all Part B bills, and specifies that they are to be paid an amount determined in accordance with the otherwise applicable Part B fee schedule for the particular item or service.

• *Effective Date:* The SNF PPS is effective for cost reporting periods beginning on or after July 1, 1998. The law provides that the consolidated billing and coding requirements are effective for services and items furnished on or after July 1, 1998.

An interim final rule implementing the SNF PPS was published in the **Federal Register** on May 12, 1998 (63 FR 26252), and the comment period was initially scheduled to close on July 13, 1998. A follow-up notice (63 FR 37498, July 13, 1998) extended the public comment period for an additional 60 days, and a second notice (63 FR 65561, November 27, 1998) reopened the comment period for another 30 days. In addition, a correction notice (63 FR 53301, October 5, 1998) made a number of minor technical and editorial corrections to the interim final rule. We have also issued several Program Memorandums (PMs) on claims processing and billing under the SNF PPS that are available on the SNF PPS home page at the HCFA website on the Internet, at the following location: <www.hcfa.gov/medicare/snfpps.htm>.

As described in the interim final rule, the BBA requires implementation of a Medicare SNF PPS for cost reporting periods beginning on or after July 1, 1998. Under the PPS, SNFs are no longer paid under the previous, reasonable cost-based system, but rather through per diem prospective case-mix adjusted payment rates applicable to all covered SNF services. These payment rates cover all the costs of furnishing covered skilled nursing services (that is, routine, ancillary, and capital-related costs) other than costs associated with approved educational activities. Covered SNF services include posthospital SNF services for which benefits are provided under Part A and all items and services that, prior to July 1, 1998, had been paid under Part B (other than physician and certain other services specifically excluded under the BBA), but furnished to SNF residents during a Part A covered stay.

A. Payment Provisions—Federal Rate

The statute sets forth a fairly prescriptive methodology for calculating the amount of payments under the SNF PPS. The PPS uses per diem Federal payment rates based on mean SNF costs in a base year updated for inflation to the first effective period of the system. We developed the Federal payment rates using allowable costs from hospital-based and freestanding SNF cost reports during the base year (that is, for reporting periods that began in FY 1995). The data used in developing the Federal rates also incorporate an estimate of the amounts that were paid separately under Part B for covered SNF services furnished during the base year to individuals who were residents of a facility and receiving Part A covered services.

In developing the rates, we update costs to the first effective year of the PPS (15-month period beginning July 1, 1998) using an SNF market basket index, and standardize for facility differences in case-mix and for geographic variations in wages. Providers that received ''new provider'' exemptions from the routine cost limits are excluded from the data base used to compute the Federal payment rates. In addition, costs related to payments for exceptions to the routine cost limits are excluded from the data base used to compute the Federal payment rates. In accordance with the formula prescribed in the BBA, we set the Federal rates at a level equal to a weighted mean of freestanding costs plus 50 percent of the difference between the freestanding mean and a weighted mean of all SNF costs (hospital-based and freestanding) combined. We compute and apply separately payment rates for facilities located in urban and rural areas.

The Federal rate also incorporates adjustments to account for facility case-mix using a resident classification system that accounts for the relative resource utilization of different patient types. This classification system, RUG–III, uses resident assessment data (from the MDS) completed by SNFs to assign residents into one of 44 groups. SNFs complete these assessments according to an assessment schedule specifically designed for Medicare payment (that is, on the 5th, 14th, 30th, 60th, and 90th days after admission to the SNF).

For Medicare billing purposes, there are specific codes associated with each of the 44 RUG–III groups, and each assessment applies to specific days within a resident's SNF stay. SNFs that fail to perform assessments timely are paid a default payment for the days of a patient's care for which they are not in compliance with this schedule. In addition, we adjust the portion of the Federal rate attributable to wage-related costs by a wage index.

For the initial period of the PPS, beginning on July 1, 1998, and ending on September 30, 1999, the payment rates were contained in the interim final rule. For each succeeding fiscal year, we will publish the rates in the **Federal Register** before August 1 of the year preceding the affected Federal fiscal year. Pursuant to section 1888(e)(4)(E)(ii) of the Social Security Act (the Act), for FY 2000 through 2002, we will increase the rates each year by a factor equal to the SNF market basket change minus one percentage point. For subsequent fiscal years, we will increase the rates by the applicable SNF market basket change.

B. Payment Provisions—Transition Period

Beginning with a provider's first cost reporting period beginning on or after July 1, 1998, there is a transition period covering three cost reporting periods. During this transition phase, SNFs receive a payment rate comprising a blend between the Federal rate and a facility-specific rate based on each facility's FY 1995 cost report. Under section 1888(e)(2)(E)(ii) of the Act, SNFs that received their first payment from Medicare on or after October 1, 1995, receive payment according to the Federal rates only.

For SNFs subject to the transition, the composition of the blended rate varies depending on the year of the transition. For the first cost reporting period beginning on or after July 1, 1998, we make payment based on 75 percent of the facility-specific rate and 25 percent of the Federal rate. In the next cost reporting period, the rate consists of 50 percent of the facility-specific rate and 50 percent of the Federal rate. In the following cost reporting period, the rate consists of 25 percent of the facility-specific rate and 75 percent of the Federal rate. For all subsequent cost reporting periods, we base payment entirely on the Federal rate.

C. Payment Provisions—Facility-Specific Rate

For most facilities, we compute the facility-specific payment rate used for the transition using the allowable costs of SNF services for cost reporting periods that began in FY 1995 (cost reporting periods beginning on or after October 1, 1994, and before October 1, 1995). Included in the facility-specific per diem rate for most facilities is an

estimate of the amount that was paid separately under Part B for covered SNF services furnished during the base year to individuals who were residents of the facility and receiving Part A covered services. Under section 1888(e)(3)(A) of the Act, the facility-specific rate (in contrast to the Federal rates) includes amounts paid to SNFs for exceptions to the routine cost limits. In addition, we also take into account ''new provider'' exemptions from the routine cost limits, but only to the extent that routine costs do not exceed 150 percent of the routine cost limit.

We update the facility-specific rate for each cost reporting period after FY 1995 to the first cost reporting period beginning on or after July 1, 1998 (the initial period of the PPS) by a factor equal to the SNF market basket percentage increase minus 1 percentage point. For the FYs 1998 and 1999, we update this rate by a factor equal to the SNF market basket increase minus 1 percentage point, and, for each subsequent year, we update it by the applicable SNF market basket increase.

D. Consolidated Billing for Skilled Nursing Facilities

Section 4432(b) of the BBA sets forth a consolidated billing requirement applicable to all SNFs providing Medicare services. SNF consolidated billing is a comprehensive billing requirement (similar to the one that has been in effect for inpatient hospital services for well over a decade), under which the SNF itself is responsible for billing Medicare for virtually all of the services that its residents receive. As with hospital bundling, the SNF consolidated billing requirement does not apply to the services of physicians and certain other types of medical practitioners. In a related provision, section 4432(b)(3) of the BBA requires the use of fee schedules and uniform coding specified by the Secretary of Health and Human Services (the Secretary) for SNF Part B bills. The law provides that these requirements are effective for services furnished on or after July 1, 1998.

II. Provisions of the Interim Final Rule

In the interim final rule that was published on May 12, 1998, we made a number of revisions in the regulations in order to implement both the PPS and the SNF consolidated billing provision and its conforming statutory changes:

- With regard to payment, we revised the regulations in 42 CFR part 413, subpart A (that deal with Medicare payment to providers of services) to reflect the replacement of the existing reasonable cost reimbursement methodology for SNFs by the new SNF PPS.
- We revised the regulations to provide that for SNF residents who are in a covered Part A stay, Medicare makes payment under the PPS described in new subpart J of part 413, effective with cost reporting periods beginning on or after July 1, 1998.
- For SNF residents who are not in a covered Part A stay, we revised the regulations to provide that Medicare makes payment on the basis of the otherwise applicable Part B fee schedule amounts, effective for services furnished on or after July 1, 1998.
- We made a conforming change in subpart B of part 483 (requirements for long term care facilities) to indicate that the frequency of resident assessments is subject to the timeframes prescribed under the SNF PPS in the new subpart J of part 413.
- We made a number of revisions to implement the consolidated billing provision, under which the SNF itself has the Medicare billing responsibility for virtually all of the services that its residents receive.
- We revised the regulations in part 410 (payment of benefits under Part B) to provide that Part B makes payment for these services to the SNF rather than to the beneficiary. We also made conforming changes with regard to Part B coverage of certain individual medical and other health services.
- We revised part 411 (exclusions from coverage) to exclude from coverage any service furnished to an SNF resident (other than certain specified service categories) when billed to Medicare by an entity other than the SNF itself, and we added a definition of an SNF ''resident'' for purposes of this provision.
- We revised the regulations in subpart B of part 489 (Medicare provider agreements) to add compliance with the consolidated billing provision to the specific terms of an SNF's provider agreement.
- We revised subpart C of part 424 (claims for payment) to require the inclusion of an SNF's Medicare provider number on claims for physician services furnished to an SNF resident, and the inclusion of HCPCS coding on an SNF's Part B claims.
- We made a number of conforming changes in subparts C, D, and F of part 409 of the regulations which describe, respectively, the scope of covered SNF benefits under Part A, the criteria for determining a covered SNF level of care, and benefit period determinations.

As noted previously, the PPS legislation did not change the basic statutory definition of an SNF level of care. However, because RUG–III classification is based, in part, on the resident's need for skilled nursing care and therapy, our revisions in the level of care criteria reflected an attempt where possible to coordinate claims review procedures with the outputs of resident assessment and RUG–III classifying activities. For example, we believe that an initial 5-day assessment, properly completed, that places the resident in one of the upper 26 RUG–III classifications provides the basis for us to assume that the resident needed a covered level of SNF care upon admission and at least up until the assessment reference date of the initial Medicare-required 5-day assessment. We will, however, continue to make individual review determinations for claims of individuals who classify in the lower 18 RUG–III categories.

III. Analysis of and Responses to Public Comments

We received almost 500 comments on the SNF PPS interim final rule published on May 12, 1998 (63 FR 26302). Comments were submitted by nursing homes and other providers, suppliers and practitioners (both individually, and through their respective trade associations), State agencies, nursing home resident advocacy groups, elected officials, health care consulting firms, and private citizens.

The comments basically fell into three broad areas. The first involved the payment rates, including treatment of ''outlier'' situations and non-therapy ancillaries, calculation of the Federal rates themselves and of the Part B add-on, and the transition from facility-specific rates to the Federal rates. The second area concerned the clinical aspects of the SNF PPS, including MDS assessment and scheduling requirements, certification and recertification procedures, medical review criteria, treatment of rehabilitation therapy under the RUG–III classification system, nurse staffing and staff time measurement studies, and coverage and level of care determinations. The third broad area involved the consolidated billing requirement and the scope of the extended care benefit.

As noted in the interim final rule, because of the large number of items of correspondence we normally receive on **Federal Register** documents published for comment, we are unable to acknowledge or respond to them individually. In particular, a number of commenters on the interim final rule raised extremely technical and detailed questions regarding the MDS and the

billing process. These questions are of a nature that would more appropriately be addressed through manual instructions and other issuances than in these regulations. In this final rule, we are addressing the general concerns raised by the commenters. A summary of the major issues and our responses follows:

A. Federal Rates—Outliers/Non-therapy Ancillaries (NTAs)

Comment: We received a number of comments expressing concern over the ability of the PPS to provide adequate payment for certain outlier or extraordinary cases. Several of the comments noted specific examples of these cases, such as HIV-infected patients with significant drug therapy needs, patients receiving intravenous (IV) drug therapy for antibiotic-resistant infections, ventilator-dependent patients, or simply patients with generally high costs. A number of commenters recommended the adoption of an outlier payment process or exceptions process to provide higher payments for these cases.

Other comments suggested use of a later base year (for example, FY 1997) or add-on to the rates in order to recognize changes made by facilities after 1995, the year on which the rates are based. These commenters argued that many facilities increased the scope of services provided to beneficiaries and served a higher acuity resident population after 1995 and, therefore, the costs associated with providing this higher level of care were not reflected in the calculation of the Federal rate.

Response: Section 1888(e)(4) of the Act provides specific requirements related to the formula and cost data to be used in computing the Federal rates. The statute provides that ''the amount of the payment for all costs * * * of covered skilled nursing facility services'' during the transition period is ''equal to'' a prescribed blended payment, and after the transition period is ''equal to'' the applicable adjusted Federal per diem rate. The statute does not provide for additional payments over and above these prescribed amounts. While the Act includes specific statutory authority for the application of outlier policies in relation to the acute care hospital PPS (section 1886(d) through (f) of the Act), home health PPS (section 1895 of the Act), and inpatient rehabilitation PPS (section 1886(j) of the Act), it does not provide such explicit authority with regard to the SNF PPS. However, we are concerned about this matter and are pursuing the basic issue of the accuracy of payments through an examination of the case-mix classification system.

In addition, the statute mandates use of the FY 1995 cost data in the development of the payment rates. It should be noted that when the rates were computed, the FY 1995 data were the latest available to compute the rates. We believe the Congress took this into consideration when developing the statutory language related to the computation of the Federal rates as well as the specific impact of using the 1995 data on the accumulation of Medicare savings, a key goal of the BBA.

We also note that while the Congress provided for Medicare budgetary savings through the SNF PPS (which had an obvious downward effect on the rates), there are numerous reports by the U.S. General Accounting Office (GAO) and Office of the Inspector General (OIG) suggesting Medicare payment for SNF ancillary services under cost reimbursement was inappropriately inflated in the past. If correct, this would mitigate the impact of the budgetary savings. The OIG includes an expanded discussion of this concept in a 1998 report on the SNF PPS titled ''Review of the Health Care Financing Administration's Development of a Prospective Payment System for Skilled Nursing Facilities'' (Number A–14–98–00350).

We understand the concerns expressed in the comments related to this issue. As discussed in the impact analysis accompanying the interim final rule, the SNF PPS will have a varying impact on providers. Because ''prices'' are based on averages, SNFs should expect that certain patients cost more than payments and others less. The extent to which certain facilities can provide quality care, while incorporating efficiencies in their purchasing of services and operations, will affect how well they manage under this payment system, which uses mean-based prices rather than reasonable costs. Financial performance should, therefore, be determined by looking across each facility's Medicare population, not on a patient specific comparison of costs and the payment rate under which the rate would become essentially a limit.

We will focus our efforts on ensuring that these prices are as accurate as possible with respect to the resources used by Medicare beneficiaries. The SNF PPS, through case-mix classification and adjustment, currently reflects a full range of SNF patient types with varying characteristics and degrees of resource intensity. Through research and refinements to the PPS, we will try to ensure that the PPS not only continues to account for a high level of resource intensity, but improves in terms of its sensitivity to less common conditions or patient types. This aspect of our plan is discussed later in the context of the comments on payment for certain ancillary services.

Comment: There were a number of comments expressing concern with the adequacy of the PPS rates to cover the costs of ancillary services other than occupational, physical, and speech therapy (non-therapy ancillaries), including such things as drugs, laboratory services, respiratory therapy, and medical supplies. Prescription drugs or medication therapy were frequently noted areas of concern due to their potentially high cost for particular residents. Some commenters suggested that the RUG–III case-mix classification methodology does not adequately provide for payments that account for the variation in, or the real costs of, these services provided to their residents. A number of commenters stated their belief that the payment rates do not generally reflect the costs of certain of these services (for example, drugs or respiratory therapy).

Recommendations from commenters included removing all or some of these services from the PPS rates and continuing to pay for them on a cost basis, and making changes to the case-mix system and indices to account for these services more accurately.

Response: We are aware of the challenges certain providers have faced as they transition from a payment system based on reasonable costs to one that uses mean-based prices such as the SNF PPS. In fact, many of the same concerns raised in the comments to the interim final rule were voiced by hospitals when we implemented the hospital PPS system in the early 1980s. However, we believe this is an important issue that calls for a broader discussion of the PPS itself, and requires the clarification of certain technical issues related to the PPS and to the statute.

Section 1888(e)(1) of the Act requires that the PPS provide payment for ''all costs'' (including routine, ancillary, and capital related costs) of covered SNF services. Consistent with the statute, the PPS rates are based on 1995 allowable costs calculated from Medicare Part A cost report data and applicable Part B allowable charges. Thus, a facility's historical costs (from FY 1995) of drugs, laboratory services, respiratory therapy, and other non-therapy ancillary services were captured in these cost reports and reflected in both the Federal and facility-specific transition rates.

In addition, many of these non-therapy ancillary services (for example, respiratory therapy, IV medications, and

IV feedings) are captured both directly and indirectly in the case-mix methodology and result in higher payments for SNFs. The issue of whether the nursing case-mix index adequately reflects the relative costs of non-therapy ancillary services was one that was studied in the development of the interim final rule and the associated payment rates.

As indicated in the preamble of that rule, using MDS assessments to classify patients into RUG–III groups, we compared the relative charges for non-therapy ancillaries to the nursing case-mix indices for each RUG–III group. We found that the pattern of the two relative amounts was similar across the RUG–III groups. That is, RUG–III groups with high nursing weights also tended to have relatively high charges per stay for non-therapy ancillaries.

Based on this comparison, we concluded that it was reasonable to include non-therapy ancillary costs in the nursing component of the rate. Accordingly, the idea that the PPS rates do not reflect the cost of respiratory therapy, drugs, and other non-therapy ancillaries is simply not accurate. Whether the accuracy of the rates can be enhanced in this regard is a subject for research and development that we discuss below.

The recommendation to remove or ''carve out'' these services as a class from the PPS rates and continue to pay for them on a cost basis raises some fundamental concerns related to both the statutory and conceptual framework of the PPS. As discussed above, section 1888(e)(A)(1) of the Act requires that the PPS provide payment for ''all costs'' (including routine, ancillary, and capital related costs) of covered SNF services. The conference report associated with section 4432 of the BBA explicitly states that under the SNF PPS, ''services and supplies provided to residents will be included in pre-determined per diem payment rates.''

Beyond the threshold issue of statutory language, the issue of whether specific services should be identified and paid separately appears to conflict with certain fundamental concepts embodied in a PPS. Carried to its logical conclusion, this approach is antithetical to the very concept of the SNF PPS itself, which is based on bundling services for similar patients and paying an average, prospectively determined amount for all services included in the bundle. The PPS rate already recognizes differences between nursing, rehabilitation therapy, and ancillary services, as well as non-case-mix components.

It is important to consider the budgetary impact of the commenters' proposal to remove certain services from the PPS rates and to continue paying for them on a cost basis. The budgetary impact would be significant and would reduce the savings to Medicare associated with the SNF PPS provisions of the BBA. Implementing the provision in a way that would have a budget neutral impact on savings (for example, a downward adjustment to the Federal rates) would penalize providers that have made changes to their operations in order to provide services more efficiently, and would benefit those that have not. Therefore, we believe that further disaggregation of the payment rate would not be consistent with the objectives of prospective payment from a conceptual, statutory, or budgetary perspective.

Finally, we agree with the commenters' recommendation that we explore the potential for refinements to the PPS and, more specifically, the case-mix classification system (RUG–III) to ensure that it continues to account more accurately for the services provided to SNF residents. We consider the continuing adequacy of the PPS rates, and the case-mix methodology in particular, to be a high priority. We believe very strongly that the case-mix methodology should be periodically evaluated to determine the appropriateness of the RUG–III groups in relation to changes in patient care practices and the Medicare population.

In addition, the conference report language associated with section 4432 of the BBA specifically recommended examining payment for medication therapy in the context of the SNF PPS. Accordingly, we are funding substantial research to examine the potential for refinements to the case-mix methodology, including an examination of medication therapy, medically complex patients, and other non-therapy ancillary services.

We are currently funding two research contracts to determine the potential for refinements to the RUG–III model. The first contract was awarded in FY 1997 and provides preliminary analysis and alternatives for refinements using a limited database. The next phase of the research focuses on fully developing these options using more extensive data. Completion of the research is targeted for January 1, 2000. Potential refinements to the case-mix model may include the division of the current 44 groups or the addition of new ones based on items currently on the MDS 2.0 (for example, new extensive care groups combining both medical ancillaries and rehabilitation).

In addition, a new payment index (or set of relative weights) based on ancillary charges, rather than the current staff-time based indices, is being explored for the non-therapy ancillary component of the PPS rates. Any refinements to the RUG–III model and case-mix indices that result from this research would have a distributional effect on payments resulting in a new set of payment weights across the various groups. If the research supports refinements, we anticipate their implementation in conjunction with the October 1, 2000, update to the PPS rates. This time line is dictated by the complexity of the research and by operational and regulatory requirements, including publication of a proposed rule.

It should be noted that the BBA provisions establishing the SNF PPS provided for over $9 billion in savings to Medicare (in fee for service) as a result of the statutory formula used for developing the rates. Accordingly, an SNF's current costs may well exceed the PPS rates if the SNF does not revise the historical purchasing and charging practices that it followed under the preexisting cost-based payment system.

B. Federal Rate Calculation

Section 4432(a) of the BBA amended section 1888 of the Act by adding a new paragraph (e) that provides for the establishment of per diem Federal payment rates under the SNF PPS. These rates encompass all costs of furnishing covered skilled nursing services (that is, routine, ancillary, and capital-related costs), other than costs associated with approved educational activities. In the interim final rule, we established a new subpart J in the regulations at 42 CFR part 413, that describes this new payment methodology. In this section of the preamble, we are providing responses to comments on a number of important issues related to the Federal rates. These include payment for non-rehabilitation ancillary services, outlier cases, and a variety of issues related to the data and design of the Federal payment rates. In addition, we are providing for a minor increase in the unadjusted rates effective October 1, 1999, based on the recommendation of one commenter.

Comment: We received a number of comments recommending that we periodically recompute the PPS rates using the most recent data. Reasons commonly mentioned include that rebasing would allow the PPS to recognize changes over time in the intensity and scope of services provided in SNFs, and that it would provide an opportunity for re-standardization of the

payment rates using actual resident assessment (MDS) data.

Conversely, we received comments that recommended against rebasing payment rates periodically. These commenters were concerned that because the PPS provides incentives for SNFs to provide services more efficiently and eliminate distinct parts (that would tend to lower average SNF costs, as determined from Medicare cost reports), the impact of rebasing the rates would be unfair, since it would tend to penalize providers for being efficient.

Response: While we are not able to predict the absolute impact on SNF costs of the incentive for SNFs to provide services more efficiently or their continued desire to maintain distinct parts under PPS, we have no doubt that the PPS will result in some downward pressure on costs. Anecdotal evidence up to this point certainly supports this conclusion.

Section 1888(e)(4)(A) of the Act requires a 1995 base year. Section 1888(e)(5)(A) of the Act specifically provides for the establishment of an SNF market basket index, while section 1888(e)(4)(E) of the Act requires that the SNF PPS rates be updated annually using that index.

As discussed in response to earlier comments, we believe that it is appropriate to recognize changes over time in the Medicare population or care delivery practices in SNFs in the context of case-mix adjustments. Our periodic evaluation of the case-mix classification and indices will provide an opportunity for making refinements to the PPS that recognize changes in the intensity and scope of services provided in SNFs.

Comment: We received several comments regarding certain costs that were not included in the computation of the Federal rate. Specifically, the commenters expressed concern that all SNFs receiving ''new'' provider exemptions from the routine cost limits and all allowable costs associated with atypical services exceptions to the cost limits have not been included in the data used for computation of the Federal rates.

The commenters suggested that it is unfair to exclude the cost associated with those providers that are providing atypical levels of care. Further, they noted that these are the same providers that would have a high case-mix in the new payment rates and, therefore, should be included. Virtually all of these commenters suggested that the rates are distorted due to the exclusion of many providers and costs of furnishing atypical services.

Response: The statute is very specific regarding the exclusion of providers that have received ''new'' provider exemptions from the calculation of the Federal rates. Section 1888(e)(4)(A) of the Act requires that cost data from SNFs ''that were subject to (and not exempted from) the per diem limits'' be used in computing the payment rates. Similarly, the statute specifically requires the exclusion of allowable costs associated with exceptions granted in the FY 1995 base year. Section 1888(e)(4)(A)(i) requires the use of the allowable costs of SNF services ''excluding exceptions payments'' in calculating the payment rates.

Comment: Several commenters were concerned that we eliminated certain cost reports from the calculation of the Federal rates on the basis of their duration. Cost reports in excess of 13 months or less than 10 months in duration were eliminated from the rate computations. In addition, concerns were expressed over the use of a geometric outlier elimination process to remove SNF costs from the data.

Response: As we indicated in the interim final rule, we used only those cost reports for periods of at least 10 months but not more than 13 months. We excluded those periods that fell outside these parameters on the basis that those cost reports may not be reflective of a normal cost reporting period and, therefore, may tend to distort the rate computation. For example, providers entering or exiting the Medicare program could have abnormally high or low costs due to fluctuations in occupancy. This approach does not affect a large number of cost reports and is consistent with our rate setting methodology in other areas of Medicare.

Similarly, we believe the application of a geometric outlier elimination process for the SNF costs used to calculate the payment rates is an appropriate analytical approach consistent with rate setting for payment systems in other areas of Medicare. We believe that three standard deviations from the geometric mean of the log value for each cost component is a fair level of tolerance that focuses on the truly aberrant cost values. In addition, this process involved the removal of both high cost and low cost aberrant values, resulting in a more equitable and more meaningful computation of the rate components.

We would also add that we used all FY 1995 cost reports that were available at the time of the development of the interim final rule and associated payment rates. While some cost reports may not have been available at that time, we constructed the rates based upon the best available data and are confident it was more than adequate for construction of the rates. Finally, a small number of cost reports were eliminated from the computation of the rates due to faulty or missing data on critical items.

Comment: Several commenters expressed concern with our methodology related to the use of a MEDPAR analog in the standardization of the Federal payment rates. They questioned whether the MEDPAR data were sufficiently accurate for the purpose of developing payment rates and referred to the 28 percent difference, reported in the interim final rule (63 FR 26260), between the therapy index calculated from actual MDS assessments and the MEDPAR analog-generated index. They noted additional limitations of the analog, such as the lack of functional status information and recommended that we use actual MDS data, when available, to re-standardize the payment rates, possibly in conjunction with a rebasing of the cost data.

Response: As noted in the interim final rule, an adequate national sample of MDS data for use in standardizing the Federal payment rates does not yet exist. In the absence of these data, we believe the MEDPAR analog, adjusted by the case-mix adjustment factor, provides an appropriate estimate of case-mix for the purpose of rate standardization. Based on our comparison of actual MDS and MEDPAR data, we concluded that limitations of the MEDPAR case-mix analog had no effect on the nursing component of the rate. Whatever inaccuracy existed in the MEDPAR analog data, the effect was limited to the therapy component and tended to increase, not decrease, the payment rate. The fact that the available MDS data yielded a therapy index value 29 percent higher than the MEDPAR analog data for the same cases demonstrates that use of the MEDPAR data alone would have made the therapy component inappropriately high. That is the reason that the correction factor was applied to the therapy component.

Comment: A few commenters expressed concern about the adjustment we made to the cost report data in developing the Federal rates, to account for providers with cost reports that were not settled. One commenter indicated that all SNFs should not be penalized by this adjustment. It was also suggested that the rates be redone in the future to account for the actual change between the as-submitted cost reports and the settled ones. In addition, one comment

addressed the methodological application of the adjustment in the computation of the rates, suggesting an alternative where the adjustment is applied to total Medicare routine costs as opposed to only costs subject to the routine limit.

Response: As we indicated in the interim final rule, the adjustment made pursuant to section 1888(e)(4)(A)(i) of the Act was applied to unsettled cost reports and was based on the average ratio for all providers in 1995, between their as-submitted and settled cost report. This adjustment is only applied to the cost report data of providers whose cost report was not settled as of the time we computed the rates. It is an actuarial adjustment required under the law that affects how the average SNF costs are determined and does not penalize other providers with settled reports.

As we indicated in the interim final rule, these adjustment factors were validated using data from three previous years, that showed this ratio remains fairly constant. To update and change the rates in the future based on revised cost reports is impractical. Revisions are constantly being made to cost reports (for many years) and our validation exercise indicates the ratios are accurate.

Finally, we have decided to incorporate the methodological alternative described above and will adjust the unadjusted nursing case-mix component of the urban and rural Federal rates by +$.32 and +$.24, respectively. In addition, we will adjust the unadjusted non-case-mix component of the urban and rural Federal rate by +$.25 and +$.21, respectively. We believe this refinement in the application of the adjustment factor may result in a more accurate estimate of the routine costs of SNFs. This adjustment will be prospective and will be effective at the next scheduled update of the SNF PPS rates on October 1, 1999. That is the earliest point at which we can implement changes to the standard claims processing systems.

Comment: We received one comment asking why the issue of payments for low-volume SNFs was not addressed in the interim final rule.

Response: The new Part A PPS established in section 1888(e) of the Act applies to all SNFs, and does not include any special treatment for low-volume SNFs. Section 1888(d) of the Act provided for a separate, optional payment system for SNFs with less than 1500 days (that is, low-volume SNFs) in their preceding cost reporting period. However, according to current law, this special payment system for low-volume SNFs is only in effect for cost reporting periods beginning before July 1, 1998.

Comment: Numerous comments were received from hospital-based facilities and their representatives indicating that the rates are too low and do not recognize the additional overhead incurred in a hospital-based facility. The commenters pointed out that the Federal rate uses a mean of the average for all freestanding providers and the average for all freestanding and hospital-based providers. This computation double counts freestanding providers, thus lowering the rates. Some commenters suggested the rates should be redone, or an add-on or separate rate for freestanding versus hospital-based providers be established, similar to what was done for routine cost limits.

Response: As many of the commenters have already recognized, the computation as described above is clearly mandated in the formula set out in section 1888(e)(4) of the Act.

Comment: We received several comments regarding the wage index that is used to standardize and adjust the rates. The commenters suggested that the hospital wage index might not adequately represent wages paid in SNFs. Many of the commenters pointed out that SNF wages and hours are excluded from the hospital wage index computation, yet we are applying it to SNF payments. Most commenters want the wage index updated periodically and often to reflect the most recent changes in wages. One commenter suggested that we make other changes to the method for how the wage index is calculated by including costs that are now excluded, such as physician salaries, and excluding items like interns' and residents' salaries. There were also a few commenters who suggested that any move to a wage index based on SNF wage data be done slowly to ensure it is done accurately. Most commenters hope to see a wage index based on SNF data soon. In addition, many commenters want us to use a later wage index to reflect the recent mandated changes in the minimum wages rates paid to some employees.

Response: As we indicated in the interim final rule, we are using the hospital wage data since the SNF wage data have not been completed. We used the latest completed hospital wage index that was available at the time of publication. It is our intent to use the latest wage index data that are complete and available when we publish rates or updates to the rates in the future.

We have been unable to evaluate a wage index based on SNF wage data, as not all SNF providers reported data via the worksheet S–3. Now that we have a full year of wage data for both freestanding and hospital-based facilities, we will begin to evaluate and analyze the wage and hourly data from the SNF and hospital-based SNF cost reports. We will analyze and develop these data to evaluate their accuracy and validity. It is our intent, if the data are accurate, eventually to use and publish a wage index based on SNF wage data. However, it has been our experience in the past that when new wage data are used, they can result in enormous and erratic shifts in the wage indexes; many providers could be adversely affected while others experience a windfall. Therefore, before we use any SNF wage data, we will perform numerous edits to ensure quality. In addition, we will ask for public comments once the wage index data are available. Since we have not yet developed a wage index based on SNF wage data, we do not know the impact of excluding or including any particular cost centers.

As discussed above and in the interim final rule, until an appropriate wage index based on SNF data is available, we will use the latest available hospital wage index data in making annual updates to the payment rates. We believe that SNFs and hospitals compete in the same labor market areas and, therefore, absent specific SNF wage data, we continue to believe that the hospital wage data accurately reflect the relative wage costs between labor areas. In making these annual updates, section 1888(e)(4)(G)(ii) of the Act requires that the application of this wage index be made in a manner that does not result in aggregate payments which are greater or less than would otherwise be made in the absence of the wage adjustment. For the initial period of the SNF PPS, the adjustment required by this section was accounted for through the standardization of the cost data that formed the basis for the per diem rate components. By means of standardization, each rate component was adjusted for wage index and case-mix differences so that aggregate payments were unaffected by the presence of these payment adjustors.

Since, for the second PPS year (Federal rates effective October 1, 1999), we plan to update the wage index applicable to SNF payments using the most recent hospital wage data, it is necessary to ensure that the aggregate payments in the second year are neither greater nor less than they would be if we continued to use the wage index from the initial year. This requirement, established pursuant to section 1888(e)(4)(F)(ii) of the Act, will be met by multiplying each of the per diem rate components by the ratio of the volume

weighted mean wage adjustment factor (using the wage index from the initial year) to the volume weighted mean wage adjustment factor, using the wage index for the fiscal year beginning October 1, 1999. The same volume weights are used in both the numerator and denominator and will be derived from 1997 MedPAR data. The wage adjustment factor used in this calculation is defined as the labor share of the rate component multiplied by the wage index plus the non-labor share.

Comment: We received two comments suggesting that the rates should have an add-on to account for the additional cost of completing resident assessments and the administrative costs associated with implementing this new payment system and other unfunded mandates.

Response: We recognize that the increased frequency of assessment may result in additional costs for SNFs. However, as we indicated in response to an earlier comment, the Congress mandated both the basic formula and the fiscal year cost data that we are to use in developing the rates. To the extent that any of these assessment costs are included in the base year data, they are reflected in the rates. We would note that, as we indicated in the interim final rules discussion of the Paperwork Reduction Act, it was determined that the increased assessments required and the time to transmit them has a minimal impact on each individual facility. We recognize that providers will incur additional costs associated with more frequent assessments but we believe our current rate scheme is consistent with the law.

Comment: Several commenters suggested that capital should not be part of the rate, suggesting that it be an add-on or pass-through to recognize those facilities that were committed to large capital expenditures incurred after 1995.

Response: In accordance with section 1888(e)(2)(B) of the Act, the calculation of the Federal rates included the capital costs. We realize that committed capital expenditures after 1995 may create some hardship on some providers. However, we believe that the present rate scheme, which includes capital, is consistent with the language and intent of the statute. Further, we believe that the capital costs included in the rates are adequate to cover capital costs that would be incurred for providers over time.

Comment: We received numerous requests, particularly from rural hospital-based facilities, suggesting that we allow providers to reclassify to a nearby adjacent urban area to receive the urban wage index or the rates applicable to the adjoining urban area, especially in circumstances where the hospital has been reclassified because it is in a county that was defined as urban under section 1886(d)(8)(B) of the Act (sometimes referred to as a ''Lugar'' county) or as a result of geographic reclassifications based on decisions of the Medicare Geographical Classification Review Board (MGCRB) or the Secretary under section 1886(d)(10) of the Act for purposes of the hospital PPS. These commenters suggested that the SNFs are competing in the same market as hospitals. One commenter suggested that a board similar to the MGCRB be established to consider an SNF's request to be reclassified.

Response: While we have broad authority to develop an SNF wage index, we continue to believe that the reclassifications permitted for hospitals under sections 1886(d)(8)(B) and 1886(d)(10) of the Act are specific to hospitals. The Congress could have chosen to extend this provision to SNFs under section 1888(e) of the Act, but it did not. In addition, it has been our longstanding policy not to allow or recognize reclassification for SNFs for payment under the routine cost limits. Since we hope eventually to develop a wage index specific to SNFs, the possible effect of reclassification on the wage index is unclear and might have unintended consequences.

Comment: Two comments were received asking that we consider an adjustment for the non-labor portion for Alaska and Hawaii providers, similar to what is done for routine cost limits for SNFs. These commenters suggested that these areas experience a much higher cost than those providers in the continental United States and, therefore, are entitled to this adjustment.

Response: The hospital inpatient PPS does have an adjustment similar to that requested by these commenters; however, it was mandated by the statute governing the hospital PPS. By contrast, the Congress did not provide for such an adjustment in the legislation for the SNF PPS. Costs incurred by Alaska and Hawaii providers are, of course, included in the base year computation.

Comment: One comment we received suggested that SNFs that were subject to the low-volume rates should have been eliminated from the calculation of the Federal rates. Furthermore, the commenter added that these providers should be exempt from PPS and continue to be paid under the low-volume rates.

Response: Section 1888(e)(4)(A) of the Act specifically included low-volume facilities in the SNF PPS rate calculation.

C. Federal Rates—Part B Add-on

In describing the data to be used in developing the Federal rates, section 1888(e)(4)(A)(ii) of the Act provides for including an estimate of the amounts payable under Part B for covered SNF services furnished during FY 1995 to individuals who were residents of a facility and receiving Part A covered services. This estimate is also known as the ''Part B add-on.'' In this section of the preamble we are providing an expanded discussion of the development of the add-on for Part B services which is included in the Federal rates.

Comment: We received a number of comments questioning the accuracy of our estimate of Medicare Part B allowable charges associated with patients in Medicare Part A stays during the FY 1995 base year used for determining both the Federal and facility-specific payment rates. Certain commenters cited evidence of missing bills and charges associated with individual providers for particular types of services (for example, laboratory services or rehabilitation therapy). In addition, several commenters suggested that we allow for an appeals process related to the Part B estimate associated with facility-specific rates.

Response: We took great care in both the methodological design and construction of the data sources necessary for the development of this estimate. We are aware of several independent industry efforts to review this methodology which found no defects in the design. In this final rule, we are providing the following, more detailed discussion of the methodology used for the development of the Part B estimate with the hope that doing so will clarify our process of determining this estimate and respond to questions and concerns.

The facility-specific payment rate used for the transition is computed using the allowable costs of SNF services for cost reporting periods beginning in FY 1995 (cost reporting periods beginning on or after October 1, 1994, and before October 1, 1995). Included in the facility-specific per diem rate is an estimate of the amount payable under Part B for covered SNF services furnished during cost reporting periods beginning in FY 1995 to individuals who were residents of the facility and receiving Part A covered services.

These estimates were developed using allowed charges (including coinsurance and deductibles) from all Medicare Part

B claims actually submitted (other than those specifically excluded from the consolidated billing requirements, such as physician services) associated with SNF residents in a Part A stay during cost reporting periods that began in FY 1995. Applying the methodology described below, we provided the fiscal intermediaries (FIs) in May of 1998 with the total aggregate amount payable under Part B. In addition, at the request of the nursing home industry, we included a detailing of certain components of that amount for informational purposes.

At that time, we instructed the FIs that only the item listed as ''Total Part B Add-on Amount'' should be incorporated in the calculation of the facility-specific rates. We noted that, while the total Part B amount was an accurate estimate based on the universe of Part B claims, the assignment of allowed charges into the different service components was only an approximation due to the level of specificity of the codes and the variation in supplier billing and coding practices. The following description details the methodology used to determine the Part B add-on amounts:

1. Identify Cost Report Period

For each SNF, determined appropriate FY 1995 cost report period. Used all FY 1995 cost reports on file as of January 30, 1998. If no FY 1995 cost report was available, estimated a FY 1995 period from the latest cost report available.

2. Create List of Dates for SNF Stays for Each Beneficiary

For each SNF, identified all Part A SNF claims with the discharge date on the claim falling within the cost report period. For each beneficiary, identified the dates of each stay during the cost report period.

3. Identify All Non-Physician Part B Claims

Obtained all Part B physician, supplier, DME claims for 1994, 1995, and 1996. Omitted all professional services, defined as any service associated with a physician specialty code. Obtained all Part B outpatient department facility claims for 1994, 1995, and 1996.

4. Match List of Part A SNF Stays to Part B Claims

By beneficiary, matched list of Part A SNF stays to Part B claims. Kept all non-physician services or facility claims falling on or between dates of admit and discharge for each SNF stay.

5. Drop Claims for DME

For non-physician Part B claims, that is, not facility claims, reviewed all alphanumeric HCPCS and identified and dropped obvious DME codes, for example, wheelchairs, canes, transcutaneous electrical nerve stimulation (TENS), glucose monitors, commodes, walkers, bath and toilet aids, lifts, and oxygen equipment. Because coverage under the Part B DME benefit is not allowed for beneficiaries in an SNF stay, we believe that these codes probably occurred on either the day of admission or the day of discharge or were associated with erroneous payments.

6. Adjust Outpatient Claims to Reflect Costs

Adjusted total charges on Part B outpatient facility bills to reflect total Medicare payments using a payment to charge ratio calculated from FY 95 outpatient cost reports. If no FY 95 cost report was available, used ratio from FY 94 or, if necessary, FY 93 cost report. If a FY 93 cost report was not available, used the payment amount associated with the claim.

7. Drop Outpatient Bills

Removed claims with home health and dialysis provider numbers. Dropped Part B outpatient facility claims where the SNF provider number matched the hospital outpatient provider number. Dropped bills with at least one of the following revenue centers: surgery, emergency room (ER), ambulatory surgical center (ASC), cardiac catheterization, computerized axial tomography (CT) scan, and magnetic resonance imaging (MRI). These outpatient hospital services are excluded from the consolidated billing requirements.

8. Calculate Totals

Calculated total allowed charges for all non-physician Part B claims. Calculated total payments for Part B outpatient facility claims.

9. Create Descriptive Categories Within Totals

At request of certain members of the industry, created general categories to describe the distribution of dollars among types of services. Categories are not exact due to the lack of precision in categories for HCPCS ranges, local codes, and the structure of facility claims. For example, dollars for laboratory services could appear in (a) the ''laboratory'' category for non-physician Part B, (b) the ''other'' category for non-physician Part B if the code was local, or (c) the outpatient department's (OPD) ''other'' category for laboratory tests conducted by an outpatient facility.

Created categories for non-physician Part B claims using HCPCS and CPT ranges. Often, broad HCPCS categories capture some unrelated codes. In addition, temporary local codes had to be placed into the ''other'' category.

The structure of the outpatient facility claims prevents associating a code with a specific dollar amount. Created outpatient therapy category by combining all claims from CORF hospitals and any claim with only one physical therapy (PT), occupational therapy (OT), or speech-language pathology (SLP) code. Left all remaining bills in OPD category.

As discussed in the above description of our methodology, a number of factors prevented us from disaggregating the total Part B allowable charges precisely into distinct high level categories (for example, laboratory services). However, we decided to attempt to provide an approximate breakout by category to provide SNFs some notion of what their Part B service mix may have looked like in the FY 1995 base year.

While we did note in the listing of Part B add-ons provided to FIs that the categorization of charges was only an approximation, this qualification may not have always been understood by providers. We regret any confusion caused by this breakout. We would note that our purpose in developing the total estimate of Part B allowable charges did not go beyond providing an accurate account of the total allowed charges to be included in the PPS rates, and we believe our estimate accomplished this. However, even if our purpose had been to map every charge and HCPCS code precisely to some broad category, once again, the data and structure of Medicare's billing system would not have permitted it.

Beyond issues related to the categorization of Part B charges, we received no comments that contained substantiated evidence of systematic defects in the methodology or data. We would note that section 1888(e)(8)(B) of the Act limits administrative review of this estimate.

Comment: We received numerous comments indicating that we should publish, or otherwise make available to the public and the industry, the complete and itemized data that were included in the computation of the rates. Of particular concern was the percentage of the nursing case-mix component of the rate that is attributable to nursing services and non-therapy ancillary costs. Some commenters suggested that they were

unable to replicate the rates we published with the data currently available.

Response: Much of the data necessary to compute the rates have been available for some time, including the 1995 SNF cost reports and the MEDPAR files. We have also put data and information related to the computation of the case-mix indices on our SNF PPS website, at: <www.hcfa.gov/medicare/snfpps.htm>. A public use file containing the most significant data items relating to the calculation of the unadjusted Federal rates can also be found on the website. The standardization and case-mix correction factors are included with the public use data.

It is our understanding from conversations with a number of users of the data that the public use file, along with the data that were already available, has been quite helpful in understanding the calculation of the rates. In addition, we have honored several requests under the Freedom of Information Act for data associated with the rate calculations, and have provided further information through data release agreements.

Regarding the percentage of the nursing case-mix component of the rate that is attributable to nursing services and social services and non-therapy ancillary costs, we agreed with earlier comments to the interim final rule that the public would benefit by knowing the percentages for nursing and social services and non-therapy ancillary services included in the rate. Accordingly, on November 27, 1998, we published a notice in the **Federal Register** (63 FR 65561) to reopen comments to the interim final rule. We also provided the public with a percentage breakdown of the nursing case-mix component of the rates to the extent feasible.

Comment: We received a number of comments concerning our discussion in the interim final rule related to OIG's proposal to adjust the Federal rates to account for costs in the 1995 base year cost data that result from medically unnecessary services or improper payments. These comments strongly recommended that we not proceed with such an adjustment, citing the already significant downward impact on the Federal rates of the BBA budgetary savings, the inadequate statistical basis for pursuing such an adjustment, and insufficient statutory authority for proceeding with an actuarial adjustment of this type to the rates.

Response: We are concerned about the application of an adjustment that would have a downward impact on the Federal rates in light of the substantial reduction already incorporated into the calculation under the BBA requirements. According to the impact analysis contained in the interim final rule, this reduction is 17 percent on average. However, there is a substantial body of evidence, in the form of OIG and GAO studies, that at least suggests there were inappropriate services or improper payments associated with SNF services during the 1995 base year. Consequently, it could reasonably be argued that exclusion of the costs of these services from the cost base used to compute the Federal payment rates is appropriate.

However, we believe that in considering the level of budgetary savings to incorporate into the statutory formula for establishing the Federal rates, the Congress took into account the existing cost base and aggregate SNF payment levels to determine an appropriate level of budgetary savings. Our policy with regard to this issue will be not to proceed with such an adjustment in the absence of specific statutory direction from the Congress.

D. Facility-specific Rates-Transition

Section 1888(e)(2) of the Act provides, for most facilities, a phased transition from facility-specific payment rates (which reflect the individual facility's historical cost experience) to the Federal rates. During such a facility's first three cost reporting periods under the SNF PPS, it receives a blended payment rate, in which the Federal portion initially represents 25 percent of the facility's total payment rate, and then increases by 25 percent increments in each succeeding period until the facility is paid at the full Federal rate.

In this section of the preamble, we are providing responses to comments on a number of issues related to the PPS transition period and the calculation of the facility-specific rates. These include issues related to the eligibility of certain SNFs for the transition. In addition, this section includes policy changes related to the calculation of the Federal rates for certain SNFs with short cost reporting periods and the eligibility for the transition of SNFs with cost reporting periods beginning in FY 1994 but including the entire FY 1995 period.

Comment: We received several comments suggesting that we should define a new SNF as one that first furnished patient care on or after October 1, 1995, rather than one that first received payment on or after October 1, 1995, as our present policy dictates.

Response: We understand that there are many concerns regarding the issue of eligibility for the PPS transition. However, we believe current policy is consistent with the statute. Section 1888(e)(2)(E) of the Act specifically refers to the date an SNF first received payment from Medicare on or after October 1, 1995, as the threshold date. However, it is important to understand that the threshold for determining eligibility for the transition period affects providers in different ways, creating both winners and losers. Thus, while many providers may want to receive PPS transition payments, many other providers would rather be paid on the basis of the full Federal rate. We do not see the benefit of a policy change that creates losers under the system from winners and vice versa.

Comment: We received a number of comments recommending that we modify our policy with regard to the PPS transition, to allow existing SNFs to elect to bypass the transition and be paid 100 percent of the Federal rate if they had experienced significant shifts in case-mix or significant capital expenditures after the 1995 base year used for determining the facility-specific rate. One commenter included a detailed assessment of this proposed policy, including an estimate of the aggregate costs to the Medicare program of its adoption.

Response: We understand the concern of SNFs that have operated under the Medicare program since 1995 or earlier and yet find themselves disadvantaged by the PPS transition due to changes in their care delivery model or significant capital expenditures that occurred after the 1995 base year used for computing the facility-specific rate. However, we believe our present policy to be reasonable and consistent with the plain language of the statute. Section 1888(e)(2)(E)(ii) of the Act sets forth the requirements concerning whether a facility receives payment under the PPS transition or solely according to the Federal rates. This section provides that for SNFs that ''first received Medicare payment for services under this title on or after October 1, 1995, payment for such services shall be made under this subsection as if all services were furnished after the transition period.'' In our view, this language establishes clear criteria related to provider eligibility for the transition and the appropriate basis for Medicare payment. Accordingly, we have established a policy which relies on the date an SNF first received payment (interim or otherwise) from Medicare to determine the basis of their payment.

Comment: We received one comment asking us to reconsider our policy regarding eligibility for the transition for providers that do not have a cost

reporting period beginning in FY 1995, but whose period contains the entire 1995 FY. Examples of these cost reporting periods include a 13-month cost reporting period beginning September 1, 1994, and ending on September 30, 1995 or reporting periods with a floating beginning date (that is, tied to a specific day of the week) of September 27, 1994.

Response: In Transmittal 405 of the Provider Reimbursement Manual (PRM, HCFA Pub. 15–1), we had initially required these providers to be paid at the Federal rate without a transition period, since these providers did not have a cost reporting period beginning in FY 1995 (the statutory basis for computing the facility-specific transition rate). However, we have reconsidered our policy, because these providers did receive their first payment from Medicare before October 1, 1995. These providers will now be eligible for the transition period.

In addition, any provider that has been paid the full Federal rate based on our original policy contained in Transmittal 405 of the Provider Reimbursement Manual will be held harmless, since they have already transitioned to the PPS. In short, this means that providers with a cost reporting period beginning date in 1994 and whose period contains the full 1995 fiscal year (that is, the 12 months beginning October 1, 1994, through September 30, 1995), will be able to elect either a PPS transition based payment or the full Federal rate. Whichever rate the provider chooses must be used for all the years of the transition period.

Comment: We received a number of comments regarding our policy on changes of ownership and mergers as they relate to a provider's eligibility for the PPS transition.

Response: As discussed earlier in this section, SNFs that first received payment from Medicare on or after October 1, 1995 receive payment based on the Federal rate only while SNFs that first received payment from Medicare prior to October 1, 1995 are paid according to the transition rate and are precluded from receiving payment solely based on the Federal rate. In addition, our policy, as stated broadly in transmittal 405 of the Provider Reimbursement Manual, requires that, for purposes of determining a provider's eligibility for the transition, Medicare makes its determination based on the date of first Medicare payment (interim or otherwise) under the present provider number.

For example, when an SNF undergoes a change in ownership, such as a merger or a consolidation, the payment is determined by the payment history of the surviving entity as indicated by the surviving SNF's provider number. This conforms with longstanding reimbursement policy and payment principles as applied under the former reasonable cost payment system and provides administrative simplicity in addressing complex transactions among SNFs, hospitals, and other entities.

Comment: We received several comments recommending that we adopt a policy where SNFs would be allowed to elect to bypass the transition period and receive payment based on the full Federal rate.

Response: Similar to our response to an earlier comment, we understand how the transition payment methodology may disadvantage certain providers. However, section 1888(e)(1) and (2)(E) of the Act specifically addresses the issue of which providers are paid the full Federal rate and which ones must receive transition payments. As we discussed, the statute requires that SNFs that received their first payment under Medicare before October 1, 1995, are to be paid based on the transition payment methodology described in the interim final rule.

Comment: We received a number of comments related to the Part B add-on and the methodology for computing facility-specific rates for SNFs that participated in the Multistate Nursing Home Case-Mix and Quality Demonstration (NHCMQD) in 1997. Under the interim final rule, these facilities did not receive a Part B add-on as part of their facility-specific rate. The commenters argued that a Part B add-on is appropriate for these SNFs. Several commenters provided detailed arguments asserting that a Part B add-on for these providers is legally supportable under the statute.

Response: It appears to us that a Part B add-on to the facility-specific rate for providers participating in the NHCMQD in 1997 could well be an appropriate payment policy in light of the historical circumstances.

During the NHCMQD, many Medicare Part A patients in these SNFs received certain ancillary items or services provided by suppliers who then billed Medicare directly under Part B. However, we find that the statutory language at section 1888(e)(3)(B) of the Act, that provides the formula for computing facility-specific rates for NHCMQD providers, does not support this policy outcome.

Accordingly, we are maintaining the policy, set forth in the interim final rule, of not including a Part B add-on in the calculation of facility-specific rates for SNFs participating in the NHCMQD in 1997. We believe this policy is consistent with the statute. The statute treats NHCMQD providers differently from other facilities. For most facilities, the statute directs the Secretary to use a 1995 base year and provides for a Part B ''add-on''; for NHCMQD facilities, the statute directs the Secretary to use a later base year (1997) and does not provide for a Part B ''add-on.'' Although a Part B add-on for NHCMQD facilities might be appropriate as a conceptual matter, the statute does not provide for a Part B add-on and we do not believe the lack of a Part B add-on leads to an absurd result.

In our effort to ensure the appropriateness of the payment methodology set forth in the interim final rule, we have decided to make a modification to one aspect of the calculation of the facility specific rates. This change only affects the methodology for determining the inflation factor applied in the calculation of the facility specific rates for certain providers with short cost reporting periods (that is, less than 12 months).

There were three different types of short periods discussed in the interim final rule:

a. A short period in the base year,

b. A short period in the initial period, and

c. A short period between the base year and the initial period.

The interim final rule included separate instructions on how to determine which factor to use for an SNF having a short period. There was, however, no discussion of how to determine which factor to use if a SNF had more than one short period. For example, an SNF could have a short period in the base year and a short period between the base year and the initial period of the PPS.

We now believe that the instructions for item c should not be applied to SNFs which have both a short period in the base year and a short period between the base year and the initial period. If an SNF has a short period in the base year and a short period between the base year and the initial period, the instructions in section (a) should be applied using the short period in the base year.

E. MDS Assessments

Under the SNF PPS, the Federal rate incorporates adjustments to account for case-mix, using a resident classification system that accounts for the relative resource utilization of different patient types. This classification system, RUG–III, assigns beneficiaries into one of 44

groups, using assessment data from the MDS that the SNF completes according to an assessment schedule specifically designed for Medicare payment.

In the interim final rule, we discussed issues relating to the use of the RUG–III classification system under the SNF PPS, including scheduling and other requirements pertaining to the MDS, use of the RUG–III ''grouper'' software, and the use of an Other Medicare Required Assessment (OMRA) in certain situations following the discontinuation of rehabilitation therapy services.

In this section of the preamble, we are providing responses to comments on a number of issues related to the use of the OMRA, grace days, and the Health Insurance Prospective Payment System (HIPPS) codes used to bill Medicare Part A covered SNF stays. We also address comments and questions about the midnight rule and its effect on the MDS schedule, and provide clarification regarding counting therapy minutes on the MDS, as well as the requirements for the therapy plan of treatment. In addition, we are responding to comments concerning recognition of respiratory therapy and recreational therapy in the payment rates and on the MDS.

Comment: We received numerous suggestions of ways to improve the MDS instrument, the assessment schedule, and the classification system. These comments included suggestions both to increase and decrease the frequency of required MDS assessments, to improve the MDS staging of pressure ulcers, ideas for modifications to individual RUG–III groups, and commenters' requests that we be more directive in our rules about how facilities are to spend the payments they receive from Medicare.

Response: We appreciate all of the suggestions and will consider them in our future work in these areas. The comments were very specific and too numerous to address in this context. Rather, the subject matter and degree of specificity of some of these suggested changes would be more appropriately addressed through manual issuances.

It is also worth noting that at this time, the SNF PPS has been in effect in most facilities for less than 12 months. In the future, when providers have achieved greater stability and familiarity with the system, and we have additional data to guide our decisions, we can consider making additional refinements such as those suggested by the commenters.

1. Billing Issues

Comment: There were several questions submitted with the comments regarding the HIPPS codes used for billing SNF PPS claims. The questions focused on how to use these codes for billing as distinguished from MDS coding instructions.

Response: Although these codes were not mentioned in the interim final rule, we believe that it would be helpful and appropriate to explain here what the HIPPS codes are as distinct from the MDS information. The HIPPS codes are 5-character codes used solely for billing the Medicare FI for the Part A SNF stay. The codes reflect the RUG–III group into which the beneficiary classified and the reason for the assessment used for determining the classification. The HIPPS code does not appear anywhere on the MDS. The reason for assessment reflected in the HIPPS code is based on information coded in items A8a and A8b of the MDS, but is not a duplication of the data reported on the MDS. Rather, a conversion must be made from the information on the MDS to the reason for assessment identifier that comprises the last two digits of the HIPPS code.

For instructions for billing on the Unified Billing Form 92 (UB–92), see Transmittal 405 of the Provider Reimbursement Manual (PRM, HCFA Pub. 15–1, 7/98) published on our website. These instructions are sent to our FIs and are also available through them.

Further, in the context of billing procedures, we would also like to use this opportunity to clarify our policy on Periodic Interim Payments (PIP). Since the inception of the Medicare program, SNFs reimbursed on the basis of reasonable costs received interim payments during their cost reporting year for the cost of Part A services provided to Medicare beneficiaries. For many years, SNFs have also been permitted to receive PIP—interim payments paid in equal biweekly amounts—for these services if they met the requirements in § 413.64(h) and received intermediary approval. Since July 1987, the statutory authority for PIP for qualifying SNFs has been in section 1815(e)(2) of the Act. Section 1815(e)(1) of the Act was added to include certain requirements, in addition to the requirements in § 413.64(h), specifically applicable to hospitals receiving prospective payments under section 1886(d) of the Act in order for the hospitals to receive PIP. Section 1815(e)(2) of the Act clarified that the additional requirements applicable to those hospitals were not applicable to other types of providers, including SNFs, entitled to PIP. Accordingly, the regulations at § 413.64(h) were revised to provide for the continuing availability of PIP after July 1987 for these other types of providers, including for Part A services provided by SNFs.

Interim payments, including PIP, provide cost reimbursed providers with estimated payments during the cost reporting year pending submittal and subsequent settlement of a Medicare cost report. A provider can submit its cost report to the intermediary as late as the last day of the fifth month after the end of the cost reporting period. Following submittal, the intermediary's determination of Medicare cost reimbursement to the provider for services provided to beneficiaries during the year cannot be made until the cost report is reviewed, sometimes including audit of the provider's records. Because determination of Medicare reimbursement takes place after the end of the cost reporting year, interim payments are needed during the year until this final payment can be determined.

Because a cost report is not required to calculate prospective payments, interim payments are not necessary to a provider for services paid on the basis of prospective payments. Nevertheless, with the exception of special requirements for hospitals receiving prospective payments under section 1886(d) of the Act, section 1815(e) currently provides for the availability of PIP for certain services, including Part A services provided by SNFs, if the requirements in § 413.64(h) are met. It does not prohibit PIP for SNFs receiving prospective payments.

While the BBA eliminated PIP under the provisions mandating a PPS for home health agencies (HHAs), the Congress made no such requirement under the statutory provisions related to SNF PPS. This may be because, like the preceding SNF payment system, the SNF PPS continues to rely on a daily payment amount, while for the HHA PPS, changes in the unit of payment were contemplated. However, at this time, we see no reason to discontinue administratively our existing policy of allowing PIP for qualified SNFs, though we may choose to evaluate its continuing need in the future.

Therefore, we are permitting the continued availability of PIP for services of SNFs paid under the PPS. For those services, PIP is based on estimated prospective payments for the year rather than on estimated cost reimbursement. An SNF receiving prospective payments, whether or not it received PIP prior to receiving prospective payments, may receive PIP if it meets the requirements in § 413.64(h) and receives approval by its intermediary. Likewise, if an intermediary determines that an SNF which received PIP prior to

receiving prospective payments is no longer entitled to receive PIP, it will remove the SNF from PIP. As provided in § 413.64(h)(5), intermediary approval of PIP is conditioned upon the intermediary's best judgment as to whether payment can be made under the PIP method without undue risk of its resulting in an overpayment to the provider.

An SNF can receive Medicare payment for the bad debts of Medicare beneficiaries if it meets the requirements at § 413.80 and implementing instructions. Payment for these bad debts are not included in the prospective payments but rather are claimed on the Medicare cost report. Also, some SNFs may incur costs for an approved medical education program or may incur other costs that are not included in the prospective payment. Payment for these costs are determined based on the completion of a Medicare cost report. Because final payment for Medicare bad debts and for costs paid outside the prospective payment system is not determined until the cost report is settled, it is appropriate that SNFs which receive prospective payments should receive estimated interim payments during the year for bad debts and for costs paid outside the prospective payment system. Payments for these costs are made in equal biweekly payments in the same manner as PIP. There is no requirement for an SNF to meet in order to receive biweekly payments for these costs because it is the only type of interim payment made for them.

The new regulations providing for PIP for SNFs receiving prospective payments and for biweekly interim payments for costs outside the prospective payment system closely follow the regulations at § 412.116 which provide for PIP for hospitals receiving prospective payments under section 1886(d) of the Act, as adjusted to remove provisions specifically applicable to those hospitals. As with § 412.116 for hospitals and § 413.64 for SNFs under the previous cost-based system, these regulations for SNFs also provide for accelerated payments in certain situations.

2. Corrections

Comment: We received several comments with questions and suggestions regarding the policies governing the correction of MDS errors and billing errors.

Response: The MDS corrections policy is set forth in the State Operations Manual (SOM, HCFA Pub. 7) by HCFA's Center for Medicaid and State Operations. The corrections policy applies to all users of the MDS and, thus, is beyond the scope of this regulation. We address issues and provide clarification of Medicare policy regarding how to correct or adjust SNF Part A bills to the Medicare program in the Provider Reimbursement Manual.

3. Other Medicare Required Assessment (OMRA)

Comment: There were a number of questions about the OMRA. These included questions about when the OMRA is to be performed and whether it is a full or comprehensive assessment.

Response: An OMRA is required 8 to 10 days after rehabilitation therapy is discontinued for Medicare beneficiaries who have been receiving rehabilitation therapy in the SNF. Specifically, there is confusion regarding whether or not this assessment type is required in certain circumstances. For example, when the beneficiary has no further need for skilled care and has been moved out of the Medicare-certified portion of the institution before the eighth day following the cessation of rehabilitation services or when one or two of three therapy services are discontinued. As stated in our corrections notice to the interim final rule, published in the **Federal Register** on October 5, 1998 (63 FR 53301), the OMRA is not required to be a comprehensive assessment. There are no PPS requirements for comprehensive assessments (that is, those including Resident Assessment Protocols (RAPs)). Comprehensive assessments are only required for clinical reasons, as they have been since implementation of the nursing home reform requirements enacted in the Omnibus Budget Reconciliation Act of 1987 (OBRA 87, Public Law 100–203).

An SNF must perform an OMRA only for those beneficiaries who continue to have skilled care requirements after their rehabilitation therapy services have been discontinued. For those beneficiaries who are not ready for discharge from the facility, and who continue to require a Medicare covered skilled level of care, an OMRA must be performed in order to obtain an accurate classification into one of the non-therapy RUG–III groups.

The assessment reference date of the OMRA must be set on day 8, 9, or 10 after the last day any rehabilitation therapy services were provided. This timing ensures that no therapy minutes will be captured on the OMRA and that the beneficiary's new classification will be into one of the non-therapy RUG–III groups. An OMRA will always result in classification into a non-therapy RUG–III group. For the days between the cessation of rehabilitation therapy and the assessment reference date of the OMRA, the beneficiary continues to be covered at the therapy RUG–III group level to which he or she was classified before cessation.

We expect that there will be many cases in which the beneficiary will be discharged from the facility shortly after rehabilitation therapy services end. Before PPS, beneficiaries were often discharged from the SNF immediately upon the discontinuation of rehabilitation therapies. Likewise, many SNF residents who received rehabilitation therapy services under Medicare Part A were moved to a non-Medicare level of care following the cessation of therapy services. These same patterns are expected to continue under the PPS.

In circumstances in which the beneficiary is discharged from the facility (or from the Medicare-certified portion of a larger, noncertified institution) before the eighth day following the end of all rehabilitation therapy, there is no expectation by Medicare that an OMRA will be performed. If the beneficiary remains in the Medicare-certified facility through the eighth day following rehabilitation therapy discontinuation, there must be some clinical reason for his or her continuing skilled stay that is supported by documentation in the medical record. We realize that there will be cases in which the beneficiary stays in the SNF for a number of days after rehabilitation therapy ends, in order for the facility staff to verify that his or her status is stable and to assure that the plans for his or her next destination are appropriate and in the best interests of the beneficiary.

By contrast, always waiting to perform the OMRA to verify that the beneficiary is stable and no longer in need of skilled nursing or therapy services is not appropriate. A pattern of OMRA assessments immediately preceding discharge from the facility, or from the Medicare level of care within the facility, would indicate that perhaps the facility is at times using those 8 to 10 days inappropriately. We believe it is unfair to the beneficiary to use any of the 100 Medicare SNF benefit days available in a benefit period unless he or she is actually in need of skilled services. Likewise, it is an inappropriate use of Medicare trust fund dollars for Medicare to pay for SNF days that are not needed by the beneficiary.

The beneficiary should not be kept in a Medicare Part A stay if skilled services are neither needed, nor being provided. We believe that nursing homes' clinical staff should know when there are no

skilled services being provided to a beneficiary. Our guidelines provided in the PRM (Transmittal 405) reinforce the expectation that facilities may, and in fact are expected to, act in the best interest of the beneficiary with regard to use of the beneficiary's limited SNF benefit days, by ending Medicare Part A coverage appropriately. (See also the discussion below regarding circumstances that serve to discontinue a presumption that the SNF level of care requirement is met by a beneficiary who has classified into one of the upper 26 RUG–III groups.)

F. Certification and Recertification

Comment: We received a few comments regarding the statutory requirement for initial certification and periodic recertification as to level of care, as required under section 1814(a)(2) of the Act.

Response: The comments regarding this particular provision are addressed later, in the discussion on coverage and level of care determinations under the SNF PPS. However, we would like to take this opportunity to clarify that the required certification and recertification statements are not the same as any requirements specifically related to the plan of treatment for therapy that is required for purposes of coverage, or to the overall requirement for the multidisciplinary plan of care required by the long-term care facility requirements for participation at section 1819(b)(2) of the Act.

G. MDS Scheduling Requirements

1. Grace Days

Comment: We received several comments asking about the appropriate use of the 3-day grace period provided for the Medicare 5-day assessment. There is some confusion about when use of the grace days could result in the facility being at a high risk for an audit.

Response: Days six, seven, and eight, of the Medicare covered stay, were provided as grace days for setting the assessment reference date for the Medicare 5-day assessment. This assessment is to have an assessment reference date (MDS 2.0 Item A3a) of any day one through eight of the Medicare Part A stay. Days one through five are optimal but days six through eight are also acceptable, and for some residents may actually be more appropriate; for example, to allow maximum flexibility for nurses to determine when to set the assessment reference date for the beneficiary's MDS, and thereby lessen the burden of the increased frequency of assessments that accompanied the PPS. Thus, the resident can be assessed using any one of these first eight days as the assessment reference date for the Medicare-required 5-day assessment.

However, we discourage the routine use of grace days for assessing every Medicare admission. We plan to identify patterns of inappropriate use as we gain a better understanding of what facilities' practice patterns are. When a facility routinely uses a grace day as the assessment reference date for the 5-day assessment, it loses the cushion that these days provide against performing the MDS later than day eight and, thus, risks being faced with payment at the default rate.

At this time our main interest is to encourage facilities to perform assessments timely and to recognize the grace days as a cushion and to use them as such, rather than as deadlines for setting each beneficiary's assessment reference date. The grace days are also provided to offset any incentive that facilities may have to initiate therapy services before the beneficiary is able to tolerate that level of activity.

Our discussion in the interim final rule about the possibility of audits was intended to address the possible practice of routinely using grace days for Medicare assessments. We were cognizant that the routine use of a grace day for the 5-day assessment would pose a temptation to back-date the assessment fraudulently when day eight was missed. We believed that any facility that routinely used grace days for the required assessments was liable to have assessments billed at the default rate; and that the absence of default rate billings in the facility's claims might indicate that some misrepresentation of the assessment reference dates had occurred.

