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SOCIAL SECURITY ADMINISTRATION

20 CFR Parts 404 and 416

[Regulations No. 4 and 16]

RIN 0960-AF40

Supplemental Security Income; Determining Disability for a Child Under Age 18

AGENCY: Social Security Administration.

ACTION: Final rules.

SUMMARY: On February 11, 1997, we published interim final rules with a request for comments to implement the Supplemental Security Income (SSI) childhood disability provisions of sections 211 and 212 of Public Law (Pub. L.) 104-193, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996. We are now publishing revised final rules in response to public comments. We are also conforming our rules to amendments to Public Law 104-193 made by the Balanced Budget Act of 1997, Public Law 105-33. Finally, we are simplifying and clarifying some rules in keeping with the President's goal of using plain language in regulations.

DATES: These rules are effective January 2, 2001.

FOR FURTHER INFORMATION CONTACT:

Georgia Myers, Regulations Officer, Social Security Administration, 6401 Security Boulevard, Baltimore, MD 21235, regulations@ssa.gov, (410) 965-3632 or TTY (410) 966-5609 for information about these rules. For information on eligibility or filing for benefits, call our national toll-free number, 1-800-772-1213 or TTY 1-800-325-0778, or visit our Internet web site, *SSA Online*, at www.ssa.gov.

SUPPLEMENTARY INFORMATION: We are revising and making final the interim final rules we published on February 11, 1997, to implement the childhood disability provisions of Public Law 104-193 (62 FR 6408). Even though we published interim final rules in 1997, we asked for public comments on those rules. We are now summarizing and responding to the public comments and making revisions to the interim final rules based on the public comments and on our program experience in applying the interim rules since February 1997. In the final rules, we continue to define the statutory standard of "marked and severe functional limitations" in terms

of marked limitations in two areas of functioning or extreme limitation in one such area. However, we are also making a number of changes to our rules on functional equivalence and "other factors" in response to the comments.

We are also conforming our rules to amendments to Public Law 104-193 made by the Balanced Budget Act of 1997, Public Law 105-33, 111 Stat. 251. Even though the amendments were enacted after we published the interim final rules, the changes are required by the statute and make no discretionary policy changes. We are also simplifying and clarifying the language of some rules in keeping with the President's goal of using plain language in regulations.

A number of individuals who commented on the interim final rules expressed concern that we had not consulted with outside experts in the development of those rules. Given the short time we had under Public Law 104-193 to develop the interim final rules, it was not feasible to engage in the type of consultation the commenters suggested before we published those rules. However, in response to the comments, and to ensure that these final rules are as accurate and inclusive as possible, we asked a number of individual experts for information as we formulated these final rules. The experts included pediatricians, psychologists, and other pediatric specialists, and individual advocates for children with disabilities who have expert knowledge about the SSI program.

History

For a detailed history of the childhood disability provisions before the changes made by Public Law 104-193, interested readers may review the preamble to the interim final rules (62 FR 6408). That preamble explains how we first implemented the prior statutory definition of disability for children, based on "comparable severity" to the definition of disability for adults, and the changes we made to our rules in 1991 after the Supreme Court's decision in *Sullivan v. Zebley*, 493 U.S. 521 (1990).

Public Law 104-193, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, 110 Stat. 2105, removed the comparable severity standard and provided a new statutory definition of disability for children claiming SSI benefits. It also directed us to make significant changes in the way we evaluate childhood disability claims. Under the law, which created a new section 1614(a)(3)(C) of the Social Security Act (the Act), a child's impairment or combination of

impairments must cause more serious impairment-related limitations than the old law and our prior regulations specified.

Section 1614(a)(3)(C) of the Act provides the following definition of disability for children claiming SSI benefits:

(C)(i) An individual under the age of 18 shall be considered disabled for the purposes of this title if that individual has a medically determinable physical or mental impairment, which results in marked and severe functional limitations, and which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months.

(ii) Notwithstanding clause (i), no individual under the age of 18 who engages in substantial gainful activity * * * may be considered to be disabled.

The conference report that accompanied Public Law 104-193 explained:

The conferees intend that only needy children with severe disabilities be eligible for SSI, and the Listing of Impairments and other current disability determination regulations as modified by these provisions properly reflect the severity of disability contemplated by the new statutory definition. In those areas of the Listing that involve domains of functioning, the conferees expect no less than two marked limitations as the standard for qualification. The conferees are also aware that SSA uses the term "severe" to often mean "other than minor" in an initial screening procedure for disability determination and in other places. The conferees, however, use the term "severe" in its common sense meaning.

H.R. Conf. Rep. No. 725, 104th Cong., 2d Sess. 328 (1996), *reprinted in* 1996 U.S. Code, Cong. and Ad. News 2649, 2716. The House report contains similar language. See H.R. Rep. No. 651, 104th Cong., 2d Sess. 1385 (1996), *reprinted in* 1996 U.S. Code, Cong. and Ad. News 2183, 2444.

Further provisions concerning childhood disability adjudication are summarized below with references to the relevant sections of Public Law 104-193 and, where appropriate, the Act.

- We were directed to remove references to "maladaptive behavior" in the prior personal/behavioral domain from §§ 112.00C2 and 112.02B2c(2) of the childhood mental disorders listings (Public Law 104-193, section 211(b)(1)).
- We were directed to discontinue the individualized functional assessment (IFA) for children in §§ 416.924d and 416.924e of our former rules, which we had used since 1991 (Pub. L. 104-193, section 211(b)(2)).
- Within 1 year after the date of enactment, we were to redetermine the eligibility of individuals under the age

of 18 who qualified for SSI based on disability as of August 22, 1996, and whose eligibility might terminate because of changes made by Public Law 104-193. We were required to use the eligibility criteria we use for new applicants, not the medical improvement review standard in section 1614(a)(4) of the Act and § 416.994a that we use in continuing disability reviews (CDRs) (Pub. L. 104-193, section 211(d)(2)).

- The medical improvement review standard for determining continuing eligibility for children was revised to conform to the new definition of disability for children (Pub. L. 104-193, section 211(c); section 1614(a)(4)(B) of the Act).

- Not less frequently than once every 3 years, we must conduct a CDR for any childhood disability recipient eligible by reason of an impairment(s) that is likely to improve. At the option of the Commissioner, we may also perform a CDR with respect to those individuals under age 18 whose impairments are unlikely to improve (Pub. L. 104-193, section 212(a); section 1614(a)(3)(H)(ii) of the Act).

- We must redetermine the eligibility of individuals who were eligible for SSI based on disability in the month before the month in which they attained age 18. This age-18 redetermination must use the initial adult eligibility rules and must occur during the 1-year period beginning on the individual's 18th birthday. The medical improvement review standard used in CDRs does not apply to these redeterminations (Pub. L. 104-193, section 212(b); section 1614(a)(3)(H)(iii) of the Act).

- We must conduct a CDR not later than 12 months after the birth of the child for any child whose low birth weight is a contributing factor material to our determination that the child was disabled (Pub. L. 104-193, section 212(c); section 1614(a)(3)(H)(iv) of the Act).

- At the time of a CDR, a child's representative payee must present evidence that the child is and has been receiving treatment to the extent considered medically necessary and available for the disabling impairment. If a payee refuses without good cause to provide such evidence, we may select another representative payee, or pay benefits directly to the child, if we determine that it is appropriate and in the best interests of the child (Pub. L. 104-193, section 212(a); section 1614(a)(3)(H)(ii) of the Act).

The Interim Final Rules

The interim final rules we published on February 11, 1997, implemented all

of the provisions of sections 211 and 212 of Pub. L. 104-193, except section 211(d)(2). See 62 FR 6408; corrected at 62 FR 13537, March 21, 1997, and 62 FR 36460, July 8, 1997. Section 211(d)(2) required us to redetermine the eligibility of children who might be affected by the change in law, and did not require regulations. In brief, we deleted references to the former standard of "comparable severity" to adults and deleted the IFA regulations and all references to the IFA in other regulations. We deleted references to "maladaptive behaviors" and related references in the sections of our regulations and the Listing of Impairments cited in Pub. L. 104-193. We also made other changes in our rules that were necessary because of these revisions.

In §§ 416.902 and 416.906 of the interim final rules, we explained that, to be found disabled, an individual under age 18 must have "marked and severe functional limitations." In § 416.902, we explained that the term "marked and severe functional limitations," when used as a phrase, means the standard of disability in the Act for children claiming SSI benefits. This standard of disability requires a level of severity that meets, medically equals, or functionally equals the severity of an impairment(s) in the listings; *i.e.*, is of listing-level severity. We explained that the separate words "marked" and "severe" are also terms used throughout our rules, but the meanings of these words in the phrase "marked and severe functional limitations" are not the same as their meanings when used separately.

Other significant changes made by the interim final rules included the following:

- We revised § 416.924, "How we determine disability for children," to reflect the changes made by Pub. L. 104-193 and to establish a new sequential evaluation process for determining disability for children. The new three-step process required a child who was not working to show that he or she had a "severe" impairment or combination of impairments that met, medically equaled, or functionally equaled the severity of an impairment(s) in the listings.

- In new § 416.924(g) we referred to a Childhood Disability Evaluation Form, Form SSA-538, which we issued in conjunction with the interim final rules. Section 416.924(g) required our adjudicators (except disability hearing officers) at the initial and reconsideration levels of our administrative review process to complete an SSA-538 to show their findings in each case. We also explained

that disability hearing officers, administrative law judges, and administrative appeals judges on the Appeals Council (when the Appeals Council makes a decision) will not complete the form but will indicate their findings at each step in the sequential evaluation process in their determinations or decisions.

- We revised § 416.925(b)(2), which explains the purpose of the childhood listings in part B of the listings, to explain that "listing-level severity" generally means marked limitations in two broad areas of functioning or extreme limitation in one such area.

- We revised § 416.926 to provide rules for determining medical equivalence for both adults and children. Our prior rules had addressed medical equivalence for children separately, in § 416.926a. We also incorporated in § 416.926 of the interim final rules language from prior § 416.926a and our operating instructions to clarify the rules. We also intended the changes to be consistent with our rules in § 404.1526 (the rule for disability claims under title II of the Act), which we did not change in the interim final rules.

- We published revised and expanded guidelines for determining functional equivalence to the listings in § 416.926a. The interim final rules continued to provide four methods for determining functional equivalence, and the primary method continued to be evaluating whether a child had marked limitations in two broad areas of development or functioning or extreme limitation in one area. We also added a new area, called "motor development" or "motor functioning," to help our adjudicators better evaluate physical impairments. We also retained our requirement that a finding of functional equivalence must be related to a particular listing. Generally, we used a childhood mental disorders listing to make this finding. However, adjudicators could use any listing that included disabling functional limitations among its criteria.

In publishing the improved functional equivalence rules, we noted that even though Congress eliminated the IFA, it directed us to continue to evaluate a child's functional limitations where appropriate, although using a higher level of severity than under the former IFA. Congress also explicitly endorsed our functional equivalence policy as a means to evaluate impairments that would not meet or medically equal any listings and without which some needy children with severe disabilities would not be found eligible. (62 FR 6413)

- We revised the rules in §§ 416.990 and 416.994a relating to CDRs of children to reflect the changes in the frequency of CDRs. The changes we made to these rules included requiring CDRs for children who qualified because of low birth weight, and making conforming changes to reflect the definition of disability for children in Pub. L. 104–193.

- We published a new § 416.987 to provide rules for redetermining the eligibility of individuals who attain age 18 and who were eligible for SSI based on disability in the month before the month in which they attained age 18. The section included a rule that we would not count an individual's earnings when we determine disability under this section. It also provided rules for notifying individuals who will have these redeterminations.

- We revised §§ 416.635 and 416.994a of our rules to include the statutory requirement that, at the time of a CDR, a child's representative payee must present evidence that the child is and has been receiving treatment that is considered medically necessary and available for the disabling impairment(s). We also explained how we would determine whether and how treatment was medically necessary and available.

We made many other changes to conform our rules to the major changes noted above. We also expanded and clarified several rules, including sections in the listings, and defined terms related to the new regulations. For a complete description of the changes in the interim final rules and our reasons for making them, interested readers may refer to the preamble to the interim final rules.

The Balanced Budget Act of 1997 (Pub. L. 105–33)

Pub. L. 105–33, 111 Stat. 251, enacted on August 5, 1997, contained two provisions that affect these final rules, and other provisions that affected the redeterminations and protected the Medicaid eligibility of children who lost SSI eligibility because of the new disability standard.

The amendments affecting these final rules provided the following:

- Pub. L. 104–193 required us to perform a redetermination of a beneficiary's eligibility within 1 year after the individual turns 18. Pub. L. 105–33 changed this requirement and provided that we may perform this redetermination either during the 1-year period beginning on the individual's 18th birthday, or in lieu of a CDR whenever we determine that the individual's case is subject to a

redetermination (Pub. L. 105–33, section 5522(a)(1); section 1614(a)(3)(H)(iii) of the Act).

- Pub. L. 104–193 required us to do a CDR not later than 12 months after the birth of a child for whom low birth weight is a contributing factor material to our determination of disability. Pub. L. 105–33 changed this provision to provide that we do not have to do a CDR by age 1 if we determine at the time of our initial disability determination that the child's impairment(s) is not expected to improve by age 1, and we schedule a CDR for a time after the child turns age 1 (Pub. L. 105–33, section 5522(a)(2)(B); section 1614(a)(3)(H)(iv)(VI) of the Act).

Pub. L. 105–33 also extended the deadline for redetermining the eligibility of children who might be affected by the new disability standard. Pub. L. 104–193 required us to perform redeterminations within 1 year after enactment of the law, or by August 22, 1997. Section 5101 of Pub. L. 105–33 extended that date by an additional 6 months, to February 22, 1998. For any redetermination not performed by that date, the law also allowed us to perform the redeterminations "as soon as practicable thereafter." Because we do not have regulations addressing this redetermination process, this provision of Pub. L. 105–33 does not affect these final rules.

Finally, section 4913 of Pub. L. 105–33 required States to continue Medicaid coverage for disabled children who were receiving SSI as of the enactment date of Pub. L. 104–193 if they lost SSI eligibility because of the changes to the definition of disability. The authority for making the determination about restored or continued Medicaid eligibility remains with the States, so this change in the law also does not affect these final rules.

Actions Since We Published the Interim Final Rules

Many of the public comments, most of which were submitted during the first half of 1997, expressed concerns about how we would conduct the required redeterminations of the eligibility of children who qualified under the old disability standard. Many commenters expressed concerns that the law required us to do the redeterminations too quickly and that the new rules were unfamiliar to our adjudicators. Some commenters were concerned that we would not get proper evidence. They were especially concerned that we would not get sufficient evidence from schools because we would conduct many redeterminations in the summer. We also received allegations that the

State agencies were purchasing substandard consultative examinations and using them to cease children's eligibility.

Some commenters expressed concern that children and their families would not understand that they could appeal determinations that they were no longer eligible and that they could continue to receive benefits while appealing. Some were concerned about how the redeterminations and loss of benefits would affect children and their families in the future.

In response to these and other concerns, Commissioner Kenneth Apfel promised, during his confirmation hearings before the Senate Finance Committee in 1997, to perform a "top-to-bottom" review of how we implemented the changes made to the SSI childhood disability program that were required by Pub. L. 104–193. He ordered this review as his first official act after being confirmed as Commissioner, and we issued a report, *Review of SSA's Implementation of New SSI Childhood Disability Legislation*, on December 17, 1997. (Pub. No. 64–070. The report is also available at our public Internet site: www.ssa.gov/policy/child.htm.)

The report showed that, overall, the vast majority of the redeterminations were handled properly. The review indicated that SSA and the State agencies making disability determinations for us had done a good job of implementing the new provisions, but found some inconsistencies in the application of the rules and in compliance with our instructions. Commissioner Apfel immediately ordered several corrective actions to address these issues.

In the report, we identified three specific areas of concern, and the corrective actions we would take above and beyond our normal actions:

1. Children Classified in Our Records as Having Mental Retardation

Of the approximately one million children on the SSI rolls in December 1996, 407,000 were shown on our records with our diagnosis code for mental retardation. Eighty percent of these children were not subject to redetermination under Pub. L. 104–193. However, at the time of the report, we had found ineligible under the new law slightly more than half of the approximately 79,500 children whose eligibility we reviewed and who were coded in our computer records as having mental retardation. Our review concluded that part of this could be attributed to the fact that, historically, some children were coded using the

diagnosis code for mental retardation incorrectly or because we did not have a diagnosis code for the child's impairment. Over half of the cases in which benefits had been ceased involved children who were not diagnosed with mental retardation at the time of the cessation. Of these cases, almost 40 percent involved a learning disability and others involved borderline intellectual functioning. Thus, in a large number of cases with the diagnosis code for mental retardation, the children did not have mental retardation, were never thought to have mental retardation, but were shown in our records with that diagnosis code.

However, our review also showed concerns about the accuracy of these redeterminations, especially for children with IQs in the range of 60 to 70 and slightly above 70. The concerns included whether listings were misapplied and whether children with mental retardation who had IQ scores above 70 incorrectly lost eligibility.

To address the concerns, we reviewed the cases of all children who had a diagnosis code for mental retardation if we had found they were ineligible after a redetermination or if we had denied their initial applications on or after August 22, 1996. We automatically reopened and issued new determinations in the cases of all children who were coded as having mental retardation and who had an IQ score of 75 or below. We also provided additional training to all of our adjudicators on how to evaluate claims involving children with mental retardation under the new rules, before they reviewed the cases again.

2. Quality of Case Processing

We found that the concerns about sufficient case development were unfounded, especially the concerns that we would not get school records we needed and that our consultative examinations were inadequate. However, we did find some issues related to the quality of case processing.

In some States, we found problems in cases that were ceased based on a "failure to cooperate." Our procedures require additional attempts to contact a child's parent or legal guardian when this individual does not respond to official notices regarding the child's eligibility. Our procedures also require us to make special efforts to identify and contact another adult or agency responsible for the child's care. We also require written documentation of those attempts. We determined that in some cases all required contacts were not attempted or they were not documented

in the case file. Therefore, we reviewed all "failure to cooperate" cessations to ensure that proper procedures were followed. When those reviews indicated deficiencies, we gave families another opportunity to cooperate and to have their benefits reinstated during the new redetermination process, including any benefits that would have been paid since the month when payments ceased. We also provided additional written instructions and training on this issue to our personnel.

We also found that, although the accuracy of the redeterminations was above the regulatory threshold for accuracy nationally, it varied by State and by type of impairment, particularly for certain mental disorders other than mental retardation. Therefore, we instructed all of our State agencies to review a portion of the cases they had ceased on redetermination. Depending on the quality assurance results in each State, we identified cases involving both physical and mental impairments (other than mental retardation) for review based on the cases that had the greatest likelihood of error within a given State. When we found deficiencies in a redetermination, the case was reopened, developed if necessary, and the determination revised if appropriate.

Before these reviews began, we provided additional training to all our adjudicators on how to evaluate mental impairments other than mental retardation and on the evaluation of speech disorders in combination with cognitive limitations. We also issued Social Security Ruling (SSR) 98-1p, on the evaluation of speech disorders in combination with cognitive limitations. (63 FR 15248 (1998))

3. Appeals and Requests for Benefit Continuation During Appeal

When we notified families (or other payees) that a redetermination found that a child no longer qualified, the notice also advised them of their legal rights. This information included:

- How to ask for a reconsideration,
- How to request continuation of benefit payments while appealing, and
- How to obtain legal assistance to appeal.

Concerns were raised that the cessation notice was hard to understand. We also received reports that some families were discouraged from filing appeals or were not told about free legal services. We received reports that some families were discouraged from asking for benefit continuation during their appeals, especially because the overpayment waiver process was not fully explained to them. Some families did not

understand that they might not have to pay back the benefits they received during the appeal if the appeal decision was still unfavorable.

We made changes to clarify our procedures and provided training as the redeterminations proceeded. However, we found that these actions helped only those children whose cases were redetermined later in the process and that some individuals who did not appeal—and some who appealed, but did not request benefit continuation—did not understand their rights.

To address this concern, on February 18, 1998, we sent a new notice using simpler language to families (or other payees) of all children who lost their SSI eligibility under the new childhood disability rules and did not appeal. The notice gave them another chance to appeal and to ask for benefit continuation during the appeal. We also sent a new, simpler notice to families (or other payees) of all children who had appealed their initial redeterminations but who did not request benefit continuation during the appeals. The notice gave them another chance to request benefit continuation during the appeal. Both notices included information on the right to request waiver of any overpayment that might result from continuing benefits during appeal and on how to get free legal assistance.

On March 18, 1998, we also sent new, simpler notices to individuals who had attained age 18 and who lost their eligibility because of the changes in Pub. L. 104-193. We sent these notices to individuals who did not appeal or who appealed but did not request benefit continuation during their appeal.

We also took several other actions. For example, we provided a "script" for employees in our Field Offices and Teleservice Centers to follow when informing claimants of their appeal and benefit continuation rights. The script ensured that all families received the same information. We also made concerted efforts to ensure that families knew about available legal assistance by providing toll-free numbers for the American Bar Association's (ABA's) Children's SSI Project referral service in our Field Offices, Teleservice Centers, and on our Internet site. We also included the ABA's toll-free numbers for legal assistance on our notices for States in which toll-free numbers were available.

In addition to the corrective actions outlined above, we have taken many other actions. For example, we continue to monitor case quality through our quality assurance system. We conducted

several training classes in addition to those noted above and trained a “cadre” of specialists in childhood disability who served as experts in their respective regions. We are now studying several issues related to childhood disability, which we describe in the public comments section of this preamble, including the effects on families of the loss of eligibility resulting from Pub. L. 104–193.

These final childhood rules represent another step in our actions to ensure that all children who meet the SSI eligibility requirements receive their benefits. The final rules respond to extensive comments on the interim final rules that we received from a wide range of child-serving professional organizations as well as advocacy, legal, and family groups and individuals. Their comments, together with our experience, input from individual medical and other professionals, and other actions, support the adjustments made in the interim final regulations that we publish today as the final childhood disability regulations.

Explanation of the Effective Date

As we noted in the effective date section of this preamble, these final rules will be effective on January 2, 2001. We have delayed the effective date of the rules to give us time to provide training and instructions to all of our adjudicators and to revise Form SSA–538 and other forms and notices before we implement the final rules. The interim final rules will continue to apply until the effective date of these final rules. When the final rules become effective, we will apply them to new applications filed on or after the effective date of the rules. We will also apply them to the entire period at issue for claims that are pending at any stage of our administrative review process, including claims that are pending administrative review after remand from a Federal court.

With respect to claims in which we have made a final decision, and that are pending judicial review in Federal court, we expect that the court’s review of the Commissioner’s final decision would be made in accordance with the rules in effect at the time of the final decision. If the court determines that the Commissioner’s final decision is not supported by substantial evidence, or contains an error of law, we would expect that the court would reverse the final decision, and remand the case for further administrative proceedings pursuant to the fourth sentence of section 205(g) of the Act, except in those few instances where the court determines that it is appropriate to

reverse the final decision and award benefits, without remanding the case for further administrative proceedings. In those cases decided by a court after the effective date of the rules, where the court reverses the Commissioner’s final decision and remands the case for further administrative proceedings, on remand, we will apply the provisions of these final rules to the entire period at issue in the claim.

Summary of Final Rules

We are adopting the interim final rules with the changes set out below, and are publishing only those rules that we have changed. For a summary of the rules we are adopting without change, see the 1997 interim final rules (62 FR 6408).

For clarity, we refer to the changes we are making here as “final” rules and to the rules that will be changed by these final rules as the “interim final” rules. We also use the past tense to describe the interim final rules we are changing. However, it must be remembered that these final rules do not go into effect until January 2, 2001. Therefore, the interim final rules will still be in effect until that date.

Changes to § 416.902 General Definitions and Terms for This Subpart

We are adding a new definition to this section to help simplify the language of our regulations. We define the term “the listings” to mean the Listing of Impairments in appendix 1 of subpart P of part 404 of this chapter. Throughout these final rules, we use the new term in the phrase “medically or functionally equals the listings” to replace longer phrases that refer to appendix 1 of subpart P of part 404 of this chapter. For example, when we say that we consider whether an impairment(s) medically or functionally “equals the listings” we mean “whether an impairment medically or functionally equals in severity the criteria of a listing in appendix 1 of subpart P of part 404 of this chapter.”

We are making this change because of changes we are making in the functional equivalence provisions of the regulations in response to public comments. As we explain more fully under the explanation of changes to final § 416.926a, we will no longer refer to specific listings when we determine functional equivalence. The change also simplifies the language of our rules and removes some inconsistencies among various rules.

We are also including in our current definition of the words “you” or “your” the words “me,” “my” and “I.” Under the President’s plain language initiative,

we are changing some of our rules to use first-person questions in paragraph and section headings. We used this technique in final § 416.987(c), using a question and the pronoun “my” in the heading, “When will my eligibility be redetermined?” and in final § 416.987(d), using the pronoun “I” in the heading, “Will I be notified?” Therefore, we need to add a definition of these words in § 416.902. In anticipation of similar future changes, we are also indicating that we may use the word “me.” The new terms, which are only editorial, help clarify our rules.

Changes to § 416.924 How We Determine Disability for Children

In final § 416.924(c), we are adding language to clarify that at step two of the sequential evaluation process we consider both whether a child has a medically determinable impairment and whether any impairment or combination of impairments the child has is “severe.” In the interim final rules, we did not include the first part of the statement.

The new language only clarifies our rules and helps to make them consistent with changes we made in final §§ 416.924a and 416.926a in response to public comments. It is based on our interpretation of step two of the sequential evaluation processes for both adults and children, as explained in SSR 96–4p. (61 FR 34488 (1996))

In response to public comments that suggested we include more cross-references in our regulations, we changed § 416.924(d)(3) of the interim final rules, to final § 416.924(e), “Other rules.” Section 416.924(d)(3) of the interim final rules provided cross-references to our rules on meeting, medically equaling, and functionally equaling the listings. Final § 416.924(e) now adds cross-references to final §§ 416.924a, 416.924b, and 416.929 in addition to cross-referencing the rules on meeting and medically or functionally equaling the listings. The last of the new cross-references is to our rules for the evaluation of pain and other symptoms.

Because of this change, we redesignated paragraph (e) of the interim final rules, “If you attain age 18 after you file your disability application but before we make a determination or decision,” as paragraph (f). As we explain below in our explanation of the changes in final § 416.924a, we moved the provisions of § 416.924(f) of the interim final rules, “Basic considerations,” to final § 416.924a(a).

We have not changed § 416.924(g) of the interim final rules, “How we will explain our findings.” Therefore, we are

not reprinting it in this **Federal Register** notice. However, by the time these rules become effective, we will issue a revised Form SSA-538, Childhood Disability Evaluation Form, to reflect the changes in these final rules. (See the public comments section of this preamble for more information about Form SSA-538.) We also changed some of the language throughout § 416.924 for consistency; e.g., to refer to impairments that “equal the listings.”

General Changes in Final §§ 416.924a and 416.924b

In the final rules, we extensively reorganized and revised the provisions of the interim final rules in §§ 416.924a, “Age as a factor of evaluation in childhood disability,” 416.924b, “Functioning in children,” and 416.924c, “Other factors we will consider,” and some of the provisions of § 416.926a, “Functional equivalence for children.” These changes respond to many of the public comments, many of which affected more than one section of our rules.

We are replacing §§ 416.924a, 416.924b, and 416.924c of the interim final rules with final §§ 416.924a, “Considerations in determining disability for children,” and 416.924b “Age as a factor of evaluation in the sequential evaluation process for children.” For the most part, the final rules include the provisions of the interim final rules. However, in reorganizing the provisions, we found a number of redundancies that we eliminated and text we could combine and shorten. We also simplified much of the language and expanded some of our guidance, as suggested by the commenters. We also deleted some sections that we no longer need because of the revisions.

We made these changes because many public commenters recommended that we provide a better explanation of how our provisions on “other factors” in § 416.924c of the interim final rules apply in evaluating childhood disability. Many commenters urged us to clarify these rules and to provide more guidance about how we apply the factors when we evaluate a child’s functioning. Many commenters also suggested that we include more factors for our adjudicators to consider when they evaluate a child’s functioning. Some commenters urged us to incorporate information from our operating manuals and training, and to give more prominence to these important principles so that they are not overlooked. Others asked us to add cross-references throughout the

childhood disability regulations so that no relevant provisions are overlooked.

In final § 416.924a, we no longer refer to the factors as “other” factors because the comment letters showed that our intent was not clear. Our intent in the interim final rules was only to include guidance about some of the more important factors we consider when we evaluate a child’s functioning to decide whether the child has a “severe” impairment and whether the child’s impairment(s) meets or equals the listings. But our earlier wording led people to believe that we meant to consider the “other factors” separately, after an initial assessment of a child’s functioning, to see whether there are additional limitations the child might have based on the “other factors.” That has never been our intent. Like our consideration of symptoms, the factors in this rule are an integral part of our evaluation of a child’s functioning.