Unlike the routine use of grace days described above, we do expect that many beneficiaries who classify into the rehabilitation category will have 5-day assessment reference dates that fall on grace days. There are many cases in which the beneficiary is not physically able to begin therapy services until he or she has been in the facility for a few days. Thus, for a beneficiary who does not begin receiving rehabilitation therapy until the fifth, sixth, or seventh day of his or her SNF stay, the assessment reference date may be set for one of the grace days in order to capture an adequate number of days and minutes in section P of the current version of the MDS to qualify the resident for classification into one of the rehabilitation therapy RUG–III groups.

Another reason for the provision of three grace days for the 5-day assessment was to make it possible for beneficiaries to classify into the two highest RUG–III rehabilitation sub-categories. Classification into the Ultra High and Very High Rehabilitation sub-categories is not possible unless the beneficiary receives the sub-category's minimum level of services during the first seven days of the stay.

We also intended to minimize the incentive to facilities to provide too high a level of rehabilitation therapy to newly admitted beneficiaries. Having these extra few days allows time for those beneficiaries who need it, to stabilize from the acute care setting and be prepared for the beginning of rehabilitation in the SNF. We expect facilities will not compromise any beneficiary's health by beginning rehabilitation therapy prematurely or at a level that is too rigorous for the individual's status. In summary, use of grace days is acceptable and permitted for patients with any condition. However, a facility that uses grace days routinely may be subject to audit to determine that assessment reference dates are accurately reflected.

Comment: One commenter requested that we modify the statement at section II.B.7 of the interim final rule that states SNFs ''must submit the Resident Assessment Protocols (RAPs) with either the 5-day or the 14-day assessment'' to indicate that the SNFs must submit the completed RAP Summary Form, section V of the MDS with either the 5-day or 14-day assessment.

Response: This may be a helpful clarification for providers; however, we want to be certain that providers fully understand this requirement. We will take this opportunity to make clear that the RAPs are not a PPS requirement. The requirements for completion of section V and the care planning responsibilities of facility clinical staff are unchanged by the PPS. We included the clinical requirement for RAPs in the interim final rule in an effort to help providers to understand how the Medicare required SNF PPS assessments coordinate with the required clinical assessments.

The requirement for RAPs is entirely outside of the SNF PPS. In fact, if the clinical initial admission assessment (item AA8a of the MDS 2.0 = ''01'') was performed before the beneficiary started his Medicare covered SNF stay, neither the Medicare required 5-day, nor the Medicare 14-day assessment is required to have a completed section V. There are no care planning requirements associated with any full MDS assessment performed solely for the purpose of complying with the Medicare assessment schedule for a Part

A Medicare beneficiary's SNF stay. The Medicare PPS requirements are separate from the clinical requirements. However, we have designed the Medicare requirements so that an SNF can coordinate the scheduling of assessments to avoid duplication of effort.

2. Completion and Locking

For Medicare payment, we are requiring that any assessment, including the 5-day, must be ''completed'' (that is, signed by all members of the care team) within 14 days of the assessment reference date (MDS item A3a). That is, the completion date at MDS item R2b, must be a date that is within 14 days of the date at A3a. Then the assessment must be ''locked'' within seven days of the date at R2b, and transmitted to the State in which the SNF operates within 31 days of the final lock date (State Operations Manual, HCFA Pub. 7).

However, there are other considerations to keep in mind. There is still the clinical requirement that an Initial Admission Assessment must be ''completed'' by the 14th day of the nursing home stay. This means that for a Medicare beneficiary who is newly admitted to the SNF for a covered Part A stay, the SNF must complete a comprehensive MDS by day 14, regardless of the assessment reference dates on the Medicare-required 5 day and 14 day assessments.

As has been the case since the OBRA 1987 requirements were implemented, a comprehensive assessment (Initial Admission Assessment) is due to be completed by the 14th day of the SNF stay. In addition, for Medicare beneficiaries in the SNF for a covered Part A stay, a 5-day assessment must be performed, with an assessment reference date on any day one through eight of the Medicare Part A covered stay, and must be completed within 14 days of the assessment reference date. Also, by the end of the second week in the Medicare Part A covered stay, the Medicare 14-day assessment must be performed. This assessment must have an assessment reference date of any day 11 through 19 (including the 5-day grace period provided for this assessment).

Given these requirements during the first weeks of the SNF stay, and considering that Medicare Part A coverage often begins on the day of admission, we believe that in many cases nursing homes will opt to complete a single assessment to satisfy the requirements for both the 5-day (or 14-day) assessment and the Initial Admission Assessment. In this example, the Medicare 5-day assessment, with an assessment reference date of any day, one through eight of the stay, will be a comprehensive assessment and will have to be completed within 14 days of the start of the SNF stay. The day of admission is counted as day one. The assessment must comply with the requirements for the Initial Admission Assessment. That is, it must be a comprehensive assessment, including the RAPs.

When the Medicare 5-day assessment is also used to fulfill the requirement for the Initial Admission Assessment, the Medicare 14-day assessment may be performed using any day 11 through 14 of the stay as the assessment reference date (MDS item A3a) and, in addition, the SNF may use the five available grace days (through day 19), if necessary. The Medicare 14-day assessment must then be completed (dated at item R2b) 14 days after the assessment reference date, locked in seven days, and so forth. Keep in mind that there are no grace days for completion of the Initial Admission Assessment. As always, the Initial Admission Assessment must be completed by day 14. Another factor to consider in timing completion and locking of assessments is that bills may only be sent for assessments that have been locked.

3. Discharge and Leave of Absence

Comment: One commenter asked for a definition of ''leave of absence'' as distinguished from a ''discharge.''

Response: Although this is not a distinction that is specific to the PPS, we would like to define these terms in the context of clarifying another somewhat misunderstood aspect of Medicare coverage, the so-called ''midnight rule'' and the clinical requirements for Discharge forms and Re-Entry Tracking forms. We received questions from other commenters on how to handle cases in which the beneficiary is out of the facility at the time of census-taking, midnight. These activities are all interrelated and have generated many questions during the initial phase of PPS implementation. There are a number of reasons why a beneficiary may leave the SNF for a ''leave of absence.'' These include a temporary home visit, a temporary therapeutic leave, or a hospital observational stay of less than 24 hours in which the beneficiary is not formally admitted to the hospital and is not discharged from the SNF. In each of these situations, there is no requirement for the SNF to complete a Discharge or a Re-Entry Tracking form.

When a beneficiary goes to an acute care hospital emergency room (ER) during his or her SNF stay and is in the ER at midnight, there is an additional aspect with regard to Medicare payment. According to Medicare rules, the day preceding the midnight on which the beneficiary was absent from the facility becomes a day for which the SNF may not bill Part A of Medicare. This is known as the ''midnight rule.'' However, for clinical purposes, as long as the beneficiary returns to the facility in less than 24 hours, was not admitted to the hospital, and was not discharged from the SNF, this time in the ER is considered a ''leave of absence'' and requires no discharge form.

Likewise, from the perspective of Medicare payment under PPS, there is no requirement for any additional assessment. The day preceding the midnight is not a covered Part A day and, therefore, the Medicare assessment ''clock'' is altered by skipping that day in calculating when the next Medicare assessment is due. From a clinical standpoint, the leave of absence does not affect the ''clock'' for the clinical assessments.

For example, if the beneficiary is due for his 30-day assessment on March 30 (day 30 of his Medicare covered stay), but he spends midnight of March 27 in the ER, day 30 of his Medicare Part A covered stay now falls on March 31, as March 27 does not count as one of the beneficiary's 100 days of Medicare SNF care. In other words, the count of days in the Medicare covered stay changes when there is a noncovered day because the facility cannot count that day as one of the beneficiary's benefit days. Given the flexibility of the assessment windows for the Medicare assessments, altering the count of days as described here should have no more than a negligible effect on assessment scheduling for facilities.

Of course, a beneficiary who is required to be in the ER at midnight may well have experienced a significant change in clinical status. In that case, the facility must comply with the clinical requirement to complete a Significant Change in Status Assessment when the beneficiary returns to the SNF. The Medicare payment requirements and the midnight rule have no bearing on this requirement for completion of a Significant Change in Status Assessment.

Alternatively, if the beneficiary is in the ER for more than 24 hours, or is actually admitted to the hospital or discharged from the SNF, a Discharge Tracking form is required. In addition, when the beneficiary returns to the SNF, a Re-Entry Tracking form is required, and a Return/Readmission Assessment (MDS 2.0 item A8b=5) must be performed to restart the Medicare assessment schedule. The Return/

Readmission Assessment fulfills the requirement for a Medicare 5-day assessment in this situation, and the next required assessment would be the Medicare 14-day assessment.

Finally, with regard to MDS scheduling requirements, we are taking this opportunity to clarify the regulations text at § 413.343(b), which specifies the assessment schedule required under the SNF PPS. The current language requires the performance of such assessments on the 5th, 14th, 30th, 60th, and 90th days ''following admission.'' However, as indicated in the preceding discussion, it is not the admission date per se that determines the start of the Medicare assessment schedule, but rather, the commencement of Medicare-covered care in the SNF. Although Medicare-covered posthospital SNF care often does begin immediately upon a beneficiary's admission to the SNF, the existing language fails to address those situations in which such care does not commence until sometime after the day of admission. The Medicare required assessment schedule is based only on those days in the Medicare Part A covered stay and, thus, cannot be scheduled based on the day of admission per se. Therefore, we are revising the language in the regulations text to take into account the possibility that a beneficiary's ''posthospital SNF care'' (that is, SNF care that is covered under Medicare Part A) may begin subsequent to the day of his or her actual admission to the facility. The Medicare required assessments are to be performed so that, using the first day of posthospital SNF care as day 1, there is a full MDS assessment on the 5th day, the 14th day, the 30th day, the 60th day and the 90th day of the SNF stay.

H. Other Medicare MDS Requirements

In the interim final rule, we stated that collection of medication information using a revised version of section U of the MDS would be required under PPS, beginning October 1, 1999. The criteria we established for this process anticipated that a refined section U would be developed to facilitate streamlined data collection, maximize data accuracy, and minimize burden to facilities. We have, to date, made considerable progress in our work on the section U refinements. However, due to systems constraints resulting from the need to achieve Year 2000 (Y2K) compliance (see the further discussion of the Y2K issue below in the context of the partial delay in SNF consolidated billing implementation), we will not be able to implement the refined version of section U until after the first months of the year 2000 have passed. Therefore, we have determined that the most straightforward and least burdensome approach is to defer section U implementation until October 1, 2000.

I. Medical Review

Comment: We received several comments requesting that we publish the medical review criteria to be used now that PPS is in place. Also, there were requests that we institute consistent medical review policies across FIs.

Response: We are currently formalizing the medical review criteria that will be used in the review of SNF PPS bills. Certainly, one of the primary goals of the new policy is to provide reviewers with guidelines that will facilitate consistent national medical review policy, one of the initial goals of implementing the PPS. We recently published a PM (PM transmittal No. A–99–20, May 1999) to instruct medical reviewers in the new process. One aspect of the reviews of SNF PPS bills to be performed by the FIs focuses on the MDS information and its consistency with the documentation in the rest of the medical record. In addition, the review process focuses on identification of instances in which inappropriate services were provided or in which the beneficiary did not meet the requirements for Medicare Part A coverage in an SNF.

Comment: There were questions about how the MDS information might be matched to claims data to facilitate monitoring or auditing of SNF reporting practices.

Response: The process for matching the bill to the MDS takes place at HCFA. We use the bill data forwarded to us by the FIs to match to the appropriate MDS from the HCFA MDS Repository. From these matched or unmatched files, we generate various reports for use by HCFA and the FIs in their audit functions.

Comment: We received a comment requesting that we instruct FIs to give demand bills a high priority within the review process and to process these submissions no later than 30 days from the date of the request.

Response: The policy governing how demand bills will be processed under the SNF PPS will be determined by considering the FIs' overall workloads, of which the SNF PPS represents only a small portion.

Comment: A commenter requested that we generate and disseminate to the nursing home industry and to the payers, the full process of transmission of clinical Medicare Part A information and claims submission requirements, including documentation requirements needed by the fiscal intermediary for late assessment reference dates.

Response: The requirements for the transmission of all MDS assessments can be found in the **Federal Register** published on December 23, 1997 (62 FR 67174). There are no separate requirements for Medicare Part A information. The facility must submit the MDS to the State in which it operates and the State transmits it to us. In contrast, the SNF submits claims to the FI, as they did before PPS. Each claim is transmitted to us by the FI after it has been paid, and we match the claim to the appropriate MDS. The FI may request any information it deems to be necessary to verify the level of services billed by the facility.

Comment: We received one comment suggesting that we should exempt from post-payment review or on-site audit, any 5-day assessment with an assessment reference date on one of the grace days that results in the beneficiary's classification into a Low Rehabilitation group.

Response: This comment reflects a misunderstanding of our policy regarding grace days. As explained above in this final rule, the grace days are available for use, without penalty. The reference to audits in the interim final rule was not intended to preclude any appropriate use of the grace days. Therefore, although the comment indicates that beneficiaries who classify into one of the low rehabilitation groups should be exempt from review (presumably because of the requirement for six days of nursing rehabilitation services in order to qualify for this RUG–III group), there is no reason for us to consider excluding any type of Medicare SNF claims from post-payment review.

Comment: Several commenters cited the BBA mandate that we must implement a quality monitoring system. Section 4432(c) of the BBA requires the Secretary to establish a medical review process to examine the effects of the SNF and PPS related provisions on the quality of SNF services furnished to Medicare beneficiaries, with particular emphasis on the quality of non-routine covered services and Medicare-covered physician services.

Response: The quality of care provided to beneficiaries is paramount in our view. We will use our existing survey and enforcement activities (along with the new techniques and data that are now becoming available with the advent of prospective payment) to ensure the quality of SNF services provided to Medicare beneficiaries.

In addition to the more traditional medical review process we are establishing, as described above, we have also begun work toward the establishment of a quality medical review process that is specifically designed to fulfill the BBA mandate. We have developed an SNF PPS Quality Medical Review Pilot project that uses MDS and other data to monitor and target quality and program integrity problems. This monitoring will be accomplished by testing a more integrated and cooperative approach to medical review of SNF services using several pilot states to partner Peer Review Organizations (PROs), FIs, State Survey Agencies, and Medicaid agencies to assess, monitor, and improve the quality of Medicare SNF services under the PPS.

We are implementing a two-tier strategy using the PRO Special Project process. This strategy is expected to strengthen program integrity and quality review in SNFs, promote SNF quality improvement, deter fraud and abuse, and enhance beneficiary protection. The first tier is a statistical analysis PRO (StatPRO), that is testing a data driven approach which analyzes MDS data to flag potential quality of care and program integrity problems. The MDS data set will be linked with other HCFA data sets (such as, Medicare Part A and B claims, OSCAR-Online Survey Certification and Reporting System, HCIS–HCFA Customer Information System, FI payment, and program integrity data) to identify patterns and trends in care. The second tier of the project pilot tests a data based approach using StatPRO and other data to examine State trends and variations in SNF data and patient care through the collaboration of quality medical review (QMR) teams composed of the PRO, FI, and State survey agency in two States (NC and CO) and in three States (AZ, MA, and MD) the Medicaid Agency is added. The QMR pilots will field test an integrated model where they will work together to better understand each other's program integrity and quality review roles, develop collaborative approaches within their regulatory authority, test a targeted clinical data driven intervention strategy, target beneficiary protection, and deterrence of fraud and abuse. Finally, we will use the vast data resources available from the national MDS data repository to support our quality initiatives.

J. Rehabilitation Therapy Services and PPS

Comment: Many commenters questioned when rehabilitation therapy may begin in the SNF stay.

Response: Although rehabilitation therapy may begin as early as day one of the Medicare Part A SNF stay, we note that all of the rehabilitation therapy services (PT, OT, and SLP) must meet each of the following criteria in order to be coded in the MDS as minutes of rehabilitation therapy:

- The service must be ordered by a physician.
- The therapy intervention must relate directly and specifically to an active written treatment regimen established by the physician after any needed consultation with the qualified rehabilitation therapy professional and must be reasonable and necessary to the treatment of the beneficiary's illness or injury (section 230 of the Medicare Skilled Nursing Facility Manual, HCFA Pub. 12).
- An appropriately licensed or certified individual must provide or directly supervise the therapeutic service and coordinate the intervention with nursing services.

Even though these three criteria are not new with PPS, the establishment of a new payment system has heightened interest in understanding and satisfying these standards. For instance, in addition to the commenters' question about when rehabilitation therapy services can begin, we have received many questions during the first year of PPS implementation regarding standards for supervision of rehabilitation therapy assistants and aides, and many questions regarding the physician signature requirements for the rehabilitation therapy plan of treatment. Accordingly, we will take this opportunity to provide further clarification of those issues. The rehabilitation therapy service must be ordered by a physician. The Medicare policy regarding the requirement for the physician signature on the therapy plan of treatment has not changed. As is stated in the SNF Manual, rehabilitation therapy services provided to a beneficiary in a SNF must be directly and specifically related to an active written treatment plan established by the physician after any needed consultation with a qualified therapist. Implementation of the PPS did nothing to alter this guideline. We will, however, take this opportunity to clarify what is required for coverage of rehabilitation therapy.

As stated in the language in the SNF Manual cited in the preceding paragraph, Medicare requires the physician to make decisions regarding the amount and intensity of rehabilitation therapy services provided to Medicare beneficiaries in SNFs after consulting with the professional therapist. This requirement is based on our commitment to ensuring quality care for Medicare beneficiaries, and also reflects the requirements for participation (at section 1819(b)(6)(A) of the Act), which specify that the medical care of every SNF resident must be provided under the supervision of a physician. Our policy has not changed, and we are taking this opportunity to clarify that policy. The physician's responsibility in the development of a rehabilitation therapy plan of treatment ensures that the services to be provided will not exceed the beneficiary's abilities as constrained by his clinical status. In addition, we believe that the physician's clinical judgement is an important aspect in preventing injuries that can result from the provision of inappropriate rehabilitation therapy. For example, the rehabilitation plan of treatment for a beneficiary with a hip fracture should be developed with an awareness of his or her limitations due to severe osteoporosis and emphysema. Unless the beneficiary's entire clinical condition is taken into account, there is a significant risk of injury and of a compromised medical status.

We expect that the same care will be taken by the physician and SNF staff to document physician responsibility for developing the therapy plan of treatment, including precautions, that is reasonably expected to be taken for any other element of the medical record. We realize, however, that in the SNF setting there may not be a physician on the premises every day. Therefore, Medicare allows the professional therapist to develop a suggested plan of treatment and to begin providing services based on that plan prior to obtaining the physician's signature on the plan. We continue to require that the plan of treatment must be a physician's responsibility after any needed consultation with a qualified therapist, and that the requirement for physician verification of the suggested plan of treatment will be obtained within a reasonable amount of time. However, a physician signature must be obtained before the facility bills Medicare for payment for the rehabilitation therapy services provided to the beneficiary based on the plan of treatment he or she has approved. In this way, the facility can be sure that the level of therapy for which it bills Medicare is the level the physician deems to be medically necessary. We expect that the type and intensity of therapy billed will always match the type and intensity of therapy on the signed therapy plan of treatment.

We understand that many physicians use the fax to participate actively in the review of written plans of care and so

believe that it is appropriate to accept physicians' faxed signatures for the plan of treatment. As always, whenever the plan of treatment is altered in any way, the modification must be made in writing. If the physician is not the person making the modification, the therapist who is making the change must notify the physician timely, and the physician must sign the change within a reasonable amount of time.

In addition to the issues discussed above, we would like to clarify the requirements for the rehabilitation therapist's initial evaluation of a Medicare beneficiary in a SNF stay and the requirements for licensed therapist supervision of therapy assistants and therapy aides when they provide therapy services to Medicare beneficiaries. The initial evaluation, performed by the licensed therapist and necessary for the development of the plan of treatment, must be performed during the beneficiary's SNF stay. It is not acceptable to use an evaluation that was performed for instance, in the acute care hospital or the rehabilitation hospital setting as the evaluation of the beneficiary in the SNF, because the beneficiary's status must be evaluated as he or she presents in the SNF setting. The evaluation, and the resultant plan of treatment, developed in the acute care hospital or rehabilitation hospital is relevant to the specific type of setting and is not interchangeable with an evaluation and plan of treatment developed for the beneficiary in the SNF setting. The time that it takes for the therapist to perform this evaluation may not be recorded as minutes of therapy received by the beneficiary.

An appropriately licensed or certified individual must provide or supervise the therapeutic service and coordinate the intervention with nursing services. As stated above, Medicare expects that services will be provided by, or supervised by, appropriately licensed or certified professionals.

Physical and occupational therapy assistants may provide rehabilitation therapy services under the supervision of the professional therapist. A rehabilitation therapy assistant must be under the general supervision of a professional therapist who is accessible while the assistant is providing services to the beneficiary. The therapy assistant cannot supervise a therapy aide. It is up to the professional therapist to ensure that the assistant is capable of performing therapy services without the more stringent ''line-of-sight'' level of supervision required by therapy aides.

A therapy aide must be supervised personally by the professional therapist in such a way that the therapist has visual contact with the aide at all times. Therapy aides are not to perform any services without ''line-of-sight'' supervision. Similarly, a therapy aide must never be responsible for provision of group therapy services, as this is well beyond the scope of services that they are qualified to provide.

A therapy student who is participating in field experience must also be under the ''line-of-sight'' level of supervision of the professional therapist. Even though these students may become licensed therapists within months of the field training portion of their school program, they are not licensed or certified for practice in an unsupervised status. Further, none of the minutes of therapy services provided by the students may be recorded on the MDS as minutes of therapy received by the beneficiary. Medicare recognizes the costs associated with approved educational activities as a pass-through (see § 413.85).

Comment: Many commenters had questions about the correct counting and recording in the MDS of minutes of rehabilitation therapy.

Response: Section P of the current version of the MDS contains the items that capture the amount of time each nursing home resident spends receiving rehabilitation therapy. Thus, it is in section P that the clinician records the number of days and minutes of rehabilitation therapy (PT, OT, ST) received by the individual beneficiary during the past seven days, or since admission to the SNF, whichever is shorter.

The directions for completion of section P instruct the assessor to look back over the ''last 7 calendar days,'' counting only post admission days and minutes of therapy, when counting the days and minutes of rehabilitation therapy received by the beneficiary. The number of minutes recorded here must be the actual number received by the beneficiary. Seven calendar days are, by definition, consecutive days.

In the case of a Medicare 5-day assessment, however, the nurse assessor will choose as the assessment reference date (MDS item A3a), any day one through eight of the covered stay, and will look back over the prior seven calendar days (or over the days since admission if there are fewer than seven days since admission) to count the number of days upon which more than 15 minutes of therapy were received and the number of minutes that were received by the beneficiary during those days. It is irrelevant if there is a break in therapy (for example, for a weekend or holiday) during that time. For example, if day five of the stay is chosen as the assessment reference date, the assessor would look back to admission to count the patient's PT, OT, and ST time. If the beneficiary received PT for 50 minutes on both the second and fifth days of the Part A covered stay, that would be recorded as two days of PT and 100 total minutes of PT. The actual number (not rounded) of minutes must be recorded on the MDS. Minutes cannot be rounded to multiples of 10 or 15.

The rehabilitation therapy time reported on the MDS is a record of the time the beneficiary spent receiving therapy services, not a record of the therapist's time. As stated in the August 1996 publication, Long Term Care Resident Assessment *Instrument Questions and Answers, Version 2.0,* the beneficiary's ''therapy time starts when he begins the first treatment activity or task and ends when he finishes with the last apparatus and the treatment is ended.''

Set-up time is included, as is time under the therapist's or therapy assistant's direct supervision. PT, OT, and ST provided outside the building may be counted and recorded on the MDS, as long as the staff who provide therapy are qualified to provide the service. In the State Operations Manual (SOM, HCFA Pub. 7) Transmittal #272, pp. R64, ''The therapy treatment may occur inside or outside the facility.'' This includes the time it takes for the therapist to take the beneficiary to his or her home for a home visit before discharge as long as the therapist uses the time in the car to teach or discuss the beneficiary's treatment or treatment goals, and for family conferences when the beneficiary is also present.

Whether the time spent evaluating the beneficiary is counted depends on whether it is the formal initial evaluation or an evaluation performed after the course of therapy has begun. The time it takes to perform the formal initial evaluation and develop the treatment goals and the plan of treatment may not be counted as minutes of therapy received by the beneficiary. However, a reevaluation—that is, a hands-on examination of the beneficiary and not simply an update to the documentation and revision of the care plan—that is performed once a therapy regimen is underway (for example, evaluating goal achievement as part of the therapy session) may be counted as minutes of therapy received.

This policy was established because we do not wish to provide an incentive for facilities to perform initial evaluations for therapy services for patients who have no need of those specialized services. However, we

believe that the initial evaluation is an appropriate cost of doing business. Therefore, the cost of the initial assessment is included in the payment rates for all Medicare beneficiaries in covered Part A SNF stays.

For beneficiaries who do not classify into one of the Rehabilitation RUG–III groups, the therapy non-case-mix component is part of the daily rate. The amount, $0.91, is reflected in the rate for all of the non-therapy RUG–III groups.

The Long Term Care Resident Assessment Instrument Questions *and Answers Version 2.0,* clarifies how to account for therapy provided to an individual within a group setting. It states that if the group has four or fewer participants per supervising therapist (or therapy assistant under general supervision by the therapist) then it is appropriate to report the full time as therapy for each patient. The example used is that of a therapist working with three patients for 45 minutes on training to return to the community. Each patient's MDS would reflect receipt of 45 minutes of therapy for this session.

Although we recognize that receiving PT, OT, or ST as part of a group has clinical merit in select situations, we do not believe that services received within a group setting should account for more than 25 percent of the Medicare resident's therapy regimen during the SNF stay. For this reason, no more than 25 percent of the minutes reported in the MDS may be provided within a group setting. This limit is to be applied for each therapy discipline; that is, only 25 percent of the PT minutes reported in the MDS may be minutes received in a group setting and, similarly, only 25 percent of the OT, or the ST minutes reported may be minutes received in a group setting.

To summarize, the minutes of therapy provided by at least one supervising therapist (or therapy assistant under general supervision by the therapist) within a group of four or fewer participants, may be fully counted, provided that those minutes account for no more than 25 percent of the resident's weekly therapy in that discipline, as reported in the MDS. The supervising therapist may not be supervising any individuals other than the four or fewer individuals who are in the group at the time of the therapy session. Naturally, provision of group therapy time in excess of the 25 percent threshold is allowable, but those minutes may not be counted in section P of the MDS for purposes of RUG–III classification for Medicare Part A beneficiaries.

Under section 1814(a)(2)(B) of the Act, a covered SNF level of care is defined in terms of those services that necessitate the involvement of skilled personnel, are needed and received on a daily basis and, as a practical matter, can be provided only in an SNF on an inpatient basis. Additionally, the requirements for participation at section 1819(b)(4)(A) of the Act require an SNF to furnish the full range of nursing and specialized rehabilitative services needed to attain or maintain each resident's highest practicable state of well-being, in accordance with the comprehensive plan of care. This means that there are to be no limits placed on the services to be provided to the beneficiary due to the facilities interpretations of how many minutes are ''allowed'' by the given RUG–III group.

The RUG–III classification system uses minimum levels of minutes per week as qualifiers for classification into the rehabilitation therapy groups. These minutes are minimums and are not to be used as upper limits for service provision. Similarly, there are instances in which beneficiaries in the so-called ''clinical categories,'' Extensive Services, Special Care and Clinically Complex, will need some limited amounts of rehabilitation therapy services, which they should receive, even though they may not require a level that would qualify them for one of the rehabilitation groups. The SNF PPS is based on averages, and a facility that continues to provide services as they are needed by its beneficiaries should receive payments that, in the aggregate, are adequate to pay for those services. Any policy of holding therapy to the bare minimum, regardless of beneficiary need, is inconsistent with the statutory requirements discussed above, and will result in poor outcomes, longer lengths of stay, and a degradation in the facility's quality of care.

Section T of the current version of the MDS must be included with each Medicare PPS assessment, but in the case of a Medicare five day assessment, the clinician captures minutes of therapy that are anticipated for the beneficiary during the first two weeks of the nursing home stay. This makes it possible for the beneficiary to classify into the appropriate RUG–III rehabilitation group based on the anticipated receipt of rehabilitation therapy, even though the assessment is done during the first few days of the SNF stay.

Section T of the current version of the MDS contains three items, T1b, T1c and T1d, in which the assessor is to record ''ordered therapies.'' The T1b item asks, ''Has physician ordered any of the following therapies to begin in FIRST 14 days of stay—PT, OT, or speech pathology service?'' If the answer to this question is yes, then the number of expected minutes and days is completed in items T1c and T1d of the current version of the MDS. If the answer is no, then there is nothing to report in T1c or T1d.

If the physician orders therapy for 10 days, the projected number of days in section T will be 10 rather than 14; likewise, if the physician does not order a limited number of days, the projection will be based on the entire two weeks, assuming the beneficiary's continued stay and receipt of services.

The RUG–III grouper takes into consideration both the days and minutes already received by the beneficiary, as reported in section P of the current version of the MDS, and the days and minutes expected to be received in the first two weeks of the stay. The number of days and minutes expected, as reported in section T, should include those already received.

For example, the beneficiary received an hour of OT on both the fourth and fifth days (a Monday and Tuesday) of the SNF stay. The prescribed regimen calls for the beneficiary to receive an hour of OT daily, Monday through Friday, during the first two weeks in the SNF. The assessment reference date was set for the fifth day of the stay; two days and 120 minutes were reported as having been received in section P of the MDS, and 10 days and 600 minutes were reported as anticipated in section T. The 10 days and 600 minutes recorded in section T include the 2 days and 120 minutes already received, in addition to the upcoming three days and 180 minutes expected to be received in the first week, and the five days and 300 minutes of therapy in the second week.

We realize that reporting therapy time that has not yet been provided is a significant change for providers, but it is in compliance with the grouper logic and allows the facility to provide the most accurate representation of the services to be provided to the beneficiary during the first assessment period.

K. RUG–III Groups

Comment: We received a few comments stating that the ''limits'' on therapy minutes imposed by the RUG–III groups were too low, and that more than 720 minutes should be allowed for beneficiaries in the highest RUG–III groups.

Response: The RUG–III system does not impose limits on the services a resident may receive; rather, it is used to determine how much Medicare pays for the services that the resident

receives. The minutes used to classify beneficiaries into RUG–III groups are in no way to be taken as upper limits. The 720-minute threshold for the Ultra High sub-category is a minimum for purposes of classifying residents. In fact, during the demonstration, there were beneficiaries who were receiving more that 1,000 minutes per week, and we expect that there will be similar instances during the national implementation. All of the groups were created based on a continuum of minutes being provided, including Ultra High. Just as we expect to see beneficiaries in the High Rehabilitation sub-category receiving 450 minutes per week, we expect that as many minutes as are needed will be provided to beneficiaries in the Ultra High groups.

Comment: We received a comment requesting that we explain how the RUG–III grouper works. The commenter believed that we failed to explain fully in the interim final rule the grouping logic that restricts classification into the Rehabilitation Ultra High and Very High sub-categories to beneficiaries who have a full week of therapy recorded in section P of the MDS.

Response: The grouper software uses the minutes and days recorded in sections P and T together to classify beneficiaries into the RUG–III rehabilitation groups. However, in order for a beneficiary to classify into the upper two sub-categories, Ultra High and Very High, he or she must have received at least one full week (five days) of therapy at the level that would qualify for these groups.

For example, suppose a beneficiary is admitted on Monday, May 1 and begins PT and OT on May 4. The beneficiary receives 90 minutes of PT and 60 minutes of OT on the 4th, 5th, 6th, 7th, and 8th of May. The assessment reference date for the Medicare 5-day assessment is Monday, May 8. The beneficiary will classify into the Ultra High sub-category based on having received more than 720 minutes of therapy across at least two disciplines during the past seven days, as recorded in section P of the MDS. If, on the other hand, the beneficiary received this level of therapy on only four of the first seven days in the SNF, he or she would classify into the High Rehabilitation sub-category since this is the highest level of classification that is possible when a minimum of 500 minutes and five days of therapy have not been provided.

We have posted a tool on our web site that allows the user to follow the grouper logic manually. It walks through each step of the grouping logic and we believe it is a useful learning tool. The website address is: <www.hcfa.gov/medicare/hsqb/mds20/>.

Comment: There were a few comments regarding the use of the combination of physician visits and order changes to qualify beneficiaries for the Clinically Complex RUG–III category. One of the commenters argued that these criteria are unacceptable because an SNF represents not a medical model but rather a nursing model; as such, the physician's involvement and participation may be limited, or may result from consultation sought by the facility's nursing staff due to changes in a resident's condition or the need for specific services. Another commenter inquired about the specific definition being used to define a ''physician order change.''

Response: These comments are representative of concerns that have been expressed during the initial implementation of the SNF PPS. While we are aware that many facilities operate using a nursing model as opposed to a medical model of care delivery, the commenter's further observation on why the nursing staff would consult with the physician provides the explanation for why physician order changes and visits are qualifiers for the RUG–III groups.

The RUG–III system uses clinical events, conditions, and services as indicators of severity. The results of the research that is the basis of the RUG–III system showed that an increased frequency of physician visits and order changes are indicators of a beneficiary's clinical instability. As in the commenter's example, the nursing staff may consult with the physician due to changes in the beneficiary's condition that require medical intervention or the need for specific services that require a physician order.

We would also like to make clear what constitutes an order change. The specific issues that have been raised include whether an order to continue a specified treatment is a new order and, therefore, counts as an order change; whether a sliding scale medication order counts as a new order every time the clinician administers one of the different dosages specified in the scale; whether orders written to clarify a previous order count; and, whether all doctor's visits count in the number of physician visits item.

A physician's order to continue or renew some specified treatment or regimen would not be considered to be an order change, nor would an order written solely to clarify an earlier order. As stated in the Long Term Care RAI User's Manual, the definition of an order change does not include admission orders, return admission orders, or renewal orders without changes. Similarly, a sliding scale dosage schedule that is written to cover different dosages depending on lab values, does not count as an order change simply because a different dose is administered based on the sliding scale guidelines. ''Physician visits'' are also defined in the *Long Term Care RAI User's Manual.* The physician is defined to include an ''MD, osteopath, podiatrist, or dentist who is either the primary physician or consultant. Also include an authorized physician assistant or nurse practitioner working in collaboration with the physician.'' The visit is defined as a partial or full exam at the facility or in the physician's office.

L. Nurse Staffing and the Staff Time Measurement Studies

Comment: We received a variety of questions related to the staff time measurement (STM) studies performed in 1995 and 1997 that were used to set the case-mix indices. These included questions about what portion of the nurses' time was accounted for in the study, whether all nursing minutes (resident specific and non-specific) were used, whether medication aide time was counted, and what nurse staffing mix was used. Also, the suggestion was made that we should conduct another STM study after the PPS has been in place for a year.

Response: Before addressing the specific comments, we are taking this opportunity to provide a brief background explanation of the STM studies. As stated in the interim final rule, we conducted the STM studies in 12 States across 154 SNFs and 3,900 residents. The 1997 STM was performed to supplement the 1995 study to secure additional STM data from SNFs identified as providing both high quality care and more than an average level of rehabilitation therapy to patients on their Medicare-certified nursing units, and to include a broad geographic distribution of providers.

The STM data collection accounted for all nursing staff time during the 48-hour collection period. This time included that of the registered nurses (RNs), licensed practical nurses (LPNs), aides (certified nursing assistants (CNAs)), and medication aides. The resident-specific component counted all nursing time of 30 seconds or more spent in an activity directly attributable to a specific resident. The non-resident specific component included all time

not directly related to a specific resident, such as meetings, nursing unit administration, and staff meal times. Also, if the nursing staff member worked past the end of the shift, that time was counted as well.

The therapy staff time was collected over a 7-day period. All time that the therapist, therapy assistant, and therapy aides spent working in the certified nursing unit was accounted for and was apportioned between resident specific and non-resident specific, following the same methodology as was used in the nursing time allocation. All of these collected time data were used in the development of the indices.

The staffing levels and the nurse staffing mix on the units selected for the study met the OBRA 87 staffing requirements and provided more than 110 minutes of daily resident specific nurse staff time. Both freestanding and hospital-based facilities were used in the study. Salaries were adjusted based on the American Health Care Association's 1995 study of national nursing home salaries.

The nurse staffing mix found on the certified nursing units in the study were determined per unit, based on the mix of residents on the nursing unit at the time of the data collection. Based on a case-mix of 0.92, the average time across the two staff time studies was: 1.2 hours per resident, per day of RN time; 0.7 hours per resident, per day of LPN time; 2.6 hours per resident, per day of CNA time (including medication aides). This adds up to 4.6 hours per resident, per day of nursing time.

An important point to understand about the nursing time is how it affects the rates. The nursing time associated with any one group in the RUG–III hierarchy does not represent the nursing minutes that must be provided (and that will be paid for by Medicare) to each of those beneficiaries. Rather, the minutes are a distributional value—an average for the RUG–III group—and were an important factor in the development of the case-mix indices. The weight for each of the 44 RUG–III groups represents the average resources (including, of course, nursing) required to care for beneficiaries who classify to that group relative to the average resources required to care for beneficiaries in all of the other RUG–III groups. The RUG–III group with a value of 1.0 is identified and the weights for the other groups are calculated once that has been done. The value of 1.0 indicates that the average resources required to care for beneficiaries in that group are the average compared to all of the other groups. Accordingly, the resource requirements to care for beneficiaries in the other 43 RUG–III groups are either higher or lower than for the group with the weight of 1.0. Depending on the distribution of beneficiaries across the RUG–III groups, the group with the relative value of 1.0 will vary. It is important to bear this concept in mind, in order to avoid the misconception that a RUG–III group with a relative weight that changes from one year to the next has staffing requirements that have changed from the original staff time measurement study. The RUG–III system does not impose any new staffing requirements. The data are available from the HCFA PPS website address: <www.hcfa.gov/medicare/snfpps.htm.>

Comment: One commenter requested that we explain why the Behavior Category is so low in the RUG–III hierarchy, even though beneficiaries who classify into that group require intensive amounts of staffing resources.

Response: The reason for this is that the RUG–III hierarchy is in large part based on minutes of licensed nursing time and on the clinical conditions that require the attention of licensed staff. This is a result of early research findings that indicated that beneficiaries who have the clinical characteristics that would classify them into the medically complex categories, like Extensive Care, generally require much more RN and LPN time than do beneficiaries who classify into the groups in the lower end of the clinical scale. Similarly, beneficiaries who classify into groups lower in the hierarchy generally require less licensed nurse time but, as stated by the commenter, may require intensive amounts of staffing resources.

Beneficiaries in the Behavior Category may not need much licensed nurse time, but instead may require a large amount of certified nurse assistant (CNA) time. Much of the care required in these lower-end RUG–III groups is of the type provided by CNAs, such as assistance with activities of daily living (ADLs) and other types of maintenance care. In general, the need for CNA time is reflected in the beneficiaries' ADL sum scores, whereas the need for licensed nurse time is predicted by clinical complexity as reflected by the level in the hierarchy. Thus, beneficiaries who classify into the Extensive Services category where the ADL sum score is at least 7, have highly complex clinical needs and require high levels of both licensed nurse (RN/LPN) and CNA time. Beneficiaries in the lower-weighted RUG–III groups may also require skilled nursing care, but generally not as much as required in the higher groups.

Comment: Several commenters had concerns that the STM was collected over too short a period, that too few facilities were used and that not enough of them were hospital-based facilities, and that too few of the facilities used were located in metropolitan statistical areas (MSAs) with populations in excess of 500,000 people.

Response: We are confident that the methodology used for the STM studies was valid and appropriate for the task. Three STM studies were conducted. The first was in 1990, followed by another in 1995, and the last in 1997. The staff time studies were conducted in 13 States, in units of more than 300 nursing homes, representing care provided to about 12,000 residents. The States included were California, Colorado, Florida, Kansas, Maine, Maryland, Mississippi, Nebraska, New York, Ohio, South Dakota, Texas, and Washington. These States are geographically representative and include rural areas, as well as MSAs with populations in excess of 500,000.

Within each of these States, the selection of SNFs was guided by the research design that called for a sample that would adequately represent units that provide high quality, high-acuity care. The facilities in the combined 1995 and 1997 study sample were 55 percent for-profit facilities, 45 percent non-profit, 22 percent hospital-based facilities; 36 percent of the facilities had a head trauma unit, a ventilator unit, a special rehabilitation therapy unit, or a dialysis unit, or had been recommended as a high intensity unit by the Technical Expert Panel. Although the amount of time spent collecting data on any particular unit was short, the studies were conducted during different years and each year's study was performed over a period of months. In this way, the study was reflective of practice in the facilities in the aggregate, if not precisely representative of any particular facility over time.

Comment: One commenter argued that the staffing patterns (using 1995 as the base year) used in developing the rate structure lock SNFs into historic staffing patterns. Another commenter asserted that since there is no language in the regulation requiring SNFs to use a certain proportion of the rate on direct care services, they will not do so, and suggested that we adopt the staffing recommendations of the Institute for Geriatric Nursing of the John A. Hartford Foundation.

Response: As indicated earlier, the RUG–III system does not impose staffing requirements. We do not believe that our use of the 1995 base year locks facilities into any particular level of nurse staffing, either directly or indirectly. As stated above, the staffing

levels in the staff time studies were based on the unit's case-mix at the time. The study used units that had a mix of payor types. Nationally, of the 14,000 Medicare certified facilities, fewer than 4,000 have an average daily census of more than 10 Medicare beneficiaries. We do not believe that it is appropriate to require staffing standards based on the needs of such a small portion of the facility's population, but this is an issue that is outside of this regulation's scope. We will carefully review and consider the findings of the National Academy of Sciences report (the report cited by the commenter is part of this larger effort) when it becomes available.

Comment: One commenter suggested that we include speech language pathology assistant times when we perform our next staff time measurement study. The commenter recommended that we include the times for these care providers in our update of the RUG–III case-mix indices.

Response: While we are not prepared to address the issue of when to conduct another staff time measurement study within the context of this final rule, we would note that services of speech language pathology assistants are not recognized for separate coverage under Medicare. In order for this class of providers to be eligible for Medicare payment, they must first achieve licensure or some other standard credential recognized at the national level. To date, these assistants have not obtained this standing.

Comment: We received a number of comments regarding the treatment of respiratory therapy services under the RUG–III. Several commenters expressed concern that facilities would be using inappropriately trained nurses rather than appropriately trained personnel to provide respiratory therapy services.

Response: We share the commenters' concern with regard to the quality of care. As stated in the SNF Manual at section 230.10.B.1, Medicare requires that respiratory services must be provided by respiratory therapists or technicians, physical therapists, nurses, or other qualified personnel. We currently have no evidence that unqualified personnel are administering respiratory treatments, but note that the State surveyors monitor long-term care facilities for such lapses in quality. The rules governing the provision of respiratory treatment were not altered by the implementation of PPS but certainly, in light of the PPS and its associated incentives, we are determined to monitor closely the provision of SNF care, including respiratory treatments. A key provision in implementing the new payment system is to safeguard quality of care for nursing home residents, and this issue warrants particular attention from our quality and enforcement initiative.

Comment: Several commenters raised concerns with the manner in which respiratory therapy is recognized in the SNF PPS.

Response: As discussed earlier in this preamble in the context of the Federal PPS rates, the treatment of respiratory therapy services in the SNF PPS was the result of careful consideration and extensive analysis. The RUG–III case-mix classification system, which forms the basis for the payment rates, does not include respiratory therapy in the same category as the rehabilitation therapies (occupational, speech, and physical therapy).

The primary reason for this was the difference in treatment patterns between respiratory therapy and the rehabilitation therapies. A secondary reason is that the costs of respiratory therapy services are not always separately identifiable on SNF cost reports, since trained nurses are qualified to provide these services, and often do so. However, we note that all costs from the base year data associated with respiratory therapy were captured in the computation of the payment rates, and the provision of respiratory therapy, as indicated on the resident assessment, can result in a higher payment in the non-rehabilitation RUG–III groups.

We believe that the SNF PPS accounts for respiratory therapy appropriately, and we do not believe that the RUG–III classification system will discourage the provision of needed respiratory rehabilitation. However, as discussed earlier, we are engaged in research to determine the potential for making refinements to the current case-mix model to improve accuracy of the payments. Ancillary services, such as pharmacy and respiratory therapy, will be one focus of the research.

Comment: One commenter noted that Medicare beneficiaries with more than $1,000 in paid respiratory therapy claims account for only 18 percent of all Medicare beneficiaries who received respiratory therapy services in 1996, and that the top four diagnoses (excluding a generic category of ''other diseases of the lung'')—chronic bronchitis, chronic airway obstruction, pneumonia due to solids or liquids, and pneumonia—average between $75 and $100 per day in respiratory services. The commenter added that this amount far exceeds the payment amounts associated with the 42 RUG–III categories that do not have respiratory adjustments, and that this warrants the development of an outlier policy to insure adequate care for these beneficiaries.

Response: Please refer to the preamble discussion on the Federal rates, in which we discuss ''outlier'' situations.

Comment: One commenter suggested that any future revisions to the MDS 2.0 should include an expansion of data collection fields to capture critical respiratory therapy diagnoses and medication requirements, and that certain data items in the current MDS related to respiratory care should be considered in revising the RUG–III classifications, so that patient acuity and payment will be appropriately recognized.

Response: These are important issues to consider as we revise the MDS and implement new versions in the future; however, we will not be making any changes to the MDS in this final rule.

Comment: Several commenters raised issues in connection with recreational therapy. Some indicated that the definitions and language within section T should accurately reflect and comply with the recreational therapy profession's standards and practices. To provide an accurate picture of the resident's rehabilitation needs, sections T1c and T1d should include recreational therapy within the mix of comprehensive rehabilitation services.

Response: Recreational therapy has long been among the services that Medicare has recognized as related to patient care in SNFs; however, it is not a therapy specifically identified for coverage in the statute. For this reason, recreational therapy services are not included in the RUG–III system in the same way as the rehabilitation therapies.

Comment: One commenter expressed a belief that the RUG–III system fails to reflect the importance of interdisciplinary comprehensive rehabilitation services. The commenter argued that recreational therapy is identified as a viable and recognized treatment option within all rehabilitation treatment settings, and noted that within the present RUG–III version, Recreation Therapy treatment minutes are not used in identifying the RUG–III rehabilitation classification.

Response: To the extent recreational therapy services were furnished in the SNF PPS base year, they are reflected in the SNF PPS payments. Thus, the SNF PPS reflects the provision of recreational therapy services to Medicare beneficiaries. Accordingly, we find no evidence to support the notion that the RUG–III classification system in any way prevents Medicare beneficiaries from receiving recreational therapy services.

M. SNF Coverage and Level of Care Determinations

One of the prerequisites for coverage under the ''extended care'' (that is, Part A SNF) benefit is the beneficiary's need for and receipt of an SNF level of care. In the preamble to the interim final rule (63 FR 26283–85), we designated the upper 26 of the 44 RUG–III groups as representing an SNF level of care. We specified that a beneficiary's assignment to one of the upper 26 RUG–III groups as the result of a resident assessment would automatically classify the beneficiary as meeting the SNF level of care definition. Beneficiaries assigned to one of the lower 18 RUG–III groups would not automatically classify as either meeting or not meeting the level of care definition, but would instead receive an individual determination under the longstanding level of care criteria in regulations at Part 409, subpart D.

As discussed below, in this final rule we are clarifying the role played by a beneficiary's RUG–III assignment in the process of making SNF level of care determinations, and we are also restoring portions of the regulations text that appeared previously in § 409.33(a) on management and evaluation, observation and assessment, and patient education, which were deleted by the interim final rule.

Comment: We received numerous comments regarding the procedures for making SNF level of care determinations under the SNF PPS. Several commenters were under the impression that, in view of the prospective nature of the SNF PPS, and the interim final rule's designation of the upper 26 RUG–III groups as representing an SNF level of care, a resident assessment that triggers assignment to one of the upper 26 groups would result in automatic coverage that continues for the entire duration of the period to which that assessment applies, regardless of any changes in condition or services provided that might occur subsequent to the completion of the assessment itself. This impression was reinforced, in their view, by a table (Table 2.D) on the Medicare Assessment Schedule, which appeared in the preamble of the interim final rule (63 FR 26267), and which included a column entitled ''Number of Days Authorized for Coverage and Payment.'' These commenters also asserted that making coverage determinations for a predetermined block of time was the approach that had been adopted under the NHCMQD, which served as the forerunner of the SNF PPS.

Response: In order to understand the actual effect of an assignment to one of the upper 26 RUG–III groups in making level of care determinations under the SNF PPS, it is also necessary to consider how SNF coverage determinations were made before the inception of the PPS. Before the SNF PPS, when a beneficiary met the ''posthospital'' requirements for SNF coverage (that is, the timely initiation of SNF care following the beneficiary's discharge from a qualifying hospital stay), an individual level of care determination was made, using the longstanding criteria that appear in regulations at §§ 409.31 through 409.35, and manual instructions in the Medicare Intermediary Manual, Part 3 (MIM–3, HCFA Pub. 13–3), sections 3132ff and the Skilled Nursing Facility Manual, sections 214ff.

As discussed in the interim final rule, this determination entailed a retrospective review by the Medicare FI, which focused primarily on a beneficiary's need for and receipt of specific, individual skilled services. Along with the posthospital and level of care requirements, the SNF services also had to meet additional requirements that apply to Medicare coverage generally; for example, the overall requirement that a service must be reasonable and necessary to diagnose or treat the beneficiary's condition (section 1862(a)(1) of the Act). Under this system of retrospective review, it was possible for an FI to issue a denial of coverage that was retroactive all the way back to—and even including—the day of SNF admission itself. As noted in the interim final rule, this situation made it extremely difficult for an SNF to predict with any degree of certainty that a particular admission ultimately would, in fact, be covered.

In the interim final rule, we designated a beneficiary's correct assignment to one of the upper 26 RUG–III groups as representing an SNF level of care in an effort to bring more predictability and certainty to the process of making coverage determinations. However, this designation was made specifically with respect to the SNF level of care requirement itself, and was never intended to supersede any of the other existing criteria for coverage under the SNF benefit, such as the posthospital requirements, or the overall requirement for services to be reasonable and necessary to diagnose or treat the beneficiary's condition. Thus, under this approach, when the initial Medicare (that is, 5-day) required assessment results in a beneficiary being correctly assigned to one of the upper 26 RUG–III groups, this effectively creates a presumption of coverage for the period from admission up to, and including, the assessment reference date for that assessment, and the coverage that arises from this presumption remains in effect for as long thereafter as it continues to be supported by the actual facts of the beneficiary's condition and care needs. Relative to the situation that existed before the SNF PPS, we believe that this approach provides the SNF with far greater confidence in coverage at the outset of a resident's stay, and enables the SNF, once coverage is established, to continue to bill for the resident's care for as long as the resident's actual care needs continue to support coverage.

The use of this presumption at the outset of a resident's SNF stay is supported by the SNF benefit's basic nature as a posthospital benefit, which is a major factor in determining the typical course of an SNF stay. In its July 1998 testimony before the House Ways and Means Committee (GAO/T–HEHS–98–214), the GAO noted that SNF residents tend to be relatively unstable and require fairly intensive skilled care during the period immediately following admission from the prior hospitalization, but that this tendency typically diminishes as they get further on in the SNF stay. The GAO indicated that a policy which continues to ''deem'' coverage for these individuals after they have clearly reached the point where they no longer need a skilled level of care would represent an unwarranted expansion in the SNF benefit.

We concur with the GAO's conclusion and, in view of the misunderstanding expressed by commenters on this point, we believe it is appropriate to clarify in this final rule that the initial presumption of coverage that arises from a beneficiary's Medicare-required 5-day assessment and his or her resulting RUG–III assignment encompasses the period from admission through the assessment reference date for the initial 5-day assessment, and is not intended to create an opportunity for continued payment beyond the point where SNF care is no longer reasonable and necessary; accordingly, the continuation of coverage, once established by the RUG–III presumption, would depend upon the subsequent course of the resident's actual condition and care needs.

We also wish to clarify that this presumption does not arise in connection with any of the subsequent assessments, but applies specifically to the period ending with the assessment reference date for the initial Medicare-required 5-day assessment that occurs shortly after the beneficiary's admission

from the prior hospital stay. Accordingly, we are amending the regulations text at § 409.30 to clarify that this presumption is valid up to and including the assessment reference date (that is, the last day of the observation period, which must occur no later than the eighth day of posthospital SNF care) for the initial Medicare-required 5-day assessment.

As the preceding discussion indicates, the course that SNF stays characteristically take over time means, in effect, that the basis for making any type of presumption with regard to coverage would tend to become progressively less conclusive as a resident moves farther into the SNF stay, and would be at its most conclusive at the very outset of the stay, during the period immediately following the resident's admission from the prior hospitalization. Accordingly, in situations in which a resident's condition upon admission is such as to warrant assignment to one of the upper 26 RUG–III groups, we regard this very tendency of SNF stays to be at their most intensive and unstable immediately following admission as justifying a presumption of coverage at the very outset of the SNF stay, during the period leading up to the assessment reference date for the initial Medicare-required 5-day assessment. This initial portion of the SNF stay provides the opportunity for the facility to initiate skilled nursing and rehabilitation services, and to begin its complete assessment of the beneficiary's clinical characteristics and care needs.

In addition, we believe that the use of the coverage presumption during these first few days of a resident's stay may provide the additional benefit of enabling medical review resources to be deployed for maximum effectiveness: by combining the clinical criteria that are captured in the upper 26 RUG–III groups with the tendency (as discussed above) for the initial portion of an SNF stay to be the most intensive and unstable, the presumption should provide a more reliable way of identifying at the outset those residents who do, in fact, require a covered SNF level of care. This, in turn, will enable medical reviewers to focus their resources elsewhere, on other residents or other portions of the SNF stay that are far more likely to involve the provision of noncovered care.

The underlying principle at work in the use of this administrative presumption at the outset of a covered stay is the fact that the RUG–III groups themselves are expressions of a certain level of services—skilled nursing care and skilled rehabilitation services, the need for which represents the SNF level of care described in the statute at section 1814(a)(2)(B) of the Act. We, therefore, believe that in situations in which a beneficiary's initial, Medicare-required 5-day assessment results in an accurate assignment to one of the highest 26 of the 44 RUG–III groups, this assignment (in combination with the proximity to the prior qualifying hospital stay) makes it appropriate to presume that the beneficiary meets the SNF level of care definition at the outset of the stay. However, as is the case with all such administrative presumptions, this presumption is itself rebuttable in those individual cases in which the services actually received by the resident do not meet the basic statutory criterion of being reasonable and necessary to diagnose or treat a beneficiary's condition (according to section 1862(a)(1) of the Act). Accordingly, the presumption would not apply, for example, in those situations in which a resident's assignment to one of the upper 26 RUG–III groups is itself based on the receipt of services that are subsequently determined to be not reasonable and necessary.

The role of this presumption in determining coverage is, in some ways, similar to that performed by a physician who correctly certifies that a beneficiary requires a covered level of care, in that both activities serve to identify a beneficiary's initial need for covered care. In this context, it is worth noting that the interim final rule amended the physician certification regulations to reflect the use of the RUG–III system specifically with regard to the initial certification (§ 424.20(a)(1)(ii)), but not the subsequent recertifications (§ 424.20(c)).

Further, we note that the process of providing appropriate resident care in SNFs (which consists of a continuous loop of resident assessment, care planning, implementing specific interventions, and assessing the resident's response to and continued need for the interventions) serves to keep the SNF apprised, on an ongoing basis, of any changes in the resident's care needs. Thus, once the SNF determines that skilled care is no longer required, it must acknowledge this change in condition at that point and issue the appropriate written notice of noncoverage to the beneficiary.

Under existing program policy, in situations involving a provider that has acted in good faith but has nonetheless had a claim for Medicare coverage denied, a separate statutory provision on limitation of liability at section 1879 of the Act might permit payment to be made on an exception basis. This provision specifically refers to denials based on the general exclusion from coverage for care that is not reasonable and necessary (section 1862(a)(1) of the Act), as well as the exclusion for custodial care (section 1862(a)(9) of the Act). Taken together, these provisions indicate that any presumption about the need for covered care at the outset of the SNF stay is rebuttable by one of these general coverage exclusions—and might be remediable by the limitation of liability provision.

We do not agree with the commenters who argued that the prospective nature of the SNF PPS should result in coverage being granted prospectively for a predetermined block of time (that is, for the entire duration of the assessment period). Rather, the SNF PPS is prospective in the sense of paying a predetermined rate that represents—in the aggregate—the cost of SNF care that would typically be associated with a beneficiary who classifies to a particular RUG–III group. However, we note that a basic feature of the SNF PPS (and one that fundamentally distinguishes it from, for example, its inpatient hospital counterpart) is that it makes payment on a per day rather than a per episode basis. This means that while there may, in practice, be some variation in resource intensity from one resident to another within a particular RUG–III group (and even from one day to another within a particular resident's stay), the SNF PPS per diem payments, when taken in the aggregate, appropriately reflect the overall intensity of resources associated with that particular RUG–III group. Further, the per diem basis for payment recognizes that in practice, the levels and types of services required and the duration of the actual need for a covered SNF level of care may vary somewhat from one resident to another.

The preamble discussion of the case-mix system in the interim final rule (63 FR) 26261) notes that in the nursing home setting, ''* * * no adequate models have been found for using length of stay or episode cost to explain resource use. Thus, the RUG–III nursing home case-mix system explains patient resource use on a daily basis.'' Accordingly, the framework set forth in the interim final rule supports the concept that the continuation of SNF coverage (once it has been initiated by the RUG–III presumption) must be supported by the resident's actual condition and care needs, and is not guaranteed for some predetermined block of time. To determine otherwise would effectively create a perverse incentive for SNFs to extend the length

of Medicare stays beyond the point where the provision of skilled care ceases to be reasonable and necessary. Additionally, with regard to dually-entitled residents, an SNF might have an additional incentive to prolong the period during which it receives Medicare per diem payments, in order to delay the change to a Medicaid payment that, in some States, is lower.

Further, with regard to the comments on the NHCMQD, we note that in contrast to the SNF PPS itself, we intentionally refrained from conducting medical review under the demonstration, in order to observe facility practices and care patterns in its absence. The resulting facility activity under the demonstration did not appear to diverge significantly from prior experience. With regard to duration of coverage, it would appear that the primary factor in determining the cessation of coverage under the demonstration was not the resident assessment cycle but, rather, the interest of beneficiaries and their families in keeping the length of SNF stays as short as possible—in order to avoid or minimize their financial liability for the daily SNF coinsurance that begins on the 21st day of Part A coverage, and to have the beneficiary return home at the earliest possible moment (under the demonstration, patients were only in the SNF long enough to have an average of 2.5 Medicare-required assessments). Based on the demonstration experience, as well as the nature of the coverage presumption itself (that is, its validity up to the assessment reference date for the initial Medicare-required 5-day assessment), this presumption clearly is not designed to guarantee payment for the entire duration of the assessment period.

Nevertheless, consistent with the averaging function of the PPS, the payment rate, once established, is guaranteed for as long as the beneficiary's care needs continue to fall within the range of covered care, even if the specific acuity of the beneficiary's care needs within this range decreases; thus, the SNF can continue to receive the higher payment rate for such a beneficiary's covered care up to the next assessment. Conversely, it is possible that a resident's acuity may decrease to the point where it actually falls below a covered level of care, even though it has not changed sufficiently to trigger a Significant Change in Status Assessment. At that point, the ongoing coverage is ended by Medicare's statutory coverage exclusion of custodial care at section 1862(a)(9) of the Act, which provides that ''* * * [n]otwithstanding any other provision of this title, no payment may be made for any expenses incurred for items or services * * * where such expenses are for custodial care'' (emphasis added), and the SNF would be required to issue a notice of noncoverage. Under the implementing regulations at 42 CFR 411.15(g), this exclusion is invoked whenever a beneficiary receives care that does not meet the requirements for coverage as SNF care as set forth in §§ 409.31 through 409.35. The qualifying language in the statute means that the custodial care exclusion from coverage takes precedence over other provisions of the program—including any presumptions made with regard to coverage. Thus, under the SNF PPS, the introduction of the coverage presumption based on a beneficiary's RUG–III group assignment was intended to streamline and simplify the initial level of care determination (which, along with the posthospital requirements, governs access to coverage under the extended care benefit). However, once this presumption has served to establish a beneficiary's initial access to coverage under the extended care benefit, it does not in any way supplant or invalidate the remainder of the basic and longstanding process for determining the duration of that coverage. While we believe that the use of this coverage presumption at the outset of the SNF stay represents a significant advancement toward achieving greater simplicity, predictability, and consistency in the coverage process, we will continue to monitor coverage determinations under the SNF PPS with a view toward the possibility of making further refinements and improvements in the future.

Finally, with regard to Table 2.D (Medicare Assessment Schedule), which appeared in the preamble to the interim final rule (63 FR 26267), we note that the heading to column four, Number of Days Authorized for Coverage and Payment, refers to the *maximum* period of coverage between assessments, but was not intended to prescribe coverage of a predetermined block of time consisting of a minimum number of days. In order to resolve any confusion that publication of this table may inadvertently have caused, we are now republishing the table below, with that particular column omitted.

TABLE 2.D.—MEDICARE ASSESSMENT SCHEDULE

Medicare MDS assessment type	Reason for assessment (AA8b code)	Assessment reference date	Applicable medicare payment days
5 day	1	Days 1—8*	1 through 14.
14 day	7	Days 11—14**	15 through 30.
30 day	2	Days 21—29	31 through 60.
60 day	3	Days 50—59	61 through 90.
90 day	4	Days 80—89	91 through 100.

*If a patient expires or transfers to another facility before day 8, the facility will still need to prepare an MDS as completely as possible for the RUG–III classification and Medicare payment purposes. Otherwise the days will be paid at the default rate.

**RAPs follow Federal rules.

Comment: One commenter questioned the appropriateness of using a resident's assignment to one of the upper 26 RUG–III groups as a determinant of a skilled level of care in situations in which the RUG–III assignment is based solely on events that occurred during the ''look-back'' period (for example, IV medications within the past 14 days). The commenter noted that this could result in a resident being covered even though the qualifying skilled services that triggered the RUG–III assignment have themselves been discontinued before admission to the SNF, and the resident is no longer actually receiving any skilled care whatsoever by the time of the assessment itself.

Response: We note that the use of the ''look-back'' period in making RUG–III assignments is essentially a clinical proxy that is designed to serve as an indicator of situations that involve a high probability of the need for skilled care. Thus, our expectation is that the occurrence of one of the specified events during the ''look-back'' period,

when taken in combination with the characteristic tendency (as discussed above) for an SNF resident's condition to be at its most unstable and intensive state at the outset of the SNF stay, should make this a reliable indicator of the need for skilled care upon SNF admission in virtually all instances. In particular, residents in such situations may need the types of services formerly listed in § 409.33(a) of the regulations, that are discussed more fully below. If it should become evident in actual practice that this is not the case, it may become appropriate at that point to reassess the validity of the RUG–III system's use of the ''look back'' period in making assignments.

Comment: In the interim final rule, we invited comments on the feasibility of dispensing with the level of care criteria in existing regulations, in favor of utilizing the RUG–III framework as the exclusive means for making level of care determinations. One commenter expressed support for this approach; however, many others supported the continuation of individual level of care determinations under the existing criteria for beneficiaries assigned to one of the lower 18 RUG–III groups. A few of these commenters suggested that we might reassess this approach after the PPS has been in operation for a few years; at that point, they suggested, it might be possible to identify specific clusters of services within the lower 18 RUG–III groups that could serve as reliable indicators of skilled care, and to incorporate those indicators into the upper 26 RUG–III groups.

Response: As requested by most of the commenters, we are retaining in the regulations the existing criteria with certain modifications, as discussed elsewhere in this preamble. To the extent that our continuing experience in implementing the SNF PPS may indicate at some future point that further revisions in these criteria are warranted, we will consider making appropriate refinements to them at that time.

Comment: We received a number of comments concerning certain incremental adjustments that we made to the existing level of care criteria in the interim final rule. We made these revisions in order to achieve greater consistency with the general approach adopted under the SNF PPS with the use of the RUG–III groups, and also to reflect the significant advances in the state of long-term care practices that have occurred during the quarter century since the current SNF level of care regulations were first promulgated. Specifically, in view of changes in medical practice over time, we deleted the previous references to hypodermoclysis and subcutaneous injections as examples of skilled nursing services. We retained enteral feeding as an example of a skilled nursing service, but adopted specific qualifying criteria from the RUG–III framework (that is, that the enteral feeding must comprise at least 26 percent of daily calorie requirements and at least 501 milliliters of fluid per day). Further, we deleted the categories previously listed in § 409.33(a) of ''management and evaluation of a care plan,'' ''observation and assessment'', and ''patient education'' as examples of skilled services, in the belief that these categories were already effectively captured by the clinical proxies that have been incorporated into the upper 26 RUG–III groups.

Additionally, in the preamble to the interim final rule (63 FR 26284), we indicated that it might well be desirable to delete the insertion, irrigation, and replacement of urinary catheters as an example of a skilled service, in order to avoid providing a perverse incentive for their inappropriate use. However, we also invited comments on the desirability of retaining this example specifically with regard to suprapubic catheters.

Of the comments we received on these changes, the largest number supported retaining suprapubic catheters as an example of a skilled nursing service, noting that this procedure is a major vector for infection that can be fatal if improperly performed, and that requires a greater amount of skilled care than foley catheters. One commenter favored deleting even suprapubic catheters from the examples of skilled nursing services, while another favored retaining all types of catheters in the examples. Several commenters advocated reinstating observation and assessment, management and evaluation, and patient education as explicit examples of skilled services in the SNF level of care regulations (or, alternatively, amending the regulations governing the home health benefit at § 409.42(c)(1), which currently cross-refer to the SNF regulations, to include them). A few commenters suggested retaining subcutaneous injections as an example of a skilled nursing service specifically with regard to those residents who, due to cognitive impairments such as those associated with dementia, are unable to self-administer the injections, and another favored retaining hypodermoclysis.

Response: As noted above, our reason for deleting the explicit references in the regulations to management and evaluation, observation and assessment, and patient education was not that they no longer represented appropriate examples of skilled care, but rather, because we believed that these separate references were no longer necessary in view of the clinical indicators that have been incorporated into the upper 26 RUG–III groups. However, in order to avoid possible confusion on this point, we are accepting the commenters' suggestion to reinstate these categories as specific examples in the SNF level of care regulations.

Further, while we continue to believe that it is inappropriate to cite the use of a urinary catheter as an example of a skilled service in most instances, we agree with the reasons advanced by the commenters who favored specifically retaining suprapubic catheters in the list of examples of skilled nursing services; accordingly, we are modifying the example regarding catheters to refer exclusively to this particular type of catheter. However, for the reasons discussed previously in the preamble to the interim final rule, we are not reinstating hypodermoclysis or subcutaneous injections as examples of skilled nursing services. Regarding the latter, we do not believe that the presence of a cognitive impairment in the person who receives the injection would significantly affect the skills required on the part of another person who actually administers it.

Finally, we are taking this opportunity to correct a technical inaccuracy that appears in the regulations at § 411.15(g), defining the term ''custodial care,'' as well as in the introductory material for § 409.30. An earlier version of the custodial care definition (which appeared at § 405.310(g)) correctly described this term in the SNF context as any care that does not meet the SNF level of care criteria, which at that time appeared in § 405.126 through § 405.128. When the SNF level of care criteria were redesignated as § 409.31 through § 409.35 (48 FR 12534, March 25, 1983), a conforming change was subsequently made to the cross-reference in the custodial care regulations (50 FR 33031, August 16, 1985).