To demonstrate our intent more clearly, and to give the provisions the prominence the public commenters thought was lacking, we moved up the provisions of § 416.924c of the interim final rules. Now, the provisions on factors we consider when we assess functioning are found in final § 416.924a instead of last in the series of childhood regulations beginning with § 416.924.

In the next section of this preamble, we explain the specific changes we made in final §§ 416.924a and 416.924b and our reasons for making them.

Specific Changes in § 416.924a Considerations in Determining Disability for Children

Final § 416.924a(a) contains the provisions of §§ 416.924(f), “Basic considerations,” and 416.924c(a), “General,” of the interim final rules. We clarified the language of the interim final rules and removed redundancies. We also added some examples of medical sources to correspond to the existing examples of nonmedical sources, and included more examples of nonmedical sources whom we may ask for information.

The term, “Other medical sources not listed in § 416.913(a),” which now appears in final § 416.924a(a), refers to medical professionals who are not “acceptable medical sources.” It is taken from a revision to § 416.913(d) (formerly § 416.913(e)) we published in the **Federal Register** on June 1, 2000 (65 FR 34950). In those final rules, we also recognize qualified speech-language pathologists and certain other specialists as acceptable medical sources for evidence of impairments that are within their areas of specialty.

In final § 416.924a(1), we also included a cross-reference to our rules in § 416.927, in response to comments that asked us to include more cross-references to provisions our adjudicators must consider before making their determinations or decisions. That section explains how we consider medical source opinion.

We added a new provision about testing in final § 416.924a(1)(ii) to respond to comments recommending that we caution our adjudicators against strict adherence to the numerical scores of IQ tests and other tests. The new provision restates our longstanding policy that we consider all relevant evidence in a child’s case record. Therefore, we do not consider any piece of evidence in isolation, including test scores, and will not rely on test scores alone when we decide if a child is disabled. The provision is also in part a response to comments that recommended revising the rules to include consideration of the standard error of measurement (SEM) that professionals use to estimate a score’s reliability. The provision includes in our rules information we have included in our training since 1997. (We explain more about the SEM in the summary of final § 416.926a and in our responses to the comments.) We also added a cross-reference to § 416.926a(e), which includes several provisions on how we consider test scores, especially in final § 416.926a(e)(4).

The last sentence of final § 416.924a(1)(iii), “Medical sources,” is new in our regulations but reflects our longstanding procedure. It explains that we may consider information provided by a nonmedical source (e.g., a parent or the child) to be a clinical sign, as defined in § 416.928(b), when the medical source has accepted and relied on it to reach a diagnosis. This often occurs for children with mental disorders, when a psychiatrist or psychologist may accept statements made by the child or parents, such as “my child has difficulty sleeping,” as his or her clinical findings. However, it may also occur for children who have other kinds of impairments.

In final § 416.924a(2), “Information from other people,” we expanded the guidance we gave in § 416.924(f) of the interim final rules. We added new guidance about information we will request from early intervention and preschool programs, and provide more guidance about the information we will request from schools.

Final § 416.924a(b), “Factors we consider when we evaluate the effects of your impairment(s) on your functioning,” incorporates the

provisions of §§ 416.924c(b) through (h) of the interim final rules; *i.e.*, what we formerly called the “other factors.” In response to public comments, we expanded the list of factors we will consider and incorporated principles from our training and other instructions we have used since we published the interim final rules in 1997.

In final § 416.924a(b)(1), “General,” we explain that we must consider a child’s functioning when we decide whether the child has a “severe” impairment(s) at step two of the sequential evaluation process and when we consider functional equivalence at step three. We also explain that we will consider a child’s functioning when we decide whether his or her impairment(s) meets or medically equals the requirements of a listing if the listing we are considering includes functioning among its criteria.

In final § 416.924a(b)(2), “Factors we consider when we evaluate your functioning,” we explain that we will consider any factors that are relevant to how the child functions when we evaluate his or her impairment or combination of impairments. In response to many commenters who thought we should include a reference to pain and other symptoms in this section, we added an example of symptoms and provided a cross-reference to our rules on evaluating symptoms in § 416.929. We also clarified that the factors we list in the remainder of the section are only “some” of the factors we may consider.

Final § 416.924a(b)(3), “How your functioning compares to the functioning of children your age who do not have impairments,” is new in this section, although it reflects our longstanding policy. It explains that when we consider whether a child has functional limitations because of his or her impairment(s), we will consider the child’s functioning in age-appropriate terms; *i.e.*, in relation to other children of the same age who do not have impairments.

In final § 416.924a(b)(3)(ii), we added a corollary to this principle. When we consider evidence that formally or informally rates a child’s functioning, we will consider the standards used by the person who did the rating and the characteristics of the group to whom the child was compared. We include the familiar example from our training and instructions that a child in a special education class who is compared to other children in the class is not being compared to children of the same age who do not have impairments.

Final § 416.924a(b)(4) is also new. It specifies in the context of our childhood

disability rules our longstanding policy that, when a child has more than one impairment (*i.e.*, multiple impairments), we consider the combined effects of the impairments. We have had a rule on this issue (§ 416.923) for many years, and specific provisions in the interim final rules that addressed the point (*e.g.*, §§ 416.924(a), 416.924(c), 416.924b(a), and 416.926a(a)). The new provision is one of our responses to those comments that asked us to explain better how we consider “multiple” impairments. This provision is intended to recognize that limitations resulting from a combination of impairments may be greater than the limitations that we might expect to find if we looked separately at each impairment; *i.e.*, the impairments may have interactive and cumulative effects. We also use the word “comprehensively” to emphasize that we look at all of these effects when we evaluate the child’s functioning.

However, we also explain in the first sentence that we do not always need to look at the combined effects of a child’s multiple impairments. Sometimes we can decide that any single impairment is “severe” or that one of a child’s impairments meets, medically equals, or functionally equals the listings without considering the child’s other impairments.

Final § 416.924a(b)(5), “How well you can initiate, sustain, and complete your activities, including the amount of help or adaptations you need and the effects of structured or supportive settings,” incorporates provisions from several interim final rules and includes new provisions that respond to public comments. Final § 416.924a(b)(5)(i), “Initiating, sustaining, and completing activities,” incorporates principles from the “Concentration, persistence or pace” area of functioning in § 416.926a of the interim final rules. The principle that a child should be able to initiate, sustain, and complete activities independently and at the same rate as other children his or her age who do not have impairments is inherent in all evaluations of functioning.

We clarify this principle further in final § 416.924a(b)(5)(ii), “Extra help,” which expands on the guidance we provided in the last sentence of § 416.926a(c)(2) of the interim final rules. We incorporated this guidance in final § 416.924a because it is appropriate whenever we must evaluate a child’s functioning, not just at the functional equivalence step.

In the final provision, we explain that an important indication of the severity of a child’s impairment(s) and its resulting limitations is the amount of effort that must be made to help the

child function. By “help,” we mean not only help from parents, medical providers, school personnel, or other people, but also the “help” a child may get from special equipment, devices, or medications in order to complete his or her tasks. We may decide that a child has limitations compared to other children the same age who do not have impairments because of extraordinary efforts that must be made for the child to function as well as he or she does.

Final § 416.924a(5)(iii), “Adaptations,” incorporates the provisions of § 416.924c(e) of the interim final rules. We clarified some of the earlier language and reinforced the requirement that we compare a child’s functioning to the typical functioning of children the same age who do not have impairments.

We also deleted two examples. We deleted the word “appliances” from the previous second sentence because it is included in the concept of “assistive devices” that appears in the same sentence. We also deleted the “hearing aids” example from the third sentence. Hearing aids are not a good example of an adaptation that may allow a child to function normally because they do not restore normal hearing the way eyeglasses may restore essentially normal vision.

Final § 416.924a(b)(3)(iv), “Structured or supportive settings,” corresponds to § 416.924c(d) of the interim final rules, “Effects of structured or highly supportive settings.” We deleted the word “highly” because we are clarifying that we consider how a child functions in all settings compared to the typical functioning of same-age children who do not have impairments. The basic principles that apply to the evaluation of functioning in “highly” supportive settings also apply to the evaluation of a child’s functioning in other supportive settings.

We also made a number of editorial changes for clarity, added several examples, and expanded some statements from the interim final rules to better explain our intent.

Final § 416.924a(b)(6), “Unusual settings,” is new. It includes in our rules our longstanding policy that a child’s functioning in an unusual situation, such as a consultative examination or a one-to-one setting, may not be typical of his or her functioning in routine settings on a day-to-day basis. It is another example of our policy that we do not consider any single piece of evidence in isolation from the other relevant evidence in the case record.

We added this section because some commenters noted correctly that there are medical impairments (such as

attention deficit hyperactivity disorder) that may not be as manifest in unusual settings as they are in typical settings, such as at home and in school. A child with such an impairment may appear to be relatively normal in an unusual setting but be very limited in others. Other impairments can be more or less severe at any given point in time, so that a child may appear more or less limited on any single examination or in any one-to-one or other unusual setting. We included this principle in our training after we implemented the interim final rules, so the new provision only reflects our existing policy.

Final § 416.924a(b)(7), "Early intervention and school programs," incorporates, expands, and clarifies provisions of § 416.924c(g) of the interim final rules. To respond to comments requesting more explanation of how other factors apply when we evaluate a child's limitations, we added more discussion about how we consider evidence from early intervention services, preschools, and schools. We also provide specific guidance about how we use school records (subparagraph (ii) of the final rule) and how we consider assessments from early intervention services or special education programs or accommodations in school (subparagraphs (iii) and (iv) of the final rule).

We also made clear in this section, and throughout the rules, that "school" includes preschool. We also explain better (in subparagraph (v) of the final rule) how the impact of chronic or episodic impairments or a child's need for therapy or treatment may interfere with his or her ability to participate in school activities.

Final § 416.924a(b)(8), "The impact of chronic illness and limitations that interfere with your activities over time," incorporates the relevant provisions of § 416.924c(b), "Chronic illness," from the interim final rules. Much of interim final § 416.924c(b) addressed the effects of treatment as it related to chronic illness and was not specifically relevant to this heading. Therefore, we moved those provisions into the section on treatment, final § 416.924a(b)(9). In response to a comment, we also added new second and third sentences in the paragraph to explain better the importance of considering functioning over time when a child has a chronic impairment that is characterized by episodes of exacerbation (worsening) and remission (improvement). For these new sentences, we adopted language we use in the third paragraph of section 12.00D of the adult mental disorders listings. This principle is equally

applicable to children and adults, and to both physical and mental impairments.

Final § 416.924a(b)(9), "The effects of treatment (including medications and other treatment)," incorporates the provisions of paragraphs (c) ("Effects of medication"), (f) ("Time spent in therapy"), and (h) ("Treatment and intervention, in general") of § 416.924c of the interim final rules. We expanded the list of factors we will consider when we evaluate the effects of a child's medications. We deleted the reference to "marked and severe functional limitations" that was in the third sentence of interim final § 416.924c(c) to clarify that the factors in § 416.924a apply when we evaluate a child's functioning beginning at step two of the sequential evaluation process. We also clarified language and added examples and new language reinforcing some of the principles discussed above.

Specific Changes in Final § 416.924b Age as a Factor of Evaluation in the Sequential Evaluation Process for Children

As already noted, we redesignated § 416.924a from the interim final rules as final § 416.924b. We revised the heading of the section to make clearer that it addresses the consideration of age at steps two and three of the sequential evaluation process for children.

Except for editorial changes and one addition, final § 416.924b(a), "General," is the same as § 416.924a(a) of the interim final rules. We expanded the provision on children who may be too young to be tested, now in final § 416.924b(a)(4), with language we adopted from section 114.00D4 of the listings. The new language explains that we will consider all relevant information in the child's case record, including "other generally acceptable methods consistent with the prevailing state of medical knowledge and clinical practice that will help us evaluate the existence and severity" of the child's impairment(s). This is not a policy change since it only clarifies what we do in all cases, including for infants and toddlers.

Final § 416.924b(b), "Correcting chronological age of premature infants," is identical to § 416.924a(b) of the interim final rules. For that reason, we are not reprinting it in the **Federal Register**.

We are deleting all of § 416.924a(c) of the interim final rules, primarily because these provisions are better addressed elsewhere in these final rules. For example, the provisions of § 416.924a(c)(1) of the interim final rules, which address how a child adapts to an impairment, are better addressed

by several provisions in final § 416.924a, as already explained above, and § 416.926a. The principles in § 416.924a(c)(3)(ii) of the interim final rules, which explained the interactive and interdependent process of development within a child, are better addressed by final § 416.926a(c), "The interactive and cumulative effects of an impairment or multiple impairments," and throughout the general and age-specific descriptions of each domain in final § 416.926a. Likewise, using work-related activities to measure functioning in adolescents is now addressed by the age-specific domain descriptors found in § 416.926a.

We deleted some provisions for consistency. The final rules emphasize our longstanding policy that we consider the specific effects of each child's impairment(s) on his or her functioning based on the evidence in the case record. Some provisions in § 416.924a(c) of the interim final rules, however, provided more general guidance about how impairments might theoretically affect children who were older or younger. We originally included this guidance in our rules in 1991 when we first instituted the functional equivalence and IFA policies because we thought it would help our adjudicators better understand how impairments might affect children at different ages. However, we believe that we no longer need such guidance in our rules and that our focus on the need to assess the specific limitations each child has regardless of age is clearer without it.

Deletion of § 416.924b of the Interim Final Rules

Because of the changes we made in final §§ 416.924a and 416.924b, and in final § 416.926a, as described below, we deleted all of § 416.924b of the interim final rules, "Functioning in children." Section 416.924b(a), "General," merely restated the principle that we consider all of a child's limitations when we evaluate whether the child has a "severe" impairment and whether the impairment causes "marked and severe functional limitations." Since we make identical and similar statements repeatedly throughout the final rules, it was unnecessary to retain this statement.

Section 416.924b(b) of the interim final rules, "Terms used to describe functioning," included definitions of the terms "age-appropriate activities," "developmental milestones," "activities of daily living," and "work-related activities." However, we used the term "work-related activities" only in § 416.924a(c)(4) of the interim final

rules. We did not use the other terms at all in the interim final rules, although we used the phrase “age-appropriate” and the word “development” in § 416.926a to describe the method of functional equivalence based on “broad areas of functioning.” We believe the changes we made throughout the final rules to indicate that we consider a child’s functioning in relation to children of “the same age who do not have impairments” adequately cover the idea we intended by the term “age-appropriate activities.” Likewise, final § 416.926a continues to refer to a child’s “development” and incorporates appropriate principles with examples for each age category. As already noted, we also included examples of work and work-related activities in the sections describing the domains for adolescents in final § 416.926a.

Changes to § 416.925 Listing of Impairments in Appendix 1 of Subpart P of Part 404 of This Chapter

We revised § 416.925(b)(2) of the interim final rules to make it consistent with other changes we made in these final rules, especially changes in final § 416.926a. As we explain below when describing the changes to the functional equivalence rules, we will no longer refer to specific listings when we consider whether an impairment functionally equals the listings. In keeping with this change, we removed the reference to the childhood mental disorders listings in our definition of “listing-level severity” in final §§ 416.925 and 416.926a. We also updated the references to include the new domains described below and provided a better cross-reference to the rules defining the terms “marked” and “extreme.”

Changes to § 416.926a Functional Equivalence for Children

We received many comments about our functional equivalence rules. Most commenters raised at least one of the following issues:

- Many commenters said that our rules on functional equivalence were too complicated and suggested that we simplify them. Some commenters noted that it was difficult for adjudicators to determine which listings contained “disabling functional limitations.”

- Most commenters focused on the method of functional equivalence that was based on “broad areas of development or functioning,” set out in § 416.926a(c) of the interim final rules. Some of these commenters noted that we did not provide the same number of areas of functioning for all children and thought that this was unfair to children

who had fewer functional areas in which to be rated. These commenters pointed out that for children age 1 to 3 we provided only three areas of functioning, while for older children we provided five.

- Many commenters asked us to separate communication from cognition in the cognitive/communicative area of functioning.

- Many commenters asked us to provide better ways to evaluate physical impairments. Many of these commenters suggested that we include another area of functioning to evaluate physical disorders in addition to the “motor” domain we added in 1997.

- Many commenters also asked us to clarify the rules to explain more clearly how we evaluate combinations of impairments, particular kinds of impairments, and particular kinds of functional limitations.

- A number of commenters asked us to clarify how we consider the results of testing, including the SEM, and how we define the terms “marked” and “extreme.”

For a more detailed summary, see the public comments section of this preamble. As we note there, we adopted or partially adopted these comments in the final rules. In many cases, we incorporated specific suggestions made by commenters.

Final § 416.926a has the following key features:

- *Simplified rules.* Under the interim final rules, we provided four methods for evaluating functional equivalence. (See §§ 416.926a(b)(1)–(b)(4) of the interim final rules.) In the final rules, we are providing a single method, based only on domains of functioning. The methods were somewhat redundant and, by far, the most commonly used one was based on broad areas of development or functioning, which we call “domains” in the final rules. The word “domain” is consistent with the language used in the conference report on the legislation, and much simpler than the phrase we used in the interim final rules, which meant the same thing.

- *Delinking from specific listings.* We also simplified the final rules so that adjudicators will no longer consider or refer to any of the listings when deciding functional equivalence. Although we provided self-contained domain criteria under the “broad areas of development or functioning” method in the interim final rules, we still required reference to listing 112.02 or 112.12 when a child’s impairment(s) functionally equaled the listings under this method. The other three methods of functional equivalence in the interim final rules required adjudicators to

identify specific listings containing disabling functional limitations and to refer to them when they found functional equivalence.

Also, a frequent criticism of the broad areas of functioning was that they were “the same” as the domains in the childhood mental disorders listings because they used the same names. Although this criticism was inaccurate, it is true that the names of the domains in the interim final rules confused many people. The new domains are specifically designed for determining functional equivalence and are completely delinked from the mental disorders and other listings.

- *New domain for evaluating the physical effects of impairments.* We added a sixth domain, called “Health and physical well-being,” for evaluating the physical effects of both physical and mental impairments, except for motor functioning limitations, which will be evaluated in a separate domain (“Moving about and manipulating objects”). This domain includes guidance that was relevant to the prior functional equivalence method called “episodic impairments” (see § 416.926a(b)(3) of the interim final rules) but also includes new guidance in response to public comments.

- *The same number of domains for all children.* All six domains in the final rules apply to children from birth to the attainment of age 18. We agreed with the commenters that it is possible to describe domains that apply to all ages. We provide general descriptions of the domains and specific examples of typical and atypical functioning for each domain. In five of the six domains (all except “Health and physical well-being”), we provide detailed descriptors for each age group.

- *Communication addressed in the appropriate domains.* In the final rules, we no longer have a domain called “cognitive/communicative.” The different aspects of communication are addressed in each domain that they affect.

- *Guidance on evaluating multiple impairments.* We added more guidance and reminders about evaluating the functional limitations that result from combinations of impairments throughout these final rules, including in final § 416.926a. Final § 416.926a(c), “The interactive and cumulative effects of an impairment or multiple impairments,” addresses this issue specifically.

- *Clarification of how we use test results.* We did not adopt the comments that asked us to include specific reference to the SEM in our rules or to apply SEMs in certain ways. However,

in response to these comments, we clarified that we do not rely on any test score alone. We also clarified our longstanding policy that we may consider a child to have "marked" or "extreme" limitations with test scores that are slightly higher than the levels we use to define those terms. However, we explain that we may also consider the converse; *i.e.*, that a child with test scores that appear to be in the "marked" or "extreme" range may not have such limitations. We consider test scores in the context of all the evidence in the case record.

- *Better general guidance for considering all types of impairments.* In final §§ 416.924a and 416.926a, we provide better guidance for evaluating the effects of all impairments, including a number of specific impairments singled out by some commenters. In addition to improvements we made in final §§ 416.924a and 416.926a already noted, we also included more detailed guidance and examples for evaluating limitations in each of the domains. We included examples that we believe will be useful for evaluating both physical and mental impairments.

We continue to define listing-level severity as "marked" limitation in two domains or an extreme limitation in one domain.

Therefore, although we delinked our policy of functional equivalence from reference to specific listings, we continue to use the phrase "functionally equals the listings," to underscore that the impairment(s) must be of listing-level severity.

The following is an explanation of the specific changes we made in final § 416.926a.

We revised § 416.926a(a), "General," to reflect the changes to our functional equivalence policy in these final rules. We deleted the reference to "any listed impairment that includes disabling functional limitations among its criteria" in the first sentence because we no longer refer to specific listings. We deleted the second and third sentences for the same reason. We replaced the discussion with an explanation that an impairment or combination of impairments functionally equals the listings if it is of listing-level severity. We also included the definition of listing-level severity from § 416.925(b)(2) of the interim final rules, revised to reflect other changes; *i.e.*, to show that the impairment(s) must result in marked limitations in two domains or an extreme limitation in one domain.

We expanded the guidance in final paragraph (a) about what we consider when we evaluate a child's functioning. The first sentence of paragraph (a) of the

interim final rules indicated that, when we assess functional limitations, we consider what the child "cannot do" because of his or her impairment(s). In the final rules, we clarify that we consider what the child "cannot do, [has] difficulty doing, need[s] help doing, or [is] restricted from doing" because of his or her impairment(s). This clarifies that we consider all of a child's limitations, even when the child has some ability to do an activity. We also added a reminder that we consider the interactive and cumulative effects of all the child's impairments for which we have evidence and references to other relevant rules we consider, especially those found in final § 416.924a.

We replaced §§ 416.926a(b), "How we determine functional equivalence," and 416.926a(c), "Broad areas of development or functioning," of the interim final rules with a series of new paragraphs. Paragraph (b) of the interim final rules explained the four methods we could use to determine functional equivalence. Since functional equivalence is now simplified into one method, we deleted those provisions of the interim final rules. However, we incorporated some of the principles of these paragraphs into other sections of the final rules, as already noted in the explanation of the changes in final § 416.924a and the summary of the key provisions of final § 416.926a.

We deleted the statement in the last sentence of interim final § 416.926a(b) about when we will complete a form SSA-538. This restatement of our policy in § 416.924(g) was redundant and unnecessary. A greater concern was that it was the only place in our rules where we repeated this requirement. We believe this may have given the mistaken impression that we do not complete the form when we decide whether a child's impairment(s) is severe, meets a listing, or medically equals a listing, as required in § 416.924(g).

In final §§ 416.926a(b), "How we will consider your functioning," we explain that we use the word "activities" to mean everything a child does at home, in childcare, at school, and in the community. In final paragraph (b)(1), we list the new domain headings. They are:

- Acquiring and using information,
- Attending and completing tasks,
- Interacting and relating with others,
- Moving about and manipulating objects,
- Caring for yourself, and
- Health and physical well-being.

As we explain below, the new domain names largely clarify the broad areas of development or functioning we used in

the interim final rules. In most cases, they rename, and to some extent reorganize, the prior areas of functioning, incorporating features of the other methods of functional equivalence we have deleted. They also respond to the major public comments about the domains by applying the same domains to children from birth to age 18, addressing the component parts of communication (explained later in this preamble) in the appropriate domains, providing better ways to evaluate the physical effects of impairments, and clarifying how we evaluate the effects of combinations of impairments and particular impairments.

We believe that the revised domains will be easier for our adjudicators to apply and for the public to understand. We believe that the new approach, together with the changes in final §§ 416.924a, provides a clearer, more comprehensive way to assess the effects of a child's impairment or combination of impairments on his or her functioning.

Final §§ 416.926a(b)(2) and (b)(3) provide guidance and reminders based on key provisions of final §§ 416.924a and 416.926a(a). Paragraph (b)(2) explains that there are six basic questions we will consider when we evaluate a child's functioning under the functional equivalence provisions. The six questions focus on the child's abilities and limitations, where the child has difficulty (*i.e.*, at home, in childcare, at school, or in the community), the quality of any limitations (*i.e.*, difficulty initiating, sustaining, or completing activities), and the kind, extent, and frequency of help the child needs. Final paragraph (b)(3) is based on § 416.926a(c)(2) of the interim final rules. It provides reminders of the kinds of evidence we will consider when we evaluate functioning under this section. In response to a public comment, we added cross-references to our rules on evidence and purchasing consultative examinations.

Final § 416.926a(c), "The interactive and cumulative effects of an impairment or multiple impairments," is based on and clarifies our intent in §§ 416.924a(c) and 416.926a(c)(1) of the interim final rules. We included this paragraph in response to comments suggesting that we provide better guidance about these issues and that we simplify our functional equivalence policy.

The provisions of the paragraph are based on our longstanding policy that we consider the limitations that result from a single impairment or a combination of impairments in any domains that are affected. The interim

final rules recognized that these effects may be in areas that “may not be obviously relevant,” and provided (in § 416.924a(c)(3)(ii)) examples of young children who might have delays in developing motor skills or bonding emotionally because of visual or hearing impairments. We decided to delete the examples because they focused only on the youngest children and certain kinds of impairments. We also believed that the provision was misplaced with the rules on how we consider age because it provided guidance on how we consider functioning. Therefore, it was more appropriate to include this guidance in final §§ 416.924a and 416.926a.

Final paragraph (c) assumes that at this step in the sequential evaluation process for children we have already established the existence of at least one medically determinable impairment that is “severe.” Therefore, we explain that at this point we are looking primarily at the extent of the limitation of the child’s functioning. We look at all of the child’s activities to determine the child’s limitations or restrictions and then decide which domains to use. (Of course, when we decide whether the child’s medically determinable impairment(s) is “severe” we will look comprehensively at the combined effects of all of the child’s impairments, unless we are able to decide the issue by looking at each of the child’s impairments separately. We explain this point above and in § 416.924a(b)(4) of the final rules.)

We evaluate the limitations that result from a medically determinable impairment(s) in any single domain or in as many domains as are affected. We explain that any given activity may involve the integrated use of many abilities and skills. We also explain that any single impairment may have effects in more than one domain.

In final § 416.926a(d), “How we will decide that your impairment(s) functionally equals the listings,” we provide the basic rule for functional equivalence. To functionally equal the listings, an impairment or combination of impairments must be of “listing-level severity”; *i.e.*, it must result in marked limitations in two domains of functioning or extreme limitation in one domain. The disability must also meet the duration requirement; *i.e.*, it must have lasted or be expected to last for 12 months or to result in death. The provision is based on “listing-level severity” and the provisions of §§ 416.902, 416.925(b), and 416.926a(c) of the interim final rules. However, in the third sentence of this paragraph, we provide explicitly that we will not

compare a child’s functioning to the requirements of any specific listing to underscore that we are delinking the policy from direct reference to the listings.

Final § 416.926a(e), “How we define ‘marked’ and ‘extreme’ limitations,” is based on § 416.926a(c)(3) of the interim final rules. We reorganized and clarified the provisions from the interim final rules and expanded some of our guidance.

We begin with a general paragraph that reviews the major principles of all of the final rules. In subparagraph (ii), we repeat and expand our guidance about formal testing that appears in final § 416.924a(a)(1), which was based on § 416.924(f) of the interim final rules. The final provision explains that standard scores, such as percentiles, can be converted to standard deviations, and that we consider such scores with all the other evidence when we determine whether a child has a marked or extreme limitation in a domain.

In final § 416.926a(e)(2), “Marked limitation,” we reorganized the provisions of § 416.926a(c)(3)(i) from the interim final rules to provide the general definition of “marked” first. We explain that a child has a “marked” limitation in a domain when his or her impairment(s) “interferes seriously” with functioning in the domain before we provide the more specific definition based on standardized testing. We expanded the definition to refer to limitations in the ability to independently initiate, sustain, and complete activities to be consistent with our other revisions and to clarify the definition in response to comments. For the same reasons, we also revised the statement that “marked limitation may arise when several activities or functions are limited or even when only one is limited.” The final sentence provides that there may be a marked limitation when a child’s “impairment(s) limits only one activity or when the interactive and cumulative effects of [the] impairment(s) limit several activities.”

In addition to retaining the other definitions of “marked” from the interim final rules, we also added a new one explaining that “marked” is the equivalent of functioning we would expect to find on standardized testing with scores that are at least two, but less than three, standard deviations below the mean. This includes in our rules a longstanding instruction from the training manual we provided to our adjudicators when the interim final rules were implemented. (Childhood Disability Training, SSA Office of

Disability, Pub. No. 64–075, March 1997.)

In subparagraph (e)(2)(ii), we clarified our rule defining “marked” in terms of a developmental quotient for children who have not attained age 3. We continue to provide that such a child will have a “marked” limitation if he or she is functioning at a level that is more than one-half but not more than two-thirds of his or her chronological age. However, in response to a comment, we clarified that if there are standard scores from standardized testing in the case record, these scores take precedence over the more subjective estimate based on functioning relative to chronological age.

In subparagraph (e)(2)(iii), we retain our rule that a “marked” limitation is shown with a valid score that is two standard deviations below the mean, but less than three standard deviations, on a standardized test. We clarified the provision to indicate that the test must be a “comprehensive standardized test designed to measure ability or functioning in [the] domain” and that the test results and the child’s day-to-day functioning in the domain-related activities must be consistent. This is another example of a clarification we made in response to comments that asked us to explain better how we will consider test scores.