However, in addition to the level of care regulations at redesignated § 409.31 through § 409.35, this conforming change inadvertently revised the cross-reference erroneously to include the SNF benefit's posthospital requirements at redesignated § 409.30. Since the posthospital requirements are not an element of the custodial care definition, we are deleting that portion of the citation from the cross-reference, which is revised to refer correctly to the SNF

level of care criteria at § 409.31 through § 409.35. Similarly, we are revising the cross-reference in the second sentence of the introductory material in § 409.30 (regarding the use of the RUG–III groups in making level of care determinations) to refer solely to the level of care requirements in § 409.31, and not to the posthospital requirements set forth in the remainder of § 409.30 itself.

Comment: Some comments reflected certain longstanding misconceptions regarding the SNF level of care definition, in terms of a beneficiary's need for and receipt of skilled services on a daily basis which, as a practical matter, can be furnished only in an SNF on an inpatient basis. One recurring misconception with regard to the ''daily basis'' requirement (which some of the commenters expressed as well) is that Medicare coverage guidelines provide for specific breaks in skilled therapy services for the observance of a prescribed list of national holidays. Another longstanding misconception shared by some commenters is that the cessation of therapy for so much as a single day due, for example, to the beneficiary's temporary illness or fatigue, would mandate an automatic discontinuance of coverage. The recurring misconception with regard to the ''practical matter'' requirement is that a beneficiary's ability to have even an occasional, brief absence from the SNF in order to attend, for example, a holiday meal with family or friends, would result in the loss of Medicare coverage. As explained below, these interpretations of Medicare SNF coverage requirements are incorrect.

Response: We note that the commenters' misunderstandings reflect certain recurring misconceptions about the SNF level of care criteria that long predate the SNF PPS. With regard to the ''practical matter'' requirement, it is true that a beneficiary's ability to have frequent or prolonged absences from the facility may raise a question as to whether the beneficiary, as a practical matter, can only receive the care that he or she needs on an inpatient basis in the SNF. However, this is not the case when a beneficiary is capable of having only occasional, brief absences from the facility. As section 214.6.C. of the Medicare SNF Manual indicates:

> An SNF should * * * not interpret the ''practical matter'' criterion so strictly that it results in the automatic denial of coverage for patients who have been meeting all of the SNF level of care requirements but who have occasion to be away from the SNF for a brief period of time. While most beneficiaries requiring an SNF level of care find that they are unable to leave the facility for even the briefest of time, the fact that a patient is granted an outside pass, or short leave of absence, for the purpose of attending a special religious service, holiday meal or family occasion, for going on a ride or for a trial visit home, is not by itself evidence that the individual no longer needs to be in an SNF to receive required skilled care. Very often special arrangements, not feasible on a daily basis, have had to be made to allow for absence from the facility.

Thus, the requirement for daily skilled services should not be applied so strictly that it would not be met merely because there is a brief, isolated absence from the facility in a situation where discharge from the facility would not be practical. It is also worth noting that, in addition to the coverage guidelines discussed above, the Medicare certification requirements for SNFs, at § 483.15(d), provide that each resident has the right to participate in social, religious, and community activities that do not interfere with the rights of other residents in the facility. Similarly, with regard to the ''daily basis'' requirement, the Medicare program does not specify in regulations or guidelines an official list of holidays or other specific occasions that a facility may observe as breaks in rehabilitation services, but recognizes that the resident's own condition dictates the amount of service that is appropriate. Accordingly, the facility itself must judge whether a brief, temporary pause in the delivery of therapy services would adversely affect the resident's condition.

Comment: A commenter asked whether the certification and recertification statements for posthospital skilled nursing facility services required under section 1814(a)(2) of the Act must be performed only by a physician, or can be performed by an authorized facility staff member. Another requested that we authorize a physician assistant to perform certification and recertification statements (as nurse practitioners and clinical nurse specialists already are under current law). One commenter noted that the SNF benefit's requirement for a physician to certify (and periodically recertify) that a beneficiary needs an SNF level of care was waived under the NHCMQD, and argued that this requirement is a needless burden that should be permanently eliminated.

Response: Section 1814(a)(2) of the Act requires that a physician (or a nurse practitioner or clinical nurse specialist who does not have a direct or indirect employment relationship with the facility, but who is working in collaboration with a physician) initially certifies, and periodically recertifies, the need for a skilled level of care. However, this provision does not currently authorize facility staff members or physician assistants to perform this function. Section 424.20 sets forth the timing of the required certifications as follows: the initial certification must occur at the time of admission or as soon thereafter as is reasonable and practicable; the first recertification is required no later than the 14th day of posthospital SNF care; and, subsequent recertifications are required at least every 30 days after the first recertification.

Comment: One commenter noted that the upper 26 groups of RUG–III are designated as representing a covered SNF level of care only in the preamble to the interim final rule, and suggested that this designation should also be made explicit in the regulations text itself.

Response: The reason that we declined to specify particular RUG–III groups in the regulations text itself was not to expand or contract coverage relative to the types of conditions that the upper 26 RUG–III groups currently identify, but rather, to allow for the possibility that the RUG–III groups themselves might be reconfigured in the future. This gives us the necessary flexibility to designate (in the routine annual update of Federal prospective rates described in regulations at § 413.345) those reconfigured RUG–III groups that would correspond to the upper 26 groups under the current RUG–III configuration, without having to go through the full rulemaking process in order to make specific revisions in the regulations text itself. (Of course, any such reconfiguration in the RUG–III groups would itself be effected through rulemaking.)

N. SNF Consolidated Billing

The consolidated billing requirement (established by section 4432(b) of the BBA) places with the SNF itself the Medicare billing responsibility for virtually the entire package of services furnished to a resident of an SNF. In the interim final rule, we addressed both the scope of services and the definition of an SNF ''resident'' that apply for purposes of this provision. As discussed below, this final rule provides additional clarification on implementation timeframes for this provision and on the scope of services to which this provision applies, including the role played by the SNF care planning process.

Comment: We received many comments regarding timeframes for implementation of the SNF consolidated billing provision, particularly with respect to those SNF residents who are

not in a covered Part A stay. Many expressed support for a delay in the implementation of this aspect of the provision, and requested that advance notification be given before implementing it.

Response: Section 4432(d) of the BBA provides that, unlike the effective date for the PPS itself (which is tied to the start of the individual SNF's first cost reporting period that begins on or after July 1, 1998), the consolidated billing provision applies to items and services furnished on or after July 1, 1998. In April 1998, we published PM transmittal number AB–98–18, which contained operational instructions for Medicare contractors on consolidated billing implementation.

As noted in the preamble to the interim final rule, in order to accommodate individual SNFs that lacked the capability to perform consolidated billing as of the July 1, 1998, effective date, the PM provided for a ''transition period,'' under which such a facility would be required to begin consolidating its bills for items and services furnished on or after the earlier of either (1) January 1, 1999 or, (2) the facility's PPS start date.

However, this instruction was subsequently superseded by PM transmittal number AB–98–35 (July 1998), which eliminated the transition period described in PM transmittal number AB–98–18, and provided instead that an SNF must consolidate its bills as of its PPS start date, for those of its residents who are in a covered Part A stay. For those SNF residents who are not in a covered Part A stay (for example, who have exhausted their available days of coverage under the Part A SNF benefit, or who do not meet that benefit's posthospital or level of care requirements), the PM postponed implementation of consolidated billing indefinitely. This was necessitated by systems modification delays in connection with achieving Y2K compliance.

The Y2K problem arose because computer programming, which has commonly employed only two digits to record the year in the date for transactions and other entries, will not be able to distinguish the year 2000 from the year 1900 without reprogramming. This problem must be corrected on a timely basis in order to avoid the potential for significant disruption of the automated systems that are essential to administering the entire Medicare program. (For a more detailed discussion of Medicare and the Y2K problem, please refer to the preamble for the proposed rule on the outpatient hospital PPS, 63 FR 47605, September 8, 1998.) Making the necessary systems renovations to correct this problem is an extensive and complex process that must be given priority over other systems modifications.

Accordingly, consolidated billing implementation with regard to those SNF residents who are in noncovered stays is being postponed at present, because it will require systems modifications that are far more extensive than those needed for the SNF PPS under Part A—modifications of a magnitude that simply cannot be accomplished until the current actions to achieve Y2K compliance have been completed. We plan to publish a notice of the anticipated implementation date for this aspect of consolidated billing in the **Federal Register** at least 90 days in advance.

Comment: Numerous commenters recommended a wide variety of items and services that they believe should be categorically excluded from the SNF consolidated billing requirement and paid separately from the PPS. Some examples included: laboratory services, intravenous medications, medications for patients with acquired immune deficiency syndrome (AIDS), and various types of practitioner services. Some of these commenters noted our discussion in the preamble to the interim final rule regarding a technical amendment to section 1833(h)(5)(A) of the Act (which would specifically authorize SNFs to receive Part B payment for laboratory tests that they do not themselves either perform or supervise), and advocated deferring the application of consolidated billing to those services until after the actual enactment of this legislation. Other commenters argued that since the consolidated billing legislation specifically excludes several types of practitioner services, the services of certain additional types of practitioners, such as clinical social workers and audiologists, should similarly be excluded. One commenter mistakenly understood the exclusion of ''physician services'' from consolidated billing to be the result of an administrative decision by us, and expressed support for this decision; another argued that the statute's categorical exclusion of ''physician services'' from this provision mandates the exclusion not only of a diagnostic test's professional component (representing the physician's interpretation of the diagnostic test), but also of the technical component (representing the test itself).

Response: The only types of services furnished to SNF residents that are categorically excluded from the PPS and consolidated billing provisions are the ones specified in a short list of statutory exclusions at section 1888(e)(2)(A)(ii) of the Act, for which an outside supplier can still bill Medicare directly and receive a separate payment under Part B. All other services are subject to consolidated billing when furnished to an SNF resident, and are included in the PPS payment that Medicare makes to the SNF for a covered Part A stay. In addition, we note that the issue of an SNF receiving Part B payment for laboratory services under consolidated billing does not arise at present since, as discussed previously, the implementation of SNF consolidated billing is currently on hold for those residents who are not in a covered Part A stay.

Further, we note that although the consolidated billing legislation does exclude the services of psychiatrists and clinical psychologists, it does not exclude the services of clinical social workers. (In this context, it is worth noting that the SNF consolidated billing requirement was modeled on the corresponding Medicare comprehensive billing or ''bundling'' requirement for inpatient hospital services (section 1862(a)(14) of the Act), which has been in effect for well over a decade and similarly includes clinical social worker services, while excluding the services of certain other types of mental health professionals.) Similarly, section 1888(e)(2)(A)(ii) of the Act does not exclude audiologists; in fact, it is quite explicit in specifying that ''speech language therapy'' services are always subject to consolidated billing, even when performed by a type of practitioner (such as a physician) whose services would otherwise be categorically excluded from this provision.

We note that the exclusion of physician services themselves from consolidated billing is statutory rather than the result of an administrative decision; further, the implementing regulations at § 411.15(p)(2)(i) define the excluded ''physician's services'' as those meeting the criteria of § 415.102(a), and the latter provision specifies, in part, that this definition encompasses only those services that are furnished personally by the physician. Thus, under consolidated billing, only the professional component of a diagnostic test (representing the interpretation that the physician performs personally) is billed separately as a physician service, while the technical component represents the diagnostic test itself, which must be billed by the SNF.

Finally, in connection with further defining the bundle of services subject to consolidated billing when furnished to an SNF resident, we are taking this opportunity to make a conforming change in the regulations governing Medicare provider agreements in subpart B of Part 489. The interim final rule amended this subpart by adding a new paragraph (s) to § 489.20 to implement section 1866(a)(1)(H)(ii) of the Act, which makes compliance with the consolidated billing provision a specific requirement under the terms of an SNF's Medicare provider agreement. We are now adding a new paragraph (h) to § 489.21, which explicitly precludes an SNF from charging a resident for any items or services that are subject to the Medicare consolidated billing requirement. (We note that this new provision parallels the longstanding provision in paragraph (f) of § 489.21, which similarly prohibits a hospital from charging its inpatient for any items or services that are subject to the Medicare hospital bundling provision.)

Comment: Several commenters wrote regarding the provision in section 4541 of the BBA, which imposes a $1500 annual per beneficiary limit on Part B payments for outpatient PT services (including speech-language therapy services) and a similar limit for outpatient OT services, but specifically excepts services furnished by a hospital's outpatient department from each of these annual limits. (This $1500 Part B payment limit does not affect SNF residents who are in a covered Part A SNF stay, since the therapy services that they receive are bundled to the SNF and included in the PPS payment made under Part A, rather than being billed separately to Part B.)

The commenters objected to the interim final rule's exclusion of beneficiaries who are considered SNF ''residents'' for consolidated billing purposes from the outpatient hospital exception to the Part B therapy payment limit (63 FR 26299). The commenters argued that this decision results in a reduction of an SNF resident's available Part B therapy benefits in relation to residents of a totally noncertified nursing home (who would, by comparison, get a richer benefit package), thus effectively depriving SNF residents of the ''escape hatch'' that would otherwise be afforded by the exception of services furnished in the outpatient hospital setting from the $1500 therapy payment limit.

Another commenter cited the discussion in Program Memorandum transmittal number AB–98–63 (October 1998) of the $1500 limit on Part B therapy payment, and asked whether the SNF billing and tracking requirements for Part B therapy services described in the PM indicate that the decision to postpone consolidated billing implementation for residents in noncovered SNF stays has been reversed specifically with regard to therapy services.

Response: As discussed in the preamble to the SNF PPS interim final rule, we decided not to except services furnished to SNF residents in the outpatient hospital setting from the Part B $1500 therapy payment limit, specifically in order to avoid creating a perverse incentive to have the hospital outpatient department furnish therapy services that the resident could appropriately receive from the SNF itself. We note that section 1819(a)(1) of the Act defines an SNF, in part, as an institution that is primarily engaged in furnishing skilled rehabilitation services to its residents. This means that the provision of therapy services to its residents is an inherent and essential function of this type of facility.

Moreover, the long-term care facility requirements for participation (at section 1819(b)(4)(a)(i) of the Act) specifically require an SNF to provide ''. . . specialized rehabilitative services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident . . .'' Thus, an SNF that fails to provide medically necessary therapy services simply because a resident had reached the $1500 annual Part B payment limit for these services would be in violation of this requirement, and would be subject to appropriate enforcement remedies.

In addition, we wish to clarify that the SNF billing and tracking responsibilities described in PM AB–98–63 arise solely in the context of implementing the $1500 Part B therapy payment limit, which represents an entirely separate BBA provision (and statutory authority) from SNF consolidated billing; as specified in PM AB–98–35 (July 1998), the consolidated billing provision itself currently remains on hold for all services furnished to SNF residents in noncovered stays.

Finally, in addition to the comments on the $1500 therapy cap provision specifically as it affects SNF residents, several commenters included more general observations about the nature of the provision itself. However, these concerns are beyond the scope of this regulation, and were addressed instead in the June 5, 1998, proposed rule on Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 1999 (63 FR 30818), and in the final rule published on November 2, 1998 (63 FR 58814).

Comment: One commenter noted that the regulation at § 413.335(b) concerning prospective payment for SNFs indicates that the PPS payment represents payment in full for the costs associated with furnishing inpatient SNF services to Medicare beneficiaries, but does not contain language that specifically excepts those types of services (such as physician services) that are categorically excluded by law.

Response: The qualifying language that the commenter requested is, in fact, already contained in the regulations at § 413.1(g)(2), which specify that, for an SNF resident in a covered Part A stay, the PPS determines the amounts paid for services furnished, ''other than those described in § 411.15(p)(2) of this chapter.'' The latter provision lists the services that are categorically excluded from the PPS bundle.

Comment: We received a large number of comments about the treatment of ambulance services under the consolidated billing provision. Some advocated exclusion of all ambulance services from the consolidated billing provision. Others expressed concern that confusion over the circumstances in which these services are subject to consolidated billing could result in payment delays. Several commenters specifically requested clarification on whether emergency and other outpatient trips to a hospital via ambulance are subject to consolidated billing. Others argued that the inclusion of ambulance services under consolidated billing is inconsistent with the negotiated fee schedule provisions for ambulance services in the BBA.

Response: As discussed previously, the only types of services furnished to SNF residents that are categorically excluded from the PPS and consolidated billing provisions are the ones specified in a short list of statutory exclusions at section 1888(e)(2)(A)(ii) of the Act. Since ambulance services do not appear on this statutory excluded list, they are subject to consolidated billing when furnished to an SNF resident and are included in the PPS payment that Medicare makes to the SNF for a covered Part A stay.

The statute specifies that the consolidated billing provision applies only to those services that are furnished to an SNF ''resident.'' Thus, as explained in the preamble to the interim final rule, an ambulance trip is considered to be furnished to an SNF resident (and, thus, subject to consolidated billing) if it occurs during the course of an SNF stay, but not if it occurs at either the very beginning or

end of the stay. (This policy is comparable to the one governing ambulance services furnished in the inpatient hospital setting, which has been subject to a similar comprehensive Medicare billing or ''bundling'' requirement for well over a decade.) Accordingly, the initial ambulance trip that first brings a beneficiary to an SNF is not subject to consolidated billing because the beneficiary has not yet been admitted to the SNF as a resident at that point. Similarly, the regulations at § 411.15(p)(2)(x) provide that an ambulance trip that conveys a beneficiary from the SNF is not subject to consolidated billing when it occurs in connection with one of the events specified in §§ 411.15(p)(3) (i) through (iv) as ending the beneficiary's SNF ''resident'' status. The events are—

- A trip for an inpatient admission to a Medicare-participating hospital or critical access hospital (CAH), or to another SNF.
- A trip to the beneficiary's home to receive services from a Medicare-participating home health agency under a plan of care.
- A trip to a Medicare-participating hospital or CAH for the specific purpose of receiving emergency services or certain other intensive outpatient services that are not included in the SNF's comprehensive care plan.
- A formal discharge (or other departure) from the SNF that is not followed within 24 hours by readmission to that or another SNF.

With regard to the third bullet above, § 411.15(p)(3)(iii) of the regulations excludes from consolidated billing those types of outpatient hospital services ''. . . that are not furnished pursuant to the [SNF's] comprehensive care plan.'' This outpatient hospital exclusion (as discussed in greater detail below, in the context of the SNF comprehensive plan of care) applies to a small number of exceptionally intensive services that lie well beyond the scope of care that SNFs would ordinarily furnish (and, thus, beyond the ordinary scope of SNF care plans), as well as emergency services (which, by their nature, cannot be anticipated and planned for in advance). This means that when an outpatient visit to a hospital occurs for the purpose of receiving one of these excluded types of services, the individual receiving the services ceases to be a ''resident'' of the SNF for consolidated billing purposes and, thus, the associated ambulance transportation to the hospital is also excluded from consolidated billing. We note that this exclusion applies to the return trip from the hospital to the SNF as well, since the beneficiary's status as an SNF ''resident'' for consolidated billing purposes (once ended by the receipt of an excluded outpatient hospital service) does not resume until he or she returns to the SNF.

With regard to the concerns about the negotiated fee schedule provisions for ambulance services, section 4531 of the BBA—the same provision that mandates the development of an ambulance fee schedule through a negotiated rulemaking process—also prescribes an interim payment methodology to be used until the ambulance fee schedule takes effect. Under the interim payment methodology, Part B will continue to pay for ambulance services that an SNF furnishes (either directly with its own resources, or under arrangements made with an outside supplier) on a reasonable cost basis, in which the cost per trip is limited to the prior year's reasonable cost per trip, updated by an inflation factor (that is, the consumer price index for all urban consumers (CPI–U) minus one percentage point). We note that the Medicare contractors have already received instructions (PM Number A–97–15 (November 1997) and PM Number A–98–2 (February 1998)) that describe this payment methodology in detail.

Comment: One commenter noted that the regulations at § 410.40(b)(4) require ambulance services furnished to an SNF resident to be furnished by, or under arrangements made by, the SNF itself. The commenter questioned whether this requirement is consistent with our policy of allowing certain ambulance services (such as those furnished in connection with the receipt of excluded outpatient hospital services) to be excluded from consolidated billing.

Response: In discussing services furnished to an SNF resident, § 410.40(b)(4) includes a specific cross-reference to the SNF ''resident'' definition at § 411.15(p)(3) which, in turn, specifies certain circumstances (such as the receipt of excluded outpatient hospital services) as ending a beneficiary's status as a ''resident'' of the SNF for consolidated billing purposes.

Comment: One commenter noted that our designation of certain categories of outpatient hospital services as ending (for consolidated billing purposes) a beneficiary's status as an SNF ''resident'' also has the effect of unbundling ambulance transportation that is associated with the beneficiary's receipt of those services. The commenter then suggested that we should similarly designate a beneficiary's receipt of excluded dialysis services at an offsite location as ending his or her SNF resident status in order to permit the associated ambulance transportation to be unbundled as well.

Response: We believe that this comment reflects a misunderstanding of the underlying purpose of the outpatient hospital exclusion. This exclusion from consolidated billing does not serve as a mechanism for unbundling ambulance services per se. Rather, as discussed above, this exclusion is intended to encompass those services—specific to the outpatient hospital setting—that are so exceptionally intensive, costly, or emergent as to lie well beyond the ordinary scope of SNF care. The resulting unbundling of ambulance services associated with these excluded outpatient hospital services occurs simply because the bundling of ambulance services is itself tied to a beneficiary's status as an SNF ''resident'' for consolidated billing purposes, which is suspended by the beneficiary's receipt of these excluded types of outpatient hospital services.

By contrast, the performance of dialysis—even if it occurs offsite in the outpatient hospital setting—is a type of activity that clearly falls well within the normal scope of SNF care. (As discussed below, the effect of the exclusion of dialysis services from the SNF consolidated billing provision is that an SNF is not itself required to furnish—either directly or under arrangements—dialysis services to its residents; however, if an SNF nonetheless elects to furnish these services, they are included within the scope of the Part A extended care benefit, as well as in the PPS per diem payment that Part A makes to the SNF.) Accordingly, while the statute categorically excludes dialysis services themselves from the requirement for SNF consolidated billing, their receipt offsite does not have the effect of ending a beneficiary's status as an SNF resident for purposes of this requirement and, consequently, does not result in unbundling the associated ambulance transportation.

We note, in addition, that the policy regarding ambulance services in the SNF setting is also affected by a final rule on ambulance services coverage that was published in the **Federal Register** on January 25, 1999 (64 FR 3637). Although this rule was published well after the SNF PPS interim final rule, it has raised certain questions and concerns about ambulance trips (and transportation generally) in the SNF context.

In addition to the specific service categories listed in sections 1861(h)(1) through (6) of the Act, the extended care benefit includes coverage of ''. . . such other services necessary to the health of the patients as are generally provided

by, or under arrangements made by, skilled nursing facilities'' (section 1861(h)(7) of the Act). As explained in the interim final rule on the SNF PPS (63 FR 26302), the medical and other health services specified in section 1861(s) of the Act (which include ambulance services) are considered to be ''generally furnished'' by SNFs and, therefore, coverable under the Part A extended care benefit (see regulations at § 409.27(a)).

As discussed previously, under the SNF consolidated billing provision, the SNF itself is responsible for billing Medicare for virtually all of the services that a resident receives, except for a short list of excluded service categories specified in the statute at section 1888(e)(2)(A)(ii) of the Act. Since the Congress did not specify ambulance services as one of the excluded categories, such services must be billed to Medicare by the SNF when furnished to an SNF resident. As explained above and in the interim final rule (63 FR 26298), the consolidated billing provision does not apply to an ambulance trip that conveys a beneficiary to the SNF for the initial admission, or from the SNF following a final discharge, but only to ambulance transportation that is furnished during the period that the beneficiary is actually an SNF resident.

Nevertheless, as noted in the interim final rule (63 FR 26296), it is possible for particular service categories (such as preventive or screening services) to be subject to the SNF consolidated billing provision, and yet not be included within the scope of coverage under the Part A SNF benefit. It has been suggested that this is also the case with ambulance services, in view of instructions in the SNF Manual at sections 260.2 and 262 that indicate ambulance services are covered only under Part B. However, we note that these sections appear in a portion of the instructions that deal exclusively with situations involving SNF services covered under Part B when no payment under the Part A SNF benefit is possible (Part A benefits exhausted, no prior qualifying hospital stay, etc.); thus, the reference to ''ambulance services'' in this context applies specifically to the Part B benefit described in section 1861(s)(7) of the Act.

By contrast, for situations that do involve payment under the Part A SNF benefit, the applicable SNF Manual instructions in this regard appear at section 230.10.A. These instructions correspond to section 1861(h)(7) of the Act, which includes within the scope of the extended care benefit those services—not otherwise specified in section 1861(h)—that are generally furnished by (or under arrangements made by) SNFs. As explained in the preamble to the interim final rule (63 FR 26302), this provision is considered to include the full range of medical and other health services described in section 1861(s) of the Act, other than those particular service categories (such as preventive and screening services) that, under the statute, lie specifically beyond the scope of the extended care benefit. The remainder of the medical and other health services described in section 1861(s) of the Act are considered to be ''generally furnished'' by SNFs and, therefore, within the scope of the extended care benefit when furnished to a resident in a covered Part A stay.

Thus, when an SNF provides or makes arrangements for a resident's transportation by ambulance during the course of a covered Part A stay, such services are not considered Part B ambulance services under the separate Part B benefit at section 1861(s)(7) of the Act, but Part A extended care services that SNFs generally furnish under section 1861(h)(7) of the Act. This is essentially similar to the use of the term ''durable medical equipment'' (DME), which refers exclusively to the Part B benefit described in section 1861(s)(6) of the Act; however, when an SNF furnishes the same types of items to a resident during the course of a covered Part A stay, they are not covered as DME under the separate Part B benefit, but rather, ''as supplies, appliances and equipment'' under the Part A extended care benefit at section 1861(h)(5) of the Act. Further, section 1833(d) of the Act prohibits Part B payment for any service that is payable under Part A.

In order to clarify that the Part A SNF benefit covers ambulance transportation under the authority of section 1861(h)(7) of the Act, we are relocating the ambulance provision from § 409.20(a)(8) to a new subparagraph of § 409.27, the section of the regulations that implements this particular portion of the statute. We are also clarifying that the SNF benefit's coverage of ambulance transportation is limited to those circumstances meeting the general medical necessity requirements that would apply to Part B coverage under the separate ambulance services benefit (as set forth in § 410.40(d)(1)) if the services were not covered under Part A—that is, those situations in which a beneficiary's medical condition is such that other means of transportation would be contraindicated.

We note that the ambulance rule's primary objective in revising the extended care benefit regulations was to clarify that the scope of this benefit specifically includes coverage of transportation via ambulance. In the SNF PPS context, this effectively results in bundling the cost of all ambulance trips made in connection with an individual who has the status of an SNF resident, regardless of whether, prior to the PPS, the SNF undertook to furnish these services itself as ''patient transportation'' under Part A or, alternatively, allowed an outside supplier to furnish them as ''ambulance services'' under Part B.

However, the ambulance rule's revision was made in a manner that also raises the issue of coverage of transportation generally, by modes other than ambulance. In the institutional context, the issue of non-ambulance transportation arises mainly in the SNF setting, since this particular institutional setting is one in which a facility may routinely utilize offsite sources of services for its resident during the course of his or her stay, under circumstances that do not necessarily require the use of an ambulance.

Further, we note that unlike transportation via ambulance (which involves a service that is precisely delineated in terms of vehicle type, appropriate destinations, etc., and is recognized as a specific benefit category), the concept of non-ambulance transportation is a more generalized one that denotes the basic function of conveying an individual from one place to another, rather than a particular benefit or mode of conveyance. Under the long-term care facility requirements for participation at § 483.25, an SNF's essential obligation is to provide each resident with those services that are necessary ''* * * to attain or maintain the [resident's] highest practicable physical, mental, and psychosocial well-being. * * *'' The SNF can meet this obligation either by providing the needed services onsite at the SNF, or by securing them at an offsite location. SNFs that pursue the latter course have historically used a wide variety of means for conveying a resident to receive offsite services. Some of these (like community wheelchair transportation) were available at no cost and others generally involved various non-Medicare funding sources (such as Medicaid, or the resident's own family).

We note that, unlike transportation via ambulance, no separate benefit category has ever existed under Part B of Medicare for coverage of non-ambulance modes of transportation. Thus, prior to the inception of the SNF PPS, non-ambulance transportation for SNF residents occurred in a wide variety of ways that did not generally

involve any Medicare payment under either Part A or Part B. In making the ambulance final rule's revision to the extended care benefit regulations, it was not our intent to create an SNF benefit expansion by establishing a new entitlement under the Medicare program that did not heretofore exist in this setting; nor is it our intent to define as part of the SNF PPS bundle any services for which the Medicare program did not previously assume financial responsibility under either Part A or Part B. Therefore, we are revising § 409.27, as discussed above, to refer specifically to ambulance transportation rather than to transportation generally.

Comment: Several commenters requested clarification regarding the status of dialysis services under consolidated billing. One commenter suggested that Part B should pay for dialysis performed at the hospital outpatient department or, alternatively, when furnished by a freestanding dialysis center on the SNF's premises.

Response: Dialysis is one of the service categories that the BBA specifically excludes from the SNF consolidated billing provision. Most of the other excluded service categories are, by definition, outside the scope of the Part A extended care benefit. For example, an SNF cannot bill Part A for physician services, since section 1861(b)(4) of the Act defines these services as being outside the scope of the inpatient hospital benefit which, in turn, has the effect of excluding them as well from the extended care benefit under section 1861(h) of the Act (see the undesignated clause following section 1861(h)(7) of the Act).

By contrast, dialysis services have always been included within the scope of the Part A extended care benefit under section 1861(h)(7) of the Act that provides for coverage of those services (not specified elsewhere in section 1861(h)) that are generally furnished by, or under arrangements made by, SNFs. Thus, the exclusion of dialysis from the consolidated billing provision means that an SNF is not itself required to furnish or make arrangements for this service. However, even though the SNF is not required to furnish or make arrangements for dialysis during the course of a covered Part A stay, if it nonetheless elects to do so, the dialysis is included within the scope of the Part A extended care benefit, as well as in the PPS per diem payment. Alternatively, since the exclusion of dialysis services from the consolidated billing provision allows the SNF the option of declining to furnish or make arrangements for dialysis services, those services that meet the following coverage requirements for the Part B dialysis benefit could be furnished and billed to Medicare directly by an outside dialysis supplier.

There are two situations under which dialysis services would be considered a Part B service and billable by an end stage renal disease (ESRD) facility or supplier when provided to an SNF resident. The first is for institutional dialysis services received at a Medicare certified ESRD facility. Institutional dialysis services must be provided by entities that meet the ESRD conditions of coverage that are specified in regulations at part 405, subpart U. These regulations limit outpatient maintenance dialysis services to those services provided ''on the premises'' of the facility. Thus, it is not possible for Part B institutional dialysis services to be provided at the site of a nursing facility or SNF that does not itself meet the ESRD conditions of coverage. The second situation involves Part B coverage of home dialysis services for residents of nursing facilities or SNFs, as these facilities may qualify as the residents' home for purposes of this benefit.

In order for Medicare payment of home dialysis to be made, the resident must elect to become a home dialysis patient and have completed a training program provided by an approved ESRD facility. Once a patient has completed the training, he or she must elect either Method I, where an ESRD approved facility furnishes the dialysis equipment and supplies, or Method II, where the patient elects a single supplier other than the ESRD facility to furnish all of the dialysis equipment and supplies, other than laboratory services and support services which are provided by a certified ESRD facility. Each home patient must have his or her own supplies and equipment. These cannot be shared with other SNF residents. Also, home dialysis is intended to be self-dialysis performed by the patient or the patient's family. Therefore, Medicare does not cover the services of staff to assist with the home dialysis services.

Comment: Many commenters requested clarification of the relationship between the SNF comprehensive care plan and a beneficiary's status as a ''resident'' of the SNF for consolidated billing purposes. Section 1862(a)(18) of the Act defines the applicability of the consolidated billing requirement in terms of services that are furnished to an individual who is a ''resident'' of an SNF. The implementing regulations at § 411.15(p)(3) specify several circumstances that have the effect of ending a beneficiary's status as an SNF ''resident'' for consolidated billing purposes.

Section 411.15(p)(3)(iii) specifies as one such circumstance the receipt of those types of outpatient hospital services ''. . . that are not furnished pursuant to the [SNF's] comprehensive care plan.'' Many commenters expressed confusion about the appropriate interpretation of this provision, along with the erroneous belief that a given outpatient hospital service is subject to the SNF consolidated billing provision only if it is actually specified in the individual care plan of the particular beneficiary to whom the service is furnished. Other commenters suggested additional types of outpatient hospital services for exclusion beyond the specific categories already identified in the preamble to the interim final rule. Still others advocated extending the exclusion to apply to services furnished in nonhospital settings as well (for example, MRIs performed at freestanding imaging centers).

Response: The purpose of citing the SNF's comprehensive care plan in the context of an outpatient hospital visit is to clarify that the SNF retains the overall billing responsibility for essentially the entire package of care furnished during the outpatient visit, other than certain specifically excluded services. As explained in the interim final rule (63 FR 26298), in the outpatient hospital context, this exclusion applies to the small number of exceptionally intensive services that lie well beyond the scope of care that SNFs would ordinarily furnish (and, thus, beyond the ordinary scope of SNF care plans), as well as emergency services (which, by their nature, cannot be anticipated and planned for in advance).

In November 1998, we issued PM transmittal number A–98–37, which provided additional clarification on the outpatient hospital exclusion, as well as a list of the specific HCPCS codes that identify the excluded services. The PM explains that this exclusion is not invoked merely because a particular outpatient hospital service does not appear in the individual SNF care plan of the person receiving the service; rather, the exclusion applies only to those specified categories of services that, by definition, lie well beyond the scope of SNF care plans generally. Currently, only those services that are specifically cited in the PM itself are excluded from consolidated billing on this basis: cardiac catheterization; computerized axial tomography (CT) scans; MRIs, ambulatory surgery involving the use of an operating room;

emergency room services; radiation therapy; angiography; and, lymphatic and venous procedures. However, as indicated in the interim final rule, we continue to consider further refinements in this policy as the new PPS for outpatient hospital services is being developed, and any further refinements would be made through future rulemaking.

In this context, we note that a key concern underlying the development of the consolidated billing exclusion of certain outpatient hospital services specifically involves the need to distinguish those services that comprise the SNF bundle from those that will become part of the outpatient hospital bundle that is currently being developed in connection with the outpatient hospital PPS. Accordingly, we are not extending the outpatient hospital exclusion from consolidated billing to encompass any other, freestanding settings.

Finally, in order to resolve the confusion that commenters expressed regarding the role of the comprehensive care plan, we are revising the parenthetical in § 411.15(p)(3)(iii) to read as follows: ''. . .(but only with respect to those services that are beyond the general scope of SNF comprehensive care plans, as required under § 483.20).'' This is to clarify that an outpatient hospital service is not excluded from consolidated billing merely because it does not appear in the particular care plan of the individual beneficiary receiving the service; rather, consolidated billing excludes only those types of outpatient hospital services that we specifically identify as being beyond the scope of SNF care plans generally. As indicated above, this exclusion currently encompasses only those particular service categories that we have specifically identified in PM A–98–37; however, as we continue to examine this issue, we may make further modifications in future instructions.

Comment: Many commenters requested further clarification regarding the definition of ''emergency'' outpatient hospital services in terms of their exclusion from SNF consolidated billing. One commenter argued that it is unreasonable to define an emergency as including only ''life or death'' situations. Another commenter noted the interim final rule's description of emergency outpatient hospital services as being beyond the general scope of SNF care plans (since, by their nature, they cannot be anticipated and planned for in advance), and questioned whether this characterization would be appropriate in those instances where ''emergency'' situations actually are addressed in a resident's plan of care (for example, contingency plans that are based on risk factors identified in the resident assessment). Another inquired as to whether the exclusion of emergency services extends to other services that are clearly unrelated to the emergency itself, but that happen to be performed during the individual's visit to the emergency room.

Response: As noted in the preceding discussion of the relationship between the outpatient hospital exclusion and the comprehensive care plan, PM transmittal number A–98–37 (November 1998) provided additional clarification on the exclusion of certain outpatient hospital services from SNF consolidated billing. As the PM indicates, we are not establishing a special definition of ''emergency'' services unique to consolidated billing, but instead are incorporating the longstanding definition contained in regulations at § 424.101, ''services that are necessary to prevent death or serious impairment of health and, because of the danger to life or health, require use of the most accessible hospital available and equipped to furnish those services.'' This definition is not limited to ''life or death'' situations, since it specifically includes those that present a risk of ''serious impairment of health'' as well. The PM also explains that emergency services are excluded from consolidated billing by virtue of their designation as being beyond the scope of SNF care plans generally, which would be true regardless of whether the individual care plan of a particular resident may occasionally address contingency plans in the event of a medical emergency. The PM also clarifies that the exclusion from consolidated billing is limited to, ''Those services and supplies that are directly related and required to complete the procedure or treat the emergency condition for which the beneficiary came to the hospital, for example, anesthesia when used during ambulatory surgery involving the use of an operating room.'' All other services and supplies must be bundled back to the SNF and the hospital must look to the SNF for payment.

Thus, for example, a laboratory test that is required to diagnose the condition that occasioned the emergency visit would be excluded from consolidated billing, and can be billed to Part B by the hospital. By contrast, a routine diagnostic test that is unrelated to the emergency condition itself would not be excluded from consolidated billing merely because it happens to be performed during the beneficiary's visit to the emergency room.

Comment: Two commenters noted that the outpatient hospital exclusion of ambulatory surgery from SNF consolidated billing applies specifically to those procedures that involve the use of an operating room, and they requested clarification on whether this exclusion would encompass the insertion and replacement of a percutaneous esophageal gastrostomy (PEG) tube when performed in a hospital's gastrointestinal (GI) suite or endoscopy suite rather than in an operating room.

Response: The procedure codes that specifically pertain to PEG tubes are 43750 (percutaneous placement of gastrostomy tube) and 43760 (change of gastrostomy tube), both of which come under the general exclusion from SNF consolidated billing for ambulatory surgery involving the use of an operating room. The reason that the instructions in PM A–98–37 restrict the outpatient hospital exclusion for ambulatory surgery to those procedures that involve the use of an operating room is to avoid encompassing procedures that are simple enough to be performed at bedside in the SNF itself. Accordingly, with respect to PEG tube procedures, we regard the use of a GI suite or an endoscopy suite as equivalent to the use of an operating room for purposes of this exclusion.

Comment: We received many comments on various aspects of an SNF's relationship with its suppliers. In the interim final rule (63 FR 26300), we noted that section 1888(e)(9) of the Act provides that the amount of Part B payment to an SNF shall be determined in accordance with the applicable fee schedule for the particular service. We also noted the concern that if an SNF were to arrange with an outside supplier for the provision of a particular service for less than the applicable fee schedule amount, allowing the SNF to retain the difference could create a perverse incentive for the SNF to provide unnecessary services.

We invited comments on possible ways to address this concern, including pursuing legislation (to limit the SNF's Part B payment to the lower of the applicable fee schedule amount or the amount that the supplier actually charges the SNF) or, alternatively, to require the SNF to pay its supplier the full fee schedule amount. A few commenters expressed support for limiting the SNF's Part B payment to the lower of the applicable fee schedule amount or the amount of the supplier's actual charge to the SNF, but only if the SNF is required to pass this entire

amount (as so limited) on to the supplier. A greater number supported requiring the SNF to pass the full fee schedule amount on to the supplier, regardless of the supplier's actual charge (some of these commenters advocated permitting the SNF to retain a ''reasonable'' administrative charge).

By far the largest group of commenters, however, argued against imposing any restrictions in this area, noting that transactions between the SNF and its suppliers are a private contractual matter in which we should not intervene. They maintained that the appropriate way to address any abusive practices would be through more vigorous enforcement of existing statutes and regulations (such as medical review procedures), rather than to prescribe the specific terms of payment between the SNF and its suppliers. Other commenters expressed concerns about possible violations of the anti-kickback provisions at section 1128B(b) of the Act, as well as more general concerns about the timeliness and adequacy of the SNF's payment to its suppliers.

Response: We agree that, under current law, an SNF's relationship with its supplier is essentially a private contractual matter, and the terms of the supplier's payment by the SNF must be arrived at through direct negotiations between the two parties themselves. Accordingly, we believe that the most effective way for a supplier to address any concerns that it may have about the adequacy or timeliness of the SNF's payment would be for the supplier to ensure that any terms to which it agrees in such negotiations satisfactorily address those concerns.

We remain concerned, however, over the potential for the provision of unnecessary services, and will continue to evaluate possible legislative and other approaches to addressing this concern. In addition, we note that our discussion of the relationship between an SNF and its suppliers should not be construed as addressing in any manner the potential applicability of the statutory anti-kickback provisions, since matters relating specifically to the enforcement of these provisions lie exclusively within the purview of the Office of the Inspector General.

O. Scope of Extended Care Benefits

Along with the promulgation of regulations specifically describing the SNF PPS itself, the interim final rule also included a number of conforming revisions in other portions of the regulations. One such revision was a reorganization of subpart C of part 409 (describing the scope of covered services under the Part A SNF benefit), which now tracks more accurately the corresponding portion of the Medicare statute at section 1861(h) of the Act.

Comment: One commenter requested us to clarify that the regulations at § 409.26(a) (coverage of transfer agreement hospital services) provide for separate Part B payment for the medical services of an intern or resident of the SNF's transfer agreement hospital.

Response: The commenter's understanding of the purpose of this provision is incorrect. This section of the regulations implements section 1861(h)(6)(A) of the Act, which describes the scope of services included in the Part A extended care benefit. Accordingly, the medical services of interns and residents described in § 409.26(a) are covered as SNF services under Part A, rather than being covered separately as practitioner services under Part B.

P. Impact Analysis

As required by Executive Order 12866, the Unfunded Mandates Reform Act of 1995, and the Regulatory Flexibility Act (RFA) (Public Law 96–354), the interim final rule included a Regulatory Impact Statement, on which we received numerous comments.

Comment: Many commenters were concerned about the budgetary savings from the SNF PPS as indicated in the interim final rule, as compared with CBO's estimate at the time of the BBA. Many of these commenters felt that this ''extra'' money should be given back to the SNFs through the calculation of the rates to be used in the PPS.

Response: CBO's estimate of savings of $9.2 billion over five years only shows the effect on SNFs under Medicare fee for service and does not include the indirect savings due to reduced managed care payments, which are based on average fee for service payments by county. The estimate of 5-year savings shown in the interim final rule (63 FR 26304) of $12.87 billion includes both the fee-for-service effect and the managed care effect (which, as stated in the interim final rule, is about 25 percent of the total). If savings attributable to managed care are taken out, the result is very close to the $9.5 billion in savings which CBO had estimated.

Comment: Many commenters were concerned about the behavioral offset which was assumed in the savings estimate. Some argued that there should have been no offset assumed whatsoever, and all believed that the offset that actually was assumed was much too large. In addition, many commenters expressed concern about the potential for nursing home closures and diminished beneficiary access to needed care.

Response: The ''behavioral'' offset assumed for the impact analysis is only used as a device to assess impact. It is not used to adjust the payment rates. Along with the possible sources of this offset listed in the interim final rule, there are probably many additional factors which would also have the effect of offsetting the savings from this provision.

We are aware and concerned about the statements being reported about potential closures of nursing homes and the delay in patient discharges from hospitals that are being attributed to the change in payments resulting from implementation of the PPS for SNFs. At this time, however, we do not have sufficient claims or MDS data either to confirm or refute these statements. It will be several months before we can establish a baseline and begin to assess the impact on access and quality. As we accumulate data and learn more about the effects of the new payment system, we will report the results.

Regarding the issue of beneficiary access to care, we note that in terms of the impact analysis itself, if these beneficiaries had to remain in higher cost care as opposed to moving to SNFs, this could affect the budgetary savings to Medicare and, therefore, would be part of this offset factor. The final result is that this behavioral offset factor is only used to determine the total budget effect of a provision. It is not meant to indicate abusive behavior by the providers. The 45 percent factor that was used in our impact analysis is in the typical range for offset factors related to a significant payment system change like the SNF PPS. While little empirical data is currently available to estimate the overall impact of the PPS and consolidated billing on access to care in SNFs, this is an important issue in the context of the payment system, certification requirements and quality monitoring activities.

However, from a broader policy perspective, this issue involves not only the payment characteristics of the PPS itself, but also a number of related requirements regarding provider participation in the Medicare program. Some commenters expressed concern that the payment rates under the SNF PPS may be inadequate and could result in SNFs withholding needed care and services from Medicare beneficiaries, or even denying admission to them. We note that in order to be certified for participation in the Medicare program as an SNF, a nursing home must first meet a set of requirements for

participation designed to protect and promote resident health and safety. These certification standards include the requirement to ''* * * provide services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident * * *'' (section 1819(b)(2) of the Act). Thus, an SNF that fails to provide or make the necessary arrangements for the care and services that a resident requires would jeopardize its program certification.

Further, the statutory provision regarding Medicare provider agreements (section 1866(a)(1) of the Act) requires an SNF to accept the Medicare payment for covered SNF services as payment in full. The corresponding regulations at § 489.53(a)(2) specify that one of the grounds for terminating a provider agreement is when the provider '' * * * places restrictions on the persons it will accept for treatment and it fails either to exempt Medicare beneficiaries from those restrictions or to apply them to Medicare beneficiaries the same as to all other persons seeking care.'' In addition, longstanding program guidelines in section 134 of the Medicare SNF Manual (HCFA Pub. 12) indicate that, while a provider may restrict the types of health conditions it accepts or may establish other criteria relating to the admission of patients, if those restrictions apply to Medicare beneficiaries, they must apply in the same manner to all other persons seeking care and treatment by the provider.

Comment: One commenter felt that a 17 percent level of budgetary savings cited in the interim final rule was significant for providers of care.

Response: The 17 percent savings factor is an average based on the Medicare business of a provider. When this factor is converted to a total facility basis, it is estimated to be a 1.7 percent savings on average. This does not meet the threshold of three percent which we have used in the past to determine that an anticipated impact is significant. We do realize that using average values does not totally reflect each individual SNF's effect, which was acknowledged in the impact analysis of the interim final rule. However, for many of the factors included in the calculation, only averages existed. Specific data were not available for each individual facility.

Comment: One commenter stated that the 17 percent savings would be higher once the PPS was fully implemented. This factor only was for the first year of implementation, when most facilities would be paid based on 75 percent of their facility-specific rate and 25 percent of the Federal rate.

Response: We agree with this comment that the estimated savings will be greater in future years. The effect of a system that paid all facilities entirely at the Federal rate as of the first year, instead of having the transition, would be that it would save 21 percent on average instead of 17 percent (see table IX.2). This effect would be felt much more heavily by hospital-based facilities (33 percent savings) as opposed to freestanding facilities (18 percent). This result was not included in the original interim final rule because that rule only deals with setting rates for the first year and not with what will happen when it is fully implemented. The results listed here have the same caveats as those done in the original impact analysis; primarily, that averages have been used and the effects on individual providers may differ. Future impacts will be shown as the rates are developed and published in the future.

Comment: Several commenters stated that the 17 percent reduction may be true on average but specific providers may have much larger reductions (based on geographical characteristics).

Response: As was stated in the interim final rule, we do not know the effect on individual providers. Some providers will have a greater than 17 percent reduction in payments while others will have less than that or even an increase. As more data becomes available through the implementation of this system, we will be able to complete a much more thorough analysis of the effects of this system on many of these smaller groups of characteristics.

Comment: Several commenters asserted that the savings were understated because they did not take into account the added costs of implementing PPS for the facilities.

Response: It is true that the savings estimate shown in the interim final rule in table IX.1 (63 FR 26304) does not include any additional costs due to implementing PPS. This is because these savings are the difference in payments to facilities under the PPS compared to the previous payment system (either based on reasonable cost or the optional low-volume PPS). In developing the impact analysis, the previous system payments would not include the costs of implementing PPS. Likewise, the estimates of the new PPS costs do not include the implementation costs. Therefore, the differences between these costs or the savings do not include any effect of this additional cost. On the other hand, the savings estimates do not reflect the lower costs which result from providing services more efficiently, which is a natural outcome of implementing a PPS.

Comment: One commenter stated that the Congress had only intended to reduce the rate of growth in SNF payments and not actually reduce the level of payments.

Response: The statute prescribes the methodology for calculating the payment rate. The statute specifies the base year and specifies the updates to the base year costs. The legislation which implemented this system called for only allowing a market basket minus 1 percentage point increase going back to 1995. This amounted to a total of about seven percent over the three years. In the meantime, costs on a per diem basis had been increasing at a total of about 40 percent during that same period. Some of that increase is due to an increase in case-mix during that period, but as can easily be seen from these numbers, a very stringent limit had been placed on facilities' rate of growth for the last three years. Payments under this system are higher, on average, when compared to 1995 payments, but when compared to 1996 and 1997 payments, could very well be lower.

In addition, due to the formula expressed in the statute, many hospital-based facilities may face a reduction even in comparison to 1995 payments, because the formula for calculating the Federal rate is more weighted to the freestanding average. Thus, because of the statutory formula, most facilities may see a drop in payments in their first year of PPS as opposed to their last year under the previous payment system.

Comment: One commenter wished to know if we considered the probability of units closing or decertifying because of reimbursement levels. They wanted an estimate of the potential closings of small rural facilities since they are usually the only such units in these communities.

Response: We did consider the chance of some facilities closing due to the implementation of PPS. As stated in the interim final rule, the effect on individual SNFs will depend on their ability to adapt to the incentives resulting from the new system. If a provider decides that it cannot (or will not) adapt to the PPS, then that provider may decide to drop out of the Medicare program. This certainly may be a consequence of this provision but, as shown in the impact analysis of the interim final rule, the effect of these provisions are fairly equitable across urban and rural and hospital-based and freestanding ranges. Of course, individual SNFs may be affected in very different ways and this may prompt a variety of responses, including an election to drop out of the program.

There is no way to estimate the number of facilities that will make the election to leave the Medicare program. However, as part of the offset factor development, this possibility was considered and, therefore, some of that offset is due to the possibility that beneficiaries may be required to stay in more expensive care settings in the absence of SNF care being available. This was one of the reasons reflected in the impact analysis to the interim final rule that budgetary savings from this provision would be diminished.

Comment: Several commenters expressed concern that suppliers would be significantly affected by the changes made in this system.

Response: The way suppliers do business will to some extent be affected by these provisions. Since the suppliers will now have to negotiate with facilities in order to receive payment for their services, this will be different from the current process for suppliers in situations involving an SNF that had not previously elected to do the Medicare billing for its residents' supplies. However, we do not anticipate that this change will be uniformly significant, even among this subset of suppliers, since its effect will be limited primarily to those particular areas that have an abundance of suppliers competing for the business of a relatively small number of SNFs. By contrast, we believe that in most situations suppliers should be able to negotiate a fair amount of payment from the facilities and, thus, will not be significantly affected economically by these provisions, as discussed further in section VI below.

Comment: One commenter argued that since the interim final rule is a major rule (savings over $100 million), it appears inconsistent to state that an assessment of costs and benefits pursuant to the Unfunded Mandates Reform Act was not needed since local governments and the private sector would not be incurring costs of over $100 million. This commenter felt that there would be cost shifting and these entities would be picking up the amount of savings the Federal government was realizing.

Response: The interim final rule implemented major changes in how SNFs will be paid by Medicare. Other payers, being prudent purchasers of health care services, will still be able to negotiate with the providers to reach a fair and equitable payment for services rendered to patients they cover. Because other payers are able to negotiate we believe that if providers attempt to shift costs due to SNF PPS other payers will quickly negotiate what they will pay to avoid being unduly burdened with additional costs. Therefore, there is a great amount of uncertainty regarding the amounts, if any, that other payers may have to bear due to the payment changes as a result of SNF PPS. In previous cases, what has occurred is that other payers have adjusted their policies after we changed our payment policy.

The Unfunded Mandates Reform Act of 1995 requires that agencies prepare an assessment of anticipated costs and benefits before issuing any rule that may mandate an annual expenditure by State, local, or tribal governments, in the aggregate, or by the private sector, of $100 million or more. We believe that this final rule will not mandate expenditures in that amount. We do realize that using average values does not totally reflect each individual SNF's effect, which was acknowledged in the Impact section of the interim final rule, or the segmented aggregate effect on State, local, or tribal governments, and the private sector. However, for many of the factors in the calculation only averages existed, and facility-specific data were not available for each individual facility, not making such segmentation possible.

IV. Provisions of the Final Regulations

This final rule incorporates the provisions of the interim final rule with the following revisions, as discussed previously in this preamble:

- We are amending the regulations text at §§ 409.20 and 409.27 to clarify that transportation by ambulance that meets the general medical necessity requirements set forth in § 410.40(d)(1) is covered under the Part A SNF benefit as services that are generally furnished by (or under arrangements made by) SNFs.
- We are amending the regulations text at § 409.30 (Basic requirements) to clarify that the initial presumption of coverage that arises from a beneficiary's first Medicare assessment and his or her resulting RUG–III assignment is valid as of the assessment reference date (that is, the last day of the observation period) for the initial 5-day assessment. We are also correcting an erroneous cross-reference that appears in the introductory material for § 409.30, as well as in the definition of custodial care at § 411.15(g).
- In § 409.33 (Examples of skilled nursing and rehabilitation services), we are restoring certain portions of the regulations text that the interim final rule deleted, with regard to the overall management and evaluation of the care plan; observation and assessment of the patient's changing condition; and, patient education. We are also clarifying that the use of insertion, sterile irrigation, and replacement of catheters as an example of a skilled nursing service applies solely with regard to suprapubic catheters.
- In § 411.15(p)(3)(iii) we are revising the parenthetical phrase to clarify that our basis for determining that a particular type of outpatient hospital service is subject to the SNF consolidated billing provision is its inclusion within the customary scope of SNF care plans generally, without regard to whether it appears in the individual care plan of a particular beneficiary.
- We are adding a new § 413.350 that provides for making periodic interim payments under the SNF PPS, and we are making a conforming revision in § 413.64(h)(2)(iii). We are also revising the regulations text at § 413.343(b), in order to clarify the language that describes the required Medicare assessment schedule.
- We are amending § 489.21 by adding a new paragraph (h), which specifically precludes charging an SNF resident for an item or service that is subject to the consolidated billing requirement.

V. Collection of Information Requirements

The information collection requirements associated or referenced in this rule, which are subject to the Paperwork Reduction Act, have been approved by the Office of Management and Budget. The titles, approval numbers and current expiration dates of the collection requirements are as follows: ''Medicare Common Claim Form,'' 0938–0008, 08/31/99; ''SNF Resident Assessment MDS Data,'' 0938–0739, 04/30/99.

VI. Impact Analysis

A. Background

Summary of the Interim Final Rule Regulatory Impact Statement

Section 1888(e) of the Act specifies that the base year for computing the RUG payment rates is FY 1995 (that is, October 1, 1994, through September 30, 1995.) Pursuant to the statute, we incorporated several elements into the SNF PPS such as case-mix methodology, the MDS assessment schedule, a market basket index, a wage index, the urban and rural distinction used in the development or adjustment of the Federal rates, and coverage requirements.

In the interim final rule, we stated that SNF PPS will result in estimated annual savings over five years ranging from $30 million in the first year to

$4.28 billion in the fifth year. Savings included both the savings from Medicare fee-for-service and managed care payments. It was projected that 8958 SNFs would experience a decrease in Medicare payments as a result of the SNF PPS. The percentage reduction in payments was estimated to be 17 percent.

However, because Medicare SNF payments account for only approximately 10 percent on average of a SNF's total revenue the revenue reduction of a SNF as a result of the interim final rule was approximately 1.7 percent. These were average figures and we did not (and do not) have data that would allow us to determine if a substantial number of SNFs will experience revenue decreases greater than the estimated average.

As stated in the interim final rule, we did not expect suppliers of services to SNFs to be significantly affected by the consolidated billing provisions. Total Medicare reimbursement to suppliers was estimated in the interim final rule to be about $4 billion each year. The reimbursement to suppliers for SNF services was estimated to be about $60 million each year. Therefore, we believed that the consolidated billing provisions related to the services provided to patients in Part A SNF stays would generally have a minimal impact on suppliers.

As stated in the interim final rule the majority of ancillary services are provided directly by SNFs or under arrangements with suppliers and are, therefore, already billed to Medicare by the SNFs. While there was a possibility that, for those services being consolidated as a result of the statute and the interim final rule, a sizeable number of these suppliers might be reimbursed by SNFs at rates lower than the rates at which they were reimbursed by Medicare under the previous system, we believed that this was highly dependent on the reaction each individual supplier had to the new payment system.

In addition, with regard to consolidated billing related to services provided to SNF patients who are not in a Part A stay, to the extent that these services have been necessary in the past, they will still be required and provided to these patients by suppliers. Accordingly, it was anticipated that the total impact on suppliers would be minimal. However, determining the effect on individual suppliers was not possible due to a lack of data. Therefore we were not able to determine if the new SNF per diem rates would result in a substantial number of suppliers experiencing significant decreases in their total revenues.

B. Impact of This Final Rule

We have examined the impacts of this final rule as required by Executive Order 12866, section 1102(b) of the Act, the Unfunded Mandates Reform Act of 1995, and the Regulatory Flexibility Act (RFA) (Public Law 96–354). Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more annually).

The purpose of this final rule is not to initiate significant policy changes with regard to the SNF PPS but, rather, to clarify and make minor modifications in the policies that were established in the SNF PPS interim final rule published on May 12, 1998 (63 FR 26251). Accordingly, we believe that the revisions and clarifications mentioned elsewhere in the preamble (for example, the adjustment to the nursing case-mix component of the urban and Federal rates) will have, at most, only a negligible overall effect upon the regulatory impact estimate specified in the interim final rule. As such, these revisions will not represent an additional burden to the industry.

Columns A–C of Table IX.2 below, published in the interim final rule (63 FR 26304) depicted the number of facilities that were projected to experience a decrease in Medicare SNF payments under the new SNF PPS rates and the percentage change for the type of facility.

TABLE IX.2.—IMPACT ON SNFS BY TYPE

Type of SNF	Total number of SNFs (A)	Number of SNFs with lower payment (B)	Estimated average percentage reduction in payments for first year transition (C)	Estimated average percentage reduction in payments for fully implemented PPS (D)
MSA Freestanding	5617	5585	17	18
MSA Hospital Based	683	679	19	34
Non-MSA Freestanding	2204	2189	17	18
Non-MSA Hospital Based	533	531	18	30
Total	9037	8984	17	21

Specifically, column (A) of the table depicted the total number of SNFs in the data base for FY 1995 cost reporting periods. Column (B) depicted the number of SNFs whose payment rate for cost reporting periods beginning July 1, 1998 would be lower than the payment they would have received under the former cost-based methodology for cost reporting periods beginning July 1, 1998.

As described in the interim final rule, the payments received under SNF PPS would initially be based on a facility level case-mix score developed using the case-mix indices and the MEDPAR analog. The payments that would have been received under the former (pre-SNF PPS) system were estimated by using the same average inflation factor from the 1995 data for each facility. Column (C) depicts the estimated reduction in payments on a percentage basis between the two payment methodologies for the first year of transition. New column (D) depicts the estimated reduction in payments on a percentage basis between the two payment methodologies for the fully implemented SNF PPS.

The estimated effect of the fully implemented SNF PPS (if, instead of having the transition, it paid all

facilities entirely at the Federal rate as of the first year) is that it would save 21 percent on average instead of 17 percent. This effect is felt much more heavily by hospital-based facilities (34 percent savings) as opposed to freestanding facilities (18 percent).

As was stated in the interim final rule, the results listed in Table IX.2 should be viewed with caution and as illustrative of broad groupings of SNFs. Averages have been used and the effects on individual SNFs may differ. Future impacts will be shown as the rates are developed and published in the future.

As stated in the interim final rule, in developing the estimate, we assumed each facility would increase costs at the national average rate. This national average increase includes the higher costs of new facilities entering the program. Therefore, this increase might be slightly higher than the true amount for existing facilities. We do, however, expect total payments to SNFs to decrease compared to payments that would have occurred under the former cost-based methodology. The effects of this decrease in payments to any individual SNF will depend on that SNF's ability to operate under the new payment methodology and on the proportion of its revenues that come from the Medicare program.

The RFA requires agencies to analyze options for regulatory relief of small entities. The BBA mandates implementation of SNF PPS. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and governmental agencies. Most SNFs and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $5 million or less annually. States and tribal governments are not considered to be small entities, nor are intermediaries or carriers.

Under the RFA, an economic impact is significant if the annual total costs or revenues of a substantial number of entities will be increased or decreased by at least 3 percent. Medicare payments generally do not account for a high proportion of SNF revenue (about 10 percent on average) and the estimated average percentage reduction in payments for the fully implemented SNF PPS reduces those payments by approximately 21 percent on average. Therefore, total revenues for SNFs will be reduced by about 2.1 percent. As stated above, we are unable to determine the effects on individual SNFs and therefore are unable to determine if the new SNF per diem rates will result in a substantial number of SNFs experiencing significant decreases in their total revenues.

C. Rural Hospital Impact Statement

Section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. Such 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 the Secretary certifies, that this rule will not have a significant economic impact on the operations of a substantial number of small rural hospitals.

D. Unfunded Mandates

The Unfunded Mandates Reform Act of 1995 also requires (in section 202) that agencies prepare an assessment of anticipated costs and benefits before issuing any rule that may mandate an annual expenditure by State, local, or tribal governments, in the aggregate, or by the private sector, of $100 million or more. We believe that this final rule will not mandate expenditures in that amount.

List of Subjects

42 CFR Part 409

Health facilities, Medicare.

42 CFR Part 411

Kidney diseases, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 413

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

42 CFR Part 489

Health facilities, Medicare, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, 42 CFR chapter IV is amended as follows:

PART 409—HOSPITAL INSURANCE BENEFITS

A. Part 409 is amended as set forth below:

1. The authority citation for part 409 is revised to read as follows:

Authority: Sections 1102 and 1871 of the Social Security Act (U.S.C. 1302 and 1395hh).

Subpart C—Posthospital SNF Care

2. In § 409.20, remove paragraph (a)(8).

3. In § 409.27, the word ''and'' is removed from the end of paragraph (a), the period at the end of paragraph (b) is removed and a semicolon followed by the word ''and'' is added in its place, and a new paragraph (c) is added, to read as follows:

§ 409.27 Other services generally provided by (or under arrangements made by) SNFs.

* * * * *

(c) Transportation by ambulance that meets the general medical necessity requirements set forth in § 410.40(d)(1) of this chapter.

Subpart D—Requirements for Coverage of Posthospital SNF Care

4. In § 409.30, the second sentence in the introductory text is removed and two sentences are added in its place to read as follows:

§ 409.30 Basic requirements.

* * * A beneficiary in an SNF is also considered to meet the level of care requirements of § 409.31 up to and including the assessment reference date for the 5-day assessment prescribed in § 413.343(b) of this chapter, when assigned to one of the Resource Utilization Groups that is designated (in the annual publication of Federal prospective payment rates described in § 413.345 of this chapter) as representing the required level of care. For the purposes of this section, the assessment reference date is defined in accordance with § 483.315(d) of this chapter, and must occur no later than the eighth day of posthospital SNF care.

* * * * *

5. In § 409.33, paragraphs (a), (b), and (c) are redesignated as paragraphs (b), (c), and (d), respectively; a new paragraph (a) is added; and newly designated paragraph (b)(4) is revised to read as follows:

§ 409.33 Examples of skilled nursing and rehabilitation services.

(a) *Services that could qualify as either skilled nursing or skilled rehabilitation services.* (1) *Overall management and evaluation of care plan.* (i) When overall management and evaluation of care plan *constitute skilled services.* The development, management, and evaluation of a patient care plan based on the physician's orders constitute skilled services when, because of the patient's physical or mental condition, those activities require the involvement of technical or professional personnel in order to meet the patient's needs, promote recovery, and ensure medical safety. Those activities include the management of a plan involving a variety of personal care services only when, in light of the patient's condition, the aggregate of

those services requires the involvement of technical or professional personnel.

(ii) *Example.* An aged patient with a history of diabetes mellitus and angina pectoris who is recovering from an open reduction of a fracture of the neck of the femur requires, among other services, careful skin care, appropriate oral medications, a diabetic diet, an exercise program to preserve muscle tone and body condition, and observation to detect signs of deterioration in his or her condition or complications resulting from restricted, but increasing, mobility. Although any of the required services could be performed by a properly instructed person, such a person would not have the ability to understand the relationship between the services and evaluate the ultimate effect of one service on the other. Since the nature of the patient's condition, age, and immobility create a high potential for serious complications, such an understanding is essential to ensure the patient's recovery and safety. Under these circumstances, the management of the plan of care would require the skills of a nurse even though the individual services are not skilled. Skilled planning and management activities are not always specifically identified in the patient's clinical record. Therefore, if the patient's overall condition supports a finding that recovery and safety can be ensured only if the total care is planned, managed, and evaluated by technical or professional personnel, it is appropriate to infer that skilled services are being provided.

(2) Observation and assessment of the patient's changing *condition.* (i) When observation and assessment constitute skilled *services.* Observation and assessment constitute skilled services when the skills of a technical or professional person are required to identify and evaluate the patient's need for modification of treatment or for additional medical procedures until his or her condition is stabilized.

(ii) *Examples.* A patient with congestive heart failure may require continuous close observation to detect signs of decompensation, abnormal fluid balance, or adverse effects resulting from prescribed medication(s) that serve as indicators for adjusting therapeutic measures. Similarly, surgical patients transferred from a hospital to an SNF while in the complicated, unstabilized postoperative period, for example, after hip prosthesis or cataract surgery, may need continued close skilled monitoring for postoperative complications and adverse reaction. Patients who, in addition to their physical problems, exhibit acute psychological symptoms such as depression, anxiety, or agitation, may also require skilled observation and assessment by technical or professional personnel to ensure their safety or the safety of others, that is, to observe for indications of suicidal or hostile behavior. The need for services of this type must be documented by physicians' orders or nursing or therapy notes.

(3) *Patient education services.* (i) *When patient education services constitute skilled services.* Patient education services are skilled services if the use of technical or professional personnel is necessary to teach a patient self-maintenance.

(ii) *Examples.* A patient who has had a recent leg amputation needs skilled rehabilitation services provided by technical or professional personnel to provide gait training and to teach prosthesis care. Similarly, a patient newly diagnosed with diabetes requires instruction from technical or professional personnel to learn the self-administration of insulin or foot-care precautions.

(b) * * *

(4) Insertion and sterile irrigation and replacement of suprapubic catheters;

* * * * *

PART 411—EXCLUSIONS FROM MEDICARE AND LIMITATIONS ON MEDICARE PAYMENT

B. Part 411 is amended as set forth below:

1. The authority citation for part 411 continues to read as follows:

Authority: Sections 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

Subpart A—General Exclusions and Exclusion of Particular Services

§ 411.15 [Amended]

2. In § 411.15:

a. In paragraph (g), remove the citation ''§§ 409.30'' and add, in its place ''§§ 409.31''.

b. Paragraph (p)(3)(iii) is revised to read as follows:

§ 411.15 Particular services excluded from coverage.

* * * * *

(p) * * *

(3) * * *

(iii) The beneficiary receives outpatient services from a Medicare-participating hospital or CAH (but only with respect to those services that are beyond the general scope of SNF comprehensive care plans, as required under § 483.20 of this chapter); or

* * * * *

PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES; PROSPECTIVELY DETERMINED PAYMENT RATES FOR SKILLED NURSING FACILITIES

C. Part 413 is amended as set forth below:

1. The heading for part 413 is revised as set forth above.

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

Authority: Secs. 1102, 1861(v)(1)(A), and 1871 of the Social Security Act (42 U.S.C. 1302, 1395x(v)(1)(A), and 1395hh).

3. In § 413.64, paragraph (h)(2)(iii) is revised to read as follows:

§ 413.64 Payments to providers: Specific rules.

* * * * *

(h) * * *

(2) * * *

(iii) Part A SNF services furnished in cost reporting periods beginning before July 1, 1998. (For services furnished in subsequent cost reporting periods, see § 413.350 regarding periodic interim payments for skilled nursing facilities).

* * * * *

§ 413.343 [Amended]

4. In § 413.343(b), remove the words ''following admission'' and add, in their place, the words ''of posthospital SNF care''.

5. Add § 413.350 to subpart J to read as follows:

§ 413.350 Periodic interim payments for skilled nursing facilities receiving payment under the skilled nursing facility prospective payment system for Part A services.

(a) *General rule.* Subject to the exceptions in paragraphs (b) and (c) of this section, SNFs receiving payment under the PPS for Part A services do not receive interim payments during the cost reporting year, and receive payment only following submission of a bill. Paragraph (d) of this section provides for accelerated payments in certain circumstances.

(b) Periodic interim payments. (1) An SNF receiving payment under the prospective payment system may receive periodic interim payments (PIP) for Part A SNF services under the PIP method subject to the provisions of § 413.64(h). To be approved for PIP, the SNF must meet the qualifying requirements in § 413.64(h)(3). Moreover, as provided in § 413.64(h)(5), intermediary approval is conditioned upon the intermediary's best judgment as to whether payment can be made

under the PIP method without undue risk of its resulting in an overpayment to the provider.

(2) *Frequency of payment.* The intermediary estimates an SNF's prospective payments net of estimated beneficiary coinsurance and makes biweekly payments equal to 1/26 of the total estimated amount of payment for the year. If an SNF has payment experience under the prospective payment system, the intermediary estimates PIP based on that payment experience, adjusted for projected changes supported by substantiated information for the current year. Each payment is made 2 weeks after the end of a biweekly period of service as described in § 413.64(h)(6). The interim payments are reviewed at least twice during the reporting period and adjusted if necessary. Fewer reviews may be necessary if an SNF receives interim payments for less than a full reporting period. These payments are subject to final settlement.

(3) Termination of PIP. (i) Request by the SNF. An SNF receiving PIP may convert to receiving prospective payments on a non-PIP basis at any time.

(ii) Removal by the intermediary. An intermediary terminates PIP if the SNF no longer meets the requirements of § 413.64(h).

(c) Interim payments for Medicare bad debts and for Part A costs not paid under the prospective payment system. For Medicare bad debts and for costs of an approved education program and other costs paid outside the prospective payment system, the intermediary determines the interim payments by estimating the reimbursable amount for the year based on the previous year's experience, adjusted for projected changes supported by substantiated information for the current year, and makes biweekly payments equal to 1/26 of the total estimated amount. Each payment is made 2 weeks after the end of a biweekly period of service as described in § 413.64(h)(6). The interim payments are reviewed at least twice during the reporting period and adjusted if necessary. Fewer reviews may be necessary if an SNF receives interim payments for less than a full reporting period. These payments are subject to final cost settlement.

(d) *Accelerated payments.* (1) *General rule.* Upon request, an accelerated payment may be made to an SNF that is receiving payment under the prospective payment system and is not receiving PIP under paragraph (b) of this section if the SNF is experiencing financial difficulties because of the following:

(i) There is a delay by the intermediary in making payment to the SNF.

(ii) Due to an exceptional situation, there is a temporary delay in the SNF's preparation and submittal of bills to the intermediary beyond its normal billing cycle.

(2) Approval of payment. An SNF's request for an accelerated payment must be approved by the intermediary and HCFA.

(3) Amount of payment. The amount of the accelerated payment is computed as a percentage of the net payment for unbilled or unpaid covered services.

(4) *Recovery of payment.* Recovery of the accelerated payment is made by recoupment as SNF bills are processed or by direct payment by the SNF.

PART 489—PROVIDER AGREEMENTS AND SUPPLIER APPROVAL

D. Part 489 is amended as set forth below:

1. The authority citation for part 489 continues to read as follows:

Authority: Secs. 1102, 1819, 1861, 1864(m), 1866, and 1871 of the Social Security Act (42 U.S.C. 1302, 1395i-3, 1395x, 1395aa(m), 1395cc, and 1395hh).

2. In § 489.21, a new paragraph (h) is added to read as follows:

§ 489.21 Specific limitations on charges.

* * * * *

(h) Items and services (other than those described in § 489.20(s)(1) through (11)) furnished to a resident (as defined in § 411.15(p)(3) of this chapter) of an SNF for which Medicare payment would be made if furnished by the SNF or by other providers or suppliers under arrangements made with them by the SNF. For this purpose, a charge by another provider or supplier for such an item or service is treated as a charge by the SNF for the item or service, and is also prohibited.

(Catalog of Federal Domestic Assistance Program Number 93.773, Medicare—Hospital Insurance; and Program Number 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: June 14, 1999.

Nancy-Ann Min DeParle,

Administrator, Health Care Financing Administration.

Dated: July 22, 1999.

Donna Shalala,

Secretary.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

[HCFA–1056–N]

RIN 0938–AJ65

Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities—Update

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

ACTION: Notice.

SUMMARY: This notice sets forth the updates required in section 1888(e) of the Social Security Act (the Act), as added by section 4432 of the Balanced Budget Act of 1997, related to Medicare payments and consolidated billing for skilled nursing facilities.

EFFECTIVE DATE: This notice is effective October 1, 1999. This notice is a major rule as defined in Title 5, United States Code, section 804(2). Pursuant to 5 U.S.C. section 801(a)(1)(A), we are submitting a report to the Congress on this notice on July 30, 1999.

FOR FURTHER INFORMATION CONTACT:
Dana Burley, (410) 786–4547 (for information related to the case-mix classification methodology).
John Davis, (410) 786–0008 (for information related to the Federal Rates).
Jackie Gordon, (410) 786–4517 (for information related to consolidated billing).
Steve Raitzyk, (410) 786–4599 (for information related to the facility-specific transition rates).
Bill Ullman, (410) 786–5667 (for information related to coverage and level-of-care determinations).
Laurence Wilson, (410) 786–4603 (for general information).

SUPPLEMENTARY INFORMATION:

I. Background

A. Current System for Payment of Skilled Nursing Facility Services Under Part A of the Medicare Program

Section 4432 of the Balanced Budget Act of 1997 (BBA) (Pub. L. 105–33) mandated the implementation of a per diem prospective payment system (PPS) for skilled nursing facilities (SNFs), covering all costs (routine, ancillary, and capital) of covered SNF services furnished to beneficiaries under Part A of the Medicare program effective for cost reporting periods beginning on or after July 1, 1998. Major elements of the system include:

Rates: Per diem Federal rates were established for urban and rural areas using allowable costs from FY 1995 cost reports. These rates also included an estimate of the cost of services that before July 1, 1998, had been paid under Part B, but furnished to SNF residents during a Part A covered stay. Rates are case-mix adjusted using a resident classification system (Resource Utilization Groups, version III (RUG–III)) based on resident assessments (using the Minimum Data Set (MDS) 2.0). In addition, the Federal rates are adjusted by the hospital wage index to account for geographic variation in wages. Finally, the rates will be adjusted annually using an SNF market basket index.

- Transition: The SNF PPS includes a 3-year transition that blends a facility-specific payment rate with the Federal case-mix adjusted rate. The blend that is used changes each cost reporting period after a facility migrates to the new system. For most facilities, the facility-specific rate is based on allowable costs from FY 1995.
- Coverage: The PPS statute did not change Medicare's fundamental requirements for SNF coverage. However, because RUG–III classification is based, in part, on the resident's need for skilled nursing care and therapy, we have attempted where possible to coordinate claims review procedures with the outputs of resident assessment and RUG–III classifying activities. For example, we believe that an initial Medicare-required (5-day) assessment, properly completed, that places the resident in one of the upper 26 RUG–III classifications provides the basis for us to assume that the resident needed a covered level of SNF care upon admission and at least up until the assessment reference date for the initial Medicare-required assessment. We will, however, continue to make individual review determinations for claims of individuals who classify in the lower 18 RUG–III categories.
- Consolidated Billing: The statute includes a billing provision that requires an SNF to submit consolidated Medicare bills for its residents for virtually all services that are covered under either Part A or Part B. The statute excludes a small list of services (primarily those of physicians and certain other types of practitioners). A related statutory provision requires SNFs to use HCFA Common Procedure Coding System (HCPCS) coding on all Part B bills, and specifies that they are to be paid an amount determined in accordance with the otherwise applicable Part B fee schedule for the particular item or service.
- Effective Date: The PPS is effective for cost reporting periods beginning on or after July 1, 1998. The law provides that the consolidated billing and coding requirements are effective for services and items furnished on or after July 1, 1998.

An interim final rule implementing the SNF PPS was published in the **Federal Register** on May 12, 1998 (63 FR 26252) and the comment period was initially scheduled to close on July 13, 1998. A follow-up notice (63 FR 37498, July 13, 1998) extended the public comment period for an additional 60 days, and a second notice (63 FR 65561, November 27, 1998) reopened the comment period for another 30 days. In addition, a correction notice was published (63 FR 53301, October 5, 1998) that made a number of minor technical and editorial corrections to the interim final rule. We also published a final rule found elsewhere in this **Federal Register** document that addressed comments on the May 12, 1998 interim final rule. We have also issued several Program Memorandums on claims processing and billing under the SNF PPS that are available on the SNF PPS home page at the HCFA website on the Internet, at the following location: <www.hcfa.gov/medicare/snfpps.htm>

B. Requirements of the Balanced Budget Act of 1997 for Updating the Prospective Payment System for Skilled Nursing Facilities

As described above, section 1888(e)(4)(H) of the Act requires that we publish in the **Federal Register**:

1. The unadjusted Federal per diem rates to be applied to days of covered SNF services furnished during the fiscal year.
2. The case-mix classification system to be applied with respect to these services during the fiscal year.
3. The factors to be applied in making the area wage adjustment with respect to these services. In addition, in the interim final rule (May 12, 1998, 63 FR 26252), we indicated that we would announce any changes to the Medicare coverage guidelines or the RUG–III classifications.

This notice updates the rates as mandated by the Social Security Act (the Act).

C. Skilled Nursing Facility Prospective Payment—General Overview

As described above, the Medicare SNF PPS was implemented for cost reporting periods beginning on or after July 1, 1998. Under the PPS, SNFs are paid through per diem prospective case-mix adjusted payment rates applicable to all covered SNF services. These payment rates cover all the costs of

furnishing covered skilled nursing services (that is, routine, ancillary, and capital-related costs) other than costs associated with approved educational activities. Covered SNF services include posthospital SNF services for which benefits are provided under Part A and all items and services that, before July 1, 1998, had been paid under Part B (other than physician and certain other services specifically excluded under the BBA) but furnished to SNF residents during a Part A covered stay. (For a complete discussion of these provisions see the May 12, 1998 interim final rule (63 FR 26252).)

1. Payment Provisions—Federal Rate

The statute sets forth a fairly prescriptive methodology for calculating the amount of payment under SNF PPS. The PPS utilizes per diem Federal payment rates based on mean SNF costs in a base year updated for inflation to the first effective period of the PPS. We developed the Federal payment rates using allowable costs from hospital-based and freestanding SNF cost reports for reporting periods beginning in fiscal year 1995. The data used in developing the Federal rates also incorporate an estimate of the amounts that would be payable under Part B for covered SNF services to individuals who were residents of a facility and receiving Part A covered services. In developing the rates for the initial period, we updated costs to the first effective year of PPS (15-month period beginning July 1, 1998) using a SNF market basket index, and standardized for facility differences in case-mix and for geographic variations in wages. Providers that received ''new provider'' exemptions from the routine cost limits were excluded from the database used to compute the Federal payment rates. In addition, costs related to payments for exceptions to the routine cost limits were excluded from the database used to compute the Federal rates. In accordance with the formula prescribed in the BBA, we set the Federal rates at a level equal to the weighted mean of freestanding costs plus 50 percent of the difference between the freestanding mean and weighted mean of all SNF costs (hospital-based and freestanding) combined. We compute and apply separately payment rates for facilities located in urban and rural areas.

The Federal rate also incorporates adjustments to account for facility case-mix using a resident classification system that accounts for the relative resource utilization of different patient types. This classification system, RUG–III, utilizes resident assessment data (from the Minimum Data Set or MDS) completed by SNFs to assign residents into one of 44 groups. The May 12, 1998 interim final rule (63 FR 26252) has a complete and detailed description of the RUG–III classification system.

In addition, we adjust the portion of the Federal rate attributable to wage related costs by a wage index.

For the initial period of PPS, the rates were published in the May 12, 1998 interim final rule (63 FR 26252). The Federal rates reflected in this notice updates those rates by a factor equal to the SNF market basket index amounts minus 1 percentage point. Pursuant to section 1888(e)(4)(E)(ii) of the Act, for fiscal years 2001 and 2002, we will inflate the rates each year in the same way, by increasing the current rates by the SNF market basket change minus 1 percentage point. For subsequent fiscal years, we will increase the rates by the applicable SNF market basket change.

2. Payment Provisions—Transition Period

Beginning with a provider's first cost reporting period beginning on or after July 1, 1998, there is a transition period covering three cost reporting periods. During the transition phase, SNFs receive a payment rate comprising a blend between the Federal rate and a facility-specific rate based on each facility's fiscal year 1995 cost report. Under section 1888(e)(2)(E)(ii) of the Act, SNFs that received their first payment from Medicare on or after October 1, 1995 receive payment according to the Federal rates only.

For SNFs subject to transition, the composition of the blended rate varies depending on the year of transition. For the first cost reporting period beginning on or after July 1, 1998, we make payment based on 75 percent of the facility-specific rate and 25 percent of the Federal rate. In the next cost reporting period, the rate consists of 50 percent of the facility-specific rate and 50 percent of the Federal rate. In the following cost reporting period, the rate consists of 25 percent of the facility-specific rate and 75 percent of the Federal rate. For all subsequent cost reporting periods, we base payments entirely on the Federal rates.

3. Payment Provisions—Facility-Specific Rate

For most facilities, we compute the facility-specific payment rate utilized for the transition using the allowable costs of SNF services for cost reporting periods beginning in fiscal year 1995 (cost reporting periods beginning on or after October 1, 1994 and before October 1, 1995). Included in the facility-specific per diem rate for most facilities is an estimate of the amount that would be payable under Part B for covered SNF services furnished during fiscal year 1995 to individuals who were residents of the facility and receiving Part A covered services under section 1888(e)(3)(A). The facility-specific rate, in contrast to the Federal rates, includes amounts paid to SNFs for exceptions to the routine cost limits. In addition, we also take into account ''new provider'' exemptions from the routine cost limits but only to the extent that routine costs do not exceed 150 percent of the routine cost limit.

We update the facility-specific rate for each cost reporting after fiscal year 1995 to the first cost reporting period beginning on or after July 1, 1998 (the initial period of the PPS) by a factor equal to the SNF market basket percentage increase minus 1 percentage point. For fiscal years 1998 and 1999, we updated this rate by a factor equal to the SNF market basket increase minus 1 percentage point, and each subsequent year, we update it by the applicable SNF market basket increase.

II. Prospective Payment System for Skilled Nursing Facilities

A. This notice sets forth a schedule of Federal prospective payment rates applicable to Medicare Part A SNF services beginning October 1, 1999. This schedule incorporates per diem Federal rates designed to provide payment for all costs of services furnished to a Medicare resident of an SNF.

1. Cost and Services Covered by the Federal Rates

The Federal rates apply to all costs (that is, routine, ancillary, and capital related costs) of covered skilled nursing services other than costs associated with operating approved educational activities as defined in 42 CFR 413.85. Under section 1888(e)(2) of the Act, covered SNF services include posthospital SNF services for which benefits are provided under Part A (the hospital insurance program) and all items and services (other than services excluded by statute) for which, before July 1, 1998, payment may be made under Part B (the supplementary medical insurance program) and that are furnished to SNF residents during a Part A covered stay. (These excluded service categories are discussed in greater detail in Section V.B.2 of the May 12, 1998 interim final rule (63 FR 26252).)

2. Methodology Used for the Calculation of the Federal Rates

The methodology to compute the Federal rates has not changed, except as we published in the final rule found

elsewhere is this **Federal Register** document, we have adjusted the unadjusted nursing case-mix component of the urban and rural Federal rates by +$0.32 and +$0.24, respectively. In addition, we adjusted the unadjusted non-case-mix by $0.25 for urban and $0.21 for rural. Additionally, as required by the Act, the data are updated using the latest market basket percentage minus 1 percentage point. For a complete listing of the multistep process, see the May 12, 1998 interim final rule (63 FR 26252).

The SNF market basket is used to adjust each per diem amount forward to reflect cost increases occurring between the midpoint of the cost reporting period represented in the data and the midpoint of the period beginning October 1, 1999 and ending September 30, 2000 to which the payment rates apply. In accordance with section 1888(e)(4)(B) of the Act, the cost data are updated between the cost reporting period and the current period by a factor equivalent to the annual market basket index percentage minus 1 percentage point.

TABLE 1.—UNADJUSTED FEDERAL RATE PER DIEM URBAN

Rate component	Nursing—case-mix	Therapy—case-mix	Therapy—non-case mix	Non-case-mix
Per Diem Amount	$111.89	$84.25	$11.12	$57.20

TABLE 2.—UNADJUSTED FEDERAL RATE PER DIEM RURAL

Rate component	Nursing—case-mix	Therapy—case-mix	Therapy-non-case-mix	Non-case-mix
Per Diem Amount	$107.12	$97.33	$11.88	$58.25

B. Case-Mix Adjustment

As required by the Act, any changes to the case-mix classification system to be applied with respect to services furnished for SNF Medicare SNF PPS residents must be published each August for the succeeding year. At this time, we are not making any changes or refinements to the case-mix or RUG–III classification system. The RUG–III classification system is discussed in the May 12, 1998 interim final rule (63 FR 26252) and describes in detail the design and implementation of the case-mix and RUG–III classification system and assessment schedule for SNFs to submit MDSs.

Application of the case-mix indices as described in the May 12, 1998 interim final rule (63 FR 26252) to the updated per diem Federal rates presented in Tables 1 and 2 above, results in 44 separate RUG–III classification groups. The case-mix adjusted payment rates are listed separately for urban and rural SNFs (44 each) in Tables 3 and 4 below with the corresponding case-mix index values. The rates are listed in total and by component. The application of the wage index, described later in this section, is the final adjustment applied to the Federal rates.]

TABLE 3.—CASE-MIX ADJUSTED FEDERAL RATES AND ASSOCIATED INDICES URBAN

RUG III category	Nursing index	Therapy index	Nursing component	Therapy component	Therapy non-case-mix component	Non-case-mix component	Total rate
RUC	1.30	2.25	$145.46	$189.56		57.20	392.22
RUB	0.95	2.25	106.30	189.56		57.20	353.06
RUA	0.78	2.25	87.27	189.56		57.20	334.03
RVC	1.13	1.41	126.44	118.79		57.20	302.43
RVB	1.04	1.41	116.37	118.79		57.20	292.36
RVA	0.81	1.41	90.63	118.79		57.20	266.62
RHC	1.26	0.94	140.98	79.20		57.20	277.38
RHB	1.06	0.94	118.60	79.20		57.20	255.00
RHA	0.87	0.94	97.34	79.20		57.20	233.74
RMC	1.35	0.77	151.05	64.87		57.20	273.12
RMB	1.09	0.77	121.96	64.87		57.20	244.03
RMA	0.96	0.77	107.41	64.87		57.20	229.48
RLB	1.11	0.43	124.20	36.23		57.20	217.63
RLA	0.80	0.43	89.51	36.23		57.20	182.94
SE3	1.70		190.21		11.12	57.20	258.53
SE2	1.39		155.53		11.12	57.20	223.85
SE1	1.17		130.91		11.12	57.20	199.23
SSC	1.13		126.44		11.12	57.20	194.76
SSB	1.05		117.48		11.12	57.20	185.80
SSA	1.01		113.01		11.12	57.20	181.33
CC2	1.12		125.32		11.12	57.20	193.64
CC1	0.99		110.77		11.12	57.20	179.09
CB2	0.91		101.82		11.12	57.20	170.14
CB1	0.84		93.99		11.12	57.20	162.31
CA2	0.83		92.87		11.12	57.20	161.19
CA1	0.75		83.92		11.12	57.20	152.24
IB2	0.69		77.20		11.12	57.20	145.52
IB1	0.67		74.97		11.12	57.20	143.29

TABLE 3.—CASE-MIX ADJUSTED FEDERAL RATES AND ASSOCIATED INDICES URBAN—Continued

RUG III category	Nursing index	Therapy index	Nursing component	Therapy component	Therapy non-case-mix component	Non-case-mix component	Total rate
IA2	0.57		63.78		11.12	57.20	132.10
IA1	0.53		59.30		11.12	57.20	127.62
BB2	0.68		76.09		11.12	57.20	144.41
BB1	0.65		72.73		11.12	57.20	141.05
BA2	0.56		62.66		11.12	57.20	130.98
BA1	0.48		53.71		11.12	57.20	122.03
PE2	0.79		88.39		11.12	57.20	156.71
PE1	0.77		86.16		11.12	57.20	154.48
PD2	0.72		80.56		11.12	57.20	148.88
PD1	0.70		78.32		11.12	57.20	146.64
PC2	0.65		72.73		11.12	57.20	141.05
PC1	0.64		71.61		11.12	57.20	139.93
PB2	0.51		57.06		11.12	57.20	125.38
PB1	0.50		55.95		11.12	57.20	124.27
PA2	0.49		54.83		11.12	57.20	123.15
PA1	0.46		51.47		11.12	57.20	119.79

TABLE 4.—CASE-MIX ADJUSTED FEDERAL RATES AND ASSOCIATED INDICES RURAL

RUG III category	Nursing index	Therapy index	Nursing component	Therapy component	Therapy non-case-mix component	Non-case-mix component	Total rate
RUC	1.30	2.25	$139.26	$218.99		$58.25	$416.50
RUB	0.95	2.25	101.76	218.99		58.25	379.00
RUA	0.78	2.25	83.55	218.99		58.25	360.79
RVC	1.13	1.41	121.05	137.24		58.25	316.54
RVB	1.04	1.41	111.40	137.24		58.25	306.89
RVA	0.81	1.41	86.77	137.24		58.25	282.26
RHC	1.26	0.94	134.97	91.49		58.25	284.71
RHB	1.06	0.94	113.55	91.49		58.25	263.29
RHA	0.87	0.94	93.19	91.49		58.25	243.93
RMC	1.35	0.77	144.61	74.94		58.25	277.80
RMB	1.09	0.77	116.76	74.94		58.25	249.95
RMA	0.96	0.77	102.84	74.94		58.25	236.03
RLB	1.11	0.43	118.90	41.85		58.25	219.00
RLA	0.80	0.43	85.70	41.85		58.25	185.80
SE3	1.70		182.10		11.88	58.25	252.23
SE2	1.39		148.90		11.88	58.25	219.03
SE1	1.17		125.33		11.88	58.25	195.46
SSC	1.13		121.05		11.88	58.25	191.18
SSB	1.05		112.48		11.88	58.25	182.61
SSA	1.01		108.19		11.88	58.25	178.32
CC2	1.12		119.97		11.88	58.25	190.10
CC1	0.99		106.05		11.88	58.25	176.18
CB2	0.91		97.48		11.88	58.25	167.61
CB1	0.84		89.98		11.88	58.25	160.11
CA2	0.83		88.91		11.88	58.25	159.04
CA1	0.75		80.34		11.88	58.25	150.47
IB2	0.69		73.91		11.88	58.25	144.04
IB1	0.67		71.77		11.88	58.25	141.90
IA2	0.57		61.06		11.88	58.25	131.19
IA1	0.53		56.77		11.88	58.25	126.90
BB2	0.68		72.84		11.88	58.25	142.97
BB1	0.65		69.63		11.88	58.25	139.76
BA2	0.56		59.99		11.88	58.25	130.12
BA1	0.48		51.42		11.88	58.25	121.55
PE2	0.79		84.62		11.88	58.25	154.75
PE1	0.77		82.48		11.88	58.25	152.61
PD2	0.72		77.13		11.88	58.25	147.26
PD1	0.70		74.98		11.88	58.25	145.11
PC2	0.65		69.63		11.88	58.25	139.76
PC1	0.64		68.56		11.88	58.25	138.69
PB2	0.51		54.63		11.88	58.25	124.76
PB1	0.50		53.56		11.88	58.25	123.69
PA2	0.49		52.49		11.88	58.25	122.62
PA1	0.46		49.48		11.88	58.25	119.41

C. Wage Index Adjustment to Federal Rates

Section 1888(e)(4)(G)(ii) of the Act requires that we provide for adjustments to the Federal rates to account for differences in area wage levels using ''an appropriate'' wage index as determined by the Secretary. In addition, as discussed in the final rule found elsewhere is this **Fedreal Register** document, it is our intent to evaluate a wage index based on SNF data once it becomes available. The SNF wage data are currently being collected and evaluated to determine if we can utilize them in the future. Once a wage index based on SNF data is developed, we will publish it for comment. However, in the interim, the BBA as well as many commenters urged us to incorporate the latest wage data available. We continue to believe that until a wage index based on SNF wage data is collected and analyzed, the hospital wage index wage data provide the best available measure of comparable wages that should be paid by SNFs. We believe, since hospitals and SNFs compete in the same labor market area, that the use of the hospital wage data results in an appropriate adjustment to the labor portion of the costs based on an appropriate wage index as required under section 1888(e) of the Act.

For rates effective with this rule, we are using wage index values that are based on hospital wage data from cost reporting periods beginning in fiscal year 1996—the most recent hospital wage data available. Accordingly, the wage index values used in this rule are based on the same wage data as used to compute the FY 2000 wage index values for the hospital inpatient PPS.

The computation of the wage index is identical to past years, and a detailed discussion can be found in the **Federal Register** published on May 12, 1998 (63 FR 26252).

The SNF wage index values are based on the Metropolitan Statistical Area (MSA) designations in effect as of June 30, 1999. For purposes of computing SNF wage index values, we are not taking into account changes in geographic reclassifications for certain rural hospitals required under section 1886(d)(8)(B) of the Act or geographic reclassifications based on decisions of the Medicare Geographic Classification Review Board or the Secretary under section 1886(d)(8)–(10) of the Act. Accordingly, we continue to believe that the MSA (or non-MSA) designation provides the best method for determining the wage index values used for SNF payments, and physical location of hospitals is an appropriate basis upon which to construct the wage index.

Table 5 at the end of this section presents the wage indices applicable to urban and rural areas for use in making geographic adjustments to the Federal rates. The wage index adjustment is applied to the labor-related portion of the Federal rate, which is 77.545 percent of the total rate. The schedule of Federal rates below shows the Federal rates by labor-related and non-labor-related components. Instructions and an example related to the application of the wage index to the case-mix adjusted rates are provided following the table.

As discussed above and in the interim final rule, until appropriate wage index based on SNF data is available, HCFA will use the latest available hospital wage index data in making annual updates to the payment rates. In making these annual updates, section 1888(e)(4)(G)(ii) of the Act requires that the application of this wage index be made in a manner that does not result in aggregate payments that are greater or less than would otherwise be made in the absence of the wage adjustment. For the initial period of the SNF PPS, the adjustment required by this section was accounted for through the standardization of the per diem Federal rate components. By means of standardization, each rate component was adjusted for wage index and case-mix differences so that aggregate payments were unaffected by the presence of these payment adjustors. In this second PPS year (Federal rates effective October 1, 1999), we are updating the wage index applicable to SNF payments using the most recent hospital wage data and applying an adjustment to fulfill the budget neutrality requirement. This requirement will be met by multiplying each of the per diem rate components by the ratio of the volume weighted mean wage adjustment factor (using the wage index from the initial year) to the volume weighted mean wage adjustment factor, using the wage index for the fiscal year beginning October 1, 1999. The same volume weights are used in both the numerator and denominator and will be derived from 1997 Medicare Provider Analysis and Review File (MedPAR) data. The wage adjustment factor used in this calculation is defined as the labor share of the rate component multiplied by the wage index plus the non-labor share. The budget neutrality factor for FY 2000 is 0.9981 which is multiplied by each of the Federal rate components.

TABLE 5.—CASE-MIX ADJUSTED FEDERAL RATES FOR URBAN SNFS BY LABOR AND NON-LABOR COMPONENT

RUGs III category	Labor-related	Non-labor-related	Total federal rate
RUC	$304.15	$ 88.07	$392.22
RUB	273.78	79.28	353.06
RUA	259.02	75.01	334.03
RVC	234.52	67.91	302.43
RVB	226.71	65.65	292.36
RVA	206.75	59.87	266.62
RHC	215.09	62.29	277.38
RHB	197.74	57.26	255.00
RHA	181.25	52.49	233.74
RMC	211.79	61.33	273.12
RMB	189.23	54.80	244.03
RMA	177.95	51.53	229.48
RLB	168.76	48.87	217.63
RLA	141.86	41.08	182.94
SE3	200.48	58.05	258.53
SE2	173.58	50.27	223.85
SE1	154.49	44.74	199.23
SSC	151.03	43.73	194.76
SSB	144.08	41.72	185.80

TABLE 5.—CASE-MIX ADJUSTED FEDERAL RATES FOR URBAN SNFS BY LABOR AND NON-LABOR COMPONENT—Continued

RUGs III category	Labor-related	Non-labor-related	Total federal rate
SSA	140.61	40.72	181.33
CC2	150.16	43.48	193.64
CC1	138.88	40.21	179.09
CB2	131.94	38.20	170.14
CB1	125.86	36.45	162.31
CA2	124.99	36.20	161.19
CA1	118.05	34.19	152.24
IB2	112.84	32.68	145.52
IB1	111.11	32.18	143.29
IA2	102.44	29.66	132.10
IA1	98.96	28.66	127.62
BB2	111.98	32.43	144.41
BB1	109.38	31.67	141.05
BA2	101.57	29.41	130.98
BA1	94.63	27.40	122.03
PE2	121.52	35.19	156.71
PE1	119.79	34.69	154.48
PD2	115.45	33.43	148.88
PD1	113.71	32.93	146.64
PC2	109.38	31.67	141.05
PC1	108.51	31.42	139.93
PB2	97.23	28.15	125.38
PB1	96.37	27.90	124.27
PA2	95.50	27.65	123.15
PA1	92.89	26.90	119.79

TABLE 6.—CASE-MIX ADJUSTED FEDERAL RATES FOR RURAL SNFS BY LABOR AND NON-LABOR COMPONENT

RUGs III category	Labor-related	Non-Labor related	Total federal rate
RUC	$322.97	$93.53	$416.50
RUB	293.90	85.10	379.00
RUA	279.77	81.02	360.79
RVC	245.46	71.08	316.54
RVB	237.98	68.91	306.89
RVA	218.88	63.38	282.26
RHC	220.78	63.93	284.71
RHB	204.17	59.12	263.29
RHA	188.38	54.55	242.93
RMC	215.42	62.38	277.80
RMB	193.82	56.13	249.95
RMA	183.03	53.00	236.03
RLB	169.82	49.18	219.00
RLA	144.08	41.72	185.80
SE3	195.59	56.64	252.23
SE2	169.85	49.18	219.03
SE1	151.57	43.89	195.46
SSC	148.25	42.93	191.18
SSB	141.60	41.01	182.61
SSA	138.28	40.04	178.32
CC2	147.41	42.69	190.10
CC1	136.62	39.56	176.18
CB2	129.97	37.64	167.61
CB1	124.16	35.95	160.11
CA2	123.33	35.71	159.04
CA1	116.68	33.79	150.47
IB2	111.70	32.34	144.04
IB1	110.04	31.86	141.90
IA2	101.73	29.46	131.19
IA1	98.40	28.50	126.90
BB2	110.87	32.10	142.97
BB1	108.38	31.38	139.76
BA2	100.90	29.22	130.12
BA1	94.26	27.29	121.55
PE2	120.00	34.75	154.75
PE1	118.34	34.27	152.61
PD2	114.19	33.07	147.26
PD1	112.53	32.58	145.11

TABLE 6.—CASE-MIX ADJUSTED FEDERAL RATES FOR RURAL SNFS BY LABOR AND NON-LABOR COMPONENT—Continued

RUGs III category	Labor-related	Non-Labor related	Total federal rate
PC2	108.38	31.38	139.76
PC1	107.55	31.14	138.69
PB2	96.75	28.01	124.76
PB1	95.92	27.77	123.69
PA2	95.09	27.53	122.62
PA1	92.60	26.81	119.41

For any RUG–III group, to compute a wage-adjusted Federal payment rate, the labor-related portion of the payment rate is multiplied by the SNF's appropriate wage index factor listed in Table 7. The product of that calculation is added to the corresponding non-labor-related component. The resulting amount is the Federal rate applicable to a patient in that RUG–III group for that SNF. See the example below.

XYZ SNF is located in State College, Pennsylvania. The per diem Federal rate applicable to an Ultra High Rehabilitation 'A' patient (RUA) is calculated using the rates listed in Table 5 and the wage index factor found in Table 7. Accordingly, the computation of the adjusted per diem rate is made as follows:

$(259.02 \times 0.9138) + 75.01 = \$311.70$ per diem

This Federal rate will be applicable to all patients in the RUA category for the XYZ SNF (effective October 1, 1999 through September 30, 2000).

D. Updates to the Federal Rates

In accordance with section 1888(e)(4)(H) of the Act, the payment rates here have been updated by the SNF market basket minus 1 percentage point, which equals 2.1 percent. For each succeeding fiscal year, we will publish the rates in the **Federal Register** before August 1 of the year preceding the affected Federal fiscal year.

For the current fiscal year (FY 2000) through 2002, section 1888(e)(4)(ii) of the Act requires the rates to be increased by a factor equal to the SNF market index change minus 1 percentage point. In addition, for subsequent fiscal years this section requires the rates to be increased by the applicable SNF market basket index increase.

TABLE 7.—WAGE INDEX FOR URBAN AREAS

Urban area (constituent counties or county equivalents)	Wage index
0040 Abilene, TX	0.8179
Taylor, TX	
0060 Aguadilla, PR	0.3814
Aguada, PR	
Aguadilla, PR	
Moca, PR	
0080 Akron, OH	1.0163
Portage, OH	
Summit, OH	
0120 Albany, GA	1.0372
Dougherty, GA	
Lee, GA	
0160 Albany-Schenectady-Troy, NY	0.8754
Albany, NY	
Montgomery, NY	
Rensselaer, NY	
Saratoga, NY	
Schenectady, NY	
Schoharie, NY	
0200 Albuquerque, NM	0.8499
Bernalillo, NM	
Sandoval, NM	
Valencia, NM	
0220 Alexandria, LA	0.7869
Rapides, LA	
0240 Allentown-Bethlehem-Easton, PA	1.0227
Carbon, PA	
Lehigh, PA	
Northampton, PA	
0280 Altoona, PA	0.9342
Blair, PA	
0320 Amarillo, TX	0.8381
Potter, TX	
Randall, TX	
0380 Anchorage, AK	1.2859
Anchorage, AK	
0440 Ann Arbor, MI	1.1483
Lenawee, MI	
Livingston, MI	
Washtenaw, MI	
0450 Anniston, AL	0.8462
Calhoun, AL	
0460 Appleton-Oshkosh-Neenah, WI	0.8913
Calumet, WI	
Outagamie, WI	
Winnebago, WI	
0470 Arecibo, PR	0.4815
Arecibo, PR	
Camuy, PR	
Hatillo, PR	
0480 Asheville, NC	0.8884
Buncombe, NC	
Madison, NC	
0500 Athens, GA	0.9704
Clarke, GA	
Madison, GA	
Oconee, GA	
0520 Atlanta, GA	1.0050
Barrow, GA	
Bartow, GA	
Carroll, GA	
Cherokee, GA	
Clayton, GA	
Cobb, GA	
Coweta, GA	
De Kalb, GA	
Douglas, GA	
Fayette, GA	
Forsyth, GA	
Fulton, GA	
Gwinnett, GA	
Henry, GA	
Newton, GA	
Paulding, GA	
Pickens, GA	
Rockdale, GA	
Spalding, GA	
Walton, GA	
0560 Atlantic City-Cape May, NJ	1.1310
Atlantic City, NJ	
Cape May, NJ	
0580 Auburn-Opelika, AL	0.7748
Lee, AL	
0600 Augusta-Aiken, GA–SC	0.9013
Columbia, GA	
McDuffie, GA	
Richmond, GA	
Aiken, SC	
Edgefield, SC	
0640 Austin-San Marcos, TX	0.9081
Bastrop, TX	
Caldwell, TX	
Hays, TX	
Travis, TX	
Williamson, TX	
0680 Bakersfield, CA	0.9618
Kern, CA	
0720 Baltimore, MD	0.9891
Anne Arundel, MD	
Baltimore, MD	
Baltimore City, MD	
Carroll, MD	
Harford, MD	
Howard, MD	
Queen Annes, MD	
0733 Bangor, ME	0.9609
Penobscot, ME	
0743 Barnstable-Yarmouth, MA	1.3302
Barnstable, MA	
0760 Baton Rouge, LA	0.8707

TABLE 7.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index
Ascension, LA	
East Baton Rouge, LA	
Livingston, LA	
West Baton Rouge, LA	
084 Beaumont-Port Arthur, TX	0.8624
Hardin, TX	
Jefferson, TX	
Orange, TX	
0860 Bellingham, WA	1.1394
Whatcom, WA	
0870 Benton Harbor, MI	0.8457
Berrien, MI	
0875 Bergen-Passaic, NJ	1.2028
Bergen, NJ	
Passaic, NJ	
0880 Billings, MT	1.0038
Yellowstone, MT	
0920 Biloxi-Gulfport-Pascagoula, MS	0.7868
Hancock, MS	
Harrison, MS	
Jackson, MS	
0960 Binghamton, NY	0.8750
Broome, NY	
Tioga, NY	
1000 Birmingham, AL	0.8994
Blount, AL	
Jefferson, AL	
St Clair, AL	
Shelby, AL	
1010 Bismarck, ND	0.7759
Burleigh, ND	
Morton, ND	
1020 Bloomington, IN	0.8593
Monroe, IN	
1040 Bloomington-Normal, IL	0.8993
McLean, IL	
1080 Boise City, ID	0.9060
Ada, ID	
Canyon, ID	
1123 Boston-Worcester-Lawrence-Lowell-Brockton, MA–NH	1.1358
Bristol, MA	
Essex, MA	
Middlesex, MA	
Norfolk, MA	
Plymouth, MA	
Suffolk, MA	
Worcester, MA	
Hillsborough, NH	
Merrimack, NH	
Rockingham, NH	
Strafford, NH	
1125 Boulder-Longmont, CO	0.9944
Boulder, CO	
1145 Brazoria, TX	0.8516
Brazoria, TX	
1150 Bremerton, WA	1.1011
Kitsap, WA	
1240 Brownsville-Harlingen-San Benito, TX	0.9212
Cameron, TX	
1260 Bryan-College Station, TX	0.8501
Brazos, TX	
1280 Buffalo-Niagara Falls, NY	0.9604
Erie, NY	
Niagara, NY	
1303 Burlington, VT	1.0558
Chittenden, VT	
Franklin, VT	

TABLE 7.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index
1Grand Isle, VT	
1310 Caguas, PR	0.4561
Caguas, PR	
Cayey, PR	
Cidra, PR	
Gurabo, PR	
San Lorenzo, PR	
1320 Canton-Massillon, OH	0.8771
Carroll, OH	
Stark, OH	
1350 Casper, WY	0.9199
Natrona, WY	
1360 Cedar Rapids, IA	0.9018
Linn, IA	
1400 Champaign-Urbana, IL	0.9163
Champaign, IL	
1440 Charleston-North Charleston, SC	0.8988
Berkeley, SC	
Charleston, SC	
Dorchester, SC	
1480 Charleston, WV	0.9095
Kanawha, WV	
Putnam, WV	
1520 Charlotte-Gastonia-Rock Hill, NC–SC	0.9433
Cabarrus, NC	
Gaston, NC	
Lincoln, NC	
Mecklenburg, NC	
Rowan, NC	
Stanly, NC	
Union, NC	
York, SC	
1540 Charlottesville, VA	1.0573
Albemarle, VA	
Charlottesville City, VA	
Fluvanna, VA	
Greene, VA	
1560 Chattanooga, TN–GA	0.9731
Catoosa, GA	
Dade, GA	
Walker, GA	
Hamilton, TN	
Marion, TN	
1580 Cheyenne, WY	0.8176
Laramie, WY	
1600 Chicago, IL	1.0872
Cook, IL	
De Kalb, IL	
Du Page, IL	
Grundy, IL	
Kane, IL	
Kendall, IL	
Lake, IL	
McHenry, IL	
Will, IL	
1620 Chico-Paradise, CA	1.0390
Butte, CA	
1640 Cincinnati, OH–KY–IN	0.9418
Dearborn, IN	
Ohio, IN	
Boone, KY	
Campbell, KY	
Gallatin, KY	
Grant, KY	
Kenton, KY	
Pendleton, KY	
Brown, OH	
Clermont, OH	

TABLE 7.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index
Hamilton, OH	
Warren, OH	
1660 Clarksville-Hopkinsville, TN–KY	0.8090
Christian, KY	
Montgomery, TN	
1680 Cleveland-Lorain-Elyria, OH	0.9688
Ashtabula, OH	
Geauga, OH	
Cuyahoga, OH	
Lake, OH	
Lorain, OH	
Medina, OH	
1720 Colorado Springs, CO	0.9218
El Paso, CO	
1740 Columbia, MO	0.8904
Boone, MO	
1760 Columbia, SC	0.9357
Lexington, SC	
Richland, SC	
1800 Columbus, GA–AL	0.8510
Russell, AL	
Chattanoochee, GA	
Harris, GA	
Muscogee, GA	
1840 Columbus, OH	0.9907
Delaware, OH	
Fairfield, OH	
Franklin, OH	
Licking, OH	
Madison, OH	
Pickaway, OH	
1880 Corpus Christi, TX	0.8702
Nueces, TX	
San Patricio, TX	
1890 Corvallis, OR	1.1087
Benton, OR	
1900 Cumberland, MD–WV	0.8801
Allegany, MD	
Mineral, WV	
1920 Dallas, TX	0.9606
Collin, TX	
Dallas, TX	
Denton, TX	
Ellis, TX	
Henderson, TX	
Hunt, TX	
Kaufman, TX	
Rockwall, TX	
1950 Danville, VA	0.9061
Danville City, VA	
Pittsylvania, VA	
1960 Davenport-Moline-Rock Island, IA–IL	0.8706
Scott, IA	
Henry, IL	
Rock Island, IL	
2000 Dayton-Springfield, OH	0.9460
Clark, OH	
Greene, OH	
Miami, OH	
Montgomery, OH	
2020 Daytona Beach, FL	0.8987
Flagler, FL	
Volusia, FL	
2030 Decatur, AL	0.8679
Lawrence, AL	
Morgan, AL	
2040 Decatur, IL	0.8321
Macon, IL	

TABLE 7.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index
2080 Denver, CO	1.0189
Adams, CO	
Arapahoe, CO	
Denver, CO	
Douglas, CO	
Jefferson, CO	
2120 Des Moines, IA	0.8754
Dallas, IA	
Polk, IA	
Warren, IA	
2160 Detroit, MI	1.0421
Lapeer, MI	
Macomb, MI	
Monroe, MI	
Oakland, MI	
St Clair, MI	
Wayne, MI	
2180 Dothan, AL	0.7798
Dale, AL	
Houston, AL	
2190 Dover, DE	0.9335
Kent, DE	
2200 Dubuque, IA	0.8520
Dubuque, IA	
2240 Duluth-Superior, MN–WI	1.0165
St Louis, MN	
Douglas, WI	
2281 Dutchess County, NY	1.0552
Dutchess, NY	
2290 Eau Claire, WI	0.8957
Chippewa, WI	
Eau Claire, WI	
2320 El Paso, TX	0.8947
El Paso, TX	
2330 Elkhart-Goshen, IN	0.9379
Elkhart, IN	
2335 Elmira, NY	0.8533
Chemung, NY	
2340 Enid, OK	0.7953
Garfield, OK	
2360 Erie, PA	0.9023
Erie, PA	
2400 Eugene-Springfield, OR	1.0603
Lane, OR	
2440 Evansville-Henderson, IN–KY	0.8303
Posey, IN	
Vanderburgh, IN	
Warrick, IN	
Henderson, KY	
2520 Fargo-Moorhead, ND–MN	0.8620
Clay, MN	
Cass, ND	
2560 Fayetteville, NC	0.8494
Cumberland, NC	
2580 Fayetteville-Springdale-Rogers, AR	0.7773
Benton, AR	
Washington, AR	
2620 Flagstaff, AZ–UT	1.0348
Coconino, AZ	
Kane, UT	
2640 Flint, MI	1.1020
Genesee, MI	
2650 Florence, AL	0.7927
Colbert, AL	
Lauderdale, AL	
2655 Florence, SC	0.8618
Florence, SC	
2670 Fort Collins-Loveland, CO	1.0302
Larimer, CO	
2680 Ft Lauderdale, FL	1.0172
Broward, FL	
2700 Fort Myers-Cape Coral, FL	0.8951
Lee, FL	
2710 Fort Pierce-Port St Lucie, FL	0.9998
Martin, FL	
St Lucie, FL	
2720 Fort Smith, AR–OK	0.7844
Crawford, AR	
Sebastian, AR	
Sequoyah, OK	
2750 Fort Walton Beach, FL	0.8713
Okaloosa, FL	
2760 Fort Wayne, IN	0.9096
Adams, IN	
Allen, IN	
De Kalb, IN	
Huntington, IN	
Wells, IN	
Whitley, IN	
2800 Forth Worth-Arlington, TX	0.9835
Hood, TX	
Johnson, TX	
Parker, TX	
Tarrant, TX	
2840 Fresno, CA	1.0262
Fresno, CA	
Madera, CA	
2880 Gadsden, AL	0.8688
Etowah, AL	
2900 Gainesville, FL	1.0102
Alachua, FL	
2920 Galveston-Texas City, TX	0.9732
Galveston, TX	
2960 Gary, IN	0.9390
Lake, IN	
Porter, IN	
2975 Glens Falls, NY	0.8606
Warren, NY	
Washington, NY	
2980 Goldsboro, NC	0.8333
Wayne, NC	
2985 Grand Forks, ND–MN	0.9097
Polk, MN	
Grand Forks, ND	
2995 Grand Junction, CO	0.9188
Mesa, CO	
3000 Grand Rapids-Muskegon-Holland, MI	1.0135
Allegan, MI	
Kent, MI	
Muskegon, MI	
Ottawa, MI	
3040 Great Falls, MT	1.0459
Cascade, MT	
3060 Greeley, CO	0.9722
Weld, CO	
3080 Green Bay, WI	0.9132
Brown, WI	
3120 Greensboro-Winston-Salem-High Point, NC	0.9037
Alamance, NC	
Davidson, NC	
Davie, NC	
Forsyth, NC	
Guilford, NC	
Randolph, NC	
Stokes, NC	
Yadkin, NC	
3150 Greenville, NC	0.9500
Pitt, NC	
3160 Greenville-Spartanburg-Anderson, SC	0.9188
Anderson, SC	
Cherokee, SC	
Greenville, SC	
Pickens, SC	
Spartanburg, SC	
3180 Hagerstown, MD	0.8842
Washington, MD	
3200 Hamilton-Middletown, OH	0.8946
Butler, OH	
3240 Harrisburg-Lebanon-Carlisle, PA	0.9917
Cumberland, PA	
Dauphin, PA	
Lebanon, PA	
Perry, PA	
3283 Hartford, CT	1.1715
Hartford, CT	
Litchfield, CT	
Middlesex, CT	
Tolland, CT	
3285 Hattiesburg, MS	0.7634
Forrest, MS	
Lamar, MS	
3290 Hickory-Morganton-Lenoir, NC	0.9112
Alexander, NC	
Burke, NC	
Caldwell, NC	
Catawba, NC	
3320 Honolulu, HI	1.1475
Honolulu, HI	
3350 Houma, LA	0.7837
Lafourche, LA	
Terrebonne, LA	
3360 Houston, TX	0.9387
Chambers, TX	
Fort Bend, TX	
Harris, TX	
Liberty, TX	
Montgomery, TX	
Waller, TX	
3400 Huntington-Ashland, WV–KY–OH	0.9757
Boyd, KY	
Carter, KY	
Greenup, KY	
Lawrence, OH	
Cabell, WV	
Wayne, WV	
3440 Huntsville, AL	0.8822
Limestone, AL	
Madison, AL	
3480 Indianapolis, IN	0.9792
Boone, IN	
Hamilton, IN	
Hancock, IN	
Hendricks, IN	
Johnson, IN	
Madison, IN	
Marion, IN	
Morgan, IN	
Shelby, IN	
3500 Iowa City, IA	0.9607
Johnson, IA	
3520 Jackson, MI	0.8840

TABLE 7.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index
Jackson, MI	
3560 Jackson, MS	0.8387
Hinds, MS	
Madison, MS	
Rankin, MS	
3580 Jackson, TN	0.8600
Chester, TN	
Madison, TN	
3600 Jacksonville, FL	0.8957
Clay, FL	
Duval, FL	
Nassau, FL	
St Johns, FL	
3605 Jacksonville, NC	0.7852
Onslow, NC	
3610 Jamestown, NY	0.7857
Chautaqua, NY	
3620 Janesville-Beloit, WI	0.9656
Rock, WI	
3640 Jersey City, NJ	1.1674
Hudson, NJ	
3660 Johnson City-Kingsport-Bristol, TN–VA	0.8853
Carter, TN	
Hawkins, TN	
Sullivan, TN	
Unicoi, TN	
Washington, TN	
Bristol City, VA	
Scott, VA	
Washington, VA	
3680 Johnstown, PA	0.8640
Cambria, PA	
Somerset, PA	
3700 Jonesboro, AR	0.7231
Craighead, AR	
3710 Joplin, MO	0.7678
Jasper, MO	
Newton, MO	
3720 Kalamazoo-Battlecreek, MI	0.9981
Calhoun, MI	
Kalamazoo, MI	
Van Buren, MI	
3740 Kankakee, IL	0.8598
Kankakee, IL	
3760 Kansas City, KS–MO	0.9322
Johnson, KS	
Leavenworth, KS	
Miami, KS	
Wyandotte, KS	
Cass, MO	
Clay, MO	
Clinton, MO	
Jackson, MO	
Lafayette, MO	
Platte, MO	
Ray, MO	
3800 Kenosha, WI	0.9033
Kenosha, WI	
3810 Killeen-Temple, TX	0.9932
Bell, TX	
Coryell, TX	
3840 Knoxville, TN	0.9199
Anderson, TN	
Blount, TN	
Knox, TN	
Loudon, TN	
Sevier, TN	
Union, TN	
3850 Kokomo, IN	0.8918
Howard, IN	
Tipton, IN	
3870 La Crosse, WI–MN	0.8933
Houston, MN	
La Crosse, WI	
3880 Lafayette, LA	0.8339
Acadia, LA	
Lafayette, LA	
St Landry, LA	
St Martin, LA	
3920 Lafayette, IN	0.8809
Clinton, IN	
Tippecanoe, IN	
3960 Lake Charles, LA	0.7966
Calcasieu, LA	
3980 Lakeland-Winter Haven, FL	0.8816
Polk, FL	
4000 Lancaster, PA	0.9255
Lancaster, PA	
4040 Lansing-East Lansing, MI	0.9977
Clinton, MI	
Eaton, MI	
Ingham, MI	
4080 Laredo, TX	0.8323
Webb, TX	
4100 Las Cruces, NM	0.8590
Dona Ana, NM	
4120 Las Vegas, NV–AZ	1.1258
Mohave, AZ	
Clark, NV	
Nye, NV	
4150 Lawrence, KS	0.8222
Douglas, KS	
4200 Lawton, OK	0.9532
Comanche, OK	
4243 Lewiston-Auburn, ME	0.8899
Androscoggin, ME	
4280 Lexington, KY	0.8531
Bourbon, KY	
Clark, KY	
Fayette, KY	
Jessamine, KY	
Madison, KY	
Scott, KY	
Woodford, KY	
4320 Lima, OH	0.8905
Allen, OH	
Auglaize, OH	
4360 Lincoln, NE	0.9670
Lancaster, NE	
4400 Little Rock-North Little Rock, AR	0.8614
Faulkner, AR	
Lonoke, AR	
Pulaski, AR	
Saline, AR	
4420 Longview-Marshall, TX	0.8738
Gregg, TX	
Harrison, TX	
Upshur, TX	
4480 Los Angeles-Long Beach, CA	1.2051
Los Angeles, CA	
4520 Louisville, KY–IN	0.9381
Clark, IN	
Floyd, IN	
Harrison, IN	
Scott, IN	
Bullitt, KY	
Jefferson, KY	
Oldham, KY	
4600 Lubbock, TX	0.8411
Lubbock, TX	
4640 Lynchburg, VA	0.8814
Amherst, VA	
Bedford City, VA	
Bedford, VA	
Campbell, VA	
Lynchburg City, VA	
4680 Macon, GA	0.8530
Bibb, GA	
Houston, GA	
Jones, GA	
Peach, GA	
Twiggs, GA	
4720 Madison, WI	0.9729
Dane, WI	
4800 Mansfield, OH	0.8475
Crawford, OH	
Richland, OH	
4840 Mayaguez, PR	0.4674
Anasco, PR	
Cabo Rojo, PR	
Hormigueros, PR	
Mayaguez, PR	
Sabana Grande, PR	
San German, PR	
4880 McAllen-Edinburg-Mission, TX	0.8120
Hidalgo, TX	
4890 Medford-Ashland, OR	1.0492
Jackson, OR	
4900 Melbourne-Titusville-Palm Bay, FL	0.9296
Brevard, Fl	
4920 Memphis, TN–AR–MS	0.8244
Crittenden, AR	
De Soto, MS	
Fayette, TN	
Shelby, TN	
Tipton, TN	
4940 Merced, CA	1.0277
Merced, CA	
5000 Miami, FL	1.0233
Dade, FL	
5015 Middlesex-Somerset-Hunterdon, NJ	1.1122
Hunterdon, NJ	
Middlesex, NJ	
Somerset, NJ	
5080 Milwaukee-Waukesha, WI	0.9845
Milwaukee, WI	
Ozaukee, WI	
Washington, WI	
Waukesha, WI	
5120 Minneapolis-St Paul, MN–WI	1.0929
Anoka, MN	
Carver, MN	
Chisago, MN	
Dakota, MN	
Hennepin, MN	
Isanti, MN	
Ramsey, MN	
Scott, MN	
Sherburne, MN	
Washington, MN	
Wright, MN	
Pierce, WI	
St Croix, WI	

TABLE 7.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index
5140 Missoula, MT	0.9085
Missoula, MT	
5160 Mobile, AL	0.8267
Baldwin, AL	
Mobile, AL	
5170 Modesto, CA	1.0111
Stanislaus, CA	
5190 Monmouth-Ocean, NJ	1.1258
Monmouth, NJ	
Ocean, NJ	
5200 Monroe, LA	0.8221
Ouachita, LA	
5240 Montgomery, AL	0.7703
Autauga, AL	
Elmore, AL	
Montgomery, AL	
5280 Muncie, IN	1.0834
Delaware, IN	
5330 Myrtle Beach, SC	0.8529
Horry, SC	
5345 Naples, FL	0.9839
Collier, FL	
5360 Nashville, TN	0.9449
Cheatham, TN	
Davidson, TN	
Dickson, TN	
Robertson, TN	
Rutherford TN	
Sumner, TN	
Williamson, TN	
Wilson, TN	
5380 Nassau-Suffolk, NY	1.4074
Nassau, NY	
Suffolk, NY	
5483 New Haven-Bridgeport-Stamford-Waterbury-Danbury, CT	1.2356
Fairfield, CT	
New Haven, CT	
5523 New London-Norwich, CT	1.2428
New London, CT	
5560 New Orleans, LA	0.9089
Jefferson, LA	
Orleans, LA	
Plaquemines, LA	
St. Bernard, LA	
St. Charles, LA	
St. James, LA	
St. John The Baptist, LA	
St. Tammany, LA	
5600 New York, NY	1.4517
Bronx, NY	
Kings, NY	
New York, NY	
Putnam, NY	
Queens, NY	
Richmond, NY	
Rockland, NY	
Westchester, NY	
5640 Newark, NJ	1.1646
Essex, NJ	
Morris, NJ	
Sussex, NJ	
Union, NJ	
Warren, NJ	
5660 Newburgh, NY–PA	1.0908
Orange, NY	
Pike, PA	
5720 Norfolk-Virginia Beach-Newport News, VA–NC	0.8440
Currituck, NC	
Chesapeake City, VA	
Gloucester, VA	
Hampton City, VA	
Isle of Wight, VA	
James City, VA	
Mathews, VA	
Newport News City, VA	
Norfolk City, VA	
Poquoson City, VA	
Portsmouth City, VA	
Suffolk City, VA	
Virginia Beach City VA	
Williamsburg City, VA	
York, VA	
5775 Oakland, CA	1.5058
Alameda, CA	
Contra Costa, CA	
5790 Ocala, FL	0.9615
Marion, FL	
5800 Odessa-Midland, TX	0.8873
Ector, TX	
Midland, TX	
5880 Oklahoma City, OK	0.8587
Canadian, OK	
Cleveland, OK	
Logan, OK	
McClain, OK	
Oklahoma, OK	
Pottawatomie, OK	
5910 Olympia, WA	1.0932
Thurston, WA	
5920 Omaha, NE–IA	1.0455
Pottawattamie, IA	
Cass, NE	
Douglas, NE	
Sarpy, NE	
Washington, NE	
5945 Orange County, CA	1.1590
Orange, CA	
5960 Orlando, FL	0.9795
Lake, FL	
Orange, FL	
Osceola, FL	
Seminole, FL	
5990 Owensboro, KY	0.8104
Daviess, KY	
6015 Panama City, FL	0.9169
Bay, FL	
6020 Parkersburg-Marietta, WV–OH	0.8414
Washington, OH	
Wood, WV	
6080 Pensacola, FL	0.8442
Escambia, FL	
Santa Rosa, FL	
6120 Peoria-Pekin, IL	0.8349
Peoria, IL	
Tazewell, IL	
Woodford, IL	
6160 Philadelphia, PA–NJ	1.1160
Burlington, NJ	
Camden, NJ	
Gloucester, NJ	
Salem, NJ	
Bucks, PA	
Chester, PA	
Delaware, PA	
Montgomery, PA	
Philadelphia, PA	
6200 Phoenix-Mesa, AZ	0.9464
Maricopa, AZ	
Pinal, AZ	
6240 Pine Bluff, AR	0.7697
Jefferson, AR	
6280 Pittsburgh, PA	0.9634
Allegheny, PA	
Beaver, PA	
Butler, PA	
Fayette, PA	
Washington, PA	
Westmoreland, PA	
6323 Pittsfield, MA	1.0255
Berkshire, MA	
6340 Pocatello, ID	0.8973
Bannock, ID	
6360 Ponce, PR	0.4971
Guayanilla, PR	
Juana Diaz, PR	
Penuelas, PR	
Ponce, PR	
Villalba, PR	
Yauco, PR	
6403 Portland, ME	0.9475
Cumberland, ME	
Sagadahoc, ME	
York, ME	
6440 Portland-Vancouver, OR–WA	1.0974
Clackamas, OR	
Columbia, OR	
Multnomah, OR	
Washington, OR	
Yamhill, OR	
Clark, WA	
6483 Providence-Warwick-Pawtucket, RI	1.0690
Bristol, RI	
Kent, RI	
Newport, RI	
Providence, RI	
Washington, RI	
6520 Provo-Orem, UT	0.9818
Utah, UT	
6560 Pueblo, CO	0.8853
Pueblo, CO	
6580 Punta Gorda, FL	0.9508
Charlotte, FL	
6600 Racine, WI	0.9216
Racine, WI	
6640 Raleigh-Durham-Chapel Hill, NC	0.9544
Chatham, NC	
Durham, NC	
Franklin, NC	
Johnston, NC	
Orange, NC	
Wake, NC	
6660 Rapid City, SD	0.8363
Pennington, SD	
6680 Reading, PA	0.9436
Berks, PA	
6690 Redding, CA	1.1263
Shasta, CA	
6720 Reno, NV	1.0655
Washoe, NV	
6740 Richland-Kennewick-Pasco, WA	1.1224
Benton, WA	
Franklin, WA	

TABLE 7.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index
6760 Richmond-Petersburg, VA	0.9545
Charles City County, VA	
Chesterfield, VA	
Colonial Heights City, VA	
Dinwiddie, VA	
Goochland, VA	
Hanover, VA	
Henrico, VA	
Hopewell City, VA	
New Kent, VA	
Petersburg City, VA	
Powhatan, VA	
Prince George, VA	
Richmond City, VA	
6780 Riverside-San Bernardino, CA	1.1210
Riverside, CA	
San Bernardino, CA	
6800 Roanoke, VA	0.8138
Botetourt, VA	
Roanoke, VA	
Roanoke City, VA	
Salem City, VA	
6820 Rochester, MN	1.1429
Olmsted, MN	
6840 Rochester, NY	0.9184
Genesee, NY	
Livingston, NY	
Monroe, NY	
Ontario, NY	
Orleans, NY	
Wayne, NY	
6880 Rockford, IL	0.8783
Boone, IL	
Ogle, IL	
Winnebago, IL	
6895 Rocky Mount, NC	0.8735
Edgecombe, NC	
Nash, NC	
6920 Sacramento, CA	1.2284
El Dorado, CA	
Placer, CA	
Sacramento, CA	
6960 Saginaw-Bay City-Midland, MI	0.9287
Bay, MI	
Midland, MI	
Saginaw, MI	
6980 St Cloud, MN	0.9421
Benton, MN	
Stearns, MN	
7000 St Joseph, MO	0.8943
Andrews, MO	
Buchanan, MO	
7040 St Louis, MO–IL	0.9052
Clinton, IL	
Jersey, IL	
Madison, IL	
Monroe, IL	
St Clair, IL	
Franklin, MO	
Jefferson, MO	
Lincoln, MO	
St Charles, MO	
St Louis, MO	
St Louis City, MO	
Warren, MO	
Sullivan City, MO	
7080 Salem, OR	0.9949
Marion, OR	
Polk, OR	
7120 Salinas, CA	1.4710
Monterey, CA	
7160 Salt Lake City-Ogden, UT	0.9854
Davis, UT	
Salt Lake, UT	
Weber, UT	
7200 San Angelo, TX	0.7845
Tom Green, TX	
7240 San Antonio, TX	0.8318
Bexar, TX	
Comal, TX	
Guadalupe, TX	
Wilson, TX	
7320 San Diego, CA	1.1930
San Diego, CA	
7360 San Francisco, CA	1.4001
Marin, CA	
San Francisco, CA	
San Mateo, CA	
7400 San Jose, CA	1.3608
Santa Clara, CA	
7440 San Juan-Bayamon, PR	0.4657
Aguas Buenas, PR	
Barceloneta, PR	
Bayamon, PR	
Canovanas, PR	
Carolina, PR	
Catano, PR	
Ceiba, PR	
Comerio, PR	
Corozal, PR	
Dorado, PR	
Fajardo, PR	
Florida, PR	
Guaynabo, PR	
Humacao, PR	
Juncos, PR	
Los Piedras, PR	
Loiza, PR	
Luguillo, PR	
Manati, PR	
Morovis, PR	
Naguabo, PR	
Naranjito, PR	
Rio Grande, PR	
San Juan, PR	
Toa Alta, PR	
Toa Baja, PR	
Trujillo Alto, PR	
Vega Alta, PR	
Vega Baja, PR	
Yabucoa, PR	
7460 San Luis Obispo-Atascadero-Paso Robles, CA	1.0470
San Luis Obispo, CA	
7480 Santa Barbara-Santa Maria-Lompoc, CA	1.0819
Santa Barbara, CA	
7485 Santa Cruz-Watsonville, CA	1.3927
Santa Cruz, CA	
7490 Santa Fe, NM	1.0437
Los Alamos, NM	
Santa Fe, NM	
7500 Santa Rosa, CA	1.3000
Sonoma, CA	
7510 Sarasota-Bradenton, FL	0.9905
Manatee, FL	
Sarasota, FL	
7520 Savannah, GA	0.9953
Bryan, GA	
Chatham, GA	
Effingham, GA	
7560 Scranton-Wilkes-Barre-Hazleton, PA	0.8372
Columbia, PA	
Lackawanna, PA	
Luzerne, PA	
Wyoming, PA	
7600 Seattle-Bellevue-Everett, WA	1.1290
Island, WA	
King, WA	
Snohomish, WA	
7610 Sharon, PA	0.8283
Mercer, PA	
7620 Sheboygan, WI	0.8202
Sheboygan, WI	
7640 Sherman-Denison, TX	0.9329
Grayson, TX	
7680 Shreveport-Bossier City, LA	0.9049
Bossier, LA	
Caddo, LA	
Webster, LA	
7720 Sioux City, IA–NE	0.8549
Woodbury, IA	
Dakota, NE	
7760 Sioux Falls, SD	0.8776
Lincoln, SD	
Minnehaha, SD	
7800 South Bend, IN	0.9793
St Joseph, IN	
7840 Spokane, WA	1.0799
Spokane, WA	
7880 Springfield, IL	0.8684
Menard, IL	
Sangamon, IL	
7920 Springfield, MO	0.7991
Christian, MO	
Greene, MO	
Webster, MO	
8003 Springfield, MA	1.0677
Hampden, MA	
Hampshire, MA	
8050 State College, PA	0.9138
Centre, PA	
8080 Steubenville-Weirton, OH–WV	0.8614
Jefferson, OH	
Brooke, WV	
Hancock, WV	
8120 Stockton-Lodi, CA	1.0518
San Joaquin, CA	
8140 Sumter, SC	0.8238
Sumter, SC	
8160 Syracuse, NY	0.9412
Cayuga, NY	
Madison, NY	
Onondaga, NY	
Oswego, NY	
8200 Tacoma, WA	1.1478
Pierce, WA	
8240 Tallahassee, FL	0.8484
Gadsden, FL	
Leon, FL	
8280 Tampa-St Petersburg-Clearwater, FL	0.9044
Hernando, FL	
Hillsborough, FL	
Pasco, FL	

TABLE 7.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index
Pinellas, FL	
8320 Terre Haute, IN	0.8570
Clay, IN	
Vermillion, IN	
Vigo, IN	
8360 Texarkana, AR-Texarkana, TX	0.8135
Miller, AR	
Bowie, TX	
8400 Toledo, OH	0.9815
Fulton, OH	
Lucas, OH	
Wood, OH	
8440 Topeka, KS	0.9326
Shawnee, KS	
8480 Trenton, NJ	1.0102
Mercer, NJ	
8520 Tucson, AZ	0.8742
Pima, AZ	
8560 Tulsa, OK	0.8086
Creek, OK	
Osage, OK	
Rogers, OK	
Tulsa, OK	
Wagoner, OK	
8600 Tuscaloosa, AL	0.8064
Tuscaloosa, AL	
8640 Tyler, TX	0.9369
Smith, TX	
8680 Utica-Rome, NY	0.8298
Herkimer, NY	
Oneida, NY	
8720 Vallejo-Fairfield-Napa, CA	1.3345
Napa, CA	
Solano, CA	
8735 Ventura, CA	1.1454
Ventura, CA	
8750 Victoria, TX	0.8378
Victoria, TX	
8760 Vineland-Millville-Bridgeton, NJ	1.0517
Cumberland, NJ	
8780 Visalia-Tulare-Porterville, CA	1.0411
Tulare, CA	
8800 Waco, TX	0.8075
McLennan, TX	
8840 Washington, DC–MD–VA–WV	1.1053
District of Columbia, DC	
Calvert, MD	
Charles, MD	
Frederick, MD	
Montgomery, MD	
Prince Georges, MD	
Alexandria City, VA	
Arlington, VA	
Clarke, VA	
Culpepper, VA	
Fairfax, VA	
Fairfax City, VA	
Falls Church City, VA	
Fauquier, VA	
Fredericksburg City, VA	
King George, VA	
Loudoun, VA	
Manassas City, VA	
Manassas Park City, VA	
Prince William, VA	
Spotsylvania, VA	
Stafford, VA	

TABLE 7.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index
Warren, VA	
Berkeley, WV	
Jefferson, WV	
8920 Waterloo-Cedar Falls, IA	0.8517
Black Hawk, IA	
8940 Wausau, WI	0.9445
Marathon, WI	
8960 West Palm Beach-Boca Raton, FL	1.0012
Palm Beach, FL	
9000 Wheeling, OH–WV	0.7644
Belmont, OH	
Marshall, WV	
Ohio, WV	
9040 Wichita, KS	0.9421
Butler, KS	
Harvey, KS	
Sedgwick, KS	
9080 Wichita Falls, TX	0.7652
Archer, TX	
Wichita, TX	
9140 Williamsport, PA	0.8449
Lycoming, PA	
9160 Wilmington-Newark, DE–MD	1.1274
New Castle, DE	
Cecil, MD	
9200 Wilmington, NC	0.9707
New Hanover, NC	
Brunswick, NC	
9260 Yakima, WA	1.0332
Yakima, WA	
9270 Yolo, CA	0.9719
Yolo, CA	
9280 York, PA	0.9309
York, PA	
9320 Youngstown-Warren, OH	0.9996
Columbiana, OH	
Mahoning, OH	
Trumbull, OH	
9340 Yuba City, CA	1.0662
Sutter, CA	
Yuba, CA	
9360 Yuma, AZ	0.9924
Yuma, AZ	

TABLE 7.—WAGE INDEX FOR RURAL AREAS

Nonurban area	Wage index
Alabama	0.7390
Alaska	1.2057
Arizona	0.8544
Arkansas	0.7236
California	0.9951
Colorado	0.8813
Connecticut	1.2413
Delaware	0.9166
Florida	0.8986
Georgia	0.8094
Guam	0.7268
Hawaii	1.0726
Idaho	0.8651
Illinois	0.8047
Indiana	0.8396
Iowa	0.7926
Kansas	0.7460
Kentucky	0.8043

TABLE 7.—WAGE INDEX FOR RURAL AREAS—Continued

Nonurban area	Wage index
Louisiana	0.7381
Maine	0.8639
Maryland	0.8631
Massachusetts	1.1369
Michigan	0.8815
Minnesota	0.8669
Mississippi	0.7306
Missouri	0.7723
Montana	0.8395
Nebraska	0.8007
Nevada	0.9097
New Hampshire	0.9905
New Jersey [1].	
New Mexico	0.8378
New York	0.8636
North Carolina	0.8290
North Dakota	0.7647
Ohio	0.8649
Oklahoma	0.7255
Oregon	0.9867
Pennsylvania	0.8524
Puerto Rico	0.4249
Rhode Island [1].	
South Carolina	0.8264
South Dakota	0.7576
Tennessee	0.7650
Texas	0.7471
Utah	0.8906
Vermont	0.9407
Virginia	0.7904
Virgin Islands	0.6389
Washington	1.0446
West Virginia	0.8068
Wisconsin	0.8759
Wyoming	0.8859

[1] All counties within the State are classified urban.