Subparagraph (e)(2)(iv) is new. It provides an alternative definition for the term “marked” as it applies to the sixth domain of functioning, “Health and physical well-being.” As we explain below, this new domain considers the physical effects of both physical and mental impairments. It includes (but is not limited to) such effects as frequent exacerbations and frequent illnesses, and incorporates aspects of the functional equivalence method based on episodic impairments found in § 416.926a(b)(3) of the interim final rules.

The definition in this subparagraph describes the frequency of effects that demonstrate a “marked” limitation in this domain. Under the final rules, a child may have a marked limitation in this domain if he or she has illnesses or exacerbations from his or her impairment(s) that result in significant, documented symptoms or signs occurring on an average of 3 times a year or once every 4 months, each lasting 2 weeks or more. We provide alternative criteria for children who have more frequent, but shorter, episodes or less frequent, but longer, episodes.

We adopted this definition from other rules and guidance. We provide a similar criterion in section 14.00D8 in

the Immune System section of part A of our listings, which we use when we decide whether an individual meets the criteria of listing 14.08N. An individual who has HIV infection meets that listing with "repeated" manifestations of the illness as defined in 14.00D8 and "marked" limitations in one other specified domain. We also have operating instructions that we use to evaluate the frequency of exacerbations of serious mental disorders in adults under the fourth paragraph B criterion for most listings under section 12.00. It provides essentially the same criteria for assessing frequency in that domain as used here in the final childhood disability rules. (See Program Operations Manual System, DI 22511.005D.)

In both cases, the frequency criterion is the equivalent of one "marked" limitation, and individuals must still show "marked" limitation in a second domain to meet the listings. We believe the standard is appropriate for evaluating the frequency of exacerbations or illnesses in children too. The other definitions of the term "marked" in these final rules will also apply to the health and physical well-being domain when appropriate.

In final paragraph (e)(3), "Extreme limitation," we made revisions to parallel the revisions in paragraph e)(2). To maintain consistency with the provision that describes a "marked" limitation when an impairment(s) "seriously" interferes with functioning in the domain, we added a parallel definition for extreme limitation when an impairment(s) "very seriously" interferes with functioning.

We also clarified the definition based on a public comment. In § 416.926a(c)(3)(ii)(C) of the interim final rules, we defined "extreme" as having "no meaningful function in a given area." A commenter thought that this was a stricter standard than we intended, equivalent to a requirement that a child be completely unable to function. To clarify that this was not our intent, we deleted the phrase and added in the final rule that, while "extreme" is the rating we use for the worst limitations, it does not necessarily mean a total lack or loss of ability to function. It means that the impairment very seriously limits functioning, and is the equivalent of the functioning we would expect to find on standardized testing with scores that are at least three standard deviations below the mean.

For the domain of "Health and physical well-being," we provide that episodes of illness or exacerbations of a child's impairment(s) "substantially in excess of" the criteria in paragraph

(e)(2)(iv) will also constitute "extreme" limitation. However, we caution that impairments that occur with such frequency or for such extended periods of time that they could be rated as "extreme" under this definition should meet or medically equal a listing in most cases.

In final paragraph (e)(4), "How we will consider your test scores," we expand on the guidance we provided in final § 416.924a(a)(1), focusing more on issues relating to the rating of the domains for functional equivalence. We added the paragraph in response to comments that suggested we include provisions specifying how we would apply the SEM. The paragraph explains that we may find that a child has a "marked" or "extreme" limitation with a test score that is slightly higher than the levels provided in this section if other information in the case record indicates that the child's functioning is seriously or very seriously limited because of his or her impairment(s). This means that we may find that a child has "marked" or "extreme" limitation in a domain even if he or she has test scores that are slightly higher than is required to satisfy the definitions of those terms based on standard deviations. Conversely, we explain that we may find that a child does not have a "marked" or "extreme" limitation even if the test scores are at the levels provided in this section if other information in the case record indicates that the child's functioning is not seriously or very seriously limited. We provide examples to illustrate both situations.

We also incorporate in the final rules guidance from our adjudicator training on how to consider IQ testing (Childhood Disability Evaluation Issues, SSA Office of Disability Pub. No. 64-076, March, 1998). This guidance applies to all testing, and explains how we resolve material inconsistencies between a child's test scores and the other information in the case record. We explain that, while it is our responsibility to resolve any material inconsistencies, the interpretation of a test is primarily the responsibility of the professional who administered the test. If necessary, we may recontact the individual who administered the test for further clarification.

However, we may also resolve an inconsistency with other information in the case record, by questioning other individuals who can provide us with information about a child's day-to-day functioning, or by purchasing a consultative examination. We also explain what we will do when we do not rely on a test score.

We believe these final provisions address most of the concerns of the commenters who asked us to include provisions recognizing the SEM. All measures of functioning are less than perfectly precise and have some range of error around their scores.

The SEM is one method of quantifying this variation. It is a statistical unit that can be used to construct a confidence interval. This interval reflects the reliance that can be placed in the accuracy of an obtained test value. For clinical purposes, the SEM is considered to fall symmetrically around a test score. Therefore, the confidence interval is described by the obtained score plus and minus the desired number of SEMs.

For example, given an obtained score of 72 and a hypothetical SEM of 5 points, one can say with 68 percent confidence that the examinee's true score falls somewhere within the range of 67 to 77. To be 95 percent confident, we must go to plus and minus two SEMs, or a score range of 62 to 82.

SEMs differ from test to test, summary score by summary score (e.g., full scale IQ, verbal IQ, and performance IQ), and by age. Tables of SEMs are typically published within test manuals.

Because of the imprecision inherent in all psychometric devices, professionals who administer tests do not rely on the test scores alone. They consider as much other information as is available to help them judge whether a given test score is a meaningful measurement of a child's ability (or in some tests, the child's functioning) in the area addressed by the test.

For example, the major professional manuals defining mental retardation provide a rough clinical rule of thumb that IQs in the range of 50 to 75 indicate one level of mental retardation, but caution that the child's adaptive functioning must also be considered and must be consistent with the abilities suggested by such scores before a diagnosis of mental retardation may be made. Of course, the professional who administered the test is in the best position to determine the precision of his or her findings.

We believe that the final rules are the best possible way to recognize the less than perfect precision of test results. They recognize that we cannot rely on any given test score without considering it in the context of all the other evidence. They explain that we will generally defer to the judgment of the person who gave the test about the accuracy of the results, and they incorporate into our rules procedures for adjudicators to follow when they question test results.

In final § 416.926a(f), “How we will use the domains to help us evaluate your functioning,” we provide general information about the domains and how we will use them. Each domain description in final paragraphs (g) through (l) begins with a general description of the kinds of activities that should be evaluated under the domain in terms of what a child of the same age who does not have impairments is expected to be able to do.

Then, each domain description (except “Health and physical well-being,” which contains examples only of limitations) includes two kinds of examples: ones to illustrate typical functioning of children who do not have impairments, generally presented by age category, and ones to illustrate limitations. The examples are not all-inclusive, and we will not require our adjudicators to develop evidence about each specific example. They are intended only to help our adjudicators understand better some of the kinds of activities and limitations they should evaluate within each domain when this information is in the case record.

We also explain that the limitations do not necessarily describe “marked” or “extreme” limitations, only limitations of functioning within the domain. We must consider all of the information in the case record when we decide whether there is a “marked” or “extreme” limitation in a domain.

Final § 416.926a(g), “Acquiring and using information,” is, in part, the successor to the prior area of functioning called cognition/communication. In response to public comments about including communication in that area, these final rules recognize that “communication” comprises speech and language, and that language is used both for learning and for interacting and relating. Therefore, we address the three components of communication (speech, language used for learning, and language used for interacting and relating) in the domains that are appropriate to the function.

- Final paragraph (g)(1)(i) recognizes that the ability to acquire information, or learn, requires perceptual, sensorimotor, language, and memory processes that allow the child to acquire the fundamental skills of reading, writing, and doing arithmetic.

- Final paragraph (g)(1)(ii) recognizes that the ability to use information, or think, employs those same processes, through visual and verbal reasoning, to solve problems, make choices, develop ideas, and construct arguments or theories.

- Paragraph (g)(2) provides some examples of activities in “Acquiring and Using Information” typical of children in our designated age groups.

- Paragraph (g)(3) provides examples of some limitations in this domain.

Final § 416.926a(h), “Attending and completing tasks,” incorporates aspects from two prior areas of functioning. It includes some of the former area, “Responsiveness to Stimuli,” which applied only to children from birth to the attainment of age 1, and aspects of the former area, “Concentration, Persistence, or Pace,” which applied only to children from age 3 to the attainment of age 18. As with all of the domains in the final rules, this domain now applies to children of all ages.

The domain recognizes how attention evolves from an infant’s earliest response to all types of environmental stimuli, to a school-age child’s capacity to focus on certain stimuli (and ignore others) in a formal learning situation, and then eventually to an adolescent’s capacity to maintain attention in work or work-like tasks.

- Paragraph (h)(1)(i) describes attention in terms of level of alertness, concentration, and the initiating, sustaining, and changing of focus needed to perform tasks.

- Paragraph (h)(1)(ii) further details the role of attention in physical and mental effort, in allaying impulsive thinking and acting, and in performing tasks at an appropriate pace, within appropriate timeframes.

- Paragraph (h)(2) provides some examples of activities in “Attending and Completing Tasks” typical of children in our designated age groups.

- Paragraph (h)(3) provides examples of some limitations in this domain.

Final § 416.926a(i), “Interacting and relating with others,” includes all aspects of social interaction and relationship with individuals or groups (in formal, informal, or intimate contexts) as well as the speech and language skills needed to communicate effectively in all social settings. This domain incorporates the prior area of “Social Functioning,” but now includes the ability to use speech and the aspect of language needed to interact and relate in social contexts (called “pragmatics”).

- Paragraph (i)(1)(i) discusses interacting with others as the broad set of social behaviors a child uses with any other person, whether in a single encounter or on a daily basis.

- Paragraph (i)(1)(ii) discusses relating to others as the formation of intimate relationships with particular people, which requires interacting skills as well as a wide array of emotional behaviors.

- Paragraph (i)(1)(iii) explains that interacting and relating entail responding to a variety of emotional and behavioral cues, speaking intelligibly, following social rules for conversation and interaction, and responding appropriately to others.

- Paragraph (i)(1)(iv) notes that interacting and relating occur in all of a child’s activities that involve other people and may involve only one person or a group. Interacting and relating also occur across a wide range of social situations, from participating in school activities voluntarily to having appropriate responses to persons in authority.

- Paragraph (i)(2) provides some examples of activities in “Interacting and relating” typical of children in our designated age groups.

- Paragraph (i)(3) provides examples of some limitations in this domain.

Final § 416.926a(j), “Moving about and manipulating objects,” is the successor to the prior area of “Motor Functioning,” and includes gross and fine motor skills.

- Paragraph (j)(1)(i) describes the range of actions involved in moving one’s body from one place to another, such as sitting, standing, balancing, shifting weight, transferring, bending, crouching, crawling, and running.

- Paragraph (j)(1)(ii) describes the kinds of actions involved in moving, holding, carrying, transferring, or manipulating objects.

- Paragraph (j)(1)(iii) discusses the underlying aspects of motor skill, such as coordination, dexterity, integration of sensory input with motor output, and the capacity to plan, remember, and execute controlled motor movements.

- Paragraph (j)(2) provides some examples of activities in “Moving about and manipulating objects” typical of children in our designated age groups.

- Paragraph (j)(3) provides examples of some limitations in this domain.

Final § 416.926a(k), “Caring for yourself,” incorporates and clarifies provisions of the “Personal” area in the interim final rules. It also incorporates principles from the areas in the interim final rules called “Responsiveness to Stimuli” and “Concentration, Persistence, or Pace” that are not covered by the domain for “Attending and completing tasks” in the final rules.

It includes aspects of the child’s ability to appropriately care for physical needs (such as feeding, dressing, toileting, and bathing), maintain a healthy emotional and physical state by coping with stress and changes in his or her environment, and take care of his or her health and safety. Development is measured in terms of such things as the

child's increasing sense of independence and competence, ability to cooperate with others in meeting physical and emotional wants and needs, and increasing independence in making decisions and in taking actions involved in caring for himself or herself. Impaired ability is manifested by such things as pica (eating non-nutritive or inedible objects), self-injurious actions, refusal to take medication, and disturbances in eating and sleeping patterns.

- Paragraph (k)(2) provides some examples of activities in "Caring for yourself" typical of children in our designated age groups.

- Paragraph (k)(3) provides examples of some limitations in this domain.

Final § 416.926a(l), "Health and physical well-being," is a new domain. It incorporates aspects of the two prior methods of determining functional equivalence called "Episodic impairments" and "Limitations related to treatment or medication effects." (See §§ 416.926a(b)(3) and (b)(4) of the interim final rules.)

The domain addresses the cumulative physical effects of physical or mental impairments and the impact of their associated treatments or therapies on a child's functioning. Consistent with the definition of "extreme" in final § 416.926a(e)(3)(iv), it explains that an impairment(s) that causes "extreme" limitation in this domain will generally meet or medically equal a listing.

- Paragraph (l)(1) takes note of the variety of physical effects that a child may experience, such as shortness of breath, reduced stamina, poor growth, or pain.

- Paragraph (l)(2) notes that a child's medications or treatments may have physical effects that limit the performance of activities.

- Paragraph (l)(3) concerns children whose illness may be chronic with stable or episodic symptoms, or who may be medically fragile and need intensive medical care to maintain health.

- Paragraph (l)(4) provides some examples of limitations in health and physical well-being that may affect a child of any age.

We redesignated § 416.926a(d) of the interim final rules, "Examples of impairments that are functionally equivalent in severity to a listed impairment," as final § 416.926a(m). We revised the heading and the opening paragraph to refer to impairments that "functionally equal the listings" consistent with other changes throughout these final rules.

We also deleted examples 5 and 10 and renumbered the remaining

examples. Example 5 previously referred to any physical impairment(s) or combination of physical and mental impairments "causing marked restriction of age-appropriate personal functioning and marked restriction in motor functioning." The example is no longer appropriate because we replaced the domain names and deleted the term "age-appropriate" from these final rules.

We could have revised the example to reflect the new terms in these final rules, but then it would simply repeat the definition of listing-level severity in final §§ 416.925 and 416.926a(a). We believe the revisions we made throughout final § 416.926a sufficiently clarify the principle that example 5 was intended to show.

Example 10 in the interim final rules referred explicitly to listing 112.12. We deleted this example because we are removing explicit reference to specific listings from our functional equivalence rules.

We also redesignated § 416.926a(e) of the interim final rules, "Responsibility for determining functional equivalence," as final § 416.926a(n). Apart from the redesignation, there are no changes in the rule.

Changes to § 416.987 Disability Redeterminations for Individuals Who Attain Age 18

The only substantive change we made to the interim final rule is to incorporate the amendment to section 1614(a)(3)(H)(iii) of the Act made by section 5522(a)(1) of Pub. L. 105-33, 111 Stat. 251, 622. Under that section, we must perform a redetermination of the disability eligibility of children who attain age 18 "either during the 1-year period beginning on the individual's 18th birthday or, in lieu of a continuing disability review, whenever the Commissioner determines that an individual's case is subject to a redetermination under this clause." The new provision is found in final § 416.987(c).

We also revised and shortened the entire section to remove redundancies and make it easier to read. These changes are only editorial and do not substantively change any provisions of the interim final rule.

Changes to § 416.990 When and How Often We Will Conduct a Continuing Disability Review

We revised § 416.990(b)(11) of the interim final rules to incorporate the amendment to section 1614(a)(3)(H)(iv) of the Act made by section 5522(a)(2)(B) of Pub. L. 105-33, 111 Stat. 251, 622. The section explains when we will do a continuing disability review (CDR) of

the eligibility of a child whose low birth weight was a contributing factor material to our determination that he or she was disabled.

The original provision in Pub. L. 104-193 required us to do a CDR by the child's first birthday in all cases. The amendment in Pub. L. 105-33 changed the provision. Now we can do a CDR after a child's first birthday if at the time of the initial determination we determine that the child's impairment is not expected to improve by age 1 and we schedule a CDR for a date after the child's first birthday.

Changes to § 416.994a How We Will Determine Whether Your Disability Continues or Ends, and Whether You Are and Have Been Receiving Treatment That Is Medically Necessary and Available, Disabled Children

In final § 416.994a(i)(1)(ii), we deleted the word "Psychiatric" in response to a comment that pointed out that "Medical management" in § 416.994a(i)(1)(i) includes medical management provided by psychiatrists. We also corrected typographical errors and changed the text so it is consistent with the final rules on functional equivalence. Otherwise, the section is unchanged.

Other Changes

We made other changes throughout the rules for consistency with changes we have described above, to correct typographical errors, and to simplify language. For example:

- In the listings sections revised in the interim final rules, we changed the phrase "medically or functionally equivalent in severity to the criteria of a listed impairment" and variations on this phrase to "medically or functionally equals the listings."

- In §§ 416.913(c)(3) and 416.919n(c)(6), we changed the names of the domains to reflect the changes in final § 416.926a.

Public Comments

In response to our request for comments on the interim final rules, we received 174 letters from different sources. Most of the comments came from advocacy and legal groups that represent children with disabilities. Other comments came from organizations representing children with specific diseases, disorders, or health problems, and from representatives of professional medical and health care organizations. We also received comments from several public agencies and professional organizations having an interest in these rules. Finally, some commenters were parents

or caregivers of children with disabilities.

In a number of cases, we received the same comment and recommendation from several, and sometimes many, commenters. When this happened, the comments and recommendations often used identical or very similar language. Several commenters also included statements in their letters indicating that, in addition to their individual comments, they agreed with the more detailed, comprehensive comments of another commenter, generally an advocacy group or coalition of advocates.

Because many of the comments were detailed, we condensed, summarized, or paraphrased them. However, we tried to summarize the commenters' views accurately and to respond to all of the significant issues raised by the commenters that were within the scope of the interim final rules.

Finally, many of the comments were outside the scope of the interim final rules. For example, some comments asked us to change rules that were not included in the interim final rules, and many comments contained opinions about Pub. L. 104-193 without suggesting changes to the interim final rules. In a few cases, we summarized and responded to such comments because they raised public concerns that we thought are important to address in this preamble. For example, we received many comments from people who were concerned about how we were going to redetermine the eligibility of children under the requirements of Pub. L. 104-193 and we thought it was important to explain what we did after the comments were submitted. In most cases, however, we did not summarize or respond to comments that were outside the scope of our rulemaking. We will retain the comments and consider them if and when they are appropriate for other rulemaking actions.

Specific Comments

Appendix 1 to Subpart P of Part 404—Listings Sections 112.00C and 112.02B2

Comment: A few commenters expressed concerns about the removal of references to behavior from sections 112.00C2 and 112.02B2c(2). One thought that this change appeared to target children with "invisible disorders," including attention deficit hyperactivity. Another asked us to instruct adjudicators not to evaluate lightly children with maladaptive behaviors, because these behaviors may indicate the presence of a serious mental impairment. Another commenter stated that the interim final rules did

not adequately capture the behavioral expression of mental illness, especially in young children who do not have fully developed language skills.

Response: We removed references to "behavior" and "maladaptive" behavior from the personal/behavioral domain of prior sections 112.00C2 and 112.02B2c(2) in accordance with the explicit requirements of the law, not because we wanted to "target" children with specific impairments. See section 211(b)(1) of Pub. L. 104-193, 110 Stat. 2105, 2189. The interim final rules made no changes to listing 112.11, our listing for evaluating claims filed on behalf of children who have attention deficit hyperactivity disorder, and children with this impairment can still meet or medically or functionally equal the requirements of the listings.

We agree with the commenter who thought that children whose mental impairments result in behavioral problems should have their claims carefully reviewed. In fact, since we published the interim final rules, we have taken a number of actions to ensure that all children, including those with mental impairments, have their claims evaluated correctly and in accordance with the law.

We conducted training for all our adjudicators in 1997, shortly after we published the interim final rules, and emphasized the evaluation of all aspects of childhood disability claims, including those involving behavioral issues. As we noted earlier in this preamble, in late 1997, we also conducted a "top-to-bottom" review of our implementation of the provisions of Pub. L. 104-193 that affected the SSI childhood disability program.

In the review, we found that about 95,000 children, or about 10 percent of the children receiving SSI in December 1996, had an impairment that likely involved maladaptive behaviors in the prior personal/behavioral area of functioning. Of these cases, about 16,500 children were not affected by the changes in the law because their impairments met or equaled the requirements of our listings without consideration of the prior personal/behavioral domain. Two-thirds of the remaining cases involving maladaptive behaviors required a redetermination because they qualified for benefits based on an IFA.

The "top-to-bottom" review, however, indicated that some redetermination cases where benefits ceased were not consistently processed, including some that involved mental impairments other than mental retardation. Consequently, we conducted additional training on these issues in the spring of 1998, and

required the State agencies to review a portion of these cases. The March 1998 training included instruction on how to identify behavioral issues and the disorders with which they are likely to be associated, and emphasized that we still consider the functional limitations resulting from a child's behavior in determining whether a child is disabled.

We disagree with the commenter who thought that the interim final rules did not allow us to consider adequately the behavioral aspects of a child's mental impairment(s). The interim final rules never precluded consideration of functional limitations that result from behavioral problems, and our training and policy statements emphasized that fact. In the interim final rules, we clarified the description of the social area of functioning to emphasize that many impairment-related behavioral problems are likely to have their most significant effects on a child's social functioning. To reinforce the point further, we provided additional training to adjudicators that instructed them to consider behavior and outlined the various aspects to evaluate, including its nature, intensity, frequency, and duration. Our training also emphasized that adjudicators need to consider how behavior is affected by interventions.

We believe that the additional clarifications in the final rules, made to respond to these and other comments, further explain the issue. We provide descriptions and examples of functional limitations throughout the domains to make clearer where we consider the functional limitations of children whose physical and mental disorders include behavioral manifestations.

Comment: Two commenters expressed concern about the childhood mental disorders listings, stating that they should be adjusted to reflect the diagnostic categories in the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Washington, DC, American Psychiatric Association, 1994 (the DSM-IV). One of these commenters believed that using the DSM-IV categories would address the "vagueness" of some mental disorders listings, especially for children and adolescents with emotional disturbance. The other commenter said that many of the adult and childhood mental disorders listings are out of date, in need of revision, and that we should regularly update them so that the functional equals concept works more equitably.

Response: We did not adopt the comments because they were outside the scope of the interim final rules. The changes we made to the listings were only those necessary to implement Pub.

L. 104–193. We do not have the authority to issue final rules that revise the mental disorders listings as extensively as these commenters suggested without first proposing changes through notice-and-comment rulemaking under the Administrative Procedure Act.

We appreciate the comment suggesting that we update both the adult and the childhood mental disorders listings. We are considering such an update and will consider this and the other comments as we prepare any proposed revisions.

Section 416.902 General Definitions and Terms for This Subpart

Comment: Many commenters stated that our interpretation of the phrase “marked and severe functional limitations” in the interim final rules did not properly reflect Congressional intent. These commenters supported their position by citing various portions of the legislative history of Pub. L. 104–193 and prior versions of the legislation that were not enacted into law.

Response: We did not adopt these comments. These final rules continue to define the term “marked and severe functional limitations,” when used as a phrase, to mean the standard for disability in the Act for children claiming SSI benefits based on disability. We continue to define this standard in the final rules as being a level of severity that meets, medically equals, or functionally equals the listings.

Before we published the interim final rules in 1997, we carefully considered the statutory language and legislative history of Pub. L. 104–193, and the prior versions of the legislation that were not enacted into law, in order to determine the appropriate level of severity that would result in “marked and severe functional limitations.” We discussed some of the legislative history that influenced our decision on this issue in the preamble to the interim final rules. (62 FR 6408, 6409 (1997))

We have again reviewed the statutory language and legislative history of Pub. L. 104–193 and the prior versions of the legislation that were not enacted into law. We do not believe that the legislative history can fairly be read to preclude us from defining the phrase “marked and severe functional limitations” we did in the interim final rules and now in these final rules. The General Accounting Office reached a similar conclusion in its report to Congress on our development of the interim final rules. (Supplemental Security Income: Review of SSA Regulations Governing Children’s

Eligibility for the Program GAO/HEHS–97–220–R, September 16, 1997.) In that report, the GAO noted that it found the “interim final regulations to be consistent with the law.” GAO also stated: “We believe SSA was well within its authority in establishing the new level of severity, and its rationale for doing so was well supported.”

Some commenters supported their position by noting that the Senate “rejected” a disability standard contained in a prior House of Representatives’ version of the legislation. This earlier version would have explicitly required a child to meet or equal the requirements of the listings as they existed as of April 1, 1995, in order to be found disabled. These commenters were referring to an early version of the legislation, under which “[e]ligibility, as determined by the Commissioner, for cash benefits * * * will be based solely on meeting or equalling [sic] the current Listings of Impairments [sic] set forth in the Code of Federal Regulations.” H.R. Rep. No. 81 (Pt. 1), 104th Cong., 1st Sess. 48 (1995). Although the House of Representatives passed this bill, the childhood disability standard contained in the bill was just one of several alternative standards that Congress considered in various bills.

For example, the childhood disability standard contained in another bill would have eliminated the IFA, and would have provided that a child would be considered disabled if his or her impairment met the requirements of the listings or a functional equivalence standard separate from the listings. Another bill would have retained the IFA, but required changes to the regulations to provide that a child would be considered disabled if he or she had two marked limitations, or a “severe” limitation in one domain.

Still another bill would have retained the comparable severity standard, but clarified it to mean an impairment that was severe and persistent and which substantially limited a child’s ability to develop or function. Under this proposed standard, “IFA-level severity” was two marked limitations, or one marked and one moderate limitation.

The Senate’s initial version of H.R. 4, the legislation passed by the House, proposed a disability standard under which a child could be found disabled if he or she had “marked, pervasive and severe functional limitations.” S. Rep. No. 96, 104th Cong., 1st Sess., 20 (1995). The Senate later amended its proposal to drop the term “pervasive” from the definition of disability for children, so that the version of the legislation enacted in Pub. L. 104–193 provided

that a child would be found disabled if he or she had an impairment(s) that resulted in “marked and severe functional limitations.”

The evolution of a childhood disability standard from the prior standard of “comparable severity” to one explicitly tied to the Listing of Impairments as it was in effect on April 1, 1995, to one requiring “marked, pervasive and severe functional limitations” to the final standard, requiring “marked and severe functional limitations,” does not represent a fundamental rejection of a standard based on listing-level severity, as some commenters seemed to assume. Rather than rejecting a disability standard based on listing-level severity, the changes made by the Senate to the definition of disability for children can best be viewed as providing a more flexible definition of disability than one explicitly tied to a specific set of regulatory criteria in effect on a specific date, as initially proposed by the House of Representatives.

The legislative history of the initial Senate version of the legislation, under which a child would be found disabled if he or she had “marked, pervasive and severe functional limitations,” indicates that “the Listing and the other disability determination regulations as modified by the Committee bill properly reflect the severity of disability contemplated by the statutory definition.” S. Rep. No. 96, 104th Cong., 1st Sess. 18 (1995). Materially identical language appears in the legislative history of Pub. L. 104–193, as we discussed in the interim final rules and earlier in this preamble.

Thus, we also disagree with commenters who noted that the Senate’s removal of the word “pervasive” from the definition supported the conclusion that the level of severity in the interim final rules was stricter than what Congress intended. As we have noted, the material legislative history concerning the level of severity intended by the respective definitions is substantially identical for each version of the legislation. *Cf.* S. Rep. No. 96, 104th Cong., 1st Sess. 18–20 (1995) with H.R. Conf. Rep. No. 725, 104th Cong., 2d Sess. 328 (1996), *reprinted in* 1996 U.S. Code, Cong. and Ad. News 2649, 2716 and H.R. Rep. No. 651, 104th Cong., 2d Sess. 1385 (1996), *reprinted in* 1996 U.S. Code, Cong. and Ad. News 2183, 2444.

On a related point, the September 14, 1995, colloquy between Senator Dole and Senator Conrad, cited by some commenters to support their position, does not indicate that the Senate deleted the term “pervasive” to reject a standard of disability based on marked limitations in two domains or extreme

limitation in one. Rather, this discussion indicates that there was concern that the inclusion of the term "pervasive" in the earlier definition "implied some degree of impairment in almost all areas of a child's functioning or body systems." Senator Dole noted that this "was not the intent of the earlier proposed change." He further noted that "[s]ometimes children will have multiple impairments, sometimes they will not." 141 Cong. Rec. S13613 (daily ed. September 14, 1995) (statement of Sen. Dole).

Thus, the colloquy indicates that the term was deleted to clarify that a child with severe disabilities could be found disabled even if he or she did not have multiple impairments that caused some degree of impairment in almost all areas of his or her functioning. The interim final and these final rules are consistent with that understanding of the term "marked and severe functional limitations." We will find a child disabled, even if his or her impairment causes limitations in only one area of functioning, as long as the limitations are sufficiently serious.