E. Relationship of RUG–III Classification System to Existing Skilled Nursing Facility

Level-of-Care Criteria

In the May 12, 1998 interim final rule (63 FR 26252), we described how the RUG–III classification system will make coverage determinations easier and more consistent. In the final rule as published elsewhere in this **Federal Register** document, we clarified how residents are classified and the determinations of coverage. A complete discussion of coverage and classification of patients is discussed in the final rule. We are not making any changes to the classifications or coverage in this notice.

However, regulations at 42 CFR 413.345 provide that the information included in each update of the Federal payment rates in the **Federal Register** shall include the designation of those specific RUGs under the resident classification system that represent the required SNF level of care, as provided in § 409.30. Accordingly, we hereby designate the upper 26 RUG–III groups for this purpose.

III. Three-Year Transition Period

Under sections 1888(e)(1) and (2) of the Act, during a facility's first three cost reporting periods that begin on or after July 1, 1998 (transition period), the facility's PPS rate will be equal to the sum of a percentage of an adjusted facility-specific per diem rate and a percentage of the adjusted Federal per diem rate. After the transition period, the PPS rate will equal the adjusted Federal per diem rate. The transition period payment method will not apply to SNFs that first received Medicare payments (interim or otherwise) on or after October 1, 1995 under present or previous ownership; these facilities will be paid based on 100 percent of the Federal rate.

The facility-specific per diem rate is the sum of the facility's total allowable Part A Medicare costs and an estimate of the amounts that would be payable under Part B for covered SNF services for cost reporting periods beginning in fiscal year 1995 (base year). The base year cost report used to compute the facility-specific per diem rate in the transition period may be settled (either tentative or final) or as submitted for Medicare payment purposes. Under section 1888(e)(3) of the Act, any adjustments to the base year cost report made as a result of settlement or other action by the fiscal intermediary, including cost limit exceptions and exemptions, or results of an appeal will result in a revision to the facility-specific per diem rate. The instructions for calculating the facility-specific per diem rate are described in detail in the May 12, 1998 interim final rule (63 FR 26252). For providers that received payment under the RUG–III demonstration during a cost reporting period that began in calendar year 1997, we will determine their facility-specific per diem rate using the methodology described below. It is possible that some providers participated in the demonstration but did not have a cost reporting period that began in calendar year 1997. For those providers, we will determine their facility-specific per diem rate by using the calculations outlined in the May 12, 1998 **Federal Register** interim final rule (63 FR 26252, Section III, (A)1.(a), (b), or (c). As with the facility-specific per diem applicable to other providers, the allowable costs will be subject to change based on the settlement of the cost report used to determine the total payment under the demonstration. In addition, we derive a special market basket inflation factor to adjust the 1997 costs to the midpoint of the rate setting period (July 1, 1998 to September 30, 1999).

Step 1. Determine the aggregate payment during the cost reporting period that began in calendar year 1997—RUG–III payment plus routine capital costs plus ancillary costs (other than occupational therapy, physical therapy, and speech pathology).

Step 2. Divide the amount in Step 1. by the applicable total inpatient days for the cost reporting period.

Step 3. Adjust the amount in Step 2. by 1.031532 (inflation factor)—Do not use 8.C. The amount in Step 3. is the facility-specific rate that is applicable for the facility's first cost reporting period beginning after July 1, 1998. A separate calculation for Part B services is not required.

Computation of the Skilled Nursing Facility Prospective Payment System Rate During the Transition

For the first three cost reporting periods beginning on or after July 1, 1998 (transition period), an SNF's payment under the PPS is the sum of a percentage of the facility-specific per diem rate and a percentage of the Federal per diem rate. Under section 1888(e)(2)(C) of the Act, for the first cost reporting period in the transition period, the SNF payment will be the sum of 75 percent of the facility-specific per diem rate and 25 percent of the Federal per diem rate. For the second cost reporting period, the SNF payment will be the sum of 50 percent of the facility-specific per diem rate and 50 percent of the Federal per diem rate. For the third cost reporting period, the SNF payment will be the sum of 25 percent of the facility-specific per diem rate and 75 percent of the Federal per diem rate. For all subsequent cost reporting periods beginning after the transition period, the SNF payment will be equal to 100 percent of the Federal per diem rate. See the example below.

Example of Computation of Adjusted PPS Rates and SNF Payment

Using the XYZ SNF described in this section, the following shows the adjustments made to the facility-specific per diem rate and the Federal per diem rate to compute the provider's actual per diem PPS payment in the transition period. XYZ's 12-month cost reporting period begins October 1, 1999. (This is the provider's second cost reporting period under the transition).

Step 1

Compute:

Facility-specific per diem rate—$570.00
Market Basket Adjustment (Table 8.C) × 1.09929
Adjusted facility-specific rate—$626.60

Step 2

Compute Federal per diem rate:

SNF XYZ from above is located in State College, PA with a wage index of 0.9138.

RUG group	Labor portion*	Wage index	Adjusted labor	Nonlabor portion*	Adjusted rate	Medicare days	Payment
RVC	$234.52	0.9138	$214.30	$67.41	$282.21	50	$14,111
RHC	215.09	0.9138	196.55	62.29	258.84	100	25,884
Total						150	39,995

*From Table 5.

Step 3

Apply transition period percentages:

Facility-specific per diem rate $626.60 × 150 days = $93,990
Times transition percentage (50 percent)—.*50*
Actual facility-specific PPS payment—$46,995
Federal PPS payment—$39,995
Times transition percentage (50 percent)—.50
Actual Federal PPS payment—$19,998

Step 4

Compute total PPS payment:

XYZ's total PPS payment ($46,995 + $19,998) $66,993

IV. The Skilled Nursing Facility Market Basket Index

Section 1888(e)(5)(A) of the Act requires the Secretary to establish an SNF market basket index (input price index) that reflects changes over time in the prices of an appropriate mix of goods and services included in the SNF PPS. Accordingly, as described below, we have developed a SNF market basket

index that encompasses the most commonly used cost categories for SNF routine services, ancillary services, and capital-related expenses. In the May 12, 1998 **Federal Register** (63 FR 26252), we indicated that we were rebasing the SNF market basket based on fiscal year 1992. A complete discussion on the rebasing can be found in the May 12, 1998 **Federal Register** (63 FR 26252).

Each year we calculate a revised labor-related share based on the relative importance of labor-related cost categories in the input price index. There are 21 separate cost categories and respective price proxies. These cost categories were illustrated in Table 4.A, 4.B, and the appendix found in the May 12, 1998 **Federal Register** (63 FR 26252). Table 8.A below summarizes the updated 1992-based labor-related share.

TABLE 8.—A REVISED 1992-BASED LABOR-RELATED SHARE

Cost category	1992-Based market basket weight
Wages and Salaries	56.647
Employee Benefits	12.321
Nonmedical Professional Fees	1.959
Labor-intensive Services	3.738
Capital-related	2.880
Total	77.545

The forecasted rates of growth used to compute the projected SNF market basket percentages, described in the next section, are shown below in Table 8.B.

TABLE 8.B.—SKILLED NURSING FACILITY TOTAL COST MARKET BASKET, FORECASTED CHANGE, 1997—2001

Fiscal years beginning October 1	Skilled nursing facility total cost market basket
October 1996, FY 1997	2.4
October 1997, FY 1998	2.8
October 1998, FY 1999	2.8
October 1999, FY 2000	2.9
October 2000, FY 2001	2.7
Forecasted Average: 1997–2001	2.7

Source: Standard & Poor's DRI HCC, 1st QTR, 1999;@USSIM/TREND25YR0299 @CISSIM/CONTROL991.

Released by HCFA, OACT, National Health Statistics Group.

Use of the Skilled Nursing Facility Market Basket Percentage

Section 1888(e)(5)(B) of the Act defines the SNF market basket percentage as the percentage change in the SNF market basket index, described in the previous section, from the midpoint of the prior fiscal year (or period) to the midpoint of the fiscal year (or other period) involved. The facility-specific portion and Federal portion of the SNF PPS rates effective with this rule are based on cost reporting periods beginning in Federal fiscal year 1995 (base year). The percentage increases in the SNF market basket index will be used to compute the update factors to reflect cost increases occurring between the cost reporting periods represented in the base year and the midpoint of the fiscal year (or other period). We used the Standard & Poor's DRI CC, 1st quarter 1999 historical and forecasted percentage increases of the revised and rebased SNF market basket index for routine, ancillary, and capital-related expenses, described in the previous section, to compute the update factors. The update factors, as described below, will be used to adjust the base year costs for computing the facility-specific portion and Federal portion of the SNF PPS rates.

A. Facility-Specific Rate Update Factor

Under section 1888(e)(3)(D)(i) of the Act, for the facility-specific portion of the SNF PPS rate, we will update a facility's base year costs up to the period beginning October 1, 1999 and ending September 30, 2000 by the SNF market basket percentage, minus 1 percentage point. We took the following steps to develop the 12-month cost reporting period facility-specific rate update factors shown in Table 8.C.

For the facility rate, we developed factors to inflate data from cost reporting periods beginning October 1, 1994 through September 30, 1995 to the period of October 1, 1999 through September 30, 2000. The years through FY 1999 were inflated at a rate of market basket minus 1 percentage point, while FY 2000 was inflated at the full market basket rate of increase.

1. We first determined the total growth from the midpoint of each 12-month cost reporting period that began during the period from October 1, 1994 through September 30, 1995 to the midpoint of FY 2000.

2. From this total growth we determined the average annual growth rate for each time span.

3. We subtracted 1 percentage point from each average annual growth rate.

4. These reduced average annual growth rates were converted to cumulative growth rates, using each original time span less 1 year at the reduced growth rate and with full market basket for the final year. (For example, if the time span were for 9 years, we would inflate at the market basket minus 1 percentage point annual rate for 8 years and at annual market basket rate for 1 additional year).

TABLE 8.C.—UPDATE FACTORS[1] FOR FACILITY-SPECIFIC PORTION OF THE SNF PPS RATES—ADJUST TO 12-MONTH COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 1999 AND BEFORE OCTOBER 1, 2000 FROM COST REPORTING PERIODS BEGINNING IN FY 1995 (BASE YEAR)

If 12-month cost reporting period in initial period begins	Adjust from 12-month cost reporting period in base year that begins	Using update factor of
October 1, 1999	October 1, 1994	1.09929
November 1, 1999	November 1, 1994	1.09745
December 1, 1999	December 1, 1994	1.09553
January 1, 2000	January 1, 1995	1.09378
February 1, 2000	February 1, 1995	1.09221
March 1, 2000	March 1, 1995	1.09082
April 1, 2000	April 1, 1995	1.08937
May 1, 2000	May 1, 1995	1.08788
June 1, 2000	June 1, 1995	1.08634
July 1, 2000	July 1,1995	1.08486
August 1, 2000	August 1, 1995	1.08344

TABLE 8.C.—UPDATE FACTORS[1] FOR FACILITY-SPECIFIC PORTION OF THE SNF PPS RATES—ADJUST TO 12-MONTH COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 1999 AND BEFORE OCTOBER 1, 2000 FROM COST REPORTING PERIODS BEGINNING IN FY 1995 (BASE YEAR)—Continued

If 12-month cost reporting period in initial period begins	Adjust from 12-month cost reporting period in base year that begins	Using update factor of
September 1, 2000	September 1, 1995	1.08209

[1] Source: Standard & Poor's DRI, 1st Qtr 1999; @USSIM/TREND25YR0299@CISSIM/CONTROL991.

SNFs may have cost reporting periods that are fewer than 12 months in duration (short period). This may occur, for example, when a provider enters the Medicare program after its selected fiscal year has already begun or when a provider experiences a change of ownership before the end of the cost reporting period. Since short periods affect a small number of providers, relative to the total number of SNFs, and the facility-specific portion of the SNF PPS rate is subject to a transition period, we do not believe consideration of computing a ''short period specific'' update factor is warranted. Accordingly, we will apply the following rules to short periods.

1. Short Period in Base Year

First, select the later short period in the base year for the affected provider. Second, if necessary, adjust the beginning or end of the short period as follows. Short periods may not necessarily begin on the first of the month or end on the last day of the month. In order to simplify the process of determining the short period update factor, if the short period begins before the 16th of the month, it will be adjusted to a beginning date of the 1st of that month. If the short period begins on or after the 16th of the month, it will be adjusted to the beginning of the next month. Also, if the short period ends before the 16th of the month, it will be adjusted to the end of the preceding month, or, if the short period ends on or after the 16th of the month, it will be adjusted to the end of that month. Third, determine the midpoint of the short period. Fourth, use the following midpoint guidelines to determine which 12-month update factor to use from Table 8.C.

If the midpoint of short period falls between	Use factor for this 12-month period
March 16, 1995–April 15, 1995	October 1994–September 1995.
April 16, 1995–May 15, 1995	November 1994–October 1995.
May 16, 1995–June 15, 1995	December 1994–November 1995.
June 16, 1995–July 15, 1995	January 1995–December 1995.
July 16, 1995–August 15, 1995	February 1995–January 1996.
August 16, 1995–September 15, 1995	March 1995–February 1996.
September 16, 1995–October 15, 1995	April 1995–March 1996.
October 16, 1995–November 15, 1995	May 1995–April 1996.
November 16, 1995–December 15, 1995	June 1995–May 1996.
December 16, 1995–January 15, 1996	July 1995–June 1996.
January 16, 1996–February 15, 1996	August 1995–July 1996.
February 16, 1996–March 15, 1996	September 1995–August 1996.

2. Short Period Between Base Year and Initial Period

A provider may experience a change of ownership or may receive proper approval to change its cost reporting period between the base year cost reporting period and the initial period. If this occurs, the base year cost reporting period may begin on a date that is different from that of the initial period. In these instances, use the beginning date of the initial period to determine the 12-month factor that corresponds to the beginning date of the ''adjusted to period'' in Table 8.C.

B. Federal Rate Update Factor

To update each facility's costs up to the common period, we—

1. Determined the total growth from the average market basket level for the period of July 1, 1998 through September 30, 1999 to the average market basket level for the period of October 1, 1999 through September 30, 2000.

2. Calculated the rate of growth between the midpoints of the two periods.

3. Calculated the annual average rate of growth for #2.

4. Subtracted 1 percentage point from this annual average rate of growth.

5. Using the annual average minus 1 percentage point rate of growth, determined the cumulative growth between the midpoints of the two periods specified above.

This revised update factor was used to compute the Federal portion of the SNF PPS rate shown in Tables 1 and 2.

V. Regulatory Impact Analysis

We have examined the impacts of this rule as required by Executive Order 12866 and the Regulatory Flexibility Act (RFA) (Pub. L. 96–354). Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more annually). This notice is a major rule as defined in Title 5, United States Code, section 804(2) because we estimate its impact will be to increase the payments to SNFs by approximately $120 million in FY 2000. The update set forth in this notice applies to payments in FY 2000. Accordingly, the analysis that follows describes the impact of this 1 year only. In accordance with the requirements of Social Security Act, we will publish a notice for each subsequent fiscal year that will provide for an update to the

payment rates and include an associated impact analysis.

The RFA requires agencies to analyze options for regulatory relief of small entities. The BBA did not allow options to implementing a SNF PPS. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and governmental agencies. Most SNFs and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $5 million or less annually. For purposes of the RFA, all States and tribal governments are not considered to be small entities, nor are intermediaries or carriers. Individuals and States are not included in the definition of small entity. The policies contained in this notice update the SNF PPS rates by increasing the payment rates published in the May 12, 1998 interim final rule, but will not have a significant effect upon small entities.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This 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 the Secretary certifies, that this notice will not have a significant economic impact on the operations of a substantial number of small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in an annual expenditure by State, local, or tribal governments, in the aggregate, or by the private sector, of $100 million. We believe that this notice will not mandate expenditures in that amount.

This notice updates the SNF PPS rates contained in the interim final rule, titled ''Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities,'' published on May 12, 1998 (63 FR 26251). The following table presents the projected effects of the policy changes in the SNF PPS interim final rule, as well as statutory changes effective for FY 2000, on various skilled nursing facility categories. We estimate the effects of each policy change by estimating payments while holding all other payment variables constant. We use the best data available, but we do not attempt to predict behavioral responses to our policy changes, and we do not make adjustments for future changes in such variables as days or case mix.

The data used for this analysis are the same data used to create the FY 1999 rates that were stipulated in our interim final rule published on May 12, 1998 (63 FR 26251). The final data set used in developing those rates was used here to estimate the effects of changing only one payment variable at a time. We would prefer to use more recent data in calculating the FY 2000 impact. However, it should be recalled that SNF PPS was phased-in instead of being implemented simultaneously in all SNFs nationwide. Consequently, we only have a partial database of SNF PPS claims and other data at the present time. Due to the phased-in manner in which SNFs came into the PPS, we believe that extrapolation of the current partial database of SNF PPS claims and other data as the basis of the methodology to calculate the FY 2000 impact would produce less accurate results than the method we are using.

Next year we anticipate having a full year of SNF PPS claims and other data and, under ordinary circumstances, we would be able to show the impact of the annual update for SNFs across the various RUG–III case-mix groups and associated payments. However, we also anticipate that certain events may combine that may limit the scope or accuracy of our impact analysis, because such an analysis is future oriented and, thus, very susceptible to forecasting errors due to other changes in the forecasted impact time period. Examples of such events may be newly legislated general Medicare program funding changes by the Congress, or changes specifically related to SNFs. In addition, changes to the Medicare program will continue to be made as a result of the Balanced Budget Act of 1997. Although these changes may not be specific to SNF PPS, due to the nature of the Medicare program the changes may interact, and the complexity of the interaction of these changes could make it very difficult to accurately predict the full scope of the impact upon SNFs.

While the discussion above acknowledges the difficulties we anticipate encountering, we also want to state that our first and foremost concern has always been and will continue to be the effect of policy changes on beneficiaries' access to affordable quality health care. For example, if research indicates that refinements are necessary to the case mix classification system and the PPS rates, we will make the changes that ensure that the rates properly account for the intensity of resources involved in furnishing quality patient care. As discussed earlier, we are funding substantial research to examine the potential for refinements to the case mix methodology, including an examination of medication therapy, medically complex patients, and other non-therapy ancillary services.

In addition to the above research efforts, we are proactively monitoring the impact of the Balanced Budget Act of 1997 to ensure that beneficiary access to quality SNF services is not compromised. That monitoring includes the gathering of extensive objective information using various sources from across the nation to help us determine how access to care and quality of care may be impacted by the rates, and what specific corrective actions may be necessary. As we accumulate data and learn more about the effects of the new payment system, we will report the results.

As stated previously in this preamble, the aggregate increase in payments associated with this update is estimated to be $120 million. There are four areas of change that produce this increase for facilities.

- The effect of the Federal transition, which results in most facilities being paid at 50 percent the Federal rate and 50 percent the facility-specific rate instead of the current 25 percent Federal rate and 75 percent facility-specific rate.
- The effect of the methodological change to the Federal rates described in the final rule to be published elsewhere in this **Federal Register** document. This resulted in increases of $.32 and $.24 to the unadjusted urban and rural case-mix component of the Federal rates, respectively, and a $.25 and $.21 to the unadjusted urban and rural non-case-mix component of the Federal rates, respectively.
- The effect of changes to the wage index used in this year's rates as compared to last year's rates. This is budget neutral in total but may affect individual facilities in either direction.
- The total change in payments from FY 1999 levels to FY 2000 levels. This includes all the previous changes in addition to the effect of the update to the rates.

As can be seen from the table below, some of these areas result in increased aggregate payments and others tend to lower them. The four areas of change are as follows:

The first row of the table includes the effects on all facilities. The next six rows show the effects on facilities split by hospital-based or freestanding and urban or rural. The rest of the table shows the effects on urban or rural status by census region.

The first column in the table shows the number of facilities in the database. The second column shows the effect of the transition to the Federal rates. This change has an overall effect of lowering payments by 1.4 percent with most of the lowering coming from hospital-based facilities. There are a few regions that have increased payments due to this provision but most have lower payments with the largest effect being in the West South Central region for both urban and rural facilities.

The next column shows the effect of the rate increase associated with the methodological change to the Federal rates referred to above. As seen in the table, the add-on increases payments by 0.2 percent on average and is fairly constant for all types of facilities and their location. This consistency should be expected since the add-on is a constant amount for each provider.

The next column shows the effect of the changes in the wage index in this year's rates. Since these changes were made budget-neutral, the total effect is no change. However, there is variation based on type of facility and location. Urban facilities have their payments reduced, although some regions do show slight increases. However, rural facilities have their payments increased with the largest effect in the West North Central region.

The final column of the table shows the effect of all the changes on the FY 2000 payments. This includes all the previous changes and the update to this year's rates of market basket minus 1 percentage point as required by law. Therefore, it is assumed that payments will increase by 0.9 percent in total if there are no behavioral changes by the facilities. As can be seen from this table, the effects on specific types of providers and by location differ by much larger amounts.

	Number of facilities	Transition to federal rates (percent)	Add-on to federal rates (percent)	Change in wage index (percent)	Total FY 2000 change ** (percent)
Total	9037	−1.4	0.2	0.0	0.9
Total urban	6300	−1.4	0.2	−0.3	0.6
Total rural	2737	−1.1	0.1	1.3	2.4
Hospital-based urban	683	−6.1	0.1	−0.2	−4.2
Freestanding urban	5617	−0.5	0.2	−0.3	1.5
Hospital-based rural	533	−4.6	0.1	0.9	−1.6
Freestanding rural	2204	−0.3	0.1	1.4	3.3
Urban by region:					
New England	630	3.3	0.2	−1.2	4.4
Middle Atlantic	877	1.9	0.2	0.1	4.4
South Atlantic	959	−3.0	0.1	0.4	−0.5
East North Central	1232	−0.2	0.2	−0.2	1.9
East South Central	212	−2.4	0.2	0.5	0.3
West North Central	469	−1.6	0.2	0.4	1.1
West South Central	519	−6.3	0.1	−0.5	−4.7
Mountain	303	−4.6	0.1	0.2	−2.3
Pacific	1070	−2.9	0.1	−0.3	−1.1
Rural by region:					
New England	88	2.2	0.1	1.1	5.6
Middle Atlantic	144	1.2	0.1	0.9	4.4
South Atlantic	373	−1.5	0.1	1.4	2.1
East North Central	561	−0.0	0.1	1.3	3.5
East South Central	255	−2.3	0.1	1.6	1.4
West North Central	581	−0.4	0.1	2.8	4.6
West South Central	354	−4.4	0.1	1.0	−1.3
Mountain	204	−1.9	0.1	2.1	2.4
Pacific	151	−0.2	0.1	0.6	2.6

** The effects of the various changes are not additive.

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

Authority: Section 1888(e) of the Social Security Act (42 U.S.C. 1395yy (e)).

(Catalog of Federal Domestic Assistance Program No. 93.773 Medicare—Hospital Insurance Program; and No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: June 17, 1999.

Nancy-Ann Min DeParle,

Administrator, Health Care Financing Administration.

Approved: July 19, 1999.

Donna E. Shalala,

Secretary.

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BILLING CODE 4120–01–P

federal register

Friday
July 30, 1999

Part IV

Department of Education

Office of Postsecondary Education; Federal Pell Grant Program; Notice

DEPARTMENT OF EDUCATION

Office of Postsecondary Education

[CFDA No.: 84.063]

Federal Pell Grant Program

AGENCY: Department of Education.

ACTION: Notice; deadline and submission dates for receipt of applications, reports, and other documents for the 1999–2000 award year.

SUMMARY: The Secretary announces the deadline dates for receiving documents from persons applying for grants under the Federal Pell Grant Program in the 1999–2000 award year, and the earliest submission and deadline dates for receiving documents from institutions participating in that program in that year.

SUPPLEMENTARY INFORMATION: The Federal Pell Grant Program, administered by the U.S. Department of Education (Department), provides grants to students attending eligible institutions of higher education to help them pay for their educational costs. The program supports Goals 2000, the President's strategy for moving the Nation toward the National Education Goals, by enhancing opportunities for postsecondary education. The National Education Goals call for increasing the rate at which students graduate from high school and pursue high quality postsecondary education and for supporting life-long learning. Authority for the Federal Pell Grant Program is contained in section 401 of the Higher Education Act of 1965, as amended, 20 U.S.C. 1070a.

Deadline and Submission Dates

The following table provides deadline dates for application processing and receipt of Student Aid Reports (SARs) or Institutional Student Information Records (ISIRs) for the Federal Pell Grant Program.

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A. Deadline Dates for Application Processing and Receipt of Student Aid Reports (SARs) or Institutional Student Information Records (ISIRs)

Who Submits?	What is Submitted?	Where is it Submitted?	What is the Deadline Date for Receipt?
Student	Free Application for Federal Student Aid (FAFSA) on the Web, Renewal FAFSA on the Web, or FAFSA Express electronic application	Electronically to the Central Processing System	June 30, 2000*
	Signature Page (if required)	The address printed on the signature page	August 16, 2000
Student through an institution	An electronic original or renewal application	Electronically to the Central Processing System	June 30, 2000*
Student	A paper original Free Application for Federal Student Aid (FAFSA) or paper Renewal FAFSA	The address indicated on the FAFSA, Renewal FAFSA, or envelope provided with the form	June 30, 2000
Student	Free Application for Federal Student Aid (FAFSA) from .pdf file obtained from http://www.fafsa.ed.gov	The address indicated on the FAFSA.pdf file	June 30, 2000
Student through an Institution	Electronic corrections and duplicate requests	Electronically to the Central Processing System	August 25, 2000*
Student	SAR corrections	The address indicated on the SAR	August 16, 2000
Student	Change of address, change of institutions, and duplicate requests	The address indicated on the SAR	August 16, 2000
		The Federal Student Aid Information Center by calling 1-800-433-3243	August 25, 2000
Student	Valid SAR	Institution	The earlier of: - the student's last date of enrollment; or - August 31, 2000
Student Through the Central Processing System	Valid ISIR****	Institution receives ISIR from Central Processing System	

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A. Deadline Dates for Application Processing and Receipt of Student Aid Reports (SARs) or Institutional Student Information Records (ISIRs)			
Student	Verification documents	Institution	The earlier of:** - 90 days after the student's last date of enrollment; or - August 31, 2000
Student	Verified SAR	Institution	The earlier of:*** - 90 days after the student's last date of enrollment; or - August 31, 2000
Student Through the Central Processing System	Verified ISIR****	Institution receives ISIR from Central Processing System	

* The deadline for electronic transactions is 7:00 PM (Central Time) on the deadline date. Transmissions must be completed and accepted by 7:00 PM to meet the deadline. If transmissions are started before 7:00 PM but are not completed until after 7:00 PM, those transmissions will not meet the deadline. In addition, any transmission picked up on the deadline date that gets rejected may not be able to be reprocessed because the deadline will have passed by the time the user gets the information notifying him/her of the reject.

** Although the Department has set this deadline date for the submission of verification documents, if corrections to the SAR or ISIR are required, the above deadline dates for submission of paper or electronic corrections must still be met.

*** The institution must have already received a SAR or ISIR with an eligible EFC while the student was enrolled and eligible for payment for those students completing verification while no longer enrolled. These students will be paid based on the higher of the two EFCs.

****For this purpose, the date the ISIR transaction was processed by the Central Processing System is considered to be the date the institution received the ISIR.

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The following table provides the earliest submission and deadline dates for submitting Federal Pell Grant Disbursement Records. The origination record and the disbursement record have replaced the Payment Data record referred to in previous Federal Pell Grant notices. Except for the amount of specific disbursements, the origination record contains basically the same information as the previously used payment data record. This information is used by the Department's Recipient Financial Management System (RFMS) to edit the accuracy of a student's annual award amount and includes information such as the student's annual award amount calculated by the institution, expected family contribution, and cost of attendance. An institution uses the disbursement record: (1) to report a disbursement or expected disbursement for each student, and (2) for those institutions that participate in the Just-in-time payment method pilot, to request funds. The "regular" disbursement record basically includes an origination record unique identifier and the amount and date of the disbursement. RFMS uses totals of the accepted disbursement record data in the funding process as either the basis for adjusting an institution's authorization level or as a request for funds. Starting in the 1999–2000 award year, an institution may submit a disbursement record earlier than the reported disbursement date in the record. The Department considers a disbursement of Federal Pell Grant funds to have occurred on the earlier of the date that the institution: (a) Credits a student's account at the institution's general ledger or any subledger of the general ledger; or (b) pays a student directly with funds received from the Department. The Department considers a disbursement to have occurred even if institutional funds are used in advance of receiving the program funds from the Department (34 CFR part 668.164(a)). Table B provides the earliest date an institution can submit a disbursement record to the Department. Any disbursement record received prior to the earliest submission date is rejected. Table B also includes the latest date an institution may submit a disbursement record. The Department may impose an adverse action such as a fine or other penalty for an institution's failure to submit a Federal Pell Grant disbursement record within the required 30-day timeframe. Also, failing to submit a disbursement record within the required 30-day timeframe may result in an audit or program review finding for an institution.

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B. Earliest Submission and Deadline Dates for Submitting Federal Pell Grant Disbursement Records

Who Submits?	What is Submitted?	Where is it Submitted?	What is the Earliest Submission and Deadline Date for Receipt?
Institution	At least one acceptable disbursement record must be submitted for each Federal Pell Grant recipient at the institution by: Recipient Data Exchange (RDE)*; or Electronic Data Exchange (EDE)**	1. Through the Recipient Financial Management System (RFMS) using Recipient Data Exchange: Regular Mail: U.S. Department of Education Student Aid Origination Team, PSS P.O. Box 6565 Rockville, Maryland 20850-6565 Or Commercial Couriers/Hand Deliveries: U.S. Department of Education Student Aid Origination Team, PSS c/o Affiliated Computer Services, RFMS, Federal Pell Grant Program Mail Stop 3200, One Curie Court Rockville, Maryland 20850-4389 2. Through RFMS using EDE or custom software: Title IV Wide Area Network	An institution may submit disbursement records as early as June 25, 1999, but can not submit a disbursement record any earlier than: (a) 30 calendar days prior to the disbursement date under the Advance payment method; (b) 5 calendar days prior to the disbursement date under the Just-in-time payment method; or (c) the date of disbursement under the Reimbursement or Cash Monitoring payment methods. An institution is required to submit a disbursement record not later than the earlier of: (a) 30 calendar days after the institution - makes a payment; or - becomes aware of the need to make an adjustment to previously reported disbursement data; or (b) October 2, 2000. After October 2, 2000, an institution may submit a disbursement record only if: (a) downward adjustment of previously reported award; or (b) program review or initial audit finding per 34 CFR 690.83.
	Requests for Year-To-Date Records	1. Pell Grant User Support Hotline: 1-800-474-7268 2. http://www.pellgrantsonline.ed.gov 3. Using the information provided in items #1 (RDE) and #2 (EDE) for submitting a disbursement record	August 16, 2000***

B. Earliest Submission and Deadline Dates for Submitting Federal Pell Grant Disbursement Records			
Who Submits?	What is Submitted?	Where is it Submitted?	What is the Earliest Submission and Deadline Date for Receipt?
Institution	Request for administrative relief based on an administrative error by the Department or Departmental contractors	U.S. Department of Education Institutional Financial Management Division, AFMS P.O. Box 23791 Washington, D.C. 20026-0791	January 31, 2001

*The 1999-2000 award year is the last year the Department accepts RDE tape submissions.

**An institution must ensure that its transmission of disbursement records is completed before midnight (local time at the institution's EDE destination point) on October 2, 2000.

***Year-To-Date records may be requested after this date, however, there may not be sufficient time for institutions to receive the file, create a disbursement record batch and submit to the Department by the October 2, 2000 deadline date for receipt of all 1999-2000 requests for payment.

NOTE: RFMS must accept a student origination record for a student from an institution before it accepts a disbursement record from the institution for that student. An institution may submit an origination and a disbursement record for a student in the same transmission.

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Proof of Delivery for Federal Pell Grant Payment Documents

The Department accepts as proof of delivery, if the documents were submitted by mail or by non-U.S. Postal Service courier, one of the following:

(1) A legible mail receipt with the date of mailing stamped by the U.S. Postal Service.

(2) A legibly-dated U.S. Postal Service postmark.

Note: The U.S. Postal Service does not uniformly provide a dated postmark. Before relying on this method of proof of mailing, an institution should check with the post office at which it mails its submission. An institution is strongly encouraged to use First Class Mail.

(3) A dated shipping label, invoice, or receipt from a commercial courier.

(4) Other proof of mailing or delivery acceptable to the Secretary.

The Department accepts commercial couriers or hand deliveries between 8 a.m. and 4:30 p.m. Eastern Time, Monday through Friday except Federal holidays.

Other Sources for Detailed Information on the Application and Automated Processes

A more detailed discussion of the student application process for the Federal Pell Grant Program is contained in the *1999–2000 Student Guide, Funding Your Education, the 1999–2000 High School Counselor's Handbook, A Guide to 1999–2000 SARs and ISIRs,* and the *1999–2000 Federal Student Financial Aid Handbook.* A more detailed discussion of the institutional reporting requirements for the Federal Pell Grant Program is contained in the *Federal Student Financial Aid Handbook* and the Information for Financial Aid Professionals web site at http://www.ifap.ed.gov.

Applicable Regulations

The following regulations apply: (1) Federal Pell Grant Program, 34 CFR part 690, (2) Student Assistance General Provisions, 34 CFR part 668, and (3) Institutional Eligibility, 34 CFR part 600.

FOR FURTHER INFORMATION CONTACT: Jacquelyn C. Butler, Program Specialist, U.S. Department of Education, Office of Student Financial Assistance Programs, 400 Maryland Avenue, S.W. (ROB–3, Room 3045), Washington, DC 20202–5447. Telephone: (202) 708–8242. Individuals who use a telecommunications device for the deaf (TDD) may call the Federal Information Relay Service (FIRS) at 1–800–877–8339.

Individuals with disabilities may obtain this document in an alternate format (e.g., Braille, large print, audiotape, or computer diskette) on request to Katie Mincey, Director of Alternate Format Center, U.S. Department of Education, 400 Maryland Avenue, S.W. (Switzer Bldg., Room 1000), Washington, D.C. 20202–4560. Telephone: (202) 260–9895.

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Program Authority: Authority: 20 U.S.C. 1070a.

Dated: July 26, 1999.

Greg Woods,

Chief Operating Officer, Office of Student Financial Assistance.

[FR Doc. 99–19442 Filed 7–29–99; 8:45 am]

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federal register

Friday
July 30, 1999

Part V

Department of Health and Human Services

Food and Drug Administration

21 CFR Parts 801, 878, and 880

Surgeon's and Patient Examination Gloves; Reclassification and Medical Glove Guidance Manual Availability; Proposed Rule and Notice

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

21 CFR Parts 801, 878, and 880

[Docket No. 98N–0313]

RIN 0910–AB74

Surgeon's and Patient Examination Gloves; Reclassification

AGENCY: Food and Drug Administration, HHS.

ACTION: Proposed rule.

SUMMARY: The Food and Drug Administration (FDA) is proposing regulations to reclassify all surgeon's and patient examination gloves as class II medical devices because it believes that general controls are insufficient to provide a reasonable assurance of safety and effectiveness. The reclassified gloves, including those made of natural rubber latex (NRL) or synthetic material, will be regulated in four categories: Powdered surgeon's gloves, powder-free surgeon's gloves, powdered patient examination gloves, and powder-free patient examination gloves. The proposed special controls are in the form of a proposed guidance document entitled ''Medical Glove Guidance Manual,'' which includes recommended protein and glove powder limits, and new label caution statements including protein and powder labeling requirements. FDA is also proposing to require expiration dating. This proposed rule is intended to reduce the adverse health effects from allergic and foreign body reactions caused by the natural latex (NL) protein allergens and glove powder found on surgeon's and patient examination gloves and to reduce the adverse health effects from defects in the barrier integrity and quality of surgeon's and patient examination gloves.

DATES: Written comments by October 28, 1999. Written comments on the information collection requirements should be submitted by August 30, 1999.

ADDRESSES: Submit written comments to the Dockets Management Branch (HFA–305), Food and Drug Administration, 5630 Fishers Lane, rm. 1061, Rockville, MD 20852. Submit written comments on the information collection requirements to the Office of Information and Regulatory Affairs, Office of Management and Budget (OMB), New Executive Office Bldg., 725 17th St. NW., rm. 10235, Washington, DC 20503, Attn.: Wendy Taylor, Desk Officer for FDA.

FOR FURTHER INFORMATION CONTACT: Donald E. Marlowe, Center for Devices and Radiological Health (HFZ–100), Food and Drug Administration, 5600 Fishers Lane, Rockville, MD 20857, 301–827–4777.

SUPPLEMENTARY INFORMATION:

I. Background

Surgeon's and patient examination gloves are intended to provide an effective barrier against potentially infectious materials and other contaminants. However, the use of surgeon's and patient examination gloves has been associated with a number of adverse health effects in patients and users, including allergic reactions, foreign body reactions, and irritation.

NL is a milky fluid that consists of extremely small particles of rubber obtained from plants, principally from the *Heavea brasiliensis* (rubber) tree, dispersed in an aqueous medium. NL contains a variety of naturally occurring substances, including plant proteins, which are believed to be the primary allergens associated with NL allergy. NL is employed in the natural rubber latex manufacturing process. Products made by the natural rubber latex manufacturing process, such as medical gloves, are referred to as containing or made of NRL. For a more complete description of the NRL manufacturing process and further definition of related terms, see the final rule entitled ''Natural Rubber-Containing Medical Devices; User Labeling,'' published on September 30, 1997 (62 FR 51021), and codified in part 801 (21 CFR part 801) at § 801.437.

Glove powder is defined as the total particulate matter on a finished glove, including donning and dusting powder, as well as former-release (or mold-release) compounds and manufacturing debris. The main component of donning and dusting powder is most commonly cornstarch.

Health care workers, comprised of physicians, dentists, pharmacists, nurses, technologists, technicians, and phlebotomists, use millions of NRL gloves during procedures involving millions of patients; this makes NRL gloves a significant source of exposure to NL allergens (Ref. 1).

Studies of health care workers, blood donors, and ambulatory surgical patients have demonstrated an appreciable prevalence of NL sensitivity (Refs. 2 to 8). FDA has received 330 reports of adverse events attributed to NL allergy occurring in patients and health care workers, which suggests that allergic reaction to NRL products in health care settings manifests itself in a variety of symptoms ranging from dermatitis to anaphylaxis (Ref. 9). The general population is directly exposed to NRL from a variety of sources, including consumer products such as industrial gloves and NRL balloons, as well as medical devices such as barrier contraceptives and NRL gloves.

FDA has significant concerns about the role of glove powder as a carrier of airborne allergens, because NL allergens have been shown to bind to cornstarch. A number of published clinical and experimental studies support this conclusion (Refs. 10 to 14). In addition to the role of glove powder as a carrier of airborne allergens, FDA is also aware that glove powder contributes to a number of other adverse health effects. As particulate matter, it can cause foreign body reactions, resulting in inflammation, granulomas and adhesions of peritoneal tissues after surgery (Refs. 15 to 19). Glove powder may serve as an absorbent or adsorbent for unbound chemicals that may be irritants or chemical contact sensitizers. In addition, glove powder from nonsterile patient examination gloves may also support microbial growth and act as a carrier for endotoxins (Ref. 20). These multiple concerns of adverse health effects associated with particulate matter from the surface of medical gloves constitute compelling reasons for FDA to reduce the amount of powder on all gloves, as well as to ensure that both powdered gloves and powder-free alternatives are clearly labeled so users and consumers may make informed choices. Although data is not currently available to quantify a maximum allowable level of glove powder, decreased exposure to glove powder will decrease the prevalence of adverse health effects. Therefore, FDA is recommending a powder level it believes is achievable by industry.

In June 1997, the National Institute of Occupational Safety and Health (NIOSH) issued a safety alert recommending the use of powder-free, reduced protein content NRL or synthetic gloves as a means to reduce exposure to NL allergens, specifically via the airborne route of exposure (Ref. 21). While FDA agrees with the goal of reducing exposure to airborne allergens, FDA is concerned that efforts to produce powder-free gloves with satisfactory donning properties may require additional manufacturing processes that, if not appropriately controlled, have deleterious effects on physical properties, performance, and shelf-life of the gloves (Refs. 22 and 23).

II. Statutory Authority

The Federal Food, Drug, and Cosmetic Act (the act), as amended by the Medical Device Amendments of 1976 (the 1976 amendments) (Public Law 94–295), the Safe Medical Devices Act of 1990 (SMDA) (Public Law 101–629), and the Food and Drug Administration Modernization Act of 1997 (FDAMA) (Public Law 105–115), established a comprehensive system for the regulation of medical devices intended for human use. Section 513 of the act (21 U.S.C. 360c) established three categories (classes) of devices, depending on the regulatory controls needed to provide a reasonable assurance of their safety and effectiveness.

The three categories of devices are class I (general controls), class II (special controls), and class III (premarket approval). The effect of classifying a device into class I is to require that the device meet only the general controls that are applicable to all devices. The effect of classifying a device into class II is to require the device to meet special controls as well as general controls, which together provide reasonable assurance of the safety and effectiveness of the device. Class II devices are devices which cannot be classified in class I because general controls by themselves are insufficient to provide reasonable assurance of safety and effectiveness and for which there is sufficient information to establish special controls to provide such assurance, including the issuance of performance standards, postmarket surveillance, patient registries, and guidelines (see section 513(a)(1)(B) of the act). The effect of classifying a device into class III is to require each manufacturer of the device to submit to FDA a premarket approval application (PMA) that includes information concerning safety and effectiveness of the device.

Under section 513 of the act, devices that were in commercial distribution before May 28, 1976 (the date of enactment of the amendments), generally referred to as preamendments devices, are classified after FDA has: (1) Received a recommendation from a device classification panel (an FDA advisory committee); (2) published the panel's recommendation for comment, along with a proposed regulation classifying the device; and (3) published a final regulation classifying the device. FDA has classified most preamendments devices under these procedures.

A device that is first offered in commercial distribution after May 28, 1976, generally referred to as a postamendments device, and which FDA determines to be substantially equivalent to a device classified under this scheme, is classified into the same class as the device to which it is substantially equivalent. The agency determines whether new devices are substantially equivalent to previously offered devices by means of premarket notification procedures in section 510(k) of the act (21 U.S.C. 360(k)) and part 807 of the regulations (21 CFR part 807). A device that was not in commercial distribution prior to May 28, 1976, and that has not been found by FDA to be substantially equivalent to a legally marketed device, is classified automatically by statute (section 513(f) of the act) into class III, without any FDA rulemaking proceeding.

Reclassification of classified preamendments devices is governed by section 513(e) of the act (21 U.S.C. 360c(e)). This section provides that FDA may, by rulemaking, reclassify a device (in a proceeding that parallels the initial classification proceeding) based upon ''new information.'' The reclassification can be initiated by FDA or by the petition of an interested person. The term ''new information,'' as used in section 513(e) of the act, includes information developed as a result of the reevaluation of the data before the agency when the device was originally classified, as well as information not presented, not available, or not developed at that time. (See, e.g., *Holland Rantos* v. *United States Department of Health, Education, and Welfare*, 587 F.2d 1173, 1174 n.1 (D.C. Cir. 1978); *Upjohn* v. *Finch*, 422 F.2d 944 (6th Cir. 1970); *Bell* v. *Goddard*, 366 F.2d 177 (7th Cir. 1966).)

Reevaluation of the data previously before the agency is an appropriate basis for subsequent regulatory action where the reevaluation is made in light of changes in ''medical science.'' (See *Upjohn* v. *Finch*, supra, 422 F.2d at 951.) However, regardless of whether data before the agency are past or new data, the ''new information'' on which any reclassification is based is required to consist of ''valid scientific evidence,'' as defined in section 513(a)(3) of the act (21 U.S.C. 360c(a)(3)) and 21 CFR 860.7(c)(2). FDA relies upon ''valid scientific evidence'' in the classification process to determine the level of regulation for devices. For the purpose of reclassification, the valid scientific evidence upon which the agency relies must be publicly available. Publicly available information excludes trade secret and/or confidential commercial information.

On November 21, 1997, the President signed into law FDAMA. Section 206 of FDAMA added a new section 510(m) (21 U.S.C. 360(m)) to the act. Section 510(m)(2) of the act provides that FDA may, on its own initiative or upon petition of an interested person, exempt a class II device from the requirement of premarket notification in section 510(k) of the act, if FDA determines that a 510(k) submission is not necessary to provide reasonable assurance of the safety and effectiveness of the device. Such an exemption would permit manufacturers to introduce the generic type of device into commercial distribution without first submitting a premarket notification to FDA.

Section 701(a) of the act (21 U.S.C. 371(a)) authorizes FDA to issue substantive binding regulations for the efficient enforcement of the act. (*Weinberger* v. *Hynson, Westcott & Dunning, Inc.*, 412 U.S. 609 (1973); see also *Weinberger* v. *Bentex Pharmaceuticals*, Inc., 412 U.S. 645, 653 (1973); *National Ass'n of Pharmaceutical Manufacturers* v. *FDA*, 637 F.2d 877 (2d Cir. 1981); *National Confectioners Ass'n* v. *Califano*, 569 F.2d 690 (D.C. Cir. 1978); *National Nutritional Foods Ass'n* v. *Weinberger*, 512 F.2d 688 (2d Cir.), cert. denied, 423 U.S. 825 (1975).)

Section 502(a) of the act (21 U.S.C. 352(a)) provides that a device is misbranded ''[I]f its labeling is false or misleading in any particular.'' Section 201(n) of the act (21 U.S.C. 321 (n)) provides that, in determining whether labeling of a regulated article (such as a device) is misleading

> * * * there shall be taken into account * * * not only representations made or suggested by statement, word, design, device, or any combination thereof, but also the extent to which the labeling * * * fails to reveal facts material in light of such representations * * * with respect to consequences which may result from the use of the article to which the labeling * * * relates under the conditions of use prescribed in the labeling or advertising thereof or under such conditions of use as are customary or usual.

The courts have upheld FDA's authority to prevent false or misleading labeling by issuing regulations requiring label warnings and other affirmative disclosures (See, e.g., *Cosmetic, Toiletry, and Fragrance Association* v. *Schmidt*, 409 F. Supp. 57 (D.D.C. 1976), aff'd without opinion, Civil No. 75–1715 (D.C. Cir. August 19, 1977), even in the absence of a proven cause-and-effect relationship between product usage and harm (*Council for Responsible Nutrition* v. *Goyan*, Civil No. 80–1124 (D. D. C. August 1, 1980)).

FDA may impose testing requirements in a labeling regulation issued under its general rulemaking authority. (See, e.g.,

American Frozen Food Inst. v. *Mathews*, 413 F. Supp. 548 (D.D.C. 1976), aff'd per curiam sub nom. *American Frozen Food Inst.* v. *Califano*, 555 F.2d 1059 (D.C. Cir. 1977); see also *National Nutritional Foods Ass'n* v. *Weinberger*, supra.) Thus, FDA may require that all manufacturers use the same conditions to test aging to ensure that the expiration date reflects the period of time a product can be used safely. Similar requirements are imposed in § 801.430(f) for absorbency testing for menstrual tampons, and in § 801.420(c)(4) on hearing aid manufacturers and distributors who must determine and state technical data values for hearing aid labeling in accordance with specified test procedures. The hearing aid regulation has been upheld. (*American Speech and Hearing Ass'n* v. *Califano*, Medical Devices Report (CCH) No. 77–1327 §§ 15004, 15007 (D.D.C. August 23, 1977) aff'd No. 77–1327 (D.C. Cir. Dec. 19, 1977).) Food regulations issued under section 701(a) of the act also impose many such specific testing requirements (see e.g., 21 CFR 113.40 (tests for low-acid canned foods); 21 CFR 155.190(b)(2)(i) (test for determining drained weight of canned tomatos); 21 CFR 161.190 (method for determining color designation of tuna).

III. Powder and Protein Concerns

Although FDA has been concerned about airborne NL allergens associated with the use of powdered medical gloves and has undertaken continued efforts to address these concerns, recent heightened awareness within the health care community and State and Federal Government agencies of adverse health effects has prompted this proposed action.

Over the past 3 years, FDA has received requests to ban the use of all glove powders. These requests have been based on a number of clinical and experimental studies reporting that cornstarch on surgical gloves can reduce tissue resistance to infection, enhance the development of infection, cause formation of granulomas and adhesions, act as a carrier of NL protein from NRL products, and serve as a potential source of occupational asthma. Although a ban of all powdered medical gloves has been requested by petitioners and would reduce the problem of airborne powder, it would not completely address the problem of NL allergy and would potentially leave a significant and important need for high quality barrier products unmet.

One of the concerns regarding glove powder, in general, is its capability, as particulate material, to cause foreign body reaction, resulting in inflammation, granulomas and adhesions of peritoneal tissues after surgery (Refs. 15 to 19). Although cornstarch was considered to be absorbable by United States Pharmacopeia (USP), changes in the sterilization processes have reduced absorbability significantly (Ref. 15). Cornstarch represents a growth source for bacteria, and it is also a carrier of endotoxin, which can play a role in enhancing both delayed and immediate hypersensitivity (Ref. 20). Clinical experience suggests that powder on NRL gloves, in addition to its role in Type I allergy, may also be a contributing factor in the development of irritant dermatitis and Type IV allergy. Irritant skin reactions have been observed in association with frequent exposure to glove powder. Compromised skin barrier properties resulting from such reactions may permit penetration of allergens and other substances into the skin, thereby increasing chances for the development of both Type I and Type IV allergy (Ref. 24).

In addition, a significant concern, specific to NL gloves, exists regarding the role of glove powder as a carrier of airborne NL allergens. A number of respiratory problems and episodes of bronchial spasms in hospital employees and patients, reported since the mid 1980's, were ascribed to inhalation of airborne NL allergens in settings with heavy use of powdered gloves (Refs. 25 to 30). The implication of glove powder in the previous clinical reports was based on medical histories of individuals presenting with symptoms, on positive skin tests, positive tests for the presence of antibodies to NL allergens in blood and, in some cases, on positive inhalation challenge tests. A number of published clinical and experimental studies support this conclusion.

Binding of NL proteins to cornstarch was demonstrated in recent laboratory studies, which support a causal relationship between asthmatic reactions in individuals with NL allergy and the exposure to airborne particles from NL products (Refs. 10 and 11). The level of exposure and the severity of the reactions depend on both the amount of powder and the amount of NL protein allergens on the finished products. Measurements of airborne particle levels in environments where NL gloves were used frequently demonstrated that the level of airborne allergen is directly related to the frequency of powdered NL glove usage in particular areas and to the level of allergen and/or powder on the gloves used (Refs. 12 and 14).

Direct evidence that NL protein allergens, bound to the glove powder particles, provoke respiratory allergic reactions and asthma-like attacks has been documented by the bronchial provocation tests with powders on NL gloves. The bronchial provocation tests were performed by having allergic individuals inhale the extracts from powder-free surgeon's gloves, from powdered surgeon's gloves, and from cornstarch powder not exposed to NL. The studies indicated that cornstarch powder not exposed to NL did not cause any reaction in sensitized subjects, while nebulized powdered NL surgeon's glove extract, and to some extent, nebulized powder-free glove extract induced bronchoconstriction in tested subjects (Ref. 31).

However, the scientific data to define the quantitative relationship between respiratory allergic reactions and powder level on NL gloves are not available at this time. Such data and the specific dose-response relationship would be difficult to establish, because allergenicity of the airborne glove powder depends on the amount of powder and also on the amount of powder-bound allergenic proteins. Standardized methods for measuring the amount of powder-bound proteins or allergens and the amount of inhaled powder are not available.

NL protein has been widely reported as a cause of Type I sensitivity in individuals who have been exposed to NL devices (Refs. 2 to 8). Repeated exposure to NL protein is considered to increase the probability that an individual will become sensitized. Total water-extractable protein on the finished NL product is considered an indirect measure of the potential allergenicity. Because several NL proteins have already been identified as allergenic and others may be identified in the future, exclusion of any proteins from the evaluation may result in an inaccurate determination of potential allergenicity. The total water-extractable protein level measured using the standard American Society for Testing and Materials (ASTM) D 5712 method was found to correlate well with currently used allergen measurement methods. Most importantly, a total water-extractable protein level correlates also with the skin prick test, which is a direct measure of allergic response in sensitized individuals (Ref. 32). Since May 1991, FDA has advised manufacturers of NL devices to reduce the water-extractable protein on their NL devices. This reduction is now addressed in the Quality System (QS) Regulation at 21 CFR 820.3(p) and 820.70(h).

Initially, a labeling claim for a protein level was not accepted in a 510(k) submission because a standard test method for measuring water-extractable protein in NL did not exist. In 1995, with the help of industry and FDA, ASTM published the ''ASTM Standard Test Method for Analysis of Protein in Natural Rubber and its Products, D 5712–95.'' FDA subsequently issued a document entitled ''Interim Guidance On Protein Content Labeling Claim For Latex Medical Gloves,'' which is based on this test method. Manufacturers were allowed to use this guidance to submit a 510(k) submission for NL gloves identifying the level of water-extractable protein for the device. FDA is now proposing that a recommended limit on water-extractable protein per glove and the actual protein level appear on the label.

The amount of powder required for satisfactory donning of gloves has not been quantified, and the level of glove powder used varies greatly. Limited laboratory data from measurements of a number of surgeon's and patient examination gloves demonstrated that powder levels ranged from 70 to 375 milligrams (mg) per glove for surgeon's gloves and from 50 to 426 mg per glove for patient examination gloves (Ref. 31). Because of the multiple concerns regarding adverse health effects associated with particulate matter from the surface of surgeon's and patient examination gloves, FDA is now proposing that a recommended limit on glove powder and the actual level of glove powder appear on the label. FDA recognizes there is a correlation between powder level and ease of glove donning and that powder level is correlated with adverse health effects. For this reason, FDA is encouraging industry to find the balance between donning requirements and reducing the risks of adverse health effects.

Lowering the powder level and the amount of protein on surgeon's and patient examination gloves will reduce exposure to NL allergens and benefit both allergic individuals and those at risk to develop allergy. In addition, the reduction of glove powder levels will help reduce exposure to particulate materials responsible for foreign body reactions. However, the reduction of powder and protein levels must be accomplished by methods that do not compromise the availability of or barrier properties of surgeon's and patient examination gloves.

IV. Barrier and Other Quality Issues

In the **Federal Register** of October 21, 1980 (45 FR 69723), FDA issued a final rule classifying the patient examination glove into class I and exempting manufacturers of the device from compliance with premarket notification procedures under section 510(k) of the act and certain requirements of the current good manufacturing practice (CGMP) regulation. FDA granted the exemptions in the 1980 regulation because, at that time, no adverse experiences had been related to patient examination gloves. Furthermore, the role of the gloves as a protective barrier against human immunodeficiency virus (HIV) transmission was not recognized and the concomitant risks associated with glove failure were not well understood.

In the **Federal Register** of January 19, 1982 (47 FR 2810 at 2852), FDA proposed that the surgeon's glove be classified into class II because of concerns about tissue compatibility and the risk of infection if the devices were not properly sterilized. Comments offered in response to the proposed classification stated that those problems could be addressed through general controls, including labeling and CGMP adherence, and recommended that the device be classified into class I because of the history of its safe and effective use. In the **Federal Register** of June 24, 1988 (53 FR 23856), FDA issued a final rule classifying the surgeon's glove into class I without exemptions. Manufacturers and importers of surgeon's gloves have been required to comply with the premarket notification and CGMP regulations since the initial classification of the device.

Over the years, many issues regarding surgeon's and patient examination gloves have been brought to the attention of FDA. The acquired immune deficiency syndrome (AIDS) epidemic resulted in an elevated reliance on medical gloves as a barrier against blood-borne viral transmission. The increased demand for gloves soon outstripped the domestic supply. Foreign glove manufacturers began to meet the demand for additional gloves. Many manufacturers with little or no medical glove manufacturing experience began operations, resulting in large quantities of gloves of uncertain quality entering the U.S. market.

Following the advent of AIDS as a major public health concern and recommendations from the Centers for Disease Control and Prevention (CDC) that health care workers use appropriate barrier precautions to prevent exposure to the HIV virus, FDA recognized the need for greater assurance that cross-contamination between patients and health care workers be prevented. Accordingly, in the **Federal Register** of January 13, 1989 (54 FR 1602), FDA revoked the exemption for patient examination gloves from certain CGMP requirements in order to assure that manufacturers provide an acceptable manufacturing quality level. FDA similarly revoked the exemption from premarket notification requirements for patient examination gloves. On December 12, 1990 (55 FR 51254), FDA published regulations describing certain circumstances under which surgeon's and patient examination gloves would be considered adulterated, and establishing the sampling plans and test methods the agency would use to determine whether gloves were adulterated (§ 800.20 (21 CFR 800.20)). Subsequently, FDA initiated inspections of glove manufacturers to assure conformance with the acceptable quality levels (AQL) identified in that regulation.

FDA has sought to address many concerns regarding the quality and barrier integrity of medical gloves. Certain processes or conditions can often contribute to degradation of the barrier. NL degrades if it is not correctly formulated and processed. Proper formulation includes the use of stabilizers, antiozonants, and antioxidants to reduce degradation. Improper curing can also cause thin spots on the glove surface, which may lead to early barrier failure.

Gloves composed of synthetic polymer, such as nitrile, are produced by essentially the same processes as NL. The same accelerators, antioxidants, and stabilizers are used to reduce degradation. Thus, improper formulation and processing may also lead to rapid degradation of synthetic gloves.

Storage conditions can also cause degradation of the polymers, whether natural or synthetic. These storage conditions include the temperature at which the material is held, the humidity of their environment, and any radiation (for example, sunlight or fluorescent lights) to which the material may be exposed.

Additionally, chlorination is widely used to reduce the tackiness of NL gloves and thus eliminate the need for donning powder. Chlorination works by degrading the surface of the gloves. Therefore, chlorination must be carefully controlled in order to prevent destruction of the glove barrier. Improperly chlorinated gloves rapidly degrade, and breaks in the latex film may occur in a matter of months.

Another concern has been the presence of minute defects known as pinholes, which directly affect the barrier integrity of the gloves. FDA studies of micro-photographs of

defective NL devices have shown that dust, dirt, rust, paint chips, charred starch, insect parts, and other debris may cause pinholes. Therefore, appropriate environmental and processing controls, as required by the QS regulation, are needed. Manufacturers also need to control other causes of pinholes such as former vibration, air bubbles in the dipping tanks, dirty formers, incorrect formulation, and excessive curing temperatures.

If gloves have pinholes, breaks or tears, viruses can potentially penetrate the glove wall, eliminating or reducing the gloves' effectiveness as a barrier. On April 6 and 7, 1989, the University of Maryland, in conjunction with FDA, held a conference entitled ''Latex as a Barrier Material,'' which reiterated the value of NL as a barrier film and generated continued support towards more research in this area by industry and FDA.

Although manufacturers have data to show that their gloves meet their company AQL for defects when the gloves are shipped, for some manufacturers, the same gloves which passed the manufacturer's tests are sometimes rejected at the port of entry in the United States because the gloves fail the FDA water leak test at that point. This test result disparity, whether due to degradation or for other reasons, is a primary reason why, upon importation, the gloves of some manufacturers have been detained without physical examination. Manufacturers should assure, by means of stability testing, that their surgeon's and patient examination gloves will continue to meet the manufacturers' specifications over the expected life of the gloves.

FDA is aware that microbial growth on gloves also can be a problem. The QS regulation requires manufacturers to control processing, shipping and storage environment, and contamination when these can adversely affect the product. Therefore, processing controls should include: Using only cornstarch with an acceptable bioburden, properly storing the cornstarch until it is used, applying cornstarch by established procedures, cooling the cornstarch slurry and/or using an antimicrobial in the cornstarch slurry tanks, checking finished gloves on a sampling basis to assure that excessive cornstarch is not applied, keeping the finished gloves clean, establishing and meeting a dryness specification for finished gloves, and protecting finished gloves from adverse environmental conditions.

Although synthetic materials have improved in recent years, NL gloves may be superior to some synthetic gloves in regard to barrier properties (Ref. 34). Both NL and synthetic surgeon's and patient examination gloves provide protection against microorganisms; however, it has been demonstrated that compared to vinyl, NL has more effective and durable barrier qualities (Refs. 35 and 36).

There are other safety and performance issues related to gloves and other barrier devices that are currently being considered by industry and FDA. These issues include puncture resistance, tear resistance, reliability, and biocidal claims.

V. The Proposed Rule

Based upon new information that was not presented, not available, or not developed when FDA originally classified surgeon's and patient examination gloves, FDA has reevaluated its classification in light of changes in the medical science discussed in sections III and IV of this document. The new, publicly available, valid scientific evidence demonstrates that these gloves should not remain as class I devices because of: (1) Barrier integrity concerns; (2) degradation of quality during storage; (3) contamination concerns; and (4) concerns about exposure to NL allergens and the role of glove powder as a carrier of airborne NL allergens, and the inability of general controls to address these concerns. The agency believes that general controls are no longer sufficient to provide reasonable assurance of the gloves' safety and effectiveness and, therefore, FDA is proposing that these gloves be reclassified into class II.

Surgeon's and patient examination gloves are intended for use as an effective barrier against potentially infectious materials and other contaminants. Risk to the user or patient may result from lack of barrier integrity from degradation, pinholes, breaks, tears, or loss of quality during storage, potentially causing penetration of the glove wall by viruses or other infectious materials. When glove powder comes into contact with compromised human tissue, risk to the user or patient may result from foreign body reactions caused by NL allergens bound to the glove powder. Allergic reactions may also be caused by inhalation of NL allergens bound to the glove powder. Reducing the degree of risk to acceptable levels depends on effective maintenance of the barrier properties of the gloves and on reducing exposure to NL allergens, particularly exposure to airborne NL allergens. The highest risk products are those with large amounts of glove powder and NL protein and those products with poor barrier properties.

In order to enable users to distinguish between powdered and powder-free gloves and to choose the glove type appropriate for their needs, FDA proposes to reclassify surgeon's gloves into two separate classifications, based on powder level: Powdered surgeon's gloves, and powder-free surgeon's gloves. FDA similarly proposes to reclassify patient examination gloves into two categories: Powdered patient examination gloves, and powder-free patient examination gloves.

FDA is proposing that these gloves be subject to two special controls: A guidance document entitled, ''Medical Glove Guidance Manual,'' and new user labeling requirements. FDA believes that the proposed guidance document and user labeling requirements are necessary to provide reasonable assurance of the safe and effective use of the devices. The guidance is currently being issued in draft as a Level 1 guidance consistent with the good guidance practices (GGP's) FDA adopted for the development, issuance, and use of guidance documents (62 FR 8961, February 27, 1997). Elsewhere in this issue of the **Federal Register**, FDA is announcing the availability of the guidance in draft form, to provide an opportunity for comment.

The proposed guidance document recommends that manufacturers of powdered surgeon's and patient examination gloves limit the amount of powder to no more than 120 mg of powder per glove, regardless of glove size. In order to limit total exposure to the user, a ''per glove'' measurement (mg per glove) is used instead of the ''per unit'' dose (mg per gram (g) of glove material). Under the proposed labeling requirements, manufacturers of all powdered gloves would be required to include the actual level of glove powder on the label. FDA believes that the recommended limit should be sufficient for proper donning of gloves, but would reduce exposure to airborne glove powder particles. In addition to the role of glove powder as a carrier of airborne allergens, FDA is also aware that glove powder contributes to a number of other adverse health effects. As particulate matter, it can cause foreign body reactions, resulting in inflammation, granulomas and adhesions of peritoneal tissues after surgery (Refs. 15 to 19). Glove powder may serve as an absorbent or adsorbent for unbound chemicals that may be irritants or chemical contact sensitizers.

The proposed guidance document further recommends that manufacturers of powder-free surgeon's and patient

examination gloves limit the amount of total trace (residual) powder to no more than 2-mg particulate weight (based on the ASTM test standard D 6124–97) per glove, regardless of glove size. Previously, this limit was recommended to manufacturers who wanted to market gloves with a powder-free labeling claim. A number of premarket notification submissions based on this claim already have been cleared for market.