Although we believe that the level of severity reflected in the interim final and final rules is consistent with the statutory text and legislative history of Pub. L. 104-193, we made a number of changes to improve and clarify them. We discuss these changes elsewhere in this preamble.

Comment: Several commenters who objected to a standard of disability based on listing-level severity suggested revisions of the standard to a specified level of severity less than marked limitations in two domains or extreme limitation in one domain. One commenter stated that a standard of disability based on listing-level severity was inappropriate because the listings describe extreme pathology and gross failure of treatment, and, for the most part, do not provide a meaningful level of functional ability.

Commenters proposed a variety of standards for establishing disability, including: Marked limitation in one domain and moderate limitation in another; marked limitation in one domain and moderate limitations in two others; and moderate limitations in three "crucial" areas. Other commenters stated that we should revise the rules to provide that children with moderate limitations in multiple areas should be found disabled, or suggested other alternatives that would have similar results. Other commenters thought we should retain or reinstate the IFA.

Response: We did not adopt these comments, but we have made changes in the final rules to address many of the

commenters' concerns. As we explained above, we believe that the disability standard we adopted in the interim final and final rules is consistent with the statutory definition of disability in children. We explained our reasons for this conclusion above and in the preamble to the interim final rules.

As the commenters recognized, in enacting Pub. L. 104-193, Congress intended that we apply a stricter standard of disability than the one used under the prior law. Previously, a child would be considered disabled if he or she had an impairment or combination of impairments that was of "comparable severity" to one that was disabling in an adult. Our rules interpreting the comparable severity standard at the IFA step contained guidance that illustrated a level of impairment severity that generally, though not invariably, would be found sufficient to establish comparable severity. See § 416.924e (1996) in the rules that preceded the interim final rules. Under these regulations, we could find a child disabled if we found on an IFA that his or her impairment or combination of impairments resulted in a "marked" limitation in one domain and a "moderate" limitation in another domain, or if his or her impairment(s) resulted in "moderate" limitations in three domains. See § 416.924e(c)(1) (i) and (ii), and § 416.924e(c)(2)(i) and (ii) (1996).

Section 211(b)(2) of Pub. L. 104-193, 104 Stat. 2105, 2189, specifically directed us to discontinue use of the IFA set forth in former § 416.924d and 416.924e. In accordance with that statutory directive, we deleted those rules in the interim final rules. We have no authority to retain or reinstate the IFA. Furthermore, the suggestions to revise the disability standard to include children with impairments of less than listing-level severity (e.g., one marked and one moderate limitation or three moderate limitations in "crucial" areas) would, in essence, result in the same level of severity we used when we performed an IFA under the prior law.

We do not believe that it would be consistent with the statutory definition of disability to allow a child to be found disabled based on one marked and two moderate limitations, or multiple moderate limitations, as some commenters suggested. "Moderate" limitations represent a wide spectrum, ranging from just above "slight" to just below "marked." Consequently, we do not believe that a standard of severity based on moderate limitations, even multiple moderate ones, reflects a level of impairment severity that results in

marked and severe functional limitations.

We disagree with the commenter who characterized our listings as "extreme" pathology, gross failure of treatment, and no meaningful level of functional ability. Our definition of "listing-level severity" in §§ 416.902 and 416.925(b) of the interim final rules—based on marked limitations in two domains or extreme limitation in one—made clear that a child could meet the standard without being as functionally limited as this commenter indicated.

We have, however, made many changes to address these concerns. Throughout the final rules, we made a number of changes to better explain how we consider the combined effects—what we now call the "interactive and cumulative effects"—of impairments. For example, we clarify in final § 416.926a(e)(2), what we have always intended by our statement in § 416.926a(c)(3)(C) of the interim final rules, that "marked limitation may arise when several activities or functions are limited or even when only one is limited." We have clarified the sentence to provide that there may be a marked limitation when a child's "impairment(s) limits only one activity or when the interactive and cumulative effects of [the] impairment(s) limit several activities." We made similar changes in the definition of "extreme" limitation in final § 416.926a(e)(3). We also clarified our definitions of these rating terms and improved our rules for evaluating functional limitations. We believe that the changes we made in the functional equivalence rules will address many commenters' concerns about how cases are evaluated using the childhood disability standard.

Comment: Some commenters thought that there was "no justification in medical practice" for our interpretation of the statutory definition of disability for children, and that regulations need to more accurately reflect the current knowledge-base about what constitutes severe disorders in children. These commenters maintained that our interpretation would place many children with severe disorders at risk of losing their SSI payments.

A few commenters thought the severity standard represented an overreaction to the problem of program abuse, e.g., alleged parental "schooling" (i.e., coaching) of children, or that it was our solution to budgetary problems, at the expense of children with disabilities.

Response: The references to "medical practice" and the "current knowledge-base about * * * severe disability in children" were unclear. We do not

believe that any part of these childhood disability regulations is inconsistent with, or contrary to, current medical practice or knowledge. Our intent is to fully recognize and fairly adjudicate cases of severe disability in children under the standard required by Pub. L. 104–193. Also, as noted in the previous response and in our summary of the final rules, we made many changes that we believe will address the commenters' concerns about how we evaluate a child's functional limitations within the domains.

We believe that the summary of our actions since 1997 at the beginning of this preamble responds to commenters who expressed concern that our interpretation would place many children with severe disorders at risk of losing their SSI payments. As we noted there, the Commissioner shared their concern and ordered a top-to-bottom review of our implementation of the law. As a result of that review, we took a number of major actions to ensure that children receiving benefits who should not have lost eligibility as a result of the changes in Pub. L. 104–193 retained their eligibility. The actions we took also helped to improve adjudication of new childhood disability claims.

As noted earlier, we believe that we have implemented Pub. L. 104–193 as Congress intended. Our interpretation was not an "overreaction" to reports of "coaching." The commenter correctly noted that the issue of "coaching" of children, which was raised several years ago, was addressed in numerous ways before Congress changed the definition of disability. We studied the issue ourselves, as did the Office of the Inspector General for the Department of Health and Human Services, and the General Accounting Office. None of those studies found any noticeable incidence of parental coaching of children. Of the few instances in which coaching (or malingering) was suspected, none involved a finding of disability or eligibility for SSI payments.

Comment: A few commenters suggested that we adopt eligibility criteria for other Federal and State programs for the children's SSI program. They specifically mentioned programs administered under Part H of the Individuals with Disabilities Education Act (IDEA) (now Part C of the IDEA, 20 U.S.C. 1431–1445, as a result of the Individuals with Disabilities Education Act Amendments of 1997, Pub. L. 105–17, 111 Stat. 37, 106–123). Some commenters suggested that we adopt the decisions made by other agencies.

Response: We did not adopt the comments. As we noted in both the preamble to the interim final rules and

earlier in this one, Congress provided a specific statutory standard for evaluating disability in children under SSI. We do not have the authority to adopt a definition from another statute.

Consistent with our longstanding policy, we cannot adopt disability determinations made by any other Federal or State programs. (*See* § 416.904.) The Act requires that the Commissioner of Social Security and his delegates, and not another governmental or non-governmental party, make the determination that a child is or is not disabled.

Comment: One commenter stated that the nature and cost of caring and providing support for individuals not properly served early in life increases significantly in their adult and aging years. This commenter believed that this argued for early intervention and a broader interpretation of the regulations.

Response: As noted above and in the preamble to the interim final rules, we believe that the disability standard in these rules is consistent with the level of severity intended by the statutory definition of disability. However, we believe that the final rules will address concerns expressed by this commenter by ensuring that children who apply for SSI benefits will have their impairments evaluated fairly and in a manner consistent with the law. We also believe that the changes clarify our rules and procedures for evaluating the eligibility of infants and toddlers by providing the same number of domains of functioning and more detailed instructions and examples for them.

Comment: Several commenters noted that the word "severe" had two different definitions under the law and that the regulations contained at least two instances where the two were used in the same sentence. They suggested that we change the regulations to minimize confusion, and provided specific language changes.

Response: We partially adopted the comments. In the final rules we revised sentences noted by one commenter that used the word "severe" twice in different contexts within the same sentence. We also replaced many of the references to "marked and severe functional limitations," the statutory standard, with phrases indicating that our intent is listing-level severity; *i.e.*, that the child's impairment(s) must meet, medically equal, or functionally equal the listings, avoiding the use of the word "severe."

However, we did not adopt the comments that asked us to replace the word "severe" in step two of the sequential evaluation process for children with another term. We have

used this term of art in our regulations and other instructions for evaluating disability in adults for over 20 years and for children since 1991. We believe that changing it now would be confusing.

Section 416.912 Evidence of Your Impairment and Section 416.913 Medical and Other Evidence of Your Impairment(s)

Comment: One commenter said we should ask specific, individualized questions when requesting information from a treating source, teacher, or other individual to ensure the evidence addresses the critical issues for the particular applicant's impairment.

Response: Our operating procedures already instruct the State agencies to make requests for information as specific as possible. We revise and update our forms for requesting information to ensure that we ask for relevant information. For example, we are developing a national teacher questionnaire for teachers to report specific information about a child's functioning. The State agencies also revise their forms as necessary to reflect changes in our rules and the needs and practices of their local medical providers, schools, and other sources.

Comment: Several commenters said some children will not have resources to obtain a medical professional's opinion about the causes of their functional limitations. One commenter thought we should provide more assistance to families, especially in rural areas, to help them obtain relevant medical evidence for their disabled children. Another believed that functional limitations are self-evident, so there is no need for other expensive corroboration. One commenter expressed concern about parents of children from non-English-speaking households who lack a network of medical treating sources to provide evidence.

One commenter recommended that we emphasize that evidence other than symptoms, signs, and laboratory findings can play an extremely important role in establishing SSI eligibility. The commenter said that evidence from other qualified professionals, such as speech-language pathologists, audiologists, occupational and physical therapists, educators and early intervention specialists should be used, when appropriate, and examples of such evidence should be provided.

Response: Section 416.912(d) of our regulations has long provided that we will make every reasonable effort to help individuals, including children and their families, to get medical reports from their own medical sources and

other evidence if we have their permission to do so. Section 416.914 of our rules also provides that we will pay for existing medical evidence, if there is a charge.

Under our rules in §§ 416.917 through 416.919a, we may also ask a child to go to one or more consultative examinations to get evidence we need to make a determination. There are several reasons we may ask a child to undergo a consultative examination, especially to get medical evidence when there is no medical source. When we ask a child to go to a consultative examination, we pay for the examination. We also have procedures to help people who do not speak English when they go to one.

In many cases, information we receive from schools includes medical evidence. Also, we recently revised our rules on medical evidence in § 416.913 to recognize school psychologists and speech-language pathologists as acceptable medical sources for certain kinds of impairments. (See 65 FR 34950.)

In response to these comments and others, the final rules clarify the different sources from whom we may seek evidence of a child's medical condition or functional limitations. For example, we added references to early intervention programs, preschool, and childcare. We emphasized our longstanding policy that school evidence is important information about a child's functioning, and added references to other important sources of information about functioning, such as physical, occupational, and rehabilitation therapists, who may see a child at school or elsewhere. Finally, we added cross-references to our rules on evidence to final § 416.926a(b)(3), the section on how we consider functioning.

We disagree with the commenter who thought that a child's functional limitations are always self-evident. On the contrary, these final rules recognize that children may function differently in different settings and that some serious limitations may not be obvious; for example, when a child appears to be functioning well but is in fact receiving extraordinary assistance or supervision in a structured setting. In any event, section 1614(a)(3)(H)(i) of the Act (which incorporates by reference the provisions of section 223(d)(5)(A) of the Act) and §§ 416.928(a) and 416.929 of our rules specify that we need medical evidence (signs, symptoms, and laboratory findings) to determine disability.

These provisions indicate that a claimant's statements of symptoms are not by themselves conclusive evidence

of disability. We must first establish the existence of a medically determinable impairment based on evidence from acceptable medical sources. Then, the evidence we use to assess the severity of a medically determinable impairment may come from both the "acceptable medical sources" listed in § 416.913(a), and "other sources" listed in § 416.913(d)(1) (including audiologists, occupational and physical therapists, educators, and early intervention specialists). Section 416.912(b)(4) includes a cross-reference to the sources listed in § 416.913(d).

Comment: One commenter thought we should consider assessments provided by psychiatric social workers, clinical psychologists and clinical nurse specialists, as "valid and appropriate documentation" of a child's disability.

Response: We consider licensed or certified psychologists to be "acceptable medical sources" in § 416.913(a)(2) of our regulations. As we previously stated, once we find that there is a medically determinable impairment with evidence from acceptable medical sources, we consider all relevant evidence we have in the case record when we decide whether a person is disabled. This may include evidence from health care professionals such as psychiatric social workers and clinical nurse-practitioners. Evidence from these other health care professionals helps us understand how a child's impairment(s) affects his or her ability to function, even though these sources are not "acceptable medical sources" for purposes of establishing the existence of a medically determinable impairment. This decision reflects our determination that there is insufficient standardization of their qualifications among the States for us to use them as acceptable medical sources.

Comment: One commenter believed that the regulations should require school psychologists or other appropriately qualified mental health professionals, familiar with the school context and educational disabilities, to be involved in reporting information to us, because the way that observations of a child's disability are communicated could affect an eligibility determination. The commenter was concerned that the interim final rules could "marginalize[]" or exclude information from schools from the disability determination process. Similarly, another commenter requested that we amend the section on school attendance in § 416.924c(g) of the interim final rules to state that information on school functioning is always relevant and must be available.

Response: The first comment was not clear to us, possibly because the letter

did not specify language in the interim final rules that the commenter believed could lead to the exclusion of information from schools and education professionals. We consider reports from school professionals to be very important evidence of a child's functioning, and we made changes to the final rules to clarify this point.

We do not require information from school professionals in all cases because sometimes we can decide that a child is disabled without it, such as when a child's impairment(s) meets the requirements of certain listings. We also cannot require school evidence in all other cases because sometimes we are unable to get it despite reasonable efforts. However, our rules require our adjudicators to try to get school records whenever they are needed to make a determination or decision regarding a child's disability.

In addition to strengthening our rules about school evidence, which we explained previously, we are taking other actions to improve the type of evidence we get from schools. As already noted, we are developing a national teacher questionnaire to improve the evidence we get from teachers and other educational professionals. We also recently issued final rules to make school psychologists, or other licensed or certified individuals with other titles who perform the same function as a school psychologist in a school setting, "acceptable medical sources" in § 416.913(a) for the purpose of establishing mental retardation, learning disabilities, and borderline intellectual functioning.

Section 416.919a When We Will Purchase a Consultative Examination and How We Will Use It

Comment: Several commenters suggested that we amend the regulations to indicate that State agencies will purchase tests to assess functioning when relevant or specifically to help establish functional equivalence. Others stated that we should require State agencies to schedule consultative examinations to obtain standardized testing to measure functioning when such testing is appropriate and not available from the child's treating source. One commenter also recommended that we regularly provide guidance to the State agencies about which tests are currently available and reliable to assess functioning for different age groups.

Response: We did not adopt the comments in these final rules. We do not have general rules specifying the kinds of tests we purchase in all cases and, generally, we do not endorse

particular instruments in our regulations. Many standardized tests, like IQ tests, measure a child's abilities, not functioning, and may or may not reliably predict any given child's actual functioning. In some cases, there are no standardized tests to measure functioning in particular domains or for particular age groups, nor are all test instruments widely used or available. In many cases, we do not need to purchase standardized tests of ability or functioning because the case record contains sufficient information about functioning for us to make a determination or decision.

On the other hand, we agree that standardized testing can help improve the uniformity of decisionmaking. For this reason, we stress in the final rules the need to request records from early intervention programs, preschools, and schools, which often include the results of standardized testing. However, as already noted, we repeatedly caution our adjudicators not to rely exclusively on such tests because it is critical to consider their results in the context of all other evidence in the case record.

Sections 416.917 and 416.919a of our regulations provide for State agencies to purchase appropriate consultative examinations when evidence in the case record is not sufficient for us to make a disability determination or decision. These examinations may include standardized tests to assess ability or functioning.

We believe that the general suggestion that we provide guidance to our adjudicators about tests that are currently available and reliable is a good one. We have provided such guidance in the past in subregulatory documents and will consider whether to do so in the future. However, we believe that it would not be feasible for us to regularly provide information on all available, reliable tests because there are so many of them and new ones are constantly developed. To some extent, we must rely on the professional judgment of individuals who provide evidence to us and the ability of the individuals who adjudicate or review claims to follow what is available in their local area and to know which tests are available and appropriate for particular cases.

Comment: Two commenters recommended that we clarify that if information received from a treating source, teacher, therapist, or other source is not sufficient to make a determination, adjudicators must seek additional consultation in order to make a determination based on complete and accurate information.

Response: We agree with these comments, but do not believe that any

changes are needed in these final rules. Sections 416.917 and 416.919a of our regulations already provide appropriate guidance for when to purchase a consultative examination. We have, however, included cross-references to our rules on consultative examinations in final § 416.926a(b)(3) in response to these and other comments.

Section 416.919n Informing the Examining Physician or Psychologist of Examination Scheduling, Report Content, and Signature Requirements

Comment: Several commenters thought that the rules describing a complete consultative examination should include more detail about a child's functional limitations. They suggested adding a cross-reference to the areas of functioning for each age group, and requiring consultative examination reports to include an analysis of a child's functioning by comparison to the specific areas for the relevant age groups. They also recommended adding the appropriate cross-references to the rules on consideration of age (§ 416.924a of the interim final rules), functioning (§ 416.924b), other factors (§ 416.924c), and symptoms, including pain (§ 416.929).

Response: As explained above in the summary of the changes, we adopted most of these comments by adding cross-references throughout the final rules. In addition, we revised §§ 416.913(c)(3) and 416.919n(c)(6), our rules on the content of medical reports and reports of consultative examinations, to reflect the new domain names in final § 416.926a.

Section 416.924 How We Determine Disability for Children

Comment: One commenter suggested that we revise the sequential evaluation process for children by separating the third step of the process (meets, medically equals, functionally equals) into three parts. The commenter thought that this would help ensure that adjudicators will apply each aspect of the third step before denying a claim.

Response: We did not adopt the comment. We believe that adjudicators properly understand and apply the current three-step sequential evaluation process. However, we made a number of changes to clarify and improve § 416.924, as we explained in the summary of changes earlier in this preamble.

Comment: A few commenters thought that we should require all adjudicators, including administrative law judges and administrative appeals judges on the Appeals Council, to explain their

findings using our Form SSA-538, the Childhood Disability Evaluation Form. Others thought that we should include the form in the text of the rules or make the form widely available to the public, including members of the medical community, by publishing the form in the **Federal Register** or posting it on our Internet site. Others suggested specific revisions to the form, such as adding cross-references to various rules to the form.

Response: We did not adopt the comments.

As we discussed in the preamble to the interim final rules (62 FR at 6412), our decision not to require administrative law judges or administrative appeals judges on the Appeals Council (when the Appeals Council issues a decision) to complete the form was based on the fact that these adjudicators issue decisions with detailed rationales and findings that explain how they apply the three steps of the sequential evaluation process for each child. Administrative law judge and Appeals Council decisions are quite different in form from most determinations prepared by a State agency because they include a more detailed explanation of the findings and conclusions, supported by a narrative rationale.

Consequently, requiring administrative law judges and administrative appeals judges to complete Form SSA-538 and append it to their decisions would only repeat information that is already contained in their decisions. This policy parallels what is done for adult disability claims, for which we do not require these adjudicators to complete or attach to their decisions residual functional capacity assessment forms. However, the final rules do not prohibit the use of Form SSA-538 at the hearings or appeals levels as a checklist or to help organize information in the record.

We did not require disability hearing officers in the State agencies to complete the form because they also provide detailed rationales on a special form that replicates information on Form SSA-538. However, we plan to issue a new form for disability hearing officers to use in childhood disability cases that will be specific to these final rules.

Although our forms are widely available to the public in our local offices, we do not include the text of any of our forms in our rules because they are not part of our substantive rules. Moreover, including Form SSA-538 in the rules would codify it and unnecessarily limit our flexibility to

change it as needed without undertaking rulemaking proceedings.

However, we agree with commenters who recommended that we revise the form. We are revising the form to be consistent with the changes in the final rules, and plan to have it ready by the time these rules go into effect. When we revise the form, we will consider ways in which we can ensure that it continues to be made available to the public, including the suggestions from the commenters.

Section 416.924b Functioning in Children, Interim Final Rules

Comment: One commenter objected to the following statement in § 416.924b(b)(3): “Ordinarily, activities of daily living are most important as indicators of functional limitations in children aged 3 to attainment of age 16, although they may be used to evaluate children younger than age 3.” The commenter believed this statement ignores the importance of considering school functioning and social relationships.

Response: We agree that the statement could have been confusing. For this and other reasons described earlier in this preamble, we deleted the provision and all the terms previously defined in § 416.924b, including “activities of daily living.”

Section 416.924c Other Factors We Will Consider, Interim Final Rules

Comment: Several commenters recommended that we provide more specific guidance to adjudicators about how to consider “other factors” when evaluating disability. Some suggested that we link the “other factors” rules specifically to those for functional equivalence either by cross-references or by citing the areas of functioning affected by “other factors” considerations. A number of commenters recommended that we incorporate more detailed guidance from our operating instructions on “other factors” into the regulations. These commenters recommended that we clarify that:

- Structured settings or other highly supportive environments may appear to improve a child’s functioning when the child’s impairment(s) results in functional limitations outside the setting;
- A child may appear less impaired on a single examination than the evidence over time may show; and that
- Treatment may cause side effects that result in functional limitations.

Response: We adopted the substance of all of these comments, although we did not necessarily duplicate text from

our prior operating manual sections. As explained above in the summary of the changes, we significantly improved the “other factors” section of the rules. See final § 416.924a, “Considerations in determining disability for children.” We believe it is now a more comprehensive rule that expands and clarifies our guidance for considering the various individual factors, including some that are addressed in these comments. Provisions of the final rules that address specific factors mentioned in the comments are found in final § 416.924a(b)(5) (structured and supportive settings), new § 416.924a(b)(6) (one-time examinations, such as consultative examinations), and § 416.924a(b)(9) (medication and other kinds of treatment).

Comment: One commenter suggested that we explain that other factors could increase the severity of a limitation in a specific area. This commenter noted that the presence of a significant “other factor” should allow an adjudicator to find a greater degree of limitation than would exist without consideration of the factor(s). The commenter provided an example of a child who has a moderate limitation and uses an assistive device. The commenter believed that such a child should be found to have a marked limitation.

Response: We clarified the rules in response to this and other comments, but not in the specific way recommended. The purpose of the section on “Other factors” in the interim final rules was to provide guidance about some of the factors we consider when we evaluate a child’s functional limitations, in addition to the objective medical findings and the child’s symptoms. They are not additional factors to apply after we evaluate functioning, but are an integral part of the functional analysis. In response to this and other comments, we clarified all of the “other factors” rules in final § 416.924a and clarified in final § 416.926a that, at the functional equivalence step, we first look at a child’s functional limitations in any domain that is affected.

We do not agree with the commenter’s example, but it is to some extent addressed by several of the final provisions, especially final § 416.924a(b)(5). In that section, we explain that when we rate a child’s functioning we consider the amount of extra help or adaptation the child may need to function as well as he or she does compared to other children of the same age who do not have impairments. Thus, we consider the need for an adaptation when we consider how

seriously a child’s functioning is limited.

However, that does not mean that we automatically presume that a child with an unspecified “moderate limitation in motor functioning” has a “marked” limitation merely because he or she uses an adaptive device. Apart from the fact that these rules do not define a “moderate” limitation, the example was too nonspecific. As we explain in final § 416.924a(b)(5), we consider how well a child functions by examining how independently the child is able to initiate, sustain, and complete his or her activities despite his or her impairment(s), compared to children of the same age who do not have impairments. We also clarify in these final rules our longstanding policy that we consider each child’s impairment(s) and the functional limitations that result from it in any and all of the affected domains.

Comment: A number of commenters recommended that we include in the list of other factors the “risk factors” that were proposed by some of the individual experts who gave us information to help us formulate the childhood disability regulations in 1991. Some commenters suggested that applicable “risk factors” would include: biological factors (e.g., malnutrition, anemia and recurrent infections); factors related to health care (e.g., less than optimal treatment availability); a history of abuse and neglect; multiple foster home placements; separation from family; and “toxic environment.” The commenters recommended these risk factors because they believed they are objectively observable and are considered indispensable by the professional communities when evaluating pediatric impairments.

Response: We did not adopt the comments that asked us to include specific “risk factors,” although we expanded the list of factors in final § 416.924a that we will consider when evaluating a child’s functioning. We also revised the areas of functioning to consider more specifically physical effects of impairments when we decide functional equivalence.

We addressed the issue of “risk factors” extensively in earlier versions of the childhood disability rules. We first addressed the issue in 1991 when we published regulations in response to the *Zebley* decision (56 FR 5534, 5551 (1991)). We received a number of identical public comments in response to those rules and again addressed the issue when we published revised rules in 1993 (58 FR 47532, 47552, 47575 (1993)). As we made clear in those earlier rules, we do consider what the

commenters called “risk factors” to the extent that they affect a child’s medical status and functioning. However, some of the other factors recommended by the commenters are not relevant to a determination of disability. Interested readers may read a more extensive discussion of our reasons for not adopting this comment in those earlier publications.

Comment: One commenter suggested that we strengthen the language regarding periods of remission because with medication, intervention, and therapy, many children experience periods of adequate functioning and require more intensive treatment and intervention only during periods of deterioration. The commenter believed that a period of 12 “contiguous” months of disability may not be appropriate for such children, and that the variation in the expression of “severe mental impairment” is not adequately addressed in the regulations and may lead to some children being inappropriately disqualified.

Response: We adopted the comment by clarifying how we evaluate chronic impairments, especially in final § 416.924(b)(8), where we added new sentences to address the comment. We explain in that section that we recognize that when a child has a chronic impairment(s), his or her functioning may vary considerably over time and that we need to take into account the child’s ability to function over time. This means that we will take into account any variation in a child’s level of functioning to determine the impact of a chronic illness on his or her ability to function.

However, we do not agree with the suggestion that a child with a chronic impairment should not have to show disability over a continuous period of 12 months. The Act requires that a child be disabled for a continuous period of 12 months (or be expected to be disabled for a continuous period of 12 months), unless the impairment is expected to result in death.

Section 416.926 Medical Equivalence for Adults and Children

Comment: Several commenters recommended that we clarify this section to ensure that adjudicators will consider all relevant evidence, not just symptoms, signs and laboratory findings, when we make a finding regarding medical equivalence.

Response: We agree with the commenters’ concerns that the regulation could be misinterpreted. Our policy is that the phrase “medical evidence only” in § 416.926(b) excludes consideration of only the vocational

factors of age, education, and work experience. Other than these vocational factors, in accordance with § 416.926(a), we consider all relevant evidence in the case record when we make a finding regarding medical equivalence.

This issue was raised in the decision in *Hickman v. Apfel*, 187 F.3d 683 (7th Cir. 1999). In *Hickman*, the Court of Appeals interpreted our language in § 416.926(b) to preclude an adjudicator from relying on evidence other than evidence from a medical source when making a finding regarding medical equivalence. The *Hickman* decision differs from our national policy by requiring adjudicators to consider only a narrow definition of medical evidence, that is, evidence from medical sources, in determining medical equivalence and not permitting the use of other relevant evidence. In contrast, we interpret “medical evidence” broadly, to include not just objective test results or other findings reported by medical sources, but other information about an individual’s medical conditions and their effects, including the individual’s own description of his or her impairments. Thus, the Court’s decision that medical equivalence is decided based solely on evidence from medical sources interprets the “medical evidence only” language of the regulation more narrowly than we intend.

On May 3, 2000, we published an acquiescence ruling, AR 00–2(7), for the *Hickman* decision (65 FR 25783). As we noted in that acquiescence ruling, we intend to clarify the regulations at issue in *Hickman* through the rulemaking process (65 FR at 25785). The concerns raised by the commenters here were focused on the title XVI regulations, the regulations for SSI benefits. We believe, however, that similar concerns apply to our regulations under title II of the Act, the regulations for Social Security Disability Insurance benefits, 20 CFR 404.1526. Since clarifying the title II regulations would be outside the scope of this rulemaking proceeding, we intend to consider the commenters’ concerns on this issue when we clarify the regulations in response to *Hickman*.

Comment: A few commenters suggested that we provide examples of impairments that we consider to be medically equivalent to a listed impairment, as we did for functional equivalence in § 416.926a(d) of the interim final rules. The commenters believed that such examples would be useful to adjudicators. One commenter believed that the examples should clarify how a child can establish medical equivalence when the impairment is in the listings, but the

child is either missing a criterion of a listing or presents with a listed criterion but at a level less severe than required by the listing.

Response: We did not adopt the comment because it is outside the scope of this rulemaking process. We will consider the suggestions, and if we decide to adopt them we will issue an appropriate notice of proposed rulemaking in the **Federal Register**.

Section 416.926a Functional Equivalence for Children

Comment: A number of commenters thought that the functional equivalence policy was too complicated or vague. These commenters asserted that adjudicators would be unable to apply the policy consistently and meaningfully, and would improperly deny applications when they were in doubt about how to apply the rules. Other commenters said the regulation did not provide a workable framework for determining whether one or more impairments functionally equal a listed impairment.

The commenters made various suggestions. Some commenters wanted us to provide additional information, examples, and guidance about how to apply each functional equivalence method, or to specifically instruct adjudicators to apply the policy. Others suggested that we simplify the policy, because it was too difficult for adjudicators and the public to determine which listings had “disabling functional limitations” among their criteria. One commenter suggested that we include a section-by-section guide of the functional consequences contained in the listings because the list of impairments is very long and complicated. One commenter recommended that we incorporate in the regulations more detailed and specific explanations, definitions, and examples to help clarify the process for establishing functional equivalence.

Some commenters recommended that we delink the functional equivalence policy from the listings. One commenter recommended that we adopt one simple, easily understood method for determining functional equivalence rather than four methods.

Response: As noted in the summary of changes, we made a number of changes in response to these comments. We simplified the process for determining functional equivalence to a single method, delinked it from explicit reference to the listings, and provided more guidance throughout the final rules, including in § 416.926a. We clarified and expanded the definitions of “marked” and “extreme” limitations.

In all but one case (health and physical well-being), we provided within each domain descriptions of typical functioning of children who do not have impairments, broken out by age group. For all six domains, we also provided examples of limitations.

We do not agree with those commenters who thought that adjudicators might have improperly denied applications when in doubt about how to apply the functional equivalence provision. However, we recognize that these comments were made when the interim final rules were published in 1997, when some people were worried about this possibility. These comments were submitted before we began the corrective actions described earlier, including the Commissioner's top-to-bottom review and extensive adjudicator training to ensure proper application of the rules.

We do not agree that we need to specifically instruct adjudicators to apply the functional equivalence provision, as some commenters recommended. The regulations provide a sequential evaluation process for childhood disability claims in § 416.924, and they discuss the determination process at step three in detail in §§ 416.924a through 416.926a. We believe that these regulations make clear that if a child's impairment(s) is severe and does not meet or medically equal the requirements of a listing, the adjudicator must evaluate whether the child's impairment or combination of impairments functionally equals the listings.

Comment: Some commenters said the interim final rules did not adequately define what constitutes a "marked" or an "extreme" limitation and that this could result in incorrect and inconsistent determinations and decisions. In addition, some commenters recommended that case illustrations of impairments that interfere seriously with a child's functioning, and thus result in a "marked" limitation, should be included in the regulations.

A few commenters thought the definition of an "extreme" limitation was internally inconsistent. These commenters noted that the definition of an "extreme" limitation for children from birth to the attainment of age 3 was one resulting in functioning at less than one-half chronological age. In contrast, the definition for children from age 3 to the attainment of age 18 was "no meaningful function in a given area." These commenters pointed out that a child functioning at less than one-half of chronological age may be less impaired

than one with no meaningful function in a given area.

Response: As noted in the summary of the changes and responses above, we clarified and expanded our definitions of the terms "marked" and "extreme" in response to these comments. However, we did not include examples or case illustrations of impairments that result in "marked" or "extreme" limitations. As we clarify throughout these rules, any physical or mental impairment or combination of impairments may result in a marked or extreme limitation in one or more domains if it causes sufficiently serious functional limitations. Also, to properly provide examples of functional limitations that satisfy the definitions of the terms would have required far too many examples to cover each of the six domains and five age categories, as well as physical and mental impairments and combinations of impairments.

We agreed with the commenter who observed that people might misunderstand what we intended by "no meaningful function" in our definition of "extreme." In response, we deleted the phrase. In its place, we now explain in the final rules that, although we use "extreme" to rate the worst limitations, it does not necessarily mean a total lack or loss of ability to function. Our intention is to parallel the definition of a "marked" limitation as the equivalent of the functioning we would expect to find on standardized testing with scores that are at least two, but less than three, standard deviations below the mean. Therefore, we define "extreme" limitation as the equivalent of the functioning we would expect to find on standardized testing with scores that are at least three standard deviations below the mean.

Comment: Many commenters referred to the provisions of § 416.926a(c)(3) of the interim final rules defining "marked" limitation to mean a valid score that is two standard deviations or more below the norm for the test, but less than three standard deviations. Most noted that no test is exact, and that all tests include a measure of uncertainty called the "standard error of measurement" (the SEM), which they urged us to recognize.

Some commenters believed that we should establish rules to provide that a child's impairment(s) meets or equals the requirements of a listing when the child's test scores are within one, or even two, SEMs for the particular test or protocol. Others referred to specific tests, such as the Wechsler Intelligence Scale for Children—Third Edition, and noted that a child who had a score of 70 on that test, plus or minus two SEMs, should be found to have a marked

limitation of cognitive functioning. The commenters asserted that many children will be unfairly denied benefits unless the rules recognize the concept of the SEM.

Response: In response to these comments, we clarified our rules on how we consider test scores in final §§ 416.924a(1) and 416.926a(e)(4). However, we did not adopt the comments that asked us to refer explicitly to the SEM in our rules. We also did not adopt the comments that said we should accept as meeting a test criterion in the listings or satisfying the definition of "marked" or "extreme" any test score that was within one or two SEMs above the requirements in these final rules and other regulations.

As noted in our summary of the changes, we agree that all test scores are less than perfectly reliable. Professionals use the SEM to estimate how reliable any given score may be as a measurement of a child's ability in the area being tested. For example, one can reasonably conclude that 68 percent of the time a child's score on an IQ test with an SEM of 5 will fall within a band of 10 points (plus or minus one SEM) of the score that was actually obtained; e.g., 67 to 77 with a score of 72 and an SEM of 5. Ninety-five percent of the time a child's score on an IQ test with an SEM of 5 will fall within a band of 20 points (plus or minus two SEMs) of the score that was actually obtained; e.g., 62 to 82 with a score of 72 and an SEM of 5. This means that a child who scores a 75 on an IQ test with an SEM of 5 has a 95 percent chance of having a "true" ability that would be shown by a score somewhere between 65 and 85.

Therefore, it would be incorrect, as many of the commenters suggested, to assume that an IQ (or other test score) of 74 or 75 with an SEM of 5 "includes" an IQ of 70. It would also be wrong both scientifically and as a matter of public policy for us to issue a rule that requires our adjudicators to apply only the "minus" half of the "plus or minus" consideration that the SEM requires.

The final rules include two important principles we have taught our adjudicators over the years. First, no test score can be considered in isolation from all of the other information about a child's abilities and actual functioning. Second, it is primarily the responsibility of the person who administered the test to decide whether it reliably measures a child's abilities. The final rules also incorporate specific requirements for our adjudicators when they do not believe that a test score accurately indicates a child's abilities. We believe that these changes address the major concerns of the commenters.

Comment: Several commenters expressed concern about how the definitions of “marked” and “extreme” that are based on a developmental quotient apply to the evaluation of children from birth to attainment of age 3. One letter (from a group of medical professionals) pointed out that the standard becomes progressively stricter for older children within this age range. For example, the letter noted that under the rules a child has an “extreme” limitation when he or she is functioning at one-half of his or her chronological age in a domain. Therefore, a 1-year-old child would meet the standard by being 6 months behind, while a 3-year-old would need to be delayed 18 months. As a result, the 3-year-old would have to demonstrate a more serious limitation by functioning at a level appropriate to a child 1½ years old.

The letter suggested that we evaluate children from birth to age 3 based on three age categories (birth to 12 months, 13 to 24 months, and 25 to 36 months) and suggested new definitions for our terms to fit the three proposed categories. Another commenter recommended that the criteria used to define and describe “marked” and “extreme” should be used as guidelines rather than standards, since there is no objective way to evaluate accurately whether a child has reached a level of functioning that is characteristic of one-half (versus two-thirds) of his or her chronological age.

Response: We revised the rules in response to these comments but did not adopt the specific suggestions.

We used a developmental quotient in the interim final rules as an approximation for when we do not have standard scores in the case record. To make this clear in response to the comments, we revised the definitions of “marked” and “extreme” to indicate that in this age range we will base our findings on developmental quotients only when there are no standard scores from standardized tests in the case record.

We did not agree with the proposal to divide the birth to age 3 range into three separate ranges because we believe that at these early ages our single rule yields a sufficiently accurate estimate. We also expect that the older children in this range will have more standardized testing in their case records and that we will not have to use the developmental quotient alternative as often as for the very youngest children.

In response to the commenter who thought that the definitions of “marked” and “extreme” should not be strict standards, we explain throughout the final rules that we must consider all

relevant information in a child’s case record to determine whether the totality of the information indicates that a child has a “marked” or an “extreme” limitation. That is why we provide alternative definitions for the terms.

Comment: A number of commenters urged us to separate the cognitive/communicative area of functioning into two separate domains. Some noted that neurological disorders or brain injuries can affect cognition and communication differently, because the two functions involve separate areas of the brain and impairments may affect each area differently. Some commenters stated that communication warranted a separate domain because no other facet of human behavior has such a direct impact on daily life: it is the foundation for acquiring many other skills and for adapting to other impairments. They asserted that from a clinical perspective, a child with mental retardation and a “moderate to severe” limitation in communication is extremely disabled, and would have minimal ability to compensate for functional limitations by using assistive technology.

Response: The new domains respond to these concerns. Communication comprises both language and speech, and language serves two purposes: it enables us to think and to communicate. Although the ability to think and the ability to use language may be affected differently by brain injuries and disorders, language ability is inherent in verbal reasoning or thinking in normal human functioning. This makes it necessary to consider thought and some aspects of language in a single domain. The new domain of Acquiring and Using Information recognizes that a child uses language to learn (acquire information) and to think (use information).

Language also enables us to communicate with words, and the use of both verbal and nonverbal communication skills in social contexts (called the pragmatics of language) is an essential aspect of social functioning. The new domain of Interacting and Relating With Others recognizes that a child uses language to play with friends, to interact with peers and adults at school, and to relate to family members and other children. This domain also recognizes that, since limitations in speech (articulation, voice, and fluency) can interfere with a child’s oral communication skills at home, at school, or in the community, it can affect how the child interacts with and relates to other people.

Finally, a child with mental retardation may have difficulty in using language to learn or to interact and

relate with others that is not a function of intellectual ability but, rather, is a separate impairment that causes an additional, significant limitation of functioning. This situation is recognized by, and evaluated under, listings 112.05D and F. However, any child who must use assistive technology to communicate, even one who does not have mental retardation, would likely have an impairment that meets or medically equals a listing.

Comment: Several commenters recommended that we provide areas of functioning for children with physical impairments such as respiratory and digestive disorders. They thought that the addition of other areas of functioning was needed to address associated problems such as lack of endurance, frequency of infections, and recovery time after multiple procedures. One commenter recommended that we divide the motor area of functioning into separate areas for fine and gross motor skills, because the field of child development regards them as distinct and different.

Response: We adopted the first comment with the new domain Health and Physical Well-Being, which addresses the cumulative physical manifestations of physical or mental impairments and the effects of their associated treatments or therapies on a child’s functioning. We did not adopt the second comment because we believe that the domain of Moving About and Manipulating Objects is sufficiently described to make clear that fine and gross motor skills are different, but also that they work together in some aspects of a child’s functioning.

Comment: A number of commenters recommended that we add more domains for children from age 1 to the attainment of age 3. Some thought that having only three areas of functioning for children in this age range meant that the child would have to show a “pervasive” impairment of functioning, in a manner contrary to the statute. Many commenters recommended that we apply the domains of personal functioning and concentration, persistence, or pace, to children in that age group.

Response: We adopted these comments by revising the domains. As we have already noted, all six new domains apply to children in every age group.

Comment: One commenter thought that restricting the domain in the interim final rules we called “Responsiveness to Stimuli” to children from birth to age 1 ignored the impact of severe sensory deficits on the

functional capability of children older than 1 year.

Response: We adopted the comment. Sensory functions spread across virtually all of the domains for all ages, and sensory deficits or hypersensitivities can affect a wide range of a child's activities. In the final rules, we incorporated the principle of "responsiveness to stimuli" in the domain of Attending and Completing Tasks, which is applicable to children in all age groups. This domain addresses the child's capacity to respond appropriately to all kinds of stimuli, as well as its evolution into the capacity to attend appropriately to stimuli in all activities and settings. We also recognize more broadly, however, that limitations in sensory functioning may also affect a child in any of the domains.

Comment: Several commenters recommended that we add cross-references in § 416.926a to adequately integrate into the functional equivalence determination the need for consideration of a child's age, functioning, other factors, and pain and other symptoms. They provided specific language for a new subparagraph for § 416.926a that would include only cross-references.

Response: We adopted these comments, but did not introduce a separate paragraph of cross-references. Instead, where appropriate, we included cross-references throughout final §§ 416.924a and 416.926a. As we noted in the summary of changes, we also made a number of changes to give the "other factors" provisions greater prominence and to make them more comprehensive and easier to understand.

Comment: One commenter asked us to clarify the provision on the "combined effects of limitations due to ongoing treatment" in § 416.926a(b)(4) of the interim final rules. This commenter stated that the language in the regulations is not very relevant to children who have a serious emotional disturbance, such as a child who is placed in a self-contained classroom or in day treatment.

Response: We believe that the commenter was concerned that a child in a structured or supportive setting would not be functioning as well outside of this special environment. In final § 416.924a(b)(5), we clarified our longstanding rules on how we consider the effects of structured or supportive settings on children. We agree that such children may be more limited in their functioning than their symptoms and signs in the structured setting would indicate. Like the interim final rules, the final rules provide that we will also

consider the child's functioning outside of the structured or supportive setting.

Comment: A number of commenters expressed concerns about the 12 examples of functional equivalence in § 416.926a(d) of the interim final rules. The primary concern was that adjudicators may rely solely on the list and not recognize that other impairments may also functionally equal a listing. They suggested that we emphasize and reinforce through training and written instructions that the list is not exhaustive, that we update the list as more rare syndromes or disorders are identified, and that we explain why these particular examples functionally equal the listings. One commenter asked us to eliminate the age limit for example 12, gastrostomy in a child who has not attained age 3.

Response: We did not adopt the comments. We received the same comments in response to the 1991 childhood disability regulations. In the 1993 regulations, we added language to emphasize that "the examples do not describe all the possible effects of impairments that might establish equivalence to a listed impairment." In the preamble to the 1993 regulations, we explained why we did not adopt comments suggesting that we add rationales to some or all of the examples to provide more insight into their intent, and that we state the particular listings that are equaled in the various examples (58 FR at 47564). Those explanations are applicable to the current comments as well.

However, as already noted in our explanation of the final rules, we did delete examples 5 and 10 because of other changes we made; *i.e.*, the new domains and the delinking of the functional equivalence policy from specific listings.

Section 416.987 Disability Redeterminations for Individuals Who Attain Age 18

Comment: One commenter disagreed with the provision that requires us to redetermine the eligibility of SSI recipients who attain age 18 using the adult standard, required in section 1614(a)(3)(H)(iii) of the Act. This provision also requires that we do not consider the medical improvement review standard that applies in continuing disability reviews of adult and children. The commenter questioned the fairness of applying the criteria for new applicants, rather than the medical improvement review standard, when a child reaches age 18.

Response: We did not adopt the comment. Section 1614(a)(3)(H)(iii) of the Act states that when we perform an

age-18 disability redetermination under this provision, "paragraph (4)" (*i.e.*, section 1614(a)(4) of the Act) "shall not apply." Section 1614(a)(4) of the Act sets out the medical improvement review standard that we use when we perform CDRs. In light of the plain language of the statute, we have no discretion to apply the medical improvement review standard to age-18 disability redeterminations.

Section 416.990 When and How Often We Will Conduct a Continuing Disability Review

Comment: One commenter recommended that we provide a cross-reference in this section to § 416.924a(b) and provide that the corrected chronological age be used as the "trigger date" for a CDR.

Response: We did not adopt the comment, but revised this section to reflect a change in the law made in 1997 that addresses the commenter's concerns. As noted in the supplementary information section of this preamble, section 5522(a)(2) of the Balanced Budget Act of 1997, Pub. L. 105-33, 111 Stat. 251, 622, amended section 1614(a)(3)(H)(iv) of the Act, which required us to conduct a CDR at age 1 for children for whom low birth weight is a contributing factor material to the determination of disability. This revision allows us to schedule a CDR later than age 1 for a low birth weight child if, at the time we make the initial disability determination, we determine that the child's impairment(s) is not expected to improve within 12 months after birth.

We believe that the statutory change now reflected in final § 416.990(b)(11) addresses the commenter's concerns by providing us with greater flexibility in scheduling CDRs for these cases.

Section 416.994a How We Will Determine Whether Your Disability Continues or Ends, and Whether You Are and Have Been Receiving Treatment That Is Medically Necessary and Available, Disabled Children

Comment: One commenter had several concerns about § 416.994a(e), which describes the limited situations in which disability can be found to have ended even though medical improvement has not occurred. The commenter believed that each "exception" appeared to be our attempt to "circumvent [our] legal burden to show that a recipient's impairment has medically improved." The commenter asserted that the statement in the regulation that there can be a lessening or absence of functional limitations without any decrease in the severity of

the underlying impairment was, "on its face, absurd." The commenter thought that if there has been no medically determinable improvement in the underlying impairment, by definition, the resulting functional limitations cannot have changed. The commenter further stated that the second exception, in which the claimant never should have been found disabled, was an "illegal" reopening and revision of our previous final determination or decision.

Response: The first sentence of § 416.994a(e) explains that "[t]he law provides certain limited situations when [a child's] disability can be found to have ended even though medical improvement has not occurred." The provisions in this regulation section are required by, and consistent with, section 1614(a)(4)(B) and (C) of the Act.

The commenter's second assertion was unclear. There is no statement in § 416.994a(e) or elsewhere in § 416.994a that there can be "a lessening or absence of functional limitations without any decrease in the severity of the underlying impairment."

The commenter also seems to have misunderstood the intent of the provisions in §§ 416.1487 through 416.1493 of our regulations. Those provisions allow us to reopen and revise determinations and decisions so that we can change the original determination or decision retroactively. The provisions in § 416.994a(e) generally do not affect a child's eligibility in prior months the way a reopening would. They simply provide a basis in certain rare instances for ceasing eligibility when there has not been medical improvement. In such cases, we find that disability ends in the month specified by the provisions of § 416.994a(g), usually not earlier than the month in which we mail the child and his or her family a notice saying that the information we have shows that the child is not disabled.

Comment: One commenter expressed concern that the medical improvement rules seem to "reward" children who receive higher levels of service. The commenter pointed out that children who are severely emotionally disturbed are at particular risk of having their benefits ceased because, given the short-term nature of mental health services, problems may improve and services may be terminated before the problem is addressed.

Response: As we have long indicated in § 416.994a(c)(3), we do consider the fact that some impairments are subject to temporary remissions, which can give the appearance of medical improvement when in fact there has been none. This section further explains that, with these

kinds of impairments, we will consider the longitudinal history of the impairment, including the occurrence of prior remissions or the prospect for a future worsening of the impairment when we decide whether there has been medical improvement. Even if there has been medical improvement, however, this does not necessarily mean that a child's benefits will cease. We must still determine whether the child is currently disabled despite medical improvement.

Comment: One commenter asked us to include psychiatric management with medical management in § 416.994a(i)(2)(i) instead of grouping it with psychological and psychosocial counseling in § 416.994a(i)(2)(ii). The commenter noted that psychiatric patient management includes medication management as well as other medical evaluation and management services.

Response: We adopted the comment by deleting the word "psychiatric" from § 416.994a(i)(1)(ii).

Comment: Several commenters expressed concern about how we would interpret the requirement to show "treatment that is medically necessary and available." They recommended that we provide examples and guidance to ensure that the provision is applied consistently. One commenter noted that the concept of "medical necessity" is very controversial within Medicaid managed care programs for children with special health care needs. The commenter recommended that we change the wording in § 416.994a(i)(1) from "improve and [sic] restore" to "maintain or restore" and provide examples of treatment that would be considered medically necessary under this provision.

Response: These comments were submitted before we implemented the treatment requirement of the law. Since that time, we have issued very detailed operating instructions that address the concerns the commenters raised.

The comment regarding "medical maintenance" raises a point that is more germane to access to medical care than to the purpose of the treatment provision. We did not adopt the suggested wording change because we believe that the original wording better reflects the intent of the law. We also did not adopt the suggestion that we add examples of treatment that we consider medically necessary because the appropriate and available level and type of treatment will vary for each child.

Comment: One commenter asked if school-based behavioral or mental health interventions are considered evidence that a representative payee

must present to show the child is and has been receiving treatment considered medically necessary and available. If so, the commenter recommended that we clarify this section to include school-based interventions.

Response: Although we may consider school-based treatment to be treatment that is "medically necessary and available," we did not adopt the comment. Children may receive medical management, psychological or psychosocial counseling, and various kinds of therapy in a school setting. To that extent, we would consider that a payee has satisfied the requirement for showing that the child is receiving the appropriate treatment under the examples we provided in the interim final rules, as modified by these final rules. However, we do not want to give the impression that everything a child may do in school can be a requirement under this section, which we believe would be too much of a burden on families and would go beyond the intent of the statute. Therefore, we chose not to single out therapy received in a school setting in the final rules.

Other Comments

Comment: Several commenters expressed disagreement with the statute itself. One believed the law appeared to be an attempt to "get around" the Supreme Court's 1990 decision in *Zebly* and wondered how the Court would rule on this new law.

Response: The issue the Supreme Court addressed in *Zebly* was whether we had correctly interpreted the prior statutory standard of "comparable severity." Nothing in the *Zebly* decision, however, precluded Congress from revising the definition of disability for children.

A Supreme Court decision construing a statute does not freeze the law and preclude Congress from later amending the statute, as the commenter seemed to assume. Indeed, the Supreme Court has recognized that "Congress frequently 'responds' to judicial decisions construing statutes, and does so for a variety of reasons," and noted that according to one commentator, between 1967 and 1990, Congress "overrode" Supreme Court decisions at an average of 10 per Congress. *Rivers v. Roadway Express, Inc.*, 511 U.S. 298, 305 n.5 (1994) (citing Eskridge, *Overriding Supreme Court Statutory Interpretation Decisions*, 101 Yale L. J. 331, 338 (1991)).

Comment: One commenter noted that the rules appeared too cumbersome and complex, used too many legal words, and needed to be simplified and structured to be more user-friendly.

Another thought that the complex language and the structure of the regulations were inconsistent with the "plain language" goal and simplification efforts of the Agency. This commenter also believed the rules in general lacked basic clarity, and that we needed to eliminate the "unnecessary" differences in wording between the mental impairment listings for children and for adults.

Response: We adopted most of these comments. We revised several of the interim final rules to make them clearer and to use "plain language" as much as possible. These changes are not substantive changes from the interim final rules, only clarifications. Also, as explained earlier in this preamble, we simplified and restructured prior §§ 416.924a through 416.924c into final §§ 416.924a and 416.924b and simplified the rules on functional equivalence.

We did not adopt the comment that asked us to revise both the adult and childhood mental disorders listings to eliminate "unnecessary" differences. The only changes we made to the childhood mental disorders listings in the prior rules were to reflect changes mandated by Pub. L. 104-193. We do not have authority under the Administrative Procedure Act to make the type of extensive changes suggested by the commenters to these other rules without first proposing such changes to the public in a notice of proposed rulemaking.

Comment: A number of commenters suggested ways that we could provide information to families, advocacy groups, medical and other professionals, and State agency personnel who work on behalf of children with disabilities. The commenters made a number of suggestions for how we could do this.

Response: Although the comments did not address the prior rules, we thought that some of the ideas were very good, and have kept them in mind as we provided public information over the years since we published the prior rules. We will also consider some of the specific ideas for future use.

Comment: One commenter asked if we had consulted with members of the Federal Interagency Coordinating Council (FICC), which coordinates policy for young children with disabilities, to benefit from their expertise as we developed the rules.

Response: We are a member of and active participant in the FICC. The FICC is established under 20 U.S.C. 1444 (as amended by Pub. L. 105-17, the Individuals with Disabilities Education Act Amendments of 1997, 111 Stat. 37, 121). Among other things, the FICC

ensures the effective coordination of Federal early intervention and preschool programs and policies across Federal agencies.

We agree that the FICC has a wealth of expertise on disability issues for young children. We believe our involvement with the FICC has provided us with further insight into childhood disability issues and has positively influenced our decision to make some of the changes in these final rules.

Comment: Several commenters expressed regret that we developed the regulations quickly and without consulting with child-serving professionals, especially regarding the development of age categories and the selection of tests to evaluate functional limitations. One commenter offered to participate. Another commenter said a more deliberative process that used the workgroup concept that we had employed in the past would have been a better mechanism for developing rules that will have such a significant effect on the lives of poor children.

Response: Most of the changes to the childhood disability program made by Pub. L. 104-193 were made effective on enactment, or within a short time after enactment, without regard to whether regulations had been issued to implement the provisions. In addition, section 215 of Pub. L. 104-193, 110 Stat. 2105, 2196, required us to issue regulations within 3 months after the date of enactment of the law. Since many provisions were effective without regard to whether we had issued regulations, and since Congress required timely implementation of the changes to the childhood program, we had to act quickly.

As we explained earlier in this preamble, however, we also took a number of actions, such as the "top-to-bottom" review, to ensure that we implemented the changes to the childhood disability program fairly, in a manner consistent with the law. In addition, as noted in the supplementary information section, we asked a number of individual experts for information as we formulated these final rules. We believe that our actions have addressed the commenters' concerns.

Comment: Several commenters said that we must adequately train physicians and psychologists who perform consultative examinations to assess and document all of a child's areas of functioning and development and to determine any impairment-related restrictions. Several other commenters thought we should help the medical community and psychologists by providing them with written training

materials and seminars explaining the term "functional equivalence" to help them in responding to requests for information.

Response: Physicians, psychologists, and other health care professionals who perform consultative examinations are required to conduct testing in accordance with standard medical practice, including testing and evaluation of abilities or functioning in childhood cases where appropriate. Professional relations officers employed by the State agencies train consultative examiners where possible.

We also provide information to the medical community and to psychologists by distributing literature and training materials and exhibiting at numerous medical conventions each year. Our medical and psychological consultants are often available at these conventions to answer specific questions from other doctors or other attendees.

We also sponsor and present continuing medical education seminars at select medical conventions. These activities are all directed towards educating physicians, psychologists, and other professionals so that they can provide us with the evidence we need to make a decision on a claim.

Publications for health professionals are listed in the "Social Security Disability Public Information Products List." (SSA Publication No. 64-065). This list can be ordered by calling 410-965-0945, sending a request by fax to 410-965-0696, or sending a written request to: Public Information Distribution Center, P.O. Box 17743, Baltimore, Maryland 21235-7743.

Finally, we plan to produce a new training package on SSI childhood disability for medical professionals in 2001.

Comment: Several commenters recommended that we provide uniform guidance and training at all levels of the administrative review process to emphasize the importance of using all relevant evidence in making eligibility determinations, and to ensure a consistent developmental and adjudicative outcome to the extent possible.

Response: We agreed with these comments. Administrative law judges and the Appeals Council use the regulations and SSRs when they make decisions, but State agencies, quality reviewers, and other adjudicators use the Program Operations Manual System, or POMS, which are based on and consistent with the regulations and rulings. To ensure that everyone used the same, exact instructions, we printed the text of the interim final rules

verbatim in the POMS and will do the same with these final rules.

Likewise, we provided the same training to all our adjudicators when we first implemented the rules in 1997 and in training classes we conducted in 1998 in response to our findings in the top-to-bottom review. As noted earlier in this preamble, we issued manuals for two of these training classes. The training manuals went to all adjudicators at all levels of the process. We also issued SSR 98-1p in 1998 to address the evaluation of speech and cognition, and it is printed verbatim in the POMS.

Under our Process Unification initiative, these actions are not unusual or confined to childhood disability issues. For several years, we have published all of our new regulations and SSRs for adults and children verbatim in the POMS, and whenever appropriate provided uniform national training to all adjudicators.

Comment: Some commenters thought that the 1-year period for redetermining the eligibility of children who might lose eligibility because of the changes in Pub. L. 104-193 was too short. They stated that because the regulations would be difficult and time-consuming to apply, case processing time, quality, and staff commitment would be adversely affected. They were concerned that the State agencies and administrative law judges would be pressured to make up time lost during the regulatory process and be blamed for falling behind in case dispositions, resulting in hasty decisions. One commenter was concerned that the deadline would not give recipients adequate time to get information needed to show that a child meets the eligibility criteria or time to adjust to a loss of benefits resulting in reduced family income.