The proposed guidance document also recommends that manufacturers of NL surgeon's and patient examination gloves limit the amount of water-extractable protein on the gloves to no more than 1,200 micrograms (µg) of protein per glove, regardless of glove size. In order to limit total exposure to the user, a ''per glove measurement'' (mg per glove) is used instead of a ''per unit'' dose (mg per g of glove material). Under the proposed labeling requirements, labeling on all NL gloves would be required to include the level of water-extractable protein measured, as recommended in the guidance, by the currently recognized ASTM D 5712 modified Lowry method. The lowest acceptable amount of water-extractable protein that may be stated in the labeling will be limited by the sensitivity of the current ASTM D 5712 test method to 50 µg of protein per g of natural rubber product (which translates to 300 µg per glove for a 6 g glove, i.e., 6 x 50 = 300). FDA believes that without a more sensitive standard method, lower claims would be misleading.

The proposed labeling requirements are a special control intended to provide guidance to users of surgeon's and patient examination gloves. They would require manufacturers to provide new caution statements, which would include both the FDA recommended limit for glove powder and protein levels, as well as the actual glove powder and protein levels present in the manufacturer's gloves. The labeling special control provides essential decisionmaking information for health professionals, patients, and lay users. The information required under the proposed regulations would assist health care professionals, patients and lay users to select a lower risk device by providing information about protein and glove powder levels.

The proposed caution statements would be required to appear on all device labels and other labeling, including the principal display panel of the device packaging, the outside package, container or wrapper, and the immediate device package, container or wrapper. The proposed caution statements for powdered and powder-free NL gloves (surgeon's and patient examination) would supersede the caution statements in § 801.437(d) for devices containing NRL currently required in the regulation published in the **Federal Register** of September 30, 1997 (effective September 30, 1998).

Labeling for powdered surgeon's and patient examination gloves containing NL that contacts humans would be required to bear the following statement:

''Caution: This product contains natural rubber latex which may cause allergic reactions. FDA recommends that this product contain no more than 120 mg powder and 1,200 µg extractable protein per glove. This product contains no more than [insert level] mg powder and no more than [insert level] µg extractable protein per glove.''

Labeling for powder-free surgeon's and patient examination gloves containing NL that contacts humans would be required to bear the following statement:

''Caution: This product contains natural rubber latex which may cause allergic reactions. FDA recommends that this product contain no more than 1,200 µg extractable protein per glove. This product contains no more than [insert level] µg extractable protein per glove.''

FDA is also proposing new labeling requirements for powdered gloves made of synthetic material. FDA proposes that labeling for those gloves bear the following statement:

''Caution: Glove powder is associated with adverse reactions. FDA recommends that this product contain no more than 120 mg powder per glove. This product contains no more than [insert level] mg powder per glove.''

FDA is proposing no new labeling for powder-free surgeon's gloves and patient examination gloves made of synthetic materials.

FDA is also proposing to require expiration dating on the labeling of all powdered surgeon's and patient examination gloves and powder-free surgeon's and patient examination gloves. Previously, expiration dating has not been required for surgeon's or patient examination gloves, although it is customary for surgeon's gloves to bear an expiration date for sterility. A few glove manufacturers have voluntarily used expiration dates based on real-time data to support the integrity of the gloves throughout the shelf-life period.

In view of the quality concerns discussed in section IV of this document, especially those relating to degradation of barrier integrity over time, FDA believes that expiration dating is necessary to allow users to correctly store and use stock of gloves, and to allow users to avoid gloves that may have degraded. Users must be aware of the potential for degradation of gloves in order to safely use such products to provide a barrier from infectious agents. Accordingly, FDA believes that shelf life is a fact material to the consequences of use of surgeon's and patient examination gloves. Therefore, FDA is now proposing that all surgeon's and patient examination gloves be required to bear an expiration date on their primary and retail packaging and shipping carton. The expiration date should consist of the month and year for which data exists to support the shelf-life of the gloves. The time period upon which the expiration date is based starts with the date of manufacture.

This expiration date must be based on testing conducted according to a validated stability study protocol to determine the shelf-life of the gloves. The stability study protocol should employ tests commonly used by industry to demonstrate the physical and mechanical integrity of the gloves over their claimed shelf-life.

Manufacturers will not be required to provide new section 510(k) of the act submissions to demonstrate the shelf-life of gloves. However, for each distinct glove design, the records of study protocols and test data must be retained for a period equivalent to the design and expected life of the gloves, and must be made available for inspection by FDA personnel.

Expiration dates for sterile surgeon's or patient examination gloves should either be based on the shelf-life determined by stability studies as outlined in the proposed rule, or on the sterility shelf-life, whichever is shorter. Only one expiration date should appear on each product.

FDA does not intend to require a new submission under section 510(k) of the act based upon labeling changes or reductions in glove powder or NL protein made to comply with any final regulation based upon this proposed regulation, provided that no other changes requiring a new 510(k) submission under § 807.81 are made to the device.

Section 510(m) of the act allows FDA to exempt a class II device from the requirement of premarket notification in section 510(k) of the act. FDA does not intend to exempt powdered or powder-free surgeon's or patient examination gloves from premarket notification because of FDA's concerns regarding the effective maintenance of barrier properties and adverse health effects associated with NL allergens, glove powder and residual chemical sensitizers and irritants.

This proposed rule would not impose requirements on glove users or user facilities. Therefore, it would not affect

the authority of the Secretary of Labor, under the Occupational Safety and Health Act (OSH act), to enforce regulations, standards, or other directives issued under the OSH act.

VI. Specific Request for Comments

FDA recognizes that this regulation affects surgeon's and patient examination gloves in different ways, depending on glove powder level. FDA also recognizes that manufacturing processes for powdered and powder-free gloves vary. FDA welcomes comments on all aspects of the proposed regulation, but particularly invites comments on the following issues:

1. FDA requests comments on the timeframe for implementation of the proposed rule considering the need for changes in production, technology, and labeling, as well as the immediate need to address adverse health concerns associated with medical gloves. Although FDA prefers a 1-year effective date, FDA is proposing a 2-year effective date based on indications from industry that the necessary changes could not be made in 1 year and that a shortage of medical gloves could result.

2. In the proposed guidance document, FDA recommends a limit of no more than 120 mg powder per powdered glove, regardless of size, as the maximum level in order to reduce exposure to particulates and airborne allergens. FDA requests comments on the recommended limit with regard to the minimum level of powder needed for adequate donning of gloves.

3. FDA requests comments on the feasibility and desirability of additional labeling requiring manufacturers to state the primary ingredients in glove powder in the product labeling.

4. In the proposed guidance document, FDA is recommending no more than 2 mg powder per glove, regardless of size, as the recommended powder level for those surgeon's and patient examination gloves labeled ''powder-free.'' FDA requests comments on the proposed limit. FDA is also seeking comments on the possible impact of this powder limit on barrier properties and shelf-life of NL gloves.

5. FDA is also considering a future requirement that all surgeon's and patient examination gloves marketed in the United States be powder-free. FDA requests comments as to whether a continued need for powdered gloves exists, and, if so, the reason for this need.

6. FDA considered restrictions on the sale (advertising), distribution, and use of powdered surgeon's and patient examination gloves. FDA is seeking comments on the feasibility of such restrictions.

7. In the proposed guidance document, FDA is recommending an upper limit of no more than 1,200 µg protein per NL glove, regardless of size, as the maximum level for NL surgeon's and patient examination gloves. FDA is seeking comments on the proposed recommended limit.

8. FDA's objectives in this proposed rulemaking are to reduce adverse health effects from allergic reactions and foreign body reactions by controlling the levels of water-extractable protein and glove powder on NL gloves. FDA requests comments as to whether there are feasible alternative approaches to achieve these objectives. If other alternatives or data submitted present feasible methods to protect the public health or suggest that different powder or protein levels are adequate to protect the public health, FDA may incorporate such data or approaches in a final rule.

9. FDA also invites comments on the issue of whether the recommended limits on powder and protein proposed in this rule should be recommended limits or required limits.

10. FDA considered allowing manufacturers to establish an initial tentative shelf-life up to a certain duration based on accelerated aging data, provided that manufacturers initiate concurrent real-time shelf-life studies to confirm and extend the tentative shelf-life. FDA has been unable, however, to determine whether any validated stability study protocols exist employing accelerated aging methodologies. The agency invites comments or information on the availability of accelerated aging stability study protocols which are predictive of glove shelf-life. If convincing information concerning such protocols is available, FDA may incorporate such an approach in a final rule.

11. FDA considered requiring the use of a special air handling system at the point of use for those facilities using powdered surgeon's and patient examination gloves with powder levels over 120 mg per glove, regardless of glove size. FDA is seeking comments on the appropriateness of this restriction.

12. FDA seeks comments as to whether a provision permitting affected persons to request exemptions or variances from the labeling requirements or restrictions on distribution and use proposed in this rule should be added.

VII. General Request for Comments

Interested persons may submit written comments regarding this proposed rule by October 28, 1999, to the Dockets Management Branch (address above). Comments regarding the information collection provisions should be submitted by August 30, 1999, to the Office of Information and Regulatory Affairs, Office of Management and Budget (address above). Two copies of any comments are to be submitted, except that individuals may submit one copy. Comments are to be identified with the docket number found in brackets in the heading of this document. Received comments may be seen in the office above between 9 a.m. and 4 p.m., Monday through Friday.

VIII. Access to Special Control

The availability of the special control entitled ''Medical Glove Guidance Manual'' is being announced elsewhere in this issue of the **Federal Register**. A copy of the ''Medical Glove Guidance Manual'' may be seen by interested persons in the Dockets Management Branch (address above) between 9 a.m. and 4 p.m., Monday through Friday.

Persons interested in obtaining a copy of the guidance may also do so using the World Wide Web (WWW). FDA's Center for Devices and Radiological Health (CDRH), maintains an entry on the WWW for easy access to information including text, graphics, and files that may be downloaded to a PC with access to the Web. The CDRH home page is updated on a regular basis and includes the draft ''Medical Glove Guidance Manual;'' device safety alerts; **Federal Register** reprints; information on premarket submissions (including lists of approved applications and manufacturers' addresses); small manufacturers' assistance; and information on video conferencing and electronic submissions, mammography matters, and other device-oriented information. The CDRH home page may be accessed at ''http://www.fda.gov/cdrh''.

Submit written requests for single copies of the draft guidance to the Division of Small Manufacturers Assistance, Center for Devices and Radiological Health (HFZ–220), Food and Drug Administration, 1350 Piccard Dr., Rockville, MD 20850. Send two self-addressed adhesive labels to assist that office in processing your request, or fax your request to 301–443–8818.

To receive the directions via fax machine on receiving the proposed guidance document, call CDRH Facts-on-Demand system at 800–399–0381, or 301–827–0111 from a touch-tone telephone. At the first voice prompt, press 1 to access the Division of Small Manufacturers Assistance (DSMA) Fax, at the second voice prompt, press 2, and then enter the document number 852

followed by the pound sign (#). Then follow the remaining voice prompts to complete your request.

IX. Analysis of Impacts

FDA has examined the impacts of the proposed rule under Executive Order 12866, under the Regulatory Flexibility Act (5 U.S.C. 601–612), and under the Unfunded Mandates Reform Act (Public Law 104–4). Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety, and other advantages; distributive impacts; and equity). Unless the agency certifies that the rule is not expected to have a significant economic impact on a substantial number of small entities, the Regulatory Flexibility Act requires agencies to analyze regulatory options that would minimize any significant economic impact of a rule on small entities. Section 202 of the Unfunded Mandates Reform Act requires that agencies prepare an assessment of anticipated costs and benefits before proposing any rule that may result in an expenditure by State, local, and tribal governments, in the aggregate, or by the private sector, of $100 million in any one year (adjusted annually for inflation).

The agency believes that this proposed rule is consistent with the principles set out in the Executive Order and in these two statutes. The rule is an economically significant regulatory action as defined by the Executive Order. With respect to the Regulatory Flexibility Act, FDA does not believe that this proposal will have a significant effect on a substantial number of small entities, but recognizes the uncertainty of its estimates. Therefore, the agency has prepared an IRFA. FDA is not required to conduct a cost-benefit analysis according to the Unfunded Mandates Reform Act, because the rule will not impose any mandates on State, local, or tribal governments, or the private sector, that will result in an annual expenditure of $100 million or more.

Furthermore, in accordance with the Small Business Regulatory Enforcement Fairness Act of 1995 (Public Law 104–121), it has been determined that this proposed rule would be a major rule for the purpose of congressional review.

A. Objectives of the Proposed Regulations

The objectives of this proposed regulation are to reduce the adverse health effects from allergic and foreign body reactions caused by the NL protein allergens and glove powder found on surgeon's and patient examination gloves, and from defects in the barrier integrity and quality of surgeon's and patient examination gloves. The rule will accomplish these objectives by encouraging manufacturers to limit both the level of water-extractable protein allowed on gloves and the level of powder packaged with the gloves, and by requiring the inclusion of caution statements and the actual level of protein and powder in the labeling of the gloves. In addition, labeling will include expiration dates to ensure that the gloves provide adequate barrier protection and that all medical gloves meet quality standards specified in the special control guidance referenced elsewhere in this preamble. FDA believes that by reducing the amount of powder dispersed, these special controls will reduce the incidence and severity of the allergic reactions caused by NL proteins without compromising the barrier performance of these products.

B. Risks of NL Protein Allergic Reactions

FDA recognizes that no systemic epidemiological data exist to identify the risk of airborne NL protein allergens. However, several sources indicate that a proportion of the U.S. population have developed NL sensitivity (Refs. 1 to 8) due to increased exposure to NL proteins. The increased use of NL gloves with unlimited powder and protein levels in recent years is believed to contribute to these adverse events.

FDA's Adverse Experience Reporting System received a total of 330 NL allergy Medical Device Reports (MDR's) associated with medical gloves for the 12-month period of August 15, 1996, through August 15, 1997 (Ref. 9). These reports included reactions of 435 affected persons. Despite the lack of representative sampling and the unconfirmed nature of these reports, FDA believes these data may provide a reasonable measure of the magnitude of existing risk. Table 1 classifies these reports by type and severity of reaction and shows the results by number of affected patients.

TABLE 1.—NUMBER OF PATIENTS REPORTING TO FDA NATURAL RUBBER LATEX ALLERGIES REACTIONS ASSOCIATED WITH MEDICAL GLOVES BETWEEN AUGUST 15, 1996, AND AUGUST 15, 1997

	Type of Allergic Reaction[1]			
	Local Topical	Systemic Topical (i.e., rash not in area with direct contact)	Systemic Respiratory (e.g., wheezing, shortness of breath)	Respiratory Requiring Aggressive Treatment (e.g., anaphylaxis, hospitalization)
Number of Patients Reporting Reaction	20	21	294	100

[1]Includes 40 patients with unclassified reactions that were distributed by proportion of reported reactions.

FDA has long been aware that MDR's received by the agency may account for as little as one percent of the actual events (Ref. 37). If true, the reports received for allergic reactions associated with medical gloves could represent as many as 43,500 allergic incidents during the 12-month period. Because patients may often fail to connect an allergic incident to use of gloves, FDA believes that this estimate better reflects the true number of incidents associated with medical gloves. Given that approximately 22.0 billion gloves (Ref. 38) were used and 2.16 billion patient visits occurred during that period (Ref. 39), the projected baseline rate of annual allergic reaction incidents to the total population (0.0001626) at current protein/powder levels does not seem unreasonable.

Despite the widespread under-reporting cited in the General Accounting Office (GAO) report, FDA believes that those allergic reactions that require the most aggressive treatment would be subject to less under-reporting. For this analysis, FDA has assumed that MDR's for patients with severe allergic reactions are under-reported by 33 percent, and the other three categories are proportionally

increased to account for the total under-reporting (Table 2). Specifically, FDA believes that the 100 reported incidents of respiratory allergic reactions requiring aggressive treatment (from Table 1) represent only 150 actual such incidents; not 1,000 as would be indicated by MDR underreporting. The difference of 850 expected incidents were distributed to the remaining three categories to result in 43,500 total incidents. Table 2 also shows the proportion of each category of reactions reporting long-term and short-term effects, based on reported lost work-time due to recovery. As expected, only 6 percent of all topical local reactions were considered long-term, while almost half of the serious systemic reports were long-term. As discussed in the benefits section (section IX.F of this document), FDA has assumed, based on discussions with clinicians, that short-term impacts have a duration of 1 day and long-term impacts a duration of 2 months.

Table 2 also presents FDA's estimated annual number of each type of allergic reaction. Although no mortalities were reported in the MDR's for this period, anaphylaxis carries a risk of mortality that FDA statisticians place at up to 2 percent, even in health care settings. Because not all reported serious systemic respiratory reactions were anaphylaxis, FDA assigned a probability of 0.002 to the adjusted reports to account for potential fatalities due to anaphylactic shock caused by NL allergens. (This assumes that only 10 percent of all respiratory reactions that require aggressive treatment were due to anaphylaxis.) Given the estimated under-reporting rate, this implies an annual risk of 0.3 mortalities. FDA expects that by encouraging lower protein and powder levels for medical gloves, the proportion of allergic reactions to NL protein allergens will be reduced.

TABLE 2.—ESTIMATED NUMBER OF PATIENTS EXPERIENCING NATURAL RUBBER LATEX ALLERGIC REACTION ASSOCIATED WITH MEDICAL GLOVES FROM AUGUST 15, 1996, TO AUGUST 15, 1997, AND PROPORTION EXPERIENCING SHORT- AND LONG-TERM EFFECTS

	Type of Allergic Reaction				
	Local Topical	Systemic Topical	Systemic Respiratory	Respiratory Requiring Aggressive Treatment	
				Other Reactions	Mortality
Estimated Number of Patients Experiencing Reaction	2,588	2,717	38,045	149.7	0.3
Proportion Exhibiting Short-Term Effects (duration of 1 day)	94%	74%	73%	51%	NA
Proportion Exhibiting Long-Term Effects (duration of 2 months)	6%	26%	27%	49%	NA

C. Costs of the Proposed Regulation

This section develops estimates of the costs of compliance with the proposed rule by comparing the expected costs of using surgeon's and patient examination gloves after the rule is in effect to the costs that would have been incurred in the absence of the rule. Regulatory costs occur in four categories. First, the proposed regulation is expected to accelerate the trend of the glove market towards more costly, powder-free products. Second, higher average glove purchase prices will result from the increased cost of gloves with recommended levels of powder and NL proteins compared to the cost of gloves with unregulated levels of powder and NL proteins. Third manufacturers will be required to conduct shelf-life testing on gloves in order to support expiration dates. Fourth, increased labeling costs will result from the addition of protein and powder levels and/or expiration dating to each package of surgeon's and patient examination gloves. Because many of the estimates are derived from uncertain projections based on limited data, sensitivity analyses are presented for the most critical variables and assumptions.

D. Baseline Conditions

1. Annual Number of Gloves

To measure the incremental costs of the regulation against a baseline of nonregulation, FDA first projected future glove sales. An estimated 22.0 billion surgeon's and patient examination gloves were used in the United States in 1997, more than an 11-fold increase from the approximately 2.0 billion gloves used in 1987 (Ref. 38). The major contributors to this growth were the recognition of the potential risk from AIDS infection and the publication of Occupational Safety and Health Administration (OSHA) regulations requiring barrier protection for patients and employees exposed to blood borne pathogens (Ref. 40).

FDA assumed that the demand for surgeon's and patient examination gloves will continue to grow as a result of expected increases in employment within the health services industry (Standard Industrial Classification (SIC) 80). The Bureau of Labor Statistics has suggested that employment within this industry may continue to grow at an annual rate of 3.9 percent (Ref. 41). Assuming that annual glove use per employee remains at current levels of approximately 10 pairs per day, the agency projected that the annual demand for gloves will increase over the next 10 years at an approximate rate of 3.9 percent per year (see Table 3). As expected growth in employment or patient health service visits may also predict future glove use. FDA tested this assumption by forecasting alternative rates of growth in the sensitivity analyses presented in section IX.G of this document.

About 65 percent of the current glove market consists of powdered gloves (Ref. 38), but both health service facilities and glove manufacturers agree that the market share of powdered gloves is decreasing rapidly as facilities gain awareness of the potential adverse health effects associated with NL protein allergens. Manufacturers, however, explain that powdered gloves will not soon disappear, because new chlorinators and production lines associated with powder-free glove production take at least 18 months to

install and because powdered gloves are still desired by a proportion of customers. However, manufacturers have estimated that even in the absence of this regulation, the market share of powder-free gloves could reach as high as 60 percent within 18 months (Ref. 38). For this analysis, FDA assumed that, even in the absence of regulation, the market share for powdered gloves would decrease from the current 65 percent down to 20 percent within 4 years. Concurrently, the market share for powder-free gloves would increase from 35 percent up to 80 percent over the same period (see Table 3).

Next, FDA estimated that gloves manufactured with synthetic materials (referred to as synthetic gloves), which are available in both powdered and powder-free varieties, account for approximately 10 percent of the current market. Most synthetic gloves are manufactured of vinyl, but other polymers are also used. Synthetic gloves are generally believed to provide less acceptable barrier protection after extended use and reduced tactile sensitivity compared to NL. FDA assumed that, in the absence of regulation, this market share would increase slightly each year, accounting for 20 percent of the market within 5 years. Table 3 includes the projected market shares for each glove type.

Because these projections contain considerable uncertainty, FDA analyzed several alternative assumptions in the sensitivity analysis section presented in section IX.G of this document. These scenarios assume that, in the absence of this rule, the anticipated baseline market adjustments would take either 10 years, or would not occur at all.

TABLE 3.—SURGEON'S AND PATIENT EXAMINATION GLOVE MARKET SHARES—BASELINE ESTIMATE

Year	All Surgeon's and Patient Examination Gloves	Synthetic Gloves			Natural Rubber Latex Gloves		
	Number of Gloves (billion)	Number for Powder-Free (billion)	Number of Powdered (billion)	Total (billion)	Number of Powder-Free (billion)	Number of Powdered (billion)	Total (billion)
Current	22.00	0.77	1.43	2.20	6.93	12.87	19.80
1	22.86	1.37	1.37	2.74	10.06	10.06	20.12
2	23.75	1.99	1.33	3.32	12.25	8.17	20.42
3	24.68	2.76	1.18	3.95	14.51	6.22	20.73
4	25.64	3.69	0.92	4.61	16.82	4.20	21.02
5	26.64	4.26	1.07	5.33	17.05	4.26	21.31
6	27.68	4.43	1.11	5.54	17.71	4.43	22.14
7	28.76	4.60	1.15	5.75	18.40	4.60	23.00
8	29.88	4.78	1.20	5.98	19.12	4.78	23.90
9	31.04	4.97	1.24	6.21	19.87	4.97	24.83
10	32.25	5.16	1.29	6.45	20.64	5.16	25.80

2. Baseline Glove Cost

There are an estimated 198 current marketers of surgeon's and patient examination gloves in the United States, 10 of which are domestic manufacturers. Approximately 95 percent of all gloves purchased in the United States are imported. Although individual marketers of surgeon's and patient examination gloves operate in a highly competitive industry and face highly elastic demand curves, the aggregate market demand for the gloves is assumed to be price inelastic, because of workplace regulations that require gloves as barrier protection (Ref. 42). Demand is inelastic if the percentage increase in price exceeds the percentage decrease in quantity sold. Consequently, most glove manufacturing cost increases would be passed on to health care facilities in the form of industry wide price increases. Although over 95 percent of the manufacturing facilities are located overseas and the world wide demand for gloves is high, the United States market dominates global sales. According to Malaysian manufacturers (Ref. 38), about 80 percent of their gloves are for U.S. customers.

Current prices of powdered NL gloves average $3.90 per 100, while powder-free NL gloves average $5.80 per 100 (Ref. 38). Prices were reported as averages of both surgeon's and patient examination gloves. The price difference of $1.90 per 100, or almost $.02 per pair, is attributable to a number of factors, but the predominant reason is the increased cost of removing former-release powder and/or applying other lubricants to produce powder-free gloves. The estimated cost for synthetic gloves is $4.15 per 100 for powdered and $5.03 per 100 for powder-free. Vinyl gloves account for 90 percent of the synthetic glove market, with the remaining gloves manufactured from polymers and other materials.

The nation's annual expenditures for surgeon's and patient examination gloves are currently estimated at over $1.0 billion. Even in the absence of regulation, FDA expects that these outlays would increase to $1.1 billion within 1 year and $1.7 billion within 10 years.

E. Estimation of Compliance Costs

The net costs of compliance with the proposed regulation is the difference between glove-related costs with and without the regulation. As noted earlier, industry comments suggest that even in the absence of this regulation, the market share of powder-free gloves is expected to increase from 35 percent to about 80 percent over a 4-year period. With regulation, this trend will be accelerated. Although the market effects of the rule cannot be known with certainty, FDA estimates that powder-free gloves will achieve the 80 percent market share 2 years earlier, or within 2 years of the rule's implementation. In addition, manufacturers would experience increased costs due to the recommendation to limit the level of protein to 1,200 g per glove and the level of powder on NL and synthetic powdered gloves to 120 mg per glove. These costs would be passed through to health care facilities in the form of higher prices. Finally, each package of NL gloves must include labeling that includes protein and powder levels and expiration dating, and shelf-life testing must support this labeling.

1. Accelerated Market Share for Powder-Free and Synthetic Gloves

Figure 1 illustrates FDA's forecast that powder-free gloves would gain 80 percent of the surgeon's and patient examination glove market share within 4 years without regulation and within 2 years with regulation. Manufacturers have indicated (Ref. 38) that if U.S. facilities are willing to bear the market price for powder-free gloves, the powder-free supply to other parts of the world could be shifted to meet U.S. demand and powder-free market shares could reach as high as 60 percent within 18 months. FDA forecasts that the proposed regulations will accelerate this trend by reinforcing incentives for facilities to use powder-free gloves. The shaded area of the chart measures the expected substitution of powder-free for powdered gloves caused by facilities choosing to increase use of powder-free gloves in response to regulatory controls. In addition, FDA projects that the synthetic market share will rise from 10 to 20 percent within 5 years without regulation, but within 2 years with regulation. The expected market shares with the proposed regulation in place are shown in Table 4.

FDA also examined the potential of this regulation to result in domestic shortages of latex gloves and concluded that there would be minimal disruption to the U.S. market, as it constitutes such a major proportion of global sales (up to 80 percent (Ref. 38)). If other countries do not restrict glove powder, it is possible that the number of powder-free gloves sold in those markets would fall in the short-term, while producers adjusted to the demand shift. FDA solicits public comment on how manufacturers would respond to these altered market forces.

TABLE 4.—SURGEON'S AND PATIENT EXAMINATION GLOVE MARKET SHARES WITH REGULATION

Year	Surgeon's and Patient Examination Gloves	Synthetic Gloves			Natural Rubber Latex Gloves		
	Total Number (billion)	Number of Powder-Free (billion)	Number of Powdered (billion)	Total (billion)	Number of Powder-Free (billion)	Number of Powdered (billion)	Total (billion)
Current	22.00	0.77	1.43	2.20	6.93	12.87	19.80
1	22.86	1.37	1.37	2.74	10.06	10.06	20.12
2	23.75	2.47	1.33	3.80	12.97	6.98	19.95
3	24.68	3.95	0.99	4.94	15.79	3.95	19.74
4	25.64	4.10	1.03	5.13	16.41	4.10	20.51
5	26.64	4.26	1.07	5.33	17.05	4.26	21.31
6	27.68	4.43	1.11	5.54	17.71	4.43	22.14
7	28.76	4.60	1.15	5.75	18.40	4.60	23.00
8	29.88	4.78	1.20	5.98	19.12	4.78	23.90
9	31.04	4.97	1.24	6.21	19.87	4.97	24.83
10	32.25	5.16	1.29	6.45	20.64	5.16	25.80

Because the regulation would not be implemented until 2 years after publication of the final rule (as shown in Figure 1), no costs would be incurred in the first year. Moreover, there would be no market share-associated costs expected after the fourth year, because, by that time, there would be no difference in the respective market shares of powdered and powder-free gloves. Based on these assumptions, the accelerated increase in the powder-free market share results in increased regulatory costs of $18.9 million in the second year and $37.3 million in the third year. In the fourth year following implementation of the rule, costs would fall by $2.9 million due to the increased use of lower cost synthetic gloves. As shown in Table 5, the average annualized costs (at a 7 percent discount rate over a 10-year period) attributable to the accelerated market share for powder-free gloves are calculated at $6.4 million.

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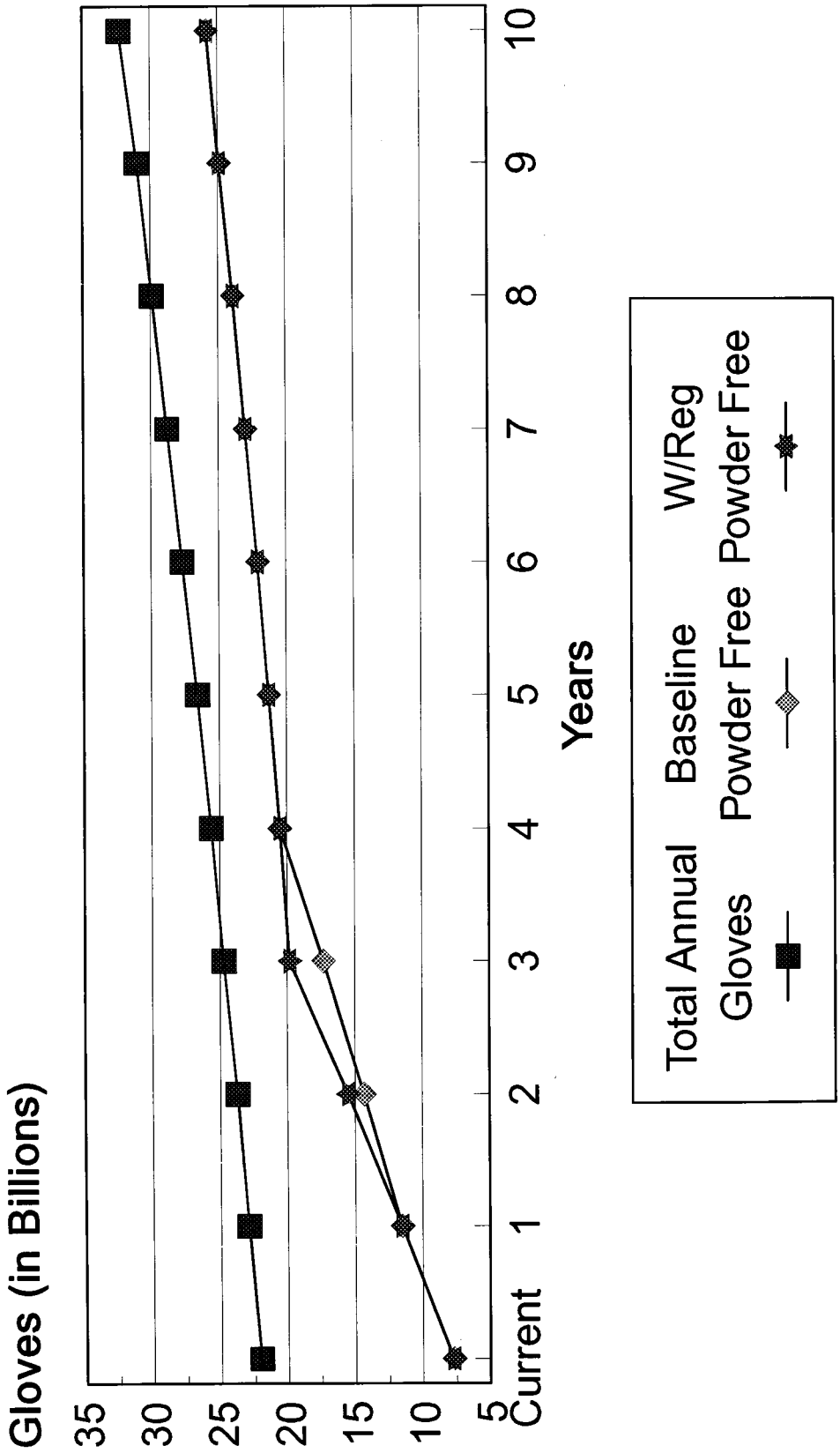
Figure 1
Annual Glove Sales



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2. Increased Costs for Powdered Gloves

Limiting the amount of protein and powder permitted on gloves would increase the production cost and therefore raise the purchase price of gloves to health care facilities. Although the limits are only recommended, both the actual and recommended levels of protein and powder must be included on the product label. Thus, FDA believes it likely that most glove manufacturers will meet the recommended levels. According to tests conducted by FDA, current powder levels on powdered gloves vary between 50 mg and 426 mg per glove. For this analysis, FDA assumed that a typical powdered NL or synthetic glove contains 260 mg of powder (based on the observed distribution). Current glove protein levels vary widely.

Several manufacturers indicated that even minimal recommendations on powder and protein would result in cost increases of as much as five percent. These increases would be due to the increased testing and validation required to ensure that gloves did not exceed limits, the slower production times resulting from more controlled processes, the increased inventory damage when stripping gloves from molds, the increased controls for slurry mixtures, the increased time spent cleaning or replacing filters and other equipment, and the other costs associated with more careful controls for the entire manufacturing process. Manufacturers stated that limiting powder is more a question of adding controls in the production process than adding new production lines or facilities. Equipment such as slurries and tumblers are currently in place, and controls are likely to consist of simply weighing finished gloves or weighing the slurry filters. However, these costs are expected to result in increased contract prices for U.S. health facilities, because there are no substitute products for medical gloves.

To calculate the costs of alternative permissible powder limits, FDA estimated an average cost function where the cost of reducing each mg of powder increases as the proportion of powder remaining on the manufactured glove decreases. Because current powdered NL gloves cost $3.90 per 100 and powder-free gloves cost $5.80 per 100, FDA calculated that the $1.90 cost of removing the average 260 mg of powder per 100 gloves is about $0.0073 per mg ($1.90/260 mg). If the cost function were linear, the incremental cost of reducing powder levels by 140 mg (i.e., from the current average 260 mg of powder to the recommended level of 120 mg) would be calculated as $0.0073 times 140, or $1.022 per 100 gloves. However, FDA believes that the relationship is unlikely to be linear as several manufacturers indicated that significant control costs would be needed to achieve even modest reductions in powder levels, after which average costs would rise slowly and then more steeply as powder concentrations approach zero. Such a functional form is typical of many manufacturing processes and illustrated by the solid sigmoid curve shown in Figure 2 (Refs. 44 and 45). A cost equation fitting this illustrated functional form is:

$$Y = 0.00365 + 0.0292(X - 0.5)^3$$

Where:

Y equals the cost per mg removed per 100 gloves, and

X equals the proportion of powder removed.

Figure 2 includes the estimated cost function for removing powder from synthetic gloves as the hashed line. The expected costs per mg removed are less than for NL gloves because the current price difference between powder-free and powdered synthetic gloves ($0.88 per 100) is less than the difference for NL gloves ($1.90 per 100).

On the assumption that these equations approximate the actual relationships, FDA estimates that the cost of limiting powder to 120 mg per 100 NL gloves is about $0.003652 per mg removed, or about $0.511 per 100 NL gloves. For synthetic gloves, the estimated costs are $0.001693 per mg removed, or about $0.237 per 100 synthetic gloves. As shown in Figure 3, the control costs rise sharply for limits below 120 mg. For example, a proposed powder limit of 100 mg per NL and synthetic glove would result in costs over 15 percent greater than the proposed 120 mg limit. Because of the control processes required, FDA assumes that the previous estimates would also account for the cost of limiting protein levels for NL gloves.

Table 5 shows these estimated costs over a 10-year period. Because the regulation is expected to be implemented 2 years after publication of the final rule, no increased powdered glove costs are incurred in the first year. In year 2, the higher prices for powdered NL gloves result in increased costs of $35.7 million. In year 3, these costs fall to $20.2 million. Thereafter, the yearly incremental compliance costs associated with NL glove powder and protein limits vary between $21.0 and $26.4 million. The average annualized contribution of this cost category (at a 7 percent discount rate over 10 years) equals $21.4 million.

Within 2 years, higher costs for powdered synthetic gloves will equal $3.1 million. The yearly incremental compliance cost for powdered synthetic gloves is expected to decrease to $2.3 million in year 3, and then increase slightly each year throughout the evaluation period. The average annualized contribution of this cost category (at a 7 percent discount rate over 10 years) equals $2.4 million.

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Figure 2. Cost per mg of Powder Removed from 100 Gloves by Proportion of Powder Removed

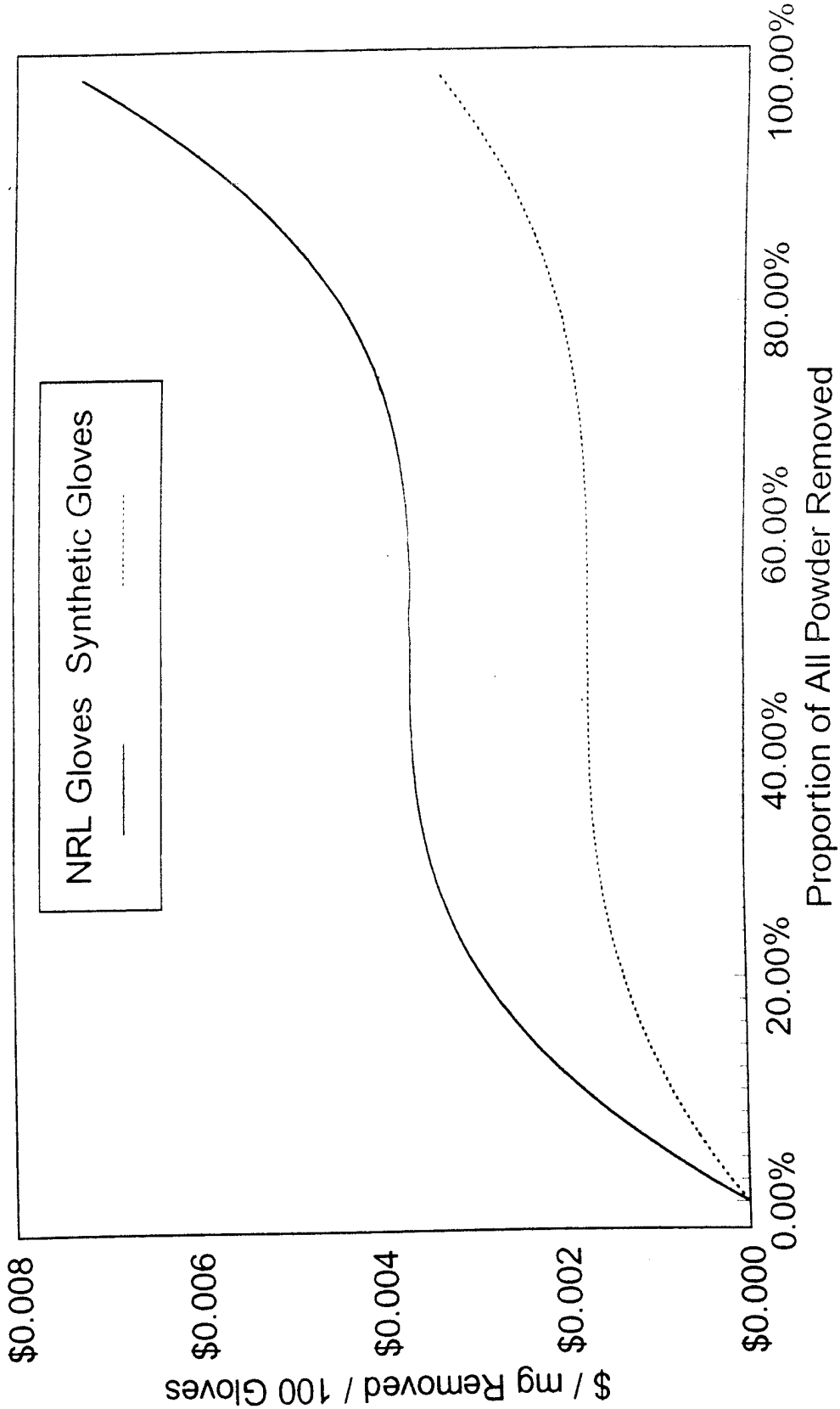

Figure 3. Increased Cost per 100 Gloves by Powder Level

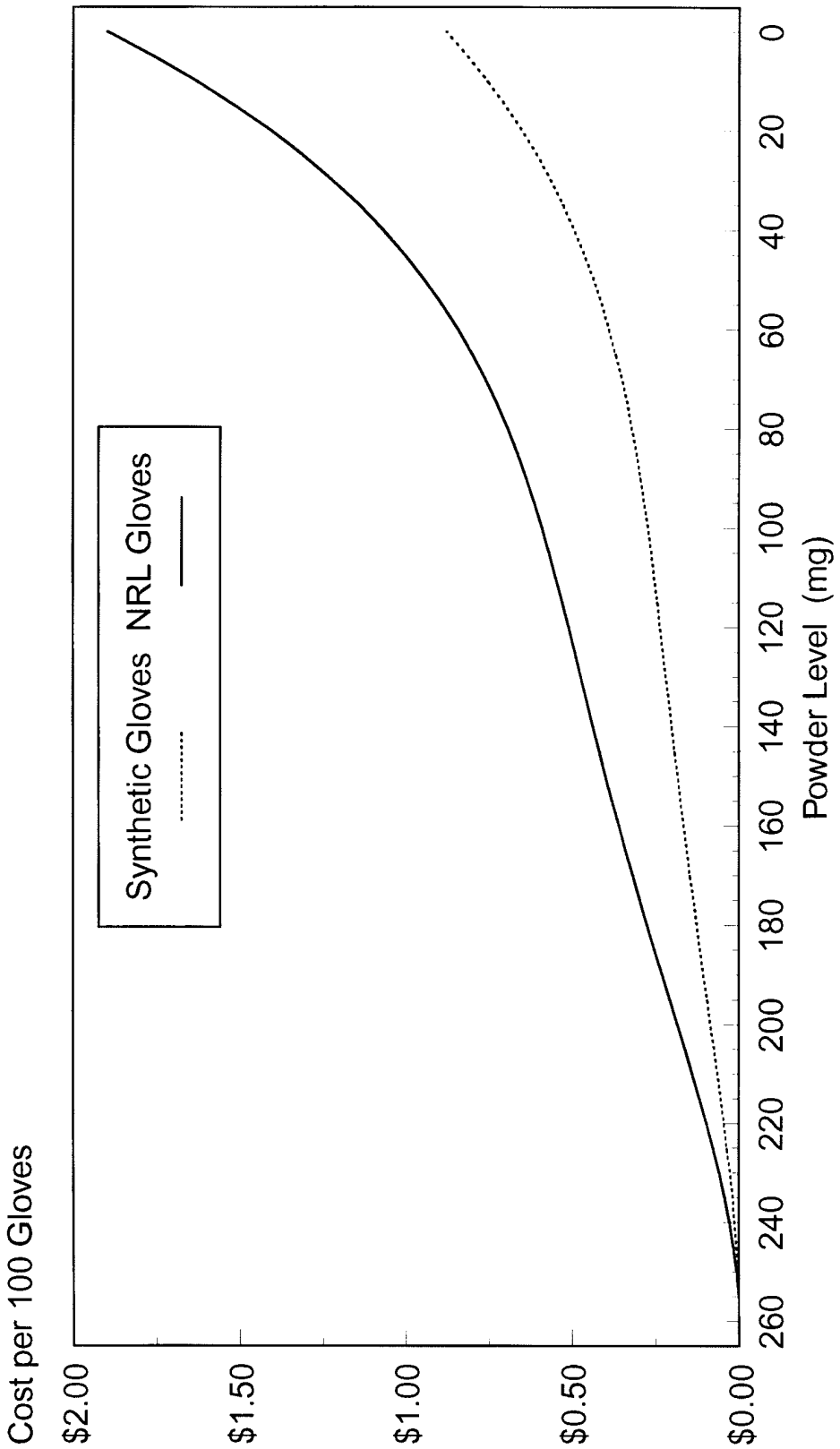

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TABLE 5.—COMPLIANCE COSTS OVER 10–YEAR PERIOD

Year	Cost of Accelerated Market Share ($ million)	Increased Powdered NRL Gloves ($ million)	Cost of Synthetic Gloves ($ million)	Cost of Shelf-Life Testing		Labeling Cost ($ million)	Total Cost ($ million)
				Test Cost ($ million)	Lost Inventory ($ million)		
1	0.0	0.0	0.0	0.0	0.0	0.0	0.0
2	18.9	35.7	3.1	1.6	3.0	1.6	63.9
3	37.3	20.2	2.3	1.2	1.3	0.6	62.9
4	2.9	21.0	2.4	1.2	1.1	0.5	23.3
5	0.0	21.8	2.5	1.3	1.4	0.7	27.7
6	0.0	22.6	2.6	1.3	1.2	0.5	28.2
7	0.0	23.5	2.7	1.5	1.1	0.6	29.4
8	0.0	24.4	2.8	1.5	1.6	0.8	31.1
9	0.0	25.5	2.9	1.4	1.3	0.6	31.7
10	0.0	26.4	43.1	1.5	1.3	0.6	32.9
Total	53.3	221.0	24.6	12.5	13.3	6.5	331.2
Average Annualized (7 percent discount rate)	6.4	21.4	2.4	1.2	1.3	0.7	33.4

3. Costs of Shelf-life Testing and Inventory Loss

The proposed regulation will require manufacturers of patient examination and surgical gloves to develop and affix labeling to their products that will include expiration dating. To ensure that medical gloves will maintain adequate barrier protection for the entire stated period, manufacturers will likely conduct real-time shelf-life testing of gloves. The compliance costs of this testing includes both the actual cost of conducting laboratory tests, and the lost revenues of inventory lost due to sampling.

a. *Shelf-life testing.* FDA contracted with the Eastern Research Group (ERG), an economic consulting firm, to contact domestic and foreign glove manufacturers and research laboratories to determine the expected unit costs of shelf-life testing, and to determine current levels of industry compliance. ERG developed a cost model that estimated compliance costs according to the size of the manufacturer (Ref. 45a).

ERG estimated that the expected marketing life for each glove model is approximately 3 years. During this period, stability testing is likely to occur at 6-month, 1-year, 2-year, and 3-year intervals. The actual tests were assumed to consist of a combination of real-time and accelerated tests. Overall, the estimated costs of a shelf-life test was found to approximate $265 for foreign tests and $865 for domestic tests. (The difference in testing costs are attributable to the lower purchasing power parity per capita in foreign countries that produce medical gloves.)

As explained in Ref. 45a, almost 3,000 separate glove models are currently produced by 198 separate manufacturers. Only 160 models are marketed by the 10 domestic manufacturers. Given the expected growth in the demand for gloves, and the shift to powder-free and synthetic glove models, the estimated costs of shelf-life testing varies with FDA's projected number of future glove models. It was assumed that new models would have two shelf-life tests during the year of introduction while models already marketed would have one annual shelf-life test. Finally, ERG and industry sources estimated the current level of shelf-life testing based on both domestic/foreign and size characteristics.

Based on these assumptions, the greatest increase in shelf-life testing is expected during year 2, with over 6,000 additional tests due to this proposed regulation. The total cost of conducting these tests equals $1.6 million, of which $0.1 million is incurred by domestic glove manufacturers. Amortizing the annual testing costs by 7 percent over 10 years, the average annualized costs of conducting the required shelf-life tests equals $1.2 million.

b. *Inventory losses.* As part of these tests, manufacturers will be required to set inventory aside from which test samples will be selected. ERG, with discussions with laboratories and manufacturers, has determined that small glove manufacturers would be likely to set 10,000 gloves per model aside for shelf-life testing while large manufacturers would set 30,000 gloves per model. Given the industry characteristics as discussed in Ref. 45a, this implies that over 115 million gloves would be set aside in year 2. In addition, the relative market shares of synthetic, NL, powdered and powder-free gloves is expected to change over time which will affect the average lost revenue per sample. FDA analyzed the impact of this future inventory loss and found that during year 2 of the evaluation period, the value of lost inventory for testing is expected to equal over $3.0 million for the entire industry. The average annualized cost of this lost inventory (as shown in Table 5) at 7 percent over 10 years equals $1.3 million.

4. *Costs of Labeling.* ERG also developed estimates of the costs of developing the proposed enhanced labeling for gloves. These estimates included the costs of artwork, design, regulatory review, production and application, as shown in Ref. 45a. Overall, the average cost of developing a label for a foreign medical glove model was estimated to equal $411, while a domestic model would cost $1,444. The number of domestic and foreign glove models expected to be introduced throughout the 10-year evaluation period and the market characteristics as discussed in Ref. 45a, indicate that the costs of labeling will equal $1.4 million in year 2. These yearly costs will then decrease to as low as $0.3 million by the 10th year. The average annualized cost of developing and producing labeling for medical gloves attributable to this proposed regulation is estimated to equal $0.7 million, as shown in Table 5.

5. Total Incremental Costs

Figure 4 presents the estimated annual expenditures imposed by the proposed rule. Overall, costs of $63.9 million are expected in year 2. These costs decreased to $62.9 million in year 3, and then decrease to $23.3 million in the third year. Costs are expected to

increase slightly for each subsequent year. Most of the incremental costs, as shown in Table 5, are due to increases in glove costs (powdered NL and synthetic gloves with limited powder levels). The estimated average annualized cost over a 10-year period (at a 7 percent discount rate) is $33.4 million.

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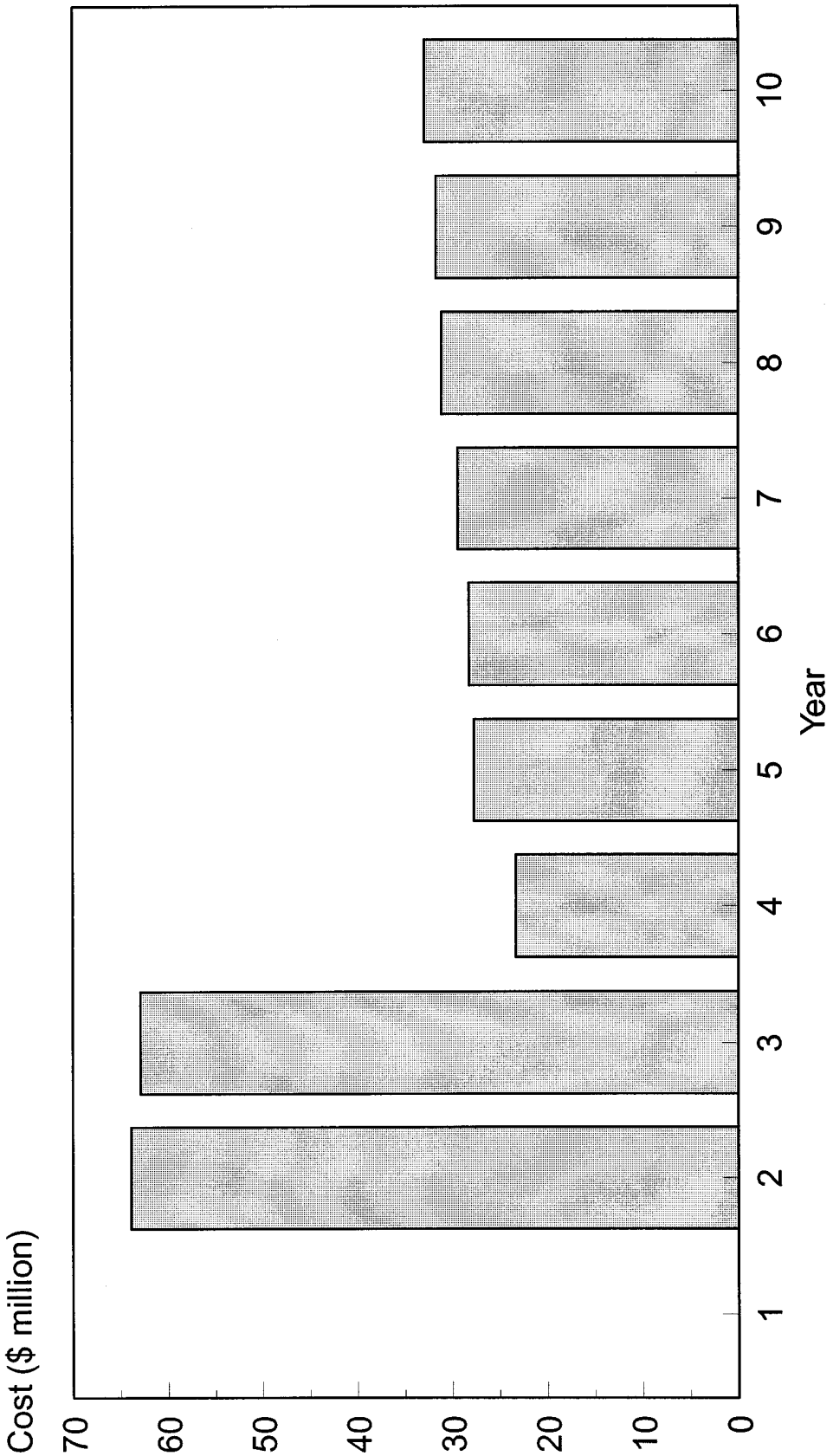
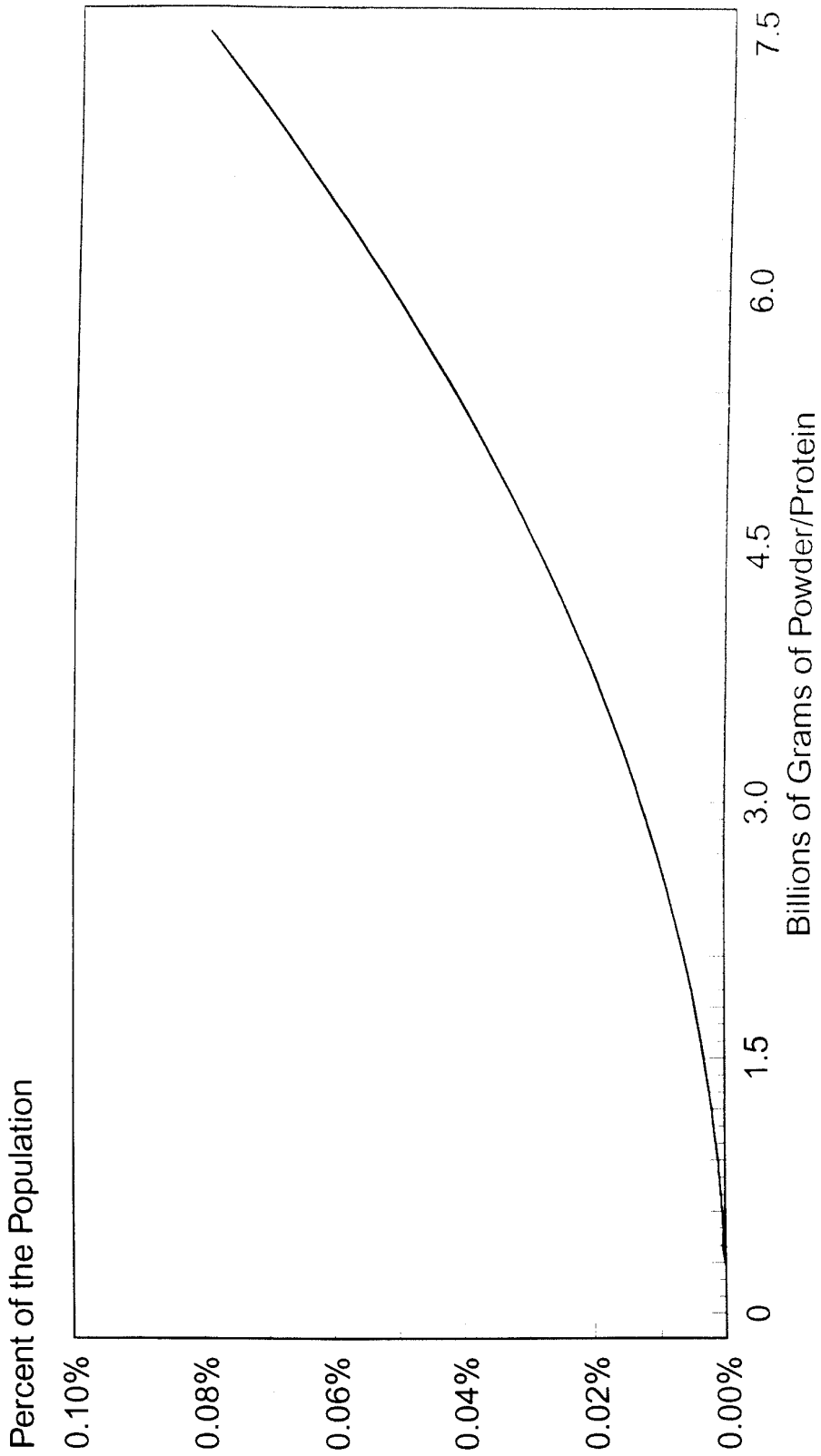


Figure 4. Total Annual Compliance Costs

Figure 5

Percent of the Population Experiencing Allergic Reaction to Natural Latex Proteins in Relation to the Level of Powder



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F. Benefits of the Proposed Regulations

1. Expected Risk Reduction

As discussed previously, the estimated annual proportion of the population (0.0001626) that experiences allergic reactions associated with medical gloves is assumed to be related to the prevalence of environmental protein and powder. Consequently, reducing protein and powder levels would reduce the proportion of the population expected to experience an allergic reaction. Decreases would be expected in NL sensitization as well as allergic reactions.

To estimate this relationship, FDA assumed that the proportion of the population affected would vary directly with the total quantity of environmental protein/powder. The annual level of environmental protein/powder was calculated from the expected annual number of powdered NL gloves multiplied by the average level of powder per glove. The current market share of powdered NL gloves (Table 3) and the current average level of glove powder (260 mg) yield an aggregate estimate of 3.346 billion g of protein/powder. This quantity of protein/powder is associated with allergic reactions in 0.0001626 of the population, or 0.000049 reactions per billion g. If the relationship between the number of reactions and the quantity of protein/powder were linear, the model implies a 30 percent reduction in allergic prevalence for each billion g of powder reduction. Alternatively, the function relationship may take other forms, and FDA suspects that the increasing number of reports of allergic reactions to NL in recent years likely indicates a nonlinear relationship. Figure 5 presents a polynomial projection that FDA tentatively adopts as a plausible estimate for this analysis. The equation of the function illustrated in Figure 5 is:

$$Y = (0.0000143)X^2$$

Where:

Y equals the proportion of the population with NL allergic reactions, and

X equals the level of environmental protein/powder (in billions of g).

Although the exact relationship is speculative, FDA believes that an exponential relationship as shown in Figure 5 is most likely. As shown in section IX.G of this document, the agency's sensitivity analysis indicates that due to the rising baseline projection, this polynomial projection yields smaller benefits than a linear model.

Table 6 shows the expected number of allergic reactions associated with protein/powder levels with and without the proposed regulation. The protein/powder amounts are derived from the expected numbers of powdered NL gloves shown in Tables 3 and 4, the current average glove powder level (260 mg per glove), and the new recommended glove powder level (120 mg per glove). Powdered synthetic gloves do not affect this relationship because no NL proteins are associated with those products. Table 6 shows that in the absence of the proposed regulation, the expected increased market share of powder-free gloves would reduce the number of annual allergic reactions attributable to medical gloves from 43,500 to only 4,800 within 4 years. With the proposed regulation in place, the expected number of allergic reactions would decrease to only 900 within 3 years, and consistently remain several thousand fewer than those expected without regulations.

2. Benefits

To estimate the potential benefits of the proposed rule, the number of reduced expected allergic reactions shown in Table 6 were distributed in proportion to the categories shown in Table 2. Assuming that the decreased number of reactions would not modify the severity distribution as reported in the MDR's (as adjusted to account for under-reporting), the proposed regulation would reduce annual allergic reactions by 15,100 within 2 years. The characteristics of these second year avoided reactions are shown in the first four columns of Table 7.

TABLE 6.—EXPECTED NUMBER OF ALLERGIC REACTIONS

Year	In the Absence of Regulation[1]			With Regulation[2]			Difference in Allergic Reactions with Regulation (000)
	Number of Powdered Natural Rubber Latex Gloves (billion)	Level of Powder (billion g)	Estimated Number of Allergic Reactions (000)	Number of Powdered Natural Rubber Latex Gloves (billion)	Level of Powder (billion g)	Estimated Number of Allergic Reactions (000)	
Current	12.87	3.35	43.5	- NA -	- NA -	- NA -	- NA -
1	10.06	2.62	26.9	10.06	2.62	26.9	0.0
2	8.17	2.13	17.9	6.98	0.84	2.8	(15.1)
3	6.22	1.62	10.4	3.95	0.47	0.9	(9.5)
4	4.20	1.09	4.8	4.10	0.49	1.0	(3.8)
5	4.26	1.11	5.0	4.26	0.51	1.1	(3.9)
6	4.43	1.15	5.4	4.43	0.53	1.2	(4.3)
7	4.60	1.20	5.9	4.60	0.55	1.3	(4.7)
8	4.78	1.24	6.4	4.78	0.57	1.4	(5.1)
9	4.97	1.29	7.0	4.97	0.60	1.5	(5.5)
10	5.16	1.34	7.6	5.16	0.62	1.6	(6.0)

[1] Powder level of 0.260 g per glove
[2] Powder level of 0.120 g per glove

There is no methodology that permits a precise assignment of monetary values to regulatory health benefits. However, one approach recently described in the health economics literature (Refs. 47 and 48) combines relative states of well-being with observed willingness to pay for risk avoidance. FDA adopted this methodology and used the Kaplan-Bush Indices of Well-Being (Refs. 49 and 50) to estimate the value of reducing the number of allergic reactions.

The first step was to assign to each category of reaction a functional index based on mobility/physical/sociability scales. The index of relative well-being (as described in Refs. 49 and 50) utilize functionality levels as a basis for estimating well-being. The functionality scales are described in Table 8. Baseline levels of well-being were defined for 43 distinct combinations of mobility, physical activity, and sociability. For example, if a hypothetical patient could drive a car and use transportation without help (mobility equals 5), could walk without a physical problem (physical activity equals 4), and had no morbidity symptoms or problem, then this patient would have an assigned well-being of 1.0000. However, if this hypothetical patient could perform all of these activities, but suffered from any morbidity (including requiring eyeglasses), the assigned baseline level of well-being was found to equal 0.7433. The baseline levels of well-being are then adjusted, either up or down, based on the predominant symptom or problem that is on-going. This methodology is described in detail in Refs. 49 and 50. For example, a local topical reaction is unlikely to interfere with normal activities, such as driving a car or performing housework. A patient suffering from a local topical reaction is expected to continue to be able to interact with others in a normal manner. This functional state is assigned a relative well-being rate of 0.7433, or roughly 74 percent of optimum well-being. This baseline functional index is based on the prevailing medical problem. In this case, the problem/symptom is identified as ''burning and/or itching of skin'' and the 0.0171 value for this problem/symptom (from Refs. 49 and 50) is added to the basic functional state. Thus, by combining these indices, a person suffering a local, topical allergic reaction is expected to have a relative well-being of 0.7604. Each of the categories of reactions have been assigned values, as included in Table 7. Mortalities are valued as 0.0000.

Next, optimum values of well-being were derived for both short-term durations (1 day) and long-term durations (2 months). The economic literature includes many attempts to quantify society's willingness-to-pay (WTP) to avoid risks. Various methodologies have resulted in an average value of approximately $5.0 million as a measure of the WTP to avoid a statistical death (Refs. 51, 52, and 53). By amortizing this value to account for life expectancy and expected disability-days (Refs. 54 and 55), FDA estimates that a quality-adjusted life-year (QALY) has an approximate value of $373,000. Using this estimate, the expected value of a quality-adjusted life-day is approximately $1,022 and the expected value of two quality-adjusted life-months is $62,166.

The relative wellness values for each category shown in Table 7 represent the proportion of wellness relative to an optimum level. The willingness of society to pay for avoiding each incident were reflected as the difference between the wellness state and an optimum level multiplied by the duration of the event. For example, a local topical allergic reaction has an expected wellness value of 0.7604, or 0.2396 below optimum. This difference is used to calculate the amount that society is willing to pay to avoid a reaction of this type.

TABLE 7.—CHARACTERISTICS OF REDUCTIONS IN SECOND YEAR ALLERGIC REACTIONS

Category of Reaction	Number of Avoided Reactions (000)	Number of Avoided Short-Term Reactions (000)	Number of Avoided Long-Term Reactions (000)	Functional State[1]	Problem/ Symptom Weight[2]	Relative Wellness	Value per Short-Term Reaction	Value per Long-Term Reaction ($ 000)	Value per Short-Term Reaction Avoided ($ 000)	Value per Long-Term Reaction Avoided ($ 000)	Total Value ($ 000)
Local Topical	0.89	0.84	0.05	0.7433	0.0171	0.7604	245	14,900	205	794	999
Systemic Topical	0.94	0.69	0.24	0.6065	0.0171	0.6236	385	23,400	267	5,709	5,976
Systemic Respiratory	13.24	9.66	3.57	0.525	-0.0075	0.5175	493	30,000	4,764	107,194	111,958
Respiratory Requiring Aggressive Treatment	0.05	0.03	0.03	0.5284	-0.1507	0.3777	636	38,700	17	972	989
Mortality	0.00	NA	NA	0	0	0	NA	NA	NA	NA	514[3]
Totals	15.11	11.22	3.90								120,436

[1] Functional states: Mobility - 5; Physical activity - 4; Social - 5 = 0.7433
Mobility - 4; Physical activity - 4; Social - .4 = 0.6065
Mobility - 4; Physical activity - 3; Social - 3 = 0.525
Mobility - 4; Physical activity - 1; Social - 2 = 0.5284
Mortality = 0.0000

[2] Problem/Symptom Adjustments:
Burning or itching rash on body = +0.0171
Wheezing or shortness of breath = -0.0075
Loss of consciousness, fainting = -0.1507

[3] Value per mortality is $5 million. May not add due to rounding.

For 1 day, this value is $245 ($1,022 x .2396) and for 2 months, the estimated value per reaction is $14,895. The derived values for each of the reaction categories and terms are shown in Table 7.

The values for each category, when multiplied by the number of decreased reactions expected due to this regulation, result in the expected annual benefit. Table 7 includes this estimate for only the second evaluation year. It indicates that society would be willing to pay a value of approximately $120.4 million to avoid 15,100 allergic reactions to NL protein.

Taking these steps for each year in the evaluation period yields estimates of the willingness to pay to avoid these reactions as shown in Table 9. The undiscounted benefits equal $120.4 million in year 2, then decrease to $30.4 million in year 4. Between years 4 and 10, the estimated annual benefit increases to a value of $47.5 million. The estimated annualized benefit of avoiding these reactions is $46.9 million.

FDA notes that other potential benefits, such as the avoidance of third-party payments as a result of treating fewer allergic reactions, the value of reduced anxiety due to lowering NL sensitization, the reduction in defects in glove barrier integrity, and the reduction in other foreign body reactions caused by glove powder have not been quantified at this time. FDA recognizes the considerable uncertainty of all of these estimates, however, and requests comment on all of the data and assumptions.

TABLE 8.—DESCRIPTION OF INPUTS TO FUNCTIONALITY LEVELS

Mobility	Physical Activity	Social Activity
5-Drove car and used transportation without help		5-Did work, school, or housework and other activities
4-Did not drive, needed help with transportation	4-Walked without physical problem	4-Did work, school, or housework, but other activities limited
3-In house	3-Walked with physical problem	3-Limited in work, school or housework
2-In hospital	2-Moved own wheelchair without help	2-Performed self-care
1-In special unit	1-In bed or chair	1-Had help in self-care

Source: Kaplan, Bush, et. al. (Refs. 49 and 50)

TABLE 9.—Expected Benefit of Decreased NRL Allergic Reactions Due to Regulation

Year	Decreased Reactions (000)	Value of Decreased Reactions ($ million)	Net Present Value of Decreased Reactions ($ millions)
Current	NA	NA	NA
1	0.0	NA	NA
2	(15.1)	120.4	105.2
3	(9.5)	76.0	62.0
4	(3.8)	30.4	23.2
5	(3.9)	31.1	22.2
6	(4.3)	34.0	22.7
7	(4.7)	37.1	23.1
8	(5.1)	40.3	23.4
9	(5.5)	43.7	23.8
10	(6.0)	47.5	24.2
Average Annual Benefit ($ million)			46.9

G. Sensitivity Analyses

FDA examined the impact of various assumptions that affect future conditions. These analyses are as follows:

1. Growth Rate of the Demand for Surgical and Patient Examination Gloves

FDA used 1992 to 1994 rates of employment growth within the health services industry (SIC 80) to project a 3.9 percent annual growth in the future demand for surgical gloves (Ref. 41). However, more recent data obtained for the period up to 1998 suggest the more modest growth rate of 2.7 percent for this industry (Ref. 55a). Examining the expected costs and benefits after lowering the expected growth for surgical and patient examination gloves to 2.7 percent indicates that average annual costs decrease from $33.4 to $31.5 million and average annual benefits decrease from $46.9 to $42.1 million. If the forecast relied instead on the growth of total employment hours in the health service industry (Ref. 55b), the rate in recent years has been approximately 2.0 percent. Using this rate as the expected growth rate for surgical and patient examination gloves results in average annual costs of $30.4 million and average annual benefits of $39.6 million.

FDA notes that under the alternative assumptions, both costs and benefits are lower than under the scenario presented earlier, but the regulation would still be justified.

2. Market Shares of Powder-Free and Synthetic Gloves

FDA has estimated that in the absence of regulation, within 4 years, 80 percent of the glove market would consist of powder-free gloves; and within 5 years, 20 percent of all gloves would be manufactured of synthetic material. The proposed regulation is expected to accelerate these trends to within 2 years of implementation.

To examine the sensitivity of these assumptions, FDA calculated the costs and benefits of the rule assuming that, in the absence of regulation, it would take 10 years rather than 4 years for powder-free gloves to account for 80 percent of the market and 10 years rather than 5 years for synthetic gloves to account for 20 percent of the market. The expected average annual costs in this scenario equal $72.7 million, and the average annual benefits equal $112.1 million. FDA also examined the impact of assuming no expected change in baseline market share from the first implementation year, in the absence of regulation. In this case, the average

annual costs equal $135.7 million, and the average annual benefits equal $283.2 million.

3. Linear Relationship between Environmental Protein/Powder and Allergic Reactions

FDA expects that an exponential relationship exists between protein/powder levels and allergic reactions, but the agency also examined the effect of a linear relationship. The linear model increased the expected average annual benefit of reducing exposure from $46.9 million to $75.7 million, by increasing the number of avoided incidents as protein/powder levels were decreased. Table 9 indicates the magnitude of the expected decrease in NL reactions using the expected exponential relationship. A total of 57,900 avoided reactions were forecast. If the actual relationship were linear, the rule would be expected to result in the avoidance of 88,100 incidents over the same period.

4. Conclusion

FDA has tested several key assumptions used in the analysis of impacts. Each simulation resulted in estimated benefits exceeding costs. Nonetheless, FDA recognizes the significant uncertainty in this analysis and requests any additional information that would improve the projections.

H. Small Business Impact

1. Initial Regulatory Flexibility Analysis

FDA believes that the proposed regulation will not have a significant impact on a substantial number of small entities, but conducted an initial regulatory flexibility analysis (IRFA) to ensure that impacts on small entities were assessed and to alert any potentially impacted entities to the opportunity to submit comments to the agency.

2. Description of Impact

The objectives of the proposed regulation are to reduce the adverse health effects attributable to allergic and foreign body reactions from NL allergens and glove powder and to defects in barrier protection and quality of surgeon's and patient examination gloves. The proposed regulation will accomplish these objectives by reclassifying surgeon's and patient examination gloves into class II products, and requiring product labeling. In addition, the proposed regulation recommends protein and powder levels for surgeon's and patient examination gloves. FDA's statutory authority for the proposed rulemaking under the act is discussed in section II of this document.

Two separate industries will be affected by the proposed regulation: Manufacturers of surgeon's and patient examination gloves (found in Standard Industrial Classification 3842, Medical Equipment and Supplies) and Health Facilities (found in SIC 80).

TABLE 10.—NON-HEALTH CARE INDUSTRIES THAT USE GLOVES AS PROTECTION

Industry Sector	SIC Code	Number of Establishments	Number of Employees
Government	9,461	10,893	56,345
Residential Care	836	2,423	NA
Personal Services	7,362	1,348	163,477
Funeral Services	726	19,890	57,013
Health Units in Industry	NA	202,540	178,732
Non-Health Research Laboratories	8,221	1,453	89,159
Linen Services	7,218	1,250	50,000
Medical Equipment Repair	384	1,076	6,185
Law Enforcement	9,221	4,946	341,546
Fire and Rescue	9,224	3,174	252,048
Lifesaving	9,229	100	5,000
Schools	9,411	6,321	4,132
Waste Removal	4,953	940	13,300

Source: OSHA (Ref. 40)

FDA considered the potential impact of the proposed regulation on a number of nonhealth industries, but found that any impact would be insignificant. When OSHA issued its final regulations on blood-borne pathogens (Ref. 40), it considered a wide-range of establishments including: Law enforcement agencies, schools, linen services, and funeral parlors (see Table 10). While a substantial number of these establishments are small under the Small Business Administration definition, this proposed regulation does not require the use of FDA-regulated medical gloves at these sites. OSHA assumed that many of these industries would use utility gloves or consumer-grade gloves to provide barrier protection. For example, janitorial services and waste removal establishments were assumed to use utility work gloves, while law enforcement agencies were expected to use consumer-grade vinyl gloves. Few industries or establishments were expected to use FDA-regulated medical gloves in nonmedical settings. However, even in settings where medical gloves may be used, the frequency of glove usage was much less in these sectors. OSHA estimated that an average school would use approximately eight pairs of gloves per day. In contrast, a small physician/dental office would be expected to use 30 pairs of gloves per day. Both the relative frequency of glove use and the concentration of FDA-regulated medical gloves convinced FDA to focus on the Health Services Industry (Table 11) as the area of largest potential impact.

TABLE 11.—ESTABLISHMENT AND EMPLOYMENT IN THE HEALTH SERVICES[1]

Establishments and (Standard Industrial Classification Codes)	Number of Establishments (thousand)	Number of Employees (thousand)	Average Number of Employees per Establishment
Total Health Services (80)	1,030.0	11,000.0	10.7

TABLE 11.—ESTABLISHMENT AND EMPLOYMENT IN THE HEALTH SERVICES[1]—Continued

Establishments and (Standard Industrial Classification Codes)	Number of Establishments (thousand)	Number of Employees (thousand)	Average Number of Employees per Establishment
Clinics and Offices of MD's (801)	328.9	1,908.4	5.8
Clinics and Offices of Dentists (802)	138.5	709.4	5.1
Clinics and Offices of Osteopathy (803)	18.4	60.6	3.3
Other Health Practitioners (804)	243.0	483.6	2.0
Nursing Facilities (805)	57.7	2,011.8	34.9
Hospitals (806)	7.1	4,496.5	633.3
Medical/Dental Laboratories (807)	29.4	229.3	7.8
Home Health Services (808)	99.9	743.9	7.4
Other Allied Services (809)	107.7	356.5	3.3

[1] 1992 Census of Service Industries and Bureau of Labor Statistics projections of employment trends in the health services industries.

Glove manufacturers will be affected by labeling that requires additional warnings and statements concerning recommended protein and powder limits, testing and validation measures that are necessary to ensure the accuracy of this information, and limitations on the use of powder for mold release. Health facilities will face increased expenditures for surgeon's and patient examination gloves by either shifting from powdered gloves to more expensive powder-free products or continuing to use powdered gloves that cost more due to production cost increases.

Manufacturers classified within the four-digit SIC code 3842 are typically small. Only 38 percent of all establishments had 20 or more employees in 1992 (Ref. 56), and companies had an average of 1.12 separate establishments. The manufacturers are highly specialized, with over 92 percent of their products considered within the medical equipment and supplies industry, and 94 percent of all medical equipment and supplies manufactured by these firms. The Small Business Administration classifies as small any entity within this industry with 500 or fewer employees (Ref. 57), capturing the majority of establishments. However, the affected manufacturers of surgeon's and patient examination gloves have some product-specific characteristics that distinguish them from the average establishment in this industry.

FDA's registration system for medical devices shows 198 manufacturers of surgeon's and patient examination gloves, the vast majority of which are located outside the United States and operate in a world-wide market, although the U.S. constitutes the most significant regional market. FDA examined the records of current manufacturers and identified 10 domestic manufacturers of surgeon's and patient examination gloves out of the total 198 marketers. Only 1 of these 10 domestic manufacturers reported employment of fewer than 1,200 employees. However, FDA acknowledges that additional small domestic manufacturers could enter the market in the future.

The main impacts of the proposed regulations on small manufacturers would occur if the manufacturer had to conduct additional validation tests to ensure the accuracy of protein and powder levels displayed on the product labeling and if increased inventory loss or slower production times occurred due to limited uses of powder as a mold release. Although FDA does not stipulate the acceptable validation test method in the regulation, and is soliciting comments on this issue in order to minimize its impact, it is possible that a chemist would be required on a contract basis to ensure that the actual levels of protein and powder matched the levels on the label. FDA is working with industry groups to ensure that an acceptable and reliable test method is chosen. Despite this outreach, the selected test method could impose additional and disparate costs to a small manufacturer. Similarly, increased inventory loss because of tearing in the production process due to limited powder would affect small production runs to a greater degree than large production runs. Discussions with manufacturers have indicated that any additional validation testing or negative impacts on production capability could increase the production costs of medical gloves by 5 percent or more.

As discussed earlier in the analysis of impacts section (section IX.D of this document), the demand for medical gloves is highly price inelastic due to the regulatory requirement for health facilities (SIC 80) to provide barrier protection (Ref. 40) and the lack of substitute products (Ref. 42). The characteristics of the medical glove market therefore indicate that production cost increases resulting from the proposed rule are likely to be passed through in the form of higher contract prices. In addition, many facilities are currently accepting increased glove prices by establishing powder-free environments in the absence of any rule-making. Thus, production cost increases by glove manufacturers are likely to be offset by revenue gains for these same manufacturers, with the result of shifting the cost impact to the health facilities.

Small health facilities therefore will also bear some regulatory impact. The Small Business Administration has defined as small any ''for-profit'' health facility with annual revenues of $5 million or less (Ref. 57). Most hospitals and nursing facilities would be considered large under this definition. However, nonprofit facilities not dominant in their field are also considered small entities. Industry characteristics of the health facility industry are shown in Table 11. Approximately 95 percent of the hospitals and nursing facilities are considered as small entities (6,700 hospitals and 54,800 nursing facilities).

FDA examined the potential impact of the proposed regulations on two types of health care user facilities: Small physician/dental facilities and small hospitals. A small physician or dental facility may use as many as 25,000 (based on 120 patient visits per week) gloves each year. If the facility substitutes powder-free for powdered gloves as a result of this regulation, costs would increase by $475 per year ((25,000/100) x $1.90).

Similarly, a small hospital is also likely to experience increased annual costs of acquiring gloves. An extremely small hospital with only 6 beds and a staff of 11 might use about 22,000 gloves annually. If the facility faced increased glove costs, the total increase in costs could amount to about $950.

FDA wishes to collect additional information on the nature of the impacts on small entities in order to ensure that all such impacts are noted. In addition,

other public facilities such as prisons, and police or fire departments may face higher glove prices due to this regulation. FDA does not expect these costs to be significant, but solicits comments on this potential burden.

3. Analysis of Alternatives

FDA has examined and rejected the following alternatives to the proposed rule:(1) Banning powdered gloves; (2) mandating protein and powder levels on medical gloves; (3) requiring all users of powdered gloves to comply with restrictions on distribution and use; (4) retaining the class I classification for all (or some) of the medical gloves; and (5) excluding powdered synthetic gloves from this rulemaking; and (6) providing for a shorter or longer compliance period. FDA has rejected the alternatives at this time for the following reasons:

Alternative 1: A ban of all powdered medical gloves has been requested in a citizen petition submitted to FDA. FDA considered banning powdered gloves because that action would meet the stated objective of eliminating airborne powder and greatly reducing exposure to airborne allergens associated with the use of medical gloves. However, FDA did not select this alternative because a ban would not address exposure to NL allergens from medical gloves with high levels of NL proteins. Moreover, such a ban of powdered gloves might compromise the availability of high quality medical gloves and greatly increase the annual costs by almost as much as $64 million over the selected alternative.

Alternative 2: FDA also considered mandating powder and protein levels for medical gloves because this alternative would accomplish the stated objectives more completely than banning. FDA rejected mandating powder and protein levels for medical gloves because the agency believes that the increased regulatory flexibility of the proposed rule may reduce the costs of compliance by allowing for more efficient methods of reaching the goal. Inventories could be lowered and industry capacity could be assured. Mandating specific protein and powder levels, as well as the acceptable test method, may preclude all parties from developing a more efficient system. In addition, FDA inspectional and compliance costs are minimized by relying on recommended levels of powder and protein. By ensuring user access to relevant information, the agency believes that users will move the market to a more efficient level.

Alternative 3: FDA considered restricting the distribution and use of powdered NRL or synthetic material medical gloves by requiring that establishments using powdered gloves establish and maintain written procedures for selecting, purchasing and distributing gloves. FDA further considered restricting the distribution and use of powdered NRL or synthetic material medical gloves by requiring establishments using powdered gloves with more than the recommended powder levels to establish and maintain written procedures to evaluate, monitor and control airborne particulate matter at the point of use, through the use of an externally exhausted air handling system, HEPA filtration, or other system. FDA believes that these restrictions would reduce the risk of adverse foreign body and allergic reactions associated with powdered glove use. However, the extent of the expected reduction is uncertain. The expected costs of complying with these restrictions was estimated to be over $21 million. Furthermore, any such workplace restrictions may impede or preempt the authority of OSHA to regulate gloves and glove powder in the workplace.

Before rejecting this alternative, the agency had examined the feasibility of exempting small facilities from the requirements of developing written procedures and air quality measures. Based on the expectation that small establishments with 10 or fewer employees would be able to communicate and control risks associated with powdered medical easier than larger institutions. Exempting small medical facilities from these controls lowers the added costs to $6.6 million. However, FDA rejected this alternative because the expected benefits of restricting glove use remained uncertain, and the potential overlap of authority with OSHA would still exist.

Alternative 4: FDA considered retaining the class I classification for all or some of the medical gloves. This alternative was rejected because it did not meet the stated objectives. In light of new information concerning barrier integrity, degradation of quality during storage, contamination concerns and concerns about exposure to foreign bodies and allergens, FDA found that general controls are no longer sufficient to provide reasonable assurances of the safety and effectiveness of medical gloves. Moreover, such concerns were not limited to only powdered gloves. To require a device to meet special controls as well as general controls, a device must be classified (or reclassified) into class II. Consequently, although compliance costs would have been reduced by this alternative, retaining some or all gloves as class I devices was rejected.

Alternative 5: Alternative 5 (excluding powdered synthetic gloves for this rulemaking) was considered in order to reduce cost by as much as $2.4 million per year. FDA rejected this alternative because it would not meet the stated objective of the applicable statutes. While synthetic gloves do not contain NL proteins, FDA is concerned about foreign body reactions caused by glove powder. These reactions occur whether the powder is present on a NRL or synthetic glove. Consequently, FDA is rejecting exempting powdered synthetic gloves from this regulation.

Alternative 6: FDA considered providing a shorter compliance period for implementation of the regulation. A compliance period of 90 days or 1 year would significantly increase the expected benefits of the rule by decreasing the number of annual allergic reactions. FDA estimates that a 90-day or 1-year implementation period would result in between 3,300 and 3,600 fewer annual allergic reactions to NL proteins than the number expected with the selected 2-year compliance period. However, FDA is concerned that the lead times necessary to manufacture limited powder gloves would make compliance difficult. As stated earlier, manufacturing equipment used to control glove powder levels is currently backordered as much as 18 months, and short compliance periods may result in inadequate supplies of medical gloves. Not including the potential of shortages, FDA has estimated that average annualized costs of shorter compliance periods could equal $10 million to $16 million more than the selected alternative. The 2-year compliance period allows firms to combine recommended changes with any other market driven changes, and will allow firms to deplete their supply of existing labels. As set forth above, however, FDA is soliciting comment on the timeframe for implementation to determine whether a 2–year compliance period is really needed. FDA also rejected providing a longer compliance period. FDA has tentatively determined that the decrease in costs is outweighed by the decrease in benefits if the compliance period is lengthened to as many as 3 years. While annual costs would decrease by almost $9 million, allowing such a long compliance period would result in about 1,800 additional average annual allergic reactions as compared to the selected alternative and benefits would be reduced to $32.0 million. Since glove manufacturers would have ample opportunity to comply within the

selected 2-year period, FDA does not believe that additional time is justified.

FDA solicits comments on other alternatives that meet the stated objectives.

4. Assuring Small Entity Participation in Rulemaking

At this time, FDA does not believe that the proposed regulation will have a significant economic impact on a substantial number of small entities. However, the agency recognizes that many facilities will be affected. The impact may range from increased glove manufacturing costs due to validation testing and control of mold powder to increased contract prices of powdered gloves used by health facilities. FDA solicits comments from affected entities to ensure that this impact is analyzed.

FDA plans to provide for access to the **Federal Register** analysis through FDA's website on the Internet. Notice of the availability of this proposed rule and request for comment will be communicated to all glove-related associations and include a request for comments.

FDA is currently preparing an article for publication in latex-related trade publications that will highlight the proposed requirements. In addition, notice of the proposed rulemaking and request for comments will be available in health-related publications and sent to trade organizations. FDA actively seeks input into this proposal and requests comments on all aspects of the analysis of impacts and the regulatory flexibility analysis.

X. Conclusion

FDA has examined the impacts of the proposed regulation of protein and powder levels of NL gloves. Based on these estimates, the average annual quantifiable benefits ($46.9 million) exceed the average annual quantifiable costs ($32.5 million). Given the high level of uncertainty and the existence of unquantified benefits, FDA solicits comment on this analysis and all of its assumptions and projections.

XI. Environmental Impact

FDA has determined under 21 CFR 25.30(k) and 25.34(b) that this action is of the type that does not individually or cumulatively have a significant effect on the human environment. Therefore, neither an environmental assessment nor an environmental impact statement is required.

XII. Paperwork Reduction Act of 1995

This proposed rule contains information collections provisions that are subject to review by the Office of Management and Budget (OMB) under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501–3520). A description of these provisions is given below with an estimate of the annual reporting burden. Included in the estimate is the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing each collection of information.

FDA invites comments on: (1) Whether the proposed collection of information is necessary for the proper performance of FDA's functions, including whether the information will have practical utility; (2) the accuracy of FDA's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques, when appropriate, and other forms of information technology.

Title: Labeling and Written Procedures Requirements for Powdered and Powder-Free Patient Examination Gloves, and Powdered and Powder-Free Surgeon's Gloves.

Description: The proposed rule intends to provide users with material information to safely use patient examination and surgeon's gloves. The proposed rule expands the labeling for medical gloves to include: (1) Caution statements including the actual levels of protein and powder on the gloves, and (2) expiration dating.

The proposed labeling requirements would require manufacturers to conduct tests to support the protein and glove powder levels and expiration date. The proposed special control, a guidance document entitled ''Medical Glove Guidance Manual,'' recommends that protein levels be measured by the ASTM D 5712 modified Lorry method and that glove powder levels be measured by the ASTM D6124–97 method. The labeling requirements also require stability testing to support the expiration date. The special control recommends that stability testing include tensile strength, elongation and water leak tests.

The labeling is intended to communicate useful information to users about FDA's guidance recommending the use of gloves with no more than 1,200 µg of protein and 120 mg of glove powder (or 2 mg of powder, for powder-free gloves) and to ensure that the labeling contains adequate directions for use. The labeling would require manufacturers to indicate the actual levels of protein and powder on the gloves so that the user can ascertain if the gloves meet the recommended limits on protein and powder, which are intended to reduce exposure to particulates and airborne allergens. The expiration date labeling is intended to ensure that medical glove users have appropriate information regarding shelf life to enable them to use medical gloves safely by avoiding products that may have degraded.

Description of Respondents: Businesses or other for profit organizations.

TABLE 12.—ESTIMATED ANNUAL REPORTING BURDEN[1]

21 CFR Section	No. of Respondents	Annual Frequency per Response	Total Annual Responses	Hours per Response	Total Hours	Total Capital Costs
801.440(a)	180	1	180	22	3,960	$985,248
801.440(b)	18	1	18	14	252	
801.440(c)	178	1	178	16	2,848	
801.440(d)	376	4[2]	1,504	72	108,288	
Total					115,348	$985,248

[1] There are no operating and maintenance costs associated with this collection of information.

[2] The annual burden reported here represents the first year in which a manufacturer would have conducted testing at 0 days, 3 months, 6 months, and 1 year. FDA expects in any succeeding years, testing would only be done at 6-month intervals.

For the proposed labeling requirements, the hours per response included the hours estimated, based upon communications with industry, to run the tests to support the powder and protein levels and the expiration date, as well as the hours estimated to change the respondent's labeling. The total capital costs were derived from multiplying the total annual responses for protein testing and multiplying it by the estimated costs of buying a spectrometer and a plate reader, instruments that are necessary to conduct the protein testing. That cost was then annualized over a 5-year period.

Based on communication with industry, FDA estimates that a respondent would take approximately 8 hours to run the protein tests necessary to obtain a protein level to add to the labeling. FDA bases its estimate on the ASTM D 6124–97 protein test.

Based on communication with industry, FDA estimates that a respondent would take approximately 6 hours to run the powder tests necessary to obtain a powder level to add to the labeling. FDA bases its estimate on the ASTM D 5712 modified Lowry method powder test.

Based on communication with industry, FDA estimates that a respondent would take approximately 16 hours to run the elongation, tensile strength, and waterleak tests recommended to support the expiration date. In the first year, FDA estimates that the tests would be run 4 times, at 0 days, 3 months, 6 months, and 1 year (16 X 4 = 64). In the second, or succeeding years, FDA expects the tests to be run twice a year.

FDA estimates that a respondent would take approximately 8 hours to change the labeling and approximately 8 hours to change the promotional materials to include the appropriate caution statement and the expiration date. This 16 hours is divided between the labeling changes proposed in § 801.440(a) and (d) resulting in 8 hours being assessed for the caution statement and 8 hours being assessed for the expiration date.

FDA estimates the number of burden hours per response for § 801.440(a) is 22. That burden comes from the sum of the hours for running the powder and protein tests (8 hours plus 6 hours) and the hours for changing the labeling (8 hours).

FDA estimates the number of burden hours per response for § 801.440(b) is 14. That burden comes from the sum of the hours for running the powder tests (6 hours) and the hours for changing the labeling (8 hours).

FDA estimates the number of burden hours per response for § 801.440(c) is 16. That burden comes from the sum of the hours for running the protein tests (8 hours) and the hours for changing the labeling (8 hours).

FDA estimates the number of burden hours per response for § 801.440(d) is 72. That burden comes from the sum of the hours for running the elongation, tensile strength, and waterleak tests four times in the first year (64 hours) and the hours for changing the labeling (8 hours).

FDA believes that manufacturers already have the equipment necessary to do the tests to support the powder levels and expiration dating because such equipment is currently being used to test the gloves. In order to do the protein tests recommended by FDA, FDA believes a manufacturer would need to obtain a spectrometer and a plate reader. FDA estimates that buying this equipment would cost approximately $22,000 (approximately $10,000 for the spectrometer and $12,000 for the plate reader). In addition, FDA assumed a 7 percent discount on the price of the equipment and that the equipment would be annualized over a 5-year period. In order to obtain a per annualized year estimate, FDA multiplied the cost by the discount ($22,000 x .244). FDA added the discounted amount ($5,368) to the cost of the equipment ($22,000) for a total equipment cost of $27,368. That cost annualized over a 5-year period is $5,473.60. FDA multiplied that cost by the number of respondents testing for protein levels (180) for a total capital cost of $985,248.

In compliance with the Paperwork Reduction Act of 1995 (44 U.S.C. 3507(d)), FDA has submitted the information collection provisions of this proposed rule to OMB for review. Interested persons are requested to send comments regarding information collection by August 30, 1999, to the Office of Information and Regulatory Affairs, OMB, New Executive Office Bldg., 725 17th St. NW., rm. 10235, Washington, DC 20503, Attn.: Wendy Taylor, Desk Officer for FDA.

XIII. References

The following references have been placed on display in the Dockets Management Branch (address above) and may be seen by interested persons between 9 a.m. and 4 p.m., Monday through Friday.

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List of Subjects

21 CFR Part 801

Labeling, Medical devices, Reporting and recordkeeping requirements.

21 CFR Parts 878 and 880

Medical devices.

Therefore, under the Federal Food, Drug, and Cosmetic Act and under authority delegated to the Commissioner of Food and Drugs, it is proposed that 21 CFR parts 801, 878, and 880 be amended as follows:

PART 801—LABELING

1. The authority citation for 21 CFR part 801 is revised to read as follows:

Authority: 21 U.S.C. 321, 331, 351, 352, 360c, 360i, 360j, 371, 374.

2. Section 801.437 is amended by revising paragraph (d) to read as follows:

§ 801.437 User labeling for devices that contain natural rubber.

* * * * *

(d)(1) As described in paragraph (b) of this section, devices containing natural rubber latex that contacts humans, except natural rubber latex surgeon's and patient examination gloves shall bear the following statement in bold print on the device labeling:

''Caution: This Product Contains Natural Rubber Latex Which May Cause Allergic Reactions.''

This statement shall appear on all device labels, and other labeling, and shall appear on the principal display panel of the device packaging, the outside package, container, or wrapper, and the immediate device package, container, or wrapper.

(2) Natural rubber latex surgeon's and patient examination gloves shall bear the appropriate caution statement delineated in § 801.440(a) or (c). This statement shall appear on all device labels, and other labeling, and shall appear on the principal display panel of the device packaging, the outside package, container, or wrapper, and the immediate device package, container, or wrapper.

* * * * *

3. Section 801.440 is added to subpart H to read as follows:

§ 801.440 User labeling for powdered and powder-free surgeon's and patient examination gloves.

The caution statements required in this section shall appear on all device labels, and other labeling, and shall appear on the principal display panel of the device packaging, the outside package, container, or wrapper, and the immediate device package, container, or wrapper.

(a) Natural rubber latex powdered surgeon's gloves and powdered patient examination gloves shall bear the following statement: ''Caution: This product contains natural rubber latex which may cause allergic reactions. FDA recommends that this product contain no more than 120 mg powder and 1,200 μg extractable protein per glove. This product contains no more than [insert level] mg powder and no more than [insert level] μg extractable protein per glove.''

(b) Synthetic material powdered surgeon's or powdered patient examination gloves shall bear the following statement: ''Caution: Glove powder is associated with adverse reactions. FDA recommends that this product contain no more than 120 milligrams powder per glove. This product contains no more than [insert level] mg powder per glove.''

(c) Natural rubber latex powder-free surgeon's gloves and powder-free patient examination gloves shall bear the following statement: ''Caution: This product contains natural rubber latex which may cause allergic reactions. FDA recommends that this product contain no more than 1,200 μg extractable protein per glove. This product contains no more than [insert level] μg extractable protein per glove.''

(d) All surgeon's and patient examination gloves shall bear an expiration date as follows:

(1) The expiration date shall state the month and year of the shelf-life as supported by data from the studies described in paragraph (d)(3) of this section;

(2) The expiration date must be prominently displayed on the exterior of the primary and retail package, and on the shipping carton;

(3) The expiration date must be supported by stability studies demonstrating acceptable physical and mechanical integrity of the product over the shelf-life of the product from its date of manufacture;

(4) For each glove design, the testing data and stability study protocol supporting an expiration date must be maintained by the manufacturer for a period equivalent to the design and expected life of that glove type, and shall be made available for inspection and copying by FDA; and

(5) Sterile surgeon's and patient examination gloves that have a date of expiration based on sterility that is different from the expiration date based upon physical and mechanical integrity testing shall bear only the earlier expiration date.

PART 878—GENERAL AND PLASTIC SURGERY DEVICES

4. The authority citation for 21 CFR part 878 continues to read as follows:

Authority: 21 U.S.C. 351, 360, 360c, 360e, 360j, 360l, 371.

5. Section 878.4460 is revised to read as follows:

§ 878.4460 Surgeon's gloves, powdered.

(a) *Identification*. A powdered surgeon's glove is a disposable device made of natural rubber latex or synthetic material that bears powder to facilitate donning, and it is intended to be worn on the hands, usually in surgical settings, to provide a barrier against potentially infectious materials and other contaminants. The lubricating or dusting powder used on these gloves is classified separately in § 878.4480.

(b) *Classification*. Class II special controls are as follows:

(1) *Guidance document.* The Center for Devices and Radiological Health, FDA, ''Medical Glove Guidance Manual,'' as revised. The guidance document is available from the Division of Small Manufacturers Assistance (HFZ–220), Center for Devices and Radiological Health, Food and Drug Administration, 1350 Piccard Dr., Rockville, MD 20850.

(2) *Labeling.* User labeling requirements in § 801.440 of this chapter.

6. Section 878.4461 is added to subpart E to read as follows:

§ 878.4461 Surgeon's gloves, powder-free.

(a) *Identification*. A powder-free surgeon's glove is a disposable device made of natural rubber latex or synthetic material that may bear a trace amount of glove powder and is intended to be worn on the hands, usually in surgical settings, to provide a barrier against potentially infectious materials and other contaminants.

(b) *Classification*. Class II special controls are as follows:

(1) *Guidance document.* The Center for Devices and Radiological Health, FDA, ''Medical Glove Guidance Manual,'' as revised (See § 878.4460(b)(1)).

(2) *Labeling.* User labeling requirements in § 801.440 of this chapter.

PART 880—GENERAL HOSPITAL AND PERSONAL USE DEVICES

7. The authority citation for 21 CFR part 880 continues to read as follows:

Authority: 21 U.S.C. 351, 360, 360c, 360e, 360j, 371.

8. Section 880.6250 is revised to read as follows:

§ 880.6250 Patient examination gloves, powdered.

(a) *Identification*. A powdered patient examination glove is a disposable device made of natural rubber latex or synthetic material that bears powder to facilitate donning and is intended to be worn on the hand or finger(s) for medical purposes to provide a barrier against potentially infectious materials and other contaminants.

(b) *Classification*. Class II special controls are as follows:

(1) *Guidance document.* The Center for Devices and Radiological Health, FDA, ''Medical Glove Guidance Manual,'' as revised. The guidance document is available from the Division of Small Manufacturers Assistance (HFZ–220), Center for Devices and Radiological Health, Food and Drug Administration, 1350 Piccard Dr., Rockville, MD 20850.

(2) *Labeling.* User labeling requirements in § 801.440 of this chapter.

9. Section 880.6251 is added to subpart G to read as follows:

§ 880.6251 Patient examination gloves, powder-free.

(a) *Identification*. A powder-free patient examination glove is a disposable device made of natural rubber latex or synthetic material that may bear a trace amount of glove powder and is intended to be worn on the hand or finger(s) for medical purposes to provide a barrier against potentially infectious materials and other contaminants.

(b) *Classification*. Class II special controls are as follows:

(1) *Guidance document.* The Center for Devices and Radiological Health, FDA, ''Medical Glove Guidance Manual,'' as revised (See § 880.6250(b)(1)).

(2) *Labeling.* User labeling requirements in § 801.440 of this chapter.

Dated: March 2, 1999.

Jane E. Henney,

Commissioner of Food and Drugs.

Donna E. Shalala,

Secretary of Health and Human Services.

[FR Doc. 99–19191 Filed 7–29–99; 8:45 am]

BILLING CODE 4160–01–F

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. 99D–2335]

Medical Gloves; Draft Guidance Manual; Availability

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

SUMMARY: The Food and Drug Administration (FDA) is announcing the availability of the draft guidance entitled ''Medical Glove Guidance Manual.'' The draft guidance represents a major revision of this guidance document, which was initially issued in 1993 under the title ''Guidance for Medical Gloves: A Workshop Manual.'' This draft guidance is intended to provide current information to assist manufacturers and others in obtaining marketing clearance, applying manufacturing and design controls, and properly labeling medical gloves. This draft guidance also includes recommendations for limits on the amounts of glove powder and natural latex protein present on surgeon's and patient examination gloves. Elsewhere in this issue of the **Federal Register**, the FDA is proposing reclassification of surgeon's gloves and patient examination gloves into class II (special controls) because the agency believes that special controls are necessary to provide reasonable assurance of the safety and effectiveness of the gloves. The agency is proposing that the draft guidance ''Medical Glove Guidance Manual'' be one of the special controls, and the agency is requesting comment on the content of the manual at this time.

DATES: Submit written comments concerning this draft guidance by October 28, 1999 for consideration prior to implementation of the guidance as a special control.

ADDRESSES: See the **SUPPLEMENTARY INFORMATION** section for electronic access to the draft guidance. Submit written requests for single copies on a 3.5'' diskette of the guidance document entitled ''Medical Glove Guidance Manual'' to the Division of Small Manufacturers Assistance'' (HFZ–220), Center for Devices and Radiological, Food and Drug Administration, 1350 Piccard Dr., Rockville, MD 20850. Send one self-addressed adhesive label to assist that office in processing your request, or fax your request to 301–443–8818. Submit written comments concerning this guidance to the Dockets Management Branch (HFA–305), Food and Drug Administration, 5630 Fishers Lane, rm. 1061, Rockville, MD 20852. Comments should be identified with the docket number found in brackets in the heading of this document.

FOR FURTHER INFORMATION CONTACT: Arthur K. Yellin, Center for Devices and Radiological Health (HFZ–200), Food and Drug Administration, 1350 Piccard Dr., Rockville, MD 20850, 800–638–2041, ext. 146, 301–443–6597, ext. 146.

SUPPLEMENTARY INFORMATION:

I. Background

Medical gloves are a significant factor in the protection of both patients and health care personnel in the United States. Because of the increased reliance on medical gloves as a barrier against transmission of infectious diseases and contaminants, it is imperative that they be manufactured and labeled in accordance with FDA laws and regulations.

Originally entitled ''Guidance for Medical Gloves: A Workshop Manual,'' this document was first published in May 1993 to assist manufacturers in preparing premarket notification (510(k)) submissions for medical gloves and applying quality systems requirements (formerly known as good manufacturing practices, or GMP) to the production of medical gloves. It has been used extensively as a text in training workshops provided by the FDA to the regulated industry. It is heavily relied upon and widely recognized as a valuable resource to those currently in, or seeking to enter, the United States medical glove market.

The draft guidance has been revised to address and emphasize the agency's growing concerns about the role of glove powder as a cause of foreign body reactions and as a carrier of airborne natural latex allergens. The draft guidance recommends that manufacturers of powdered surgeon's and patient examination gloves limit the amount of powder to no more than 120 milligrams (mg) of powder per glove, regardless of glove size. It further recommends that manufacturers of powder-free surgeon's and patient examination gloves limit the amount of total trace (residual) powder on gloves to no more than 2 mg particulate weight (based on the American Society for Testing Materials Standard Test Method for Residual Powder on Medical Gloves (D 6124-97)) per glove, regardless of glove size.

The draft guidance also includes a recommendation that manufacturers of natural rubber latex surgeon's and patient examination gloves limit the amount of water-extractable protein on the gloves to no more than 1200 micrograms of protein per glove, regardless of glove size.

II. Significance of Guidance

This draft guidance represents the agency's current thinking on medical gloves. It does not create or confer any rights for or on any person and does not operate to bind FDA or the public. An alternative approach may be used if such approach satisfies the applicable statute, regulations, or both.

The agency has adopted good guidance practices (GGP's), which set forth the agency's policies and procedures for the development, issuance, and use of guidance documents (62 FR 8961, February 27, 1997). This draft guidance document is issued as a Level 1 guidance consistent with GGP's.

III. Electronic Access

Persons interested in obtaining a copy of the medical glove guidance manual may do so using the World Wide Web (WWW). CDRH maintains an entry on the WWW for access to information including text, graphics, and files that may be downloaded to a personal computer with access to the WWW. Updated on a regular basis, the CDRH home page includes the medical glove guidance manual, device safety alerts, access to **Federal Register** reprints, information on premarket submissions including lists of approved applications and manufacturers' addresses, small manufacturers' assistance, information on video conferencing and electronic submissions, mammography matters, and other device-oriented information. The CDRH home page may be accessed at ''http://www.fda.gov/cdrh''. The medical glove guidance manual is available at''http://www.fda.gov/cdrh/manual/glovmanl.pdf''.

You may also receive instructions about obtaining the medical glove guidance manual via your fax machine. To do so call the CDRH Facts-On-Demand (FOD) system at 800–899–0381 or 301–827–0111 from a touch-tone telephone. At the first voice prompt, press 1 to access DSMA Facts, at the second voice prompt, press 2, and then enter the document number (852) followed by the pound sign (#). Then follow the remaining voice prompts to complete your request.

IV. Comments

Interested persons may, on or before October 28, 1999 submit to Dockets Management Branch (address above) written comments regarding this draft guidance. Two copies of any comments are to be submitted, except that

individuals may submit one copy. Comments are to be identified with the docket number found in brackets in the heading of this document. The draft guidance and received comments may be seen in the Dockets Management Branch between 9 a.m. and 4 p.m., Monday through Friday.

Dated: July 15, 1999.

Margaret M. Dotzel,

Acting Associate Commissioner for Policy.

[FR Doc. 99–19192 Filed 7–29–99; 8:45 am]

BILLING CODE 4160–01–F

federal register

Friday
July 30, 1999

Part VI

Department of the Treasury

Fiscal Service

31 CFR Part 203

Payment of Federal Taxes and the Treasury Tax and Loan Program; Proposed Rule

DEPARTMENT OF THE TREASURY

Fiscal Service

31 CFR Part 203

RIN 1510–AA79

Payment of Federal Taxes and the Treasury Tax and Loan Program

AGENCY: Financial Management Service, Fiscal Service, Treasury.

ACTION: Notice of proposed rulemaking.

SUMMARY: The Department of the Treasury (Treasury), Financial Management Service (FMS), is proposing a revision of its regulations governing the Treasury Tax and Loan (TT&L) program and specifically a change to the interest rate Treasury charges on TT&L note balances, including funds loaned through the direct investment and special direct investment programs. Under the current rule, the TT&L rate of interest is the Federal funds rate published weekly by the Board of Governors of the Federal Reserve System less 25 basis points. Treasury is proposing to change the basis for computing the TT&L rate of interest to an overnight repurchase agreement rate in order to better approximate the market interest rate for collateralized lending.

Comments are specifically requested on whether the rule is well organized and states its requirement clearly. Also, we welcome suggestions on how to make the rule easier to understand.

Treasury invites comments on all aspects of the proposed change in the regulation.

DATES: Written comments must be received on or before September 28, 1999.

ADDRESSES: Comments or inquiries may be mailed to Cynthia L. Johnson, Director, Cash Management Policy and Planning Division, Financial Management Service, Room 420, 401 14th Street, SW, Washington, DC 20227. Comments also may be submitted electronically via e-mail to 203.comments@fms.sprint.com or by filling out the comment form available on the EFT website at http://www.fms.treas.gov/eftps. A copy of this notice is being made available for downloading from the Financial Management Service web site at the following address: http://www.fms.treas.gov/regs.html.

Comments on the proposed rule will be available for public inspection at the Department of the Treasury Library, Room 5030, 1500 Pennsylvania Avenue, NW, Washington, DC. Please call (202) 622–0990 to make an appointment.

FOR FURTHER INFORMATION CONTACT: Mary Bailey, Financial Program Specialist, at (202) 874–6749; Walt Henderson, Senior Financial Program Specialist, at (202) 874–6705; Cynthia L. Johnson, Director, Cash Management Policy and Planning Division, at (202) 874–6590; or Ellen Neubaurer, Senior Attorney, at (202) 874–6680.

SUPPLEMENTARY INFORMATION:

Background on the Treasury Tax and Loan Program

The Treasury Tax and Loan (TT&L) program encompasses two separate components—a depositary component through which the Treasury collects Federal tax deposits and payments from business taxpayers for employee withholding and other types of taxes, and an investment component through which the Treasury invests short-term operating balances not needed for immediate cash outlays.

Through the TT&L depositary component, which comprises nearly 10,500 commercial financial institutions and Federal Reserve Banks (FRBs), the Treasury collected almost $1.4 trillion in Fiscal Year 1998, representing approximately 80 percent of the total Federal annual receipts, from approximately 5 million business taxpayers.

More than 1,500 of the TT&L depositaries borrow excess short-term Treasury operating funds by participating in the investment component of the TT&L program. Through agreements executed under this Part, participating depositaries borrow Treasury funds in the form of a note secured with collateral pledged to Treasury and pay interest to the Treasury on these balances. In Fiscal Year 1998, the Treasury earned $1.2 billion in interest income through the TT&L investment component.

Treasury Tax and Loan Rate of Interest

The interest rate that the Treasury charges on a TT&L depositary's note balance is the Federal funds rate [computed on a weighted average effective basis by the Federal Reserve Bank of New York (FRBNY)] less 25 basis points (25 hundredths of one percentage point). The Federal funds rate is the interest rate at which financial institutions exchange balances in their accounts at the Federal Reserve with each other on an overnight, unsecured basis.

The current formula was put into place in 1978. At that time, the overnight repurchase agreement market was not mature and a published rate was not available. Thus, the TT&L rate of interest was set as an approximation of an overnight repurchase agreement rate. When the current formula was put into place in 1978, it was generally believed that the Federal funds rate averaged 25 basis points above the volume-weighted average interest rate from overnight repurchase agreements secured by Treasury securities and select Agency securities executed by the FRBNY for its monetary operations. An overnight repurchase agreement is the economic equivalent of an overnight loan collateralized by securities.

Treasury is proposing to change the TT&L rate of interest to an explicit overnight repurchase agreement rate. This change will allow Treasury to receive the actual interest rate, rather than a proxy rate, on an economically similar transaction.

Specifically, Treasury is proposing that FRBNY, as fiscal agent for the U.S. Treasury, compile and publish a volume-weighted average overnight repurchase agreement rate. We propose that the FRBNY compile this rate from data it would obtain from its domestic open market counter parties (''the primary dealers'') regarding the volume-weighted average overnight rate the primary dealers paid to finance general collateral securities. The Treasury requests comments on this proposed methodology.

Replacing the formula or proxy rate with an explicit overnight repurchase agreement rate will provide depositaries with an easily understandable rate which will be publicly available. Historically, these two rates generally have moved broadly in tandem. From the inception of the investment program in 1978 through May 1999 the Federal funds rate averaged approximately 29 basis points (29 hundredths of one percentage point) over the overnight repurchase agreement rate. Since 1990, however, the average difference between the two rates has been only approximately 2 basis points (2 hundredths of one percentage point).

Availability of the Overnight Repurchase Agreement Rate

It is important that the TT&L rate of interest be readily available to the public. The Treasury proposes to request that the Federal Reserve publish an overnight repurchase agreement rate on a basis similar to that used to publish the Federal funds rate. Thus, financial institutions that elect to maintain a TT&L note balance will have a readily accessible indicator on which to estimate the cost of funds.

Section by Section Analysis

Section 203.2—Definitions

Treasury proposes to change the definition of the ''Treasury Tax and Loan (TT&L) rate of interest'' from the Federal funds rate less 25 basis points to a volume-weighted average overnight repurchase agreement rate. Treasury also proposes to add a definition of ''Overnight Repurchase Agreement Rate''. This new term is used in the redefined ''Treasury Tax and Loan (TT&L) rate of interest''. As a result of this new definition, this section will be renumbered.

Rulemaking Analysis

Treasury has determined that this proposed regulation is not a significant regulatory action as defined in Executive Order 12866. It is hereby certified that this rule will not have a significant economic impact on a substantial number of small business entities. The proposed rule does not require any actions on the part of small entities. Accordingly, a Regulatory Flexibility Act analysis is not required.

Request for Comment

The Treasury invites comments on all aspects of the proposed change in the Treasury Tax and Loan rate of interest for calculating interest due to the Treasury on TT&L note balances. In particular, the Treasury invites comments on the potential impact to the investment component of the TT&L program—specifically, whether depositaries are likely to alter their participation in the program and, if so, by how much—and on the proposed methodology for determining the overnight repurchase agreement rate. Treasury is also interested in comments regarding the extent to which TT&L participants would be interested in obtaining TT&L note balances for a guaranteed term.

List of Subjects in 31 CFR Part 203

Banks, Banking, Electronic funds transfers, Taxes.

Accordingly, it is proposed to amend 31 CFR part 203 as follows:

PART 203—PAYMENT OF FEDERAL TAXES AND THE TREASURY TAX AND LOAN PROGRAM

Subpart A—General Information

1. The authority citation for Part 203 continues to read as follows:

Authority: 26 U.S.C. 6302; 31 U.S.C. 321; 31 U.S.C. 323; 31 U.S.C. 3301–3304; 12 U.S.C. 90; 12 U.S.C. 265–266; 12 U.S.C. 332; 12 U.S.C. 391; 12 U.S.C. 1452(d); 12 U.S.C. 1464(k); 12 U.S.C. 1767; 12 U.S.C. 1789a; 12 U.S.C. 2013; 12 U.S.C. 2122; and 12 U.S.C. 3102.

2. Section 203.2 is amended by deleting paragraph (j), redesignating paragraphs (k) through (w) as paragraphs (j) through (v), adding a new paragraph (w) and revising paragraph (kk) to read as follows:

Subpart A—General Information.

§ 203.2 Definitions.

* * * * *

(w) *Overnight repurchase agreement rate* means the interest rate calculated by the Federal Reserve Bank of New York from the volume-weighted average overnight rate paid to finance general collateral securities compiled by the Federal Reserve Bank of New York and published weekly by the Board of Governors of the Federal Reserve System.

* * * * *

(kk) *Treasury tax and loan (TT&L) rate of interest* means the overnight repurchase agreement rate.

Dated: July 26, 1999.

Donald V. Hammond,

Fiscal Assistant Secretary.

[FR Doc. 99–19564 Filed 7–29–99; 8:45 am]

BILLING CODE 4810–35–P

federal register

Friday
July 30, 1999

Part VII

Department of Education

34 CFR Part 668

Student Assistance General Provisions; Proposed Rule

DEPARTMENT OF EDUCATION

34 CFR Part 668

RIN 1845–AA04

Student Assistance General Provisions

AGENCY: Department of Education.

ACTION: Notice of proposed rulemaking.

SUMMARY: The Secretary proposes to amend the loan default reduction and prevention measures in the Student Assistance General Provisions regulations in 34 CFR part 668. This notice of proposed rulemaking (NPRM) reflects changes made by the Higher Education Amendments of 1998 to the Higher Education Act of 1965, as amended (HEA).

DATES: We must receive your comments on or before September 15, 1999.

ADDRESSES: Address all comments about these proposed regulations to Kenneth Smith, U.S. Department of Education, P.O. Box 23272, Washington, DC 20026–3272. If you prefer to send your comments through the Internet, use the following address: CDRNPRM@ed.gov

If you want to comment on the information collection requirements you must send your comments to the Office of Management and Budget at the address listed in the Paperwork Reduction Act section of this preamble. You may also send a copy of these comments to the Department representative named in this section.

FOR FURTHER INFORMATION CONTACT: Kenneth Smith. Telephone: (202) 708–8242. If you use a telecommunications device for the deaf (TDD), you may call the Federal Information Relay Service (FIRS) at 1–800–877–8339.

Individuals with disabilities may obtain this document in an alternate format (e.g., Braille, large print, audiotape, or computer diskette) on request to the contact person listed in the preceding paragraph.

SUPPLEMENTARY INFORMATION:

Invitation To Comment

We invite you to submit comments regarding these proposed regulations. To ensure that your comments have maximum effect in developing the final regulations, we urge you to identify clearly the specific section or sections of the proposed regulations that each of your comments addresses and to arrange your comments in the same order as the proposed regulations.

We invite you to assist us in complying with the specific requirements of Executive Order 12866 and its overall requirement of reducing regulatory burden that might result from these proposed regulations. Please let us know of any further opportunities we should take to reduce potential costs or increase potential benefits while preserving the effective and efficient administration of the programs.

During and after the comment period, you may inspect all public comments about these proposed regulations in room 3045, Regional Office Building 3, 7th and D Streets, SW., Washington, DC, between the hours of 8:30 a.m. and 4:00 p.m., Eastern time, Monday through Friday of each week except Federal holidays.

Assistance to Individuals With Disabilities in Reviewing the Rulemaking Record

On request, we will supply an appropriate aid, such as a reader or print magnifier, to an individual with a disability who needs assistance to review the comments or other documents in the public rulemaking docket for these proposed regulations. If you want to schedule an appointment for this type of aid, you may call (202) 205–8113 or (202) 260–9895. If you use a TDD, you may call the Federal Information Relay Service at 1–800–877–8339.

Background

The Higher Education Amendments of 1998 (Pub. L. 105–244, enacted October 7, 1998, and referred to in this NPRM as the ''1998 Amendments'') changed some requirements relating to the calculation of a school's Federal Family Education Loan (FFEL) Program cohort default rate, William D. Ford Federal Direct Loan (Direct Loan) Program cohort rate, or weighted average cohort rate. The Secretary is proposing to revise 34 CFR 668.17 of the Student Assistance General Provisions regulations to reflect these changes.

Negotiated Rulemaking Process

Section 492 of the HEA requires that, before publishing any proposed regulations to implement programs under Title IV of the Act, the Secretary obtain public involvement in the development of the proposed regulations. After obtaining advice and recommendations, the Secretary must conduct a negotiated rulemaking process to develop the proposed regulations. All published proposed regulations must conform to agreements resulting from the negotiated rulemaking process unless the Secretary reopens the negotiated rulemaking process or provides a written explanation to the participants in that process why the Secretary has decided to depart from the agreements.

To obtain public involvement in the development of the proposed regulations, we published a notice in the **Federal Register** (63 FR 59922, November 6, 1998) requesting advice and recommendations from interested parties concerning what regulations were necessary to implement Title IV of the HEA. We also invited advice and recommendations concerning which regulated issues should be subjected to a negotiated rulemaking process. We further requested advice and recommendations concerning ways to prioritize the numerous issues in Title IV, in order to meet statutory deadlines. Additionally, we requested advice and recommendations concerning how to conduct the negotiated rulemaking process, given the time available and the number of regulations that needed to be developed.

In addition to soliciting written comments, we held three public hearings and several informal meetings to give interested parties an opportunity to share advice and recommendations with the Department. The hearings were held in Washington, DC, Chicago, and Los Angeles, and we posted transcripts of those hearings to the Department's Information for Financial Aid Professionals' website (http://ifap.ed.gov).

We then published a second notice in the **Federal Register** (63 FR 71206, December 23, 1998) to announce the Department's intention to establish four negotiated rulemaking committees to draft proposed regulations implementing Title IV of the HEA. The notice announced the organizations or groups believed to represent the interests that should participate in the negotiated rulemaking process and announced that the Department would select participants for the process from nominees of those organizations or groups. We requested nominations for additional participants from anyone who believed that the organizations or groups listed did not adequately represent the list of interests outlined in section 492 of the HEA. Once the four committees were established, they met to develop proposed regulations over the course of several months, beginning in January.

The proposed regulations contained in this NPRM reflect the final consensus of the negotiating committee, which was made up of the following members:

American Association of Community Colleges

American Association of Cosmetology Schools

American Association of State Colleges and Universities

American Council on Education
Career College Association
Coalition of Associations of Schools of the Health Professions
Coalition of Higher Education Assistance Organizations
Consumer Bankers Association
Education Financial Council
Education Loan Management Resources
Legal Services Counsel (a coalition)
National Association of College and University Business Officers
National Association for Equal Opportunity in Higher Education
National Association of Graduate/Professional Students
National Association of Independent Colleges and Universities
National Association of State Student Grant and Aid Programs
National Association of State Universities and Land-Grant Colleges
National Association of Student Financial Aid Administrators
National Association of Student Loan Administrators
National Council of Higher Education Loan Programs
National Direct Student Loan Coalition
Sallie Mae, Inc
Student Loan Servicing Alliance
The College Board
The College Fund/United Negro College Fund
United States Department of Education
United States Student Association
US Public Interest Research Group

As stated in the committee protocols, consensus means that there must be no dissent by any member in order for the committee to be considered to have reached agreement. Consensus was reached on all of the proposed regulations in this document

Proposed Regulatory Changes

To help readers understand the proposed regulatory changes, we believe it is appropriate to provide a brief description of the processes available for schools to challenge or appeal their FFEL Program cohort default rates, Direct Loan Program cohort rates, or weighted average cohort rates. To avoid confusion in this NPRM, we use the word ''rate'' by itself to refer to FFEL Program cohort default rates, Direct Loan Program cohort rates, and weighted average cohort rates. We use the complete term if we are referring to another type of ''rate'': an ''economically disadvantaged rate,'' a ''completion rate,'' a ''placement rate,'' or a ''participation rate.''

Each school receives only one of the three types of rates each year: an FFEL Program cohort default rate, a Direct Loan Program cohort rate, or a weighted average cohort rate. However, unless specifically stated in the regulations, the rules and processes for submitting appeals and making challenges apply regardless of which rate a school receives. For example, under the proposed regulations, a school must notify us within 30 calendar days of its intent to appeal a rate on the grounds of exceptional mitigating circumstances, regardless of whether the school's rate is an FFEL Program cohort default rate, a Direct Loan Program cohort rate, or a weighted average cohort rate.

The rate process begins when we send draft rates to schools participating in the FFEL or Direct Loan Program. The rates are accompanied by supporting data, giving detailed information on the loans included in the calculation of the rate. A school may challenge the calculation of a draft rate by following the process outlined in the regulations. In this NPRM we refer to this process as the ''challenge'' process.

After the completion of the draft rate challenge process, we notify each school of its official rate and publish a listing of all the rates. This NPRM refers to these rates as ''published rates.'' A school may file an appeal of any sanctions resulting from published rates by following the procedures outlined in the regulations. We refer to the process for contesting published rates as an ''appeal.''

A discussion of each substantive proposed change follows.

1. Challenges and Adjustments to Inaccurate Data Used to Calculate FFEL Cohort Default Rates, Direct Loan Program Cohort Rates, or Weighted Average Cohort Rates (§§ 668.17(a)(1) and 668.17(j))

Why are changes proposed?

Amendments to section 428G of the HEA provide reduced administrative requirements for schools with FFEL Program cohort default rates, Direct Loan Program cohort rates, or weighted average cohort rates that are less than 5 or 10 percent. To help implement these new provisions, we are proposing to change the process that schools use to identify and challenge incorrect data.

Before describing the proposed changes, we will describe the current process used to identify and challenge incorrect data.

If a school is not subject to loss of participation, how does it currently correct data used to calculate its rate?

The current process for correcting data has two steps:

- *Challenging draft data.* Any school may challenge the accuracy of any data used to calculate its draft rate. We send supporting data to schools with draft rates of 20 percent or more, and any school that does not receive supporting data may request it. The supporting data reflect the basis for the calculation of a school's rate. A school compares the information in the supporting data with its own records and with information obtained from outside sources to identify possible inaccuracies. A school must challenge any inaccurate draft data within 30 calendar days of receiving the supporting data.
- *Adjustments to published rates.* We send supporting data to schools with published rates of 20 percent or more. Any school that does not receive supporting data may request it. If corrections identified during the draft challenge process are not reflected in a school's published rate, the school may request that its rate be adjusted to reflect those corrections. Adjustment requests must be made within 10 working days of receiving the supporting data. A school may not request an adjustment that is based on data that were changed or added after the draft rate was calculated. Between the calculation of the draft and official rates, data may be corrected, changed, or added by a guaranty agency (for FFEL loans) or the Direct Loan Servicing Center (for Direct Loans).

How would this process be changed under these proposed regulations?

The proposed regulations would retain the two current steps, with the following improvements:

- *Challenging draft data.* We would provide supporting data to all schools when we notify the schools of their draft rates, and we would lengthen the period during which a school may challenge the accuracy of its draft rate from 30 to 45 calendar days.
- *Adjustments to published rates.* We would provide supporting data with the notification of published rates sent to all schools having rates of 10 percent or more. Schools with rates lower than 10 percent would be able to request supporting data separately.

Will there be other changes to this process?

Yes, we will also make some administrative changes to the process for reviewing and challenging rates. Since these are administrative changes, they are not included in these proposed regulations.

The most significant administrative changes will be to the process for requesting adjustments to a published rate. The period during which a school may request an adjustment to its published rate will be extended from 10 working days to 30 calendar days. Also, upon receiving its published rate, a school will be able to request an adjustment to any incorrect new data

that were included after the draft rate was calculated. This ''new data adjustment'' will be available to schools beginning with receipt of FY 1998 rates, which will be released before September 30, 2000. This new administrative process will be explained more fully in the FY 1998 Official Cohort Default Rate Guide, which will be sent to a school with the notification of its published rate for FY 1998.

We will also make the following additional administrative improvements to this process:

• *Electronic supporting data.* We will make supporting data available to schools upon request in an electronic format. This will help schools prepare their challenges and appeals more quickly and with less work. We plan to begin this service with the publication of rates for FY 1998. Initially, it is unlikely that we will be able to send electronic data with the notifications of the rates themselves. Instead, we plan to make electronic data available to requesting schools after the notifications are issued, and for subsequent draft and published rates.

• *Real-time data.* Schools will be able to view, year-round, the loan repayment and default data that will be used to calculate their rates. By having access to this ''real-time'' data, schools will be able to identify errors and to correct them, by working with the data's provider, on a schedule that is compatible with the schools' ongoing workload. We plan to begin this service by the end of 1999.

2. Deadline for Publishing Rates (§ 668.17(b)(3))

What happens if the deadline is missed?

The 1998 Amendments adds a new section 435(m)(4)(D) to the HEA, which directs the Secretary to issue cohort default rates by September 30 each year. During the negotiated rulemaking process, some negotiators expressed a concern about the possible consequences for schools if we issued rates after that date. Under section 435(a)(2) of the HEA, a school's loss of participation in the loan programs based on excessive rates continues for the fiscal year (FY) for which the determination of the loss is made and for the 2 succeeding fiscal years. Some negotiators were concerned that schools might be subject to an additional year of ineligibility if we issued rates after September 30.

The committee discussed an example in which a determination issued before this year's deadline of September 30, 1999, would subject a school to loss of participation for the remainder of this fiscal year (FY 1999) and for the 2 following fiscal years (FY 2000 and FY 2001). By contrast, if the determination was issued after September 30, 1999, the committee asked whether the school would be subject to loss of participation for the remainder of that fiscal year (FY 2000) and for the 2 following fiscal years (FY 2001 and FY 2002).

The Department expects to meet the goal of issuing rates by September 30 each year. If, however, rates are not issued until after that date, a school's loss of eligibility in that case would continue only for the remainder of the fiscal year in which the rates are issued and for the following fiscal year. As this procedure would be administrative, it is not reflected in these proposed regulations.

3. Loss of Pell Eligibility (§ 668.17(b)(4))

How does a school's rate affect its eligibility to participate in the Pell program?

These provisions reflect amendments to section 401(j) of the HEA. Under the amendments, a school becomes ineligible to participate in the Federal Pell Grant Program when it becomes ineligible to participate in the FFEL or Direct Loan Program due to excessive rates. A school that was not participating in the FFEL or Direct Loan Program on October 7, 1998 (the date on which the 1998 Amendments was enacted), is not subject to this provision unless it subsequently participates in either of those programs.

What criteria would be used to determine that a school was not participating in the FFEL or Direct Loan Program on or after October 7, 1998?

Under the proposed regulations, a school would not be considered to have been participating in the FFEL or Direct Loan Program on or after October 7, 1998, if the school—

• Was ineligible to participate in those programs before October 7, 1998, and the school did not regain eligibility;

• Requested in writing, before October 7, 1998, to withdraw its participation in those programs and did not subsequently re-apply to participate; or

• Has not certified an FFEL loan or originated a Direct Loan on or after July 7, 1998.

The deadline date of July 7, 1998, was selected as a compromise and agreed to by the committee. The Department believes this date is appropriate because it provides some protection for a school that had stopped certifying or originating loans, intending to end its participation in these loan programs, but had not sent a written request to withdraw its participation. At the same time, we also believe that this date is appropriate because it provides a sufficient period of time before the date of enactment to verify the school's intent not to participate.

4. Liability for Unsuccessful Appeals (§§ 668.17(b)(5)(ii) and 668.17(b)(6))

What liability would a school assume for loans made while appealing a loss of participation?

These provisions reflect amendments to section 435(a)(2)(A) of the HEA that are intended to reduce the likelihood of frivolous appeals by schools that are subject to loss of eligibility due to excessive rates. A school that certifies and delivers FFEL Program loans or originates and disburses Direct Loan Program loans during its appeal would be required to reimburse the Secretary for an amount equal to the amount of interest, special allowance, reinsurance, and any related or similar payments the Secretary makes, or will be obligated to make, on those loans.

How will the Department determine a school's liability for loans made during an unsuccessful appeal?

We intend to determine a school's liability using the Department's ''Estimated Loss Formula.'' We currently use this formula to calculate schools' liabilities in other circumstances related to the loan programs. In this instance, the formula would use the school's most recent published rate to estimate the principal amount of the loans that would be expected to default. In addition, the formula would be used to estimate costs to the Secretary for interest, special allowance, and other losses on these loans, using timeframes appropriate for the type of school.

For example, an estimate of a 2-year public school's liability would be based on average timeframes for 2-year public schools. To calculate an estimate of the—

• *Interest subsidy,* the Department would project the interest that would accrue on the total principal amount of the subsidized student loans, during the average number of days, for a 2-year public school, between the date the loans were disbursed and the date they entered repayment.

• *Special allowance,* the Department would project the special allowance that would accrue on the total principal amount of the subsidized and unsubsidized student loans and PLUS loans, during the average number of days, for a 2-year public school, between the date the loans enter repayment and either the date they default or the date on which they are paid in full.

How could a school appeal its loss of participation without incurring a liability?

Any school may stop certifying and delivering FFEL Program loans or originating and disbursing Direct Loan Program loans by ending its participation in the program. Also, under the proposed regulations, a school could prevent the possibility of incurring a liability during an appeal by temporarily not certifying and delivering FFEL Program loans and originating and disbursing Direct Loan Program loans during the appeal. This suspension would be at the discretion of the school, and the school would not be required to notify or seek the approval of the Secretary.

5. Participation Rate Index (§§ 668.17(c)(1)(ii)(A) and 668.17(j)(4))

What changes would be made to a school's ability to appeal on the basis of its participation rate index (PRI)?

The proposed regulations reflect the provisions of section 435(a)(6) of the HEA. These provisions are similar in many respects to the Department's regulatory requirements for an appeal on the basis of a school's PRI under 34 CFR 668.17(c)(1)(ii)(A). However, unlike those regulatory requirements, under which a school files a PRI appeal after it receives its published rate, the 1998 Amendments provides for a PRI challenge that is made after a school receives its draft rate. Also, the provisions of the 1998 Amendments allow a school to base its PRI calculation on the fiscal year of the school's draft rate or either of its two most recent published rates, rather than the school's most recent published rate only.

What if a school's published rate isn't the same as its draft rate, and the newly published rate would make its PRI lower than 0.0375?

The proposed regulations retain the opportunity for a school to appeal its published rate on the basis of a PRI lower than 0.0375. (The process that occurs after the draft rate is a ''challenge,'' but the process that occurs after the published rate is an ''appeal.'') Because a school's draft rate is not always the same as its published rate, there may be cases in which a school's challenge based on its draft rate would be denied, but an appeal based on the school's published rate would be accepted.

For example, a school with a draft rate of 38 percent and with 10 percent of its students receiving loans would have a PRI of .0380 (0.38 multiplied by 0.10 is .0380). Since the school's PRI would be greater than .0375, its challenge would be denied. However, if the school's published rate were calculated 1 percent lower, as 37 percent, the same school would then have a PRI of .0370 (0.37 multiplied by 0.10 is .0370). Since this PRI meets the criterion, the school's appeal would be accepted.

Once a school's PRI challenge or appeal is accepted, would the school need to challenge or appeal again the following year?

A school's successful PRI challenge to the draft rate or appeal of the published rate would not apply to a future loss of participation unless the rate upon which the challenge or appeal was originally based was a rate that could also be used as a basis for the subsequent challenge or appeal. For example, a school that is subject to a loss of participation based on its rates for FY 1999, FY 1998, and FY 1997 may challenge or appeal the loss using a PRI based on any of the following rates:

Upon receipt of...	PRI based on rate for...		
	FY 1999	FY 1998	FY 1997
Draft rate	Draft	Published	Published
Published rate	Published	Published	Published

The school files a successful challenge or appeal but is again subject to loss of participation the following year, based on its rates for FY 2000, FY 1999, and FY 1998. At that time, the school may challenge or appeal using a PRI based on any of the following rates:

Upon receipt of...	PRI based on rate for...		
	FY 2000	FY 1999	FY 1998
Draft rate	Draft	Published	Published
Published rate	Published	Published	Published

The only rates that appear in both tables are the school's published rates for FY 1999 and FY 1998. If the school's successful original challenge or appeal was based on the—

- Published rate for FY 1999 or FY 1998, then the school *would not* need to file another challenge or appeal in order to continue participating.
- Draft rate for FY 1999 or the published rate for FY 1997, then the school *would* need to file another successful PRI, or other type of appeal, in order to continue participating.

6. Mitigating Circumstances Appeals (§§ 668.17(c)(1)(ii)(B) and 668.17(c)(7))

What changes would there be to appeals made on the basis of mitigating circumstances?

These provisions reflect the amendments to section 435(a)(2)(A)(ii) of the HEA and add the provisions of new section 435(a)(4) of the HEA. The amended and new provisions are similar to the current regulatory requirements for an appeal due to mitigating circumstances (see 34 CFR 668.17(c)(1)(ii)(B)). However, the 1998 Amendments makes several substantive modifications to the regulatory requirements:

- The criterion based on a school's economically disadvantaged rate is reduced from a minimum of 70 percent to a minimum of two-thirds.
- The criterion based on a school's placement rate is reduced from a minimum of 50 percent to a minimum of 44 percent.
- The groups of students used in the calculations that determine the school's appeal are re-defined.
- An independent auditor must agree, in a written opinion included with the appeal, that the school meets the appeal's criteria.

How would the modified requirement for an independent auditor's opinion be implemented under the proposed regulations?

The following process is proposed to incorporate the modified requirement for an auditor's opinion:

- Within 30 days of being notified that its participation will end due to excessive FFEL Program cohort default rates, Direct Loan Program cohort rates, or weighted average cohort rates, or that a prior loss of participation will be extended, the school must notify us that it is appealing under these provisions.
- Within 60 days of being notified that its participation will end due to excessive rates, or that a prior loss of participation will be extended, the school must send us the independent auditor's report. The report must include the school's written assertions and be in a format prescribed by us.
- We consider the auditor's report and compare the assertions in the report with the information we maintain.
- If the independent auditor's opinion supports the school's position, and the report's documentation or our data do not contradict the opinion, then the appeal is approved.
- If the independent auditor's opinion does not support the school's assertion, or if the report's documentation or our data contradict the opinion, the appeal is denied.

We rely upon the opinion of the independent auditor in determining whether a school meets the mitigating circumstance criteria. However, it would not be appropriate for us to decide that a school meets the criteria if an auditor's opinion is contradicted by data in the report itself or by data that we maintain.

As agreed during negotiated rulemaking, the data that we would use to evaluate a report's acceptability would be limited to data that the school has supplied to us for other reasons or data that is otherwise available to the school. For example, when making a determination, we may compare data in the report to the data maintained in the Federal Pell Grant Program payment systems, the National Student Loan Data System (NSLDS), the Integrated Postsecondary Education Data System (IPEDS), or other data sources.

We would not typically investigate a school's assertions in making our determination. For example, we would not routinely contact the employers of the school's former students to gather additional information to use in evaluating their placement rate assertions. If improprieties are suspected in a school's appeal, an investigation would be pursued under other legal authority.

How would the groups of students used to calculate economically disadvantaged, completion, and placement rates be re-defined?

The 1998 Amendments changes the definitions of the groups of students used to calculate economically disadvantaged rates, completion rates, and placement rates:

- A student is considered economically disadvantaged if the student is eligible to receive a Federal Pell Grant award that is at least equal to one-half the maximum Federal Pell Grant award for which the student would be eligible based on the student's enrollment status. The previous regulatory criterion considered a student with an expected family contribution (EFC) of zero to be economically disadvantaged.
- A student is considered to have completed a program or to have been placed if the student enters active duty in the Armed Forces of the United States.

Additional changes are included in these proposed regulations. Currently, the economically disadvantaged rates, completion rates, and placement rates used to determine a school's eligibility for this type of appeal are calculated as percentages of all of the school's regular students. The proposed regulations limit the groups of students for whom the percentages are calculated to include only students who are enrolled in programs eligible for Title IV aid.

This change is proposed at the request of some of the non-Federal negotiators, in consideration of the types of student records needed by a school to calculate its eligibility for this appeal and of the likelihood that these records may not be maintained by schools for students who were not enrolled in Title IV eligible programs. We especially request comments on the benefit or harm that this proposed change might cause schools.

7. Other Mitigating Circumstances Appeals (§§ 668.17(c)(1)(ii)(A), (C), and (D))

Why are additional mitigating circumstances proposed?

These provisions are based on the authority given to the Secretary under new section 435(a)(2)(iii) of the HEA. Under this section, the Secretary may identify mitigating circumstances, in addition to those identified in the HEA, that make the consequences of FFEL Program cohort default rates, Direct Loan Program cohort rates, or weighted average cohort rates inequitable. Schools meeting the criteria for these additional mitigating circumstances may be allowed to continue participating in the FFEL and Direct Loan programs.

What additional mitigating circumstances are proposed?

The proposed regulations include the following additional mitigating circumstances for a school to use in appealing a loss of participation based on three consecutive rates of 25 percent or greater:

- A successful appeal, based on a school's participation rate index, that is made upon receipt of the school's published rate rather than its draft rate. The proposed regulations retain and modify previous regulatory requirements. (See the previous discussion of ''Participation Rate Index.'')
- The total number of a school's borrowers entering repayment in the 3 most recent fiscal years for which data are available is 30 or fewer. For example, if the number of a school's borrowers entering repayment in FY 1996 was 6, in FY 1997 was 10, and in FY 1998 was 8, then the total number of a school's borrowers entering repayment during those 3 fiscal years is 24 (6+10+8=24). The school in the example would be eligible for an appeal of a loss of participation based on the rates for those 3 fiscal years, because the total number of its borrowers entering repayment (24) is 30 or fewer.

This additional mitigating circumstance was developed by the committee and based on the reasoning that schools that make very few loans only pose a minimal financial risk to the taxpayers. The aggregate amount of the funds used to make these few loans is small. The committee was of the view that it was inequitable to subject these schools to loss of participation in the FFEL and Direct Loan programs, and especially to loss of participation in the Federal Pell Grant Program.

- At least two of the three rates upon which a school's loss of participation is based are calculated as ''average'' rates (''average'' rates are calculated for schools with fewer than 30 borrowers in a fiscal year, on the basis of combined data for 3 fiscal years) and would be less than 25 percent if calculated using data specific to each fiscal year.

As an example of this appeal, data for a sample school are provided below:

FY	Students	Default	Rate based on . . .	
			3 years of data (percent)	1 year of data (percent)
FY 1994	25	7	.....	28.0
FY 1995	25	6	.....	24.0
FY 1996	25	10	30.7	40.0
FY 1997	25	4	26.7	16.0
FY 1998	25	5	25.3	20.0

In the example, a school's rates for FY 1996, FY 1997, and FY 1998, as calculated under 34 CFR 668.17(d)(1)(i)(B) (in the ''3 Years of Data'' column), are 30.7 percent, 26.7 percent, and 25.3 percent. Since calculations for FY 1997 and FY 1998, using data unique to each of those fiscal years (in the ''1 Year of Data'' column), are both less than 25 percent, the school in the example would meet the criteria for this mitigating circumstance.

The proposed regulations include this mitigating circumstance because we believe such an approach is consistent with the legislative intent of section 435(m)(1)(C) of the HEA, which provides for the calculation of ''average'' rates, the rates that are applicable to schools with fewer than 30 borrowers entering repayment during a fiscal year. In providing for a calculation based on an ''average'' rate, we believe that the legislative intent of the HEA is to reduce the effects of volatile rates on schools with fewer than 30 borrowers entering repayment in a fiscal year. However, as shown in the preceding example, using an ''average'' rate may have the opposite effect in some cases: data for a single fiscal year (in the example, FY 1996) may raise a school's subsequent rates and, absent this proposed mitigating circumstance, could cause the school to lose its eligibility to participate.

8. Definition of ''Default'' (§§ 668.17(e), 668.17(f), and 668.17(h)(2)(iii))

Why are changes to the definition of ''default'' included in these proposed regulations?

These provisions would conform 34 CFR 668.17 to an amendment to section 435(l) of the HEA, which changes the definition of ''default'' from 180 days to 270 days for borrowers who first became delinquent on or after October 7, 1998.

How would the change in the definition of ''default'' affect a school's rate?

For purposes of calculating a school's rate, an FFEL Program borrower is generally considered to be in default if a claim for insurance is paid on the borrower's loan before the end of the fiscal year that immediately follows the fiscal year in which the loan entered repayment. For Direct Loan Program loans, specific timeframes are included in regulations to determine whether a Direct Loan is considered to be in default for purposes of the Direct Loan Program cohort rate or weighted average cohort rate.

Since there is generally a 90-day delay between the date that an FFEL Program loan defaults and the date that an insurance claim is paid, a corresponding 90-day period is provided in the timeframe used for Direct Loans. Thus, since the timeframe for considering a borrower in default on an FFEL Program loan is changing from 270 days to 360 days, the proposed regulations would change, from 270 days to 360 days—

- The number of days of delinquency after which a borrower would be considered in default on a Direct Loan, if the borrower's delinquency began on or after October 7, 1998; and
- The number of days of repayment on a Direct Loan, under the income-contingent repayment plan, after which a borrower would be included in a school's rate under § 668.17 (e) or (f).

9. Loan Servicing Calculation (§ 668.17(h)(2)(ii))

What changes would there be to the calculation of a school's rate after a loan servicing appeal?

These provisions reflect amendments to section 435(m)(1)(B) of the HEA. The section specifies that a loan is removed from both the numerator and denominator of a rate's calculation if the loan is determined to have been improperly serviced or collected. This is not a change from the current method used to calculate a school's rate for this purpose. The new language in the proposed regulations is included only to reflect the changes to the statute.

10. Definition of ''Loan Servicing Records'' (§§ 668.17(h)(3)(ii)(B) and 668.17(h)(3)(iii)(B))

Why is the definition of ''loan servicing records'' changing?

These provisions reflect amendments to section 435(a)(3) of the HEA. The section clarifies the definition of the loan servicing records that guaranty agencies and the Direct Loan Servicer provide to schools during appeals on the basis of improper loan servicing or collection.

How would the definition of ''loan servicing records'' change?

The definition of ''loan servicing records'' would remain essentially the same for both the FFEL and Direct Loan programs:

- *FFEL Program* loan servicing records are the collection and payment history records used by a guaranty agency to determine whether to pay a claim on a defaulted loan.
- *Direct Loan Program* loan servicing records are the collection and payment history records that we use to determine a school's Direct Loan Program cohort rate or weighted average cohort rate.

These revisions do not reflect a change in our current procedures. The proposed regulations provide clarification to reflect more closely the language in the 1998 Amendments.

11. Special Institutions (§ 668.17(k) and Appendix H)

How would a special institution's eligibility to participate be affected by the proposed regulations?

These provisions reflect amendments to section 435(a)(2)(C) of the HEA and add the provisions of the new section 435(a)(5) of the HEA. The 1998 Amendments extends, from July 1, 1998, to July 1, 1999, the date on which the consequences of excessive rates are applicable to historically black colleges or universities, tribally controlled community colleges, and Navajo community colleges. In certain cases, the Secretary may treat one of these special institutions that is subject to loss of participation due to excessive rates as an eligible institution during the 1-year periods beginning on July 1, 1999, 2000, and 2001. The proposed regulations include the requirements under which these schools may maintain eligibility during the 1-year periods.

During negotiations, the committee had extensive discussions about the amount of procedural detail needed in these regulations for special institutions. The Department's initial position was that these regulations should provide only the most general requirements, so

that the process would be flexible enough to account for changes in circumstances and for experiences gained in administering the requirements. Negotiators for special institutions were of the view that it was more important to emphasize the consequences of the requirements and to ensure stricter, more consistent requirements throughout the process, so that schools could devote appropriate resources to the task of reducing rates and would not be subject to changing requirements. The committee came to consensus on this proposed draft.

We note that proposed § 668.17(k)(2)(iii) and the introduction to proposed Appendix H use the word ''should'' rather than the word ''must,'' which is used throughout the rest of this NPRM. The word ''should'' was included by agreement during the negotiated rulemaking process, and we chose not to change it at this stage of the process. Although the meaning of this word may differ in different circumstances, we want to emphasize that the term ''should'' in this particular case is intended to mean ''must,'' and commenters should use this interpretation in developing their comments. We intend to change this section in the final regulations to use the word ''must,'' instead of ''should,'' unless commenters indicate a substantial reason to keep the word ''should.''

Executive Order 12866

1. Potential Costs and Benefits

Under Executive Order 12866, we have assessed the potential costs and benefits of this regulatory action.

The potential costs associated with the proposed regulations are those resulting from statutory requirements and those determined to be necessary for the effective and efficient administration of the Title IV programs.

In assessing the potential costs and benefits of this regulatory action—both quantitative and qualitative—we have determined that the benefits would justify the costs.

We have also determined that this regulatory action would not unduly interfere with State, local, and tribal governments in the exercise of their governmental functions.

We note that, as these proposed regulations were subject to negotiated rulemaking, the costs and benefits of the various requirements were discussed thoroughly by negotiators. The resultant consensus reached on a particular requirement generally reflected agreement on the best possible approach to that requirement in terms of cost and benefit.

To assist the Department in complying with the specific requirements of Executive Order 12866, the Secretary invites comments on whether there may be further opportunities to reduce any potential costs or to increase any potential benefits resulting from these proposed regulations without impeding the effective and efficient administration of the title IV, HEA programs.

2. Clarity of the Regulations

Executive Order 12866 and the President's Memorandum of June 1, 1998 on ''Plain Language in Government Writing'' require each agency to write regulations that are easy to understand.

The Secretary invites comments on how to make these proposed regulations easier to understand, including answers to questions such as the following:

- Are the requirements in the proposed regulations clearly stated?
- Do the proposed regulations contain technical terms or other wording that interferes with their clarity?
- Does the format of the proposed regulations (grouping and order of sections, use of headings, paragraphing, etc.) aid or reduce their clarity?
- Would the proposed regulations be easier to understand if we divided them into more (but shorter) sections? (A ''section'' is preceded by the symbol ''§ '' and a numbered heading; for example, § 668.17 *Default reduction and prevention measures*.)
- Could the description of the proposed regulations in the **SUPPLEMENTARY INFORMATION** section of this preamble be more helpful in making the proposed regulations easier to understand? If so, how?
- What else could we do to make the proposed regulations easier to understand?

Send any comments that concern how the Department could make these proposed regulations easier to understand to the person listed in the **ADDRESS** section of the preamble.

Regulatory Flexibility Act Certification

The Secretary certifies that these proposed regulations would not have a significant economic impact on a substantial number of small entities. Entities affected by these regulations are institutions of higher education that participate in the title IV, HEA programs and individual recipients of title IV, HEA program funds. Institutions are defined as small entities, according to the U.S. Small Business Administration, if they are for-profit or nonprofit entities with total revenue of $5,000,000 or less, or entities controlled by governmental entities with populations of 50,000 or less. Individuals are not considered small entities for this purpose. These proposed regulations, which generally reduce operational burden and offer institutions additional ways to maintain their eligibility to participate in the Title IV aid programs, would not have a significant economic impact on small institutions.

The Secretary invites comments from small institutions as to whether the proposed changes would have a significant economic impact on them.

Paperwork Reduction Act of 1995

Section 668.17 contains an information collection requirement. Under the Paperwork Reduction Act of 1995 (44 U.S.C. 3507(d)), the Department of Education has submitted a copy of this section to the Office of Management and Budget (OMB) for its review.

Collection of Information: Student Assistance General Provisions—668.17—Default reduction and prevention measures.

Under the proposed regulations, a historically black college or university, tribally controlled community college, or Navajo community college may continue to participate in the FFEL or Direct Loan Program even though it is subject to loss of participation due to excessive rates. This continued participation may only occur during the 1-year periods beginning on July 1, 1999, 2000, and 2001, and depends upon the Secretary's determination of the school's compliance with the proposed regulations.

To make this determination, we need to collect information from schools. Each school is required to submit a default management plan on or before July 1, 1999. On or before July 1, 2000 and 2001, each school is required to submit evidence of the implementation of its plan and of improvement in the preceding 1-year period. Some schools may be required to submit revised default management plans.

Fourteen schools submitted this collection in 1999. We estimate that 8 schools will submit this collection in 2000 and 4 schools will submit this collection in 2001. We estimate a burden of 200 hours per school to create/revise a default management plan, and an additional burden of 200 hours per school to submit evidence of their plan's implementation and of improvement in the preceding 1-year period.

As calculated in the table below, the annual burden is estimated to be 2534 hours:

Year	Number of schools	Default plan hours (Schools × 200 hrs)	Evidence hours (Schools × 200 hrs)	Total hours (Default plan + evidence)
1999	14	2800	N/A	2800
2000	8	1600	1600	3200
2001	4	800	800	1600
Total (2800+3200+1600) =				7600
Average (Total/3) =				2534

If you want to comment on the information collection requirements, please send your comments to the Office of Information and Regulatory Affairs, OMB, room 10235, New Executive Office Building, Washington, DC 20503; Attention: Desk Officer for U.S. Department of Education. You may also send a copy of these comments to the Department representative named in the **ADDRESSES** section of this preamble.

We consider your comments on this proposed collection of information in—

- Deciding whether the proposed collection is necessary for the proper performance of our functions, including whether the information will have practical use;
- Evaluating the accuracy of our estimate of the burden of the proposed collection, including the validity of our methodology and assumptions;
- Enhancing the quality, usefulness, and clarity of the information we collect; and
- Minimizing the burden on those who must respond. This includes exploring the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology; e.g., permitting electronic submission of responses.

OMB is required to make a decision concerning the collection of information contained in these proposed regulations between 30 and 60 days after publication of this document in the **Federal Register**. Therefore, to ensure that OMB gives your comments full consideration, it is important that OMB receives your comments within 30 days of publication. This does not affect the deadline for your comments to us on the proposed regulations.

Intergovernmental Review

The Federal Supplemental Educational Opportunity Grant Program and the State Student Incentive Grant Program are subject to Executive Order 12372 and the regulations in 34 CFR part 79. One of the objectives of the Executive order is to foster an intergovernmental partnership and a strengthened federalism. The Executive order relies on processes developed by State and local governments for coordination and review of proposed Federal financial assistance.

This document provides early notification of our specific plans and actions for these programs.

The Federal Family Education Loan, Federal Supplemental Loans for Students, Federal Work-Study, Federal Perkins Loan, Federal Pell Grant, Income Contingent Loan, and William D. Ford Federal Direct Loan programs are not subject to Executive Order 12372 and the regulations in 34 CFR part 79.

Assessment of Educational Impact

The Secretary particularly requests comments on whether these proposed regulations would require transmission of information that any other agency or authority of the United States gathers or makes available.

Electronic Access to This Document

You may view this document in text or Adobe Portable Document Format (PDF) on the Internet at the following sites:

http://ocfo.ed.gov/fedreg.htm
http://ifap.ed.gov/csb_html/fedlreg.htm
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To use the PDF you must have the Adobe Acrobat Reader Program with Search, which is available free at the first of the previous sites. If you have questions about using the PDF, call the U.S. Government Printing Office (GPO), toll free, at 1–888–293–6498; or in the Washington, DC, area at (202) 512–1530.

Note: The official version of this document is the document published in the **Federal Register**. Free Internet access to the official edition of the **Federal Register** and the Code of Federal Regulations is available on GPO Access at: http://www.access.gpo.gov/nara/index.html

(Catalog of Federal Domestic Assistance Numbers: 84.007 Federal Supplemental Educational Opportunity Grant Program; 84.032 Federal Family Education Loan Program; 84.032 Federal PLUS Program; 84.032 Federal Supplemental Loans for Students Program; 84.033 Federal Work-Study Program; 84.038 Federal Perkins Loan Program; 84.063 Federal Pell Grant Program; 84.069 State Student Incentive Grant Program; 84.226 Income Contingent Loan Program; and 84.268 William D. Ford Federal Direct Loan Program)

List of Subjects in 34 CFR Part 668

Administrative practice and procedure, Colleges and universities, Consumer protection, Education, Grant programs—education, Loan programs—education, Reporting and recordkeeping requirements, Student aid, Vocational education.

Dated: July 27, 1999.

Richard W. Riley,

Secretary of Education.

For the reasons discussed in the preamble, the Secretary proposes to amend part 668 of title 34 of the Code of Federal Regulations as follows:

PART 668—STUDENT ASSISTANCE GENERAL PROVISIONS

1. The authority citation for part 668 continues to read as follows:

Authority: 20 U.S.C. 1085, 1088, 1091, 1092, 1094, 1099c, and 1141, unless otherwise noted.

2. Section 668.17 is amended to read as follows by—

A. Revising paragraph (a)(1).

B. In the introductory language for paragraph (b)(3), removing the word ''institution's'' and adding, in its place, ''institution whose''; removing the word ''respectively''; and removing the words ''section and continuing'' and adding, in their place, ''section. The loss of participation continues''.

C. Revising paragraphs (b)(4) through (b)(6).

D. In the introductory text for paragraph (c)(1), after ''except that an institution may submit an appeal under'', removing the word ''section'' and adding, in its place, ''paragraph''; removing the words ''the information required by paragraph (c)(7) may be submitted in accordance with that paragraph'' and adding, in their place, ''an institution submits an appeal under paragraph (c)(1)(ii)(B) of this section in accordance with paragraph (c)(7) of this section''; and removing the sentence, ''The additional 30-day period specified

in paragraph (c)(7) of this section is an extension for the submission of the auditor's statement only and does not affect the date by which the appeal data must be submitted.''

E. Revising paragraphs (c)(1)(ii), (c)(2), and (c)(7).

F. In paragraphs (e)(1)(ii)(A), (e)(1)(ii)(B), (f)(1)(ii)(A), and (f)(1)(ii)(B), removing the number ''270'' and adding, in its place, ''360''.

G. In paragraphs (e)(3) and (f)(3), removing ''270 days'' and adding, in its place, ''360 days (or for 270 days, if the borrower's delinquency began before October 7, 1998)''.

H. In paragraph (h)(2)(ii), adding, at the end of the paragraph, ''In excluding loans from the calculations of these rates, the Secretary removes them from both the number of students who entered repayment and the number of students who defaulted.''

I. In paragraph (h)(2)(iii), removing the number ''270'' and adding, in its place, ''360''.

J. In the introductory language for paragraph (h)(3)(ii)(B), removing the words ''with a representative sample'' and adding, in their place, ''with access, for a reasonable period of time not to exceed 30 days, to a representative sample''; and removing the words ''records submitted by the lender to the guaranty agency to support the lender's submission of a default claim and included in the claim file'' and adding, in their place, ''collection and payment history records provided to the guaranty agency by the lender and used by the guaranty agency in determining whether to pay a claim on a defaulted loan''.

K. In the introductory language for paragraph (h)(3)(iii)(B), removing the words ''with a representative sample'' and adding, in their place, ''with access, for a reasonable period of time not to exceed 30 days, to a representative sample''; and removing the words ''records maintained by the Department's Direct Loan Servicer with respect to the servicing and collecting of delinquent loans prior to the default'' and adding, in their place, ''collection and payment history records maintained by the Department's Direct Loan Servicer that are used in determining an institution's Direct Loan Program cohort rate or weighted average cohort rate''.

L. Revising paragraph (j)(1)(ii).

M. Removing paragraph (j)(1)(iii).

N. Redesignating paragraphs (j)(2), (j)(3), (j)(4), (j)(5), and (j)(7) as paragraphs (j)(3)(i), (j)(3)(ii), (j)(3)(iii), (j)(3)(iv), and (j)(3)(v), respectively.

O. Redesignating paragraph (j)(6) as (j)(2).

P. In the redesignated paragraph (j)(2), removing the cross-reference ''(h)(1)'' and adding, in its place, ''(j)(1)''.

Q. In the redesignated paragraph (j)(3)(i), removing the number ''30'' and adding, in its place, ''45''.

R. In the redesignated paragraph (j)(3)(ii), removing the citation ''(h)(2)'' and adding, in its place, ''(j)(3)(i)''.

S. In the redesignated paragraph (j)(3)(v), removing the citation ''(d)(1)'' and adding, in its place, ''(c)(1)(i)''; removing the word ''preliminary'' and adding, in its place, ''draft''; and removing the citation ''(h)'' and adding, in its place, ''(j)(3)''.

T. Adding a new paragraph (j)(4).

U. Adding a new paragraph (k).

§ 668.17 Default reduction and prevention measures.

(a) * * *

(1)(i) If the Secretary calculates an FFEL Program cohort default rate, Direct Loan Program cohort rate, or weighted average cohort rate for an institution, the Secretary notifies the institution of that rate.

(ii) If an institution has an FFEL Program cohort default rate, Direct Loan Program cohort rate, or weighted average cohort rate of 10 percent or more, the Secretary includes a copy of the supporting data used in the calculation of the rate with the notice of the rate.

(iii) An institution with an FFEL Program cohort default rate, Direct Loan Program cohort rate, or weighted average cohort rate of less than 10 percent may request a copy of the supporting data used in the calculation of the rate. The institution's request must be sent to the Secretary within 10 working days of receiving the Secretary's notice. Upon receiving the institution's request, the Secretary sends a copy of the data to the institution.

* * * * *

(b) * * *

(4) If an institution loses eligibility to participate in the FFEL or Direct Loan Program under this section, it also loses eligibility to participate in the Federal Pell Grant Program for the same period of time, except that the institution may continue to participate in the Federal Pell Grant Program if the Secretary determines that the institution—

(i) Was ineligible to participate in the FFEL and Direct Loan programs before October 7, 1998, and the institution's eligibility was not reinstated;

(ii) Requested in writing, before October 7, 1998, to withdraw its participation in the FFEL and Direct Loan programs, and the institution did not subsequently re-apply to participate; or

(iii) Has not certified an FFEL loan or originated a Direct Loan on or after July 7, 1998.

(5) An institution whose participation in the FFEL, Direct Loan, or Federal Pell Grant Program ends under paragraph (a)(3), (b)(1), (b)(2), or (b)(4) of this section may not participate in that program until the institution—

(i) Demonstrates to the Secretary that it meets all requirements for participation in the FFEL, Direct Loan, or Federal Pell Grant Program;

(ii) Has paid any amount owed to the Secretary under paragraph (b)(6)(ii)(B) of this section or is meeting that obligation under an agreement satisfactory to the Secretary; and

(iii) Executes a new agreement with the Secretary for participation in that program following the period described in paragraph (b)(3) of this section.

(6)(i) An institution may, notwithstanding 34 CFR 668.26, continue to participate in the FFEL, Direct Loan, and Federal Pell Grant programs until the Secretary issues a decision on the institution's appeal if the Secretary receives an appeal that is complete, accurate, and timely in accordance with paragraph (c) of this section; or it may suspend its participation during the appeal.

(ii) If an institution continues to participate in the FFEL or Direct Loan Program under paragraph (b)(6)(i) of this section, and the institution's appeal of its loss of participation is unsuccessful—

(A) The Secretary estimates the amount of interest, special allowance, reinsurance, and any related or similar payments made by the Secretary (or which the Secretary is obligated to make) on any FFEL or Direct Loan Program loan for which the institution certified and delivered or originated and disbursed funds during the period in which the institution would have been otherwise ineligible to certify and deliver or originate and disburse those funds, if it had not appealed;

(B) The Secretary excludes from the estimate calculated under paragraph (b)(6)(ii)(A) of this section any amount that is attributable to funds delivered or disbursed by the institution more than 45 calendar days after the date on which the institution submitted its completed appeal to the Secretary; and

(C) The institution must pay the Secretary the amount estimated under paragraph (b)(6)(ii) of this section within 45 days of the date of the Secretary's notification, unless—

(*1*) The institution files an appeal under the procedures established in subpart H of this part; or

(*2*) The Secretary permits a longer repayment period.

(iii) An institution may also continue to participate in the FFEL Program or Direct Loan Program if it is in compliance with paragraph (k) of this section.

(c) * * *

(1) * * *

(ii) The institution meets one of the following exceptional mitigating circumstances:

(A)(*1*) The institution's participation rate index, as determined under paragraph (c)(1)(ii)(A)(*2*) of this section, is equal to or less than 0.0375 for any of the 3 most recent fiscal years for which data are available.

(*2*) For the purpose of (c)(1)(ii)(A)(*1*) of this section, an institution's participation rate index for a fiscal year is determined by multiplying its FFEL Program cohort default rate, Direct Loan Program cohort rate, or weighted average cohort rate for that fiscal year by the percentage of its regular students, as defined in 34 CFR 600.2, who—

(*i*) Were enrolled on at least a half-time basis during any part of a 12-month period ending during the 6 months immediately preceding the fiscal year for which the cohort of borrowers (used to calculate the institution's FFEL Program cohort default rate, Direct Loan Program cohort rate, or weighted average cohort rate) is determined; and

(*ii*) Received an FFEL or Direct Loan for attendance at the institution for a loan period that coincides with any part of the same 12-month period.

(B)(*1*) If in the opinion of an independent auditor, as submitted under paragraph (c)(7) of this section, the institution's economically disadvantaged rate is two-thirds or more, as determined under paragraph (c)(1)(ii)(B)(2) of this section; and

(*i*) If it offers an associate, baccalaureate, graduate or professional degree, the institution's completion rate is 70 percent or more, as determined under paragraph (c)(1)(ii)(B)(*3*) of this section; or

(*ii*) If it does not offer an associate, baccalaureate, graduate or professional degree, the institution's placement rate is 44 percent or more, as determined under paragraph (c)(1)(ii)(B)(*4*) of this section.

(*2*) For the purpose of (c)(1)(ii)(B)(*1*) of this section, an institution's economically disadvantaged rate is the percentage of its students, enrolled on at least a half-time basis in an eligible program at the institution during any part of a 12-month period that ended during the 6 months immediately preceding the fiscal year for which the cohort of borrowers (used to calculate the institution's FFEL Program cohort default rate, Direct Loan Program cohort rate, or weighted average cohort rate) is determined, who—

(*i*) Are eligible to receive a Federal Pell Grant award of at least one-half the maximum Federal Pell Grant award for which the student would be eligible based on the student's enrollment status; or

(*ii*) Have an adjusted gross income that, if added to the adjusted gross income of the student's parents (unless the student is an independent student), is less than the poverty level as determined by the Department of Health and Human Services.

(*3*) For the purpose of (c)(1)(ii)(B)(*1*) of this section, an institution's completion rate is the percentage of its regular students, initially enrolled on a full-time basis in an eligible program and scheduled to complete their programs, as described in paragraph (c)(2) of this section, during the same 12-month period used to determine its economically disadvantaged rate under paragraph (c)(1)(ii)(B)(*2*) of this section, who—

(*i*) Completed the educational programs in which they were enrolled;

(*ii*) Transferred from the institution to a higher level educational program;

(*iii*) Remained enrolled and making satisfactory progress toward completion of the student's educational programs at the end of the 12-month period; or

(*iv*) Entered active duty in the Armed Forces of the United States within 1 year after their last day of attendance at the institution.

(*4*)(*i*) Except as provided in paragraph (c)(1)(ii)(B)(*4*)(*ii*) of this section, for the purpose of (c)(1)(ii)(B)(*1*) of this section, an institution's placement rate is the percentage of its former students, as described in paragraph (c)(1)(ii)(B)(*4*)(*iii*) of this section, who are employed, in an occupation for which the institution provided training, on the date following 1 year after their last date of attendance at the institution; were employed, in an occupation for which the institution provided training, for at least 13 weeks before the date following 1 year after their last date of attendance at the institution; or entered active duty in the Armed Forces of the United States within 1 year after their last date of attendance at the institution.

(*ii*) If a former student's employer is the institution, the student is not considered employed for the purposes of paragraph (c)(1)(ii)(B) of this section.

(*iii*) The former students who are used to determine an institution's placement rate under paragraph (c)(1)(ii)(B)(*4*) of this section include only students who were initially enrolled in eligible programs on at least a half-time basis; were originally scheduled, at the time of enrollment, to complete their educational programs during the same 12-month period used to determine the institution's economically disadvantaged rate under paragraph (c)(1)(ii)(B)(*2*) of this section; and remained in the program beyond the point at which a student would have received a 100 percent tuition refund from the institution. A student is not included in the calculation of the placement rate if that student, on the date that is 1 year after the student's scheduled completion date, remains enrolled in the same program at the institution and is making satisfactory progress.

(C) At least two of the rates that result in a loss of eligibility under paragraph (a)(3), (b)(1), or (b)(2) of this section—

(*1*) Are calculated using data for the 3 most recent fiscal years, pursuant to paragraph (d)(1)(i)(B), (e)(1)(i)(B), (e)(1)(ii)(B), (f)(1)(i)(B), or (f)(1)(ii)(B) of this section; and

(*2*) Would be less than 25 percent if calculated using data for only the fiscal year for which the institution received its rate, pursuant to paragraph (d)(1)(i)(A), (e)(1)(i)(A), (e)(1)(ii)(A), (f)(1)(i)(A), or (f)(1)(ii)(A) of this section, respectively.

(D) During the 3 most recent fiscal years for which the Secretary has determined the institution's rate, a total of thirty or fewer borrowers entered repayment on a loan or loans included in a calculation of the institution's rate.

(2) For the purposes of the completion rate and placement rate described in paragraphs (c)(1)(ii)(B)(*3*) and (*4*) of this section, a student is scheduled to complete an educational program on the date on which—

(i) If the student is initially enrolled full-time, the student will have been enrolled in the program for the amount of time specified in the institution's enrollment contract, catalog, or other materials, for completion of the program by a full-time student; or

(*ii*) If the student is initially enrolled less than full-time, the student will have been enrolled in the program for the amount of time that it would take the student to complete the program if the student remained enrolled at that level of enrollment throughout the program.

* * * * *

(7)(i) An institution that appeals on the grounds that it meets the exceptional mitigating circumstances criteria in paragraph (c)(1)(ii)(B) of this section must submit to the Secretary—

(A) Within 30 calendar days of the date that it was notified of its loss of

participation, notice of its intent to appeal under that paragraph, in a format prescribed by the Secretary; and

(B) Within 60 calendar days of the date that it was notified of its loss of participation, the independent auditor's compliance attestation report, as described in paragraph (c)(7)(ii) of this section, including the specific institution's management's written assertions for which the independent auditor opines, all in a format prescribed by the Secretary.

(ii)(A) The report of the independent auditor, required for an institution's appeal under paragraph (c)(1)(ii)(B) of this section, must state whether, in the auditor's opinion, the institution's management's assertion met the exceptional mitigating circumstances criteria specified in paragraph (c)(1)(ii)(B) of this section, as provided to the auditor to examine, and is fairly stated in all material respects.

(B) The engagement that forms the basis of the independent auditor's opinion must be an examination-level compliance attestation engagement performed in accordance with the American Institute of Certified Public Accountant's (AICPA) Statement on Standards for Attestation Engagements, Compliance Attestation (AICPA, Professional Standards, vol. 1, AT sec. 500), as amended, and Government Auditing Standards issued by the Comptroller General of the United States.

(iii) The Secretary denies an institution's appeal under paragraph (c)(1)(ii)(B) of this section if—

(A) The independent auditor does not opine that the institution meets the criteria for the appeal; or

(B) The Secretary determines that the independent auditor's report or institution's management's assertion described in paragraph (c)(7)(i) of this section—

(*1*) Demonstrates that the independent auditor's report or examination does not meet the requirements of this section; or

(*2*) Is contradicted or otherwise refuted, to an extent that would render the auditor's report unacceptable, by information maintained by the Secretary.

* * * * *

(j) * * *

(1) * * *

(ii) The Secretary's notice to an institution of its draft cohort default rate includes a copy of the supporting data used in the calculation of that draft rate.

* * * * *

(4)(i) Within 30 calendar days of receiving the draft default rate information from the Secretary, an institution may challenge an anticipated loss of participation under (a)(3), (b)(1), or (b)(2) of this section using the criteria in § 668.17(c)(1)(ii)(A).

(ii) In meeting the requirements of § 668.17(c)(1)(ii)(A) during a challenge under this paragraph, the institution's draft rate is considered to be its most recent rate.

(iii) The Secretary notifies an institution of the determination on its challenge before the institution's FFEL Program cohort default rate, Direct Loan Program cohort rate, or weighted average cohort rate is published.

(k) *Special institutions.* (1) *Applicability of requirements.* For each 1-year period beginning on July 1 of 1999, 2000, or 2001, the Secretary may determine that the provisions of paragraph (a)(3), (b)(1), or (b)(2) of this section and the provisions of 34 CFR 668.16(m) do not apply to a historically black college or university within the meaning of section 322(2) of the HEA, a tribally controlled community college within the meaning of section 2(a)(4) of the Tribally Controlled Community College Assistance Act of 1978, or a Navajo community college under the Navajo Community College Act if the institution submits to the Secretary—

(i) By July 1, 1999—

(A) A default management plan; and

(B) A certification that the institution has engaged an independent third party, as described in paragraph (k)(3) of this section; and

(ii) By July 1, 2000 and 2001—

(A) Evidence that it has implemented its default management plan during the preceding 1-year period;

(B) Evidence that it has made substantial improvement in the preceding 1-year period in the institution's FFEL Program cohort default rate, Direct Loan Program cohort rate, or weighted average cohort rate; and

(C) A certification that it continues to engage an independent third party, as described in paragraph (k)(3) of this section.

(2) *Default management plan.* (i) An institution's default management plan must provide reasonable assurance that it will, no later than July 1, 2002, have an FFEL Program cohort default rate, Direct Loan Program cohort rate, or weighted average cohort rate that is less than 25 percent. Measures that an institution must take to provide this assurance include but are not limited to—

(A) Establishing a default management team by engaging the chief executive officer and relevant senior executive officials of the institution and enlisting the support of representatives from offices other than the financial aid office;

(B) Identifying and allocating the personnel, administrative, and financial resources appropriate to implement the default management plan;

(C) Defining the roles and responsibilities of the independent third party;

(D) Defining evaluation methods and establishing a data collection system for measuring and verifying relevant default management statistics, including a statistical analysis of the borrowers who default on their loans;

(E) Establishing annual targets for reductions in the institution's rate; and

(F) Establishing a process to ensure the accuracy of the institution's rate.

(ii) An institution's default management plan must be acceptable to the Secretary, after consideration of that institution's history, resources, dollars in default, and targets for default reduction.

(iii) If the Secretary determines that an institution's proposed default management plan is unacceptable, the institution should consult with the Secretary to develop a revised plan, and the institution must submit the revised plan to the Secretary within 30 calendar days of notice from the Secretary that the plan is unacceptable.

(iv) If the Secretary determines, based on evidence submitted under paragraph (k)(1)(ii) of this section, that an institution's default management plan is no longer acceptable, the institution must develop a revised plan in consultation with the Secretary, and it must submit the revised plan to the Secretary within 60 calendar days of notice from the Secretary.

(v) A sample default management plan is provided in appendix H to this part. The sample is included to illustrate additional components of an acceptable default management plan. Because institutions' family income profiles, student borrowing patterns, histories, resources, dollars in default, and targets for default reduction are different, an institution must consider its own, individual circumstances in developing and submitting its plan.

(3) *Independent third party.* (i) An independent third party may be any individual or entity that—

(A) Provides technical assistance in developing and implementing the institution's default management plan; and

(B) Is not substantially controlled by a person who also exercises substantial control over the institution.

(ii) An independent third party need not be paid by the institution for its services.

(iii) The services of a lender, guaranty agency, or secondary market as an independent third party under paragraph (k) of this section are not considered to be inducements under § 682.200 or § 682.401(e).

(4) *Substantial improvement.*

(i) For purposes of this section, an institution's substantial improvement is determined based upon—

(A) A reduction in the institution's most recent draft or published FFEL Program cohort default rate, Direct Loan Program cohort rate, or weighted average cohort rate;

(B) An increase in the percentage of delinquent borrowers who avoid default by using deferments, forbearances, and job placement assistance;

(C) An increase in the academic persistence of student borrowers;

(D) An increase in the percentage of students pursuing graduate or professional study;

(E) An increase in the percentage of borrowers for whom a current address is known;

(F) An increase in the percentage of delinquent borrowers contacted by the institution;

(G) The implementation of alternative financial aid award policies and development of financial resources that reduce the need for student borrowing; or

(H) An increase in the percentage of accurate and timely enrollment status changes submitted by the institution to the National Student Loan Data System (NSLDS) on the Student Status Confirmation Report (SSCR).

(ii) When making a determination of an institution's substantial improvement, the Secretary considers the institution's performance in light of—

(A) Its history, resources, dollars in default, targets for default reduction;

(B) Its level of effort in meeting the terms of its approved default management plan during the previous 1-year period; and

(C) Any other mitigating circumstance at the institution during the 1-year period.

(5) *Secretary's determination.* (i) If the Secretary determines that an institution is in compliance with paragraph (k) of this section, then the provisions of paragraph (a)(3), (b)(1), or (b)(2) of this section and the provisions of 34 CFR 668.16(m) do not apply to the institution for that 1-year period, beginning on July 1 of 1999, 2000, or 2001.

(ii) If the Secretary determines that an institution is not in compliance with paragraph (k) of this section, the institution is subject to the provisions of paragraph (a)(3), (b)(1), or (b)(2) of this section and the provisions of 34 CFR 668.16(m). The institution's participation in the FFEL and Direct Loan programs ends on the date that the institution receives notice of the Secretary's determination.

3. A new appendix H is added to part 668 to read as follows:

Appendix H to Part 668—Default Management Plans for Special Institutions

This appendix is provided as a sample plan for those schools developing a default management plan in accordance with 34 CFR 668.17(k). It describes some measures schools may find helpful in reducing the number of students that default on federally funded loans. These are not the only measures a school could implement when developing a default management plan. In developing a default management plan, each school should consider its own history, resources, dollars in default, and targets for default reduction to determine which activities will result in the most benefit to the students and the school.

Core Default Reduction Strategies (from § 668.17(k)(2)(i))

(1) Establish a default management team by engaging the chief executive officer and relevant senior executive officials of the school and enlisting the support of representatives from offices other than the financial aid office.

(2) Identify and allocate the personnel, administrative, and financial resources appropriate to implement the default management plan.

(3) Define the roles and responsibilities of the independent third party.

(4) Define evaluation methods and establish a data collection system for measuring and verifying relevant default management statistics, including a statistical analysis of the borrowers who default on their loans.

(5) Establish annual targets for reductions in the school's rate.

(6) Establish a process to ensure the accuracy of the school's rate.

Additional Default Reduction Strategies

(1) Enhance the borrower's understanding of his or her loan repayment responsibilities through counseling and debt management activities.

(2) Enhance the enrollment retention and academic persistence of borrowers through counseling and academic assistance.

(3) Maintain contact with the borrower after he or she leaves the school by using activities such as skip-tracing to locate the borrower.

(4) Track the borrower's delinquency status by obtaining reports from lenders and guaranty agencies for FFEL Program loans and from the Secretary for Direct Loan Program loans.

(5) Enhance student loan repayments through counseling the borrower on loan repayment options and facilitating contact between the borrower and lender for FFEL Program loans and the borrower and the Secretary for Direct Loan Program loans.

(6) Assist a borrower who is experiencing difficulty in finding employment through career counseling, job placement assistance, and facilitating unemployment deferments.

(7) Identify and implement alternative financial aid award policies and develop alternative financial resources that will reduce the need for student borrowing in the first 2 years of academic study.

(8) Familiarize the parent, or other adult relative or guardian, with the student's debt profile, repayment obligations, and loan status by increasing, whenever possible, the communication and contact with the parent or adult relative or guardian.

Defining the Roles and Responsibilities of Independent Third Party

(1) Specifically define the role of the independent third party.

(2) Specify the scope of work to be performed by the independent third party.

(3) Tie the receipt of payments, if required, to the performance of specific tasks.

(4) Assure that all the required work is satisfactorily completed.

Statistics for Measuring Progress

(1) The number of students enrolled at the school during each fiscal year.

(2) The average amount borrowed by a student each fiscal year.

(3) The number of borrowers scheduled to enter repayment each fiscal year.

(4) The number of enrolled borrowers that received default prevention counseling services each fiscal year.

(5) The average number of contacts the school or its agent had with a borrower who was in deferment/forbearance or repayment status during each fiscal year.

(6) The number of borrowers at least 60 days delinquent each fiscal year.

(7) The number of borrowers who defaulted in each fiscal year.

(8) The type, frequency, and results of activities performed in accordance with the default management plan.

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Vol. 64, No. 146

Friday, July 30, 1999

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FEDERAL REGISTER PAGES AND DATES, JULY

35559–35920 1
35921–36236 2
36237–36558 6
36559–36762 7
36763–37032 8
37033–37392 9
37393–37662 12
37663–37832 13
37833–38102 14
38103–38286 15
38287–38534 16
38535–38814 19
38815–38998 20
38999–39392 21
39393–39896 22
39897–40280 23
40281–40504 26
40505–40734 27
40735–41002 28
41003–41264 29
41265–41764 30

CFR PARTS AFFECTED DURING JULY

At the end of each month, the Office of the Federal Register publishes separately a List of CFR Sections Affected (LSA), which lists parts and sections affected by documents published since the revision date of each title.

3 CFR

Proclamations:
6575 36229
6982 36549
7206 36229
7207 36549
7208 37389
7208 37393
7209 39895
7210 40723
7211 41001
7212 41003
7213 41005

Executive Orders:
July 12, 1911 (Revoked in part by PLO 7400) 38212
12722 (See Notice of July 20, 1999) 39897
12724 (See Notice of July 20, 1999) 39897
12757 (amended by 13131) 40733
12823 (See EO 13131) 40733
13010 38535
13028 (See EO 13131) 40733
13129 ..... 36757, 37033
13130 38535
13131 40733

Administrative Orders:
Memorandums:
July 7, 1999 37393
July 9, 1999 38101
July 16, 1999 40503

Notices:
Notice of July 20, 1999 39897

Presidential Determinations:
No. 99–30 of June 23, 1999 35921
No. 99–31 of June 30, 1999 ..... 37033, 38075
No. 99–32 of July 1, 1999 ..... 37035, 38075

5 CFR

330 ..... 40505, 40506
531 36763
550 36763
591 36763
890 36237

Proposed Rules:
317 41334
1204 35952
1205 35957

7 CFR

2 40735
47 38103
57 40736
271 38287
272 38287
273 38287
274 38287
275 38287
276 38287
277 38287
278 38287
279 38287
280 38287
281 38287
282 38287
283 38287
284 38287
285 38287
300 37663
301 ..... 37663, 38815, 40281, 40509
319 38108
360 41007
400 ..... 38537, 40738, 40740
402 40738
457 40740
762 38297
920 41010
925 37833
930 40511
944 37833
979 41019
981 41023
1216 41252
1477 35559
1980 38297
3700 40783

Proposed Rules:
29 39432
54 38315
56 ..... 37886, 40522
70 37886
210 38839
220 38839
225 38839
226 38839
250 36978
251 36978
253 39432
254 39432
271 37454
273 37454
276 37454
319 36608
457 41336
906 38597
924 37888
948 37890
993 41045
1000 ..... 37892, 39092
1001 ..... 37892, 39092
1002 ..... 37892, 39092
1004 ..... 37892, 39092
1005 ..... 37892, 39092
1006 ..... 37892, 39092
1007 ..... 37892, 39092

1012.....37892, 39092
1013.....37892, 39092
1030.....37892, 39092
1032.....37892, 39092
1033.....37892, 39092
1036.....37892, 39092
1040.....37892, 39092
1044.....37892, 39092
1046.....37892, 39092
1049.....37892, 39092
1050.....37892, 39092
1064.....37892, 39092
1065.....37892, 39092
1068.....37892, 39092
1076.....37892, 39092
1079 .....37892, 39092, 41047
1106.....37892, 39092
1124.....37892, 39092
1126.....37892, 39092
1131 .....37892, 38144, 39092
1134.....37892, 39092
1135.....37892, 39092
1137.....37892, 39092
1138.....37892, 39092
1139.....37892, 39092
1218.....39790, 39803
1230.....40783
1430.....39442
1710.....36609
2812.....41049

8 CFR

214.....36423
235.....36559
Proposed Rules:
241.....37461, 39560

9 CFR

1.....38546
2.....38546
3.....38546
52.....37395
72.....41268
78.....36775
91.....41269
94.....38548
331.....37666
381.....37666
Proposed Rules:
3.....38145
94.....37897, 38599
96.....37897
130.....37903

10 CFR

9.....39393
50.....38551
70.....41338
170.....38816
171.....38816
708.....37396
Proposed Rules:
20.....41050
30.....40295
31.....40295
32.....40295
40.....36615, 40784
50.....36291, 39447
72.....36291, 41050
170.....40295
171.....40295
430.....37706
474.....37905
810.....35959

11 CFR

100.....41266
110.....37397
114.....41266
Proposed Rules:
110.....39095

12 CFR

615.....38110
701.....41029
715.....41029
741.....41029
Proposed Rules:
229.....37708
701.....40786
704.....40787

13 CFR

114.....40282
Proposed Rules:
120.....40310
121.....40311, 40314
123.....36617

14 CFR

23.....39899
25.....38999
39 .....35559, 36561, 36563, 36777, 37667, 37669, 37838, 37841, 38299, 38301, 38557, 38817, 38821, 39001, 39003, 39005, 39396, 39398, 40283, 40514, 40743
71 .....36565, 36566, 36567, 36568, 37671, 38302, 38303, 38304, 38305, 38306, 38560, 38822, 38823, 38824, 39007, 39008, 39009, 39011, 39012, 39013, 39014, 39015, 39403, 40285, 40745, 41040, 41273
73.....39016
95.....41274
97 .....35562, 35564, 38561, 38562, 41281, 41283, 41284
221.....40654
250.....40654
257.....38111
258.....38111
293.....40654
1206.....39404
Proposed Rules:
21.....35902
25.....39095
27.....35902
29.....35902
39 .....36307, 36618, 36623, 36624, 36626, 36628, 37046, 37465, 37471, 37911, 37913, 37915, 37917, 37918, 37920, 38150, 38152, 38154, 38156, 38157, 38316, 38319, 38322, 38325, 38329, 38332, 38335, 38338, 38341, 38345, 38348, 38351, 38355, 38358, 38362, 38365, 38368, 38371, 38374, 38378, 38379, 38382, 38383, 38603, 38605, 38606, 38844, 38846, 38848, 38850, 39097, 39100, 39102, 39104, 39448, 39450, 39944, 39946, 40319, 40789
71 .....36630, 36631, 37713, 37714, 37715, 37716, 37717, 38385, 38386, 38607, 38609, 39949, 39950, 41054, 41357, 41358, 41359, 41360, 41362, 41363
91 .....35902, 37018, 40791
93 .....35963, 37296, 37304, 38851
139.....37026, 40791
193.....40472

15 CFR

30.....40974
774.....36779
902.....36780, 39017
Proposed Rules:
710.....39194
711.....39194
712.....39194
713.....39194
714.....39194
715.....39194
716.....39194
717.....39194
718.....39194
719.....39194
720.....39194
721.....39194
740.....40106
743.....40106
774.....40106
801.....37049
922.....38853

16 CFR

Proposed Rules:
Ch. II.....38387
23.....37051
312.....40525
432.....38610
453.....35965
1213.....37051
1500.....37051
1513.....37051

17 CFR

1.....36568
3.....39912
9.....39913, 39915
240.....37586, 39918
249.....37586
Proposed Rules:
1.....38159
5.....40528
240.....41056

18 CFR

2.....37037
153.....37037
157.....37037
275.....37037
284.....37037
290.....37037
385.....37037
430.....35566
Proposed Rules:
35.....40533
330.....37718
385.....37718

19 CFR

4.....40984
101.....40984
178.....40984
192.....40984

20 CFR

220.....36239

21 CFR

74.....39414
173.....38563
514.....40746
520.....37672, 39918
524.....37400
556.....35923
558.....35923, 37672
1020.....35924
1308 .....35928, 37673, 39560
1309.....40516
1310.....40516
1312.....35928
Proposed Rules:
16.....36492, 36517
101 .....36492, 36517, 36824
115.....36492, 36517
291.....39810
333.....39452
510.....35966
514.....35966, 40321
558.....35966
801.....41710
878.....41710
880.....41710

22 CFR

514.....40286
Proposed Rules:
103.....39244

23 CFR

655.....38307
661.....38565
1200.....40757
1205.....40757
1225.....35568

24 CFR

291.....36210
570.....38812
985.....40496
Proposed Rules:
Ch. IX.....38853
5.....40262
200.....36216, 40262
247.....40262
290.....38284
880.....40262
882.....40262
884.....40262
891.....40262
960.....40262
966.....40262
972.....40323, 40340
982.....40262

25 CFR

Proposed Rules:
516.....38164

26 CFR

1 .....35573, 36092, 36116, 36175, 37037, 37675, 37677, 38825
20.....37675
25.....37675
31.....37675
40.....37675
301 .....36092, 36569, 37677, 39020
602 .....36092, 36116, 36175, 37678
Proposed Rules:
1.....35579, 37727
301.....37727, 39106

28 CFR

0.....37038

90 39744
553 36750
600 37038
Proposed Rules:
5 37065
540 40718

29 CFR

215 40990
1203 40286
1205 40286
1209 40286
1614 37644
4044 ....38114, 38534
Proposed Rules:
1908 35972
1926 38078
2510 38390

30 CFR

210 38116
216 38116
227 36782
256 40764
920 36784
934 38826
Proposed Rules:
57 ....36632, 36826, 40533
72 36826
75 ....36632, 36826, 40533
904 37067
914 38165
916 40323
917 38391
920 38392
924 40326
938 36828

31 CFR

100 39919
103 41041
306 38124
315 40484
353 40484
357 40484
370 40484
Ch. V 35575
Proposed Rules:
203 41748

32 CFR

199 38575
989 38127
Proposed Rules:
775 37069
776 37473

33 CFR

100 ....37583, 39027, 39415
110 38828
117 ....36239, 36569, 36570, 37678, 38829, 38830
165 ....36571, 36572, 36573, 37679, 39027, 39032, 39033
173 36240
Proposed Rules:
110 38166
117 ....36318, 39454
165 ....36633, 39108, 39454

34 CFR

Proposed Rules:
600 38272
668 ....38272, 38504, 41752
674 41232
694 39109

36 CFR

242 ....35776, 35821
251 37843
Proposed Rules:
327 38854
1010 39951
1191 37326
1275 37922

37 CFR

201 ....36574, 41286
202 36574
203 36574
204 36574
211 36574
212 36576
251 36574
253 36574
259 36574
260 36574
Proposed Rules:
212 36829
255 38861

38 CFR

21 38576

39 CFR

111 38831
261 41289
262 41289
263 41289
264 41289
265 41289
266 41289
267 41289
3002 37401

40 CFR

9 ....36580, 37624
22 40138
51 35714
52 ....35577, 35930, 35941, 36243, 36248, 36586, 36786, 36790, 37402, 37406, 37681, 37847, 38577, 38580, 38832, 38836, 39034, 39037, 39920, 39923, 40287, 40767
60 ....37196, 38241
62 ....36600, 37851, 38582, 41291
63 ....37683, 38950
75 37582
80 37687
81 ....37406, 39416
82 39040
90 36423
180 ....36252, 36794, 37855, 37861, 37863, 37870, 38307, 39041, 39049, 39053, 39060, 39068, 39072, 39078, 40769, 41294, 41297
185 ....39068, 39072, 39078
186 ....39072, 39078
228 39927
260 36466
261 36466
262 37624
264 ....36466, 37624
265 ....36466, 37624
268 36466
270 ....36466, 37624
273 36466
300 39878
430 36580
745 39418
Proposed Rules:
35 ....40064, 40084
52 ....36635, 36830, 36831, 37491, 37492, 37734, 37923, 38616, 38617, 38862, 38863, 39110, 39963, 40328, 40791
62 ....36426, 36639, 37923, 38617, 41364
63 ....37734, 38993
81 37492
90 40940
131 37072
148 40192
180 36640
261 40192
262 40696
268 ....40192, 40534
271 40192
300 ....39886, 40328
302 40192
403 39564
442 38863
745 40064

41 CFR

Ch. 301 38587
102-2 39083
101-35 38588
101-42 40772
101-43 40772
301–52 38528
301–54 38528
301–70 38528
301–71 38528
301–76 38528

42 CFR

100 40517
409 41644
411 41644
412 41490
413 ....41490, 41644
431 39934
482 36070
483 41490
485 41490
489 41644
498 39934
1001 39420
1002 39420
1003 39420
Proposed Rules:
8 39810
405 38395
409 36320
410 ....36320, 39608
411 ....36320, 39608
412 36320
413 36320
414 ....39608, 40534
415 39608
416 36321
419 36320
488 36321
489 36320
498 36320
1003 36320

43 CFR

Proposed Rules:
2530 38172

44 CFR

7 38308
61 41305
64 ....38309, 38311
65 ....41306, 41309, 41312
67 ....41315, 41317
Proposed Rules:
67 ....41315, 41368

45 CFR

260 40290
261 40290
262 40290
263 40290
264 40290
265 40290
2522 37411
2525 37411
2526 37411
2527 37411
2528 37411
2529 37411
Proposed Rules:
5b 37081

46 CFR

530 41041
Proposed Rules:
10 39455
15 39455
90 39455
98 39455
125 39455
126 39455
127 39455
128 39455
129 39455
130 39455
131 39455
132 39455
133 39455
134 39455
170 39455
174 39455
175 39455
388 36831

47 CFR

1 ....35832, 39938, 41320
3 40774
18 37417
20 38313
52 41320
54 41320
63 39938
64 41320
73 ....35941, 36254, 36255, 36256, 36257, 36258, 37875, 37876, 38588, 38589, 38590, 38591, 38592, 39940, 39941, 40292
76 ....35948, 36605
90 ....36258, 39942
Proposed Rules:
1 ....38617, 41059
3 40808
15 38877
20 38396
22 ....38617, 41059
24 41059
26 41059
27 ....36642, 41059
73 ....36322, 36323, 36324, 36642, 37924, 37925, 37926, 37927, 38621, 38622, 39963, 39964, 39965, 40331, 40535, 41059
74 41059

80 41059
87 41059
90 41059
95 41059
97 41059
101 ....38617, 41059

48 CFR

Ch. 1 36222
1 36222
12 36222
14 36222
15 36222
19 36222
26 36222
33 36222
52 36222
Ch. 5 37200
53 36222
201 39429
237 39430
252 39431
828 40518
829 38592
852 40518
1509 41042
1615 36271
1632 36271
1652 36271
1801 36605
1804 36605
1809 36605
1815 36605
1827 36605
1832 36605
1833 36606
1845 36605
1852 36605
2832 37044
6103 38143

Proposed Rules:

2 40694
9 37360
12 40494
14 40494
15 40494
26 40494
31 37360
36 40494
47 ....37640, 40998
52 ....37640, 40494, 40694, 40998
201 41060
208 38878
212 38878
213 ....38878, 41060
214 38878
215 38878
232 38878
245 39456
252 ....38878, 39456
1807 38880
1811 38880
1812 38880
1815 38880
1816 38880
1823 38880
1842 38880
1846 38880
1852 38880

49 CFR

1 36801
177 36802
180 36802
195 40777
395 37689
567 38593
574 36807
578 37876
583 40777
591 37878

Proposed Rules:

71 40331
171 40810
173 40810
174 40810
175 40810
176 40810
177 40810
192 35580
195 38173
571 36657
1420 39111

50 CFR

17 ....36274, 37638, 39560
100 ....35776, 35821
216 37690
600 ....36817, 39017, 40781
622 ....36780, 37690
635 ....36818, 37700, 37883, 40782
648 40519
660 ....36817, 36819, 36820, 40293, 41044
679 ....37884, 39087, 39089, 39090, 40293

Proposed Rules:

17 ....36454, 36836, 37492, 40333, 41060, 41061
20 39460
600 40542
622 ....35981, 36325, 37082, 40544
640 37082
648 ....35984, 40542, 40545
660 ....39479, 39965
679 41068

REMINDERS

The items in this list were editorially compiled as an aid to Federal Register users. Inclusion or exclusion from this list has no legal significance.

RULES GOING INTO EFFECT JULY 30, 1999

AGRICULTURE DEPARTMENT

Agricultural Marketing Service

Peanut promotion, research, and information order; published 7-29-99

COMMERCE DEPARTMENT

]cquisition regulations:

Small, small disadvantaged and women-owned small business subcontracting plan; solicitation provisions and contract clauses; published 6-30-99

ENVIRONMENTAL PROTECTION AGENCY

Air pollutants, hazardous; national emission standards:

Maximum achievable control technology; constructed or reconstructed major sources; published 6-30-99

Pesticides; tolerances in food, animal feeds, and raw agricultural commodities:

Diuron; published 7-30-99

Propiconazole; published 7-30-99

FEDERAL EMERGENCY MANAGEMENT AGENCY

Flood insurance program:

Group flood insurance policy; published 7-30-99

HEALTH AND HUMAN SERVICES DEPARTMENT

Food and Drug Administration

Human drugs:

Cold, cough, allergy, bronchodilator, and antiasthmatic products (OTC)—

Nasal decongestant products; published 7-30-98

SECURITIES AND EXCHANGE COMMISSION

Securities:

Securities Exchange Act of 1934—

Broker-dealer registration and reporting; published 7-12-99

TRANSPORTATION DEPARTMENT

Federal Aviation Administration

Airworthiness directives:

Pratt & Whitney; published 7-30-99¶

RULES GOING INTO EFFECT JULY 31, 1999

AGRICULTURE DEPARTMENT

Food Safety and Inspection Service

Meat and poultry inspection:

Federal Meat Inspection and Poultry Products Inspection Acts; State designations—

Alaska; published 7-13-99¶

RULES GOING INTO EFFECT AUGUST 1, 1999

AGRICULTURE DEPARTMENT

Agricultural Marketing Service

Almonds grown in—

California; published 7-29-99

Kiwifruit grown in—

California; published 7-29-99

Prunes (dried) produced in California; published 5-4-99

PENSION BENEFIT GUARANTY CORPORATION

Single-employer plans:

Allocation of assets—

Interest assumptions for valuing benefits; published 7-15-99

Interest assumptions for valuing benefits; correction; published 7-16-99

POSTAL SERVICE

Domestic Mail Manual:

Nonprofit and classroom periodicals classification changes and notice of refund procedures; published 7-20-99

COMMENTS DUE NEXT WEEK

AGRICULTURE DEPARTMENT

Agricultural Marketing Service

Cherries (tart) grown in—

Michigan et al.; comments due by 8-6-99; published 6-7-99

Nectarines and peaches grown in—

California; comments due by 8-6-99; published 6-7-99

AGRICULTURE DEPARTMENT

Animal and Plant Health Inspection Service

Animal welfare:

Dogs and cats; acclimation certificates; comments due by 8-6-99; published 6-7-99

Exportation and importation of animals and animal products:

Ports of entry—

New Jersey and New York; ports designated for exportation of horses; comments due by 8-2-99; published 6-4-99

Plant-related quarantine, domestic:

Fire ant, imported; comments due by 8-6-99; published 6-7-99

Mediterranean fruit fly; comments due by 8-6-99; published 6-7-99

COMMERCE DEPARTMENT

National Oceanic and Atmospheric Administration

Endangered and threatened species:

Designated critical habitats—

Snake River spring/summer chinook salmon; comments due by 8-2-99; published 6-2-99

Fishery conservation and management:

Northeastern United States fisheries—

Northeastern multispecies; comments due by 8-2-99; published 6-1-99

DEFENSE DEPARTMENT

Air Force Department

Military personnel:

Military personnel, employees, and dependents available to civilian authorities for trial; comments due by 8-2-99; published 6-1-99

DEFENSE DEPARTMENT

Defense Logistics Agency

Defense contracting:

Wildfire Suppression Aircraft Transfer Act of 1996; implementation; comments due by 8-2-99; published 6-1-99

EDUCATION DEPARTMENT

Family educational rights and privacy

Amendments; comments due by 8-2-99; published 6-1-99

ENVIRONMENTAL PROTECTION AGENCY

Air pollution control; new motor vehicles and engines; and fuels and fuel additives:

Tier 2 motor vehicle emission standards and gasoline sulphur control requirem ents; comments due by 8-2-99; published 5-13-99

Tier 2 motor vehicle emission standards and gasoline sulphur control requirements; comments due by 8-2-99; published 6-30-99

Air programs; approval and promulgation; State plans for designated facilities and pollutants:

Illinois; comments due by 8-6-99; published 7-7-99

Air quality implementation plans; approval and promulgation; various States:

Delaware; comments due by 8-6-99; published 7-7-99

Pesticides; tolerances in food, animal feeds, and raw agricultural commodities:

Emergency exemptions; time-limited tolerances; comments due by 8-2-99; published 6-3-99

Water programs:

Underground injection control program; Alabama's Class II program withdrawn; plic hearing and comment request; comments due by 8-5-99; published 5-21-99

FEDERAL COMMUNICATIONS COMMISSION

Common carrier services, etc.:

Agency competitive bidding authority; comments due by 8-2-99; published 6-7-99

Common carrier services:

Agency competitive bidding authority—

Private Mobile Radio Service channels in 800 MHz band; licensing for use in Commercial Specialized Mobile Radio systems; comments due by 8-2-99; published 7-29-99

Radio stations; table of assignments:

Texas; comments due by 8-2-99; published 6-22-99

FEDERAL TRADE COMMISSION

Children's Online Privacy Protection Act; implementation

Initial regulatory flexibility analysis; comments due by 8-6-99; published 7-27-99

HEALTH AND HUMAN SERVICES DEPARTMENT

Food and Drug Administration

Food for human consumption:

Food labeling—
Dietary supplements; effect on structure or function of body; types of statements definition; meeting; comments due by 8-4-99; published 7-8-99

HOUSING AND URBAN DEVELOPMENT DEPARTMENT
Mortgage and loan insurance programs:
Single family mortgage insurance—
Appraiser roster; placement and removal procedures; comments due by 8-2-99; published 7-2-99

INTERIOR DEPARTMENT
Fish and Wildlife Service
Migratory bird hunting:
Seasons, limits, and shooting hours; establishment, etc.
Meeting; comments due by 8-2-99; published 7-22-99

INTERIOR DEPARTMENT
Minerals Management Service
Federal regulatory review; request for comments; comments due by 8-6-99; published 6-7-99

INTERIOR DEPARTMENT
Surface Mining Reclamation and Enforcement Office
Permanent program and abandoned mine land reclamation plan submissions:
Kentucky; comments due by 8-2-99; published 7-16-99

JUSTICE DEPARTMENT
Immigration and Naturalization Service
Nonimmigrant classes:
Adjustment of status; H-1 and L-1 status applicants; continued validity of nonimmigrant status, unexpired employment authorization, and travel authorization; comments due by 8-2-99; published 6-1-99
Status adjustment; H-1 and L-1 status applicants; continued validity of nonimmigrant status, unexpired employment authorization, and travel authorization
Correction; comments due by 8-2-99; published 6-4-99

LABOR DEPARTMENT
Mine Safety and Health Administration
Coal mine and metal and nonmetal mine safety and health:
Underground mines—
Self-rescue devices; comments due by 8-6-99; published 7-7-99

LABOR DEPARTMENT
Occupational Safety and Health Administration
Safety and health standards:
Tuberculosis; occupational exposure; comments due by 8-2-99; published 6-17-99

LIBRARY OF CONGRESS
Copyright Office, Library of Congress
Copyright office and procedures:
Vessel hulls; design protection; comments due by 8-6-99; published 7-7-99

NUCLEAR REGULATORY COMMISSION
Early site permits standard design certifications and combined licenses for nuclear power plants:
AP600 design certification; comments due by 8-3-99; published 5-20-99
Production and utilization facilities; domestic licensing:
Nuclear power reactors—
Reporting requirements; comments due by 8-5-99; published 7-6-99

SMALL BUSINESS ADMINISTRATION
Disaster loan program:
Pre-disaster mitigation loans; comments due by 8-6-99; published 7-7-99

TRANSPORTATION DEPARTMENT
Coast Guard
Ports and waterways safety:
Mandatory ship reporting systems; comments due by 8-2-99; published 6-1-99
Correction; comments due by 8-2-99; published 6-9-99
San Pedro Bay, CA; safety zone; comments due by 8-2-99; published 6-2-99
Vessel inspection alternatives:
Alternate Compliance Program; incorporations by reference; comments due by 8-6-99; published 6-8-99

TRANSPORTATION DEPARTMENT
Workplace drug and alcohol testing programs:
Organizations certifying substance abuse professionals; procedure to have members included in DOT's substance abuse professional definition; comments due by 8-2-99; published 6-3-99

TRANSPORTATION DEPARTMENT
Federal Aviation Administration
Air carrier certification and operations:
Aging airplane safety; comments due by 8-2-99; published 4-2-99
Air traffic operating and flight rules, etc.:
Flight plan requirements for helicopter operations under instrument flight rules; comments due by 8-2-99; published 7-1-99
Airworthiness directives:
Bell Helicopter Textron, Inc.; comments due by 8-2-99; published 6-3-99
Boeing; comments due by 8-6-99; published 6-22-99
Bombardier; comments due by 8-6-99; published 7-7-99
British Aerospace; comments due by 8-6-99; published 7-7-99
Israel Aircraft Industries, Ltd.; comments due by 8-6-99; published 7-7-99
Class E airspace; comments due by 8-2-99; published 6-11-99

TRANSPORTATION DEPARTMENT
Federal Highway Administration
Engineering and traffic operations:
Emergency relief program; comments due by 8-6-99; published 6-7-99

TREASURY DEPARTMENT
Internal Revenue Service
Income taxes:
Long-term contracts, income accountability; comments due by 8-3-99; published 5-5-99
Long-term contracts; income accountability
Correction; comments due by 8-3-99; published 6-16-99
Recognition of gain on stock or securities distributions; comments due by 8-2-99; published 5-3-99

VETERANS AFFAIRS DEPARTMENT
Acquisition regulations:
Simplified acquisition procedures; comments due by 8-3-99; published 6-4-99

LIST OF PUBLIC LAWS

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H.R. 4/P.L. 106–38

National Missile Defense Act of 1999 (July 22, 1999; 113 Stat. 205)

H.R. 2035/P.L. 106–39

To correct errors in the authorizations of certain programs administered by the National Highway Traffic Safety Administration. (July 28, 1999; 113 Stat. 206)

Last List July 22, 1999

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