Response: As we noted at the beginning of this preamble, the requirement to perform the redeterminations within 1 year of enactment was a provision in Pub. L. 104-193. However, subsequent amendments to the law have largely addressed this concern. Section 5101 of Pub. L. 105-33, 111 Stat. 251, 595, extended the period from 1 year to 18 months after enactment of Pub. L. 104-193, and also provided that any redetermination not performed within that time could be performed as soon as practicable thereafter. Therefore, we had more time to do the redeterminations than the commenters assumed.

We also explained earlier in this preamble that we considered in the top-to-bottom review of the childhood disability program the concerns that the

State agencies might have rushed redeterminations to meet the original August 22, 1997, deadline. We found that these concerns were largely unfounded, but we realize that the comments were sent in just after we published the interim final rules and before we had completed a significant number of redeterminations. However, we did take actions, already described, to address issues about the accuracy of some determinations. We have also explained in earlier responses the efforts we make to help families get evidence.

Comment: Several commenters were concerned about families' ability to appeal a redetermination that resulted in a finding of ineligibility and still retain Medicaid, because of the short time in which parents had to appeal adverse determinations. The commenters suggested that we and the Health Care Financing Administration (HCFA) give clear guidelines to families about when they would have to repay cash and Medicaid benefits received during the appeal period if their appeal was denied. Several commenters recommended that Medicaid coverage should be guaranteed for those children with mental, emotional, and behavioral problems who lose their eligibility.

Response: This issue also has been resolved by subsequent legislation and actions we took based on our top-to-bottom review. Section 4913 of Pub. L. 105-33, 111 Stat. 251, 573, added a provision to continue Medicaid for children who lost eligibility for SSI as a result of a redetermination under Pub. L. 104-193. In addition, we have worked closely with HCFA, the agency that administers Medicaid and is responsible for implementing this change in the law. We have periodically provided lists to the Medicaid State agencies to ensure proper identification of the children who are eligible for continued Medicaid coverage under Pub. L. 105-33.

On April 7, 2000, HCFA also sent a letter to State Medicaid directors reminding them of the effects of the changes and requiring them to take certain actions. Interested readers may see the letter at www.hcfa.gov/medicaid/smd40700.htm.

We understood the concern that our redetermination notices might have been confusing, so in 1998 we sent supplementary notices in simpler language to families (or other payees). These new notices explained that they had another chance to request a reconsideration and also gave families a new 10-day period to request benefit continuation during an appeal. We also took several actions, explained at the beginning of this preamble, to make sure

that families better understood their rights to ask for waiver of any overpayment that might result from the request.

Comment: Several commenters recommended that we instruct State agencies to postpone completing cases during the summer if school records are unavailable.

Response: We did not adopt the comment. State agencies already have the authority to postpone their determination in any case until information they need is available.

However, when sufficient information can be obtained from other sources to make a correct determination, it would not be in the best interest of children and families to require the State agencies to delay their determinations.

Comment: One commenter thought we should not apply the new regulations to claims that were pending on August 22, 1996, when Pub. L. 104-193 was enacted, because children had no control over the timing of determinations or decisions on their claims. This commenter suggested that we apply the regulations only to claims filed after the date of enactment.

Response: We did not adopt the comment. Section 211(d)(1)(A) of Pub. L. 104-193, 110 Stat. 2105, 2190, provided that the changes to the childhood disability standard applied to any individual "who applies for, or whose claim is finally adjudicated * * * on or after the date of the enactment of this Act." The statute also provided that no individual's claim may be considered to be finally adjudicated before the date of enactment if, on or after August 22, 1996, there is a request pending for administrative or judicial review of a claim that has been denied in whole.

Comment: Several commenters suggested that we provide information to policymakers about the impact of the new childhood disability regulations by presenting program data and implementing a comprehensive research plan. They recommended that we track what happens to a sample of children who lose benefits as a result of the new rules. Other commenters wanted us to report annually to Congress and the public on the number of children who lost eligibility and Medicaid coverage as a result of the redetermination of their eligibility. Others urged us to make use of techniques and sources of information already used by the Department of Health and Human Services and some States in similar research programs.

Response: We maintain detailed program data on all cases affected by the revisions to the childhood disability

regulations. If program data indicate experience that is unexpected, we undertake case reviews to ensure that our policies are being applied correctly. Periodically, we compile program data into a comprehensive report and share it with interested parties, such as Congressional staff, advocates, and researchers. In addition, we report overall program experience to the Congress in the Annual Report of the Supplemental Security Income Program. This report contains information on the number of applications filed, the rate of allowances, expenditures, and appellate experience for SSI children and adults.

To assess the effect of the legislative change in the definition of disability for children, we contracted with the RAND Corporation for a three-phase evaluation. The first phase was an analysis of administrative data to assess the characteristics of the children affected by the legislation. The second phase included field visits with SSA employees, State Medicaid workers, advocates, claimant representatives, and educators to assess implementation of the legislation. The final phase of the evaluation involves the longitudinal tracking of individual families to assess how the loss of the child's SSI eligibility affects the overall family and child. As noted above, Congress enacted legislation in 1997 to ensure that children whose eligibility for SSI was ceased based on a redetermination under Pub. L. 104-193 did not lose Medicaid eligibility.

Comment: One commenter addressed the special SSI status permitted for adults who begin or return to work despite their disability. The commenter referred to "§ 416.20" of our regulations and recommended that we include a comparable exception for children who may have difficulty returning to school or advancing to a more progressive class/program due to their disabling impairments.

Response: There is no § 416.20 in our regulations, but we believe the commenter may have been referring to § 416.260. That regulation, and several that follow it, explain how we

implement sections 1619(a) and 1619(b) of the Act. These sections provide for a special SSI cash benefit for people who still have disabling impairments but who are working and engage in substantial gainful activity, and for continuing Medicaid eligibility for disabled individuals whose earnings are too high to receive SSI payments.

The commenter did not explain how she thought the provisions should be applied to children who may have difficulty returning to school or advancing in school. When such children have disabling impairments, they qualify for SSI as long as they meet the other eligibility requirements, including the limitations on income and resources. Without a change in the Act, we do not have the authority to disregard the income requirements as recommended by the commenter.

Regulatory Procedures

Pursuant to section 702(a)(5) of the Act, 42 U.S.C. 902(a)(5), the Social Security Administration follows the Administrative Procedure Act (APA) rulemaking procedures specified in 5 U.S.C. 553 in the development of its regulations. The APA provides exceptions to its Notice of Proposed Rulemaking (NPRM) procedures when an agency finds that there is good cause for dispensing with such procedures on the basis that they are impracticable, unnecessary, or contrary to the public interest. For the reasons that follow, we have determined that under 5 U.S.C. 553(b)(B), good cause exists for waiving the NPRM procedures with respect to the changes we are making to §§ 416.987(c) and 416.990(b)(11) to reflect the provisions of sections 5522(a)(1) and 5522(a)(2)(B) of Pub. L. 105-33, the Balanced Budget Act of 1997.

Section 5522(a)(1) of Pub. L. 105-33 amended section 1614(a)(3)(H)(iii) of the Act to provide that we will do a redetermination of the disability eligibility of children who attain age 18 "either during the 1-year period beginning on the individual's 18th birthday or, in lieu of a continuing

disability review, whenever the Commissioner determines that an individual's case is subject to a redetermination under this clause." Section 5522(a)(2)(B) amended section 1614(a)(3)(H)(iv)(VI) of the Act to provide that we do not have to do a CDR by age 1 for a child for whom low birth weight is a contributing factor material to our determination of disability if we determine at the time of our initial disability determination that the child's impairment(s) is not expected to improve by age 1 and we schedule a CDR later than age 1.

Because the language of the statutory provisions added by these amendments does not provide for any discretionary policy, we have determined that the use of notice-and-comment rulemaking procedures for the issuance of rules to reflect these statutory provisions is unnecessary. On this basis, we find that good cause exists for dispensing with such procedures. Accordingly, we find that prior notice and comment are unnecessary with respect to these specific changes made to the rules.

Executive Order 12866

We have consulted with the Office of Management and Budget (OMB) and determined that these final regulations meet the criteria for a significant regulatory action under Executive Order (E.O.) 12866. Therefore, we prepared and submitted to OMB the following assessment of the potential costs and benefits of this regulatory action. We have also determined that these rules meet the plain language requirement of E.O. 12866 and the President's memorandum of June 1, 1998 (63 FR 31885).

The potential costs and benefits for the policies reflected in these final rules follow:

Program Costs

It is estimated that due to these final rules there would be increased program outlays resulting in the following costs (in millions of dollars) to the SSI program (\$215 million Total in a 5-year period):

FY2001	FY2002	FY2003	FY2004	FY2005	Total
\$5	\$25	\$45	\$60	\$75	\$215

The following is the estimated Total program outlay (in millions of dollars) for SSI childhood disability benefits (which includes the increases shown above):

FY2001	FY2002	FY2003	FY2004	FY2005	Total
\$5123	\$5478	\$5807	\$6090	\$6841	\$29339

Note: Annual numbers may not add to Total due to rounding. It is also estimated that there will be an increase in Medicaid program outlays. The estimated increased Federal Medicaid costs are:

FY2001	FY2002	FY2003	FY2004	FY2005	Total
\$2	\$8	\$15	\$22	\$29	\$76

There will also be increased Medicaid program outlays for States.

Administrative Costs and Savings

The administrative costs associated with the final rules are attributable to the cost of implementation training and the cost of post-eligibility actions for an

increased number of childhood recipients. Training costs are all in FY 2001 and Total \$1,628,000.

Ongoing Federal administrative costs are workyear costs based on increased workloads as a result of the additional children who will be allowed under

these final rules. There will be additional income and resource redeterminations, representative payee actions, and maintenance of the rolls activities.

Estimated administrative costs (\$ in millions):

FY2001	FY2002	FY2003	FY2004	FY2005	Total
\$1.8	\$.7	\$1.1	\$1.5	\$1.9	\$6.9

Note: Annual numbers may not add to Total due to rounding. Increase in SSI Recipients

The following figures show the estimated annual increase (in thousands) from these final rules on the projected numbers of recipients of Federal SSI benefits:

FY2001	FY2002	FY2003	FY2004	FY2005	Total
1	5	8	11	14	39

With the increase in SSI recipients shown above, we estimate that the average number of disabled children (in thousands) in payment status after implementation of these final rules will be:

FY2001	FY2002	FY2003	FY2004	FY2005
832	864	888	906	922

Unfunded Mandates Reform Act of 1995

These final rules do not impose any Federal mandates that may result in the expenditure by State, local, and tribal governments, in the aggregate, or by the private sector, of \$100,000,000 or more (adjusted annually for inflation) in any one year. Therefore, the statement described in section 202 of Pub. L. 104-4, the Unfunded Mandates Reform Act of 1995 (2 U.S.C. 1532), is not required.

Regulatory Flexibility Act

We certify that these regulations will not have a significant economic impact on a substantial number of small entities because they affect only individuals. Therefore, a regulatory flexibility analysis as provided in the Regulatory Flexibility Act, as amended, is not required.

Paperwork Reduction Act

These final regulations impose no new reporting or recordkeeping requirements necessitating clearance by the Office of Management and Budget. (Catalog of Federal Domestic Assistance: Program Nos. 96.001 Social Security-Disability Insurance; 96.006 Supplemental Security Income)

List of Subjects

20 CFR Part 404

Administrative practice and procedure, Blind, Disability benefits, Old-Age, Survivors, and Disability Insurance, Reporting and recordkeeping requirements, Social Security.

20 CFR Part 416

Administrative practice and procedure, Aged, Blind, Disability benefits, Public assistance programs, Reporting and recordkeeping requirements, Supplemental Security Income (SSI).

Dated: June 27, 2000.

Kenneth S. Apfel,

Commissioner of Social Security.

For the reasons set out in the preamble, interim final rules amending 20 CFR chapter III which were published at 62 FR 6408 and corrected at 62 FR 13537 and 62 FR 13733 are adopted as final rules with the following changes:

PART 404—FEDERAL OLD-AGE, SURVIVORS AND DISABILITY INSURANCE (1950—)

Subpart P—[Amended]

1. The authority citation for subpart P of part 404 continues to read as follows:

Authority: Secs. 202, 205(a), (b), and (d)–(h), 216(i), 221(a) and (i), 222(c), 223, 225, and 702(a)(5) of the Social Security Act (42 U.S.C. 402, 405(a), (b), and (d)–(h), 416(i), 421(a) and (i), 422(c), 423, 425, and 902(a)(5)); sec. 211(b), Pub. L. 104–193, 110 Stat. 2105, 2189.

Appendix 1 to Subpart P—[Amended]

2. Part B of Appendix 1 (Listing of Impairments) of subpart P to part 404 is amended by revising the third sentence of the third paragraph of 103.00A, the second sentence of the fifth paragraph of 103.00A, the fourth sentence of the fifth paragraph of 104.00A, the second sentence of the sixth paragraph of 104.00A, the second sentence of the ninth paragraph of 112.00A, and the second sentence of the third paragraph of 112.00C to read as follows:

Appendix 1 to Subpart P—Listing of Impairments

* * * * *

Part B

* * * * *

103.00 Respiratory System

A. * * *

* * * * *

* * * Even if a child does not show that his or her impairment meets the criteria of these listings, the child may have an impairment(s) that medically or functionally equals the listings.

* * * * *

* * * When a child has a medically determinable impairment that is not listed, an impairment that does not meet the requirements of a listing, or a combination of impairments no one of which meets the requirements of a listing, we will make a determination whether the child's impairment(s) medically or functionally equals the listings.

* * * * *

104.00 Cardiovascular System

A. Introduction

* * * * *

* * * Even though a child who does not receive treatment may not be able to show an impairment that meets the criteria of these listings, the child may have an impairment(s) that medically or functionally equals the listings.

* * * When a child has a medically determinable impairment that is not listed, an impairment that does not meet the requirements of a listing, or a combination of impairments no one of which meets the requirements of a listing, we will make a determination whether the child's impairment(s) medically or functionally equals the listings.

* * * * *

112.00 Mental Disorders

A. * * *

* * * * *

* * * When a child has a medically determinable impairment that is not listed, an impairment that does not meet the requirements of a listing, or a combination of impairments no one of which meets the requirements of a listing, we will make a determination whether the child's impairment(s) medically or functionally equals the listings.

C. * * *

* * * * *

* * * If the infant or toddler was born prematurely, however, we will

follow the rules in § 416.924b(b) to determine whether we should use the infant's or toddler's corrected chronological age; i.e., the chronological age adjusted by the period of gestational prematurity.

* * * * *

PART 416—SUPPLEMENTAL SECURITY INCOME FOR THE AGED, BLIND, AND DISABLED

Subpart I—[Amended]

3. The authority citation for subpart I of part 416 continues to read as follows:

Authority: Secs. 702(a)(5), 1611, 1614, 1619, 1631(a), (c), and (d)(1), and 1633 of the Social Security Act (42 U.S.C. 902(a)(5), 1382, 1382c, 1382h, 1383(a), (c), and (d)(1), and 1383b); secs. 4(c) and 5, 6(c)-(e), 14(a) and 15, Pub. L. 98-460, 98 Stat. 1794, 1801, 1802, and 1808 (42 U.S.C. 421 note, 423 note, 1382h note).

4. Section 416.901 is amended by revising paragraph (f)(2) as follows:

§ 416.901 Scope of subpart.

* * * * *

(f) * * *
(2) What we mean by the terms *medical equivalence* and *functional equivalence* and how we make those findings;

* * * * *

5. Section 416.902 is amended by adding a new definition, "The listings," between the definitions for "Impairment(s)" and "Marked and severe functional limitations," by revising the definition of "Marked and severe functional limitations," and by revising the definition of "You or your" to read as follows:

§ 416.902 General definitions and terms for this subpart.

* * * * *

The listings means the Listing of Impairments in appendix 1 of subpart P of part 404 of this chapter. When we refer to an impairment(s) that "meets, medically equals, or functionally equals the listings," we mean that the impairment(s) meets or medically equals the severity of any listing in appendix 1 of subpart P of part 404 of this chapter, as explained in §§ 416.925 and 416.926, or that functionally equals the severity of the listings, as explained in § 416.926a.

Marked and severe functional limitations, when used as a phrase, means the standard of disability in the Social Security Act for children claiming SSI benefits based on disability. It is a level of severity that meets, medically equals, or functionally equals the listings. (See §§ 416.906,

416.924, and 416.926a.) The words "marked" and "severe" are also separate terms used throughout this subpart to describe measures of functional limitations; the term "marked" is also used in the listings. (See §§ 416.924 and 416.926a.) The meaning of the words "marked" and "severe" when used as part of the phrase *marked and severe functional limitations* is not the same as the meaning of the separate terms "marked" and "severe" used elsewhere in 20 CFR 404 and 416. (See §§ 416.924(c) and 416.926a(e).)

* * * * *

You, your, me, my and *I* mean, as appropriate, the person who applies for benefits, the person for whom an application is filed, or the person who is receiving benefits based on disability or blindness.

6. Section 416.906 is amended by revising the last sentence to read as follows:

§ 416.906 Basic definition of disability for children.

* * * We discuss our rules for determining disability in children who file new applications in §§ 416.924 through 416.924b and §§ 416.925 through 416.926a.

7. Section 416.911(b)(1) is revised to read as follows:

§ 416.911 Definition of disabling impairment.

* * * * *

(b) * * *

(1) Must meet, medically equal, or functionally equal the listings, or

* * * * *

8. Section 416.913 is amended by revising paragraphs (c)(3), (d), and (e) to read as follows:

§ 416.913 Medical and other evidence of your impairment(s).

* * * * *

(c) * * *

(3) If you are a child, the medical source's opinion about your functional limitations compared to children your age who do not have impairments in acquiring and using information, attending and completing tasks, interacting and relating with others, moving about and manipulating objects, caring for yourself, and health and physical well-being.

(d) *Other sources.* In addition to evidence from the acceptable medical sources listed in paragraph (a) of this section, we may also use evidence from other sources to show the severity of your impairment(s) and how it affects your ability to work or, if you are a

child, how you typically function compared to children your age who do not have impairments. Other sources include, but are not limited to—

(1) Medical sources not listed in paragraph (a) of this section (for example, nurse-practitioners, physicians' assistants, naturopaths, chiropractors, audiologists, and therapists);

(2) Educational personnel (for example, school teachers, counselors, early intervention team members, developmental center workers, and daycare center workers);

(3) Public and private social welfare agency personnel; and

(4) Other non-medical sources (for example, spouses, parents and other caregivers, siblings, other relatives, friends, neighbors, and clergy).

(e) *Completeness.* The evidence in your case record, including the medical evidence from acceptable medical sources (containing the clinical and laboratory findings) and other medical sources not listed in paragraph (a) of this section, information you give us about your medical condition(s) and how it affects you, and other evidence from other sources, must be complete and detailed enough to allow us to make a determination or decision about whether you are disabled or blind. It must allow us to determine—

(1) The nature and severity of your impairment(s) for any period in question;

(2) Whether the duration requirement described in § 416.909 is met; and

(3) Your residual functional capacity to do work-related physical and mental activities, when the evaluation steps described in § 416.920(e) or (f)(1) apply, or, if you are a child, how you typically function compared to children your age who do not have impairments.

* * * * *

9. Section 416.919n is amended by revising the third sentence of paragraph (c)(6) to read as follows:

§ 416.919n Informing the medical source of examination scheduling, report content, and signature requirements.

* * * * *

(c) * * *

(6) * * * If you are a child, this statement should describe the opinion of the medical source about your functional limitations compared to children your age who do not have impairments in acquiring and using information, attending and completing tasks, interacting and relating with others, moving about and manipulating objects, caring for yourself, and health and physical well-being. * * *

* * * * *

10. Section 416.924 is amended by adding a new fifth sentence to paragraph (a), revising the prior tenth (now the eleventh) sentence of paragraph (a), revising paragraphs (c) and (d), removing paragraph (f), redesignating paragraph (e) as paragraph (f) and revising that paragraph, and by adding a new paragraph (e), to read as follows:

§ 416.924 How we determine disability for children.

(a) * * * We will also consider all of the relevant factors in §§ 416.924a and 416.924b whenever we assess your functioning at any step of this process.

* * * If your impairment(s) is severe, we will review your claim further to see if you have an impairment(s) that meets, medically equals, or functionally equals the listings. * * *

* * * * *

(c) *You must have a medically determinable impairment(s) that is severe.* If you do not have a medically determinable impairment, or your impairment(s) is a slight abnormality or a combination of slight abnormalities that causes no more than minimal functional limitations, we will find that you do not have a severe impairment(s) and are, therefore, not disabled.

(d) *Your impairment(s) must meet, medically equal, or functionally equal the listings.* An impairment(s) causes marked and severe functional limitations if it meets or medically equals the severity of a set of criteria for an impairment in the listings, or if it functionally equals the listings.

(1) Therefore, if you have an impairment(s) that meets or medically equals the requirements of a listing or that functionally equals the listings, and that meets the duration requirement, we will find you disabled.

(2) If your impairment(s) does not meet the duration requirement, or does not meet, medically equal, or functionally equal the listings, we will find that you are not disabled.

(e) *Other rules.* We explain other rules for evaluating impairments at all steps of this process in §§ 416.924a, 416.924b, and 416.929. We explain our rules for deciding whether an impairment(s) meets a listing in § 416.925. Our rules for how we decide whether an impairment(s) medically equals a listing are in § 416.926. Our rules for deciding whether an impairment(s) functionally equals the listings are in § 416.926a.

(f) *If you attain age 18 after you file your disability application but before we make a determination or decision.* For the period during which you are under age 18, we will use the rules in this section. For the period starting with the

day you attain age 18, we will use the disability rules we use for adults who file new claims, in § 416.920.

* * * * *

§§ 416.924b and 416.924c [Removed]

11. Sections 416.924b and 416.924c are removed.

§ 416.924a [Redesignated as § 416.924b]

12. Section 416.924a is redesignated as § 416.924b and revised to read as follows:

§ 416.924b Age as a factor of evaluation in the sequential evaluation process for children.

(a) *General.* In this section, we explain how we consider age when we decide whether you are disabled. Your age may or may not be a factor in our determination whether your impairment(s) meets or medically equals a listing, depending on the listing we use for comparison. However, your age is an important factor when we decide whether your impairment(s) is severe (see § 416.924(c)) and whether it functionally equals the listings (see § 416.926a). Except in the case of certain premature infants, as described in paragraph (b) of this section, age means chronological age.

(1) When we determine whether you have an impairment or combination of impairments that is severe, we will compare your functioning to that of children your age who do not have impairments.

(2) When we determine whether your impairment(s) meets a listing, we may or may not need to consider your age. The listings describe impairments that we consider of such significance that they are presumed to cause marked and severe functional limitations.

(i) If the listing appropriate for evaluating your impairment is divided into specific age categories, we will evaluate your impairment according to your age when we decide whether your impairment meets that listing.

(ii) If the listing appropriate for evaluating your impairment does not include specific age categories, we will decide whether your impairment meets the listing without giving consideration to your age.

(3) When we compare an unlisted impairment or a combination of impairments with the listings to determine whether it medically equals the severity of a listing, the way we consider your age will depend on the listing we use for comparison. We will use the same principles for considering your age as in paragraphs (a)(2)(i) and (a)(2)(ii) of this section; that is, we will consider your age only if we are

comparing your impairment(s) to a listing that includes specific age categories.

(4) We will also consider your age and whether it affects your ability to be tested. If your impairment(s) is not amenable to formal testing because of your age, we will consider all information in your case record that helps us decide whether you are disabled. We will consider other generally acceptable methods consistent with the prevailing state of medical knowledge and clinical practice that will help us evaluate the existence and severity of your impairment(s).

(b) *Correcting chronological age of premature infants.* We generally use chronological age (that is, a child's age based on birth date) when we decide whether, or the extent to which, a physical or mental impairment or combination of impairments causes functional limitations. However, if you were born prematurely, we may consider you to be younger than your chronological age. When we evaluate the development or linear growth of a child born prematurely, we may use a "corrected" chronological age; that is, the chronological age adjusted by a period of gestational prematurity. We consider an infant born at less than 37 weeks' gestation to be born prematurely.

(1) We apply a corrected chronological age in these situations—

(i) When we evaluate developmental delay in premature children until the child's prematurity is no longer a relevant factor; generally no later than about chronological age 2 (see paragraph (b)(2) of this section);

(ii) When we evaluate an impairment of linear growth, such as under the listings in § 100.00 in appendix 1 of subpart P of part 404 of this chapter, until the child is 12 months old. In this situation, we refer to neonatal growth charts which have been developed to evaluate growth in premature infants (see paragraph (b)(2) of this section).

(2) We compute a corrected chronological age as follows—

(i) If you have not attained age 1, we will correct your chronological age. We compute the corrected chronological age by subtracting the number of weeks of prematurity (*i.e.*, the difference between 40 weeks of full-term gestation and the number of actual weeks of gestation) from your chronological age. The result is your corrected chronological age.

(ii) If you are over age 1, have a developmental delay, and prematurity is still a relevant factor in your case (generally, no later than about chronological age 2), we will decide whether to correct your chronological age. Our decision will be based on our

judgment and all the facts of your case. If we decide to correct your chronological age, we may correct it by subtracting the full number of weeks of prematurity or a lesser number of weeks. We will also decide not to correct your chronological age if we can determine from the evidence that your developmental delay is the result of your medically determinable impairment(s) and is not attributable to your prematurity.

(3) Notwithstanding the provisions in paragraph (b)(1) of this section, we will not compute a corrected chronological age if the medical evidence shows that your treating source or other medical source has already taken your prematurity into consideration in his or her assessment of your development. Also, we will not compute a corrected chronological age when we find you disabled using the examples of functional equivalence based on low birth weight in § 416.924a(m)(7) or (8).

13. A new § 416.924a is added to read as follows:

§ 416.924a Considerations in determining disability for children.

(a) *Basic considerations.* We consider all relevant information (*i.e.*, evidence) in your case record. The evidence in your case record may include information from medical sources, such as your pediatrician, other physician, psychologist, or qualified speech-language pathologist; other medical sources not listed in § 416.913(a), such as physical, occupational, and rehabilitation therapists; and nonmedical sources, such as your parents, teachers, and other people who know you.

(1) *Medical evidence.* (i) *General.* Medical evidence of your impairment(s) must describe symptoms, signs, and laboratory findings. The medical evidence may include, but is not limited to, formal testing that provides information about your development or functioning in terms of standard deviations, percentiles, percentages of delay, or age or grade equivalents. It may also include opinions from medical sources about the nature and severity of your impairments. (See § 416.927.)

(ii) *Test scores.* We consider all of the relevant information in your case record and will not consider any single piece of evidence in isolation. Therefore, we will not rely on test scores alone when we decide whether you are disabled. (See § 416.926a(e) for more information about how we consider test scores.)

(iii) *Medical sources.* Medical sources will report their findings and observations on clinical examination and the results of any formal testing. A

medical source's report should note and resolve any material inconsistencies between formal test results, other medical findings, and your usual functioning. Whenever possible and appropriate, the interpretation of findings by the medical source should reflect consideration of information from your parents or other people who know you, including your teachers and therapists. When a medical source has accepted and relied on such information to reach a diagnosis, we may consider this information to be a clinical sign, as defined in § 416.928(b).

(2) *Information from other people.* Every child is unique, so the effects of your impairment(s) on your functioning may be very different from the effects the same impairment(s) might have on another child. Therefore, whenever possible and appropriate, we will try to get information from people who can tell us about the effects of your impairment(s) on your activities and how you function on a day-to-day basis. These other people may include, but are not limited to:

(i) *Your parents and other caregivers.* Your parents and other caregivers can be important sources of information because they usually see you every day. In addition to your parents, other caregivers may include a childcare provider who takes care of you while your parent(s) works or an adult who looks after you in a before-or after-school program.

(ii) *Early intervention and preschool programs.* If you have been identified for early intervention services (in your home or elsewhere) because of your impairment(s), or if you attend a preschool program (*e.g.*, Headstart or a public school kindergarten for children with special needs), these programs are also important sources of information about your functioning. We will ask for reports from the agency and individuals who provide you with services or from your teachers about how you typically function compared to other children your age who do not have impairments.

(iii) *School.* If you go to school, we will ask for information from your teachers and other school personnel about how you are functioning there on a day-to-day basis compared to other children your age who do not have impairments. We will ask for any reports that the school may have that show the results of formal testing or that describe any special education instruction or services, including home-based instruction, or any accommodations provided in a regular classroom.

(b) *Factors we consider when we evaluate the effects of your impairment(s) on your functioning.*

(1) *General.* We must consider your functioning when we decide whether your impairment(s) is "severe" and when we decide whether your impairment(s) functionally equals the listings. We will also consider your functioning when we decide whether your impairment(s) meets or medically equals a listing if the listing we are considering includes functioning among its criteria.

(2) *Factors we consider when we evaluate your functioning.* Your limitations in functioning must result from your medically determinable impairment(s). The information we get from your medical and nonmedical sources can help us understand how your impairment(s) affects your functioning. We will also consider any factors that are relevant to how you function when we evaluate your impairment or combination of impairments. For example, your symptoms (such as pain, fatigue, decreased energy, or anxiety) may limit your functioning. (See § 416.929.) We explain some other factors we may consider when we evaluate your functioning in paragraphs (b)(3)–(b)(9) of this section.

(3) *How your functioning compares to the functioning of children your age who do not have impairments.* (i) *General.* When we evaluate your functioning, we will look at whether you do the things that other children your age typically do or whether you have limitations and restrictions because of your medically determinable impairment(s). We will also look at how well you do the activities and how much help you need from your family, teachers, or others. Information about what you can and cannot do, and how you function on a day-to-day basis at home, school, and in the community, allows us to compare your activities to the activities of children your age who do not have impairments.

(ii) *How we will consider reports of your functioning.* When we consider the evidence in your case record about the quality of your activities, we will consider the standards used by the person who gave us the information. We will also consider the characteristics of the group to whom you are being compared. For example, if the way you do your classwork is compared to other children in a special education class, we will consider that you are being compared to children who do have impairments.

(4) *Combined effects of multiple impairments.* If you have more than one

impairment, we will sometimes be able to decide that you have a "severe" impairment or an impairment that meets, medically equals, or functionally equals the listings by looking at each of your impairments separately. When we cannot, we will look comprehensively at the combined effects of your impairments on your day-to-day functioning instead of considering the limitations resulting from each impairment separately. (See §§ 416.923 and 416.926a(c) for more information about how we will consider the interactive and cumulative effects of your impairments on your functioning.)

(5) *How well you can initiate, sustain, and complete your activities, including the amount of help or adaptations you need, and the effects of structured or supportive settings.* (i) *Initiating, sustaining, and completing activities.* We will consider how effectively you function by examining how independently you are able to initiate, sustain, and complete your activities despite your impairment(s), compared to other children your age who do not have impairments. We will consider:

(A) The range of activities you do;

(B) Your ability to do them independently, including any prompting you may need to begin, carry through, and complete your activities;

(C) The pace at which you do your activities;

(D) How much effort you need to make to do your activities; and

(E) How long you are able to sustain your activities.

(ii) *Extra help.* We will consider how independently you are able to function compared to other children your age who do not have impairments. We will consider whether you need help from other people, or whether you need special equipment, devices, or medications to perform your day-to-day activities. For example, we may consider how much supervision you need to keep from hurting yourself, how much help you need every day to get dressed or, if you are an infant, how long it takes for your parents or other caregivers to feed you. We recognize that children are often able to do things and complete tasks when given help, but may not be able to do these same things by themselves. Therefore, we will consider how much extra help you need, what special equipment or devices you use, and the medications you take that enable you to participate in activities like other children your age who do not have impairments.

(iii) *Adaptations.* We will consider the nature and extent of any adaptations that you use to enable you to function. Such adaptations may include assistive

devices or appliances. Some adaptations may enable you to function normally or almost normally (e.g., eyeglasses). Others may increase your functioning, even though you may still have functional limitations (e.g., ankle-foot orthoses, hand or foot splints, and specially adapted or custom-made tools, utensils, or devices for self-care activities such as bathing, feeding, toileting, and dressing). When we evaluate your functioning with an adaptation, we will consider the degree to which the adaptation enables you to function compared to other children your age who do not have impairments, your ability to use the adaptation effectively on a sustained basis, and any functional limitations that nevertheless persist.

(iv) *Structured or supportive settings.* (A) If you have a serious impairment(s), you may spend some or all of your time in a structured or supportive setting, beyond what a child who does not have an impairment typically needs.

(B) A structured or supportive setting may be your own home in which family members or other people (e.g., visiting nurses or home health workers) make adjustments to accommodate your impairment(s). A structured or supportive setting may also be your classroom at school, whether it is a regular classroom in which you are accommodated or a special classroom. It may also be a residential facility or school where you live for a period of time.

(C) A structured or supportive setting may minimize signs and symptoms of your impairment(s) and help to improve your functioning while you are in it, but your signs, symptoms, and functional limitations may worsen outside this type of setting. Therefore, we will consider your need for a structured setting and the degree of limitation in functioning you have or would have outside the structured setting. Even if you are able to function adequately in the structured or supportive setting, we must consider how you function in other settings and whether you would continue to function at an adequate level without the structured or supportive setting.

(D) If you have a chronic impairment(s), you may have your activities structured in such a way as to minimize stress and reduce the symptoms or signs of your impairment(s). You may continue to have persistent pain, fatigue, decreased energy, or other symptoms or signs, although at a lesser level of severity. We will consider whether you are more limited in your functioning than your symptoms and signs would indicate.

(E) Therefore, if your symptoms or signs are controlled or reduced in a structured setting, we will consider how well you are functioning in the setting and the nature of the setting in which you are functioning (e.g., home or a special class); the amount of help you need from your parents, teachers, or others to function as well as you do; adjustments you make to structure your environment; and how you would function without the structured or supportive setting.

(6) *Unusual settings.* Children may function differently in unfamiliar or one-to-one settings than they do in their usual settings at home, at school, in childcare or in the community. You may appear more or less impaired on a single examination (such as a consultative examination) than indicated by the information covering a longer period. Therefore, we will apply the guidance in paragraph (b)(5) of this section when we consider how you function in an unusual or one-to-one situation. We will look at your performance in a special situation and at your typical day-to-day functioning in routine situations. We will not draw inferences about your functioning in other situations based only on how you function in a one-to-one, new, or unusual situation.

(7) *Early intervention and school programs.* (i) *General.* If you are a very young child who has been identified for early intervention services, or if you attend school (including preschool), the records of people who know you or who have examined you are important sources of information about your impairment(s) and its effects on your functioning. Records from physicians, teachers and school psychologists, or physical, occupational, or speech-language therapists are examples of what we will consider. If you receive early intervention services or go to school or preschool, we will consider this information when it is relevant and available to us.

(ii) *School evidence.* If you go to school or preschool, we will ask your teacher(s) about your performance in your activities throughout your school day. We will consider all the evidence we receive from your school, including teacher questionnaires, teacher checklists, group achievement testing, and report cards.

(iii) *Early intervention and special education programs.* If you have received a comprehensive assessment for early intervention services or special education services, we will consider information used by the assessment team to make its recommendations. We will consider the information in your Individualized Family Service Plan,

your Individualized Education Program, or your plan for transition services to help us understand your functioning. We will examine the goals and objectives of your plan or program as further indicators of your functioning, as well as statements regarding related services, supplementary aids, program modifications, and other accommodations recommended to help you function, together with the other relevant information in your case record.

(iv) *Special education or accommodations.* We will consider the fact that you attend school, that you may be placed in a special education setting, or that you receive accommodations because of your impairments along with the other information in your case record. The fact that you attend school does not mean that you are not disabled. The fact that you do or do not receive special education services does not, in itself, establish your actual limitations or abilities. Children are placed in special education settings, or are included in regular classrooms (with or without accommodation), for many reasons that may or may not be related to the level of their impairments. For example, you may receive one-to-one assistance from an aide throughout the day in a regular classroom, or be placed in a special classroom. We will consider the circumstances of your school attendance, such as your ability to function in a regular classroom or preschool setting with children your age who do not have impairments. Similarly, we will consider that good performance in a special education setting does not mean that you are functioning at the same level as other children your age who do not have impairments.

(v) *Attendance and participation.* We will also consider factors affecting your ability to participate in your education program. You may be unable to participate on a regular basis because of the chronic or episodic nature of your impairment(s) or your need for therapy or treatment. If you have more than one impairment, we will look at whether the effects of your impairments taken together make you unable to participate on a regular basis. We will consider how your temporary removal or absence from the program affects your ability to function compared to other children your age who do not have impairments.

(8) *The impact of chronic illness and limitations that interfere with your activities over time.* If you have a chronic impairment(s) that is characterized by episodes of exacerbation (worsening) and remission

(improvement), we will consider the frequency and severity of your episodes of exacerbation as factors that may be limiting your functioning. Your level of functioning may vary considerably over time. Proper evaluation of your ability to function in any domain requires us to take into account any variations in your level of functioning to determine the impact of your chronic illness on your ability to function over time. If you require frequent treatment, we will consider it as explained in paragraph (b)(9)(ii) of this section.

(9) *The effects of treatment (including medications and other treatment).* We will evaluate the effects of your treatment to determine its effect on your functioning in your particular case.

(i) *Effects of medications.* We will consider the effects of medication on your symptoms, signs, laboratory findings, and functioning. Although medications may control the most obvious manifestations of your impairment(s), they may or may not affect the functional limitations imposed by your impairment(s). If your symptoms or signs are reduced by medications, we will consider:

(A) Any of your functional limitations that may nevertheless persist, even if there is improvement from the medications;

(B) Whether your medications create any side effects that cause or contribute to your functional limitations;

(C) The frequency of your need for medication;

(D) Changes in your medication or the way your medication is prescribed; and
(E) Any evidence over time of how medication helps or does not help you to function compared to other children your age who do not have impairments.

(ii) *Other treatment.* We will also consider the level and frequency of treatment other than medications that you get for your impairment(s). You may need frequent and ongoing therapy from one or more medical sources to maintain or improve your functional status. (Examples of therapy include occupational, physical, or speech and language therapy, nursing or home health services, psychotherapy, or psychosocial counseling.) Frequent therapy, although intended to improve your functioning in some ways, may also interfere with your functioning in other ways. Therefore, we will consider the frequency of any therapy you must have, and how long you have received or will need it. We will also consider whether the therapy interferes with your participation in activities typical of other children your age who do not have impairments, such as attending school or classes and socializing with your

peers. If you must frequently interrupt your activities at school or at home for therapy, we will consider whether these interruptions interfere with your functioning. We will also consider the length and frequency of your hospitalizations.

(iii) *Treatment and intervention, in general.* With treatment or intervention, you may not only have your symptoms or signs reduced, but may also maintain, return to, or achieve a level of functioning that is not disabling. Treatment or intervention may prevent, eliminate, or reduce functional limitations.

14. Section 416.925 is amended by revising the sixth and seventh sentences of paragraph (b)(2) to read as follows:

§ 416.925 Listing of Impairments in appendix 1 of subpart P of part 404 of this chapter.

* * * * *

(b) * * *
 (2) * * * Although the severity criteria in part B of the listings are expressed in different ways for different impairments, “listing-level severity” generally means the level of severity described in § 416.926a(a); *i.e.*, “marked” limitations in two domains of functioning or an “extreme” limitation in one domain. (See § 416.926a(e) for the definitions of the terms “marked” and “extreme” as they apply to children.) * * *

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15. Section 416.926a is amended by:

- A. Revising paragraphs (a), (b), and (c);
- B. Redesignating paragraph (d) as paragraph (m);
- C. Redesignating paragraph (e) as paragraph (n);
- D. Adding new paragraphs (d) through (l);
- E. Removing paragraphs (m)(5) and (m)(10);
- F. Redesignating paragraphs (m)(6) as (m)(5), (m)(7) as (m)(6), (m)(8) as (m)(7), (m)(9) as (m)(8), (m)(11) as (m)(9), and (m)(12) as (m)(10), and
- G. By revising the heading and introductory text of paragraph (m) to read as follows:

§ 416.926a Functional equivalence for children.

(a) *General.* If you have a severe impairment or combination of impairments that does not meet or medically equal any listing, we will decide whether it results in limitations that functionally equal the listings. By “functionally equal the listings,” we mean that your impairment(s) must be of listing-level severity; *i.e.*, it must result in “marked” limitations in two

domains of functioning or an “extreme” limitation in one domain, as explained in this section. We will assess the functional limitations caused by your impairment(s); *i.e.*, what you cannot do, have difficulty doing, need help doing, or are restricted from doing because of your impairment(s). When we make a finding regarding functional equivalence, we will assess the interactive and cumulative effects of all of the impairments for which we have evidence, including any impairments you have that are not “severe.” (See § 416.924(c).) When we assess your functional limitations, we will consider all the relevant factors in §§ 416.924a, 416.924b, and 416.929 including, but not limited to:

- (1) How well you can initiate and sustain activities, how much extra help you need, and the effects of structured or supportive settings (*see* § 416.924a(b)(5));
 - (2) How you function in school (*see* § 416.924a(b)(7)); and
 - (3) The effects of your medications or other treatment (*see* § 416.924a(b)(9)).
- (b) *How we will consider your functioning.* We will look at the information we have in your case record about how your functioning is affected during all of your activities when we decide whether your impairment or combination of impairments functionally equals the listings. Your activities are everything you do at home, at school, and in your community. We will look at how appropriately, effectively, and independently you perform your activities compared to the performance of other children your age who do not have impairments.

(1) We will consider how you function in your activities in terms of six domains. These domains are broad areas of functioning intended to capture all of what a child can or cannot do. In paragraphs (g) through (l), we describe each domain in general terms. For most of the domains, we also provide examples of activities that illustrate the typical functioning of children in different age groups. For all of the domains, we also provide examples of limitations within the domains. However, we recognize that there is a range of development and functioning, and that not all children within an age category are expected to be able to do all of the activities in the examples of typical functioning. We also recognize that limitations of any of the activities in the examples do not necessarily mean that a child has a “marked” or “extreme” limitation, as defined in paragraph (e) of this section. The domains we use are:

- (i) Acquiring and using information;

- (ii) Attending and completing tasks;
- (iii) Interacting and relating with others;
- (iv) Moving about and manipulating objects;
- (v) Caring for yourself; and,
- (vi) Health and physical well-being.

(2) When we evaluate your ability to function in each domain, we will ask for and consider information that will help us answer the following questions about whether your impairment(s) affects your functioning and whether your activities are typical of other children your age who do not have impairments.

- (i) What activities are you able to perform?
- (ii) What activities are you not able to perform?
- (iii) Which of your activities are limited or restricted compared to other children your age who do not have impairments?
- (iv) Where do you have difficulty with your activities-at home, in childcare, at school, or in the community?
- (v) Do you have difficulty independently initiating, sustaining, or completing activities?
- (vi) What kind of help do you need to do your activities, how much help do you need, and how often do you need it?

(3) We will try to get information from sources who can tell us about the effects of your impairment(s) and how you function. We will ask for information from your treating and other medical sources who have seen you and can give us their medical findings and opinions about your limitations and restrictions. We will also ask for information from your parents and teachers, and may ask for information from others who see you often and can describe your functioning at home, in childcare, at school, and in your community. We may also ask you to go to a consultative examination(s) at our expense. (See §§ 416.912–416.919a regarding medical evidence and when we will purchase a consultative examination.)

(c) *The interactive and cumulative effects of an impairment or multiple impairments.* When we evaluate your functioning and decide which domains may be affected by your impairment(s), we will look first at your activities and your limitations and restrictions. Any given activity may involve the integrated use of many abilities and skills; therefore, any single limitation may be the result of the interactive and cumulative effects of one or more impairments. And any given impairment may have effects in more than one domain; therefore, we will evaluate the limitations from your

impairment(s) in any affected domain(s).

(d) *How we will decide that your impairment(s) functionally equals the listings.* We will decide that your impairment(s) functionally equals the listings if it is of listing-level severity. Your impairment(s) is of listing-level severity if you have "marked" limitations in two of the domains in paragraph (b)(1) of this section, or an "extreme" limitation in one domain. We will not compare your functioning to the requirements of any specific listing. We explain what the terms "marked" and "extreme" mean in paragraph (e) of this section. We explain how we use the domains in paragraph (f) of this section, and describe each domain in paragraphs (g)–(l). You must also meet the duration requirement. (See § 416.909.)

(e) *How we define "marked" and "extreme" limitations.*

(1) *General.* (i) When we decide whether you have a "marked" or an "extreme" limitation, we will consider your functional limitations resulting from all of your impairments, including their interactive and cumulative effects. We will consider all the relevant information in your case record that helps us determine your functioning, including your signs, symptoms, and laboratory findings, the descriptions we have about your functioning from your parents, teachers, and other people who know you, and the relevant factors explained in §§ 416.924a, 416.924b, and 416.929.

(ii) The medical evidence may include formal testing that provides information about your development or functioning in terms of percentiles, percentages of delay, or age or grade equivalents. Standard scores (e.g., percentiles) can be converted to standard deviations. When you have such scores, we will consider them together with the information we have about your functioning to determine whether you have a "marked" or "extreme" limitation in a domain.

(2) *Marked limitation.* (i) We will find that you have a "marked" limitation in a domain when your impairment(s) interferes seriously with your ability to independently initiate, sustain, or complete activities. Your day-to-day functioning may be seriously limited when your impairment(s) limits only one activity or when the interactive and cumulative effects of your impairment(s) limit several activities. "Marked" limitation also means a limitation that is "more than moderate" but "less than extreme." It is the equivalent of the functioning we would expect to find on standardized testing with scores that are at least two, but less

than three, standard deviations below the mean.

(ii) If you have not attained age 3, we will generally find that you have a "marked" limitation if you are functioning at a level that is more than one-half but not more than two-thirds of your chronological age when there are no standard scores from standardized tests in your case record.

(iii) If you are a child of any age (birth to the attainment of age 18), we will find that you have a "marked" limitation when you have a valid score that is two standard deviations or more below the mean, but less than three standard deviations, on a comprehensive standardized test designed to measure ability or functioning in that domain, and your day-to-day functioning in domain-related activities is consistent with that score. (See paragraph (e)(4) of this section.)

(iv) For the sixth domain of functioning, "Health and physical well-being," we may also consider you to have a "marked" limitation if you are frequently ill because of your impairment(s) or have frequent exacerbations of your impairment(s) that result in significant, documented symptoms or signs. For purposes of this domain, "frequent means that you have episodes of illness or exacerbations that occur on an average of 3 times a year, or once every 4 months, each lasting 2 weeks or more. We may also find that you have a "marked" limitation if you have episodes that occur more often than 3 times in a year or once every 4 months but do not last for 2 weeks, or occur less often than an average of 3 times a year or once every 4 months but last longer than 2 weeks, if the overall effect (based on the length of the episode(s) or its frequency) is equivalent in severity.

(3) *Extreme limitation.* (i) We will find that you have an "extreme" limitation in a domain when your impairment(s) interferes very seriously with your ability to independently initiate, sustain, or complete activities. Your day-to-day functioning may be very seriously limited when your impairment(s) limits only one activity or when the interactive and cumulative effects of your impairment(s) limit several activities. "Extreme" limitation also means a limitation that is "more than marked." "Extreme" limitation is the rating we give to the worst limitations. However, "extreme limitation" does not necessarily mean a total lack or loss of ability to function. It is the equivalent of the functioning we would expect to find on standardized testing with scores that are at least three standard deviations below the mean.

(ii) If you have not attained age 3, we will generally find that you have an "extreme" limitation if you are functioning at a level that is one-half of your chronological age or less when there are no standard scores from standardized tests in your case record.

(iii) If you are a child of any age (birth to the attainment of age 18), we will find that you have an "extreme" limitation when you have a valid score that is three standard deviations or more below the mean on a comprehensive standardized test designed to measure ability or functioning in that domain, and your day-to-day functioning in domain-related activities is consistent with that score. (See paragraph (e)(4) of this section.)

(iv) For the sixth domain of functioning, "Health and physical well-being," we may also consider you to have an "extreme" limitation if you are ill because of your impairment(s) or have exacerbations of your impairment(s) that result in significant, documented symptoms or signs substantially in excess of the requirements for showing a "marked" limitation in paragraph (e)(2)(iv) of this section. However, if you have episodes of illness or exacerbations of your impairment(s) that we would rate as "extreme" under this definition, your impairment(s) should meet or medically equal the requirements of a listing in most cases. See §§ 416.925 and 416.926.

(4) *How we will consider your test scores.* (i) As indicated in § 416.924a(a)(1)(ii), we will not rely on any test score alone. No single piece of information taken in isolation can establish whether you have a "marked" or an "extreme" limitation in a domain.

(ii) We will consider your test scores together with the other information we have about your functioning, including reports of classroom performance and the observations of school personnel and others.

(A) We may find that you have a "marked" or "extreme" limitation when you have a test score that is slightly higher than the level provided in paragraph (e)(2) or (e)(3) of this section, if other information in your case record shows that your functioning in day-to-day activities is seriously or very seriously limited because of your impairment(s). For example, you may have IQ scores above the level in paragraph (e)(2), but other evidence shows that your impairment(s) causes you to function in school, home, and the community far below your expected level of functioning based on this score.

(B) On the other hand, we may find that you do not have a "marked" or "extreme" limitation, even if your test

scores are at the level provided in paragraph (e)(2) or (e)(3) of this section, if other information in your case record shows that your functioning in day-to-day activities is not seriously or very seriously limited by your impairment(s). For example, you may have a valid IQ score below the level in paragraph (e)(2), but other evidence shows that you have learned to drive a car, shop independently, and read books near your expected grade level.

(iii) If there is a material inconsistency between your test scores and other information in your case record, we will try to resolve it. The interpretation of the test is primarily the responsibility of the psychologist or other professional who administered the test. But it is also our responsibility to ensure that the evidence in your case is complete and consistent or that any material inconsistencies have been resolved. Therefore, we will use the following guidelines when we resolve concerns about your test scores:

(A) We may be able to resolve the inconsistency with the information we have. We may need to obtain additional information; *e.g.*, by recontact with your medical source(s), by purchase of a consultative examination to provide further medical information, by recontact with a medical source who provided a consultative examination, or by questioning individuals familiar with your day-to-day functioning.

(B) Generally, we will not rely on a test score as a measurement of your functioning within a domain when the information we have about your functioning is the kind of information typically used by medical professionals to determine that the test results are not the best measure of your day-to-day functioning. When we do not rely on test scores, we will explain our reasons for doing so in your case record or in our decision.

(f) *How we will use the domains to help us evaluate your functioning.* (1) When we consider whether you have "marked" or "extreme" limitations in any domain, we examine all the information we have in your case record about how your functioning is limited because of your impairment(s), and we compare your functioning to the typical functioning of children your age who do not have impairments.

(2) The general descriptions of each domain in paragraphs (g)–(l) help us decide whether you have limitations in any given domain and whether these limitations are "marked" or "extreme."

(3) The domain descriptions also include examples of some activities typical of children in each age group and some functional limitations that we

may consider. These examples also help us decide whether you have limitations in a domain because of your impairment(s). The examples are not all-inclusive, and we will not require our adjudicators to develop evidence about each specific example. When you have limitations in a given activity or activities in the examples, we may or may not decide that you have a "marked" or "extreme" limitation in the domain. We will consider the activities in which you are limited because of your impairment(s) and the extent of your limitations under the rules in paragraph (e) of this section. We will also consider all of the relevant provisions of §§ 416.924a, 416.924b, and 416.929.

(g) *Acquiring and using information.* In this domain, we consider how well you acquire or learn information, and how well you use the information you have learned.

(1) *General.* (i) Learning and thinking begin at birth. You learn as you explore the world through sight, sound, taste, touch, and smell. As you play, you acquire concepts and learn that people, things, and activities have names. This lets you understand symbols, which prepares you to use language for learning. Using the concepts and symbols you have acquired through play and learning experiences, you should be able to learn to read, write, do arithmetic, and understand and use new information.

(ii) Thinking is the application or use of information you have learned. It involves being able to perceive relationships, reason, and make logical choices. People think in different ways. When you think in pictures, you may solve a problem by watching and imitating what another person does. When you think in words, you may solve a problem by using language to talk your way through it. You must also be able to use language to think about the world and to understand others and express yourself; *e.g.*, to follow directions, ask for information, or explain something.

(2) *Age group descriptors.* (i) *Newborns and young infants (birth to attainment of age 1).* At this age, you should show interest in, and explore, your environment. At first, your actions are random; for example, when you accidentally touch the mobile over your crib. Eventually, your actions should become deliberate and purposeful, as when you shake noisemaking toys like a bell or rattle. You should begin to recognize, and then anticipate, routine situations and events, as when you grin with expectation at the sight of your stroller. You should also recognize and

gradually attach meaning to everyday sounds, as when you hear the telephone or your name. Eventually, you should recognize and respond to familiar words, including family names and what your favorite toys and activities are called.

(ii) *Older infants and toddlers (age 1 to attainment of age 3).* At this age, you are learning about the world around you. When you play, you should learn how objects go together in different ways. You should learn that by pretending, your actions can represent real things. This helps you understand that words represent things, and that words are simply symbols or names for toys, people, places, and activities. You should refer to yourself and things around you by pointing and eventually by naming. You should form concepts and solve simple problems through purposeful experimentation (*e.g.*, taking toys apart), imitation, constructive play (*e.g.*, building with blocks), and pretend play activities. You should begin to respond to increasingly complex instructions and questions, and to produce an increasing number of words and grammatically correct simple sentences and questions.

(iii) *Preschool children (age 3 to attainment of age 6).* When you are old enough to go to preschool or kindergarten, you should begin to learn and use the skills that will help you to read and write and do arithmetic when you are older. For example, listening to stories, rhyming words, and matching letters are skills needed for learning to read. Counting, sorting shapes, and building with blocks are skills needed to learn math. Painting, coloring, copying shapes, and using scissors are some of the skills needed in learning to write. Using words to ask questions, give answers, follow directions, describe things, explain what you mean, and tell stories allows you to acquire and share knowledge and experience of the world around you. All of these are called "readiness skills," and you should have them by the time you begin first grade.

(iv) *School-age children (age 6 to attainment of age 12).* When you are old enough to go to elementary and middle school, you should be able to learn to read, write, and do math, and discuss history and science. You will need to use these skills in academic situations to demonstrate what you have learned; *e.g.*, by reading about various subjects and producing oral and written projects, solving mathematical problems, taking achievement tests, doing group work, and entering into class discussions. You will also need to use these skills in daily living situations at home and in the community (*e.g.*, reading street signs,

telling time, and making change). You should be able to use increasingly complex language (vocabulary and grammar) to share information and ideas with individuals or groups, by asking questions and expressing your own ideas, and by understanding and responding to the opinions of others.

(v) *Adolescents (age 12 to attainment of age 18)*. In middle and high school, you should continue to demonstrate what you have learned in academic assignments (e.g., composition, classroom discussion, and laboratory experiments). You should also be able to use what you have learned in daily living situations without assistance (e.g., going to the store, using the library, and using public transportation). You should be able to comprehend and express both simple and complex ideas, using increasingly complex language (vocabulary and grammar) in learning and daily living situations (e.g., to obtain and convey information and ideas). You should also learn to apply these skills in practical ways that will help you enter the workplace after you finish school (e.g., carrying out instructions, preparing a job application, or being interviewed by a potential employer).

(3) *Examples of limited functioning in acquiring and using information*. The following examples describe some limitations we may consider in this domain. Your limitations may be different from the ones listed here. Also, the examples do not necessarily describe a "marked" or "extreme" limitation. Whether an example applies in your case may depend on your age and developmental stage; e.g., an example below may describe a limitation in an older child, but not a limitation in a younger one. As in any case, your limitations must result from your medically determinable impairment(s). However, we will consider all of the relevant information in your case record when we decide whether your medically determinable impairment(s) results in a "marked" or "extreme" limitation in this domain.

(i) You do not demonstrate understanding of words about space, size, or time; e.g., in/under, big/little, morning/night.

(ii) You cannot rhyme words or the sounds in words.

(iii) You have difficulty recalling important things you learned in school yesterday.

(iv) You have difficulty solving mathematics questions or computing arithmetic answers.

(v) You talk only in short, simple sentences and have difficulty explaining what you mean.

(h) *Attending and completing tasks*. In this domain, we consider how well you are able to focus and maintain your attention, and how well you begin, carry through, and finish your activities, including the pace at which you perform activities and the ease with which you change them.

(1) *General*. (i) Attention involves regulating your levels of alertness and initiating and maintaining concentration. It involves the ability to filter out distractions and to remain focused on an activity or task at a consistent level of performance. This means focusing long enough to initiate and complete an activity or task, and changing focus once it is completed. It also means that if you lose or change your focus in the middle of a task, you are able to return to the task without other people having to remind you frequently to finish it.

(ii) Adequate attention is needed to maintain physical and mental effort and concentration on an activity or task. Adequate attention permits you to think and reflect before starting or deciding to stop an activity. In other words, you are able to look ahead and predict the possible outcomes of your actions before you act. Focusing your attention allows you to attempt tasks at an appropriate pace. It also helps you determine the time needed to finish a task within an appropriate timeframe.

(2) *Age group descriptors*. (i) *Newborns and young infants (birth to attainment of age 1)*. You should begin at birth to show sensitivity to your environment by responding to various stimuli (e.g., light, touch, temperature, movement). Very soon, you should be able to fix your gaze on a human face. You should stop your activity when you hear voices or sounds around you. Next, you should begin to attend to and follow various moving objects with your gaze, including people or toys. You should be listening to your family's conversations for longer and longer periods of time. Eventually, as you are able to move around and explore your environment, you should begin to play with people and toys for longer periods of time. You will still want to change activities frequently, but your interest in continuing interaction or a game should gradually expand.

(ii) *Older infants and toddlers (age 1 to attainment of age 3)*. At this age, you should be able to attend to things that interest you and have adequate attention to complete some tasks by yourself. As a toddler, you should demonstrate sustained attention, such as when looking at picture books, listening to stories, or building with blocks, and when helping to put on your clothes.

(iii) *Preschool children (age 3 to attainment of age 6)*. As a preschooler, you should be able to pay attention when you are spoken to directly, sustain attention to your play and learning activities, and concentrate on activities like putting puzzles together or completing art projects. You should also be able to focus long enough to do many more things by yourself, such as getting your clothes together and dressing yourself, feeding yourself, or putting away your toys. You should usually be able to wait your turn and to change your activity when a caregiver or teacher says it is time to do something else.

(iv) *School-age children (age 6 to attainment of age 12)*. When you are of school age, you should be able to focus your attention in a variety of situations in order to follow directions, remember and organize your school materials, and complete classroom and homework assignments. You should be able to concentrate on details and not make careless mistakes in your work (beyond what would be expected in other children your age who do not have impairments). You should be able to change your activities or routines without distracting yourself or others, and stay on task and in place when appropriate. You should be able to sustain your attention well enough to participate in group sports, read by yourself, and complete family chores. You should also be able to complete a transition task (e.g., be ready for the school bus, change clothes after gym, change classrooms) without extra reminders and accommodation.

(v) *Adolescents (age 12 to attainment of age 18)*. In your later years of school, you should be able to pay attention to increasingly longer presentations and discussions, maintain your concentration while reading textbooks, and independently plan and complete long-range academic projects. You should also be able to organize your materials and to plan your time in order to complete school tasks and assignments. In anticipation of entering the workplace, you should be able to maintain your attention on a task for extended periods of time, and not be unduly distracted by your peers or unduly distracting to them in a school or work setting.

(3) *Examples of limited functioning in attending and completing tasks*. The following examples describe some limitations we may consider in this domain. Your limitations may be different from the ones listed here. Also, the examples do not necessarily describe a "marked" or "extreme" limitation. Whether an example applies

in your case may depend on your age and developmental stage; *e.g.*, an example below may describe a limitation in an older child, but not a limitation in a younger one. As in any case, your limitations must result from your medically determinable impairment(s). However, we will consider all of the relevant information in your case record when we decide whether your medically determinable impairment(s) results in a "marked" or "extreme" limitation in this domain.

(i) You are easily startled, distracted, or overreactive to sounds, sights, movements, or touch.

(ii) You are slow to focus on, or fail to complete activities of interest to you, *e.g.*, games or art projects.

(iii) You repeatedly become sidetracked from your activities or you frequently interrupt others.

(iv) You are easily frustrated and give up on tasks, including ones you are capable of completing.

(v) You require extra supervision to keep you engaged in an activity.

(i) *Interacting and relating with others.* In this domain, we consider how well you initiate and sustain emotional connections with others, develop and use the language of your community, cooperate with others, comply with rules, respond to criticism, and respect and take care of the possessions of others.

(1) *General.* (i) Interacting means initiating and responding to exchanges with other people, for practical or social purposes. You interact with others by using facial expressions, gestures, actions, or words. You may interact with another person only once, as when asking a stranger for directions, or many times, as when describing your day at school to your parents. You may interact with people one-at-a-time, as when you are listening to another student in the hallway at school, or in groups, as when you are playing with others.

(ii) Relating to other people means forming intimate relationships with family members and with friends who are your age, and sustaining them over time. You may relate to individuals, such as your siblings, parents or best friend, or to groups, such as other children in childcare, your friends in school, teammates in sports activities, or people in your neighborhood.

(iii) Interacting and relating require you to respond appropriately to a variety of emotional and behavioral cues. You must be able to speak intelligibly and fluently so that others can understand you; participate in verbal turntaking and nonverbal exchanges; consider others' feelings and points of view; follow social rules for

interaction and conversation; and respond to others appropriately and meaningfully.

(iv) Your activities at home or school or in your community may involve playing, learning, and working cooperatively with other children, one-at-a-time or in groups; joining voluntarily in activities with the other children in your school or community; and responding to persons in authority (*e.g.*, your parent, teacher, bus driver, coach, or employer).

(2) *Age group descriptors.* (i) *Newborns and young infants (birth to attainment of age 1).* You should begin to form intimate relationships at birth by gradually responding visually and vocally to your caregiver(s), through mutual gaze and vocal exchanges, and by physically molding your body to the caregiver's while being held. You should eventually initiate give-and-take games (such as pat-a-cake, peek-a-boo) with your caregivers, and begin to affect others through your own purposeful behavior (*e.g.*, gestures and vocalizations). You should be able to respond to a variety of emotions (*e.g.*, facial expressions and vocal tone changes). You should begin to develop speech by using vowel sounds and later consonants, first alone, and then in babbling.

(ii) *Older infants and toddlers (age 1 to attainment of age 3).* At this age, you are dependent upon your caregivers, but should begin to separate from them. You should be able to express emotions and respond to the feelings of others. You should begin initiating and maintaining interactions with adults, but also show interest in, then play alongside, and eventually interact with other children your age. You should be able to spontaneously communicate your wishes or needs, first by using gestures, and eventually by speaking words clearly enough that people who know you can understand what you say most of the time.

(iii) *Preschool children (age 3 to attainment of age 6).* At this age, you should be able to socialize with children as well as adults. You should begin to prefer playmates your own age and start to develop friendships with children who are your age. You should be able to use words instead of actions to express yourself, and also be better able to share, show affection, and offer to help. You should be able to relate to caregivers with increasing independence, choose your own friends, and play cooperatively with other children, one-at-a-time or in a group, without continual adult supervision. You should be able to initiate and participate in conversations, using

increasingly complex vocabulary and grammar, and speaking clearly enough that both familiar and unfamiliar listeners can understand what you say most of the time.

(iv) *School-age children (age 6 to attainment of age 12).* When you enter school, you should be able to develop more lasting friendships with children who are your age. You should begin to understand how to work in groups to create projects and solve problems. You should have an increasing ability to understand another's point of view and to tolerate differences. You should be well able to talk to people of all ages, to share ideas, tell stories, and to speak in a manner that both familiar and unfamiliar listeners readily understand.

(v) *Adolescents (age 12 to attainment of age 18).* By the time you reach adolescence, you should be able to initiate and develop friendships with children who are your age and to relate appropriately to other children and adults, both individually and in groups. You should begin to be able to solve conflicts between yourself and peers or family members or adults outside your family. You should recognize that there are different social rules for you and your friends and for acquaintances or adults. You should be able to intelligibly express your feelings, ask for assistance in getting your needs met, seek information, describe events, and tell stories, in all kinds of environments (*e.g.*, home, classroom, sports, extra-curricular activities, or part-time job), and with all types of people (*e.g.*, parents, siblings, friends, classmates, teachers, employers, and strangers).

(3) *Examples of limited functioning in interacting and relating with others.* The following examples describe some limitations we may consider in this domain. Your limitations may be different from the ones listed here. Also, the examples do not necessarily describe a "marked" or "extreme" limitation. Whether an example applies in your case may depend on your age and developmental stage; *e.g.*, an example below may describe a limitation in an older child, but not a limitation in a younger one. As in any case, your limitations must result from your medically determinable impairment(s). However, we will consider all of the relevant information in your case record when we decide whether your medically determinable impairment(s) results in a "marked" or "extreme" limitation in this domain.

(i) You do not reach out to be picked up and held by your caregiver.

(ii) You have no close friends, or your friends are all older or younger than you.

(iii) You avoid or withdraw from people you know, or you are overly anxious or fearful of meeting new people or trying new experiences.

(iv) You have difficulty playing games or sports with rules.

(v) You have difficulty communicating with others; *e.g.*, in using verbal and nonverbal skills to express yourself, carrying on a conversation, or in asking others for assistance.

(vi) You have difficulty speaking intelligibly or with adequate fluency.

(j) *Moving about and manipulating objects.* In this domain, we consider how you move your body from one place to another and how you move and manipulate things. These are called gross and fine motor skills.

(1) *General.* (i) Moving your body involves several different kinds of actions: Rolling your body; rising or pulling yourself from a sitting to a standing position; pushing yourself up; raising your head, arms, and legs, and twisting your hands and feet; balancing your weight on your legs and feet; shifting your weight while sitting or standing; transferring yourself from one surface to another; lowering yourself to or toward the floor as when bending, kneeling, stooping, or crouching; moving yourself forward and backward in space as when crawling, walking, or running, and negotiating different terrains (*e.g.*, curbs, steps, and hills).

(ii) Moving and manipulating things involves several different kinds of actions: Engaging your upper and lower body to push, pull, lift, or carry objects from one place to another; controlling your shoulders, arms, and hands to hold or transfer objects; coordinating your eyes and hands to manipulate small objects or parts of objects.

(iii) These actions require varying degrees of strength, coordination, dexterity, pace, and physical ability to persist at the task. They also require a sense of where your body is and how it moves in space; the integration of sensory input with motor output; and the capacity to plan, remember, and execute controlled motor movements.

(2) *Age group descriptors.* (i) *Newborns and infants (birth to attainment of age 1).* At birth, you should begin to explore your world by moving your body and by using your limbs. You should learn to hold your head up, sit, crawl, and stand, and sometimes hold onto a stable object and stand actively for brief periods. You should begin to practice your developing eye-hand control by reaching for objects or picking up small objects and dropping them into containers.

(ii) *Older infants and toddlers (age 1 to attainment of age 3).* At this age, you should begin to explore actively a wide area of your physical environment, using your body with steadily increasing control and independence from others. You should begin to walk and run without assistance, and climb with increasing skill. You should frequently try to manipulate small objects and to use your hands to do or get something that you want or need. Your improved motor skills should enable you to play with small blocks, scribble with crayons, and feed yourself.

(iii) *Preschool children (age 3 to attainment of age 6).* As a preschooler, you should be able to walk and run with ease. Your gross motor skills should let you climb stairs and playground equipment with little supervision, and let you play more independently; *e.g.*, you should be able to swing by yourself and may start learning to ride a tricycle. Your fine motor skills should also be developing. You should be able to complete puzzles easily, string beads, and build with an assortment of blocks. You should be showing increasing control of crayons, markers, and small pieces in board games, and should be able to cut with scissors independently and manipulate buttons and other fasteners.

(iv) *School-age children (age 6 to attainment of age 12).* As a school-age child, your developing gross motor skills should let you move at an efficient pace about your school, home, and neighborhood. Your increasing strength and coordination should expand your ability to enjoy a variety of physical activities, such as running and jumping, and throwing, kicking, catching and hitting balls in informal play or organized sports. Your developing fine motor skills should enable you to do things like use many kitchen and household tools independently, use scissors, and write.

(v) *Adolescents (age 12 to attainment of age 18).* As an adolescent, you should be able to use your motor skills freely and easily to get about your school, the neighborhood, and the community. You should be able to participate in a full range of individual and group physical fitness activities. You should show mature skills in activities requiring eye-hand coordination, and should have the fine motor skills needed to write efficiently or type on a keyboard.

(3) *Examples of limited functioning in moving about and manipulating objects.* The following examples describe some limitations we may consider in this domain. Your limitations may be different from the ones listed here. Also, the examples do not necessarily

describe a "marked" or "extreme" limitation. Whether an example applies in your case may depend on your age and developmental stage; *e.g.*, an example below may describe a limitation in an older child, but not a limitation in a younger one. As in any case, your limitations must result from your medically determinable impairment(s). However, we will consider all of the relevant information in your case record when we decide whether your medically determinable impairment(s) results in a "marked" or "extreme" limitation in this domain.

(i) You experience muscle weakness, joint stiffness, or sensory loss (*e.g.*, spasticity, hypotonia, neuropathy, or paresthesia) that interferes with your motor activities (*e.g.*, you unintentionally drop things).

(ii) You have trouble climbing up and down stairs, or have jerky or disorganized locomotion or difficulty with your balance.

(iii) You have difficulty coordinating gross motor movements (*e.g.*, bending, kneeling, crawling, running, jumping rope, or riding a bike).

(iv) You have difficulty with sequencing hand or finger movements.

(v) You have difficulty with fine motor movement (*e.g.*, gripping or grasping objects).

(vi) You have poor eye-hand coordination when using a pencil or scissors.

(k) *Caring for yourself.* In this domain, we consider how well you maintain a healthy emotional and physical state, including how well you get your physical and emotional wants and needs met in appropriate ways; how you cope with stress and changes in your environment; and whether you take care of your own health, possessions, and living area.

(1) *General.* (i) Caring for yourself effectively, which includes regulating yourself, depends upon your ability to respond to changes in your emotions and the daily demands of your environment to help yourself and cooperate with others in taking care of your personal needs, health and safety. It is characterized by a sense of independence and competence. The effort to become independent and competent should be observable throughout your childhood.

(ii) Caring for yourself effectively means becoming increasingly independent in making and following your own decisions. This entails relying on your own abilities and skills, and displaying consistent judgment about the consequences of caring for yourself. As you mature, using and testing your own judgment helps you develop

confidence in your independence and competence. Caring for yourself includes using your independence and competence to meet your physical needs, such as feeding, dressing, toileting, and bathing, appropriately for your age.

(iii) Caring for yourself effectively requires you to have a basic understanding of your body, including its normal functioning, and of your physical and emotional needs. To meet these needs successfully, you must employ effective coping strategies, appropriate to your age, to identify and regulate your feelings, thoughts, urges, and intentions. Such strategies are based on taking responsibility for getting your needs met in an appropriate and satisfactory manner.

(iv) Caring for yourself means recognizing when you are ill, following recommended treatment, taking medication as prescribed, following safety rules, responding to your circumstances in safe and appropriate ways, making decisions that do not endanger yourself, and knowing when to ask for help from others.

(2) *Age group descriptors.* (i) *Newborns and infants (birth to attainment of age 1).* Your sense of independence and competence begins in being able to recognize your body's signals (e.g., hunger, pain, discomfort), to alert your caregiver to your needs (e.g., by crying), and to console yourself (e.g., by sucking on your hand) until help comes. As you mature, your capacity for self-consolation should expand to include rhythmic behaviors (e.g., rocking). Your need for a sense of competence also emerges in things you try to do for yourself, perhaps before you are ready to do them, as when insisting on putting food in your mouth and refusing your caregiver's help.

(ii) *Older infants and toddlers (age 1 to attainment of age 3).* As you grow, you should be trying to do more things for yourself that increase your sense of independence and competence in your environment. You might console yourself by carrying a favorite blanket with you everywhere. You should be learning to cooperate with your caregivers when they take care of your physical needs, but you should also want to show what you can do; e.g., pointing to the bathroom, pulling off your coat. You should be experimenting with your independence by showing some degree of contrariness (e.g., "No! No!") and identity (e.g., hoarding your toys).

(iii) *Preschool children (age 3 to attainment of age 6).* You should want to take care of many of your physical needs by yourself (e.g., putting on your

shoes, getting a snack), and also want to try doing some things that you cannot do fully (e.g., tying your shoes, climbing on a chair to reach something up high, taking a bath). Early in this age range, it may be easy for you to agree to do what your caregiver asks. Later, that may be difficult for you because you want to do things your way or not at all. These changes usually mean that you are more confident about your ideas and what you are able to do. You should also begin to understand how to control behaviors that are not good for you (e.g., crossing the street without an adult).

(iv) *School-age children (age 6 to attainment of age 12).* You should be independent in most day-to-day activities (e.g., dressing yourself, bathing yourself), although you may still need to be reminded sometimes to do these routinely. You should begin to recognize that you are competent in doing some activities and that you have difficulty with others. You should be able to identify those circumstances when you feel good about yourself and when you feel bad. You should begin to develop understanding of what is right and wrong, and what is acceptable and unacceptable behavior. You should begin to demonstrate consistent control over your behavior, and you should be able to avoid behaviors that are unsafe or otherwise not good for you. You should begin to imitate more of the behavior of adults you know.

(v) *Adolescents (age 12 to attainment of age 18).* You should feel more independent from others and should be increasingly independent in all of your day-to-day activities. You may sometimes experience confusion in the way you feel about yourself. You should begin to notice significant changes in your body's development, and this can result in anxiety or worrying about yourself and your body. Sometimes these worries can make you feel angry or frustrated. You should begin to discover appropriate ways to express your feelings, both good and bad (e.g., keeping a diary to sort out angry feelings or listening to music to calm yourself down). You should begin to think seriously about your future plans, and what you will do when you finish school.

(3) *Examples of limited functioning in caring for yourself.* The following examples describe some limitations we may consider in this domain. Your limitations may be different from the ones listed here. Also, the examples do not necessarily describe a "marked" or "extreme" limitation. Whether an example applies in your case may depend on your age and developmental stage; e.g., an example below may

describe a limitation in an older child, but not a limitation in a younger one. As in any case, your limitations must result from your medically determinable impairment(s). However, we will consider all of the relevant information in your case record when we decide whether your medically determinable impairment(s) results in a "marked" or "extreme" limitation in this domain.

(i) You continue to place non-nutritive or inedible objects in your mouth.

(ii) You often use self-soothing activities showing developmental regression (e.g., thumbsucking, re-chewing food), or you have restrictive or stereotyped mannerisms (e.g., body rocking, headbanging).

(iii) You do not dress or bathe yourself appropriately for your age because you have an impairment(s) that affects this domain.

(iv) You engage in self-injurious behavior (e.g., suicidal thoughts or actions, self-inflicted injury, or refusal to take your medication), or you ignore safety rules.

(v) You do not spontaneously pursue enjoyable activities or interests.

(vi) You have disturbance in eating or sleeping patterns.

(1) *Health and physical well-being.* In this domain, we consider the cumulative physical effects of physical or mental impairments and their associated treatments or therapies on your functioning that we did not consider in paragraph (j) of this section. When your physical impairment(s), your mental impairment(s), or your combination of physical and mental impairments has physical effects that cause "extreme" limitation in your functioning, you will generally have an impairment(s) that "meets" or "medically equals" a listing.

(1) A physical or mental disorder may have physical effects that vary in kind and intensity, and may make it difficult for you to perform your activities independently or effectively. You may experience problems such as generalized weakness, dizziness, shortness of breath, reduced stamina, fatigue, psychomotor retardation, allergic reactions, recurrent infection, poor growth, bladder or bowel incontinence, or local or generalized pain.

(2) In addition, the medications you take (e.g., for asthma or depression) or the treatments you receive (e.g., chemotherapy or multiple surgeries) may have physical effects that also limit your performance of activities.

(3) Your illness may be chronic with stable symptoms, or episodic with periods of worsening and improvement.

We will consider how you function during periods of worsening and how often and for how long these periods occur. You may be medically fragile and need intensive medical care to maintain your level of health and physical well-being. In any case, as a result of the illness itself, the medications or treatment you receive, or both, you may experience physical effects that interfere with your functioning in any or all of your activities.

(4) *Examples of limitations in health and physical well-being.* The following examples describe some limitations we may consider in this domain. Your limitations may be different from the ones listed here. Also, the examples do not necessarily describe a "marked" or "extreme" limitation. Whether an example applies in your case may depend on your age and developmental stage; e.g., an example below may describe a limitation in an older child, but not a limitation in a younger one. As in any case, your limitations must result from your medically determinable impairment(s). However, we will consider all of the relevant information in your case record when we decide whether your medically determinable impairment(s) results in a "marked" or "extreme" limitation in this domain.

(i) You have generalized symptoms, such as weakness, dizziness, agitation (e.g., excitability), lethargy (e.g., fatigue or loss of energy or stamina), or psychomotor retardation because of your impairment(s).

(ii) You have somatic complaints related to your impairments (e.g., seizure or convulsive activity, headaches, incontinence, recurrent infections, allergies, changes in weight or eating habits, stomach discomfort, nausea, headaches, or insomnia).

(iii) You have limitations in your physical functioning because of your treatment (e.g., chemotherapy, multiple surgeries, chelation, pulmonary cleansing, or nebulizer treatments).

(iv) You have exacerbations from one impairment or a combination of impairments that interfere with your physical functioning.

(v) You are medically fragile and need intensive medical care to maintain your level of health and physical well-being.

(m) *Examples of impairments that functionally equal the listings.* The following are some examples of impairments and limitations that functionally equal the listings. Findings of equivalence based on the disabling functional limitations of a child's impairment(s) are not limited to the examples in this paragraph, because these examples do not describe all possible effects of impairments that

might be found to functionally equal the listings. As with any disabling impairment, the duration requirement must also be met (see §§ 416.909 and 416.924(a)). * * *

* * * * *

16. Section 416.929 is amended by revising the second, third, sixth, eighth, and ninth sentences of paragraph (d)(3) and the last sentence of paragraph (d)(4) to read as follows:

§ 416.929 How we evaluate symptoms, including pain.

* * * * *

(d) * * *

* * * * *

(3) * * * Section 416.926 explains how we make this determination. Under § 416.926(b), we will consider equivalence based on medical evidence only. * * * (If you are a child and we cannot find equivalence based on medical evidence only, we will consider pain and other symptoms under §§ 416.924a and 416.926a in determining whether you have an impairment(s) that functionally equals the listings.) * * * (If you are a child and your impairment(s) functionally equals the listings under the rules in § 416.926a, we will also find you disabled.) If they are not, we will consider the impact of your symptoms on your residual functional capacity if you are an adult. * * *

(4) * * * (See §§ 416.945 and 416.924a–416.924b.)

17. Section 416.987 is revised to read as follows:

§ 416.987 Disability redeterminations for individuals who attain age 18.

(a) *Who is affected by this section?* (1) We must redetermine your eligibility if you are eligible for SSI disability benefits and:

(i) You are at least 18 years old; and

(ii) You became eligible for SSI disability benefits as a child (i.e., before you attained age 18); and

(iii) You were eligible for such benefits for the month before the month in which you attained age 18.

(2) We may find that you are not now disabled even though we previously found that you were disabled.

(b) *What are the rules for age-18 redeterminations?* When we redetermine your eligibility, we will use the rules for adults (individuals age 18 or older) who file new applications explained in §§ 416.920(c) through (f). We will not use the rule in § 416.920(b) for people who are doing substantial gainful activity, and we will not use the rules in § 416.994 for determining whether disability continues. If you are

working and we find that you are disabled under § 416.920(d) or (f), we will apply the rules in §§ 416.260ff.

(c) *When will my eligibility be redetermined?* We will redetermine your eligibility either during the 1-year period beginning on your 18th birthday or, in lieu of a continuing disability review, whenever we determine that your case is subject to redetermination under the Act.

(d) *Will I be notified?* (1) *We will notify you in writing before we begin your disability redetermination.* We will tell you:

(i) That we are redetermining your eligibility for payments;

(ii) Why we are redetermining your eligibility;

(iii) Which disability rules we will apply;

(iv) That our review could result in a finding that your SSI payments based on disability could be terminated;

(v) That you have the right to submit medical and other evidence for our consideration during the redetermination; and

(vi) That we will notify you of our determination, your right to appeal the determination, and your right to request continuation of benefits during appeal.

(2) *We will notify you in writing of the results of the disability redetermination.* The notice will tell you what our determination is, the reasons for our determination, and your right to request reconsideration of the determination. If our determination shows that we should stop your SSI payments based on disability, the notice will also tell you of your right to request that your benefits continue during any appeal. Our initial disability redetermination will be binding unless you request a reconsideration within the stated time period or we revise the initial determination.

(e) *When will we find that your disability ended?* If we find that you are not disabled, we will find that your disability ended in the earliest of:

(1) The month the evidence shows that you are not disabled under the rules in this section, but not earlier than the month in which we mail you a notice saying that you are not disabled.

(2) The first month in which you failed without good cause to follow prescribed treatment under the rules in § 416.930.

(3) The first month in which you failed without good cause to do what we asked. Section 416.1411 explains the factors we will consider and how we will determine generally whether you have good cause for failure to cooperate. In addition, § 416.918 discusses how we determine whether you have good cause

for failing to attend a consultative examination.

18. Section 416.990 is amended by revising paragraph (b)(11) to read as follows:

§ 416.990 When and how often we will conduct a continuing disability review.

* * * * *

(b) * * *

(11) By your first birthday, if you are a child whose low birth weight was a contributing factor material to our determination that you were disabled; *i.e.*, whether we would have found you disabled if we had not considered your low birth weight. However, we will conduct your continuing disability review later if at the time of our initial determination that you were disabled:

- (i) We determine that you have an impairment that is not expected to improve by your first birthday; and
- (ii) We schedule you for a continuing disability review after your first birthday.

* * * * *

19. Section 416.994a is amended by revising the last sentence of paragraph (b)(3)(ii), the heading and first sentence of paragraph (b)(3)(iii), the fourth sentence of paragraph (d), the first and second sentences of paragraph (e)(1), and (i)(1)(ii) and (i)(2) to read as follows:

§ 416.994a How we will determine whether your disability continues or ends, and whether you are and have been receiving treatment that is medically necessary and available, disabled children.

* * * * *

(b) * * *

(3) * * *

(ii) * * * If not, we will consider whether it functionally equals the listings.

(iii) *Does your impairment(s) functionally equal the listings?* If your current impairment(s) functionally equals the listings, as described in § 416.926a, we will find that your disability continues. * * *

* * * * *

(d) * * * If not, we will determine whether an attempt should be made to reconstruct those portions of the missing file that were relevant to our most recent favorable determination or decision (e.g., school records, medical evidence from treating sources, and the results of consultative examinations). * * *

(e) * * *

(1) * * * Changing methodologies and advances in medical and other diagnostic techniques or evaluations have given rise to, and will continue to give rise to, improved methods for determining the causes of (*i.e.*,

diagnosing) and measuring and documenting the effects of various impairments on children and their functioning. Where, by such new or improved methods, substantial evidence shows that your impairment(s) is not as severe as was determined at the time of our most recent favorable decision, such evidence may serve as a basis for a finding that you are no longer disabled, provided that you do not currently have an impairment(s) that meets, medically equals, or functionally equals the listings, and therefore results in marked and severe functional limitations. * * *

* * * * *

(i) * * *

(1) * * *

(ii) Psychological or psychosocial counseling; * * *

(2) *How we will consider whether medically necessary treatment is available.* When we decide whether medically necessary treatment is available, we will consider such things as (but not limited to) * * *

* * * * *

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AGENCY FOR INTERNATIONAL DEVELOPMENT

22 CFR Part 203

Registration of Agencies for Voluntary Foreign Aid

AGENCY: United States Agency for International Development (USAID).

ACTION: Final rule.

SUMMARY: This final rule amends USAID regulations on Registration of Agencies for Voluntary Foreign Aid. Registration is required for U.S. private and voluntary organizations (PVO) to become eligible for most USAID grant funds. The final rule clarifies registration conditions by adding an express criterion for denying or withdrawing registration.

EFFECTIVE DATE: September 11, 2000.

FOR FURTHER INFORMATION CONTACT: Mary Newton, Registrar, Office of Private and Voluntary Cooperation, USAID, telephone 202-712-4747; telefax (202) 216-3041.

SUPPLEMENTARY INFORMATION: The U.S. Agency for International Development's registration process identifies PVOs engaged in foreign assistance operations and determines whether they meet established criteria to be eligible for resources intended for PVOs. Registration is the initial criterion of eligibility for U.S. PVOs to compete for

most forms of USAID assistance. Registration is not required for organizations working under contract with USAID. The regulation at 22 CFR Part 203 was published as a final rule January 21, 1983 (48 FR 2760). After operating under the regulation for a number of years it has been determined that part 203 needs revision and clarification. Under its required procedures, the Agency has conducted a review of the PVO registration process and determined that the final rule is necessary to ensure the Agency identifies suitable, qualified PVOs for registration. The final rule will clarify the Conditions of Registration and Documentation Requirements to identify which U.S.-based PVOs are eligible for USAID resources. USAID has determined that the final rule will not have a substantial direct effect on the States, on the relationship between the national Government and the States, or on the distribution of power and responsibilities among the various levels of government. Therefore, it is determined that this proposal would not have federalism implications under Executive Order 13132. USAID has determined also that 5 U.S.C. 553 and Executive Order 12866 are not applicable to this final rule because its subject matter involves foreign affairs functions of the United States. This final rule will have no significant economic impact on a substantial number of small entities under the Regulatory Flexibility Act, nor does it establish any collection of information as contemplated by the Paperwork Reduction Act.

List of Subjects in 22 CFR Part 203

Foreign aid, Nonprofit organizations, Reporting and recordkeeping requirements.

Accordingly 22 CFR Part 203 is amended as follows:

PART 203—REGISTRATION OF AGENCIES FOR VOLUNTARY FOREIGN AID

1. The authority citation for Part 203 continues to read as follows:

Authority: Sec. 621, Foreign Assistance Act of 1961, as amended (22 U.S.C. 2381).

2. Section 203.2 is amended by adding new paragraph (i) to read as follows:

§ 203.2 Conditions of registration and documentation requirements for U.S. private and voluntary organizations.

* * * * *

(i) *Condition and documentation requirement no. 9—(1) Condition.* That the applicant is not: