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Thursday
September 1, 1983

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National Transportation Safety Board

Air Pollution Control
Environmental Protection Agency

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Food and Drug Administration

Banks, Banking
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Hazardous Waste
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Title 3—

The President

Proclamation 5085 of August 29, 1983

Citizenship Day and Constitution Week, 1983

By the President of the United States of America

A Proclamation

There can be no more precious possession than United States citizenship. As the Columbus, Ohio, *Dispatch* so fittingly stated many years ago:

"In the darkness that has settled over so much of the world and which shadows the existence of men in places where individual liberty still struggles to live, the United States of America has become the source of hope and aid to the millions of oppressed who once knew freedom and the hated enemy of the overlords of darkness who would destroy it wherever they can."

The Constitution provides a framework for our continuous striving to make a better America. It provides the basic balance between each branch of government, limits the power of that government, and guarantees to each of us as citizens our most basic rights. The Constitution, however, is only the outline of our system of government. It is through each individual citizen living out the ideals of the Constitution that we reach for a full expression of those ideals. Therefore, while we celebrate Citizenship Day and Constitution Week, let us rededicate ourselves to a full realization of the potential of the great country which the Founding Fathers struggled to create more than two hundred years ago.

Not only during this week, but throughout the year, we should continue to seek that "more perfect union" which will establish justice and insure domestic tranquility for each of us and our future generations through the Constitution.

In recognition of the importance of our Constitution and the role of our citizenry in shaping our government, the Congress, by joint resolution of February 29, 1952 (36 U.S.C. 153), designated September 17th of each year as Citizenship Day and authorized the President to issue annually a proclamation calling upon officials of the government to display the flag on all government buildings on that day. The Congress also, by joint resolution of August 2, 1956 (36 U.S.C. 159), requested the President to proclaim the week beginning September 17th and ending September 23rd of each year as Constitution Week.

NOW, THEREFORE, I, RONALD REAGAN, President of the United States of America, call upon appropriate government officials to display the flag of the United States on all government buildings on Citizenship Day, September 17, 1983. I urge Federal, State and local officials, as well as leaders of civic, educational, and religious organizations to conduct ceremonies and programs that day to commemorate the occasion.

I also proclaim the week beginning September 17th and ending September 23rd, 1983 as Constitution Week, and I urge all Americans to observe that week with appropriate ceremonies and activities in their schools, churches and other suitable places.

IN WITNESS WHEREOF, I have hereunto set my hand this twenty-ninth day of August, in the year of our Lord nineteen hundred and eighty-three, and of the Independence of the United States of America the two hundred and eighth.

Ronald Reagan

[FR Doc. 83-24150
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Rules and Regulations

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This section of the FEDERAL REGIST contains regulatory documents having general applicability and legal effect, most of which are keyed to and codified in the Code of Federal Regulations, which is published under 50 titles pursuant to 44 U.S.C. 1510.
The Code of Federal Regulations is sold by the Superintendent of Documents. Prices of new books are listed in the first FEDERAL REGISTER issue of each month.

DEPARTMENT OF AGRICULTURE

Animal and Plant Health Inspection Service

7 CFR Part 301

[Docket No. 83-335]

Gypsy Moth; Outdoor Household Articles

AGENCY: Animal and Plant Health Inspection Service, USDA.

ACTION: Final rule.

SUMMARY: This document amends the gypsy moth and browntail moth quarantine and regulations by providing for the regulation of all outdoor household articles, except outdoor household articles of vacationers to gypsy moth high-risk areas, moved interstate from high-risk gypsy moth areas into or through any nonregulated areas. These amendments are necessary in order to prevent the artificial spread of gypsy moth to nonregulated areas. The effect of these amendments will be to prohibit the interstate movement of such outdoor household articles moving from high-risk gypsy moth areas into or through nonregulated areas unless such articles are free of all life stages of the gypsy moth or are accompanied by an outdoor household articles (OHA) document.

EFFECTIVE DATE: October 3, 1983.

FOR FURTHER INFORMATION CONTACT: Gary E. Moorehead, Staff Officer, Field Operations Support Staff, Plant Protection and Quarantine, Animal and Plant Health Inspection Service, U.S. Department of Agriculture, Room 663, Federal Building, 6505 Belcrest Road, Hyattsville, MD 20782, 301-436-8295.

SUPPLEMENTARY INFORMATION:

Executive Order 12291

This final rule is issued in conformance with Executive Order 12291 and Secretary's Memorandum 1512-1, and has been determined to be not a "major rule". Based on information compiled by the Department, it has been determined that this regulation will have an effect on the economy of approximately 6.6 million dollars; that this rule would not cause a major increase in costs or prices for consumers, individual industries, Federal, State or local government agencies, or geographic regions; and that this regulation will not have a significant adverse effect on competition, employment, investment productivity, innovation, or on the ability of United States based enterprises to compete with foreign based enterprises in domestic or export markets.

Several alternative actions were considered in developing this regulation. These included:

1. Make no change in the regulation;
2. Add all outdoor household articles to the list of gypsy moth regulated articles (§ 301.45-45-1(v)(1)) and require all outdoor household articles to be accompanied by a certificate or limited permit issued by an inspector after visual inspections;
3. Rescind the gypsy moth quarantine and regulations; and
4. Extend the gypsy moth quarantine (§ 301.45(b)) to all outdoor household articles, and prohibit the interstate movement from high-risk gypsy moth areas into or through nonregulated areas of any outdoor household articles unless it is found free of any life stage of the gypsy moth or is accompanied by a document which indicates that the outdoor household articles have been inspected and/or treated by an individual approved by the Department.

The alternative adopted in this regulation was alternative number 4. Alternative numbers 1 through 3 were not chosen for the following reasons:

Alternative number 1 was not chosen because of the significant pest risk posed by movement of all outdoor household articles from gypsy moth high-risk areas and because of evidence that the present regulatory scheme is not preventing the artificial spread of the gypsy moth to nonregulated areas by outdoor household articles.

Alternative number 2 was not chosen because of the present lack of available inspectors to perform the number of inspections that would be required. As a result, the overall cost of hiring additional inspectors to implement this alternative outweighed the anticipated benefits to the general public and Federal government.

Alternative number 3 was not chosen because rescinding the gypsy moth quarantine and regulations would unnecessarily place the full burden of regulating the artificial spread of gypsy moth on the States. It is believed that some States would not have adequate funds to enact a quarantine and enforce regulations. Thus, the significant pest risk posed by the movement of outdoor household articles from gypsy moth high-risk areas would remain. Further, there is a concern that adoption of alternative number 3 could result in lack of uniformity among State regulations.

Alternative number 4 was adopted for this regulation because it is necessary to take some regulatory action to prevent the artificial spread of gypsy moth to nonregulated areas by outdoor household articles moving from high-risk gypsy moth areas. Additionally, it appears that alternative number 4 is more cost effective than alternative numbers 1 and 2 because the benefits of implementing alternative number 4 are greater than the costs. Alternative number 4 also appears to be a less restrictive regulatory action than alternative numbers 1 and 2 since it provides individuals moving outdoor household articles interstate from high-risk gypsy moth areas into or through nonregulated areas with the option of self-inspection.

The Department also considered whether to regulate the outdoor household articles of vacationers, and decided to exempt from the regulations the outdoor household articles of vacationers to gypsy moth high-risk areas. This was because the Department has determined that the risk of the artificial interstate spread of gypsy moth from the movement of outdoor household articles of vacationers to gypsy moth high-risk areas is unlikely. It appears that most vacationers do not carry outdoor household articles with them, and if they do, the outdoor household articles do not remain stationary for a sufficient time, considering the habits of the gypsy moth

laying eggs, to make infestation likely. Also, it appears to be very unlikely that the vacationers would be in such an area while the gypsy moth was present. Further, the movement from gypsy moth high-risk areas of recreational vehicles (from which there is a greater risk of the artificial spread of gypsy moth) is presently regulated by § 301.45–3 of the regulations.

Certification Under the Regulatory Flexibility Act

Mr. Bert W. Hawkins, Administrator of the Animal and Plant Health Inspection Service, has determined that this action would not have a significant economic impact on a substantial number of small entities. There are approximately 750 commercial carriers that move household articles out of the generally infested areas of the northeastern United States. Although approximately 90 percent of these carriers are small entities ($1,000,000 or less annual income), the estimated annual cost of this action to all these entities would be $100,000. Since this cost will be spread among all of the small entities, there would not be a significant economic impact on any single small entity.

Background

In a document published in the **Federal Register** on June 23, 1983 (48 FR 28646–28652), the Animal and Plant Health Inspection Service proposed to amend the Gypsy Moth and Browntail Moth Quarantine and Regulations (7 CFR 301.45 *et seq.*) by providing for the regulation of all outdoor household articles, except outdoor household articles of vacationers to gypsy moth high-risk areas, moved interstate from gypsy moth high-risk areas into or through any nonregulated area. Specifically, the document of June 23, 1983, proposed prohibiting the movement of such outdoor household articles unless such articles were free of all life forms of gypsy moth at the time of the interstate movement from a gypsy moth high-risk area into or through a nonregulated area, or unless such outdoor household articles were accompanied by an OHA document issued by a qualified certified applicator within five days of the interstate movement from a gypsy moth high-risk area. The proposed regulations also provided a definition of the terms "qualified certified applicator" and "OHA document", and had provisions pertaining to the issuance of OHA documents, the accompaniment of an OHA document during the interstate movement, and the disqualification of a qualified certified applicator to issue OHA documents.

Comments

The Department received ten (10) written comments to the proposed rule. All of the comments supported the intent of the proposed rule, which is to prevent the artificial spread of gypsy moth into or through nonregulated areas. However, changes to the proposed rule were recommended in five (5) of the comments. These recommendations and the Department's response follows.

The proposed rule provided that the regulated outdoor household articles could be moved from a gypsy moth high-risk area into or through a nonregulated area if they were free of life forms of gypsy moth or if accompanied by an OHA document. This allowed, implicitly, a mover of outdoor household articles the option of self-inspection and treatment, or in the alternative, professional inspection, treatment and certification.

A state regulatory agency supported the concept of regulating outdoor household articles but opposed the concept of self-inspection. This comment recommended (1) requiring all outdoor household articles moving from a gypsy moth high-risk area into or through a nonregulated area to be accompanied by an OHA document, (2) requiring USDA to implement a comprehensive public information program and (3) requiring USDA to establish checkpoints along highways for spot checking movers. The concept of requiring all outdoor household articles to be accompanied by an OHA document, issued either by a qualified certified applicator or a USDA inspector, was also recommended by a commercial movers association. For reasons discussed below, no changes in the proposed regulations are made based on these comments.

The Department recognizes that the proposed regulation involves a regulatory approach which is different from the quarantine, inspection and certification procedures normally utilized. Further, the Department believes that the alternative recommended in these comments [i.e., requiring all regulated articles to be professionally inspected, treated, if necessary, and certified prior to movement interstate] is a desirable regulatory approach for other kinds of regulated articles. However, because of the unique nature of outdoor household articles as regulated article (and the attendant difficulty of enforcing a regulatory program that mandates inspection, treatment and certification of all outdoor household articles regardless of the circumstances of the individual mover) and because of the cost involved in implementing such a program, the Department believes that the better regulatory approach for outdoor household articles is the approach adopted in the proposed rule.

Regulating outdoor household articles of individuals is different from regulating other kinds of articles. First, it involves regulating individual movers not just an industry. Second, it involves regulating individuals moving outdoor household articles from widely diverse circumstances. For example, a person moving out of a gypsy moth high-risk area may live in an apartment building where outdoor household articles, such as grills or bicycles, are kept on balconies protected from trees and other areas where the gypsy moth would likely be found. Or, such person may live in a house where the same articles (bicycles or grills) are kept outside on a tree shaded patio or in a wooden shed where they are subjected to gypsy moth infestation. Further, the initial determination on whether an article is kept outside the home (and is, therefore, by definition an outdoor household article) must be made by the owner. These are all factors that make regulating outdoor household articles more complicated than other regulatory articles.

In addition to the unique nature of outdoor household articles, the cost of requiring professional inspection, treatment and certification had to be considered. First, it was determined that it would not be cost-effective for USDA to provide such inspections, treatments and certifications as a service to the moving public. This is because the projected expense of hiring additional personnel to conduct the inspections, treatments and certifications as a service to the public was estimated to be greater than the cost of eradicating isolated outbreaks of gypsy moth caused by moving infested outdoor household articles to noninfested areas.

Second, in considering the average cost to the mover of requiring inspection by a professional ($35 per visit), plus additional costs if treatment of the articles was required, it appears to be unnecessary and undesirable to impose this cost on all movers regardless of their situation.

It was considered unnecessary because, in fact, there are instances when movers are capable of inspecting their articles for gypsy moth themselves and determining that such articles are free of life forms of gypsy moth. In some instances restricted pesticides are not required in treating the articles when

life forms are found and, although an undesirable task, the mover is capable of removing the life forms of gypsy moth from the articles.

Recognizing, then, that there are instances when a mover is capable of ensuring that the outdoor household articles are free of life forms of gypsy moth and, therefore, that the paid services of a professional to inspect and treat are not always necessary, consideration was given to whether it was necessary to the successful implementation of the regulation that professional certification [that the articles were free of life forms of gypsy moth] be required in all instances. In this regard, an important consideration to the Department in deciding what regulatory approach to take was a recognition that public acceptance of the regulation was important to its successful implementation. It is believed that greater public cooperation can be obtained through the alternative chosen in the proposed rule [where individuals have the option to self-inspect or to obtain the services of a professional] rather than mandatory inspection, treatment, and importantly, certification by a professional regardless of the circumstances of the individual.

Therefore, for the reasons discussed above, the Department determined that at this time, the better regulatory approach was that described in the proposed rule. However, if it is determined at a later date that this approach is not effective, the Department will reconsider promulgating a regulation that requires professional inspection, treatment and certification in all instances.

Note that the provision allowing self-inspection does *not* relieve the mover of the outdoor household articles of the responsibility for inspection or, if necessary, treatment. Rather, this provision imposes the responsibility on the individual who self-inspects to ensure that all of the outdoor household articles self-inspected are free of all life forms of the gypsy moth when moved interstate. As discussed in the proposed rule (48 FR 28649), civil and criminal penalties may be imposed upon persons who violate the regulations by moving interstate to nonregulated areas outdoor household articles with life forms of gypsy moth without obtaining an OHA document. Further, as discussed in the proposed rule, the Department believes that a comprehensive public education program is very important to the success of these regulations (48 FR 28649) and intends to implement a comprehensive public education program to make the public aware of the purpose and requirements of any regulations adopted by the Department.

There is no guarantee that requiring an OHA document on all outdoor household articles moved from a gypsy moth high-risk area will necessarily ensure a higher degree of regulatory compliance than will be achieved under the provisions of the proposed regulation. In fact, because of the diverse circumstances surrounding movements of outdoor household articles, such a mandate could arguably cause more public resentment and less voluntary cooperation than the provisions of the proposed rule simply because the public would be required to bear the expense of a professional inspection and, possibly, treatment of outdoor household articles which might be perceived by the public as something they could do themselves. It is, of course, in the self-interest of the owner to move only outdoor household articles that are free of life forms of gypsy moth since it, in all probability, will be the owner's new premises that will be infested first if the gypsy moth is moved.

It is unnecessary to spell out in the regulations the Department's commitment to a public education program or to the establishment of highway checkpoints since the purpose of these regulations is advise the public of the requirements imposed on them when they move outdoor household articles from gypsy moth high-risk areas to or through nonregulated areas. However, as mentioned elsewhere, the Department intends to implement a comprehensive public education program and enforce these regulations as funding allows.

Section 301.34–1(u) of the proposed regulations defined "qualified certified applicator" as a person who is certified as a "commercial applicator" under Federal Insecticide, Fungicide and Rodenticide Act (FIFRA) (86 Stat. 983; 7 U.S.C. 136b) and who has attended and completed a workshop segment on the identification and treatment of gypsy moth and outdoor household articles.

Comments were submitted recommending that the definition of "qualified certified applicator" be limited to commercial applicators certified in the Forest and Ornamental Pest Management category or, in the alternative, to those categories of certified applicators that are allowed to use the restricted pesticides recommended for use by the Department in treatment of gypsy moth. A clarification in the definition of "qualified certified applicator" (Section 301.45–1(u)) is made in the final rule based on these comments.

In developing the proposed rule, the Department considered limiting the class of persons eligible to become approved certified applicators to persons certified under FIFRA in the Forest and Ornamental Pest Management category (or the equivalent category in each state). In discussions with representatives from various states that have designated high-risk gypsy moth areas, however, the Department found that there was a demand in some states to allow persons in other categories beside the Forest and Ornamental Pest Management category to be eligible for approval so that the public would have access to a large pool of available approved certified applicators. The Department agreed with this point of view, and the definition in the proposed rule of "qualified certified applicator" allowed anyone who was a certified commercial applicator under FIFRA (regardless of the category) to be eligible for approval as a qualified certified applicator.

However, the Department's primary concern in approving persons as eligible to issue OHA documents has always been to approve only those persons who were certified under FIFRA to use the restricted pesticides specifically recommended by USDA in the treatment of outdoor household articles for gypsy moth. Further, it appears that each certification category under FIFRA approves the use of only certain restricted pesticides. Thus, the pesticides approved for use in one category may not be the pesticides approved for use in another category. Therefore, the Department's stated objective can be achieved only by allowing those persons certified in specific categories that allow the use of the Department's recommended pesticides to be eligible for approval as a qualified certified applicator. Moreover, since certification as a commercial applicator is done in most States by the State and not by the Federal Government, and since the categories of commercial certification can vary from State to State, specific categories under FIFRA cannot be named.

Therefore, § 301.45–1(u) of the regulations is being revised in the final rule to clarify the Department's purpose that individuals must be certified under FIFRA in a category that allows them to use the specific restricted pesticides recommended by USDA for treatment of outdoor household articles. This is being done by adding the phrase "in a category allowing use of the restricted pesticides recommended for use in the treatment of outdoor household articles

for gypsy moth as provided for in Attachment A of the Appendix to Subpart—Portion of Gypsy Moth and Browntail Moth Program Manual" following the term certified commercial applicator in the definition of Qualified Certified Applicator.

The requirement that such persons attend and complete a workshop on gypsy moth and outdoor household articles is retained since the Department wants to be assured that such certified commercial applicators can recognize and can treat the particular problems of the gypsy moth and outdoor household articles—especially if someone is certified in a category that doesn't usually require treatment for problems relating to gypsy moth.

Several comments were submitted expressing concerns and requesting clarification of the potential liability of commerical shippers who move outdoor household articles interstate without OHA documents from gypsy moth high-risk areas. Specifically, questions were raised about possible delays en route (and attendant economic costs) if outdoor household articles were moved interstate to or through a nonregulated area without an OHA document. A comment also recommended amending the regulations so as to distinguish between commercial shippers who are "movers" and owners of outdoor household articles who are "movers", such that the responsibility of inspection, treatment and certification would lie solely on the owner of the outdoor household articles. For reasons discussed below, no changes to the proposed rule are made based on these comments.

As discussed above and in the proposed rule (48 FR 28647), there is a serious problem of spreading gypsy moth to nonregulated areas through the movement of outdoor household articles. As such, the Department believes from a regulatory point of view that it has correctly placed the responsibility to prevent the movement of gypsy moth to nonregulated areas on *all* parties who move such articles out of gypsy moth high-risk areas. Since it is projected that at least 60% of all regulated household moves will be made through commercial movers, the Department wanted to make sure that commercial movers did not unintentionally aid in the movement of gypsy moth infested outdoor household articles. Moreover, the language in section 8 of the Federal Plant Quarantine Act (7 U.S.C. 161) prohibits any common carrier from receiving for transportation or transporting any article that is capable of carrying any dangerous plant disease.

The Department believes that the policy objective underlying the language of the proposed rule can be achieved without placing an undue burden on commercial movers. Specifically, although a commercial mover may, if desired, self-inspect the outdoor household articles for gypsy moth or may make available the services of an approved certified applicator to ensure that an OHA document is obtained, the Department anticipates that it will normally be the owner who will obtain the inspection and treatment (whether self-inspected or through the services of a professional). This is because it is usually the owner who is in the best position to determine what articles are outdoor household articles and whether professional inspection and certification is desired. The commercial shipper, on the other hand, can refuse to accept outdoor household articles for interstate movement unless the owner presents the shipper with an OHA document or otherwise verifies that the outdoor household articles have been inspected and are free of life forms of gypsy moth. This will protect the commercial shipper from having to physically unload en route so the outdoor household articles can be inspected since the Department has no intention of inspecting, seizing or quarantining outdoor household articles carried by commercial movers unless there is probable cause to believe that such articles are moving out of gypsy moth high-risk areas, have not been inspected and treated and, therefore, may be carrying life forms of the gypsy moth. Therefore, as stated above, if an owner refuses to supply a commercial shipper with an OHA document or to verify that the articles have been self-inspected and are free of life forms of gypsy moth, then a commercial shipper has the option of inspecting the articles himself, of obtaining an OHA document, or of refusing to accept outdoor household articles for shipment.

The Department intends to work closely with the moving industry in advising them, as well as other members of the moving public, of the geographic areas that are designated as gypsy moth high-risk, of the requirements for moving outdoor household articles interstate to nonregulated areas, and where to go to obtain an OHA document if professional certification is desired. This is also information that the moving industry can, if it chooses, distribute along with other information routinely distributed to their customers before the driver arrives to pick up the household goods.

Proposed § 301.45–14(a)(3) requires that approved commercial applicators attend and complete a retraining workshop segment on outdoor household articles and gypsy moth when recertified under FIFRA. A comment was received recommending that this retraining requirement for approved commercial applicators in proposed § 301.45–14(a)(3) be deleted from the recertification process under FIFRA. There was concern that if these requirements were tied into the recertification program under FIFRA it would be an additional burden to an already complicated and time-consuming process. Further, this recertification process under FIFRA varies from State to State. The Department agrees with this recommendation. The Department has also reevaluated the need for such retraining and concluded that it is not necessary to require retraining of such persons whenever a person is recertified under FIFRA. This is because it appears that information on new pesticides will be presented to the commercial certified applicator in any recertification process required by FIFRA and it appears that information on identifying and treating outdoor household articles for gypsy moth needs only to be presented once. Therefore, proposed § 301.45–14(a) is being revised in the final rule by deleting paragraph (3). However, if the Department finds, at a later date that, for operational reasons, some kind of a workshop is needed when persons become reapproved as qualified certified applicators, these regulations will be amended accordingly.

Further, subparagraph (b) in proposed § 301.45–12 requires copies of OHA documents issued by qualified certified applicators to be sent to the plant regulatory officials for the State or Jurisdiction in which the document was issued and to the State or Jurisdiction of destination. The Department has reconsidered the necessity of requiring that copies of such documents be sent to such officials. It has been determined that it does not appear to be necessary to take this action in order to prevent the spread of gypsy moth or for monitoring the issuance of OHA documents by qualified certified applicators. Therefore, this provision is being deleted in the final rule. However, if it is determined at a later date that such action is necessary, the Department will consider amending these regulations to include such a provision.

Lastly, two comments stated that the Department had unintentionally, substantially under-estimated the annual cost of this action upon small business entities. The Department disagrees with these comments. The

Department's estimated cost of this action on small entities is primarily based upon figures and information supplied by the industry. The Department has not received any additional information to establish that those figures and information are not accurate. Furthermore, the additional costs the comments referred to appear to be based on delays for inspection caused by noncompliance with the regulations. It is true that the Department's estimated cost does not include costs incurred by delays due to noncompliance with the regulations. In this regard, the Department believes that the regulations do not place an undue burden on the industry and that the Regulatory Flexibility Act does not require consideration of costs incurred due to noncompliance.

List of Subjects in 7 CFR Part 301

Agricultural commodities, Plant diseases, Plant pests, Plants (agriculture), Quarantine, Transportation, Gypsy moth.

Accordingly, the gypsy moth and browntail moth quarantine and regulations (7 CFR 301.45 *et. seq.*) are amended as follows:

PART 301—DOMESTIC QUARANTINE NOTICE

§ 301.45 [Amended]

1. In § 301.45(b), the words "and outdoor household articles" are inserted after the words "regulated articles" in the title and language of such section.

§ 301.45–1 [Amended]

2. In § 301.45–1, paragraphs (g) through (s) are redesignated as paragraphs (h) through (t), and a new paragraph (g) is added which reads as follows:

* * * * *

(g) *OHA document.* A document issued for the interstate movement of outdoor household articles by a qualified certified applicator which contains the following information:

(1) Name and address of mover of outdoor household article covered by the OHA document;

(2) Address where outdoor household article was inspected and/or treated;

(3) Destination address of outdoor household article,

(4) Identity of each outdoor household article covered by the OHA document;

(5) Date of inspection, and if applicable, date and type of treatment applied to outdoor household article and date OHA document expires;

(6) Statement by the qualified certified applicator who issued the OHA document that (i) he/she has inspected, or that the inspection was performed under his/her direct supervision, and any outdoor household article listed thereon was found to be free of any life stage of the gypsy moth, or (ii) that any such outdoor household article was treated by or under the direct supervision of the qualified certified applicator to destroy any life stage of gypsy moth, in accordance with the methods and procedures prescribed in the section III.C.5 of the Appendix to Subpart ("Treatment of Outdoor Household Articles"); and

(7) Name, address, signature and company name, if applicable, of the certified applicator issuing the OHA document.

* * * * *

3. In § 301.45–1(v)(1)(iii) and 301.45–1(l)(v), the phrase "(unless moved as an outdoor household article)" is added following the words "firewood" and "Recreational vehicles and associated equipment", respectively.

4. In § 301.45–1(v)(3) the phrase "(e.g., outdoor household articles)" is deleted.

5. In § 301.45–1 paragraphs (t) through (z) are redesignated as paragraphs (v) through (aa), and a new paragraph (u) is added to read as follows:

* * * * *

(u) *Qualified certified applicator.* Any individual who is (1) certified pursuant to the Federal Insecticide, Fungicide, and Rodenticide Act (FIFRA) (86 Stat. 983; 7 U.S.C. 136b) as a certified commercial applicator in a category allowing use of the restricted pesticides recommended for use in the treatment of outdoor household articles for gypsy moth in section III.C.5 of the Appendix to Subpart—"Portion of Gypsy Moth and Browntail Moth Program Manual"; and (2) who has attended and completed a workshop segment approved by the Deputy Administrator on the identification and treatment of gypsy moth life stages on outdoor household articles.[1]

6. In § 301.45–1 a new paragraph (bb) is be added to read as follows:

* * * * *

(bb) *Under the direct supervision of a qualified certified applicator.* An inspection or treatment shall be considered to be applied under the direct supervision of a qualified certified applicator if the inspection or treatment is performed by a competent person acting under the instructions and control of a qualified certified applicator who is available if and when needed, even though such qualified certified applicator is not physically present at the time and place the inspection or treatment occurred.

§ 301.45–8 [Amended]

7. In § 301.45–8 the words ", outdoor household articles" is added in the title and in the language of such section following the words "regulated articles."

Subpart—Gypsy Moth and Browntail Moth [Amended]

8. Footnotes one (1) through six (6) and references thereto are redesignated as two (2) through seven (7) respectively and a new footnote one (1) is added to read as follows:

* * * * *

[1] Names of qualified certified applicators and plant regulatory officials for the States and Territories of the United States are available upon request from the Technology Analysis and Development Staff, Animal and Plant Health Inspection Service, U.S. Department of Agriculture, Room 600 Federal Building, Hyattsville, MD 20782.

9. A new § 301.45–11 is added to read as follows:

§ 301.45–11 Conditions governing the interstate movement of outdoor household articles from quarantined States.[6]

(a) No outdoor household article shall be moved interstate from a gypsy moth high-risk area into or through any nonregulated area unless:

(1) Such outdoor household article is free from all life stages of the gypsy moth at the time ot the interstate movement; or

(2) such outdoor household article is accompanied by an OHA document issued by a qualified certified applicator in accordance with the provisions of § 301.45–12 and 301.45–13 within five calendar days of the interstate movement from a gypsy moth high-risk area; or

(3) Such outdoor household articles are brought in by vacationers to the gypsy moth high-risk areas.

10. A new §301.45–12 is added to read as follows:

§301.45–12 Issuance of OHA document.

(a) An OHA document may be issued by a qualified certified applicator for the interstate movement of any outdoor household article if such qualified certified applicator determines the following:

(1) That the outdoor household article has been inspected by or under the direct supervision of the qualified certified applicator and found to be free of any life stage of the gypsy moth; or

(2) that the outdoor household article has been treated by or under the direct supervision of the qualified certified applicator to destroy any life stage of the gypsy moth in accordance with methods and procedures prescribed in

section III.C.5 of the Appendix to Subpart ("Treatment of Outdoor Household Articles").

11. A new § 301.45–13 is added to read as follows:

§ 301.45–13 Attachment of OHA document.

(a) An OHA document used in the interstate movement of any outdoor household article shall, at all times during such movement, accompany the vehicle carrying such outdoor household article.

(b) The OHA document covering the movement of outdoor household articles shall be furnished by the carrier to the consignee at the destination of the shipment.

12. A new §301.45–14 is added which reads as follows:

§ 301.45–14 Disqualification of qualified certified applicator to issue OHA documents.

(a) Any qualified certified applicator may be disqualified from issuing OHA documents by the Deputy Administrator if he determines that one of the following has occurred:

(1) Such person is not certified by a State and/or Federal Government as a commercial certified applicator under FIFRA in a category allowing use of the restricted pesticides recommended for use in treating outdoor household articles for gypsy moth as provided in section III.C.5 of the Appendix to the Subpart—Portion of "Gypsy Moth and Browntail Moth Program Manual"; or

(2) Noncompliance with any of the provisions of this subpart

(b) The disqualification is effective upon oral or written notification, whichever is earlier. The reasons for the disqualification shall be confirmed in writing as promptly as circumstances permit, unless contained in the written notification. Any qualified certified applicator who is disqualified from issuing OHA documents may appeal the decision in writing to the Administrator within ten (10) days after receiving written notification of the disqualification. The appeal shall state all of the facts and reasons upon which the person relies to show that the disqualification was a wrongful action. The Administrator shall grant or deny the appeal, in writing, stating the reasons for his decision as promptly as circumstances permit. If there is a conflict as to any material fact, a hearing shall be held to resolve such conflict. Rules of practice concerning such a hearing will be adopted by the Administrator.

Appendix—[Amended]

13. In the authorization section of the Appendix to Subpart—Portion of "Gypsy Moth and Browntail Moth Program Manual" a new sentence would be added after the third sentence and before the fourth sentence to read as follows:

* * * Procedures outlined in section III.C.5 are administratively authorized for the treatment of outdoor household articles by approved certified applicators.* * *

14. A new subpart III.C.5, "Treatment of Outdoor Household Articles" would be added to section III, "Regulatory Procedures", found in the Appendix to Subpart—Portion of "Gypsy Moth and Bowntail Moth Program Manual" to read as described in Attachment A.

(Secs. 8 and 9, 37 Stat. 318; as amended, secs. 105 and 106, 71 Stat. 33; 7 U.S.C. 161, 162, 150dd, 150ee, 37 FR 28464, 28477, as amended; 38 FR 19141)

Done at Washington, D.C. this 26th day of August 1983.

Harvey L. Ford,

Deputy Administrator, Plant Protection and Quarantine, Animal and Plant Health Inspection Service.

Attachment A (III.C.5) Treatment of Outdoor Household Articles

The chemicals authorized for treatment of outdoor household articles, in accordance with the Federal Insecticide, Fungicide, and Rodenticide Act (7 U.S.C. 136 *et seq.*), are regulated by the Environmental Protection Agency for use against gypsy moth and must be applied according to the label directions and the following instructions.

Treatments (A, B, C, D)	Approved for these GM life stages	Limitations	Special instructions
Remove the infestation by hand	Egg mass caterpillar pupa (cocoon) adult.	*None—use this treatment for most situations*—use pesticides only when hand removal is *not* practical.	If there is an opportunity for the pest to reinfest the household goods: 1. Destroy the gypsy moth life stage by crushing or soaking in fuel oil; 2. Store the household goods inside or safeguard them from reinfestation.
Spray N Kill, gypsy moth egg mass killer (EPA Registration No. 6730–30).	Egg mass only (see limitations)	For the best results, apply within 2 weeks of the date you anticipate egg hatch—never apply this more than 30 days before hatch. See label for additional instructions and follow them precisely.	If the water pH is more than 5, add teaspoons of vinegar until the pH reads 5 *then* add Spray N Kill to the water—safeguard items in situations where they may become reinfested before the move.
Ficam W (EPA Registration No. 45639–1).	Egg mass only (see limitations)	Apply within *21* days of anticipated egg hatch—see label for additional instructions and follow them precisely.	Don't *spray* Ficam where electrical short circuits might result—safeguard items in situations where they may become reinfested before the move.
Orthene tree and ornamental spray	Caterpillar only	*Use only on caterpillars* see label for additional instructions and follow them precisely.	Safeguard items in situations where they may become reinfested before the move.

Notice.—Where trade names are used, no discrimination and no endorsement is intended or implied by the USDA, APHIS, PPQ.

[FR Doc. 83-23908 Filed 8-31-83; 8:45 am]

BILLING CODE 3410-34-M

Agricultural Marketing Service

7 CFR Part 908

[Valencia Orange Reg. 315]

Valencia Oranges Grown in Arizona and Designated Part of California; Limitation of Handling

AGENCY: Agricultural Marketing Service, USDA.

ACTION: Final rule.

SUMMARY: This regulation establishes the quantity of fresh California-Arizona Valencia oranges that may be shipped to market during the period September 2–September 8, 1983. Such action is needed to provide for orderly marketing of fresh Valencia oranges for this period due to the marketing situation confronting the orange industry.

EFFECTIVE DATE: September 2, 1983.

FOR FURTHER INFORMATION CONTACT: William J. Doyle, 202–447–5975.

SUPPLEMENTARY INFORMATION:

Findings

This rule has been reviewed under USDA procedures and Executive Order 12291 and has been designated a "non-major" rule. William T. Manley, Deputy Administrator, Agricultural Marketing Service, has certified that this action

will not have a significant economic impact on a substantial number of small entities. This action is designed to promote orderly marketing of the California-Arizona Valencia orange crop for the benefit of producers and will not substantially affect costs for the directly regulated handlers.

This regulation is issued under the marketing agreement, as amended, and Order No. 908, as amended (7 CFR Part 908), regulating the handling of Valencia oranges grown in Arizona and designated part of California. The agreement and order are effective under the Agricultural Markeing Agreement Act of 1937, as amended (7 U.S.C. 601–674). The action is based upon the recommendation and information submitted by the Valencia Orange Administrative Committee and upon other available information. It is hereby found that this action will tend to effectuate the declared policy of the Act.

This action is consistent with the marketing policy for 1982–83. The marketing policy was recommended by the committee following discussion at a public meeting on February 22, 1983. The committee met again publicly on August 30, 1983 at Los Angeles, California, to consider the current and prospective conditions of supply and demand and recommended a quantity of Valencia oranges deemed advisable to be handled during the specified week. The committee reports the demand for Valencia oranges is improving.

It is further found that it is impracticable and contrary to the public interest to give preliminary notice, engage in public rulemaking, and postpone the effective date until 30 days after publication in the **Federal Register** (5 U.S.C. 553), because of insufficient time between the date when information became available upon which this regulation is based and the effective date necessary to effectuate the declared policy of the Act. Interested persons were given an opportunity to submit information and views on the regulation at an open meeting. It is necessary to effectuate the declared policy of the Act to make this regulatory provision effective as specified, and handlers have been apprised of such provisions and the effective time.

List of Subjects in 7 CFR Part 908

Marketing agreements and orders, California, Arizona, Oranges (Valencia).

PART 908—[AMENDED]

1. Section 908.615 is added as follows:

§ 908.615 Valencia orange regulation 315.

The quantities of Valencia oranges grown in California and Arizona which may be handled during the period September 2, 1983 through September 8, 1983, are established as follows:

(a) District 1: 470,000 cartons;

(b) District 2: 530,000 cartons;

(c) District 3: Unlimited cartons.

(Secs. 1–19, 48 Stat. 31, as amended; 7 U.S.C. 601–674)

Dated: August 31, 1983.

Charles R. Brader,

Director, Fruit and Vegetable Division, Agricultural Marketing Service.

[FR Doc. 83-24257 Filed 8-31-83; 11:43 am]

BILLING CODE 3410-02-M

7 CFR Part 1076

Milk in the Eastern South Dakota Marketing Area; Order Suspending Certain Provisions

AGENCY: Agricultural Marketing Service, USDA.

ACTION: Suspension of rule.

SUMMARY: This action suspends for the months of August 1983 through February 1984 the provisions of the Eastern South Dakota milk order that limit the amount of milk not needed for fluid (bottling) use that may be moved directly from farms to nonpool manufacturing plants and still be priced under the order. The suspension was requested by Land O'Lakes, Inc., a cooperative association representing most of the producers supplying the market. The suspension is needed to prevent uneconomic movements of milk.

EFFECTIVE DATE: September 1, 1983.

FOR FURTHER INFORMATION CONTACT: Robert F. Groene, Marketing Specialist, Dairy Division, Agricultural Marketing Service, U.S. Department of Agriculture, Washington, D.C. 20250, (202) 447–2089.

SUPPLEMENTARY INFORMATION: Prior document in this proceeding:

Notice of Proposed Suspension: Issued August 5, 1983; published August 11, 1983 (48 FR 36467).

This action has been reviewed under USDA procedures established to implement Executive Order 12291 and has been classified as a "non-major" action.

It has been determined that the need for suspending certain provisions of the order on an emergency basis precludes following certain review procedures set forth in Executive Order 12291. Such procedures would require that this document be submitted for review to the Office of Management and Budget at least 10 days prior to its publication in the **Federal Register**. However, this would not permit the completion of the required suspension procedures in time to include August 1983 in the requested suspension period. The initial request for the action was received on July 28, 1983. A notice of proposed suspension was issued on August 5, 1983, inviting interested parties to comment on the proposed action by August 17, 1983.

William T. Manley, Deputy Administrator, Agricultural Marketing Service, has certified that this action will not have a significant economic impact on a substantial number of small entities. This action lessens the regulatory impact of the order on certain milk handlers and tends to ensure that dairy farmers will continue to have their milk priced under the order and thereby receive the benefits that accrue from such pricing.

This order of suspension is issued pursuant to the provisions of the Agricultural Marketing Agreement Act of 1937, as amended (7 U.S.C. 601 *et seq.*), and of the order regulating the handling of milk in the Eastern South Dakota marketing area.

Notice of proposed rulemaking was published in the **Federal Register** on August 11, 1983 (48 FR 36467) concerning a proposed suspension of certain provisions of the order. Interested parties were afforded opportunity to file data, views, and arguments thereon. No comments were received in opposition to the proposed suspension.

After consideration of all relevant material, including the proposal in the notice and other available information, it is hereby found and determined that for the months of August 1983 through February 1984 the following provisions do not tend to effectuate the declared policy of the Act:

In § 1076.13, paragraphs (c) (2) and (3).

Statement of Consideration

This action makes inoperative for August 1983 through February 1984 the limit on the amount of producer milk that a cooperative association or other handlers may divert from pool plants to nonpool plants. The order now provides that a cooperative association may divert up to 35 percent of its total member milk received at all pool plants or diverted therefrom during the months of August through February. Similarly, the operator of a pool plant may divert up to 35 percent of its receipts of producer milk (for which the operator of such plant is the handler during the month) during the months of August through February.

The suspension was requested by Land O'Lakes, Inc., a cooperative

association that supplies most of the market's fluid milk needs and handles most of the market's reserve milk supplies. The suspension is necessary because milk supplies in the Eastern South Dakota milkshed in 1983 are approximately 11 percent higher than one year ago. In addition, the market's fluid milk sales in 1983 are unchanged from 1982. Furthermore, a large bottling operation, an outlet for substantial volumes of producer milk in this market, closed in August. Consequently, the cooperative's reserve milk supplies during August 1983 through February 1984 will exceed the quantity of producer milk that may be diverted to nonpool manufacturing plants under the order's present diversion limitations. In the absence of this suspension, some of the milk of the cooperative's member producers who have regularly supplied the fluid market would have to be moved, uneconomically, first to pool plants and then to nonpool manufacturing plants in order to continue producer status for such milk during August 1983 through February 1984.

In view of these circumstances, it is concluded that the aforesaid provisions should be suspended to ensure the orderly marketing of milk supplies. The suspension will provide greater flexibility in the handling of the market's reserve milk supplies and thus prevent uneconomic movements of some milk through pool plants merely for the purpose of qualifying it for producer milk status under the order.

It is hereby found and determined that thirty days' notice of the effective date hereof is impractical, unnecessary and contrary to the public interest in that:

(a) This suspension is necessary to reflect current marketing conditions and to assure the orderly marketing of milk in the affected and adjoining marketing areas;

(b) This suspension does not require of persons affected substantial or extensive preparation prior to the effective date; and

(c) Notice of proposed rulemaking was given interested parties and they were afforded an opportunity to file written data, views or arguments concerning this suspension. No views opposing this suspension were received.

Therefore, good cause exists for making this order effective upon publication in the **Federal Register**.

List of Subjects in 7 CFR Part 1076

Milk marketing orders, Milk, Dairy products.

It is therefore ordered, That the aforesaid provisions in § 1076.13 of the order are hereby suspended for August 1983 through February 1984.

Effective Date: September 1, 1983.

(Secs. 1–19, 48 Stat. 31, as amended; 7 U.S.C. 601–674)

Signed at Washington, D.C. on: August 26, 1983.

C. W. McMillan,

Assistant Secretary, Marketing and Inspection Services.

[FR Doc. 83-23894 filed 8-31-83; 8:45 am]

BILLING CODE 3410-02-M

FEDERAL RESERVE SYSTEM

12 CFR Part 217

[Docket No. R-0480]

Interest on Deposits; Regulation Q; Temporary Suspension of Early Withdrawal Penalty

AGENCY: Federal Reserve System.

ACTION: Temporary suspension of the Regulation Q early withdrawal penalty.

SUMMARY: The Board of Governors, acting through its Secretary, pursuant to delegated authority, has suspended temporarily the Regulation Q penalty for the withdrawal of time deposits prior to maturity from member banks for depositors affected by Hurricane Alicia in the Texas counties of Brazoria, Chambers, Fort Bend, Galveston, Harris, and Matagorda.

EFFECTIVE DATE: August 19, 1983.

FOR FURTHER INFORMATION CONTACT: Daniel L. Rhoads, Attorney (202/452-3711), Legal Division, Board of Governors of the Federal Reserve System, Washington, D.C. 20551.

SUPPLEMENTARY INFORMATION: On August 18, 1983, pursuant to section 301 of the Disaster Relief Act of 1974 (42 U.S.C. 5141) and Executive Order 12148 of July 15, 1979, the President, acting through the Director of the Federal Emergency Management Agency, designated the Texas counties of Brazoria, Chambers, Fort Bend, Galveston, Harris, and Matagorda major disaster areas. The Board regards the President's action as recognition by the Federal government that a disaster of major proportions had occurred. The President's designation enables victims of the disaster to qualify for special emergency financial assistance. The Board believes it appropriate to provide an additional measure of assistance to victims by temporarily suspending the Regulation Q early withdrawal penalty (12 CFR 217.4(d)). The Board's action permits a member bank, wherever located, to pay a time deposit before maturity without imposing this penalty upon a showing that the depositor has suffered property or other financial loss in the disaster areas as a result of Hurricane Alicia beginning on or about August 18, 1983. A member bank should obtain from a depositor seeking to withdraw a time deposit pursuant to this action a signed statement describing fully the disaster-related loss. This statement should be approved and certified by an officer of the bank. This action will be retroactive to August 19, 1983, and will remain in effect until 12 midnight, February 18, 1984.

List of Subjects in 12 CFR Part 217

Advertising, Banks, banking, Federal Reserve System, Foreign banking.

In view of the urgent need to provide immediate assistance to relieve the financial hardship being suffered by persons in the designated counties in Texas directly affected by Hurricane Alicia, good cause exists for dispensing with the notice and public participation provisions in section 553(b) of Title 5 of the United States Code with respect to this action. Because of the need to provide assistance as soon as possible and because the Board's action relieves a restriction, there is good cause to make this action effective immediately.

By order of the Board of Governors, acting through its Secretary, pursuant to delegated authority, August 26, 1983.

William W. Wiles,

Secretary of the Board.

[FR Doc. 83-23875 Filed 8-31-83; 8:45 am]

BILLING CODE 6210-01-M

SECURITIES AND EXCHANGE COMMISSION

17 CFR Parts 240 and 249

[Release No. 34-20121; File No. S7-965]

Exempt Credit; Rescission of Rules Requiring Reporting

AGENCY: Securities and Exchange Commission.

ACTION: Final rulemaking.

SUMMARY: The Commission is rescinding three rules and their related forms under the Securities Exchange Act of 1934 ("Act") which implement the exempt credit provisions of Regulation U under the Act. In addition, the Commission is adopting a single definitional rule, Rule 3b-8 under the Act, which defines certain terms necessary to the proper functioning of the exempt credit provisions administered by the Board of Governors of the Federal Reserve System ("FRB").

EFFECTIVE DATE: September 1, 1983.

FOR FURTHER INFORMATION CONTACT:
William U. Uchimoto, (202) 272–2409, Room 5193, Division of Market Regulation, Securities and Exchange Commission, 450 Fifth Street, NW., Washington, D.C. 20549.

SUPPLEMENTARY INFORMATION:

I. Background

Regulation U under the Act [1] regulates the extension of credit by banks to broker-dealers for the purpose of purchasing or carrying margin stocks. Pursuant to the over-the-counter ("OTC") Market Maker Exemption,[2] Qualified Third Market Exemption [3] and Block Positioner Exemption [4] of Regulation U, banks may extend credit exempt from the requirements of Regulation U to broker-dealers meeting the criteria of those exemptions ("exempt credit"), for the purpose of financing broker-dealer market making or block positioning activities. The exemptions, adopted by the FRB, require those seeking exempt credit to file reports "as required pursuant to a rule of the Commission." Accordingly, by 1972 the Commission had adopted Rules 17a–12,[5] 17a–16[6] and 17a–17,[7] and related Forms X–17A–12 (1) and (2), X–17A–16 (1) and (2), and X–17A–17, to oversee compliance with respect to those receiving exempt credit pursuant to Regulation U.

Specifically, Rule 17a–12 implements the provisions of the OTC Market Maker Exemption of Regulation U. The Rule defines "OTC Market Maker" and requires a broker-dealer applying for OTC Market Maker exempt credit for any "OTC Margin Security" [8] to notify the Commission on Form X–17A–12(1) whenever it commences or ceases making a market in an OTC Margin Security. Moreover, should a broker-dealer receive OTC Market Maker exempt credit, it must report to the Commission the amount of such credit that it has outstanding at the end of the quarter on Form X–17A–12(2).

Rule 17a–16 implements the provisions of the Qualified Third Market Maker Exemption of Regulation U. The Rule defines the term "Qualified Third Market Maker" and requires a broker-dealer applying for Qualified Third Market Maker exempt credit on any security that is listed on a national securities exchange to notify the Commission of Form X–17A–16(1). Moreover, should a broker-dealer receive Qualified Third Market Maker exempt credit, it must report the amount of such credit that it has outstanding at the end of the quarter on Form X–17A–16(2).

Rule 17a–17 implements the provisions of the Block Positioner Exemption of Regulation U. The Rule defines "Block Positioner" and requires those broker-dealers applying for Block Positioner exempt credit to notify the Commission, and requires those receiving such credit to file Form X–17A–17 with the Commission. Form X–17A–17 requires a recipient of Block Positioner exempt credit to report, among other things, the amount of Block Positioner exempt credit that it held at the beginning and at the end of the quarter as well as the total amount of credit that was extended to it during the quarter.

II. Discussion

While the Commission believes that it is important that there be vigorous policing of exempt credit under Regulation U, the current scheme of regulation has proven to be costly and inefficient. In this respect, the Commission notes that the filing requirements of the rules impose a continuing financial cost on broker-dealers because they require frequent filings and some of the forms necessitate relatively lengthy quarterly calculations. The Commission believes that these compliance costs are no longer offset by any substantial regulatory benefits because compliance with the rules is primarily ensured through inspections by the Commission and self-regulatory organizations and is not dependent on routine use of the completed forms.

The Commission, however, was not in a position to rescind these rules and forms as long as Regulation U required broker-dealers applying for exempt credit to comply with Commission filing requirements. In this respect, at the request of the Commission, the FRB proposed amending Regulation U to remove the requirement that broker-dealers receiving exempt credit file reports with the Commission.[9] The FRB, also in response to a request by the Commission, proposed amending Regulation U to refer to a single Commission rule which would function solely to define the terms "Qualified OTC Market Maker," "Qualified Third Market Maker" and "Qualified Block Positioner" for the exempt credit provisions of Regulation U.[10]

To coincide with the FRB's amendments to Regulation U, on March 14, 1983 the Commission solicited comment on the proposed rescission of Rules 17a–12, 17a–16 and 17a–17, and related Forms X–17a–12 (1) and (2), X–17A–16 (1) and (2), and X–17A–17.[11] The Commission also on that date proposed Rule 3b–8 under the Act, which would define the terms "Qualified OTC Market Maker," "Qualified Third Market Maker" and "Qualified Block Positioner" for purposes of Regulation U.[12] The Proposal Release noted that, although the definitions contained in proposed Rule 3b–8 would be substantively identical to the definitions contained in Rules 17a–12, 17a–16 and 17a–17, Rule 3b–8 would contain certain minor language changes to reflect past amendments to Rule 15c3–1 under the Act.[13]

In response to the Commission's solicitation of comments, the Commission received one comment letter from the National Association of Securities Dealers, Inc. ("NASD").[14] In supporting the Commission's proposal, the NASD stated that the "cost of compliance with rules and regulations should be offset by substantial regulatory benefits"; and accordingly the NASD "concurs with the Commission's belief that the current reporting scheme under the existing rules is both costly and inefficient."

On July 22, 1983, the FRB adopted the proposed amendments to Regulation U.[15] Accordingly, the Commission is taking corresponding rulemaking action to rescind Rules 17a–12, 16, and 17, and their related forms, and adopt proposed Rule 3b–8.

III. Regulatory Flexibility Act Considerations

The Commission prepared Initial and Final Regulatory Flexibility analyses in accordance with 5 U.S.C. 603 regarding the rescissions of Rules 17a–12, 17a–16, and 17a–17, and the adoption of Rule

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[1] 12 CFR Part 221.

[2] 12 CFR 221.3(w).

[3] 12 CFR 221.3(y).

[4] 12 CFR 221.3(z).

[5] 17 CFR 240.17a–12. Rule 17a–12 was last amended in Securities Exchange Act Release No. 9762 (September 12, 1972), 37 FR 18717.

[6] 17 CFR 240.17a–16. Securities Exchange Act Release No. 9760 (September 12, 1972), 37 FR 18718.

[7] 17 CFR 240.17a–17. Securities Exchange Act Release No. 9761 (September 12, 1972), 37 FR 18720.

[8] An "OTC Margin Security" is defined in Regulation U as a security which is not listed on a national securities exchange and which is on a list published by the FRB.

[9] *See* proposed FRB rule change, Docket No. R–0458 (February 23, 1983), 48 FR 8470.

[10] *Id.*

[11] The Commission proposed rescinding these rules and forms in Securities Exchange Act Release No. 19595 (March 14, 1983), 48 FR 13194 ("Proposal Release").

[12] The Commission proposed Rule 3b–8 in the release proposing rescission of the rules and forms.

[13] 17 CFR 240.15c3–1.

[14] *See* letter to George Fitzsimmons, Secretary, SEC, from Gordon S. Macklin, President, NASD, dated May 6, 1983.

[15] *See FRB rule change, Docket No. R–0458 (July 22, 1983), 48 FR 35074.*

3b–8. No comments were received on the Commission's Initial Regulatory Flexibility Analysis. The Commission in the Final Regulatory Flexibility Analysis indicates that this Commission rulemaking will have a significant positive impact on a substantial number of small broker-dealers in that the filing burdens related to Rules 17a–12, 16 and 17, and their attendant forms will be eliminated without diminishing any regulatory benefits. A copy of the Analysis can be obtained by contacting William W. Uchimoto (202) 272–2409, Division of Market Regulation, Securities and Exchange Commission, 450 Fifth Street NW., Washington, D.C. 20549.

IV. Effects on Competition

Section 23(a)(2) of the Act [16] requires the Commission, in adopting rules under the Act, to consider the anticompetitive effects of such rules, if any, and to balance any anticompetitive impact against the regulatory benefits gained in terms of furthering the purposes of the Act. The Commission has determined that this rulemaking reduces compliance burdens on the industry, is not anticompetitive, and does not sacrifice any regulatory benefits.

V. List of Subjects

17 CFR Part 240

Brokers, Confidential business information, Fraud, Reporting and recordkeeping requirements, Securities.

17 CFR Part 249

Brokers, Reporting and recordkeeping requirements, Securities.

VI. Text of the Rule Amendments

Accordingly, the Commission hereby amends Chapter II of Title 17 of the Code of Federal Regulations, pursuant to its authority under the Securities Exchange Act of 1934 [(15 U.S.C. 78a *et seq.*, as amended by Pub. L. No. 94–29 (June 4, 1975)], particularly Sections 2, 3, 11, 15, 17 and 23 thereof (15 U.S.C. 78b, 78c, 78k, 78*o*, 78q and 78w), as follows:

PART 240—GENERAL RULES AND REGULATIONS, SECURITIES EXCHANGE ACT OF 1934

§§ 240.17a–12, 240.17a–16 and 240.17a–17 [Removed]

1. By removing §§ 240.17a–12, 240.17a–16 and 240.17a–17.

2. By adding § 240.3b–8 to read as follows:

§ 240.3b–8 Definitions of "Qualified OTC Market Maker," "Qualified Third Market Maker" and "Qualified Block Positioner."

For the purposes of Regulation U under the Act (12 CFR 221):

(a) The term "Qualified OTC Market Maker" in an over-the-counter ("OTC") margin security means a dealer in any "OTC Margin Security" [as that term is defined in Section 2(j) of Regulation U (12 CFR 221.2(j)] who (1) is a broker or dealer registered pursuant to Section 15 of the Act, (2) is subject to and is in compliance with Rule 15c3–1 (17 CFR 240.15c3–1), (3) has and maintains minimum net capital, as defined in Rule 15c3–1, of the lesser of (i) $250,000 or (ii) $25,000 plus $5,000 for each security in excess of five with regard to which the broker or dealer is, or is seeking to become a Qualified OTC Market Maker, and (4) except when such activity is unlawful, meets all of the following conditions with respect to such security: (i) He regularly publishes bona fide, competitive bid and offer quotations in a recognized inter-dealer quotation system, (ii) he furnishes bona fide, competitive bid and offer quotations to other brokers and dealers on request, (iii) he is ready, willing and able to effect transactions in reasonable amounts, and at his quoted prices, with other brokers and dealers, and (iv) he has a reasonable average rate of inventory turnover in such security.

(b) The term "Qualified Third Market Maker" means a dealer in any stock registered on a national securities exchange ("exchange") who (1) is a broker or dealer registered pursuant to Section 15 of the Act, (2) is subject to and is in compliance with Rule 15c3–1 (17 CFR 240.15c3–1), (3) has and maintains minimum net capital, as defined in Rule 15c3–1, of the lesser of (i) $500,000 or (ii) $100,000 plus $20,000 for each security in excess of five with regard to which the broker or dealer is, or is seeking to become, a Qualified Third Market Maker, and (4) except when such activity is unlawful, meets all of the following conditions with respect to such security: (i) He furnishes bona fide, competitive bid and offer quotations at all times to other brokers and dealers on request, (ii) he is ready, willing and able to effect transactions for his own account in reasonable amounts, and at his quoted prices with other brokers and dealers, and (iii) he has a reasonable average rate of inventory turnover in such security.

(c) The term "Qualified Block Positioner" means a dealer who (1) is a broker or dealer registered pursuant to Section 15 of the Act, (2) is subject to and in compliance with Rule 15c3–1 (17 CFR 240.15c3–1), (30 has and maintains minimum net capital, as defined in Rule 15c3–1 of $1,000,000 and (4) except when such activity is unlawful, meets all of the following conditions: (i) He engages in the activity of purchasing long or selling short, from time to time, from or to a customer (other than a partner or a joint venture or other entity in which a partner, the dealer, or a person associated with such dealer, as defined in Section 3(a) (18) of the Act, participates) a block of stock with a current market value of $200,000 or more in a single transaction, or in several transactions at approximately the same time, from a single source to facilitate a sale or purchase by such customer, (ii) he has determined in the exercise of reasonable diligence that the block could not be sold to or purchased from others on equivalent or better terms, and (iii) he sells the shares comprising the block as rapidly as possible commensurate with the circumstances.

PART 249—FORMS, SECURITIES EXCHANGE ACT OF 1934

§§ 249.619, 249.620, 249.631, 249.632, and 249.633 [Removed]

3. By removing §§ 249.619, 249.620, 249.631, 249.632 and 249.633.

VII. Effective Date of the Amendments

Pursuant to Administrative Procedure Act, [17] the Commission finds good cause to waive the 30 day period between publication of the amendments and the effective date. In this respect, immediate effectiveness of the amendments (i) ensures that the recent amendments to Regulation U refer to an effective Commission rule and (ii) enables broker-dealer firms immediately to discontinue filing these forms, thereby reducing reporting burdens.

By the Commission.

Dated: August 26, 1983.

George A. Fitzsimmons,

Secretary.

[FR Doc. 83-23964 Filed 8-31-83; 8:45 am]

BILLING CODE 8010-01-M

[16] 15 U.S.C. 78 (a)(2).

[17] 5 U.S.C. 553(d)(3).

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

21 CFR Part 524

Ophthalmic and Topical Dosage Form New Animal Drugs Not Subject to Certification; N-(Mercaptomethyl) Phthalimide S-(O, O-Dimethyl Phosphorodithioate) Emulsifiable Liquid

AGENCY: Food and Drug Administration.

ACTION: Final rule.

SUMMARY: The Food and Drug Administration (FDA) is amending the animal drug regulations to reflect approval of several supplements to a new animal drug application (NADA) filed by Zoecon Industries, Inc., providing labeling revisions for use in beef cattle of an emulsifiable liquid containing the pesticide *N*-(mercaptomethyl) phthalimide *S-(3O, O*-dimethyl phosphorodithioate). This amendment adds a new claim for controlling the Lone Star Tick (*Amblyomma americanum*), adds dipping as an alternative means of administration for hornfly control, adds new dilution rates, and modifies dip maintenance directions.

EFFECTIVE DATE: September 1, 1983.

FOR FURTHER INFORMATION CONTACT: Adriano R. Gabuten, Bureau of Veterinary Medicine (HFV-135), Food and Drug Administration, 5600 Fishers Lane, Rockville, MD 20857; 301-443-4913.

SUPPLEMENTARY INFORMATION: Zoecon Industries, Inc., 12200 Denton Dr., Dallas TX 75234, is sponsor of NADA 98-895 which provides for use of an emulsifiable liquid containing 11.6 percent *N*-(mercaptomethyl) phthalimide *S-(O, O*-dimethyl phosphorodithioate). The product is administered topically as a dip, pour-on, or spray to control grubs, lice, hornflies, cattle ticks, Southern cattle ticks, and scabies mites on beef cattle. Zoecon filed several supplements to the NADA to revise the labeling to provide for the following changes in conditions of use: Addition of a dip method as an alternative to the spray procedure for hornfly control; addition of a claim for control of an additional tick species, Lone Star Tick; addition of a lower drug concentration of several approved dip, pour-on, and spray solutions; and modification of directions for maintenance of the dip.

The supplements to this NADA are approved and the regulations are amended to reflect the approval. The basis for approval is discussed in the freedom of information summary referred to below.

In accordance with the freedom of information provisions of Part 20 (21 CFR Part 20) and § 514.11(e)(2)(ii) (21 CFR 514.11(e)(2)(ii)), a summary of safety and effectiveness data and information submitted to support approval of this application may be seen in the Dockets Management Branch (HFA-305), Food and Drug Administration, Rm. 4-62, 5600 Fishers Lane, Rockville, MD 20857, from 9 a.m. to 4 p.m., Monday through Friday.

The Bureau of Veterinary Medicine has determined pursuant to 21 CFR 25.24(d)(1)(i) (proposed December 11, 1979; 44 FR 71742) that this action is of a type that does not individually or cumulatively have a significant impact on the human environment. Therefore, neither an environmental assessment nor an environmental impact statement is required.

List of Subjects in 21 CFR Part 524

Animal drugs, Topical.

Therefore, under the Federal Food, Drug, and Cosmetic Act (sec. 512(i), 82 Stat. 347 (21 U.S.C. 360b(i))) and under authority delegated to the Commissioner of Food and Drugs (21 CFR 5.10) and redelegated to the Bureau of Veterinary Medicine (21 CFR 5.83), § 524.1742 is amended by revising paragraph (c) (1), (2), and (3) to read as follows:

PART 524—OPHTHALMIC AND TOPICAL DOSAGE FORM NEW ANIMAL DRUGS NOT SUBJECT TO CERTIFICATION

§ 524.1742 N-(Mercaptomethyl) phthalimide S-(O, O-dimethyl phosphorodithioate) emulsifiable liquid.

* * * * *

(c) *Conditions of use*—(1) *Methods of application.* Methods of application to control the following conditions on beef cattle:

To control/method of use	Dilution rate (gal. drug: gal. of water)
Grubs:	
Dip	1:60
Pour-on	1:2
Spray	1:49
Lice:	
Dip	1:60
Pour-on	1:2 or 1:5
Spray	1:49 or 1:100
Hornflies:	
Dip	1:60
Spray	1:49 or 1:100
Cattle Ticks:	
Dip	1:60 or 1:240
Spray	1:49
Southern cattle ticks:	
Dip	1:60 or 1:240
Spray	1:49
Scabies mites:	
Dip	1:60
Lone Star Ticks:	
Dip	1:60
Spray	1:49 or 1:100

(i) *Dip vat procedure.* (*a*) Prior to charging vat, empty old contents and thoroughly clean the vat. Dip vats should be calibrated to maintain an accurate dilution. Add water, then drug to the vat according to the dilution rate indicated in the table. Add super phosphate at a rate of 100 pounds per 1,000 gallons of vat solution. Super phosphate is added to control the pH of the solution and ensure vat stability. Super phosphate is usually available at most fertilizer dealers as 0-45-0 or 0-46-0. Stir the dip thoroughly, preferably with a compressed air device; however, any form of thorough mixing is adequate. Re-stir vat contents prior to each use. During the dipping operation, each time the dip's volume is reduced by ⅛ to ¼ of its initial volume, replenish with water and add the drug at a rate of 1 gallon for each 50 or 200 gallons water added—depending on dilution rate 1:60 or 1:240. Also add super phosphate as necessary to maintain pH between 4.5 and 6.5. Stir well and resume dipping. Repeat replenishment process as necessary. For evaportion, add additional water accordingly. For added water due to rainfall, merely replenish dip with the product according to directions. If overflow occurs, either analyze for drug concentration and adjust accordingly or dispose of vat contents and recharge. Check pH after each addition of water or super phosphate to assure proper pH controls.

(*b*) *Dip maintenance.* (*1*) With use of dip vat tester, dipping may continue as long as the drug concentration is maintained between 0.15 and 0.25 percent, and the dip is not too foul for satisfactory use as indicated by foul odor or excessive darkening (i.e., color changes from beige to very dark brown).

(*2*) Without use of dip vat tester, vat should be emptied, cleaned, and recharged each time one of the following occurs: When the dip has been charged for 120 days; when the dip becomes too foul for satisfactory use, within the 120-day limit; if the number of animals dipped equals twice the number of gallons of the initial dip volume, within the 120-day limit.

(ii) *Spray method.* To prepare the spray, mix drug with water according to table and stir thoroughly. Apply the fresh mixture as a high-pressure spray, taking care to wet the skin, not just the hair. Apply to the point of "runoff," about 1 gallon of diluted spray per adult animal. Lesser amounts will permit runoff for younger animals.

(iii) *Pour-on method.* Dilute the drug with water according to table by slowly adding water to the product while stirring. Apply 1 ounce of the diluted

mixture per 100 pounds of body weight (to a maximum of 8 ounces per head) down the center line of the back.

(2) *Timing of applications for cattle grub control.* For optimum cattle grub control, it is important to treat as soon as possible after the heel fly season, before the grub larvae reach the gullet or spinal canal, as the rapid kill of large numbers of larvae in these tissues may cause toxic side effects, such as bloat, salivation, staggering, and paralysis.

(3) *Treatment regimens.* (i) Control of scabies mites requires two treatments, 10 to 14 days apart.

(ii) Control of Lone Star Ticks and hornflies requires two treatments, 7 days apart.

* * * * *

Effective date: September 1, 1983.

(Sec. 512(i), 82 Stat. 347 (21 U.S.C. 360b(i)))

Dated: August 26, 1983.

Richard A. Carnevale,

Deputy Associate Director, Bureau of Veterinary Medicine.

[FR Doc. 83-23970 Filed 8-31-83; 8:45 am]

BILLING CODE 4160-01-M

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

Office of Assistant Secretary for Housing—Federal Housing Commissioner

24 CFR Parts 203, 213, and 234

[Docket No. R-83-1116]

Mortgage Insurance and Home Improvement Loans; Changes in Interest Rates

AGENCY: Department of Housing and Urban Development.

ACTION: Final rule.

SUMMARY: This change in the regulations decreases the maximum allowable interest rates on insured home mortgage programs. This action by HUD is designed to bring the maximum interest rates into line with other competitive market rates and help assure an adequate supply of and demand for FHA financing.

EFFECTIVE DATE: August 23, 1983.

FOR FURTHER INFORMATION CONTACT: James B. Mitchell, Acting Director, Office of Financial Management, Department of Housing and Urban Development, 451 7th Street, SW., Washington, D.C. 20410 (202-426-4325).

SUPPLEMENTARY INFORMATION: The following miscellaneous amendments have been made to this chapter to increase the maximum interest rate which may be charged on loans insured by this Department. The maximum interest rate on HUD/FHA mortgage insurance programs has been lowered from 13.50 percent to 13.00 percent for level payment insured home mortgage programs (including operative builder home loan programs), and from 13.75 percent to 13.25 percent for graduated payment home loan programs (GPM). The Secretary has determined that such changes are immediately necessary to meet the needs of the market and to prevent speculation in anticipation of a change, in accordance with his authority contained in 12 U.S.C. 1709-1, as amended. The Secretary has, therefore, determined that advance notice and public comment procedures are unnecessary and that good cause exists for making this amendment effective immediately.

This is a procedural and administrative determination as set forth in the statutes and as such does not require a determination of environmental applicability.

List of Subjects in 24 CFR Parts 203, 213, and 234

Mortgage insurance.

Accordingly, Chapter II is amended as follows:

PART 203—MUTUAL MORTGAGE INSURANCE AND INSURED HOME IMPROVEMENT LOANS

Subpart A—Eligibility Requirements

1. In § 203.20, paragraph (a) is revised to read as follows:

§ 203.20 Maximum interest rate.

(a) The mortgage shall bear interest at the rate agreed upon by the mortgagee and the mortgagor, which rate shall not exceed 13.00 percent per annum, except that where an application for commitment was received by the Secretary before August 23, 1983, the mortgage may bear interest at the maximum rate in effect at the time of application.

* * * * *

2. In § 203.45, paragraph (b) is revised to read as follows:

§ 203.45 Eligibility of graduated payment mortgages.

(b) The mortgage shall bear interest at the rate agreed upon by the mortgagee and the mortgagor, which rate shall not exceed 13.25 percent per annum, except that where an application for commitment was received by the Secretary before August 23, 1983, the mortgage may bear interest at the maximum rate in effect at the time of application.

* * * * *

3. In § 203.46, paragraph (c) is revised to read as follows:

§ 203.46 Eligibility of modified graduated payment mortgages.

* * * * *

(c) The mortgage shall bear interest at the rate agreed upon by the mortgagee and the mortgagor, which rate shall not exceed 13.25 percent per annum, except that where an application for commitment was received by the Secretary before August 23, 1983, the mortgage may bear interest at the maximum rate in effect at the time of application.

* * * * *

PART 213—COOPERATIVE HOUSING MORTGAGE INSURANCE

Subpart C—Eligibility Requirements—Individual Properties Released From Project Mortgage

4. In § 213.511, paragraph (a) is revised to read as follows:

§ 213.511 Maximum interest rate.

(a) The mortgage shall bear interest at the rate agreed upon by the mortgagee and the mortgagor, which rate shall not exceed 13.50 percent per annum, except that where an application for commitment was received by the Secretary before August 23, 1983, the mortgage may bear interest at the maximum rate in effect at the time of application.

* * * * *

PART 234—CONDOMINIUM OWNERSHIP MORTGAGE INSURANCE

Subpart A—Eligibility Requirements—Individually Owned Units

5. In § 234.29, paragraph (a) is revised to read as follows:

§ 234.29 Maximum interest rate.

(a) The mortgage shall bear interest at the rate agreed upon by the mortgagee and the mortgagor, which rate shall not exceed 13.00 percent per annum, except that where an application for commitment was received by the Secretary before August 23, 1983, the mortgage may bear interest at the maximum rate in effect at the time of application.

* * * * *

6. In § 234.75, paragraph (b) is revised to read as follows:

§ 234.75 Eligibility of graduated payment mortgages.

* * * * *

(b) The mortgage shall bear interest at the rate agreed upon by the mortgagee

and the mortgagor, which rate shall not exceed 13.25 percent per annum, except that where an application for commitment was received by the Secretary before August 23, 1983, the mortgage may bear interest at the maximum rate in effect at the time of application.

* * * * *

7. In § 234.76, paragraph (c) is revised to read as follows:

§ 234.76 Eligibility of modified graduated payment mortgages.

* * * * *

(c) The mortgage shall bear interest at the rate agreed upon by the mortgagee and the mortgagor, which rate shall not exceed 13.25 percent per annum, except that where an application for commitment was received by the Secretary before August 23, 1983, the mortgage may bear interest at the maximum rate in effect at the time of application.

* * * * *

(Sec. 3(a), 82 Stat. 113; 12 U.S.C. 1709–1; Section 7 of the Department of Housing and Urban Development Act, 42 U.S.C. 3535(d))

Dated: August 22, 1983.

Philip Abrams,

Assistant Secretary for Housing—Federal Housing Commissioner.

[FR Doc. 83-23914 Filed 8-31-83; 8:45 am]

BILLING CODE 4210-27-M

DEPARTMENT OF TRANSPORTATION

Coast Guard

33 CFR Part 100

[CGD 5-T83-07]

Special Local Regulations; Regatta; Elizabeth River Power Boat Race

AGENCY: Coast Guard, DOT.

ACTION: Final rule.

SUMMARY: Special local regulations are adopted for the Elizabeth River Power Boat Race. This event will be held on the Elizabeth River, between the Norfolk and Portsmouth downtown areas. It will consist of 35 outboard powered boats 13 feet to 19 feet in length racing a triangular course at the junction of the Eastern and Southern branches of the Elizabeth River. The regulations are needed to provide for the safety of life on navigable waters during the event.

EFFECTIVE DATE: These regulations become effective at 1:00 pm, September 3, 1983 and terminate at 5:00 pm, September 3, 1983.

FOR FURTHER INFORMATION CONTACT: Lieutenant Commander Duane I. Preston, Chief, Boating Affairs Branch, Fifth Coast Guard District, 431 Crawford Street, Portsmouth, Virginia 23705 (804–398–6204).

SUPPLEMENTARY INFORMATION: A notice of proposed rule making has not been published for these regulations and they are being made effective in less than 30 days from the date of publication. Following normal rule making procedures would have been impracticable. The application to hold the event was not received until August 4, 1983, and there was not sufficient time remaining to publish proposed rules in advance of the event or to provide for a delayed effective date.

Drafting Information: The drafters of this regulation are LCDR Duane I. Preston, project officer, Chief, Boating Affairs Branch, Fifth Coast Guard District, and LT Walter J. Brudzinski, project attorney, Fifth Coast Guard District Legal Office.

Discussion of Regulations: The following organizations are jointly sponsoring the Elizabeth River Power Boat Race:

1. Norfolk FESTEVENTS, INC.
2. City of Portsmouth.
3. Portsmouth Power Boat Association.

The event will consist of six (06) classes of boats running two (02) heats per class. Closure of the waterway for any extended period is not anticipated and thus commercial traffic should not be severely disrupted at any given time.

List of Subjects in 33 CFR Part 100

Marine safety, Navigation (water).

PART 100—[AMENDED]

Regulations: In consideration of the foregoing, Part 100 of Title 33, Code of Federal Regulations, is amended by adding a temporary § 100.35–502 to read as follows:

§ 100.35–502. Elizabeth River, Norfolk, Virginia.

(a) *Regulated Area.* The waters of the Elizabeth River and its branches from shore to shore, bounded by the Midtown tunnel on the north, the Downtown tunnel on the south, and the Berkley Bridge on the east.

(b) *Special Local Regulations.* Except for participants in the Elizabeth River Power Boat Race, or persons or vessels authorized by the Coast Guard Patrol Officer, no person or vessel may enter or remain in the above area. The operator of any vessel in the immediate vicinity of this area shall:

(1) Stop his vessel immediately upon being directed to do so by any Coast Guard officer or petty officer on board a vessel displaying a Coast Guard ensign, and

(2) Proceed as directed by any Coast Guard officer or petty officer.

(c) Any spectator vessel may anchor outside of the area specified in paragraph (a) of these regulations.

(d) The Coast Guard Patrol Officer is a commissioned officer of the Coast Guard who has been designated by the Commander, Fifth Coast Guard District. The Patrol Commander will be stationed at the West side of Otter Berth, Town Point Park.

(e) The Coast Guard Patrol Officer has been authorized to stop the race to allow the transit of backed up marine traffic through the regulated area.

(f) These regulations and other applicable laws and regulations will be enforced by Coast Guard officers and petty officers on board Coast Guard and private vessels displaying the Coast Guard ensign.

(46 U.S.C. 454; 49 U.S.C. 1655(b); 49 CFR 1.46(b); and 33 CFR 100.35)

Dated: August 19, 1983.

John D. Costello,

Rear Admiral, Coast Guard Commander, Fifth Coast Guard District.

[FR Doc. 83-24036 Filed 8-31-83; 8:45 am]

BILLING CODE 4910-14-M

33 CFR Part 165

[COTP Baltimore, MD Reg. 83-11]

Safety Zone Regulations; Fort McHenry, Baltimore, Md.

AGENCY: Coast Guard, DOT.

ACTION: Emergency rule.

SUMMARY: The Coast Guard is establishing a safety zone at Fort McHenry, Baltimore, Maryland. The zone is needed to protect both spectators and participant craft from a safety hazard associated with a mock bombardment of the Fort by a U.S. Navy Destroyer and a fireworks display being held in conjunction with the 169th Annual Celebration of the Anniversary of the Battle of Baltimore (Defenders Day). Entry into this zone is prohibited unless authorized by the Captain of the Port.

EFFECTIVE DATE: This regulation becomes effective on September 11, 1983 at 8:00 pm. It terminates on September 11, 1983 at 8:45 p.m. unless sooner terminated by the Captain of the Port.

FOR FURTHER INFORMATION CONTACT: Lieutenant Commander Larry H. Gibson, USCG Marine Safety Office, Custom House, Baltimore, Maryland 21202 (301) 962–5105.

SUPPLEMENTARY INFORMATION: A notice of proposed rulemaking was not published for this regulation and it is being made effective in less than 30 days from the date of publication. Publishing a NPRM and delaying the effective date of this safety zone would be contrary to the public interest since action is needed to safeguard watercraft and their occupants on the scheduled display date. It has been determined that this regulation is not a major rule in accordance with Executive Order 12291.

Drafting Information: The drafter of this regulation is Lieutenant John J. O'Brien, Jr., project officer for the Captain of the Port.

Discussion of Regulation: The event requiring this regulation will occur on September 11, 1983. This safety zone is necessary due to the hazards involved with the location of the display launch site and the flammable nature of the fireworks. This action will help prevent possible damage to watercraft and their occupants in the event of a stray pyrotechnic projectile.

List of Subjects in 33 CFR Part 165

Harbors, Marine safety, Navigation (water), Security measures, Vessels, Waterways.

PART 165—[AMENDED]

Regulation: In consideration of the foregoing, Part 165 of Title 33, Code of Federal Regulations, is amended by adding a new § 165.T511 to read as follows:

§ 165.T511 Safety Zone: Fort McHenry, Baltimore, Maryland.

(a) *Location.* The following area is a safety zone: A 300 yard radius seaward between the Fort McHenry channel range Front Light, approximate position 39°15'.8" N., 076°34'7" W. then following the shoreline in a southwesterly direction to the sourthern most tip of Ft. McHenry, approximate position 39°15'65" N., 076°35'.85" W.

(b) *Regulations.* (1) In accordance with the general regulations in § 165.23 of this part, entry into this zone is prohibited unless authorized by the Captain of the Port.

(33 U.S.C. 1225 and 1231; 49 CFR 1.46; 33 CFR 165.3)

Dated: August 19, 1983.

J. C. Carlton,

Captain, Coast Guard, Captain of the Port, Baltimore, MD.

[FR Doc. 83-24040 Filed 8-31-83; 8:45 am]

BILLING CODE 4910-14-M

33 CFR Part 165

[COTP Baltimore, MD Reg. 83-12]

Safety Zone Regulations; U.S. Naval Academy, Severn River, MD

AGENCY: Coast Guard, DOT.

ACTION: Emergency rule.

SUMMARY: The Coast Guard is establishing a safety zone on the Severn River at Annapolis, Maryland, in the vicinity of the U.S. Naval Academy.

The zone is needed to protect watercraft from a possible safey hazard associated with the September 3rd fireworks display. Entry into this zone is prohibited unless authorized by the Captain of the Port.

EFFECTIVE DATE: This regulation becomes effective at 7:30 pm e.d.t., September 3, 1983. It terminates at 9:00 pm e.d.t., September 3, 1983.

FOR FURTHER INFORMATION CONTACT: Lieutenant Commander L. H. Gibson, USCG Marine Safety Office, Customhouse, Baltimore, MD, 21202, (301) 962-5105.

SUPPLEMENTARY INFORMATION: A notice of proposed rulemaking was not published for this regulation and it is being made effective in less than 30 days after Federal Register publication. Publishing a NPRM and delaying its effective date would be contrary to the public interest since immediate action is needed to safeguard watercraft and their occupants on the scheduled display date.

Drafting information: The drafter of this regulation is LCDR John F. Whiteley, project officer for the Captain of the Port, Baltimore, MD.

Discussion of regulation: The event requiring this regulation will occur on September 3, 1983. This safety zone is necessary due to the hazards involved with the location of the display launch site and the flammable nature of the fireworks. This action will prevent possible damage to watercraft and their occupants in the event of a stray pyrotechnic projectile.

List of Subjects in 33 CFR Part 165

Harbors, Marine safety, Navigation (water), Security measures, Vessels, Waterways.

PART 165—[AMENDED]

Regulation

In consideration of the foregoing, Part 165 of Title 33, Code of Federal Regulations, is amended by adding a new § 165.T0512 to read as follows:

§ 165.T0512 Safety Zone: Annapolis, Severn River, Maryland.

(a) Location. The following area is a safety zone: A 300 foot radius centered on a barge or barges located 150 yards northeast of Farragut Field, U.S. Naval Academy, on the Severn River, Approximate Position 38 59'10"N 76 28'30"W.

(b) Regulations:

(1) In accordance with the general regulations in Section 165.23 of this part, entry into this zone is prohibited unless authorized by the Captain of the Port.

(33 U.S.C. 1225 and 1231; 49 CFR 1.46; 33 CFR 165.3)

Dated: August 24, 1983.

J. C. Carlton,

Captain, Coast Guard, Captain of the Port, Baltimore, Maryland.

[FR Doc. 83-24004 Filed 8-31-83; 8:45 am]

BILLING CODE 4910-14-M

POSTAL SERVICE

39 CFR Part 10

International Express Mail Service to Luxembourg, Macao and Sweden

AGENCY: Postal Service.

ACTION: Final action on International Express Mail Service to Luxembourg, Macao and Sweden.

SUMMARY: Pursuant to agreement with the postal administrations of Luxembourg, Macao and Sweden, the Postal Service intends to begin International Express Mail Service with Luxembourg, Macao and Sweden at postage rates indicated in the tables below. Service is scheduled to begin on October 1, 1983.

EFFECTIVE DATE: October 1, 1983.

FOR FURTHER INFORMATION CONTACT: Leon W. Perlinn [202] 245-4414.

SUPPLEMENTARY INFORMATION: By a notice published in the **Federal Register** on July 22, 1983 [48 FR 33495], the Postal Service announced that it was proposing to begin International Express Mail Service to Luxembourg, Macao and Sweden on October 1, 1983. Comments were invited on published rate tables, which were proposed amendments to the International Mail Manual [incorporated by reference in the **Federal Register**, 39 CFR 10.1], and which are to become effective on the date service begins. No comments were received.

Accordingly, the Postal Service is confirming that it intends to begin International Express Mail Service with Luxembourg, Macao and Sweden on

October 1, 1983 at the rates indicated in the table below.

List of Subjects in 39 CFR Part 10

Foreign relations.

Luxembourg International Express Mail

Custom designed service [1] [2], up to and including—		On demand service [2], up to and including—	
Pounds	Rate	Pounds	Rate
1	$27.00	1	$19.00
2	29.90	2	21.90
3	32.80	3	24.80
4	35.70	4	27.70
5	38.60	5	30.60
6	41.50	6	33.50
7	44.40	7	36.40
8	47.30	8	39.30
9	50.20	9	42.20
10	53.10	10	45.10
11	56.00	11	48.00
12	58.90	12	50.90
13	61.80	13	53.80
14	64.70	14	56.70
15	67.60	15	59.60
16	70.50	16	62.50
17	73.40	17	65.40
18	76.30	18	68.30
19	79.20	19	71.20
20	82.10	20	74.10
21	85.00	21	77.00
22	87.90	22	79.90
23	90.80	23	82.80
24	93.70	24	85.70
25	96.60	25	88.60
26	99.50	26	91.50
27	102.40	27	94.40
28	105.30	28	97.30
29	108.20	29	100.20
30	111.10	30	103.10
31	114.00	31	106.00
32	116.90	32	108.90
33	119.80	33	111.80
34	122.70	34	114.70
35	125.60	35	117.60
36	128.50	36	120.50
37	131.40	37	123.40
38	134.30	38	126.30
39	137.20	39	129.20
40	140.10	40	132.10
41	143.00	41	135.00
42	145.90	42	137.90
43	148.80	43	140.80
44	151.70	44	143.70

[1] Rates in this table are applicable to each piece of International Custom Designed Express Mail shipped under a Service Agreement providing for tender by the customer at a designated Post Office.

[2] Pickup is available under a Service Agreement for an added charge of $5.60 for each pickup stop, regardless of the number of pieces picked up. Domestic and International Express Mail picked up together under the same Service Agreement incurs only one pickup charge.

MACAO INTERNATIONAL EXPRESS MAIL

Custom designed service [1] [2], up to and including—		On demand service [2], up to and including—	
Pounds	Rate	Pounds	Rate
1	$28.00	1	$20.00
2	31.70	2	23.70
3	35.40	3	27.40
4	39.10	4	31.10
5	42.80	5	34.80
6	46.50	6	38.50
7	50.20	7	42.20
8	53.90	8	45.90
9	57.60	9	49.60
10	61.30	10	53.30
11	65.00	11	57.00
12	68.70	12	60.70
13	72.40	13	64.40
14	76.10	14	68.10
15	79.80	15	71.80
16	83.50	16	75.50
17	87.20	17	79.20
18	90.90	18	82.90
19	94.60	19	86.60
20	98.30	20	90.30

MACAO INTERNATIONAL EXPRESS MAIL—Continued

Custom designed service [1] [2], up to and including—		On demand service [2], up to and including—	
Pounds	Rate	Pounds	Rate
21	102.00	21	94.00
22	105.70	22	97.70
23	109.40	23	101.40
24	113.10	24	105.10
25	116.80	25	108.80
26	120.50	26	112.50
27	124.20	27	116.20
28	127.90	28	119.90
29	131.60	29	123.60
30	135.30	30	127.30
31	139.00	31	131.00
32	142.70	32	134.70
33	146.40	33	138.40
34	150.10	34	142.10
35	153.80	35	145.80
36	157.50	36	149.50
37	161.20	37	153.20
38	164.90	38	156.90
39	168.60	39	160.60
40	172.30	40	164.30
41	176.00	41	168.00
42	179.70	42	171.70
43	183.40	43	175.40
44	187.10	44	179.10

[1] Rates in this table are applicable to each piece of International Custom Designed Express Mail shipped under a Service Agreement providing for tender by the customer at a designated Post Office.

[2] Pickup is available under a Service Agreement for an added charge of $5.60 for each pickup stop, regardless of the number of pieces picked up. Domestic and International Express Mail picked up together under the same Service Agreement incurs only one pickup charge.

SWEDEN INTERNATIONAL EXPRESS MAIL

Custom designed service [1] [2], up to and including—		On demand service [2], up to and including—	
Pounds	Rate	Pounds	Rate
1	$28.00	1	$20.00
2	31.70	2	23.70
3	35.40	3	27.40
4	39.10	4	31.10
5	42.80	5	34.80
6	46.50	6	38.50
7	50.20	7	42.20
8	53.90	8	45.90
9	57.60	9	49.60
10	61.30	10	53.30
11	65.00	11	57.00
12	68.70	12	60.70
13	72.40	13	64.40
14	76.10	14	68.10
15	79.80	15	71.80
16	83.50	16	75.50
17	87.20	17	79.20
18	90.90	18	82.90
19	94.60	19	86.60
20	98.30	20	90.30
21	102.00	21	94.00
22	105.70	22	97.70
23	109.40	23	101.40
24	113.10	24	105.10
25	116.80	25	108.80
26	120.50	26	112.50
27	124.20	27	116.20
28	127.90	28	119.90
29	131.60	29	123.60
30	135.30	30	127.30
31	139.00	31	131.00
32	142.70	32	134.70
33	146.40	33	138.40
34	150.10	34	142.10
35	153.80	35	145.80
36	157.50	36	149.50
37	161.20	37	153.20
38	164.90	38	156.90
39	168.60	39	160.60
40	172.30	40	164.30
41	176.00	41	168.00
42	179.70	42	171.70
43	183.40	43	175.40
44	187.10	44	179.10

[1] Rates in this table are applicable to each piece of International Custom Designed Express Mail shipped under a Service Agreement providing for tender by the customer at a designated Post Office.

[2] Pickup is available under a Service Agreement for an added charge of $5.60 for each pickup stop, regardless of the number of pieces picked up. Domestic and International Express Mail picked up together under the same Service Agreement incurs only one pickup charge.

A transmittal letter making these changes in the pages of the International Mail Manual will be published in the **Federal Register** as provided in 39 CFR 10.3 and will be transmitted to subscribers automatically.

(39 U.S.C. 401, 404, 407)

Fred Eggleston,

Assistant General Counsel, Legislative Division.

[FR Doc. 83-24018 Filed 8-31-83; 8:45 am]

BILLING CODE 7710-12-M

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Parts 122, 123, 124, 144, 145, 233, 270, and 271

[OW-FRL-2372-8]

Permit Regulations; Revision in Accordance with Settlement

AGENCY: Environmental Protection Agency (EPA).

ACTION: Final rulemaking.

SUMMARY: EPA is today promulgating revisions to regulations governing the following EPA permit programs: the National Pollutant Discharge Elimination System (NPDES) under the Clean Water Act (CWA), Underground Injection Control (UIC) under the Safe Drinking Water Act (SDWA), the State "dredge or fill" (404) program under Section 404 of the CWA, and the Hazardous Waste Management (HWM) permit program under the Resource Conservation and Recovery Act (RCRA). The rules promulgated today cover a number of issues affecting these permit programs and are the result of a settlement agreement between EPA and industry petitioners.

On November 16, 1981, EPA entered into a settlement agreement with numerous industry petitioners in the consolidated pemit regulations litigation (*NRDC* v. *EPA* and consolidated cases, No. 80-1607 [D.C. Cir., filed June 2, 1980]). On June 14, 1982, EPA published proposed rules which implemented the settlement agreement concerning the "common issues" affecting the NPDES, UIC, 404, and RCRA permit programs as well as several proposed rules affecting the NPDES permit program only (47 FR 25546). The final rules promulgated today address the concerns of the commenters to the proposed rules.

DATE: These regulations shall become effective September 1, 1983. For purposes of judicial review under the Clean Water Act, these regulations will be considered issued at 1:00 p.m. eastern time on September 15, 1983; see 45 FR 26894, April 22, 1980. In order to assist EPA to correct typographical errors, incorrect cross-references, and similar technical errors, comments of a technical and nonsubstantive nature on the final regulations may be submitted on or before November 1, 1983. The effective date of these regulations will not be delayed by consideration of such comments.

ADDRESS: Comments of a technical and nonsubstantive nature should be addressed to: Cathy O'Connell, Permits Division (EN-336), Office of Water Enforcement and Permits, U.S. Environmental Protection Agency, Washington, D. C. 20460.

FOR FURTHER INFORMATION CONTACT: Cathy O'Connell, Permits Division (EN-336), Office of Water Enforcement and Permits, U.S. Environmental Protection Agency, Washington, D. C. 20460. (202) 426-2970.

SUPPLEMENTARY INFORMATION:

I. Introduction

On June 7, 1979, EPA published final regulations establishing program requirements and procedures for the NPDES permit program. Shortly thereafter, on June 14, 1979, a number of petitioners representing major industrial trade associations, several of their member companies, and the Natural Resources Defense Council (NRDC) filed petitions for review of the regulations. Also on June 14, 1979, EPA published proposed regulations consolidating the requirements and procedures for five EPA permit programs, including the NPDES program under the Clean Water Act (CWA), the UIC program under the Safe Drinking Water Act (SDWA), State "dredge or fill" programs under Section 404 of the CWA, the Hazardous Waste Management program under the Resource Conservation and Recovery Act (RCRA), and the Prevention of Significant Deterioration (PSD) program under the Clean Air Act (CAA). Final Consolidated Permit Regulations were published on May 19, 1980. Again, these regulations were challenged in court. Petitions for review were filed in several Courts of Appeal and subsequently consolidated in the District of Columbia Circuit (*NRDC* v. *EPA*, and consolidated cases [No. 80-1607]). EPA held extensive discussions on all issues raised in the petitions and subsequently signed four separate settlement agreements with industry litigants. One covered only the UIC program, one all issues affecting the RCRA program, one the NPDES program, and the fourth covered issues which were common to at least two of the three programs involved in the litigation and issues which affect the definition of "new discharger" and its relationship to mobile drilling rigs under the NPDES program. Under the terms of the fourth agreement, referred to as the "Common Issues" settlement agreement, EPA published proposed rules on June 14, 1982. The final rules promulgated today reflect the intent of the "Common Issues" settlement agreement and address public comments received concerning the June 14, 1982, proposed revisions.

Several of the comments made on the proposed regulations were received from companies or organizations who were signatories to either the "Common Issues" settlement agreement or one of the settlement agreements specific to an EPA permit program.

Signatories to those settlement agreements generally agreed that to the extent EPA promulgated final regulations and preamble language which were substantially the same as and did not alter the meaning of language agreed to in the settlement agreements, the parties would drop their challenges to the regulations. Nonetheless, EPA did receive comments from signatories to the settlement agreement which requested further changes to the regulations than those agreed upon in the settlement agreements. In responding to the comments made, EPA in no way waives its right to require that signatories to the settlement agreements be held to those agreements, and in fact, expects good faith adherence to their terms.

Following the common preamble are five separate sections of regulatory language: Parts 122 and 123 covering the NPDES program; Parts 144 and 145 covering the UIC program; Part 233 covering the State "dredge or fill" programs under Section 404 of the CWA, Parts 270 and 271 covering the hazardous waste program under RCRA; and, Part 124, which covers the procedures for issuing, denying, modifying, revoking and reissuing, or terminating EPA-issued NPDES, UIC, 404, RCRA, and PSD permits.

The revisions implementing the "Common Issues" settlement agreement are presented in this manner to reflect the deconsolidation of these programs undertaken as part of the regulatory reform efforts of the President's Task Force on Regulatory Relief. In a final rule published in the **Federal Register** on April 1, 1983, 47 FR 14146, EPA "deconsolidated" what was formerly referred to as the Consolidated Permit Regulations. In that rule the Agency reorganized its presentation of several permit program requirements. While the rulemaking made no substantive changes to any of the regulations of the affected programs, it did result in a renumbering of several sections. Section numbers used in today's rulemaking are the new numbers published in that deconsolidation rulemaking. In the preamble each major section heading is followed by the section references for the NPDES, UIC, 404, and RCRA permit programs in that order. A separate section covering only NPDES issues is also included.

II. Common Issues

A. Signatories To Permit Applications and Reports (§ 122.22, § 144.32, § 233.6, § 270.11)

The May 19, 1980 permit regulations required permit applications submitted by corporations to be signed by a "principal executive officer of at least the level of vice president." Further, the regulations required that such officer had to personally examine the application and certify its truth, accuracy, and completeness based on an inquiry of those individuals who gathered the permit information.

1. *Level of Signer*

Today's revision, which is identical to the June 14, 1982 proposal, changes this requirement to allow permit applications to be signed by "a responsible corporate officer." This definition incorporates into the regulation EPA's interpretation of "executive officer of the level of vice president" adopted in a previously published policy statement (45 FR 562149, August 6, 1980). That statement clarified that an officer performing "policy-making functions" similar to those performed by a corporate vice-president could sign permit applications. The revision also allows the manager of one or more manufacturing, production, or operating facilities of a corporation to qualify as "a responsible corporate officer" if the facilities employ more than 250 persons or have gross national sales or expenditures exceeding $25 million, as long as the manager has been delegated the authority to sign permit applications in accordance with corporate procedures.

Several commenters questioned the rationale which EPA used to arrive at the 250 persons or $25 million criteria. These commenters argued that the criteria could be lowered (for example one commenter advocated a 100 persons

or $10 million criteria) without adversely affecting the company's concern and responsibility for compliance with environmental laws. Other commenters advocated language which would allow the corporation's "environmental officer" to sign permit applications without the restrictions on the size of the work force or the monetary transactions of the corporation.

EPA's goal in establishing the "signatory" requirement was to ensure high level corporate knowledge of a corporation's pollution control operations. In revising the signatory requirement in accordance with the language promulgated in today's rule, EPA recognized that some relief could be granted without compromising that goal. The intent of today's change is to provide relief from the economic and administrative burdens of having a corporation's top executive officers personally sign and be familiar with numerous permit applications for all its operations. Such problems are generally experienced by large corporations with facilities and operations spanning wide geographic areas. The cut-off criteria chosen by EPA will ensure that those plant managers who are authorized to sign permit applications have sufficient authority to direct the affairs of their facilities.

EPA does not agree with the comment which suggests that any "environmental manager" of a corporation be allowed to sign permit applications. It is not the intent of EPA's signatory requirement to designate field supervisors or facility operators to sign permit applications simply because they are located at or near the facility. They may have no ability to direct the activities of the corporation so as to ensure that necessary systems are established or actions taken to gather complete and accurate information. Rather, the signatory provision, as explained above, ensures involvement in the permit process by individuals authorized to make management decisions which govern the operation of the regulated facility. An "environmental manager" may not have sufficient responsibility and authority to direct corporate activities which guarantee that all necessary actions are taken to prepare a complete and accurate application. Of course, in cases where an "environmental officer" is an environmental vice president or comparable "responsible corporate officer" within the definition of today's rule, he would be authorized to sign permit applications.

2. *Certification*

The revisions also change the certification language which required the signer of the form to have personally examined and be familiar with all the information submitted with the permit application. Under the new certification language promulgated today, the person signing the form (the signer) must have some form of direction or supervision over the persons gathering the data and preparing the form (the preparers), although the signer need not personally nor directly supervise these activities. The signer need not be in the same corporate line of authority as the preparers, nor do the persons gathering the data and preparing the form need to be company employees (e.g., outside contractors can be used). It is sufficient that the signer has authority to assure that the necessary actions are taken to prepare a complete and accurate application form.

None of the comments received objected to the proposed change in the certification language; thus, it is unchanged from the proposed language. EPA believes this change will assure an adequate level of corporate involvement and responsibility in the permit application process while eliminating the requirement of personal examination by the signer of all information submitted with the permit application.

The immediate implementation of today's certification language in permit application and reporting forms is infeasible. Because many States and EPA regional offices have large supplies of existing forms which contain the old certification language, it is both administratively and economically impractical to immediately convert to forms containing today's certification language. Therefore, permit application and reporting forms which contain the old signatory language will continue to be used until all have been used up or until provision can be made to replace the forms with new ones containing today's signatory language. However, in order to allow permittees to use the new certification language prior to publication of new forms, the signer may cross out the old language and insert today's language. States and regional offices may also wish to prepare an addendum to permit application and reporting forms which contains the new signatory language.

It should be noted that the HWM program has proposed amendments to § 270.11(d) (formerly § 122.6(d)) which contain additional procedures for owners and operators of HWM facilities (see 47 FR 15304, April 8, 1982 and 47 FR 32038, July 23, 1982).

3. *Governmental Agencies*

Under the June 14 proposal, EPA solicited comments on whether the signatory requirement for public agencies should be amended. The U.S. Departments of the Interior and Agriculture objected to the retention of this signatory provision for Federal agencies, arguing that they are situated similarly to large private corporations and should be allowed the same "relief" as private corporations.

EPA believes that Federal officials responsible for agency operations covering widespread geographical or organizational units (similar to the Federal Regional Offices of many agencies) do experience problems similar to those of large private corporations and thus should also be entitled to relief. Where a Federal official has policy or decisionmaking authority for facilities under his widespread jurisdiction comparable to that of a "responsible corporate officer," that official would be authorized to sign permit applications.

Thus, under today's change a principal executive officer authorized to sign permit applications for a Federal agency will include the agency's chief executive officer and any senior executive officer having responsibility for the overall operations of a major geographic unit of the agency.

The intent of this change is to authorize senior agency officials comparable to EPA's own Regional Administrators to sign permit applications. Considering the information submitted by the two Federal agencies which commented on this regulation, EPA recognizes the State Directors of the Bureau of Land Management as the requisite level of authority intended in the federal signatory provision. In the case of the Forest Service, the Regional Forester would be the appropriate level for signatory authority. EPA does not consider the 122 Forest Supervisors of the Forest Service to have the required level of authority intended by today's change.

EPA does not believe that public notice and comment need be extended on the issue of the appropriate signatory level for Federal agencies. Comments were specifically solicited on the issue of providing relief to Federal agencies similar to that provided to private corporations. The comments received convinced EPA that such a change for Federal agencies is warranted.

EPA does not believe that the problem cited by industry petitioners and Federal agencies, namely the inconvenience of having a corporation's vice-president or Federal agency head personally sign and be familiar with each and every permit application covering a

corporation's or agency's numerous, far-flung operations across the country, is analogous to municipal and State operations. In the case of cities, even large cities, there are a limited number of permitted operations for which a "principal executive officer or ranking elected official" would need to be personally responsible. States also would have far fewer permit applications to deal with than a large corporation or Federal agency.

B. Duty To Mitigate (§ 122.41(d), § 233.7(d), § 270.30(d))

The May 19, 1980 permit regulations included a standard permit condition which required permittees to "take all reasonable steps to minimize or correct any adverse impact on the environment resulting from noncompliance" with NPDES, UIC, 404 or RCRA permits. Industry petitioners feared this language could be interpreted to imply that this provision imposed an obligation to assume liability for medical costs for persons harmed by the results of noncompliance. EPA made clear in the preamble to the proposed revisions published on June 14, 1982 that this was not the intent of this provision. In addition, EPA proposed that the regulatory language be amended. In the case of NPDES and State 404 "dredge or fill" permits, the June 14 proposal focused on the permittee's obligations to "minimize or prevent" noncomplying discharges which have "a reasonable likelihood of adversely affecting human health or the environment." Under the proposed revisions, RCRA permittees would be required in the event of noncompliance to "take all reasonable steps to minimize releases to the environment" and to "carry out such measures as are reasonable to prevent significant adverse impacts on human health or the environment." No change to the May 19, 1980, provision was proposed for UIC permittees.

Many commenters expressed dissatisfaction with the revised language as written, citing the difficulty to enforce the provisions because the language is broad. In addition, commenters expressed dissatisfaction because the proposed language does not explicitly note that liability for medical costs for persons harmed as a result of noncompliance is not intended by these provisions.

EPA does not agree that the language of the provisions is so broad as to be unenforceable. The provisions clearly establish the principle that every permittee is responsible for compliance with his permit and is required to take mitigation measures when noncompliance with the permit presents a risk of environmental harm. EPA also disagrees that the issue of liability for medical costs need be explicitly incorporated in the regulatory language covering a permittee's duty to mitigate. The fact that medical liability is not intended by this provision has been noted several times in the rulemaking proposals and EPA believes that this explanation is sufficient.

A few commenters objected to the retention of the requirement "to minimize or correct any adverse impact resulting from noncompliance" for UIC permittees. They argued that the UIC program should be consistent with the duty to mitigate provisions adopted for the NPDES, State 404 "dredge or fill," and RCRA programs.

The June 14, 1982 rulemaking proposal on the "Duty to Mitigate" provision explained that EPA was not proposing to change this provision for purposes of the UIC program and, therefore, was not opening it up to public comment. Industry UIC petitioners withdrew their challenge to § 122.7(d) as part of the UIC settlement agreement. Accordingly, as EPA is adopting the proposed amendments to the NPDES, 404, and HWM programs in final form, the existing text of that section has been redesignated as § 144.51(d), applicable to UIC only.

C. Other Federal Statutes (§ 122.49, § 144.4, § 270.3)

The May 19, 1980 permit regulations listed a number of Federal statutes which may be applicable to the issuance of NPDES, UIC, or RCRA permits. The introductory paragraph to this provision stated that permits would be issued in a manner and contain conditions consistent with the requirements of the applicable Federal laws. In the proposed revision to this provision, EPA rewrote the introductory paragraph to make it clear that the Agency does not intend to condition or deny permits based on those statutes when such action is not appropriate under the statutes. Today's rule promulgates this introductory language unchanged from the proposal.

Those individuals and organizations which submitted comments on the rewritten introductory paragraph either interpreted it to mean that no permits would ever be conditioned or denied under the National Environmental Policy Act (NEPA) or other Federal statutes or that all permits must be conditioned by these Federal statutes. Neither of these results is intended by this provision. The principal purpose of this provision as promulgated today is to notify permit issuers of requirements that already exist and which may be applicable to particular permits. If other Federal statutes require action on the part of EPA in issuing permits, EPA will comply with the requirements of these statutes and will condition or deny permits accordingly.

Of course, in deciding to condition or deny a permit on the basis of an applicable Federal statute, it is not necessary that the Federal Statute explicitly require the condition or denial. For example, NEPA does not mandate that EPA deny an NPDES permit under the CWA in any particular circumstance, nor does it state how a permit must be conditioned. Nonetheless, EPA, in carrying out its responsibilities under NEPA for a comprehensive evaluation of a proposed action, may determine that denial of a permit in a given case is appropriate or that conditioning the permittee's discharge in some way is justified by the findings in an environmental impact statement (EIS). Today's rule does not alter EPA's responsibilities under other Federal statutes.

D. Continuation of Expired Federal Permits in Approved States (§ 270.51)

The May 19, 1980 permit regulations provide that if an EPA-issued permit expires in a State that has been approved as the permit-issuing authority, the permit does not continue in force unless State law explicitly authorizes such a continuation. If no such State provision exists, the facility is considered to be operating without a permit and is subject to enforcement action. Where EPA is the permit issuing agency, the Administrative procedure Act [5 U.S.C. 558(c)] automatically extends the permit until EPA acts on the permit renewal application if the applicant has submitted a timely and complete application prior to the expiration of the permit.

Industry petitioners requested that the regulations be amended to allow an EPA-issued permit, which expires in a State approved to administer the NPDES or RCRA program, to continue in force, irrespective of the provisions of State law, until the State reissues or denies the permit.

In the June 14, 1982 proposal EPA stated that although it cannot provide for the automatic continuation of Federally-issued NPDES permits upon approval of a State program, the Agency would adopt the following policy. If a State NPDES program has been approved, expired Federally issued permits do not remain in effect unless continued under State law. However, if the discharger, owner, or operator has submitted a timely and complete application for a renewal permit to the

State, and the State has not acted, EPA would refrain from initiating an enforcement action based on the applicant's failure to have a permit if the applicant continues to comply with the terms of the expired permit, unless the permitted activity presents an imminent and substantial endangerment to the environment or human health.

EPA recognized that this NPDES policy would not, nor could it, provide certain protection from citizen suits against facilities without required permits. However, in these circumstances, EPA would not expect a court to assess penalties if delays in permit reissuance were not due to failure of the facility owner or operator to submit required information. No adverse comments were received on this policy, thus today's policy is adopted as proposed.

In addition to the above policy, EPA proposed revisions to allow for the continuation of RCRA permits should the need arise. The proposed revision provided for automatic extension of EPA-issued RCRA permits, even after approval of State permit-issuing authority. No objections were raised to this change in the RCRA permit program, thus today's rule is promulgated as proposed.

Several commenters felt that an Agency enforcement policy similar to that provided for NPDES should be extended to the UIC program. The need for this policy has not been demonstrated with respect to the UIC program because no Federal program has been established as yet and, thus, no Federally-issued permits exist. UIC permits generally will be issued for a term of 10 years for Class I and V wells, and for the life of the facility for Class II and III wells. Given the anticipated duration of UIC permits, and the absence of a Federal UIC program, EPA does not feel it is necessary to extend this policy to the UIC program.

E. State Adoption of EPA Civil Penalty Policy (§ 123.27, § 145.13, § 233.28, § 271.16)

The May 19, 1980 permit regulations required that States adopt specific methods for calculating civil penalties. EPA proposed that the regulation delete specification of the methods for calculating penalties and require only that any civil penalty agreed upon by the State Director be "appropriate to the violation." A note explained that, to the extent the penalties assessed by the State are in amounts substantially inadequate in comparison to amounts EPA would have sought under certain facts, EPA may exercise its authority, when authorized by applicable statute, to initiate its own action for assessment of penalties. No objections to this proposal were received, thus today's rule is promulgated as proposed.

Two commenters, both parties to the Common Issues settlement agreement, noted that the proposed change to the note explaining the requirement for State adoption of EPA's Civil Penalty Policy did not contain the entire text of the language agreed to in the settlement agreement. The language referred to by these commenters was part of the existing regulation and explains various enforcement options available to the States. These enforcement remedies are not mandatory but are highly recommended. The omission of this language was unintentional. The note now contains the entire text.

F. Commencement of Operations Pending Hearing on Appeal (§ 124.60, § 124.119)

Section 124.60 governed the circumstances under which a new source, a new discharger, or a recommencing discharger, whose initial permit has been challenged in a formal hearing, may begin operations pending the outcome of the hearing. The proposed revision established more flexible measures by which the Presiding Officer might grant an "early operation order" which, nonetheless, maintains an adequate degree of environmental protection pending "final agency action" on a permit. Under the proposal the Presiding Officer would be authorized, when granting an early operation order, to impose conditions, in lieu of the conditions set by EPA, to maintain an adequate degree of environmental protection. These conditions could be permit conditions under administrative review, or could be more or less stringent requirements. In addition, a new section, applicable only to NPDES permittees, was proposed which would extend the same procedures for "early operation orders" to non-adversary panel hearings for sources covered by an individual permit. Another section, also applicable to NPDES permittees only, was proposed which would establish a special procedure applicable to mobile drilling rigs excluded from the "new discharger" classification.

The modification to these sections apply to RCRA permits in very limited circumstances. These sections apply to a RCRA permit only to the extent it has been consolidated with an NPDES permit in a formal hearing. No early operation or construction orders are allowed for RCRA permits that are not consolidated with a NPDES permit. Formal hearings are only available for the termination of RCRA permits unless the RCRA permit has been consolidated with an NPDES permit.

Some commenters objected to the language stating that the early operation order must be granted if "no party opposes." These commenters argued that the granting of an early operation order should be discretionary, not mandatory, especially in circumstances where the public is not a party to the proceedings and thus cannot object.

EPA believes it is appropriate to require an "early operation order" to be granted if no party objects to the order, particularly since permit appeals may create significant delays in final permit issuance. It should be noted that in any hearing, EPA itself is a party which can oppose the granting of an early operation order. Thus, the lack of a third party to the hearing does not guarantee that such orders will automatically be granted in cases in which only the permittee has challenged the permit.

An early operation order can be granted if the source or facility makes a three-part showing, that it is likely to receive a permit to operate, that the environment will not be irreparably harmed, and that discharge or operation pending final agency action is in the public interest. One commenter urged EPA to clarify the demonstrations necessary for orders authorizing construction of RCRA facilities saying that the demonstrations listed seemed to apply only to the NPDES program. All demonstrations required for an early operation order must be met by both NPDES and RCRA permittees prior to the issuance of such an order, whether the order is authorizing discharge in the case of NPDES or construction or operation in the case of RCRA permits. The words "construct/construction" have been added to § 124.60(a)(2)(i)–(iii) to make clear that such orders may authorize either construction or operation in the case of RCRA permits. In connection with this, EPA has dropped the last sentence of proposed § 124.60(a)(3). That sentence merely explained that where no party has challenged a construction-related permit term or condition of a RCRA permit, the Presiding Officer shall follow the requirements of § 124.60(a)(2) in granting an order authorizing construction. Since the language "construction/construction" has been added to § 124.60(a)(2) the second sentence to § 24.60(a)(3) is redundant and no longer necessary. Of course, no order may authorize construction if a construction-related RCRA permit condition has been challenged.

In the case of non-adversary panel hearings, it was argued that permittees covered by general permits should be allowed the same opportunity to obtain an "early operation order" as those provided for permittees covered by individual permits.

EPA feels that "early operation orders" are not appropriate in the case of general permits. Because general permits can authorize entire classes or categories of discharge, EPA believes that full administrative action, including the issuance of a final permit, should be completed before an early operation order is allowed.

One commenter argued that any contested conditions of a permit undergoing administrative review should be unenforceable. Another commenter objected to the proposal which would allow contested conditions to be unenforceable pending the outcome of the hearing or subsequent appeal; this commenter believed that all conditions of the permit, including contested conditions, should be enforceable while the permit is undergoing review.

EPA has previously explained its position for staying contested permit conditions pending the completion of agency administrative review, 45 FR 33414. In order to grant some relief to dischargers who are without a permit pending final Agency action, "early operation orders" under this section were authorized. Authorizing an early operation is thus a special privilege. Since the Presiding Officer must assure that any order granted provides adequate protection of the environment during the administrative review process, he needs broad discretion to impose appropriate conditions (even more stringent than the proposed permit, if necessary).

III. NPDES Issues

A. Need To Halt or Reduce Activity Not a Defense (§ 122.41(c))

Under the May 19, 1980 permit regulations a permittee's obligation to halt or reduce activity in order to maintain compliance with the conditions of its permit was addressed in two separate provisions. Section 122.7(c) of these regulations explained that it was not a defense to an enforcement action that it was necessary to halt or reduce the permitted activity to maintain compliance. In addition, § 122.60(b) required that upon reduction, loss, or failure of the treatment facility, a permittee, in order to maintain compliance with its permit limitations, must control production on all discharges or both until treatment is restored.

Industry litigants argued that, in some cases, a mandatory obligation to cease or reduce operation or discharges would be unreasonable. For example, the requirement to halt production was particularly troublesome to the electric utilities industry, which is required under some State laws to provide a continuous reliable supply of electric power. EPA agreed that the appropriateness of controlling production or discharge may vary with the situation and thus, is more suitably dealt with as a question of defense to liability in enforcement proceedings.

In order to carry out this intent EPA made changes to both of the provisions cited above. On April 5, 1982, 47 FR 15304, in a technical amendment to the regulations, EPA revised the caption of § 122.7(c) "Duty to Halt or Reduce Activity" to "Need to Halt or Reduce not a Defense," to clarify the intent of that section that a permittee will not be allowed to defend its noncompliance in an enforcement action on the ground that it would have had to halt or reduce its regulated activity.

In addition, the Agency determined that § 122.7(c) adequately addressed its intent with respect to this issue and that § 122.60(b) was therefore redundant and unnecessary. On June 14, 1982, 47 FR 25550, the Agency proposed to delete section 122.60(b) in its entirety.

Following the technical amendment of § 122.7(c) and the proposed deletion of § 122.60(b), the Agency on April 1, 1983 deconsolidated the May 19, 1980 regulations, 47 FR 14146. In deconsolidating the May 19, 1980 regulations the Agency made no substantive changes; it merely reformatted and renumbered the regulations. In this process then existing §§ 122.7(c) and 122.60(b) were combined and renumbered § 122.41(c). The combination of these sections did not affect EPA's June 14, 1982 proposal to delete then § 122.60(b), currently found in the second and third sentences of § 122.41(c) of the April 1, 1983 regulations. Having received no comments adverse to deleting this provision, today's rule makes final the proposed deletion.

One commenter did point out what appeared to be a discrepancy between the preamble of the June 14, 1982 proposed revisions and the proposed amendment to § 122.60(b). The preamble stated that § 122.60(b) was to be deleted in its entirety. Yet the proposed rulemaking included a § 122.60(b) which concerned a permittee's duty to mitigate adverse impacts resulting from permit violations. In the June 14, 1982 rulemaking EPA did in fact propose to delete then § 122.60(b) of the May 19, 1980 regulations. Because deletion of this section left an opening at § 122.60(b), EPA then proposed to move § 122.7(d) the Duty to Mitigate provision of the May 19, 1980 regulations, to this section, renumbering it new § 122.60(b). That section was subsequently redesignated § 122.41(d) by the April 1, 1983 deconsolidation rulemaking. Consistent with the proposed regulation changes, today's final rules delete the second and third sentence of § 122.41(c) of the April 1, 1983 regulations. The first sentence of this section remains in effect. Final rules affecting § 122.41(d) are explained elsewhere in today's rulemaking.

B. New Discharger Issues (§§ 122.2, 122.28)

Determining Date

Today's rules make two changes to the definition of "new discharger." The first would change the determining date for the application of the "new discharger" classification. Under the present definition, a "new discharger" is any source which is not a "new source," and which discharges pollutants on or after October 18, 1972 from a site for which it has never received a finally effective NPDES permit. The determining date of October 18, 1972 was tied to the date of enactment of the Federal Water Pollution Control Act Amendments of 1972 (Pub. L. 92-500).

Industry petitioners argued that with the creation of the "new discharger" category on June 7, 1979, a new classification potentially subject to more stringent requirements was applied to many sources that had been in operation for years, but had not as yet received NPDES permits, though applications had been filed. In order to prevent this result the Agency proposed to revise the definition to change the triggering date to August 13, 1979, the effective date of the first NPDES regulations defining the "new discharger" classification. EPA received no comments opposed to this change; thus today's rule is promulgated as proposed.

Mobile Drilling Rigs

The definition of "new discharger" in then existing § 122.3 (currently § 122.2) specifically included mobile drilling rigs. Thus, each time a mobile drilling rig moved to a new unpermitted site, for which it is required to apply for a new NPDES permit, it was subjected once again to the new discharger requirements. The June 14, 1982 rulemaking proposed two major changes

to the regulations to address this problem. First, the proposed regulatory amendments established a general permitting scheme for oil and gas operations within the Outer Continental Shelf (OCS). The Agency's experience with the issuance of general permits for drilling operations in OCS lease sale areas in the Gulf of Mexico and off the coast of Southern California has been favorable and the use of general permits appears appropriate for other OCS areas. Therefore, section 122.28 (§ 122.59 of the May 19, 1980 regulations) was proposed to be amended to require EPA Regional Administrators to issue general permits for most discharges from oil and gas exploration and production facilities unless the use of a general permit is demonstrated to be clearly inappropriate. Second, because it will take some time before EPA can issue general permits for oil and gas facilities in all OCS lease sale areas, and because NPDES-approved States are not required to issue permits to oil and gas facilities in all OCS lease sale areas, EPA proposed to exclude mobile drilling rigs from the definition of "new discharger." The proposed exclusion covered all mobile exploratory drilling rigs operating in both offshore and coastal areas, and mobile developmental rigs operating in coastal areas. Mobile developmental rigs operating in any offshore area would continue to be included in the "new discharger" category.

Several commenters argued that developmental drilling rigs operating in offshore areas should not be included in the "new discharger" category. EPA has substantial reasons for treating developmental rigs operating offshore differently. Developmental rigs generally remain at a given site for longer periods of time than do exploratory rigs and have more advance notice before moving to new sites. Thus, the burdens of obtaining a new permit prior to moving to a new site are not as great as for exploratory rigs.

More importantly, developmental rigs pose more risk of harm to the marine environment than exploratory rigs. The volume of pollutants discharged by a developmental rig can be far greater than that from exploratory rigs, and movement to a new site could indeed constitute a significant new environmental harm. Although this is true for developmental activities in both coastal and offshore areas, EPA has an added responsibility under guidelines issued pursuant to section 403(c) of the Clean Water Act to consider the impact of discharges from offshore facilities on the marine environment. Section 403(c) is not applicable to discharges into coastal areas. In light of the increased volume of pollutants potentially discharged during developmental operations, EPA must often perform complex analyses pursuant to section 403(c) to develop adequate permit limitations and conditions to prevent unreasonable degradation of the marine environment. Due to this, EPA has decided that it is appropriate to continue to apply the potentially more stringent procedural requirements which acompany the "new discharger" classification to mobile developmental rigs operating in offshore areas. Thus developmental rigs discharging into offshore waters will continue to be included in the "new discharger" definition.

All mobile oil and gas drilling rigs operating in environmentally sensitive areas will continue to be considered "new dischargers" if they otherwise fit the definition. EPA believes that the commencement of operations in these environmentally sensitive areas (i.e., areas of biological concern) should be carefully examined before imposing appropriate permit limitations.

One commenter suggested that instead of EPA independently developing criteria to identify environmentally sensitive areas of concern on the OCS, these criteria should be subject to the ongoing development of a Memorandum of Understanding (MOU) between the Department of the Interior (DOI) and EPA. It is intended that this MOU will provide the mechanism for coordination of NPDES permit issuance and lease sale activities. EPA will most certainly consult with all interested parties, including DOI, in developing appropriate criteria to determine areas of biological concern on the OCS. However, the Agency does not believe it is necessary to include the development of this criteria in ongoing negotiations with DOI on the MOU in order to ensure DOI input in the process.

EPA proposed to revise § 122.28 (previously § 122.59) to require Regional Administrators to issue general permits, where appropriate, for most discharges from oil and gas exploration and production facilities. General permits will be used for oil and gas facilities in existing lease sale areas, as well as future lease sale areas established by the Minerals Management Service (MMS), the office within the DOI responsible for offshore leasing activities. The use of a general permit will eliminate the post-lease delay in permit issuance because sufficient information should be available to determine permit conditions without application information from individual operators. With sufficient information to determine permit conditions, general NPDES permits may be issued for entire tracts or groups of tracts offered in OCS lease sales.

Four commenters objected to the issuance of general permits either prior to or at the time of the lease sale. The objections ranged from opposition because no general uniformity exists in OCS marine life to a concern that public input in the development of permit conditions would be bypassed. All of the commenters opposed to the concept of general permits feared that such permits would be issued without the accumulation of adequate information.

EPA is committed to the issuance of all permits when, and only when, an adequate amount of information has been gathered with which to determine permit conditions. The use of general permits is an administrative mechanism designed to minimize or eliminate administrative delays in those instances where no useful purpose would be served by issuing individual permits. In each and every case, where a permit, whether individual or general, is issued, EPA will ensure that all necessary and proper public participation measures are taken prior to the issuance of a permit.

Several of EPA's own Regional Offices were concerned about the timing for issuance of general permits. The proposed regulations provided that when petitioned to issue a general permit, the Regional Administrator should issue a project decision schedule providing for the issuance of the final general permit no later than the date of final notice of lease sale or six months after the date of the request. EPA's Regional Offices responsible for the issuance of the general permits pointed out that for some areas, sufficient information to determine appropriate permit limitations may not be available even though an EIS has been completed on the lease sale area. For other areas, final notices of lease sale have been issued by the Department of the Interior (DOI) prior to proposal of these regulations. In addition, DOI has approved significant revisions in its OCS oil and gas leasing program since the time of the proposal of changes to the NPDES regulations in June 1983 which could affect EPA actions. The new leasing program now offers lease sales in whole planning areas which may include ten to over 100 million acres. The new program processes a lease sale under an accelerated, streamlined timeframe. Resources may also be a problem where numerous lease

sales are issued by DOI. In all these cases, it may be impossible for EPA to issue general permits within the timeframes proposed in the regulations.

EPA has, through this regulation, recognized the importance of prompt precessing of OCS permitting activities. As pointed out in the preamble to the proposal, the Regional Administrator should strive to meet all deadlines projected in project decision schedules. However, such decision schedules do not impose binding deadlines upon EPA. There may be situations in which factors beyond the control of EPA (e.g., the situations mentioned above by EPA Regional Offices) will delay issuance of final permits beyond the dates projected in the regulation. Because the regulation does not impose binding deadlines and is flexible enough to allow EPA to address such problem situations, EPA has not changed the proposed language in this final rule. Regional Administrators should work to ensure that permitting is tied, to the maximum extent possible, to lease sale actions.

Finally, although EPA's proposal committed the Agency to issue general permits for offshore oil and gas facilities, EPA's Regional Offices have pointed out that individual permits may be a more practicable option for permitting continental offshore stratigraphic test wells (COST wells). Stratigraphic test wells are drilled to collect seismic and scientific information on the underlying geological strata in a lease sale area. Such wells must generally be drilled at least 60 days prior to the lease sale; usually only one well is drilled per lease area. In Alaska, where the drilling seasons are severely restricted by the weather, a COST well is often drilled at least a year in advance of the lease sale. The Environmental Impact Statement developed for the lease sale area is not available that far in advance of the sale. It is generally feasible and often less time-consuming under these circumstances to develop an individual permit that clearly restricts discharges to a single COST well. Since the intent of this regulation is to expedite the issuance of NPDES permits for offshore oil and gas activities, in circumstances where an individual permit can be issued for a COST well more expeditiously than a general permit, a Region may choose this option.

EPA has determined that each of the above discussed comments can adequately be addressed within the context of the proposed regulations and therefore has promulgated final rules which are identical to the proposed rules.

C. Modification of NPDES Permits (§ 122.62)

A new modification provision was proposed to allow NPDES permits which became final after August 19, 1981, to be modified to conform to the final rules adopted under the settlement agreement for, § 122.7(c) and 122.60(b) of the May 19, 1980 regulations (these sections correspond to § 122.41 (c) and (d) of the deconsolidated NPDES regulations). The cut-off date will prevent unnecessary modifications which could place an unreasonable strain on Agency or State resources. No adverse comments were received on this proposal; thus, the regulation is promulgated unchanged from the proposal.

IV. Effective Date

Section 553(d) of the Administrative Procedure Act (APA) requires publication of a substantive rule not less than 30 days before its effective date. In addition, section 3010(b) of RCRA provides that EPA's hazardous waste regulations, and revisions thereto, take effect six months after their promulgation. The purpose of these requirements is to allow permittees sufficient lead time to prepare to comply with new regulatory requirements. For the amendments proposed today, however, EPA believes that an effective date 30 days to six months after promulgation would cause unnecessary disruption in the implementation of the regulations and would be contrary to the public interest. Section 553(d)(1) of the APA provides an exemption from the requirement to delay the effective date of a promulgated regulation for 30 days in instances where the regulation will relieve restrictions on the regulated community. These amendments relieve restrictions on permittees under the NPDES, UIC, 404, and RCRA programs by providing greater flexibility in meeting the requirements of the programs. EPA believes that these are not the type of regulations that Congress had in mind when it provided a delay between the promulgation and the effective date of revisions to regulations. Therefore, EPA is making these rules effective today.

V. Executive Order 12291

Under Executive Order 12291, EPA must judge whether a regulation is major and therefore subject to the requirement of a Regulatory Impact Analysis. These amendments clarify the meaning of several generic permit requirements and generally make the regulations more flexible and less burdensome for affected permittees. They do not satisfy and of the criteria specified in section 1(b) of the Executive Order and, as such, do not constitute major rulemaking. This is not a major regulation. This regulation was submitted to the Office of Management and Budget (OMB) for review.

VI. Regulatory Flexibility Act

Under the Regulatory Flexibility Act, U.S.C. 601 et seq., EPA is required to prepare a Regulatory Flexibility Analysis to assess the impact of rules on small entities. No regulatory flexibility analysis is required, however, where the head of the agency certifies that the rule will not have a significant economic impact on a substantial number of entities. Today's amendments to the regulations clarify the meaning of several generic permit requirements and otherwise make the regulations more flexible and less burdensome for all permittees. Accordingly I hereby certify, pursuant to 5 U.S.C. 605(b) that these amendments will not have a significant impact on a substantial number of small entities.

List of Subjects

40 CFR Part 122

Administrative practice and procedure, Reporting and recordkeeping requirements, Water pollution control, Confidential business information.

40 CFR Part 123

Indians—lands, Reporting and recordkeeping requirements, Water pollution control, Intergovernmental relations, Penalties, Confidential business information.

40 CFR Part 124

Administrative practice and procedure, Air pollution control, Hazardous materials, Waste treatment and disposal, Water pollution control, Water supply, Indians—lands.

40 CFR Part 144

Administrative practice and procedure, Reporting and recordkeeping requirements, Confidential business information, Water supply.

40 CFR Part 145

Indians—lands, Reporting and recordkeeping requirements, Intergovernmental relations, Penalties, Confidential business information, Water supply.

40 CFR Part 233

Administrative practice and procedure, Reporting and recordkeeping requirements, Confidential business information, Water supply, Indians—lands, Intergovernmental relations,

Penalties, Confidential business information.

40 CFR Part 270

Administrative practice and procedure, Reporting and recordkeeping requirements, Hazardous materials, Waste treatments and disposal, Water pollution control, Water supply, Confidential business information.

40 CFR Part 271

Hazardous materials, Reporting and recordkeeping requirements, Waste treatment and disposal, Water pollution control, Water supply, Intergovernmental relations, Penalties, Confidential business information.

Dated: August 22, 1983.

Alvin L. Alm,

Deputy Administrator.

Authorities: Clean Water Act (33 U.S.C. 1251 et seq.), Safe Drinking Water Act (42 U.S.C. 300f et seq.), Clean Air Act (42 U.S.C. 7401 et seq.), Resource Conservation and Recovery Act (42 U.S.C. 6901 et seq.).

40 CFR Parts 122, 123, 124, 144, 145, 233, 270, and 271 are amended as follows:

PART 122—NATIONAL POLLUTANT DISCHARGE ELIMINATION SYSTEM

40 CFR Part 122 is amended as follows:

1. Section 122.2 is amended by revising the definition of "New discharger" as follows:

§ 122.2 Definitions.

* * * * *

"New discharger" means any building, structure, facility, or installation:

(a) From which there is or may be a "discharge of pollutants;"

(b) That did not commence the "discharge of pollutants" at a particular "site" prior to August 13, 1979;

(c) Which is not a "new source;" and

(d) Which has never received a finally effective NDPES permit for discharges at that "site."

This definition includes an "indirect discharger" which commences discharging into "waters of the United States" after August 13, 1979. It also includes any existing mobile point source (other than an offshore or coastal oil and gas exploratory drilling rig or a coastal oil and gas developmental drilling rig) such as a seafood processing rig, seafood processing vessel, or aggregate plant, that begins discharging at a "site" for which it does not have a permit; and any offshore or coastal mobile oil and gas exploratory drilling rig or coastal mobile oil and gas developmental drilling rig that commences the discharge of pollutants after August 13, 1979, at a "site" under EPA's permitting jurisdiction for which it is not covered by an individual or general permit and which is located in an area determined by the Regional Administrator in the issuance of a final permit to be an area or biological concern. In determining whether an area is an area of biological concern, the Regional Administrator shall consider the factors specified in 40 CFR 125.122(a) (1) through (10).

An offshore or coastal mobile exploratory drilling rig or coastal mobile developmental drilling rig will be considered a "new discharger" only for the duration of its discharge in an area of biological concern.

* * * * *

2. Section 122.22 is amended by revising paragraphs (a)(1), (a)(3), and (d), and adding a note following (a)(1) as follows:

§ 122.22 Signatories to permit applications and reports.

(a) * * *

(1) *For a corporation:* by a responsible corporate officer. For the purpose of this section, a responsible corporate officer means: (i) A president, secretary, treasurer, or vice-president of the corporation in charge of a principal business function, or any other person who perfoms similar policy- or decision-making functions for the corporation, or (ii) the manager of one or more manufacturing, production, or operating facilities employing more than 250 persons or having gross annual sales or expenditures exceeding $25 million (in second-quarter 1980 dollars), if authority to sign documents has been assigned or delegated to the manager in accordance with corporate procedures.

Note: EPA does not require specific assignments or delegations of authority to responsible corporate officers identified in § 122.22(a)(1)(i). The Agency will presume that these responsible corporate officers have the requisite authority to sign permit applications unless the corporation has notified the Director to the contrary. Corporate procedures governing authority to sign permit applications may provide for assignment or delegation to applicable corporate positions under § 122.22(a)(1)(ii) rather than to specific individuals.

(2) * * *

(3) *For a municipality, State, Federal, or other public agency:* by either a principal executive officer or ranking elected official. For purposes of this section, a principal executive officer of a Federal agency includes: (i) The chief executive officer of the agency, or (ii) a senior executive officer having responsibility for the overall operations of a principal geographic unit of the agency (e.g., Regional Administrators of EPA).

* * * * *

(d) *Certification.* Any person signing a document under paragraphs (a) or (b) of this section shall make the following certification:

I certify under penalty of law that this document and all attachments were prepared under the direction or supervision in accordance with a system designed to assure that qualified personnel properly gather and evaluate the information submitted. Based on my inquiry of the person or persons who manage the system, or those persons directly responsible for gathering the information, the information submitted is, to the best of my knowledge and belief, true, accurate, and complete. I am aware that there are significant penalties for submitting false information, including the possibility of fine and imprisonment for knowing violations.

3. Section 122.28 is amended by adding a new paragraph (c) as follows:

§ 122.28 General permits (applicable to State NPDES programs, see § 123.25).

* * * * *

(c) *Offshore Oil and Gas Facilities* (Not applicable to State programs.) (1) The Regional Administrator shall, except as provided below, issue general permits covering discharges from offshore oil and gas exploration and production facilities within the Region's jurisdiction. Where the offshore area includes areas, such as areas of biological concern, for which separate permit conditions are required, the Regional Administrator may issue separate general permits, individual permits, or both. The reason for separate general permits or individual permits shall be set forth in the appropriate fact sheets or statements of basis. Any statement of basis or fact sheet for a draft permit shall include the Regional Administrator's tentative determination as to whether the permit applies to "new sources," "new dischargers," or existing sources and the reasons for this determination, and the Regional Administrator's proposals as to areas of biological concern subject either to separate individual or general permits. For Federally leased lands, the general permit area should generally be no less extensive than the lease sale area defined by the Department of the Interior.

(2) Any interested person, including any prospective permittee, may petition the Regional Administrator to issue a general permit. Unless the Regional Administrator determines under paragraph (c)(1) that no general permit is appropriate, he shall promptly provide a project decision schedule covering the issuance of the general permit or permits

for any lease sale area for which the Department of the Interior has published a draft environmental impact statement. The project decision schedule shall meet the requirements of § 124.3(g), and shall include a schedule providing for the issuance of the final general permit or permits not later than the date of the final notice of sale projected by the Department of the Interior or six months after the date of the request, whichever is later. The Regional Administrator may, at his discretion, issue a project decision schedule for offshore oil and gas facilities in the territorial seas.

(3) Nothing in this paragraph (c) shall affect the authority of the Regional Administrator to require an individual permit under § 122.28(b)(2)(i)(A) through (F).

4. Section 122.41 is amended by revising paragraphs (c) and (d) as follows:

§ 122.41 Conditions applicable to all permits (applicable to State programs, see §123.25)

* * * * *

(c) *Need to Halt or Reduce not a Defense.* It shall not be a defense for a permittee in an enforcement action that it would have been necessary to halt or reduce the permitted activity in order to maintain compliance with the conditions of this permit.

(d) *Duty to Mitigate.* The permittee shall take all reasonable steps to minimize or prevent any discharge in violation of this permit which has a reasonable likelihood of adversely affecting human health or the environment.

* * * * *

5. Section 122.49 is amended by revising the introductory paragraph as follows:

§ 122.49 Considerations under Federal law.

The following is a list of Federal laws that may apply to the issuance of permits under these rules. When any of these laws is applicable, its procedures must be followed. When the applicable law requires consideration or adoption of particular permit conditions or requires the denial of a permit, those requirements also must be followed.

* * * * *

6. Section 122.62 is amended by adding a new paragraph (a)(15) as follows:

§122.62 Modification or revocation and reissuance of permits (applicable to State programs, see § 123.25).

(a) * * *

(15) When the permit becomes final and effective on or after August 19, 1981, if the permittee shows good cause for the modification, to conform to changes respecting the following regulations issued under the Settlement Agreement dated November 16, 1981, in connection with *Natural Resources Defense Council* v. *EPA*, No. 80-1607 and consolidated cases: § 122.41(c) and (d).

* * * * *

PART 123—STATE PROGRAM REQUIREMENTS

40 CFR Part 123 is amended as follows:

1. Section 123.27 is amended by revising paragraph (c) and adding a new paragraph to the beginning of the note following paragraph (c) as follows:

§ 123.27 Requirements for Enforcement Authority.

* * * * *

(c) A civil penalty assessed, sought, or agreed upon by the State Director under paragraph (a)(3) of this section shall be appropriate to the violation.

Note.—To the extent that State judgments or settlements provide penalties in amounts which EPA believes to be substantially inadequate in comparison to the amounts which EPA would require under similar facts, EPA, when authorized by the applicable statute, may commence separate actions for penalties.

* * * * *

PART 124—PROCEDURES FOR DECISION-MAKING

40 CFR Part 124 is amended as follows:

1. Amend paragraph (g) of § 124.3 by removing the word "or" before the words "major NPDES new discharger," and by adding the phrase "or a permit to be issued under provisions of § 122.28(c)" after the words "new discharger," and before the words "the Regional Administrator shall * * *".

2. Section 124.60 is amended by revising paragraph (a)(2) and adding new paragraphs (a)(3) and (c)(7) as follows:

§ 124.60 Issuance and effective date and stays of NPDES permits.

* * * * *

(a) * * *

(2) Whenever a source or facility subject to this paragraph or to paragraph (c)(7) of this section has received a final permit under § 124.15 which is the subject of a hearing request under § 124.74 or a formal hearing under § 124.75, the Presiding Officer, on motion by the source or facility, may issue an order authorizing it to begin discharges (or in the case of RCRA permits, construction or operations) if it complies with all uncontested conditions of the final permit and all other appropriate conditions imposed by the Presiding Officer during the period until final agency action. The motion shall be granted if no party opposes it, or if the source or facility demonstrates that:

(i) It is likely to receive a permit to discharge (or in the case of RCRA permits, to operate or construct) at that site;

(ii) The environment will not be irreparably harmed if the source or facility is allowed to begin discharging (or in the case of RCRA, to begin operating or construction) in compliance with the conditions of the Presiding Officer's order pending final agency action; and

(iii) Its discharge (or in the case of RCRA, its operation or construction) pending final agency action is in the public interest.

(3) *For RCRA only,* no order under paragraph (a)(2) may authorize a facility to commence construction if any party has challenged a construction-related permit term or condition.

* * * * *

(c) * * *

(7) If for any offshore or coastal mobile exploratory drilling rig or coastal mobile developmental drilling rig which has never received a finally effective permit to discharge at a "site," but which is not a "new discharger" or a "new source," the Regional Administrator finds that compliance with certain permit conditions may be necessary to avoid irreparable environmental harm during the administrative review, he may specify in the statement of basis or fact sheet that those conditions, even if contested, shall remain enforceable obligations of the discharger during administrative review unless otherwise modified by the Presiding Officer under paragraph (a)(2) of this section.

3. Section 124.119 is amended by adding new paragraphs (c) and (d) as follows:

§ 124.119 Presiding Officer.

* * * * *

(c) Whenever a panel hearing will be held on an individual draft NPDES permit for a source which does not have an existing permit, the Presiding Officer, on motion by the source, may issue an order authorizing it to begin discharging if it complies with all conditions of the draft permit or such other conditions as may be imposed by the Presiding Officer in consultation with the panel. The motion shall be granted if no party opposes it, or if the source demonstrates that:

(1) It is likely to receive a permit to discharge at that site;

(2) The environment will not be irreparably harmed if the source is allowed to begin discharging in compliance with the conditions of the Presiding Officer's order pending final agency action; and

(3) Its discharge pending final agency action is in the public interest.

(d) If for any offshore or coastal mobile exploratory drilling rig or coastal mobile developmental drilling rig which has never received a finally effective permit to discharge at a "site," but which is not a "new discharger" or "new source," the Regional Administrator finds that compliance with certain permit conditions may be necessary to avoid irreparable environmental harm during the nonadversary panel procedures, he may specify in the statement of basis or fact sheet that those conditions, even if contested, shall remain enforceable obligations of the discharger during administrative review unless otherwise modified by the Presiding Officer under paragraph (c) of this section.

PART 144—REQUIREMENTS FOR UNDERGROUND INJECTION CONTROL PROGRAMS UNDER THE SAFE DRINKING WATER ACT

40 CFR Part 144 is amended as follows:

1. Section 144.4 is amended by revising the introductory paragraph as follows:

§ 144.4 Considerations under Federal law.

The following is a list of Federal laws that may apply to the issuance of permits under these rules. When any of these laws is applicable, its procedures must be followed. When the applicable law requires consideration or adoption of particular permit conditions or requires the denial of a permit, those requirements also must be followed.

* * * * *

2. Section 144.32 is amended by revising paragraph (a)(1); adding a new note following paragraph (a)(1); revising paragraph (a)(3); and adding a new paragraph (d) as follows:

§ 144.32 Signatories to permit applications and reports.

(a) * * *

(1) *For a corporation:* by a responsible corporate officer. For the purpose of this section, a responsible corporate officer means: (i) A president, secretary, treasurer, or vice president of the corporation in charge of a principal business function, or any other person who performs similar policy- or decisionmaking functions for the corporation, or (ii) the manager of one or more manufacturing, production, or operating facilities employing more than 250 persons or having gross annual sales or expenditures exceeding $25 million (in second-quarter 1980 dollars), if authority to sign documents has been assigned or delegated to the manager in accordance with corporate procedures.

Note.—EPA does not require specific assignments or delegations of authority to responsible corporate officers identified in § 144.32(a)(1)(i). The Agency will presume that these responsible corporate officers have the requisite authority to sign permit applications unless the corporation has notified the Director to the contrary. Corporate procedures governing authority to sign permit applications may provide for assignment or delegation to applicable corporate positions under § 144.32(a)(1)(ii) rather than to specific individuals.

(2) * * *

(3) *For a municipality, State, Federal, or other public agency:* by either a principal executive officer or ranking elected official. For purposes of this section, a principal executive officer of a Federal agency includes: (i) The chief executive officer of the agency, or (ii) a senior executive officer having responsibility for the overall operations of a principal geographic unit of the agency (e.g., Regional Administrators of EPA).

* * * * *

(d) *Certification.* Any person signing a document under paragraphs (a) or (b) of this section shall make the following certification:

I certify under penalty of law that this document and all attachments were prepared under my direction or supervision in accordance with a system designed to assure that qualified personnel properly gather and evaluate the information submitted. Based on my inquiry of the person or persons who manage the system, or those persons directly responsible for gathering the information, the information submitted is, to the best of my knowledge and belief, true, accurate, and complete. I am aware that there are significant penalties for submitting false information, including the possibility of fine and imprisonment for knowing violations.

PART 145—REQUIREMENTS FOR UNDERGROUND INJECTION CONTROL PROGRAMS UNDER THE SAFE DRINKING WATER ACT

40 CFR Part 145 is amended as follows:

1. Section 145.13 is amended by revising paragraph (c) and adding a new paragraph to the beginning of the note following paragraph (c) as follows:

§ 145.13 Requirements for enforcement authority.

* * * * *

(c) A civil penalty assessed, sought, or agreed upon by the State Director under paragraph (a)(3) of this section shall be appropriate to the violation.

Note.—To the extent that State judgments or settlements provide penalties in amounts which EPA believes to be substantially inadequate in comparison to the amounts which EPA would require under similar facts, EPA, when authorized by the applicable statute, may commence separate actions for penalties.

* * * * *

PART 233—DREDGE OR FILL (404) PROGRAM UNDER SECTION 404 OF THE CLEAN WATER ACT

40 CFR Part 233 is amended as follows:

1. Section 233.6 is amended by revising paragraphs (a)(1), (a)(3), and (d) and adding a new note following (a)(1) as follows:

§ 233.6 Signatories to permit applications and reports.

(a) * * *

(1) *For a corporation:* by a responsible corporate officer. For the purpose of this section, a responsible corporate officer means: (i) A president, secretary, treasurer, or vice president of the corporation in charge of a principal business function, or any other person who performs similar policy—or decisionmaking functions for the corporation, or (ii) the manager of one or more manufacturing, production or operating facilities employing more than 250 persons or having gross annual sales or expenditures exceeding $25 million (in second-quarter 1980 dollars), if authority to sign documents has been assigned or delegated to the manager in accordance with corporate procedures.

Note.—EPA does not require specific assignments or delegations of authority to responsible corporate officers identified in § 233.6(a)(1)(i). The Agency will presume that these responsible corporate officers have the requisite authority to sign permit applications unless the corporation has notified the Director to the contrary. Corporate procedures governing authority to sign permit applications may provide for assignment or delegation to applicable corporate positions under § 233.6(a)(1)(ii) rather than to specific individuals.

(2) * * *

(3) *For a municipality, State, Federal, or other public agency:* by either a principal executive officer or ranking elected official. For purposes of this section, a principal executive officer of a Federal agency includes: (i) The chief executive officer of the agency, or (ii) a senior executive officer having responsibility for the overall operations

of a principal geographic unit of the agency (e.g., Regional Administrators of EPA).

* * * * *

(d) *Certification.* Any person signing a document under paragraphs (a) or (b) of this section shall make the following certification:

I certify under penalty of law that this document and all attachments were prepared under my direction or supervision in accordance with a system designed to assure that qualified personnel properly gather and evaluate the information submitted. Based on my inquiry of the person or persons who manage the system, or those persons directly responsible for gathering the information, the information submitted is, to the best of my knowledge and belief, true, accurate, and complete. I am aware that there are significant penalties for submitting false information, including the possibility of fine and imprisonment for knowing violations.

2. Section 233.7 is amended by revising paragraph (d) as follows:

§ 233.7 Conditions applicable to all permits.

* * * * *

(d) The permittee shall take all reasonable steps to minimize or prevent any discharge in violation of this permit which has a reasonable likelihood of adversely affecting human health or the environment.

3. Section 233.28 is amended by revising paragraph (c) and adding a new paragraph to the beginning of note following paragraph (c) as follows:

§ 233.28 Requirements for enforcement authority.

* * * * *

(c) A civil penalty assessed, sought, or agreed upon by the State Director under paragraph (a)(3) of this section shall be appropriate to the violation.

Note.—To the extent that State judgments or settlements provide penalties in amounts which EPA believes to be substantially inadequate in comparison to the amounts which EPA would require under similar facts, EPA, when authorized by the applicable statute, may commence separate actions for penalties.

* * * * *

PART 270—EPA-ADMINISTERED PERMIT PROGRAMS: THE HAZARDOUS WASTE PERMIT PROGRAM

40 CFR Part 270 is amended as follows:

1. Section 270.3 is amended by revising the introductory paragraph as follows:

§ 270.3 Considerations under Federal law.

The following is a list of Federal laws that may apply to the issuance of permits under these rules. When any of these laws is applicable, its procedures must be followed. When the applicable law requires consideration or adoption of particular permit conditions or requires the denial of a permit, those requirements also must be followed.

* * * * *

2. Section 270.11 is amended by revising paragraph (a)(1), (a)(3), and (d) and adding a new note following (a)(1) as follows:

§ 270.11 Signatories to permit applications and reports.

(a) * * *

(1) *For a corporation:* by a responsible corporate officer. For the purpose of this section, a responsible corporate officer means (i) A president, secretary, treasurer, or vice-president of the corporation in charge of a principal business function, or any other person who performs similar policy- or decisionmaking functions for the corporation, or (ii) the manager of one or more manufacturing, production or operating facilities employing more than 250 persons or having gross annual sales or expenditures exceeding $25 million (in second-quarter 1980 dollars), if authority to sign documents has been assigned or delegated to the manager in accordance with corporate procedures.

Note.—EPA does not require specific assignments or delegations of authority to responsible corporate officers identified in § 270.11(a)(1)(i). The Agency will presume that these responsible corporate officers have the requisite authority to sign permit applications unless the corporation has notified the Director to the contrary. Corporate procedures governing authority to sign permit applications may provide for assignment or delegation to applicable corporate positions under § 270.11(a)(1)(ii) rather than to specific individuals.

(2) * * *

(3) *For a municipality, State, Federal, or other public agency:* by either a principal executive officer or ranking elected official. For purposes of this section, a principal executive officer of a Federal agency includes: (i) The chief executive officer of the agency, or (ii) a senior executive officer having responsibility for the overall operations of a principal geographic unit of the agency (e.g., Regional Administrators of EPA).

* * * * *

(d) *Certification.* Any person signing a document under paragraphs (a) or (b) of this section shall make the following certification:

I certify under penalty of law that this document and all attachments were prepared under my direction or supervision in accordance with a system designed to assure that qualified personnel properly gather and evaluate the information submitted. Based on my inquiry of the person or persons who manage the system, or those persons directly responsible for gathering the information, the information submitted is, to be the best of my knowledge and belief, true, accurate, and complete. I am aware that there are significant penalties for submitting false information, including the possibility of fine and imprisonment for knowing violations.

3. Section 270.30 is amended by revising paragraph (d) as follows:

§ 270.30 Conditions applicable to all permits.

* * * * *

(d) In the event of noncompliance with the permit, the permittee shall take all reasonable steps to minimize releases to the environment, and shall carry out such measures as are reasonable to prevent significant adverse impacts on human health or the environment.

* * * * *

4. Section 270.51 is amended by revising a new paragraph (d) as follows:

§ 270.51 Continuation of expiring permits.

* * * * *

(d) *State Continuation.* In a State with an hazardous waste program authorized under 40 CFR Part 271, if a permittee has submitted a timely and complete application under applicable State law and regulations, the terms and conditions of an EPA-issued RCRA permit continue in force beyond the expiration date of the permit, but only until the effective date of the State's issuance or denial of a State RCRA permit.

PART 271— EPA-ADMINISTERED PERMIT PROGRAMS: THE HAZARDOUS WASTE PERMIT PROGRAM

40 CFR Part 271 is amended as follows:

1. Section 271.16 is amended by revising paragraph (c) and adding a new paragraph to the beginning of the note following paragraph (c) as follows:

§ 271.16 Requirements for enforcement authority.

* * * * *

(c) A civil penalty assessed, sought, or agreed upon by the State Director under paragraph (a)(3) of this section shall be appropriate to the violation.

Note.—To the extent the State judgments or settlements provide penalties in amounts which EPA believes to be substantially inadequate in comparison to the amounts which EPA would require under similar facts, EPA, when authorized by the applicable

statute, may commence separate actions for penalties.

* * * * *

[FR Doc. 83-23750 Filed 8-31-83; 8:45 am]
BILLING CODE 6560-50-M

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40 CFR Part 271

[SW-6-FRL 2427-2]

Hazardous Waste Management Programs, Texas; Interim Authorization Phase II, Component C

AGENCY: Environmental Protection Agency.

ACTION: Approval of State Hazardous Waste Management Program.

SUMMARY: The State of Texas has applied for Interim Authorization, Phase II, Component C, permitting program for land disposal facilities. EPA has reviewed Texas' application for Phase II, Interim Authorization, Component C, and has determined that Texas' hazardous waste program is substantially equivalent to the Federal program covered in Component C. The State of Texas is hereby granted Interim Authorization for Phase II, Component C, to operate the State's hazardous waste program covered by Component C in lieu of the Federal program in the State of Texas.

EFFECTIVE DATE: Interim Authorization for Phase II, Component C, for Texas shall become effective September 1, 1983.

FOR FURTHER INFORMATION CONTACT: H. J. Parr, Hazardous Materials Branch, Air and Waste Management Division, Environmental Protection Agency, 1201 Elm St., Dallas, Texas 75270, Telephone (214) 767-2645.

SUPPLEMENTARY INFORMATION:

Background

In the May 19, 1980, **Federal Register** (45 FR 33063) the Environmental Protection Agency (EPA) promulgated regulations, pursuant to Subtitle C of the Resource Conservation and Recovery Act of 1976, as amended (RCRA), to protect human health and the environment from the improper management of hazardous waste. RCRA includes provisions whereby a State agency may be authorized by EPA to administer the hazardous waste program in that State in lieu of a Federally administered program. For a State program to receive Final Authorization, its hazardous waste program must be fully equivalent to and consistent with the Federal program under RCRA. In order to expedite the authorization of State programs, RCRA allows EPA to grant a State Interim Authorization if its program is substantially equivalent to the Federal program. During Interim Authorization, a State can make whatever legislative or regulatory changes that may be needed for the State's hazardous waste program to become fully equivalent to the Federal program. The Interim Authorization program is being implemented in two phases corresponding to the two stages in which the underlying Federal program takes effect.

Phase I regulations were published on May 19, 1980, and became effective on November 19, 1980. The Phase I regulations include the identification and listing of hazardous wastes, standards for generators and transporters of hazardous waste, standards for owners and operators of treatment, storage and disposal facilities, and requirements for State Programs. The Phase II regulations cover the procedures for issuing permits under RCRA and the standards that will be applied to treatment, storage, and disposal facilities in preparing permits. In the July 26, 1982, **Federal Register** (47 FR 32373), the Environmental Protection Agency announced that States could apply for Component C of Phase II, Interim Authorization. Component C, published in the **Federal Register** July 26, 1982 (47 FR 32274), contains standards for permitting facilities that dispose hazardous waste in waste piles, surface impoundments, land treatment, and landfills.

The State of Texas received Interim Authorization for Phase I on December 24, 1980, and Interim Authorization for Phase II, Components A & B, on March 23, 1982.

Draft Application

The State of Texas submitted its draft application for Phase II, Component C, Interim Authorization, on January 4, 1983. After detailed review, EPA transmitted comments to the State on February 2, 1983.

Three major issues were identified which the State was required to correct before being authorized. These issues involved the substantial equivalence of the State's requirements with EPA's program requirements in the following areas: (1) The construction of a new facility prior to the issuance of a permit; (2) TDWR's requirements for groundwater monitoring; and (3) necessary additions to the Memorandum of Agreement.

Each of these issues was resolved at the time of submittal of the complete application. Specifically, the Texas Legislature amended the statute so that the state could require permits for construction related elements of all hazardous waste management facilities; TDWR amended its groundwater monitoring requirements to align with those of EPA; and a Memorandum of Agreement was submitted.

On May 16, 1983, Texas submitted to EPA an official application for Phase II, Component C. An EPA review team consisting of both Headquarters and Regional personnel made a detailed analysis of Texas' hazardous waste management program.

EPA comments were forwarded to the State on June 30, 1983. No major questions were raised in the comments; however, some minor clarifications were requested. By letter dated July 13, 1983, the State responded to all the issues raised by EPA.

I conclude that the Texas application for Interim Authorization to operate the RCRA Phase II, Component C program meets all of the statutory and regulatory requirements and as such I approve this authorization.

Public Hearing and Comment Period

As noticed in the **Federal Register** on May 27, 1983, EPA gave the public until July 7, 1983, to comment on the State's application. EPA also issued a public notice for a hearing to be held in Austin, Texas on July 14, 1983, if significant public interest was expressed. EPA received requests to hold the hearing from seven (7) public interest groups and one (1) individual.

EPA found that there was significant public interest in holding a hearing on the Texas application for Phase II, Component C, Interim Authorization. Consequently on the evening of July 14, 1983, in Austin, Texas, EPA held such a public hearing and four presentations were made at that time. In addition, Region VI received eleven (11) written comments on the Texas application. Because of the interest exhibited, the comment period was extended by the hearing officer until July 21, 1983.

All comments whether presented at the hearing or in writing, were considered before reaching a decision on the Texas application for Phase II Interim Authorization for Component C.

None of the commenters opposed granting the state of Texas authorization. Eight (8) commenters specifically supported the authorization and urged EPA to expeditiously grant the authorization. Six (6) commenters made comments which were not specific to the authorization decision and one commenter supported the concept of authorization both in general and for

Texas, but suggested some conditions to be placed on this action.

A complete summary of the comments made on the Texas application, and EPA's response to the comments, may be obtained free of charge by calling or writing the contact listed above.

Decision

EPA has reviewed Texas' complete application for Interim Authorization Phase II, Component C, and has determined that the State program is substantially equivalent to Phase II, Component C, of the Federal program as defined in 40 CFR Part 271, Subpart B, as amended at 47 FR 32373 (July 26, 1982). In accordance with Section 3006(c) of RCRA and implementing regulations, Texas is hereby granted Interim Authorization for Phase II, Component C, to operate the State's hazardous waste program for permitting construction and operation of facilities that dispose of hazardous waste in lieu of the Federal program.

Regulatory Flexibility Act

Pursuant to the provisions of 5 U.S.C. 605(b), I hereby certify that this authorization will not have a significant economic impact on a substantial number of small entities. The authorization suspends the applicability of certain Federal regulations in favor of the State program, thereby eliminating duplicative requirements for handlers of hazardous wastes in the State. It does not impose any new burdens on small entities. This rule, therefore, does not require a regulatory flexibility analysis.

Executive Order 12291

The Office of Management and Budget (OMB) has exempted this rule from the requirements of Section 3 of Executive Order 12291.

List of Subjects in 40 CFR Part 271

Hazardous materials, Reporting and recordkeeping requirements, Waste treatment and disposal, Intergovernmental relations, Penalties, Confidential business information.

Authority

This notice is issued under the authority of Secs. 2002(a), 3006, and 7004(b) of the Solid Waste Disposal Act, as amended by the Resource Conservation and Recovery Act of 1976, as amended, 42 U.S.C. 6912(a), 6926, and 6974(b).

Dated: August 9, 1983.

Dick Whittington,

Regional Administrator.

[FR Doc. 83-24013 Filed 8-31-83; 8:45 am]

BILLING CODE 6560-50-M

40 CFR Part 410

[WH-FRL-2427-4]

Textile Mills Point Source Category Effluent Limitations Guidelines, Pretreatment Standards and New Source Performance Standards; Correction

AGENCY: Environmental Protection Agency (EPA).

ACTION: Final rule; correction.

SUMMARY: EPA is correcting errors of omission that appeared in the final regulation for the textile mills point source category. This regulation was published on September 2, 1982 (47 FR 38810). The purpose of this action is to ensure that the final regulation is properly applied in issuing permits applicable to wastewater discharges from the textile industry.

FOR FURTHER INFORMATION CONTACT: Richard E. Williams, Effluent Guidelines Division, (WH-552), Environmental Protection Agency, 401 M Street, S.W., Washington, D.C. 20460, or by calling (202) 382-7186.

In 40 CFR Part 410, as published on September 2, 1982 (47 FR 38810), the following corrections are made:

1. On page 38824, column 2, § 410.42, paragraph (e): change: "paragraph (a) of this section * * *" to "paragraphs (a), (b), (c) and (d) of this section * * *".

2. On page 38825, column 1, § 410.43, paragraph (e): change: "paragraph (a) of this section * * *" to "paragraphs (a), (b), (c) and (d) of this section * * *".

3. On page 38826, column 1, § 410.52, paragraph (d): change: "paragraph (a) of this section * * *" to "paragraphs (a), (b), and (c) of this section * * *".

4. On page 38826, column 2, § 410.53, paragraph (d): change: "paragraph (a) of this section" to "paragraphs (a), (b), and (c) of this section * * *".

Dated: August 24, 1983.

Rebecca W. Hanmer,

Acting Assistant Administrator for Water.

[FR Doc. 83-24002 Filed 8-31-83; 8:45 am]

BILLING CODE 6560-50-M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 435 and 436

Medicaid Program; Deeming of Income Between Spouses; Categorically Needy

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

ACTION: Final rule with comment period.

SUMMARY: These final regulations revise Medicaid rules for determining the financial eligibility and the level of Medicaid payments for the institutional care of aged, blind, and disabled categorically needy individuals when one spouse is institutionalized and the other spouse is not. In accordance with a United States Supreme Court ruling, we are reinstating the rules that were in effect prior to imposition of lower court orders (now reversed) that required HCFA to change its regulations.

The regulations affect those States that, as permitted by statute, use more restrictive eligibility criteria than those applied nationally under the Supplemental Security Income (SSI) requirements. They also apply in Puerto Rico, Guam, and the Virgin Islands. These reinstated rules permit these jurisdictions, in situations when one spouse is institutionalized, to consider a portion of the income of one spouse as available for the care of his or her institutionalized spouse, whether or not the income is actually contributed to the spouse. This practice is known as "deeming of income."

We are also clarifying a regulation that applies in States that use the SSI eligibility criteria and may apply in States that use more restrictive eligibility criteria. This clarification reflects current SSI policy. It provides that the mutual consideration of income between two spouses who are both eligible for Medicaid as aged, blind, or disabled individuals will cease with the month after the month of separation when this separation is due to the institutionalization of one spouse.

DATES:

Effective date: These regulations are effective on October 3, 1983. However, because of the time required by some of the States and Territories to effect changes to implement the requirements, HCFA will not hold a State or Territory out of compliance with the requirements if it makes the necessary changes by November 30, 1983.

Comment period: Although these regulations are final, we will consider comments on the conforming change that we made to § 435.723(c). This regulation clarifies that, in accordance with SSI policy, the mutual consideration of income of two spouses who are both eligible for Medicaid as aged, blind, or disabled individuals ceases with the month after the month of separation when this separation is caused by the institutionalization of one spouse. To assure consideration,

comments must be received by October 3, 1983.

ADDRESS: Address comments in writing to: Health Care Financing Administration, U.S. Department of Health and Human Services, Attention: BERG–214–FC, P.O. Box 26676, Baltimore, Maryland 21207.

In commenting, please refer to file code BERG–214–FC.

If you prefer, you may deliver your comments to Room 309–G Hubert H. Humphrey Building, 200 Independence Ave., SW., Washington, D.C., or to Room 132, East High Rise Building, 6325 Security Boulevard, Baltimore, Maryland 21207.

Comments will be available for public inspection as they are received, beginning approximately three weeks after publication, in Room 309–G of the Department's offices at 200 Independence Ave., SW., Washington, D.C. 20201, on Monday through Friday of each week from 8:30 a.m. to 5:00 p.m. (202–245–7890).

FOR FURTHER INFORMATION CONTACT: Marinos Svolos, Office of Eligibility Policy, (301) 594–9050.

SUPPLEMENTARY INFORMATION:

I. Background

In 1972, when Congress replaced three of the four categorical assistance programs with the Supplemental Security Income program (SSI), the number of individuals who met eligibility requirements for SSI assistance in some States was significantly larger than the number determined eligible under the earlier, State-run programs. In order not to impose a substantial fiscal burden on these States, nor to discourage these States from participating in Medicaid, Congress enacted section 1902(f) of the Social Security Act. This section allows States to provide Medicaid only to those individuals who would have been eligible under the State Medicaid plan in effect on January 1, 1972. (For a more complete discussion, see S. Rep. No. 553, 93rd Cong. 1st Sess. 56 (1973).) States selecting this option are commonly referred to as section 1902(f) States.

Section 1902(a)(17)(B) of the Act requires that, in determining an individual's eligibility for medical assistance and the amount of financial assistance provided under the plan, States must take into account only such income as is determined (under standards prescribed by the Secretary) to be "available" to the Medicaid applicant or beneficiary. Under Medicaid plans in effect on January 1, 1972, some States "deemed" a certain amount of the income of a financially responsible relative (spouse or parent) as available to an individual, without regard to the actual monetary contribution by the relative. In the case of institutionalized applicants or beneficiaries, this was often done by subtracting, from the income of the noninstitutionalized relative, a specific "protected" amount that was considered necessary for his or her own living expenses, and considering the remaining amount available to the institutionalized individual. The State then reduced its payment to the institution based on the amount considered available to the institutionalized individual.

Under the SSI program, the statute generally requires that, if an individual and his or her spouse who apply or are eligible for SSI cease to live together, their income and resources must be considered to be mutually available, for purposes of determining eligibility, for the first six months after the month they cease to live together (see sections 1602, 1611(a) and 1614(b) of the Act). However, under section 1611(e)(1)(B)(ii) of the Act, the determination of eligibility for and the amount of the SSI benefit when one member of the couple is institutionalized is based on the application of the income of each member of the couple to separate SSI income standards. The income of the noninstitutionalized spouse is not used to compute the benefit of the institutionalized spouse except during the month that they ceased to live together.

For couples where only one spouse applies for or is eligible for SSI, a specified amount of income (determined in accordance with a set formula) is deemed from the ineligible spouse to the eligible spouse, in determining the eligibility of the eligible spouse, until the end of the month the couple ceases to live together in the same household (section 1614(f)(1) of the Act). (The SSI program does not deem income or resources from an ineligible spouse when both members of the couple are living in an institution, even if they share a room.)

II. Court Orders

These final regulations represent a return to policy that was in effect until May 30, 1979, when we revised our deeming of income rules in compliance with an order of the United States District Court for the District of Columbia (*Gray Panthers v. Secretary, Department of Health, Education, and Welfare, et al.*, 461 F. Supp 319). That order prohibited any deeming of income between spouses in section 1902(f) States when one spouse is institutionalized, and required HCFA to propose and publish new regulations implementing this prohibition. No change was required in the regulations affecting non-1902(f) States, in situations when neither spouse or both are institutionalized, or regulations concerning deeming of resources.

The District Court order was subsequently amended by the U.S. Court of Appeals, which ordered the Secretary to issue new regulations after considering certain "relevant factors". Final regulations to comply with the decision of the Court of Appeals were issued December 15, 1980. Under those rules, section 1902(f) States were permitted to use SSI deeming of income criteria or any deeming criteria more liberal than SSI, when one spouse was institutionalized. In the preamble to those regulations, we stressed that the new regulations were based on a Court of Appeals decision that rejected the Department's legal analysis of the statute and required the Department to issue new regulations. We added that the Department was seeking Supreme Court review of the *Gray Panthers* decision and, if our earlier regulations were upheld, we would consider revising the December 1980 regulations (45 FR 82254).

On June 25, 1981, the United States Supreme Court ruled that the Court of Appeals was not justified in invalidating our earlier deeming regulations because the Secretary had properly exercised the authority delegated by Congress.

Because the United States Supreme Court upheld our earlier deeming regulations, we are reissuing those deeming rules for the categorically needy (aged, blind or disabled individuals who are otherwise eligible for Medicaid and who meet the financial eligibility requirements for SSI or an optional State supplement or are considered under section 1619(b) of the Act to be SSI recipients, or whose categorical eligibility is protected by statute) that we believe are compelled by the requirements of section 1902(f) of the Act.

Therefore, this final rule reflects our longstanding interpretation of the statute, that section 1902(f) States can apply more restrictive deeming of income rules than applied nationally under the SSI program.

III. Provisions of the Regulations

On July 23, 1982, we published a notice of proposed rulemaking in the **Federal Register** (47 FR 31899) in order to reissue our earlier deeming rules for categorically needy individuals in the

section 1902(f) States [1] and Guam, Puerto Rico and the Virgin Islands. Under the proposal, such States would be required to use at least SSI deeming practices or any deeming criteria more extensive than SSI practices, but not more restrictive than under the State's January 1, 1972 Medicaid plan.

This would mean that both the amount and duration of deeming could be more extensive than SSI practice, if authorized under the 1972 plan. For example, some States could continue to deem for indefinite periods of time. Under the proposed rules, section 1902(f) States would no longer be permitted to use any deeming criteria less extensive than SSI practices. Puerto Rico, Guam and the Virgin Islands are permitted to return to requirements in the State plan for OAA, AB, APTD or AABD.

After evaluating the comments, we are adopting the regulations as proposed. Also, we are revising one other regulation (§ 435.723) because several commentors brought to our attention the need to clarify the policy to conform it to current SSI deeming policy.

IV. Medically Needy Deeming Rules

These rules do not apply to "medically needy" aged, blind or disabled individuals. The medically needy are individuals whose incomes and resources are within limits set under each State Medicaid plan but who are otherwise not eligible for Medicaid as categorically needy. Deeming rules for the medically needy in section 1902(f) States were included in regulations implementing the Omnibus Budget Reconciliation Act of 1981 (OBRA), Pub. L. 97-35. Changes were made to 42 CFR 435.330, 435.823 and 436.821. (See 46 FR 47976, September 30, 1981.) However, section 137(b)(8) of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), Pub. L. 97-248, made changes in the provisions of OBRA that had formed the basis for the September 30, 1981 regulations. Therefore, to the extent that those regulations conflict with statutory changes, the regulations have no further force or effect. Since the July 23, 1982 notice of proposed rule making preceded TEFRA, it dealt exclusively with deeming for the categorically needy. Accordingly, this final rule does not apply to the medically needy. We will be issuing separate rules reflecting changes regarding financial eligibility of the medically needy that were made by TEFRA.

[1] At present, these States are—Connecticut, Hawaii, Illinois, Indiana, Minnesota, Missouri, Nebraska, New Hampshire, North Carolina, North Dakota, Ohio, Oklahoma, Utah, and Virginia.

V. Analysis and Response to Public Comments

We received 10 comments on the proposed regulations. The commentors consisted of seven State agencies, one State legislative committee, a social service agency and a legal assistance group. The commentors generally supported the change, but raised some questions about specific aspect of it.

Detrimental Effect on Recipients and Spouses

1. *Comment:* Three commentors objected to the proposed rule because they felt that it could have a detrimental effect on both spouses.

Response: Section 1902(f) of the Social Security Act provides States with the option to refuse to provide Medicaid to any aged, blind, or disabled individual otherwise eligible for SSI unless that individual would be or would have been eligible for Medicaid under the State's Medicaid plan that was in effect on January 1, 1972. Therefore, if we were to require these States to use deeming rules which are more generous to beneficiaries than those which these States used on January 1, 1972, we would be exceeding our statutory authority. Accordingly, it is not appropriate to consider the relative impact of this rule on spouses, since the rule simply restores to the States the option which was provided to them by Congress in 1972 and which we have no legal basis for restricting unless "deeming" were contrary to the provisions of the Medicaid law. Since the validity of deeming under the Medicaid statute was upheld by the United States Supreme Court in its *Gray Panthers* decision, we have no basis for restricting 1902(f) States in the manner suggested by the commentor.

No Six Months Deeming Requirement Under Medicaid

2. *Comment:* Three commentors expressed concern that SSI requires that the income of eligible couples be considered mutually available during the first six months of separation caused by institutionalization of an individual.

Response: We believe that the commentors have called attention to a problem that merits a change in the Medicaid regulations governing the mutual consideration of the income of an eligible couple in SSI States.

As discussed above, the rules governing mutual consideration of income in section 1902(f) States can be no less rigorous than those which are used under the SSI program. Therefore, the mutual consideration of income rules for SSI States prescribe the least restrictive rule that section 1902(f) States may use. The concept of mutual consideration of income for six months where eligible spouses are separated derives from section 1614(b) of the Act. That section defines an "eligible spouse" under the SSI program as the aged, blind, or disabled husband or wife of another aged, blind, or disabled individual who has not been living apart from the eligible individual for more than six months. Section 1611(a)(2) of the Act defines an eligible individual (who has an eligible spouse) in terms of joint consideration of the income and resources of the individual and spouse. Since the definition of eligible spouse contains the six month period, the Medicaid rule at 42 CFR 453.723(c) specified a six month period for the joint consideration of the income and resources of these couples. Section 1611(e)(1)(B)(ii) of the Act was amended in 1976 to specify that where either member of this couple is institutionalized throughout any month, the maximum monthly SSI benefit for the institutionalized spouse is $25 per month and for the noninstitutionalized spouse is the benefit amount established for a single noninstitutionalized individual.

Because the 1976 amendment specifically addressed SSI benefit amounts rather than SSI eligibility, the Medicaid regulations governing mutual consideration of income in SSI States maintained the six months period for eligible couples separated by institutionalization. However, in view of the comments and the SSI practice of treating the eligibility of these couples as a matter that affects both the SSI benefit amount *and* Medicaid eligibility of each individual, we have reconsidered the advisability of maintaining the current Medicaid regulation and have decided that it requires alteration.

Another factor influencing this decision is the recently enacted Tax Equity and Fiscal Responsibility Act of 1982 (Pub. L. 97-248). Section 137(b)(8) of that Act enacted section 1902(a)(10)(C)(i)(II) of the Social Security Act, which requires States that provide Medicaid to all SSI recipients to use the methodology used by the SSI program in considering income and resources of aged, blind, and disabled medically needy. The reinforced connection between Medicaid and the cash assistance programs dictates the need for greater consistency between Medicaid and SSI eligibility policy.

Therefore, we are clarifying § 435.723(c) to reflect current SSI rules which specify that the mutual

consideration of income between two spouses who are both eligible as aged, blind, or disabled individuals, ceases the month after the month of separation when this separation is caused by the institutionalization of one spouse.

Additionally, the regulation reflects SSI rules which provide that if two spouses who separate both apply for Medicaid and are not eligible as a couple, the State agency must then determine if a spouse is eligible using his or her applicable income standard.

Because this change affects SSI States in addition to the section 1902(f) States, we are soliciting public comments with respect to this change. In order not to delay the adoption of the section 1902(f) State deeming rule, we are making this change in SSI State rules effective at the same time as the section 1902(f) State deeming rule.

3. *Comment:* Three commentors recommended that all deeming of income under Medicaid cease as soon as the couple is no longer living together.

Response: Because the SSI program does not cease deeming in these circumstances until the first full month in which the couple ceases to live together, we reject the commentors' suggestion that deeming cease immediately at separation instead of ceasing at the beginning of the month following the separation.

SSI generally requires the mutual consideration of income during the first 6 months of separation of an eligible couple. The income is used to determine whether both spouses are eligible for SSI benefits and the amount of those benefits. If an SSI benefit is paid, the individual is eligible for Medicaid in States that cover all SSI recipients.

However, in the case of the eligible couple where one spouse is institutionalized, the proper application of SSI policy for purposes of determining Medicaid eligibility is to apply the income of each spouse to seperate standards. The test of the couple's combined income to a couple standard does not present a barrier to attaining Medicaid eligibility because income in excess of the standard is offset by incurred medical expenses in section 1902(f) States. Additionally, a State must consider the income of the spouse at home to be available for the medical expenses of the institutionalized spouse only through the month before the first full month of separation. This is the least restrictive policy States exercising their option under section 1902(f) can apply. To allow section 1902(f) States to apply less restrictive policies is inconsistent with the intent of section 1902(f), which is only to allow States to impose more restrictive requirements than SSI.

The basis of these SSI requirements is section 1611(e)(1)(B)(ii) of the Act.

Minimum Protection Income Level

Three commenters raised issues regarding the protected income level used for recognizing the living expenses of an ineligible spouse if a State chooses to continue deeming beyond the first full month of living apart.

4. *Comment:* One commentor suggested that a minimum protected income level should be established by the regulations with an exception for hardship situations.

Response: In the final rule, we have not set a specific minimum dollar protected income level because we believe that doing so would be inconsistent with the statute. The statute allows a section 1902(f) State to apply financial eligibility criteria as restrictive as the State used under the State plan in effect on January 1, 1972 and no less restrictive than that of the SSI program.

5. *Comment:* One commentor wanted to know if a section 1902(f) State could use the State supplement level as the protected income level for an ineligible spouse.

Response: States have a great deal of flexibility in setting the amount of the protected income level, beginning with the first full month of living apart. There is no maximum protected income level. The minimum for the protected income level is the level in the Medicaid State plan in effect on Janaury 1, 1972. Therefore, there is nothing to prohibit a State from using a State supplement level if it is no more restrictive than the level on January 1, 1972.

6. *Comment:* Another commentor stated that the protected income level is not an equitable or politically viable deeming standard. This commentor felt a fee schedule is preferable to a protected income level. A fee schedule would base the amount to be deemed on an adjusted household income.

Response: This final rule does not set a minimum for the protected level (except the statutory minimum in a section 1902(f) State; that is, the January 1, 1972 level). There is only a minimum standard recognized in the final rule. Again, we believe there is sufficient flexibility to allow a fee schedule as a method of determining the amount of deemed income beginning with the first full month of living apart.

7. *Comment:* One commentor claimed that the United States Supreme Court in *Schweiker* v. *Gray Panthers* required that the amount of income protected for the spouse at home be related to living expenses and that the regulations did not include this provision.

Response: The United States Supreme Court did not rule that the protected amount must be related to living expenses. In upholding the validity of the regulations that we are reissuing here, the Court rejected the notion that "individual determinations of need" are required as part of the "deeming" process. (See 101 S.Ct. 2633 at 2642.) Implicit in the comment that the amount of income protected for the spouse at home must be related to living expenses is the concept of individual determinations which was rejected by the Court. The Court noted that the Medicaid statute's requirement of "availability refers to resources left to a couple after the spouse has deducted a sum on which to live" (*id.* at 2642). However, the issue of whether particular States set aside more income than can reasonably be considered available addresses "a problem not presently before the Court" (*Id.* at 2643, note 21). Moreover, the regulations which we are adopting require section 1902(f) States (when determining the amount of income of the spouse at home which is considered available to the institutionalized spouse) first to deduct an amount for the living expenses of the spouse at home.

Least Restrictive Alternative

8. *Comment:* One commentor argued that the statute allows a State to choose a less restrictive treatment of income and resources of spouses separated by institutionalization than used by SSI, particularly if such a requirement was part of the State's 1972 Medicaid plan.

Response: The Department has consistently interpreted section 1902(f) of the Act to require States electing this option to be no more liberal with respect to eligibility criteria for the categorically needy than the criteria used in the SSI program. This interpretation is based upon reading section 1902(f) in conjunction with section 1902(a)(10)(A) of the Act. Thus, we believe that the pertinent portion of section 1902(f) should be paraphased as follows:

> Notwithstanding any other provision of this title which requires States to provide Medicaid eligibility to all SSI recipients, *i.e.*, section 1902(a)(10)(A), no State * * * shall be required to provide medical assistance to any aged, blind, or disabled individual, unless the State would have been required to provide Medicaid to such individuals under its Medicaid plan in effect on January 1, 1972 * * *

In our view, the obligation to provide Medicaid to aged, blind, and disabled individuals who would have been

eligible for Medicaid under the January 1, 1972 plan is limited to those individuals whom the State otherwise is currently required to make Medicaid eligible by virtue of some other provision of the law; for example, SSI recipients under section 1902(a)(10)(A) of the Act. This reading of section 1902(f) is consistent with the legislative history of section 1902(f) as reported in S. Rep. No. 92–1230, 92d Cong. 2d Sess. (1972) at 222, which characterized it as follows:

> No State would be required to furnish medical assistance *to any individual receiving aid as a needy aged, blind, or disabled adult* unless the State would be [or would have been] required to furnish such assistance to such individual under its Medicaid plan that was in effect on January 1, 1972 [italics added].

As summarized by the Senate Report, it is clear that the section 1902(f) provision applies only with respect to individuals who are both receiving cash assistance *and* with respect to whom the State would be required to furnish Medicaid if the rules of its January 1, 1972 Medicaid plan currently were in effect. Accordingly, the Department has read this portion of section 1902(f) to authorize States to restrict their Medicaid eligibility of aged, blind, and disabled individuals receiving SSI. However, we do not view section 1902(f) as providing Medicaid eligibility for aged, blind, or disabled individuals who do not meet the requirements for SSI eligibility. Therefore, we reject the commentor's suggestion that we amend the regulations to authorize section 1902(f) States to use less restrictive criteria than SSI's (which would have the effect of expanding Medicaid eligibility beyond the SSI recipient population which is the focus of this portion of section 1902(f)).

Cost Associated With Effecting a Change in Policy

8. *Comment:* One commentor agreed that the proposed change would mean a cost savings to the State, but the savings would be small, since only a small portion of the population would be affected. The commentor felt that the cost savings would be offset by the administrative cost associated with implementing the change.

Response: We recognize that changes in policy may create administrative problems. However, we believe that the statute requires this interpretation. We want to emphasize that a section 1902(f) State may choose to apply the SSI deeming rules or more restrictive rules as long as those rules are not more restrictive than allowed under the State plan in effect on January 1, 1972. If a State applies the SSI rules, the State will stop considering the income of the spouse at home to be available for the institutionalized spouse beginning with the month after the month of separation when this separation is due to institutionalization.

VI. Request for Additional Public Comments

We invite comments on one issue that was not addressed in the NPRM published July 23, 1982. In particular, we request comments on the clarification that the mutual consideration of income between two spouses who are both eligible for SSI will cease beginning with the first full month of living apart when this separation is caused by the institutionalization of one spouse. Because of the large number of comments we receive, we cannot acknowledge or respond to them individually. Since we have addressed the issues raised in comments on the July 23, 1982, proposed rule in the context of "section 1902(f) States" in the preamble to these final regulations, we will not respond a second time to any comments already addressed. If appropriate, we will respond to public comments received on this new issue in a future **Federal Register** publication.

VII. Impact Analyses

Executive Order 12291

The HCFA actuary estimates that the fiscal year 1984 savings resulting from removal of the provision that permitted use of eligibility criteria more liberal than SSI requirements in section 1902(f) States will be approximately $1.5 million in Federal funds and $1.4 million in State funds. Savings will be realized to the extent that section 1902(f) States change their deeming practices and that other States choose to become section 1902(f) States because of the flexibility the regulation now affords. The final rule only reiterates the provisions of the proposed regulations and responds to public comments concerning the proposed rule.

The amendments to the regulations to clarify the use of SSI deeming policy (in States that use SSI eligibility criteria) on consideration of income and resources of eligible spouses when they cease to live together because of the institutionalization of one spouse are estimated to result in negligible savings in Federal funds for fiscal year 1984. Savings will be realized as those States that are not currently using separate criteria for deeming income and resources of spouses when one spouse is institutionalized conform their standards to reflect the consideration of income of the noninstitutionalized spouse as available only through the month of separation, and resources as available during the month of separation and during the 6 months after the month of separation.

We have determined that this rule does not meet the threshold criteria for a major rule as defined by section 1(b) of Executive Order 12291. That is, this rule will not have an annual effect on the economy of $100 million or more; or cause a major increase in costs or prices for consumers, government agencies, industry, or a geographic region; or cause significant adverse effects on business or employment.

Regulatory Flexibility Analysis

The Regulatory Flexibility Act of 1980, Pub. L. 96–354, requires that Federal agencies prepare a regulatory flexibility analysis when regulations will have a significant economic impact on a substantial number of small businesses or small governmental jurisdictions.

These regulations affect individuals who, because a section 1902(f) State may change its deeming practices, may be determined ineligible for Medicaid. Individuals are not considered "small entities" under Pub. L. 96–354. Therefore, the Secretary certifies, under section 605(b) of Title 5, United States Code, that this final rule will not have a significant economic impact on a substantial number of small entities.

List of Subjects

42 CFR Part 435

Aid to Families with Dependent Children, Aliens, Categorically needy, Contracts (Agreements—State Plan), Eligibility, Grant-in-Aid program—health, Health facilities, Medicaid, Medically needy, Reporting and recordkeeping requirements, Spend-down, Supplemental security income (SSI).

42 CFR Part 436

Aid to Families with Dependent Children, Aliens, Contracts (Agreements), Eligibility, Grant-in-Aid program—health, Guam, Health facilities, Medicaid, Puerto Rico, Supplemental security income (SSI), Virgin Islands.

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

The authority citation for Part 435 reads as follows:

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

A. 42 CFR Part 435 is amended as set forth below:

1. Section 435.121 is amended by revising paragraph (b)(1) to read as follows:

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

* * * * *

(b) If an agency uses more restrictive requirements under this section—

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

* * * * *

2. Section 435.723 is amended by revising paragraphs (c) and (d) to read as follows:

§ 453.723 Financial responsibility of spouses.

* * * * *

(c) If both spouses apply or are eligible as aged, blind, or disabled and cease to live together, the agency must consider their income and resources as available to each other for the time periods specified below. After the appropriate time period, the agency must consider only the income and resources that are actually contributed by one spouse to the other.

(1) If spouses cease to live together because of the institutionalization of one spouse—

(i) The agency must consider their income as available to each other through the month in which they cease to live together. Mutual consideration of income ceases with the month after the month in which separation occurs.

(ii) The agency must consider their resources as available to each other for the month during which they cease to live together and the six months following that month.

(2) If spouses cease to live together for any reason other than institutionalization, the agency must consider their income and resources as available to each other for the month during which they cease to live together and the six months following that month. If the mutual consideration of income and resources causes the individuals to lose eligibility as a couple, the agency will determine if an individual is eligible in accordance with paragraph (d) of this section.

(d) If only one spouse in a couple applies or is eligible, or both spouses apply and are not eligible as a couple, and they cease to live together, the agency must consider only the income and resources of the ineligible spouse that are actually contributed to the eligible spouse beginning with the month after the month in which they cease to live together.

4. Section 435.734(a) is revised and paragraph (b) is removed and reserved as follows:

§ 435.734 Financial responsibility of spouses and parents.

(a) In determining Medicaid eligibility of an aged, blind, or disabled individual under requirements more restrictive than those used under SSI, the agency must consider the income and resources of spouses and parents as available to the individual in the manner specified in §§ 435.723 and 435.724 or in a more extensive manner, but not more extensive than the requirements in effect under the Medicaid plan on January 1, 1972.

(b) [Reserved]

PART 436—ELIGIBILITY IN GUAM, PUERTO RICO, AND THE VIRGIN ISLANDS

The authority citation for Part 436 reads as follows:

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

B. 42 CFR Part 436, § 436.711 is revised to read as follows:

§ 436.711 Determination of financial eligibility.

In determining eligibility of individuals specified in subparts B and C of this part who are not recipients of cash assistance, the agency must apply the financial eligibility requirements of the State plan for OAA, AFDC, AB, APTD, or AABD that would be used if the individual were applying for cash assistance. This includes requirements on financial responsibility of spouses and parents, except that in determining eligibility of families and children, the agency must consider parental income and resources as available to a child who is living with the parents until he becomes 21, even if State law confers adult status below age 21.

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

Dated: April 19, 1983.

Carolyne K. Davis,

Administrator, Health Care Financing Administration.

Approved: August 5, 1983.

Margaret M. Heckler,

Secretary.

[FR Doc. 83-23992 Filed 8-31-83; 8:45 am]

BILLING CODE 4120-03-M

DEPARTMENT OF TRANSPORTATION

Coast Guard

46 CFR Parts 153 and 154

[CGD 82-063b]

Revision of Staff Codes and Addresses

AGENCY: Coast Guard, DOT.

ACTION: Final rule; correction.

SUMMARY: This document corrects inadvertent errors made to the final rule document issued on February 3, 1983 (48 FR 4780). That rule revised or updated the addresses and staff codes of the component divisions of the Office of Merchant Marine Safety, U.S. Coast Guard Headquarters, to reflect recent organizational changes.

FOR FURTHER INFORMATION CONTACT: Mr. Frank K. Thompson, Office of Merchant Marine Safety (G-MTH-3/12), Room 1210, U.S. Coast Guard Headquarters, 2100 Second Street, SW., Washington, DC 20593 (202) 426-1577.

SUPPLEMENTARY INFORMATION:

List of Subjects in 46 CFR Parts 153 and 154

Hazardous materials transportation, Marine safety, Tank vessels, Barges.

The following corrections are made to CGD 82-063b appearing at 48 FR 4780 on February 3, 1983:

1. On page 4782, column one, change 27, §§ 153.436 and 153.808 are removed.

2. On page 4782, column one, change 27, paragraph (d) is added to § 153.809.

3. On page 4782, column one, change 28, § 153.530(a) is changed to § 153.530(o).

4. On page 4782, column two, change 28, § 154.912 is added to the series.

5. On page 4782, column two, change 32 is removed.

6. On page 4782, column two, change 34 is removed.

7. On page 4782, column two, change 35, reference to the change of zip code is removed.

(14 U.S.C. 632, 49 U.S.C. 1655(b); 49 CFR 1.46(b))

Dated: August 29, 1983.

C. M. Holland,

Captain, USCG, Executive Secretary, Marine Safety Council.

[FR Doc. 83-24063 Filed 8-31-83; 8:45 am]

BILLING CODE 4910-14-M

Research and Special Programs Administration

49 CFR Part 179

[Docket No. HM-174; Amdt. No. 179-27A]

Specifications for Tank Cars

AGENCY: Materials Transportation Bureau (MTB), Research and Special Programs Administration, DOT.
ACTION: Amendment of final rule; extension of the compliance date.

SUMMARY: This document amends the final rule published on January 26, 1981 (46 FR 8005), revised on August 24, 1981 (46 FR 42678) and on September 2, 1982 (47 FR 38697), which established certain construction standards for railroad tank cars used to transport hazardous materials. The amendment extends the compliance date for equipping newly constructed DOT specification 105 tank cars, built to carry ethylene oxide, with a safety valve sized in accordance with 49 CFR 179.106-2(c)(4). The compliance date is extended from September 1, 1983, until March 1, 1984. The extension will permit completion of MTB's and FRA's review and analysis of the study by the Association of American Railroads (AAR) concerning the optimum sizing for the safety valve on cars built to carry ethylene oxide. This action is taken by MTB to ensure a thorough and detailed response to the AAR study before the revised safety valve sizing requirement becomes effective.

DATES: *Effective date:* August 31, 1983. The compliance date is extended from September 1, 1983, until March 1, 1984.

FOR FURTHER INFORMATION CONTACT: Philip Olekszyk (Office of Safety), Federal Railroad Administration, 400 Seventh Street, S.W., Washington, D.C. 20590, (202) 426-0897.

SUPPLEMENTARY INFORMATION: On January 26, 1981, MTB issued a final rule establishing certain construction standards for DOT specification 105 tank cars built to carry specified commodities. The construction standards include a safety valve sizing requirement for DOT specification 105 tank cars built to carry ethylene oxide. The final rule required that after August 31, 1981, each DOT specification 105 ethylene oxide tank car shall be constructed with a safety valve sized in accordance with 49 CFR 179.106-2(c)(4).

After publication of the final rule, MTB received several petitions for reconsideration of the final rule. These petitions addressed, among other things, the safety valve sizing requirement for ethylene oxide. The petitioners argued that the larger safety valve for ethylene oxide would be less safe because of the peculiar commodity characteristics. They also argued that the valve sizing equation in the rule should not be applied because ethylene oxide is a liquid while the equation is designed for gases.

While MTB and the FRA were not persuaded that these arguments were adequately supported, the compliance date was extended from September 1, 1981 until September 1 1982 (46 FR 42678) and then from September 1, 1982 until September 1, 1983 (47 FR 38697). The extensions were granted to permit the AAR Tank Car Committee and other interested parties an opportunity to study the question of safety valve sizing for ethylene oxide and to submit the results for review and consideration.

During the past two years, an Ad Hoc Committee of the AAR Tank Car Committee has conducted an extensive study of safety valve sizing. A final report was furnished to MTB and the FRA earlier this year. FRA and MTB has been evaluating the methodology, assumptions, and computer program, involved in the report. This review and assessment is close to completion. Therefore, MTB is extending the compliance date from September 1, 1983 until March 1, 1984, so that the evaluation by FRA and MTB can be completed before final action is taken.

The final rule extending the compliance date shall become effective in less than 30 days on August 31, 1983. MTB has determined that this final rule relieves a restriction. MTB has also determined that there is good cause for making the rule effective in less than 30 days since the imposition on September 1, 1983 of the safety valve requirement contained in 49 CFR 179.106-2(c)(4) could disrupt the construction of DOT specification 105 tank cars built to carry ethylene oxide.

List of Subjects in 49 CFR Part 179

Railroad safety.

PART 179—SPECIFICATIONS FOR TANK CARS

In consideration of the foregoing, § 179.102-12(a)(9) of Part 179 of Title 49, Code of Federal Regulations, is amended, effective August 31, 1983, as follows:

§ 179.102-12 Ethylene oxide.

(a) * * *

(9) Each tank car built after August 31, 1981, shall be constructed in accordance with class 105J, except that the safety relief valve requirements of § 179.106-2(c)(4) shall not apply. Each tank built after February 29, 1984, shall be constructed in accordance with class 105J.

(49 U.S.C. 1803, 1804, 1808; 49 CFR 1.53, Appendix A to Part 1)

Note.—The Materials Transportation Bureau has determined that this document will not result in a "major rule" under the terms of Executive Order 12291 or a significant regulation under DOT's regulatory policy and procedures (44 FR 11034) or require an environmental impact statement under the National Environmental Policy Act (49 U.S.C. 4321, *et seq.*). I certify that this proposal will not, as promulgated have a significant economic impact on a substantial number of small entities because the overall economic impact of this amendment is minimal. A regulatory evaluation and environmental assessment for the action taken in HM-174 are available for review in the docket.

Issued in Washington, D.C., on August 25, 1983.

L. D. Santman,

Director, Materials Transportation Bureau.

[FR Doc. 83-24060 Filed 8-31-83; 8:45 am]

BILLING CODE 4910-60-M

INTERSTATE COMMERCE COMMISSION

49 CFR Parts 1042, 1160, 1161, 1162, 1165, 1168, and 1181

[Ex Parte No. MC-163]

Procedures for Providing Notice of Specified Applications Through an ICC Register in Lieu of "Federal Register" Notice

AGENCY: Interstate Commerce Commission.

ACTION: Rule related notice.

SUMMARY: At 48 FR 32175, July 14, 1983, the Commission published final rules that announced the formation of a new *ICC Register* which is to begin publication concurrently with the publication of the notice. The new publication will carry notices pertinent to motor carriers, water carriers, freight forwarders, passenger carriers and property brokers, as well as the text of ICC rulemaking decisions when they apply to the motor carrier industry. A complete listing of the proceedings to be published in the new publication is repeated in the notice.

ADDRESSES: Persons who wish to subscribe to the *ICC Register* should send their requests for a one-year subscription and the $225 fee to: *ICC Register Subscriptions*, Room 2221, Office of the Secretary, Interstate Commerce Commission, Washington, DC 20423.

Persons who wish to purchase an individual issue should send their request with a check or money order for $2.50 to the above-noted address.

FOR FURTHER INFORMATION CONTACT: For General Information: Ellen R. Watson (Editor), Darlene Proctor, (202) 275–7233.

For Subscription Information: Edward C. Fernandez, Lolita Leak, (202) 275–7591.

SUPPLEMENTARY INFORMATION: Items 1–12, below, will no longer appear in the **Federal Register,** but will appear in the *ICC Register.*

TYPES OF PROCEEDINGS WHICH WILL APPEAR IN THE *ICC Register.*

Type of application of proceeding	Code of Federal Regulation Reference
1. Motor Carriers of Passengers Alternate Route Deviations	49 CFR 1042.2(c)(9)
2. Motor Carriers of Property (Interstate)	49 CFR 1160.1–1160.68
Freight Forwarder	
Water Carriers	
Property Broker	
Water Carrier Exemption	
3. Motor Carriers of Passengers (Interstate and Intrastate under 49 U.S.C. 10922(c)(2)(B)).	49 CFR 1160.70–1160.87
4. Applications for the Issuance of Certificates of Registration	49 CFR 1161
5. Temporary Authority Procedures Under 49 U.S.C. 10928	49 CFR 1162
6. Applications for Authority to Provide Owner-Operator Food Transportation	49 CFR 1164
7. Restriction Removal (both Property and Passenger)	49 CFR 1165
8. Transfers of Operating Rights under 49 U.S.C. 10924, 10926, 10931, and 10932.	49 CFR 1181
9. Motor Carriers of Passengers (Intrastate under 49 U.S.C. 10922(c)(2)(A))	49 CFR 1168
10. Petitions for Exemptions of Motor Carriers of Property for Consolidation, Merger, and Acquisition of Control.	Ex Parte No. 400 (Sub-No. (367 I.C.C.113)
11. Applications for Approval of Pooling Operations	49 CFR Part 1184
12. Petitions for Exemption from Tariff Filing Requirements Filed by Contract Carriers of Passengers.	Ex Parte No. 400 (Sub-No. 1) (367 I.C.C. 113)

13. The following will appear in the *ICC Register* as well as the "Federal Register:"
   a. Notices of Proposed and of Final Rules concerning motor carriers.
   b. Petitions for Declaratory Order concerning motor carriers.
   c. Petitions for Exemptions as Single-State Operators under 49 U.S.C. 10525.
   d. Petitions to Expand the Commercial Zone Exemption under 49 U.S.C. 10526(b)(1).
   e. Motor Carrier Applications to Consolidate, Merge or Acquire Control under 49 U.S.C. 11343, 11344, and 11345a.

Agatha L. Mergenovich,
Secretary.

[FR Doc. 83-24000 Filed 8-31-83; 8:45 am]
BILLING CODE 7035-01-M

Proposed Rules

Federal Register
Vol. 48, No. 171
Thursday, September 1, 1983

This section of the FEDERAL REGISTER contains notices to the public of the proposed issuance of rules and regulations. The purpose of these notices is to give interested persons an opportunity to participate in the rule making prior to the adoption of the final rules.

GENERAL ACCOUNTING OFFICE

4 CFR Part 83

Privacy Procedures for Personnel Records

AGENCY: General Accounting Office.

ACTION: Proposed regulations.

SUMMARY: These proposed regulations would establish procedures and limitations designed to protect the privacy of General Accounting Office (GAO) personnel records. While GAO is not subject to the procedural requirements of the Privacy Act (Act), 5 U.S.C. 552a, it is GAO policy to conduct its activities, to the maximum extent possible, in a manner consistent with the spirit of the Act and its duties, functions, and responsibilities to the Congress.

DATE: Comments must be received on or before October 3, 1983.

FOR FURTHER INFORMATION CONTACT: Suzanne M. Stover-Carr, Attorney-Adviser, Office of the General Counsel, Room 7740, United States General Accounting Office, 441 G Street NW., Washington, D.C. 20548. Tel: (202) 275-5212.

SUPPLEMENTARY INFORMATION: Although GAO is not covered by the principal requirements of the Privacy Act, it has been GAO's position to conform to the spirit of that Act consistent with its duties and functions and responsibility to the Congress. Consequently, GAO proposes to amend Title 4 of the Code of Federal Regulations by adding a new Part 83 entitled "Privacy Procedures for Personnel Records." This proposal does not list either the various systems of personnel records or routine uses of such records which will be published periodically in the **Federal Register**. A listing of existing systems of personnel records and proposed routine uses will appear in the **Federal Register** after the receipt and evaluation of comments.

Section-by-Section Analysis

Section 83.1 Purpose and Scope of Part

This section would establish the purpose and scope of the proposed regulations, a purpose in harmony with the objectives of the Privacy Act. The proposed regulations would apply to systems of personnel records, which are our most important and extensive systems. The disclosure of these and other GAO records would also be governed by 4 CFR Part 81, concerning the public availability of General Accounting Office Records.

Section 83.2 Administration.

The Director, Personnel, of the General Accounting Office is responsible for administering the proposed regulations.

Section 83.3 Definitions.

The definitions used in this part include those terms defined in the Privacy Act, and Office of Personnel Management regulations published at 5 CFR Parts 294–297 (1982).

Section 83.4 Conditions of Disclosure.

The regulations would adopt most of the same conditions of disclosure that govern executive agencies under the Privacy Act. The exemptions under the Act under which records may be disclosed to the Bureau of the Census and to the National Archives are not included since GAO considers it unlikely that such a use of GAO personnel records would be made. If the records are to be so used, the statutory provisions of title 13, United States Code, concerning disclosure to the Bureau of the Census would control. Also the GAO/OPM/GSA Memorandum of Understanding, reprinted in Appendix I, as well as GSA's own statutory provisions, would govern disclosure to the National Archives.

Section 83.5 Accounting of Certain Disclosures.

This section would adopt accounting provisions similar to those under the Privacy Act, recognizing GAO's record retention schedule.

Section 83.6 GAO Policy and Requirements.

The GAO requirements generally would track the requirements imposed on executive agencies under the Privacy Act.

Section 83.7 Standards of Conduct.

This section would differ from the Privacy Act in that GAO standards of conduct involve internal controls only, whereas the Privacy Act grants statutory Federal civil and criminal jurisdiction over Privacy Act violations. Since GAO is not covered by the procedural requirements of that Act, it cannot grant similar jurisdiction for individuals to bring a cause of action to the United States courts.

Section 83.8 Social Security Number.

This section would reiterate the requirements of section 7 of the Privacy Act, the only section of that Act that is applicable to GAO. Since 1974, GAO has been following the requirements of this section.

Section 83.9 First Amendment Rights.

This section would track the Privacy Act guarantees of protecting First Amendment rights.

Section 83.10 Official Personnel Folder.

This section would reflect the most important record system of personnel systems of records—the Official Personnel Folder. Ownership of the Folder is already established by the GAO/OPM/GSA Memorandum of Understanding (Appendix I); regulations concerning the Folder would be consistent with the Office of Personnel Management's regulations concerning the Official Personnel Folders of executive branch agencies.

Section 83.11 Disclosure of Information.

The regulations concerning the availability of information would generally track the regulations of the Office of Personnel Management concerning availability of records.

Section 83.11(f) states that an Official Personnel Folder shall be disclosed to an official of GAO who has a need for the information in the performance of official duties. This includes the members of the GAO Personnel Appeals Board and its General Counsel.

The remaining regulations in this section concerning GAO disclosure of information would generally track the Privacy Act.

§ 83.12 Procedures for individual Access to Records.

This section would provide the specific procedures and identification requirements for individual requests for access to GAO personnel records and generally tracks the Office of Personnel Management regulations in this regard.

§ 83.13 Inquiries.

This section would direct the individual in making general inquiries about systems of records.

§ 83.14 Denial of Access Requests.

This section would track the Privacy Act and gives the requester the right to receive the reason for the denial of his access request and the identification of the official responsible for the decision.

§ 83.15 Request for Amendment of Record.

This section would prescribe procedures similar to the Privacy Act whereby an individual can request amendment of a personnel record.

§ 83.16 Administrative Review of Request for Amendment of Record.

This section would provide procedures whereby a requester can seek administrative review of GAO's denial of a request for amendment of the requestor's record.

§ 83.17 Fees.

This section would prescribe fees for obtaining copies of records.

§ 83.18 Rights of Legal Guardians.

This section would establish the rights of legal guardians of incompetent individuals.

§ 83.19 Government Contractors.

This section would provide that Government contractors stand in the shoes of GAO personnel when GAO provides, by contract, for the maintenance by or on behalf of GAO of a system of personnel records.

§ 83.20 Mailing Lists.

This section would establish that GAO may not sell or rent mailing lists unless specifically authorized by law.

§ 83.21 Exemptions.

Certain systems of records would be exempted from requirements relating to accounting for disclosures and the criteria for relevant and necessary information. These exemptions generally track those of the Privacy Act.

List of Subjects in 4 CFR Part 83

Administrative practices and procedures, Government employees, Privacy.

Accordingly, it is proposed that Title 4 CFR be amended by the addition of a new Part 83, to read as follows:

PART 83—PRIVACY PROCEDURES FOR PERSONNEL RECORDS

Sec.

83.1 Purpose and scope of part.
83.2 Administration.
83.3 Definitions.
83.4 Conditions of disclosure.
83.5 Accounting of certain disclosures.
83.6 GAO policy and requirements.
83.7 Standards of conduct.
83.8 Social security number.
83.9 First amendment rights.
83.10 Official Personnel Folder.
83.11 Disclosure of information.
83.12 Procedures for individual access to records.
83.13 Inquiries.
83.14 Denial of access requests.
83.15 Request for amendment of record.
83.16 Administrative review of request for amendment of record.
83.17 Fees.
83.18 Rights of legal guardians.
83.19 Government contractors.
83.20 Mailing lists.
83.21 Exemptions.
Appendix I—Memorandum of Understanding

Authority: 31 U.S.C. 711(1); Memorandum of Understanding between the U.S. Office of Personnel Management, the National Archives and Records Service of the General Services Administration and the U.S. General Accounting Office; 4 CFC Part 81; 5 CFC Parts 294–297; and 31 U.S.C. 731 *et seq.*

§ 83.1 Purpose and scope of part.

This part describes the policy and prescribes the procedures of the United States General Accounting Office (GAO) with respect to maintaining and protecting the privacy of GAO personnel records. While GAO is not subject to the Privacy Act (Act) (5 U.S.C. 552a), GAO's policy is to conduct its activities in a manner that is consistent with the spirit of the Act and its duties, functions, and responsibilities to the Congress. Application of the Privacy Act to GAO is not to be inferred from the provisions of these regulations. These regulations are designed to safeguard individuals against invasions of personal privacy by requiring GAO, except as otherwise provided by law, to—

(a) Protect privacy interests of individuals by imposing requirements of accuracy, relevance, and confidentiality for the maintenance and disclosure of personnel records;

(b) Inform individuals of the existence of systems of personnel records maintained by GAO containing personal information; and

(c) Inform individuals of the right to see and challenge the contents of personnel records containing information about them.

This part applies to all systems of personnel records (as defined in § 83.3(g)) for which GAO is responsible.

§ 83.2 Administration.

The administration of this part is the duty and responsibility of the Director, Personnel, United States General Accounting Office, 441 G Street, NW., Washington, D.C. 20548. To this end, the Director, Personnel, in consultation with the Office of the General Counsel, is authorized to issue such supplemental regulations or procedural directives as may be necessary and appropriate.

(a) The Director, Personnel, shall have general responsibility and authority for implementing this part, including—

(1) Approving all systems of personnel records to be maintained by GAO (whether physically located in GAO's Office of Personnel or elsewhere), including the contents and uses of Personnel or elsewhere), inclusing the contents and uses of such systems, accounting methods, and security methods; and

(2) Responding to an indivisual's request to gain access to or amend his or her own personnel records.

(b) The Director, Personnel, may delegate to the Office of Information Systems and Services, GAO, any of his functions under this part.

§ 83.2 Definitions.

As used in this part:

(a) "Individual" means a citizens of the Unites States or an alien lawfully admitted for permanent residence;

(b) "Information" means papers, records, photographs, magnetic storage media, micro storage media, and other documentary materials, regardless of physical form or charateristics, containing data about an individual and required by GAO in pursuance of law or in connection with the discharge of official business, as defined by statute, regulation, or administrative procedure;

(c) "Maintain" includes to collect, to use, or to disseminate;

(d) "Personnel record" means any record concerning and individual which is maintained in GAO's personnel management or personnel policy setting process;

(e) "Record" means any item, collection, or grouping of information about an individual that is maintained by GAO, including, but not limited to, education, financial transactions, medical history, criminal history, or employment history;

(f) "Routine use" means the disclosure of a record for a purpose which is compatible with the purpose for which it was collected; and

(g) "System of personnel records" means a group or records under the control of GAO from which information is retrieved by the name of the individual or by some identifying number, symbol, or other identifying particular assigned to the individual.

(h) "System manager" means the Director of Personnel, his designee, or other GAO official designated by the Comptroller General, who has the authority to decide matters relative to systems of personnel records maintained by GAO.

§ 83.4 Conditions of disclosure.

GAO shall not disclosure any record that is contained in a system of personnel records by any means of communication to any person or organization, including another agency, without the prior written consent of the individual to who the record pertains, unless disclosure of the records would be:

(a) To those officers and employees of GAO who have a need for the record in the performance of their duties; or

(b) Authorized under regulations implementing the public availability of GAO records published at Part 81 of this chapter; or

(c) For routine use as defined in § 83.3(f); or

(d) To a receipient who has provided GAO with advance adequate written assurance that the record will be used solely as a statistical research or reporting record, and the record is to be transferred in a form that is not individually identifiable; or

(e) To another agency or an instrumentality of any governmental jurisdiction within or under the control of the United States for a civil or criminal law enforcement activity if the activity is authorized by law, if the head of the agency or instrumentality has made a written request to GAO specifying the particular record desired and the law enforcement activity for which the record is sought; or

(f) To any person pursuant to a showing of compelling circumstances affecting the health of safety of an individual if upon such disclosure notification is transmitted to the last known address of such individual; or

(g) To either House of Congress, or, to the extent of matter within its jurisdiction, any committee or subcommittee of Congress; or

(h) Pursuant to the order of a court of competent jurisdiction or in connection with any judicial or quasi-judicial proceedings;

(i) To the Bureau of the Census for purposes of planning or carrying out a census or survey or related activity pursuant to the provisions of title 13, United States Code; or

(j) To the National Archives of the United States as a record which has sufficient historical or other value to warrant its continued preservation by the United States Government, or for evaluation by the Administrator of General Services or his designee to determine whether the record has such value.

§ 83.5 Accounting of certain disclosures.

(a) With respect to each system of personnel records, GAO shall, except for disclosures made under §§ 83.4(a) and 83.4(b), keep an accurate accounting of—

(1) The date, nature, and purpose of disclosure of a record to any person; and

(2) The name and address of the person, agency, or organization to whom the disclosure is made.

(b) Such accounting shall be retained for at least 3 years or the life of the record, whichever is longer, after the disclosure for which the accounting is made.

(c) Except for disclosures made under § 83.4(e), the accounting shall be available upon written request to the individual named in the record.

§ 83.6 GAO policy and requirements.

(a) GAO shall maintain in its personnel records only such information about an individual as is relevant and necessary to accomplish an authorized official purpose. Authority to maintain personnel records does not constitute authority to maintain information in the record merely because a need for it may develop in the future. Both Government-wide and internal agency personnel records shall contain only information concerning an individual that is relevant and necessary to accomplish GAO's personnel management objectives as required by statute, executive order, GAO internal directive, or formal agreements between GAO and other Federal agencies.

(b) GAO shall make every reasonable effort to collect information about an individual directly from that individual when the information may result in adverse determinations about the individual's rights, benefits, and privileges under Federal programs. Factors to be considered in determining whether to collect the data from the individual concerned or a third party are:

(1) The nature of the information is such that it can only be obtained from another party;

(2) The cost of collecting the information directly from the individual is unreasonable when compared with the cost of collecting it from another party;

(3) There is virtually no risk that information collected from other parties, if inaccurate, could result in a determination adverse to the individual concerned;

(4) The information supplied by an individual must be verified by another party; or

(5) Provisions are made, to the greatest extent practical, to verify information collected from another party with the individual concerned.

(c) GAO shall inform each individual whom it asks to supply information, on the form which it uses to collect the information or on a separate form that can be retained by the individual, of—

(1) The authority for the solicitation of the information and whether disclosure of such information is mandatory or voluntary;

(2) The principal purpose or purposes for which the information is intended to be used;

(3) The routine uses which may be made of the information, as published pursuant to paragraph (d)(4) of this section; and

(4) The effects, if any, of not providing all or any part of the requested information;

(d) Subject to the provisions of paragraph (i) of this section, GAO shall publish in the **Federal Register** at least every 2 years a notice of the existence and character of its systems of personnel records. Such notice shall include—

(1) The name and location(s) of each system of personnel records;

(2) The categories of individuals about whom records are maintained in each such system;

(3) The categories of records maintained in each system of personnel records;

(4) Each routine use of the records contained in each system of personnel records, including the categories of users and the purpose(s) of such use;

(5) The policies and practices of GAO regarding storage, retrievability, access controls, retention, and disposal of the records;

(6) The title and business address of the GAO official who is responsible for maintaining each system of personnel records;

(7) GAO procedures whereby an individual can ascertain whether a

system of personnel records contains a record pertaining to the individual;

(8) Procedures whereby an individual can request access to any record pertaining to him contained in any system of personnel records, and how the individual may contest its content; and

(9) The categories of sources of records in each system of personnel records.

(e) GAO shall maintain all records which it uses in making any determination about any individual with such accuracy, relevancy, timeliness, and completeness as is reasonably necessary to assure fairness to the individual in the determination;

(f) GAO shall, prior to disseminating any record about an individual to any persons other than a Federal agency, make all reasonable efforts to assure that such records are accurate, complete, timely, and relevant for GAO's purposes;

(g) (GAO shall make reasonable efforts to serve notice on an individual when any record on such individual is made available to any person under compulsory legal process when such process becomes a matter of public record;

(h) GAO shall establish rules of conduct for persons involved in the design, development, operation, or maintenance of any system of personnel records or files or in maintaining any record, and instruct each person with respect to such rules and requirements of this part, including any other rules and procedures adopted pursuant to this part;

(i)(1) GAO shall establish appropriate administrative, technical and physical safeguards to ensure the security and confidentiality of personnel records. At a minimum, these controls shall require that all persons whose official duties require access to and use of personnel records be responsible and accountable for safeguarding those records and for ensuring that the records are secured whenever they are not in use or under the direct control of authorized persons. Generally, personnel records should be held, processed, or stored only where facilities and conditions are adequate to prevent unauthorized access;

(2) Except for access by the data subject, only employees whose official duties require and authorize access shall be allowed to handle and use personnel records, in whatever form or media the records might appear. To the extent feasible, entry into personnel record storage areas shall be similarly limited. Documentation of the removal of records from storage areas must be kept so that adequate control procedures can be established to assure that removed records are returned on a timely basis.

(3) In addition to following the above security requirements, managers of automated personnel records shall establish administrative, technical, physical, and security safeguards for data about individuals in automated records, including input and output documents, reports, punched cards, magnetic tapes, disks, and on-line computer storage. As a minimum, the safeguards must be sufficient to:

(i) Prevent careless, accidental, or unintentional disclosure, modification, or destruction of identifiable personal data;

(ii) Minimize the risk of improper access, modification, or destruction of identifiable personnel data;

(iii) Prevent casual entry by persons who have no official reason for access to such data;

(iv) Minimize the risk of unauthorized disclosure where use is made of identifiable personal data in testing of computer programs;

(v) Control the flow of data into, through, and from computer operations;

(vi) Adequately protect identifiable data from environmental hazards and unnecessary exposure; and

(vii) Assure adequate internal audit procedures to comply with these procedures.

(4) The disposal of identifiable personal data in automated files is to be accomplished in such a manner as to make the data unobtainable to unauthorized personnel. Unneeded personal data stored on reuseable media, such as magnetic tapes and disks, must be erased prior to release of the media for reuse.

(j) At least 30 days prior to publication of information under paragraph (d)(4) of this section, publish in the **Federal Register** notice of any new use or intended use of the information in the system, and provide an opportunity for interested persons to submit written data, views, or arguments to GAO.

§ 83.7 Standards of conduct.

(a) GAO employees whose official duties involve the maintenance and handling of personnel records shall not disclose information from any personnel record unless disclosure is part of their official duties or required by statute, executive order, regulation, or internal procedure.

(b) Any GAO employee who makes an unauthorized disclosure of personnel records or a disclosure of information derived from such records, knowing that such disclosure is unauthorized, or otherwise knowingly violates these regulations, shall be subject to appropriate disciplinary action. GAO employees are prohibited from using personnel information not available to the public, obtained through official duties, for commercial solicitation or sale, or for personal gain. Any employee who knowingly violates this prohibition shall be subject to appropriate disciplinary action.

§ 83.8 Social Security Number.

(a) GAO may not require individuals to disclose their Social Security Number (SSN) unless disclosure would be required—

(1) Under Federal statute; or

(2) Under any statute, executive order, or regulation that authorizes any Federal, State, or local agency maintaining a system of records that was in existence and operating prior to January 1, 1975, to request the SSN as a necessary means of verifying the identity of an individual.

(b) Individuals asked to voluntarily provide their SSN shall suffer no penalty or denial of benefits for refusing to provide it.

(c) When GAO requests an individual to disclose his or her SSN, it shall inform that individual whether that disclosure is mandatory or voluntary, by what statutory or other authority such number is solicited, and what uses will be made of it.

§ 83.9 First amendment rights.

Personnel records or entries thereon describing how individuals exercise rights guaranteed by the First Amendment to the United States Constitution are prohibited, unless expressly authorized by statute, by the individual concerned, or unless pertinent to and within the scope of an authorized law enforcement activity. These rights include, but are not limited to, free exercise of religious and political beliefs, freedom of speech and the press, and freedom to assemble and to petition the Government.

§ 83.10 Official Personnel Folder.

(a) GAO shall establish and maintain an Official Personnel Folder for each of its employees, except when an existing Official Personnel Folder is used upon transfer from or reemployment by any Executive department, independent establishment of the Federal government, corporation wholly owned or controlled by the United States, and positions subject to civil service rules and regulations in the Legislative and Judicial branches of the Federal government and the District of Columbia government. Except as provided for in

Federal Personnel Manual (FPM) Supplement 293–31, there will be only one Official Personnel Folder maintained for each employee.

(b) GAO/U.S. OPM/GSA Memorandum of Understanding. The Memorandum of Understanding agreed to by the U.S. General Accounting Office, the U.S. Office of Personnel Management (U.S. OPM), and the National Archives and Records Service of the General Services Administration (GSA), Appendix I, constitutes the official and sole agreement concerning the continuity and coordination of the Official Personnel Folder.

(c) GAO policy is to assure continuity and coordination of the Official Personnel Folder when a person for whom an Official Personnel Folder has been established, separates from GAO, or transfers to or from GAO from or to a Federal agency subject to regulations of the U.S. OPM relating of Official Personnel Folders.

GAO will maximize the pooling of information between itself and those Federal agencies subject to OPM rules and regulations concerning the Official Personnel Folder so that a GAO employee may transfer to and from other Federal agencies with one complete and informative Official Personnel Folder.

(d) Ownership of Official Personnel Folder.

(1) The Official Personnel Folders of individuals whose employment with GAO terminated prior to October 1, 1980, are the records of U.S. OPM and are under the jurisdiction and control of U.S. OPM.

(2) The Official Personnel Folders of current GAO employees whose GAO employment began or or after October 1, 1980, and who have had no previous employment by an executive branch agency of the Federal government shall be under the jurisdiction and control of, and are the records of GAO. GAO shall retain jurisdiction over such records even when they are transferred to an executive branch agency.

(3) The Official Personnel Folders of current GAO employees who were employed prior to October 1, 1980, by either GAO or an executive branch agency shall be under the control of GAO but those records established prior to October 1, 1980, by GAO, and all records established as a result of employment by an executive branch agency shall remain under the jurisdiction of, and be part of the records of, U.S. OPM.

(4) GAO will maintain those Official Personnel Folders containing records of employment by an executive branch Federal agency, or by GAO prior to October 1, 1980, in compliance with regulations of the U.S. OPM in accordance with the procedures contained in the Memorandum of Understanding and the provisions of regulations of U.S. OPM contained in 5 CFR Parts 293, 294, and 297, as well as the provisions of FPM Chapters 293, 294, and 297.

(e) Maintenance and Content of Folder. GAO shall maintain in the Official Personnel Folder the reports of selection and other personnel actions named in section 2951 of title 5, United States Code. The Folder shall also contain permanent records affecting the employee's status and service as required by U.S. OPM instructions and as designated in FPM Supplement 293–31.

(f) Use of Existing Folders upon Transfer or Reemployment. In accordance with paragraph (a) of this section, GAO shall request the transfer of the Official Personnel Folder for a person who was previously employed with a Federal agency that maintains such a Folder. The Folder so obtained shall be used in lieu of establishing a new Official Personnel Folder.

(1) When a person for whom an Official Personnel Folder has been established transfers from GAO to another Federal agency that maintains the Folder, GAO shall, on request, transfer the Folder to the new employing agency.

(2) Before transferring the Official Personnel Folder, GAO shall—

(i) Remove those records of a temporary nature filed on the left side of the Folder; and

(ii) Ensure that all permanent documents of the Folder are complete, correct, and present in the Folder in accordance with FPM Supplement 293–31.

(g) Disposition of Folders of Former Federal Employees.

(1) Folders containing the personnel records of individuals separated from employment with GAO will be retained by GAO for 30 days after separation, and may be retained for an additional 60 days. Thereafter, the Folder shall be transferred to the same location and in the same manner as Official Personnel Folders of persons separated from Federal Agencies which are subject to U.S. OPM regulations in accordance with the Memorandum of Understanding.

(2) GAO shall remove temporary records from the Folder before it is transferred in accordance with guidelines applicable to Federal agencies which are subject to U.S. OPM regulations.

(3) If a former GAO employee is reappointed in the Federal service, the employee's Folder shall, upon request, be transferred to the new employing agency.

(h) Access Requests and Amendments to the Official Personnel Folder. Requests for access to, disclosure from, correction of, or amendments to documents contained in the Official Personnel Folder will be made in accordance with the Memorandum of Understanding.

§ 83.11 Disclosure of information.

(a) This section governs responses to a member of the public for access to information covered by this part. It does not limit in any way other disclosures of information pursuant to other provisions of this part.

(b) The following information about most present and former GAO employees is available to the public:

(1) Name;

(2) Present and past position title;

(3) Present and past grades;

(4) Present and past salaries; and

(5) Present and past duty stations (which include room numbers, shop designations, or other identifying information regarding buildings or places of employment).

(c) Disclosure of the above information will not be made where the information requested is a list of present or past position titles, grades, salaries, and/or duty stations of Government employees which, as determined by the Director, Personnel, is:

(1) Selected in such a way as to constitute a clearly unwarranted invasion of personal privacy because the nature of the request calls for a response that would reveal more about the employees on whom information is sought than the five enumerated items; or

(2) Would otherwise be protected from mandatory disclosure under an exemption of Part 81 of this title concerning the public availability of GAO records.

(d) In addition to the information that may be made available under paragraph (a) of this section, GAO may make available the following information to a prospective employer of a GAO employee or former GAO employee:

(1) Tenure of employment;

(2) Civil service status;

(3) Length of service in GAO and the Government; and

(4) When separated, the date and reason for separation shown on the required standard form.

(e) In addition to the information to be made available under paragraph (a) of

this section, the home address of an employee shall be made available to a police or court official on receipt of a proper request stating that an indictment has been returned against the employee or that complaint, information, accusation, or other writ involving nonsupport or a criminal offense has been filed against the employee and the employee's address is needed for service of a summons, warrant, subpoena, or other legal process.

(f) Upon a written official request stating the reasons for the request, an Official Personnel Folder may be disclosed to a representative of a congressional committee or subcommittee, or an official of the legislative or judicial branch:

(g) An Official Personnel Folder shall be disclosed to an authorized official of GAO who needs the information in the performance of official duties. Any questions as to whether a GAO officer or employee is entitled to such access shall be resolved by the Director, Personnel, in consultation with the Office of the General Counsel.

(h) Except as provided in paragraphs (a) through (f) of this section, and except as provided in this part, information required to be included in an Official Personnel Folder is not available to the public and is protected from disclosure by § 81.5(a)(6) of this chapter.

(i) Personnel Appeal Files. GAO, upon receipt of a request which identifies the individual from whose file the information is sought, shall disclose the following information from a Personnel Appeal File to a member of the public, except when the disclosure would constitute a clearly unwarranted invasion of personal privacy:

(1) Confirmation of the name of the individual from whose file the information is sought and the names of the other parties concerned;

(2) The status of the case;

(3) The decision on the case;

(4) The nature of the action appealed; and

(5) With the consent of the parties concerned, other reasonably identified information from the file.

(j) Leave Records. The annual and sick leave record of an employee, or information from these records, is not to be made available to the public by GAO or other Government agency. However, the leave record, or information from it, shall be disclosed to the employee concerned or, with his written consent, to a representative of the employee or any other person that he authorizes to have the record.

(k) Classified Information. GAO will not disclose information classified Executive Order 12356 of April 2, 1982, or other executive order, derived from personnel records except to individuals authorized access to it under terms of that authority.

(l) Examinations and Related Subjects. Information concerning the results of examinations will be released only to the individual concerned, and to those parties explicitly designated in writing by the individual. The names of applicants for GAO positions or eligibles on GAO or civil service registers, certificates, employment lists, or other lists of eligibles, or their ratings or relative standings are not information available to the public.

(m) Medical information.

(1) Medical information about an applicant, employee, or annuitant is not made available to the public by GAO or other government agency;

(2) Medical information about an applicant, employee, or annuitant may be disclosed by GAO to the applicant, employee, or annuitant, or a representative designated in writing, except that medical information concerning a metal or other condition of such a nature that a prudent physician would hesitate to inform a person suffering from it of its exact nature and probable outcome may be disclosed only to a licensed physician designated in writing for that purpose by the individual or his designated representative.

(n) Investigations.

(1) Upon written request, GAO will disclose to the parties concerned any report of personnel investigation under its control, or an extract of the report, to the extent the report is involved in a proceeding before GAO. For the purpose of this paragraph, the "parties concerned" means the Government employee involved in the proceeding, his or her representative designated in writing, and the representative of GAO involved in proceeding.

(2) GAO will not make a report of investigation or information from a report under its control available to the public, to witnesses, or, except as otherwise required under GAO regulations implementing the public availability of records published at Part 81 of this chapter, to the parties concerned in the investigation.

§ 83.12 Procedures for individual access to records.

(a) GAO shall, upon written request by any individual to gain access to his or her record or to any information pertaining to the individual which is contained in a system of personnel records, permit the individual and upon the individual's request a person of his or her own choosing to accompany him or her, to review the record and have a copy made of all or any portion thereof in a form comprehensible to him or her, except that the GAO may require the individual to furnish a written statement authorizing discussion of that individual's record in the accompanying person's presence. When access to the records has been granted by a system manager or designee:

(1) Inspection in person may be made in the office designated in the system notice during the hours specified by GAO.

(2) Upon the determination of the designated GAO official, records may be transferred to a GAO office more convenient to the data subject to review.

(3) Generally, GAO will not furnish certified copies of records. Where certified copies of records are to be furnished, they may be mailed at the request of the data subject or, as determined by GAO, only after waiver or payment of any fee levied in accordance with § 83.17 is received.

(4) In no event shall original records be made available for review by the individual except in the presence of a system manager or designee.

(b) The general identifying information items that the designated GAO official may ask to be furnished before a specific inquiry is granted include:

(1) Full name, signature, and home address;

(2) Picture identification card;

(3) The current or last place and dates of Federal employment, if appropriate; and

(4) Social Security Number (for those systems of records retrieved by this identifier).

(c) A request or inquiry from someone other than the individual to whom the information pertains shall contain such documents or copies of documents that establish the relationship or authorize access as follows:

(1) When the requester is the parent or legal guardian of a data subject who is a minor, the requester shall identify the relationship with the data subject and furnish a certified or authenticated (e.g. notarized) copy of any document establishing parentage or appointment as legal guardian.

(2) Where the requester is the legal guardian of a data subject who has been declared incompetent by the courts, the requester shall identify the relationship with the data subject and furnish a certified or authenticated copy of the court's appointment of guardianship.

(3) Where the requester is a representative of the data subject, the requester shall identify the relationship

with the data subject or the data subject's parent or legal guardian, and furnish documentation designating the representative as having the authority to act on behalf of the data subject.

(d) When the requester appears in person and cannot be identifed by sight and signature, proof of identity is required as follows:

(1) When a request is from the data subject, the means of proof, in order of preference, are:

(i) A document bearing the individual's photograph and signature (for example, driver's license, passport, or military or civilian identification card); or

(ii) Two documents bearing the individual's signature (for example, Medicare card, unemployment insurance book, employer identification card, major credit card, professional, draft, or union membership card).

(2) When a request is made by the parent, legal guardian, or authorized representative of the data subject, the means of identifying the requester and his or her authority for acting on behalf of the data subject shall be as prescribed in paragraphs (c) and (d) of this section. In addition, the requester shall establish the identity of the data subject in the manner prescribed in paragraph (b) of this section.

(e) When a written inquiry or request is received from the data subject, or from the data subject's parent, legal guardian, or authorized representative, it should be signed and—

(1) For an inquiry, contain sufficient identifying information about the data subject to permit searching of the record system(s) and to permit response; and

(2) For an access request—

(i) From the data subject, contain sufficient information to locate the record and establish that the requester and the data subject are the same (e.g. matching signatures);

(ii) From the data subject's parent, legal guardian, or authorized representative, contain sufficient information to locate the record, match identity with the data subject, and such documentation of association or authorization as is prescribed in paragraphs (c) and (d) of this section.

(f) The signed request from the data subject, or from the data subject's parent, legal guardian, or authorized representative specified in paragraph (c) of this section shall be sufficient proof of identity of the requester, unless for good cause, the system manager or designee determines that there is a need to require some notarized or certified evidence of the identity of the requester.

§ 83.13 Inquiries.

(a) General inquiries to request assistance in identifying which system of records may contain a record about an individual may be made in person or by mail to the Director, Personnel.

(b) An inquiry that requests GAO to determine if it has, in a given system of personnel records, a record about the inquirer, should be addressed to the official identified in the **Federal Register** notice for that system. Inquirers should specify the name of the system of personnel records, if known, as published in the **Federal Register.** Such inquiries should contain the identifying data prescribed in § 83.12 before a search can be made of that particular system of records.

§ 83.14 Denial of access requests.

(a) If an access request is denied, the official denying the request shall give the requester the following information:

(1) The official's name, position title, and business mailing address;

(2) The date of the denial;

(3) The reasons for the denial, including citation of appropriate sections of this or any other applicable part; and

(4) The individual's opportunities for further administrative consideration, including the name, position title, and address of the GAO official (see paragraph (c) of this section) responsible for such further review.

(b) Denial of a request for access to records will be made only by the official GAO designee and only upon a determination that:

(1) The record is subject to an exemption under § 83.21 when the system manager has elected to invoke the exemption; or

(2) The record is information compiled in reasonable anticipation of a civil action or proceeding; or

(3) The data subject or authorized representative of the data subject refuses to abide by procedures for gaining access to records.

(c) A request for administrative review of a denial shall be made to the Assistant Comptroller General for Human Resources, United States General Accounting Office, 441 G Street, N.W., Washington, D.C. 20548. The Assistant Comptroller General shall acknowledge receipt of a request for administrative review of a denial of access within 10 working days. If it is not possible to reach a decision within an additional 10 working days, the requester shall be informed of the approximate date (within 30 working days) when such a decision may be expected.

(d) In reaching a decision, the Assistant Comptroller General will review the criteria prescribed in this section which were cited as the basis for denying access, and may seek additional information as deemed necessary.

§ 83.15 Request for amendment of record.

(a) Individuals may request the amendment of their records in writing or in person by contacting the system manager or designee indicated in the notice of systems of records published by GAO in the **Federal Register.** Time limits will be measured from receipt at the proper office.

(b) A request for amendment should include the following:

(1) The precise identification of the records sought to be amended, deleted, or added.

(2) A statement of the reasons for the request, with all available documents and material that substantiate the request.

(c) GAO shall permit an individual to request amendment of a record pertaining to the individual. Not later than 10 working days after the date of receipt of such request, the designated GAO official shall acknowledge in writing such request and, promptly, either—

(1) Make any correction of any portion thereof which the individual believes is accurate, relevant, timely, or complete; or

(2) Inform the individual of the refusal to amend the record in accordance with his or her request, the reason for the refusal, and the name and business address of the GAO official responsible for the refusal.

(3) The GAO official shall permit an individual who disagrees with the refusal by the designated GAO official to amend his or her record to request review of such refusal. A request for administrative review of a denial shall be made in accordance with § 83.16.

(4) In any disclosure containing information about which the individual has filed a statement of disagreement, occurring after the filing of the statement under § 83.16(d), GAO shall clearly note any portion of the record which is disputed and provide copies of a concise statement of the reasons for not making the amendments requested, to persons or other agencies to whom the disputed record has been disclosed.

(5) Nothing in this section shall allow an individual access to any information compiled in reasonable anticipation of a civil action or proceeding.

(d) If necessary, the official authorized to rule on a request for amendment may

seek additional information pertinent to the request to assure that a fair, equitable, and accurate decision is reached.

(e) The following criteria will be considered by the system manager or designee in reviewing initial requests for amendment of records:

(1) The sufficiency of the evidence submitted by the data subject;

(2) The factual accuracy of the information submitted and the information in the record;

(3) The relevancy, necessity, timeliness, and completeness of the information in light of the purpose for which it was collected;

(4) The degree of possibility that denial of the request could result in unfair determinations adverse to the data subject;

(5) The character of record sought to be amended;

(6) The propriety and feasibility of complying with specific means of amendment requested by the data subject; and

(7) The possible involvement of the record in a judicial or quasi-judicial process.

§ 83.16 Administrative review of request for amendment of record.

(a) A request for administrative review of GAO's denial to amend a record in GAO's system of personnel records shall be addressed to the Assistant Comptroller General for Human Resources, United States General Accounting Office, 441 G Street, NW., Washington, D.C. 20548. The Assistant Comptroller General shall acknowledge receipt of a request for administrative review of a denial of amendment within 10 working days.

(b) If a decision cannot be made within an additional 10-day period, a letter will be sent within that time explaining the delay and furnishing an expected date for the decision. A decision on the request must be made within 60 working days after receipt of the request. Only for good cause shown, and at the discretion of the Assistant Comptroller General for Human Resources can this time limit be extended. Any extension requires written notification to the requester explaining the reason for the extension and furnishing a new expected date for the decision. Generally, such extension shall be for no more than an additional 60 working days.

(c) When a request for administrative review of an amendment denial is submitted, the individual must provide a copy of the original request for amendment, a copy of the initial denial, and a statement of the specific reasons why the initial denial is believed to be in error.

(d) An individual requesting an amendment of a record has the burden of supplying information in support of the propriety and necessity of the amendment request. The decision on the request will then be rendered based on a review of the data submitted. The GAO official is not required to gather supporting evidence for the individual and will have the right to verify the evidence which the individual submits.

(e) Amendment of a record will be denied upon a determination by the system manager or designee that:

(1) The record is subject to an exemption from the provisions of this part, allowing amendment of records;

(2) The information submitted by the data subject is not accurate, relevant, or of sufficient probative value;

(3) The amendment would violate a statute or regulation;

(4) The individual refuses to provide information which is necessary to process the request to amend the record; or

(5) The record for which amendment is requested is a record presented in a judicial or quasi-judicial proceeding, or maintained in anticipation of being used in a judicial or quasi-judicial proceeding, when such record is or will become available to the individual under that proceeding and may be contested during the course of that proceeding.

(f) If, after review, the Assistant Comptroller General for Human Resources also refuses to amend the record in accordance with the request, the individual will be permitted to file with GAO a concise statement setting forth the reasons for his or her disagreement with the refusal of GAO. Any such statement of disagreement will be treated in accordance with paragraph (c)(4) of § 83.15.

§ 83.17 Fees.

(a) Generally, GAO's policy is to provide the first copy of any record or portion thereof, furnished as a result of this part, at no cost to the data subject or authorized representative. However, in cases where GAO deems it appropriate (for example, where the record is voluminous), the system manager or designee in his or her discretion may charge a fee when the cost for copying the record (at a rate of 10 cents per page) would be in excess of ten dollars ($10).

(b) There shall be no fees charged or collected from a data subject for the following:

(1) Search for or retrieval of the data subject's records;

(2) Review of the records;

(3) Making a copy of a record when it is a necessary part of the process of making the record available for review;

(4) Copying at the initiative of GAO without a request from the individual;

(5) Transportation of the record; and

(6) Making a copy of an amended record to provide the individual with evidence of the amendment.

§ 83.18 Rights of legal guardians.

For the purposes of this part, the parent of any minor, or the legal guardian of any individual who has been declared to be incompetent due to physical or mental incapacity or age by a court of competent jurisdiction, may act on behalf of the individual.

§ 83.19 Government contractors.

When GAO provides by a contract for the operation by or on behalf of GAO of a system of personnel records to accomplish a function of GAO, GAO shall, consistent with its authority, cause the requirements of this part to be applied to such system. Any such contractor and any employee of such contractor, if such contract is agreed to on or after the effective date of this section, shall be considered, for the purposes of this part, to be an employee of GAO. Contractor employees will be required to observe the confidentiality requirements of this part. Violations of this part by contractor employees may be a sufficient ground for contract termination.

§ 83.20 Mailing lists.

An individual's name and address may not be sold or rented by GAO unless such action is specifically authorized by law. This provision shall not be construed to require the withholding of names and addresses otherwise permitted to be made public.

§ 83.21 Exemptions.

(a) All systems of personnel records are exempted from §§ 83.5(c) 83.12, 83.13, 83.14, and 83.15, relating to making an accounting of disclosure available to the data subject or his authorized representative and access to and amendment of the records and other sections relating to procedural requirements of the above-cited sections if the system of records is:

(1) Subject to the provisions of Part 81 of this chapter concerning records which may be exempt from disclosure by the General Accounting Office;

(2) Investigatory material compiled for law enforcement purposes: *Provided, however,* That if any individual is denied any right, privilege, or benefit that he would otherwise be entitled by Federal law, or for which he would

otherwise be eligible, as a result of the maintenance of such material, such material shall be provided to such individual, except to the extent that the disclosure of such material would reveal the identity of a source who furnished information to the Government under an express promise that the identity of the source would be held in confidence, or, prior to the effective date of this section, under an implied promise that the identity of the source would be held in confidence;

(3) Maintained in connection with providing protection services to the President of the United States or other individuals pursuant to section 3056 of title 18, United States Code;

(4) Required by statute to be maintained and used solely as statistical records;

(5) Investigatory material compiled solely for the purposes of determining suitability, eligibility, or qualifications for Federal civilian employment, military service, Federal contracts, or access to classified information, but only to the extent that the disclosure of such material would reveal the identity of the source who furnished information to the Government under an express promise that the identity of the source would be held in confidence, or, prior to the effective date of this section, under an implied promise that the identity of the source would be held in confidence;

(6) Testing or examination material used solely to determine individual qualifications for appointment or promotion in the Federal service the disclosure of which would compromise the objectivity of fariness of the testing or examination process; or

(7) Evaluation material used to determine potential for promotion in the armed services, but only to the extent that the disclosure of such material would reveal the identity of a source who furnished information to the Government under an express promise that the identity of the source would be held in confidence, or, prior to the effective date of this section, under an implied promise that the identity of the source would be held in confidence.

Appendix I—Memorandum of Understanding

This memorandum of understanding constitutes an agreement between the U.S. Office of Personnel Management (OPM), the National Archives and Records Service of the General Services Administration (NARS), and the U.S. General Accounting Office (GAO) concerning:

(1) The maintenance of the Official Personnel Folder (OPF) of an individual who has been employed in a position subject to the provisions of title 5, U.S.C. and to the regulations and procedures issued by OPM to govern the Federal civil service, and also in a position subject to the GAO Personnel Act of 1980 (Pub. L. 96–191) and its implementing regulations and procedures;

(2) The exchange of personnel documents and data between the Federal civil service administered by OPM and the personnel system administered by GAO;

(3) The establishment of procedures for processing requests for access to, disclosure from, and amendment of documents in the OPF of an individual who has service under both personnel systems;

(4) The establishment of procedures to be followed by the National Personnel Records Center (NPRC) when responding to requests pertaining to separated employees in any of the following circumstances:

(a) When the OPF contains documentation resulting from employment in both systems;

(b) When a request is received for transfer of an OPF between systems;

(c) When processing a request for an OPF, and that OPF contains only records of GAO employment since October 1, 1980;

(5) The agreement of the parties to consult and cooperate in matters relating to the establishment and revision of personnel procedures which may have mutual effect so as to insure the sharing of essential information while minimizing the recordkeeping burden on all three parties.

It is recognized that adjustments to this memorandum may be needed from time to time in order to conform to program changes imposed by statute, executive order, or other appropriate authority. Such adjustments will be made by mutual agreement between the parties and will be appended to this agreement.

Legal and Administrative Provisions

The Privacy Act of 1974 and the Freedom of Information Act (as amended)

Records maintained by the Legislative Branch of the Federal Government, including the GAO, are not covered by the Privacy Act of 1974 (5 U.S.C. 552a) or the Freedom of Information Act (5 U.S.C. 552). Both Acts, however, do for the most part apply to those records established as a result of employment in a position subject to regulations and procedures issued by OPM since such records remain the property of OPM even when in the physical possession of GAO.

Title 5, U.S.C.

The General Accounting Office Personnel Act of 1980 (Pub. L. 96–191) exempts the GAO personnel system from most of the provisions of title 5, U.S.C. and from most of the regulations and procedures issued by OPM. Personnel recordkeeping by GAO prior to October 1, 1980 was conducted under the provisions of title 5 U.S.C.

Executive Order 12107

Executive Order 12107, "Relating to the Civil Service Commission and Labor Management in the Federal Service," designated the OPF maintained by most Federal agencies as the property of OPM. However, GAO is not a Government agency subject to the provisions of this executive order.

Use of Existing OPFs upon Transfer to or Reemployment by GAO

Current Federal Employees

When GAO hires an individual who is currently employed by a Federal agency which maintains OPFs in accordance with OPM regulations, GAO will request that agency to transfer the subject employee's OPF. In making such a request, GAO will follow the procedures contained in FPM Supplement 293–31, and the losing agency will furnish the OPF to GAO within the time frame prescribed in that FPM Supplement.

Former Federal Employees

When GAO hires an individual who was formerly employed by a Federal agency (including a former GAO employee who was previously employed by that agency prior to October 1, 1980) which maintained OPFs in accordance with OPM regulations, and such individual is not currently employed by the Federal government, GAO will request the individual's OPF from the National Personnel Records Center (NPRC). In making such requests, GAO will follow the procedures contained in FPM Supplement 293–31, and NPRC will furnish the OPF within the established time frames therein.

Establishment and Maintenance of OPFs

GAO shall establish and maintain an OPF for each of its employees. Although GAO is not bound by OPM regulations and procedures relating to OPFs, GAO agrees to follow the OPF maintenance procedures contained in FPM Supplement 293–31, in so far as is practicable, in order to: (1) Minimize the burden and paperwork inherent in establishing and operating an independent personnel recordkeeping system; (2) insure the sharing of essential information and personnel records between the two systems; and (3) insure proper maintenance of documents related to OPM-controlled functions, e.g., civil service retirement, Federal Employee's Health Benefits (FEHB), and Federal Employee's Government Life Insurance (FEGLI).

Ownership of OPFs

Former GAO Employees

The OPFs of individuals whose employment with GAO terminated prior to October 1, 1980, are under the jurisdiction and control of, and are part of the records of OPM.

Current GAO Employees

The OPFs of current GAO employees whose GAO employment began on or after October 1, 1980, and who have had no previous employment by an Executive Branch agency of the Federal Government shall be under the jurisdiction and control of, and part of the records of GAO. GAO shall retain jurisdiction over such records even when they are transferred to an Executive Branch agency.

The OPFs of current GAO employees who were employed by either GAO prior to October 1, 1980, or an Executive Branch agency shall be under the control of GAO but those records established prior to October 1,

1980 by GAO, and all records established as a result of employment by an Executive Branch agency shall remain under the jurisdiction of, and be part of the records of, OPM.

GAO agrees to maintain those OPFs containing records of employment by an Executive Branch Federal agency, or by GAO prior to October 1, 1980, in compliance with OPM regulations in accordance with the procedures contained in this memorandum and the provisions of OPM regulations contained in 5 CFR Parts 293, 294, and 297, as well as the provisions of FPM Chapters 293, 294, and 297.

Transfer of OPFs From GAO

When a person who is currently employed by GAO, and for whom GAO maintains an OPF, transfers to an Executive Branch agency of the Federal Government, GAO shall, when requested, transfer the OPF to the new employing agency. However, before such transfer, GAO shall:

—Remove any temporary records filed in the OPF by GAO; and
—Ensure that all long term documents in the OPF are complete and correct and that all documents relevant to areas remaining under OPM control (e.g., retirement, FEHB, and FEGLI) are filed in the OPF in accordance with the requirements of FPM Supplement 293–31.

OPFs of individuals separated from employment by GAO, but not transferring to another agency, will be retained by GAO and forwarded to NPRC in accordance with GAO regulations. The OPF will be transferred to the NPRC in the same manner as an OPF of an individual separated from an Executive branch agency subject to OPM regulations. Such OPFs shall be purged of temporary material in accordance with guidelines established by OPM in FPM Supplement 293–31 and this memorandum, prior to transfer to NPRC. When such OPFs are received by NPRC, they will be maintained in accordance with the procedures and practices governing OPFs of Executive branch agencies subject to OPM regulations, including the release of OPFs or data therefrom in the same manner as with all other OPM controlled OPFs.

Use of Existing OPFs Upon Transfer From GAO to an Executive Branch Agency

When an individual who was employed by GAO on or after October 1, 1980, is transferred to, or after a break in service is subsequently reemployed by an Executive branch agency subject to OPM regulations, that agency will request the OPF from GAO or NPRC (as appropriate) in acordance with the procedures contained in FPM Supplement 293–31, and shall use that OPF in lieu of establishing a new OPF. However, records contained in such an OPF which were created by GAO for employment after October 1, 1980, are to remain in the OPF and are not to be purged or modified in any way by the Executive branch agency.

Use of SF 66, Official Personnel Folder Jackets by GAO

GAO will use the SF 66, Official Personnel Folder jacket issued by OPM. However, GAO agrees to mark or annotate the front of all GAO OPFs with the letters "GAO" in order to provide for easy identification by NPRC personnel.

Responding to FOIA Requests

OPF In Custody of GAO

When GAO has custody of an OPF containing records of employment in an Excutive branch agency subject to OPM regulations including employment by GAO prior to October 1, 1980, and GAO receives a request citing either the Freedom of Information Act (FOIA) or GAO's own procedures (if any) which equate to that Act for information about the subject individual, GAO shall respond in accordance with its own regulations. When GAO is processing the, request it will:

—Consult with OPM before releasing records or data created by an Executive Branch agency or by GAO previous to October 1, 1980; and
—Inform requesters that, insofar as there is a denial of records or data created under OPM's regulations, the requester may address a request for review to: General Counsel, U.S. Office of Personnel Management, Washington, D.C. 20415

Current Executive Branch Employee

When an executive branch agency receives a request under the FOIA for information contained in an OPF, and:

—That OPF contains data resulting from employment in GAO on or after October 1, 1980; and
—The agency determines that the request should be denied;

the agency will provide the requester with a decision in accordance with its regulations. In addition, the agency will inform the requester that, insofar as the decision to deny may relate to records created as a result of the individual's employment by GAO, the requester should address any request for review of the denial of access to those records to: General Counsel, U.S. General Accounting Office, Washington, D.C. 20548.

Review of denials of access to other records will be subject to applicable agency regulations and procedures.

Former Federal Employee

When OPM processes a request under the FOIA for records found in the OPF of a former Federal employee and that individual has service in both the Executive branch and in GAO on or after October 1, 1980, OPM will process that request in accordance with applicable regulations. When OPM is processing the request it will:

—Consult with GAO before releasing records or data created by GAO on or after October 1, 1980; and
—Inform the requester that, insofar as there is a denial of records or data created by GAO, the requester may address a request for review to: General Counsel, U.S. General Accounting Office, Washington, D.C. 20548

Privacy Act Requests

Current Employees of GAO Access

Requests for access to personnel records by current employees of GAO will be processed by GAO in accordance with GAO regulations and procedures. However, when processing requests for records which were created by an Executive branch agency subject to OPM regulations and procedures (including GAO prior to October 1, 1980), or for records created by GAO subject to OPM control (e.g., FEGLI, FEHS, retirement), GAO agrees to provide at least the same procedural rights and benefits as apply to the processing of similar requests by an Executive branch agency.

Amendment

Requests for amendment of personnel records by current employees of GAO will be processed in accordance with GAO regulations and procedures. However, when processing requests to amend records which:

—Are contained in an OPF; and
—Were created during a period of employment by an Executive branch agency subject to OPM regulations and procedures; or
—Were created by GAO prior to October 1, 1980; or
—Were created by GAO since October 1, 1980, and relate to an area which remains subject to OPM regulations and procedures;

GAO agrees to abide by OPM regulations contained in 5 CFR Part 297, and procedures contained in FPM Chapter 297. In addition, GAO agrees to consult with OPM prior to acting on any such request and to notify requesters of a right to appeal an adverse decision relating to the amendment of records subject to OPM control to: Assistant Director for Workforce Information, U.S. Office of Personnel Management, 1900 E Street, NW, Washington, D.C. 20415.

Current Employees of Executive Branch Agencies

Access

When processing a request for access to an OPF by a current employee who has previously worked for GAO on or after October 1, 1980, an Executive branch agency will follow OPM's regulations and procedures applicable to other Privacy Act access requests. However, if there is any question as to the propriety of releasing a document created by GAO on or after October 1, 1980, that agency shall consult with GAO.

Amendment

When processing a request for amendment of a record contained in an OPF of an individual who was previously employed by GAO, an Executive branch agency shall first determine whether the record involved was created by GAO on or after October 1, 1980. When the Executive branch agency determines that the record was created by GAO before October 1, 1980, the agency shall proceed to consider the request for amendment in accordance with OPM regulations contained in 5 CFR Part 297, and FPM Chapter 297. When the record in question was created by GAO prior to October 1, 1980, the Executive branch agency may (if it deems appropriate) consult with GAO prior to rendering a decision. When the request deals with a record created by GAO

on or after October 1, 1980, the Executive Branch agency will:

—Notify the requester that the record in question was created by the GAO on or after the effective date of the GAO Personnel Act of 1980, and that it is subject to GAO regulations and procedures; and

—Forward the record in question, the request for amendment and all supporting evidence to: Director of Personnel, U.S. General Accounting Office, Washington, D.C. 20548.

Former Employees

Access

Requests for access to records contained in the OPF of an individual who is not currently employed in an Executive branch agency subject to OPM regulations, or in GAO, shall be processed by OPM in accordance with procedures contained in FPM Chapter 297. When some of the records in question were created by GAO on or after October 1, 1980, and the OPM office processing the request has a question as to the propriety of releasing one or more such documents, it may consult with GAO prior to rendering a decision.

Amendment

Request for amendment of records contained in the OPF of an individual who is not currently employed in an Executive branch agency subject to OPM regulations, or in GAO, shall be processed as follows:

—If all of the records in question were created by GAO on or after October 1, 1980, and are not subject to OPM control, the requester shall be notified that the records in question are under the jurisdiction and control of GAO, and the request shall be transferred to: General Counsel, U.S. General Accounting Office, Washington, D.C. 20548.

—If some of the records in question were created by GAO on or after October 1, 1980, and those records are not subject to OPM control, OPM will: process that portion of the records subject to its control in accordance with regulations contained in 5 CFR Part 297 and FPM Chapter 297; will notify the requester that part of the records requested to be amended were created by GAO after the enactment of the GAO Personnel Act of 1980, and that those records are subject to GAO's sole jurisdiction and control; and will transfer the request, the records in question, a copy of the OPM decision, and any available background information to: General Counsel, U.S. General Accounting Office, Washington, D.C. 20548.

NPRC Procedures Relating to this Memorandum of Understanding

NPRC will process requests for OPFs in its physical custody in accordance with the following instructions:

—When NPRC receives a request from an Executive branch agency for the OPF of a former GAO employee, NPRC will forward that OPF to the requesting agency;

—When NPRC receives a request from GAO for the OPF of a former Executive branch employee, NPRC will forward that OPF to GAO;

—When the request is from an Executive branch agency for an OPF which contains records of employment both in the Executive branch and in GAO, NPRC will forward the OPF to the Executive branch agency;

—When the request is from GAO for an OPF which contains records of employment both in the Executive branch and in GAO, NPRC will forward the OPF to GAO;

—When NPRC receives a direct request for access to or amendment of an OPF which contains records of employment both in the Executive Branch and/or GAO prior to October 1, 1980 as well as in GAO after October 1, 1980, NPRC will:

• Forward the request and the OPF to the following address if the individual was last employed by an Executive branch agency (including GAO prior to October 1, 1980): Assistant Director for Workforce Information U.S. Office of Personnel Management 1900 E Street, N.W. Washington, D.C. 20415

• Forward the request and the OPF to the following address if the individual was last employed by GAO (on or after October 1, 1980):

Director of Personnel
U.S. General Accounting Office
Washington, D.C. 20548

—When NPRC receives a request for verification of employment data or for a transcript of employment, it will process that request as it would any other for the same information;

—NPRC will provide a transcript of employment when requested by a former employee of the Executive Branch or GAO;

—Requests received at NPRC from former employees seeking copies of documents or information from an OPF containing records of employment both in the Executive branch and in GAO (on or after October 1, 1980), will be forwarded either to OPM or GAO as indicated above, together with the appropriate OPF.

Requests Received from Researchers and Genealogists

NPRC will respond to requests received from genealogists, researchers, or other unauthorized third parties for information concerning individuals who were employed by GAO on or after October 1, 1980, by providing only the following information:

—Name of employee;
—Past and present position titles;
—Past and present grades;
—Past and present salaries; and
—Past and present duty stations.

Requests for additional information, or requests which provide information indicating that the individual is deceased will be forwarded to the legal custodian of the record for direct response.

Requests for Documents from the OPF

When NPRC receives a request either from a former employee or an authorized third party for information or photocopies of specified documents filed in the OPF, the request and the OPF in question will be forwarded to the legal custodian for direct response.

Requests From Federal Investigators

NPRC will grant Federal investigators access to OPFs of former GAO employees subject to the same procedures and limitations which apply to granting investigators access to OPFs under the custody and control of OPM. Such investigators shall be allowed to photocopy any material in such OPFs.

Coordination and consultation

OPM, NARS, and GAO agree that there is a need for continuing close cooperation and consultation concerning the exchange of personnel documents and data and the applicability of procedures relating to the maintenance and use of OPFs and that matters of mutual concern which may arise, but are not covered by this memorandum, will be mutually resolved.

The Assistant Director for Workforce Information of OPM, the Assistant Archivist for Federal Records Centers of NARS and The Director of Personnel of GAO are designated as the coordinators and contact points for the establishment and oversight of relevant procedures, and will assign staff members to implement this agreement. Additional detailed agreements that the coordinators jointly establish will be considered to be a part of this agreement.

Procedures and Regulations Issued to Implement this memorandum

It is agreed that OPM, NARS, and GAO may issue regulations and procedures to implement this memorandum of understanding. The coordinators agree that they will consult concerning the development and issuance of such regulations and procedures, and that when such regulations or procedures are issued, a copy will be furnished to the other parties to this agreement.

Approved:

Dated: June 11, 1982.

Felix R. Brandon, II,

Director of Personnel, U.S. General Accounting Office.

Dated: May 20, 1982.

Dr. Philip A.D. Schneider,

Assistant Director for Workforce Information, U.S. Office of Personnel Management.

Dated: July 12, 1982.

G. N. Scaboo,

Acting Assistant Archivist for Federal Records Centers, National Archives and Records Service, General Services Administration.

Dated: *August 23, 1983.*

Charles A. Bowsher,

Comptroller General of the United States.

[FR Doc. 83-23885 filed 8-31-83; 8:45 am]

BILLING CODE 1610-01-M

DEPARTMENT OF AGRICULTURE

Agricultural Marketing Service

7 CFR Part 1126

[Docket No. AO-231-A51]

Milk in the Texas Marketing Area; Hearing on Proposed Amendments to Tentative Marketing Agreement and Order

AGENCY: Agricultural Marketing Service, USDA.

ACTION: Public hearing on proposed rulemaking.

SUMMARY: The hearing is being held to consider dairy industry proposals to amend the Texas milk marketing order. Two of the proposals to be considered would provide handlers with a temporary credit of either 25 or 40 cents per hundredweight on milk used to produce butter, nonfat dry milk and cheese during the months of December 1983 and March through June 1984. Other proposals would revise the pricing structure of the order by lowering prices in certain northern zones and raising prices in southern zones of the marketing area, change the regulatory treatment of milk containing antibiotics, and revise the standards for pooling supply plants under the order. Proponents contend that the changes are needed to reflect changed marketing conditions.

DATE: The hearing will convene at 9:00 a.m., local time, on October 4, 1983.

ADDRESS: The hearing will be held at the Holiday Inn, DFW North, Highway 114 and Esters Road, Irving, Texas 75062.

FOR FURTHER INFORMATION CONTACT: John F. Borovies, Marketing Specialist, Dairy Division, Agricultural Marketing Service, U.S. Department of Agriculture, Washington, D.C. 20250, 202-447-2089.

SUPPLEMENTARY INFORMATION: This administrative action is governed by the provisions of sections 556 and 557 of Title 5 of the United States Code and, therefore, is excluded from the requirements of Executive Order 12291.

Notice is hereby given of a public hearing to be held at the Holiday Inn, DFW North, Highway 114 and Esters Road, Irving, Texas 75062, beginning at 9:00 a.m., local time, on October 4, 1983, with respect to proposed amendments to the tentative marketing agreement and to the order, regulating the handling of milk in the Texas marketing area.

The hearing is called pursuant to the provisions of the Agricultural Marketing Agreement Act of 1937, as amended (7 U.S.C. 601 *et seq.*), and the applicable rules of practice and procedure governing the formulation of marketing agreements and marketing orders (7 CFR Part 900).

The purpose of the hearing is to receive evidence with respect to the economic and marketing conditions in the Texas marketing area which relate to the proposed amendments, hereinafter set forth, and any appropriate modifications thereof, to the tentative marketing agreement and to the order.

Evidence also will be taken to determine whether emergency marketing conditions exist that would warrant omission of a recommended decision under the rules of practice and procedure (7 CFR 900.12(d)) with respect to Proposals Nos. 1 and 2.

Actions under the Federal milk order program are subject to the "Regulatory Flexibility Act" (Pub. L. 96-354). This act seeks to insure that, within the statutory authority of a program, the regulatory and informational requirements are tailored to the size and nature of small businesses. For the purpose of the Federal order program, a small business will be considered as one which is independently owned and operated and which is not dominant in its field of operation. Most parties subject to a milk order are considered as a small business. Accordingly, interested parties are invited to present evidence on the probable regulatory and informational impact of the hearing proposals on small businesses. Also, parties may suggest modifications of these proposals for the purpose of tailoring their applicability to small businesses.

Th proposed amendments, as set forth below, hve not received the approval of the Secretary of Agriculture.

Proposed by Associated Milk Producers, Inc.

Proposal No. 1.

In § 1126.60 add a new paragraph (h) to read as follows:

§ 1126.60 Handler's value of milk for computing uniform price.

* * * * *

(h) During the months of December 1983 and March, April, May and June of 1984, subtract an amount determined by multiplying the pounds of producer milk used to make butter, nonfat dry milk, and cheddar cheese by 40 cents per hundredweight.

Proposed by Land O' Lakes, Inc.

Proposal No. 2.

In § 1126.60 add a new paragraph (h) to read as follows:

§ 1126.60 Handler's value of milk for computing uniform price.

* * * * *

(h) For the months of December 1983, March and May 1984, subtract the amount obtained by multiplying the pounds of milk, skim milk and cream used to produce butter, nonfat dry milk, and cheese by 0.25 cents. For the month of April 1984, subtract the amount obtained by multiplying the pounds of milk, skim milk and cream used to produce butter, nonfat dry milk and cheese by 0.04 cents.

Proposed by Schepps Dairy, Inc.

Change the adjustments for transportation cost to the various zones by one, or a combination of both, of the following Proposals Nos. 3 and 4.

Proposal No. 3

Revise § 1126.52(a) (1), (2) and (3) to read as follows:

§ 1126.52 Plant location adjustments for handlers.

(a) * * *

(1) For a plant located within one of the zones set forth in § 1126.2, the adjustment shall be as follows:

Zone	Class I	Class II
1	-10¢	None
1-A	-22¢	None
2	-5¢	None
3	None	None
4	None	None
5	None	None
6	+30¢	+30¢
7	+35¢	+35¢
8	+45¢	+45¢
9	+51¢	+51¢
10	+62¢	+62¢
11	+75¢	+75¢
12	+84¢	+84¢

(2) For a plant located in the states of Oklahoma, Arizona, Colorado, Kansas, Missouri, Arkansas and Louisiana, the applicable adjustment shall be the amount of difference existing between the price specified under § 1126.50(a) and the Federal order price computed for such plant had such plant been fully regulated by the order nearest to such plant as measured from the plant location to the zero pricing point in the orders applicable in the states listed herein.

(3) For a plant located outside the areas described in paragraphs (a)(1) and (a)(2) of this section, the adjustment shall be the difference between the price specified in § 1126.50(a) and the higher of the prices computed for Dallas, Abilene and San Antonio, pursuant to § 1126.52(a)(1) reduced by 3.6 cents per hundredweight per 10 miles that the

plant is located from each of these points.

* * * * *

Proposal No. 4

Add a new § 1126.87 as follows:

§ 1126.87 Direct-delivery differential.

For producer milk received at a plant in the following zones, the handler in making payments to producers and cooperative association handlers pursuant to § 1126.9(c), in addition to any amounts required by other provisions of this part, shall pay the amounts shown below per hundredweight of milk so received:

Zone	Without proposal No. 3 (cents)	With proposal No. 3 (cents)
2	+10	
3	+10	
4	+10	
5	+10	
6	+5	
7	+19	
8	+36	+18
9	+23	+6
10	+19	
11	+19	
12	+19	

Proposed by Southland Corporation

Proposal No. 5

Amend § 1126.13 of the current Texas order by adding a new paragraph (f) to read as follows:

§ 1126.13 Producer milk.

* * * * *

(f) In a tank truck that is rejected at a plant due to antibiotics and is not physically received at the plant, if the market administrator is notified of such rejection and is given the opportunity to verify the antibiotics. Milk that is rejected pursuant to this paragraph shall be priced at the location of the plant at which rejected. This paragraph shall not apply to the milk of the producer(s) responsible for the antibiotics.

Proposal No. 6

Revise § 1126.40(c) (3) and (4) of the current Texas order to read as follows:

§ 1126.40 Classes of utilization.

* * * * *

(c) * * *

(3) In fluid milk products and products specified in paragraph (b)(1) of this section, and producer milk that is rejected because of antibiotics pursuant to § 1126.13(f), that are disposed of by a handler for animal feed;

(4) In fluid milk products and products specified in paragraph (b)(1) of this secuon and producer milk that is rejected because of antibiotics pursuant to § 1126.13(f), that are dumped by a handler if the market administrator is notified of such dumping in advance and is given the opportunity to verify such disposition or rejection;

* * * * *

Proposed by Mid-America Dairymen, Inc.

Proposal No. 7

Revise § 1126.7 of the current Texas order by adding new paragraphs (b)(3) and (c)(3) as follows:

§ 1126.7 Pool plant.

* * * * *

(b) * * *

(3) The shipping percentages of this paragraph may be increased or decreased temporarily up to 10 percentage points by the Director of the Dairy Division if the Director finds such revision is necessary to obtain needed shipments or to prevent uneconomic shipments, subject to the following conditions:

(i) Before making such a finding, the Director shall investigate the need for revision either on his own initiative or at the request of interested persons. If the investigation shows that a revision might be appropriate, the Director shall issue a notice stating that revision is being considered and inviting data, views, and arguments; and

(ii) No plant may qualify as a pool plant due to a reduction in the shipping percentage pursuant to this subparagraph unless it had been a pool supply plant during each of the immediately preceding three months.

(c) * * *

(3) The shipping percentages of this paragraph may be increased or decreased temporarily up to 10 percentage points by the Director of the Dairy Division if the Director finds such revision is necessary to obtain needed shipments or to prevent uneconomic shipments, subject to the following conditions:

(i) Before making such a finding, the Director shall investigate the need for revision either on his own initiative or at the request of interested persons. If the investigation shows that a revision might be appropriate, the Director shall issue a notice stating that revision is being considered and inviting data, views, and arguments; and

(ii) No plant may qualify as a pool plant due to a reduction in the shipping percentage pursuant to this subparagraph unless it had been a pool supply plant during each of the immediately preceding three months.

* * * * *

Proposed by the Dairy Division, Agricultural Marketing Service

Proposal No. 8

In § 1126.61 revise paragraph (e) to read as follows:

§ 1126.61 Computation of uniform price (including weighted average price).

* * * * *

(e) Subtract not more than 5 cents per hundredweight. The result shall be the "weighted average price."

* * * * *

Proposal No. 9

Make such changes as may be necessary to make the entire marketing agreement and the order conform with any amendments thereto that may result from this hearing.

Copies of this notice of hearing and the order may be procured from the Market Administrator, C. E. Dunham, P.O. Box 29529, Dallas, Texas 75229; or from the Hearing Clerk, Room 1077, South Building, United States Department of Agriculture, Washington, D.C. 20250, or may be there inspected.

From the time that a hearing notice is issued and until the issuance of a final decision in a proceeding, Department employees involved in the decisional process are prohibited from discussing the merits of the hearing issues on an ex parte basis with any person having an interest in the proceeding. For this particular proceeding the prohibition applies to employees in the following organizational units:

Office of the Secretary of Agriculture
Office of the Administrator, Agricultural Marketing Service
Office of the General Counsel
Dairy Division, Agricultural Marketing Service (Washington Office only)
Office of the Market Administrator, Texas Marketing Area.

Procedural matters are not subject to the above prohibition and may be discussed at any time.

List of Subjects in 7 CFR Part 1126

Milk marketing orders, Milk, Dairy products.

(Secs. 1–19, 48 Stat. 31, as amended, 7 U.S.C. 601–674)

Signed at Washington, D.C., on August 29, 1983.

William T. Manley,

Deputy Administrator, Marketing Program Operations.

[FR Doc. 83-24061 Filed 8-31-83; 8:45 am]

BILLING CODE 3410-02-M

DEPARTMENT OF THE INTERIOR

Office of Surface Mining Reclamation and Enforcement

30 CFR Part 935

Proposed Modifications to the Ohio Permanent Regulatory Program

AGENCY: Office of Surface Mining Reclamation and Enforcement (OSM), Interior.

ACTION: Reopening of public comment period.

SUMMARY: OSM is reopening the period for review and comment on modified portions of the Ohio permanent regulatory program. On July 13, 1983 (48 FR 32031), OSM announced a public comment period and procedures for requesting a public hearing on the substantive adequacy of proposed amendments to the Ohio permanent regulatory program under the Surface Mining Control and Reclamation Act of 1977 (SMCRA) submitted by the State on June 10, 1983. The amendments submitted by Ohio are modifications to the Ohio regulations concerning the permitting and subsidence control requirements for underground coal mine operators. OSM is reopening the comment period to allow the public an opportunity to comment on supplemental material submitted by Ohio on August 11 and 22, 1983.

DATE: Written comments must be received on or before 4:00 p.m. on September 16, 1983.

ADDRESSES: Written comments should be mailed or hand delivered to Ms. Nina Rose Hatfield, Field Office Director, Columbus Field Office, Office of Surface Mining, Room 202, 2242 South Hamilton Road, Columbus, Ohio 43227.

Copies of the supplemental materials submitted by Ohio and other relevant documents will be available for review at the Columbus Field Office listed above, and at the OSM Headquarters Office and the office of the State regulatory authority listed below, Monday through Friday, 8:00 a.m. to 4:00 p.m., excluding holidays.

Office of Surface Mining Reclamation and Enforcement, Administrative Record Room, 1100 "L" Street, N.W., Washington, D.C. 20240

Ohio Division of Reclamation, Building B, Fountain Square, Columbus, Ohio 43224

FOR FURTHER INFORMATION CONTACT: Ms. Nina Rose Hatfield, Field Office Director, Columbus Field Office, Office of Surface Mining, Room 202, 2242 South Hamilton Road, Columbus, Ohio 43227; Telephone: (614) 866-0578.

SUPPLEMENTARY INFORMATION: The Ohio program was conditionally approved by the Secretary effective August 16, 1982, by notice published in the August 10, 1982 **Federal Register** (47 FR 34688). The approval was conditioned on the State's correction of 28 minor deficiencies contained in 11 conditions. Information pertinent to the general background, revisions, modifications and amendments to the proposed permanent program submission, as well as the Secretary's findings, the disposition of comments and explanation of the conditions of approval of the Ohio program can be found in the August 10, 1982 **Federal Register.**

On June 10, 1983, Ohio submitted proposed regulatory amendments to revise the permitting and subsidence control requirements for underground coal mine operators. The amendments are State-generated revisions not related to conditions. The July 13, 1983 **Federal Register** announced receipt of the modifications by OSM and a public comment period. In that same notice, OSM announced that a public hearing would be held only if requested. In response to several requests, a hearing was scheduled and held August 11, 1983. A notice announcing the hearing was published August 3, 1983 (48 FR 35146). The comment period closed on August 12, 1983.

On August 11 and 22, 1983, Ohio submitted additional modifications to the proposed regulations. Copies of the additional modifications are available in the OSM Administrative Record. OSM is reopening the comment period on the proposed modifications and subsequent amendments to the Ohio program in order to allow the public an opportunity to review and comment on the modifications as clarified by the additional amendments submitted to OSM by the State.

Specifically, OSM is seeking comment on whether the regulatory revisions submitted by Ohio on June 10, 1983, as modified by the supplemental amendments submitted August 11 and 22, 1983, satisfy the criteria for approval of State program amendments at 30 CFR 732.17 and 732.15.

List of Subjects in 30 CFR Part 935

Coal mining, Intergovernmental relations, Surface mining, Underground mining.

(Pub. L. 95-87, 30 U.S.C. 1201 *et seq.*)

Dated: August 26, 1983.

William B. Schmidt,

Assistant Director, Program Operations and Inspection.

[FR Doc. 83-24066 Filed 8-31-83; 8:45 am]

BILLING CODE 4310-05-M

30 CFR Part 938

Public Comment and Opportunity for Public Hearing on Modified Portions of the Pennsylvania Permanent Regulatory Program

AGENCY: Office of Surface Mining Reclamation and Enforcement (OSM), Interior.

ACTION: Proposed rule.

SUMMARY: OSM is announcing procedures for the public comment period and for a public hearing on the substantive adequacy of certain program amendments submitted by the Commonwealth of Pennsylvania as modifications to the Pennsylvania Permanent Regulatory program (hereinafter referred to as the Pennsylvania program) under the Surface Mining Control and Reclamation Act of 1977 (SMCRA). These amendments relate to Pennsylvania's subsidence control regulations.

This notice sets forth the times and locations that the Pennsylvania program and proposed amendments are available for public inspection, the comment period during which interested persons may submit written comments on the proposed program elements, and the procedures that will be followed at the public hearing.

DATES: Written comments, data or other relevant information relating to the program amendments not received on or before 4:00 p.m., October 3, 1983 will not necessarily be considered.

A public hearing on the proposed modifications will be held on request only, on September 26, 1983, at the address listed under "ADDRESSES."

Any person interested in making an oral or written presentation at the hearing should contact Robert Biggi at the address and phone number listed below by the close of business *four working days* before the date of the hearing. If no one has contacted Mr. Biggi to express an interest in participating in the hearing by that date, the hearing will not be held. If only one person has so contacted Mr. Biggi, a public meeting, rather than a public hearing, may be held and the results of the meeting included in the Administrative Record.

ADDRESSES: Written comments should be mailed or hand delivered to: Robert Biggi, Director, Harrisburg Field Office, Office of Surface Mining, 101 South 2nd Street, Suite L–4, Harrisburg, Pennsylvania 17101.

The public hearing, if held, will be at the Penn Harris Motor Inn and Convention Center, at the Camp-Hill By-Pass and US 11 and 15, Camp-Hill, Pennsylvania, in the Keystone-A Convention Room.

Copies of the Pennsylvania program, the proposed modifications to the program, a listing of any scheduled public meetings and all written comments received in response to this notice will be available for review at the OSM Pennsylvania Field Office and the Office of the State regulatory authority listed below, Monday through Friday, 8:00 a.m. to 4:00 p.m., excluding holidays.

Harrisburg Field Office, Office of Surface Mining, 101 South 2nd Street, Suite L–4, Harrisburg, Pennsylvania 17101

Pennsylvania Department of Environmental Resources, Fulton Bank Building, Tenth Floor, Third and Locust Streets, Harrisburg, Pennsylvania 17120.

FOR FURTHER INFORMATION CONTACT: Robert Biggi, Director, Harrisburg Field Office, Office of Surface Mining, 101 South 2nd Street, Suite L–4, Harrisburg, Pennsylvania 17101, Telephone: (717–782–4036).

SUPPLEMENTARY INFORMATION: On January 25, 1982, Pennsylvania resubmitted its proposed regulatory program to OSM. On July 30, 1982, following a review of the proposed program as outlined in 30 CFR Part 732, the Secretary approved the program subject to the correction of ten minor deficiencies. The approval was effective upon publication of the notice of conditional approval in the July 30, 1982, **Federal Register** (47 FR 33050–33080).

Information pertinent to the general background, revisions, modifications, and amendments to the proposed permanent program submission, as well as the Secretary's findings, the disposition of comments and a detailed explanation of the conditions of approval of the Pennsylvania program can be found in the July 30, 1982, **Federal Register**.

Submission of Program Amendments

By letter dated August 1, 1983, OSM received from the Commonwealth of Pennsylvania, pursuant to the 30 CFR 732.17 procedures, certain revisions to its subsidence control regulations. These revisions are contained in a suspension order published in 13 Pennsylvania Bulletin 2057 dated July 2, 1983, suspending certain portions of 25 PA. Code sections 89.143–89.147 pertaining to Pennsylvania's subsidence control regulations. The suspension order is a temporary action that does not amend the Pennsylvania Code, but does suspend certain subsidence regulations pending final action by the Environmental Quality Board (EQB). The suspension will lapse if the EQB does not approve the proposed revisions to the subsidence control regulations. This action was ordered by the Chairman of the EQB in an effort to keep the requirements of the Pennsylvania program consistent with the revised Federal requirements published in the June 1, 1983 **Federal Register** (48 FR 24638).

Additionally, the State submitted to OSM a draft copy of revised subsidence control regulations that was submitted to the EQB on August 16, 1983. If the EQB approves these revised regulations, the State will publish these regulations in the Pennsylvania Bulletin as proposed rulemaking. If the EQB disapproved these regulations, the State will modify the regulations accordingly and resubmit the regulations to the EQB and to OSM for review and public comment. The State will submit to OSM any modification to the program amendments for review and public comment at the earliest possible time after the EQB acts.

The Secretary seeks public comment on these proposed amendments to the Pennsylvania program. If these amendments are approved, they will become part of the Pennsylvania program.

Additional Information

1. *Compliance with the National Environmental Policy Act.* Pursuant to Section 702(d) of SMCRA, 30 U.S.C. 1292(d), no environmental document need be prepared on this rulemaking as State program decisions are exempt from compliance with the National Environment Policy Act, 42 U.S.C. 4321 *et seq.*

2. *Executive Order No. 12291 and the Regulatory Flexibility Act.* On August 28, 1981, the Office of Management and Budget (OMB) granted OSM an exemption from Sections 3, 4, 7, and 8 of Executive Order 12291 for actions directly related to approval or conditional approval of State regulatory programs. Therefore, this action is exempt from preparation of a Regulatory Impact Analysis and regulatory review by OMB.

The Department of the Interior has determined that this rule would not have a significant economic effect on a substantial number of small entities under the Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*). This rule does not impose any new requirements; rather, it would ensure that existing requirements established by SMCRA and the Federal rules would be met by the State.

3. *Paperwork Reduction Act.* This rule does not contain information collection requirements which require approval by the Office of Management and Budget under 44 U.S.C. 3507.

List of Subjects in 30 CFR Part 938

Coal mining, Intergovernmental relations, Surface mining, Underground mining.

(Pub. L. 95–87, 30 U.S.C. 1201 et seq.)

Dated: August 26, 1983.

J. L. Harris,

Director, Office of Surface Mining.

[FR Doc. 83-24067 filed 8-31-83; 8:45 am]

BILLING CODE 4310-05-M

DEPARTMENT OF TRANSPORTATION

Coast Guard

33 CFR Part 117

[CGD3 83-037]

Drawbridge Operation Regulations; Harlem River, New York

AGENCY: Coast Guard, DOT.

ACTION: Proposed rule.

SUMMARY: At the request of the Triborough Bridge and Tunnel Authority, the Coast Guard is considering a change to the regulations governing the Triborough Bridge across the Harlem River between Harlem and Wards Island, New York by requiring that advance notice of opening be given between 10 a.m. and 5 p.m. (operational hours for the Harlem River). This proposal is being made because of limited requests to open the draw. This action should relieve the bridge owner of the burden of having a person constantly available to open the draw and should still provide for the reasonable needs of navigation.

DATE: Comments must be received on or before October 17, 1983.

ADDRESS: Comments should be submitted to and are available for examination from 9 a.m. to 3 p.m., Monday through Friday, except holidays at the office of the Commander (oan-br), Third Coast Guard District, Bldg. 135A, Governors Island, NY 10004. Comments may also be hand-delivered to this address.

FOR FURTHER INFORMATION CONTACT: William C. Heming, Bridge Administrator, Third Coast Guard District (212)668-7994.

SUPPLEMENTARY INFORMATION: Interested persons are invited to participate in this proposed rulemaking by submitting written views, comments, data, or arguments. Persons submitting comments should include their name and address, identify the bridge, and give reasons for concurrence with or for any recommended change in the proposal. Persons desiring acknowledgment that their comments have been received should enclose a stamped, self-addressed postcard or envelope.

The Commander, Third Coast Guard District, will evaluate all communications received and determine a final course of action on this proposal. The proposed regulations may be changed in light of comments received.

Drafting Information: The drafters of this notice are Ernest J. Feemster, project manager, and LCDR Frank E. Cooper, project attorney.

Discussion of Proposed Regulations: The Triborough Bridge (over the Harlem River) is a multi-laned bridge carrying a high volume of vehicular traffic. It has a minimum vertical clearance of 54 feet and is only infrequently required to open for passage of a vessel. Bridge opening logs for 1980 through 1982 indicate that an average of less than three openings were required per year from 10 a.m. to 5 p.m.

The proposed regulations would require that four hour notice be given for openings from 10 a.m. to 5 p.m. These proposed regulations are identical to regulations found acceptable for all City of New York (NYC) movable bridges across the Harlem River. This bridge is the second bridge one encounters upon entering the Harlem River from the East River. The first bridge is a NYC foot bridge with a 55 foot minimum vertical clearance. The remainder of the NYC movable bridges found acceptable for four hours notice have a 27-foot minimum vertical clearance or less.

No economic evaluation has been prepared because no economic impact is anticipated. Vessels entering the Harlem River from the East River and requiring opening of this bridge, would probably require an opening of the NYC bridge (at the entrance) since it is only a foot higher.

Economic Assessment and Certification: These proposed regulations have been reviewed under the provisions of Executive Order 12291 and have been determined not to be a major rule. In adiditon, these proposed regulations are considered to be nonsignificant in accordance with guidelines set out in the Policies and Procedures for Simplification, Analysis, and Review of Regulations (DOT Order 2100.5 of 5-22-80). As explained above, an economic evaluation has not been conducted since its impact is expected to be minimal. In accordance with section 605(b) of the Regulatory Flexibility Act (5 U.S.C. 605(b)), it is certified that these rules, if promulgated, would not have a significant economic impact on a substantial number of small entities since no existing operations will be adversely affected.

List of Subjects in 33 CFR Part 117

Bridges.

Proposed Regulations: In consideration of the foregoing, the Coast Guard proposes to amend Part 117 of Title 33, Code of Federal Regulations, by adding a new §117.160(i) to read as follows:

PART 117—DRAWBRIDGE OPERATION REGULATIONS

§117.160 Harlem River, NY.; bridges.

* * * * *

(i) The draw of the Tiborough Bridge and Tunnel bridge, mile 1.3 at Manhattan shall open on signal from 10 a.m. to 5 p.m. if at least four hours notice is given. The draw need not open at any other time except it shall be opened as soon as possible for passage of a public vessel of the United States.

* * * * *

(33 U.S.C. 499; 49 U.S.C. 1655(g)(2); 49 CFR 1.46(c) (5); 33 CFR 1.05-1 (g)(3)).

Dated: August 17, 1983.

W. E. Caldwell,

Vice Admiral, Coast Guard Commander, Third Coast Guard District.

[FR Doc. 83-24039 Filed 8-31-83; 8:45 am]

BILLING CODE 4910-14-M

DEPARTMENT OF EDUCATION

34 CFR Part 366

Centers for Independent Living

AGENCY: Department of Education.

ACTION: Withdrawal of notice of proposed rulemaking.

SUMMARY: The Secretary of Education withdraws the Notice of Proposed Rulemaking (NPRM) for the Centers for Independent Living Program. Congress will consider reauthorizing legislation for this program in Fiscal Year 1983, and new regulations may be necessary to implement any changes enacted by Congress. Withdrawal of the NPRM will permit the Department to give further study to the impact of the proposed changes and to implement any new legislation.

DATE: This withdrawal of the proposed rule is effective September 1, 1983.

FOR FURTHER INFORMATION CONTACT: Commissioner of Rehabilitation Services, 330 C Street, S.W., Switzer Building, Room 3086, Washington, D.C. 20202. Telephone: (202) 472-3796.

SUPPLEMENTARY INFORMATION: An NPRM for the Centers for Independent Living Program was published in the **Federal Register** on January 28, 1983 at 48 FR 4007. The public comment period on this NPRM ended on March 14, 1983.

The Centers for Independent Living Program is authorized under section 711 of the Rehabilitation Act of 1973, as amended. Congress will consider reauthorization of the Rehabilitation Act in Fiscal Year 1983. New regulations will be necessary to implement any changes in the legislation enacted by Congress.

In order for the Department to give further study to the proposed changes, to analyze the public comments, and to incorporate possible new legislation into proposed regulations, the Secretary withdraws the NPRM published on January 28. All substantive comments received on the NPRM will be addressed in any future Notice of Proposed Rulemaking. The schedule for completion of review of the Centers for Independent Living regulations published in the Department's Unified Agenda of Federal Regulations on April 25, 1983 (48 FR 17962) will be revised accordingly.

List of Subjects in 34 CFR Part 366

Education, Grant programs—Social programs, Vocational rehabilitation.

(Catalog of Federal Domestic Assistance No. 84.132, Centers for Independent Living)

Dated: August 25, 1983.

T. H. Bell,

Secretary of Education.

[FR Doc. 83-24017 Filed 8-31-83; 8:45 am]

BILLING CODE 4000-01-M

POSTAL SERVICE

39 CFR Part 111

Identification of Special Rate Bulk Third-Class Mail

AGENCY: Postal Service.

ACTION: Withdrawal of proposed rule.

SUMMARY: The proposed rule was designed to assure that when an authorized nonprofit organization or political committee sends bulk third-

class mail at special rates of postage, the full name and return address of the special rate permit holder would appear both on the address side of the mailing piece and in a prominent location on the material being mailed. The existing regulation, Domestic Mail Manual (DMM) 623.6, requires only that this information appear either on the envelope or in a prominent location on the enclosed material.

DATE: The withdrawal of the proposed rule is effective September 1, 1983.

FOR FURTHER INFORMATION CONTACT: Cheryl L. Beller, (202) 245–4655.

SUPPLEMENTARY INFORMATION: On June 13, 1983 (48 FR 27103), the Postal Service published for comments in the **Federal Register** a proposed change to 623.6 DMM. Interested persons were invited to submit written comments concerning the proposed changes by July 13, 1983.

Thirty-four comments were received on the proposal. Three comments favored the change as proposed.

Twelve commenters objected to the portion of the change requiring the name and return address to appear on the address side of the envelope. Six of these commenters objected because they use double window envelopes with the name and return address appearing through the window. If the names and addresses were required to be printed directly on the envelope, their printing costs would increase significantly. The other six stated that scientifically conducted surveys and studies have proved that envelope opening and response, and consequently income, would be lessened if we require the return address of the nonprofit organization on the front of the mailing piece.

Nineteen commenters voiced general objections to any additional restrictions on the direct mailing ability of nonprofit organizations.

The Postal Service was unaware of the direct and indirect financial hardship that implementation of this proposed rule could cause. Therefore, after consideration of all the comments, we are withdrawing the proposed change to DMM 623.6.

W. Allen Sanders,

Associate General Counsel, Office of General Law and Administration.

[FR Doc. 83-23974 Filed 8-31-83; 8:45 am]

BILLING CODE 7710-12-M

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39 CFR Part 111

Post Office Closing and Consolidation Procedures

AGENCY: Postal Service.

ACTION: Proposed rule.

SUMMARY: These proposed regulations would revise the Postal Service procedures for determining whether to close or consolidate a post office. The proposed revisions are designed to reduce internal paper flow, to place decisional responsibility at levels closer to the community involved, and to stress direct efforts by local managers to meet with affected customers to resolve any differences.

DATE: Written comments must be received on or before October 1, 1983.

ADDRESS: Address comments to General Manager, Delivery and Retail Policy Division, Delivery Services Department, U.S. Postal Service, 475 L'Enfant Plaza West SW., Washington, D.C. 20260–7225. copies of all written comments received will be available for public inspection and photocopying in Room 7406 at the above address between 9:30 a.m. and 4:00 p.m. Monday through Friday.

FOR FURTHER INFORMATION CONTACT: Willam B. Thomas at (202) 245–5758.

SUPPLEMENTARY INFORMATION: On December 15, 1977, the Postal Service published its existing regulations on the standards and procedures governing the consideration of post office closings and consolidations, following completion of a public rulemaking, 42 FR 59079. These regulations, which were adopted to bring Postal Service procedures into line with a provision of Pub. L. 94–421, 39 U.S.C. 404(b) effective March 15, 1977, are currently set forth in Domestic Mail Manual (DMM) 113.2 et. seq. which has been incorporated by reference at 39 CFR 111. The regulations provide necessary guidance to postal managers and to the public in closing or consolidation cases, to help them apply the criteria and follow the procedures outlined in 39 U.S.C. 404(b). These regulations, however, do not apply to the closing or consolidation of post office stations or branches, community post offices, or any other facility which is considered a component service unit of an independent post office. See 42 FR 42695 note 1, 42696, 59080.

The Postal Service wishes to emphasize that the proposed revision to its procedural regulations does not signal a campaign to close or consolidate a large number of post offices. As is now done, any post office recommended for closing or consolidation will be evaluated by local postal managers who are familiar with the surrounding area, and each case will be considered on the merits of its individual circumstances.

As now written, the Postal Service regulations provide for an investigative stage during which the Postal Service gathers information about the postal and nonpostal needs of residents of the community who may be affected by the closing or consolidation of the local post office. This information is obtained from questionnaires sent to and returned by the community residents, as well as from community meetings and other personal contacts with community residents. After gathering and analyzing the information, the Postal Service drafts and posts for 60 days a preliminary closing or consolidation proposal that formally advises the residents of the reasons for the proposed action, and how the Postal Service plans to ensure the continuation of effective and regular postal services. After the posted proposal has been removed, the entire record, at the recommendation of the responsible area postal official (Sectional Center Manager) is sent to the appropriate Postal Service Regional Headquarters for review and the initial drafting of the Postal Service Final Determination. At the recommendation of the Regional Postmaster General, the draft Final Determination and the supporting record on which the Postal Service bases its decision are sent to the Postal Service Headquarters in Washington, D.C., for a final review and determination by the Senior Assistant Postmaster General, Operations Group.

The proposed amendments are designed to reduce the number of decision-making levels required to process these cases with the Postal Service and to encourage more personalized communication with interested customers. An initial survey of community wishes and needs, including the circulation of a questionnaire, would remain the first step. After the results have been reviewed, the next stage is revised to reduce formality and encourage direct personal contact and conciliation. Instead of posting a proposed written decision for comment, the Sectional Center Manager would respond individually in writing to the customers who made comments on the questionnaires that were returned. Any customer who still objects to the closing or consolidation after receiving this response would be entitled to request a personal discussion with the Sectional Center Manager or representative. If still not satisfied, the customer could request a further review of the proposed action by the Regional Director of Customer Services before any further action is taken to effect a closing or consolidation.

The final decision would rest with the Regional Postmaster General, not postal headquarters in Washington.

If the Regional Postmaster General approves a closing or consolidation, the written Final Determination must be publicly posted and the record on which the decision was based must be available for public review. For the first 30 days that the Final Determination is posted, any customer served by the affected office is entitled by law to file an appeal with the Postal Rate Commission. The post office cannot be closed or consolidated until at least 60 days after the Postal Service's written Determination is made available.

Although exempt from the requirements of the Administrative Procedure Act (5 U.S.C. 553(b)(c)) regarding proposed rulemaking by 39 U.S.C. 410(a), the Postal Service invites public comment on the following proposed revision of the Domestic Mail Manual which is incorporated by reference in the **Federal Register**, 39 CFR 111.1

List of Subjects in 39 CFR Part 111

Postal Service.

PART 113—SERVICE IN POST OFFICES

In Part 113, revise 113.2 to read as follows:

113.2 CLOSING OR CONSOLIDATION OF POST OFFICES

.21 Introduction

.211 Coverage. This section establishes the rules and procedures that govern the closing or consolidation of any existing independent post office. The rules cover any decision to replace a post office with a community post office, station, or branch through consolidation with another post office, as well as any decision to close a post office without providing a replacement facility. These regulations *do not* apply to decisions to discontinue or take any other action involving a station, branch, community post office, or any other facility or service unit administratively attached to an independent post office.

.212 Requirements of Law.—a. *General.* By law, 39 United States Code [U.S.C.] 404(b), any decision to close or consolidate a post office must be based on the criteria established by Congress. These include:

(1) the effect on the community served by the office;

(2) the effect on employees of the post office;

(3) compliance with the statutory policy that the Postal Service shall provide a maximum degree of effective and regular postal services to rural areas, communities, and small towns where post offices are not self-sustaining;

(4) the economic savings to the Postal Service;

(5) and any other factors determined to be necessary by the Postal Service.

b. *Mandatory Procedures.* Certain procedures must be followed when closing or consolidating a post office. These include:

(1) The public must be given 60 days notice of the Postal Service's intention to close or consolidate a post office in order to enable the persons served by the affected post office to provide comments.

(2) Any Final Determination to close or consolidate a post office, after public comments are received and taken into account, must be made in writing and must include findings covering all of the required considerations.

(3) The written Determination must be made available to the persons served by the office at least 60 days before the contemplated closing or consolidation takes effect.

(4) Within the first 30 days after the written Final Determination is made available, persons served by the affected post office may appeal the decision to the Postal Rate Commission.

(5) The Commission may affirm the Final Determination of the Postal Service, or return the matter for further consideration, but may not modify the Postal Services's Determination.

(6) The Commission is required by 39 U.S.C. 404(b)(5) to make its decision on the appeal no later than 120 days after it is received.

Note.—A summary table of the notice and appeal periods under the statute and these regulations appears in Exhibit 113.212.

.213 Additional Requirements. Section 113.22 includes rules to assure that the community's identity as a postal address will be preserved. Section 113.23 contains rules for the consideration of a proposed closing or consolidation and for its implementation if approved. These rules are designed to assure that the reasons which lead a postal manager to propose the closing or consolidation of a particular post office are fully articulated and disclosed early enough for customers to present their views before a final decision is made.

.22 Preservation of Community Address

.221 Policy. The Postal Service permits use of a community's separate address to the extent practicable.

.222 Assignment of ZIP Code. The Five-Digit ZIP Code for each address formerly served from the discontinued post office ordinarily should be the ZIP Code of the facility providing replacement service to that address. In appropriate circumstances, the ZIP Code originally assigned to the discontinued post office may be retained if the responsible Sectional Center Manager submits a request with justification to the Regional Director of Customer Services before the Final Determination to close or consolidate the post office is posted. These additional procedures also apply:

a. *Consolidations.* In the case of consolidation, the Five-Digit ZIP Code provided for the replacement community post office, station, or branch will be either (1) the ZIP Code originally assigned to the discontinued post office; or (2) the ZIP Code of the replacement facility's parent post office, whichever provides the most expeditious distribution and delivery of mail addressed to the customers of the replacement facility.

b. *Offices With Several Five-Digit ZIP Codes.* If the ZIP Code is changed and the parent post office has more than one Five-Digit ZIP Code, the ZIP Code must be that of the delivery area within which the facility is located.

.223 Post Office Name in Address. If all of the delivery addresses using the name of the post office to be discontinued are assigned the same Five-Digit ZIP Code, each customer may continue to use the name of the discontinued post office in the address, instead of changing to or adding the name of the post office from which delivery is provided after the closing or consolidation.

.224 Name of Facility Established by Consolidation. If a discontinued post office is consolidated with one or more other post offices (by establishing in the place of the discontinued post office, a community post office, classified or contract station, or branch affiliated with another post office involved in the consolidation), the name of the replacement unit will be the same as the name of the discontinued post office.

.225 Listing of Discontinued Post Offices. The names of all post offices discontinued after March 14, 1977, are listed in an appropriate manner in Postal Service official directories, such as Publication 65, National ZIP Code and Post Office Directory, so long as they are used in addresses. The ZIP Codes listed for discontinued offices are assigned in accordance with 113.2.

.23 Predetermination Activity

.231 General. If a Sectional Center Manager believes that the discontinuance of a post office may be warranted, the manager:

a. Must apply the standards and procedures in 113.23 and 113.24.

b. Must investigate the situation.

c. May recommend that the post office be discontinued, if in the manager's judgment that action is justified.

.232 Consolidation. The recommended action may include a consolidation of post offices to substitute a community post office or classified or contract station or branch for the discontinued post office if:

a. The communities served by two or more post offices are being merged into a single incorporated village, town, or city; or

b. Providing a replacement facility is necessary to maintain regular and effective service to the area served by the post office being considered for discontinuance.

.233 Views of Postmasters. Whether or not the discontinuance under consideration involves a consolidation, the Sectional Center Manager must:

a. Discuss the matter with the postmaster of the post office being considered for discontinuance, and with the postmaster of any other post office that would be affected by the change; and

b. Encourage these postmasters to submit written comments and suggestions to become part of the record for further consideration and review of the proposal.

.234 Public Notice. The Sectional Center Manager must gather and preserve for the record all information pertinent to the decision to recommend a post office closing or consolidation. If the Sectional Center Manager believes a change is warranted, the manager must prepare a notice to the public that the Postal Service plans to close or consolidate the (*NAME*) Post Office. A copy of this notice must be posted in the affected post office or offices for 60 days and a copy must be sent to the Assistant Postmaster General, Government Relations Department, at least 12 days before the notice will be posted in the post office. In the case of a suspended post office, every effort should be made to post the notice in the affected community and in the nearest open post office or community post office.

.235 Predetermination Survey. In addition to a description of the planned change, the Sectional Center Manager must include in the posted notice an explanation of the alternate method of service that is being proposed to the affected customers if the post office is closed or consolidated. The manager must also conduct a predetermination survey, usually by soliciting customer comments and response to a questionnaire.

.236 Analysis of Comments. The Sectional Center Manager must prepare and include in the record an analysis of the public comments received in response to the predetermination survey. The manager should attempt to analyze all comments received, including those received late. The analysis must list and describe each of the points made favorable to the recommended closing or consolidation and each of the points made against the change, and should identify, to the extent possible, how many comments supported each point listed.

.237 Responses to Customers. The Sectional Center Manager must respond in writing to written comments received from customers during the 60 days notice period. The response must include notice of the customer's rights under this paragraph and .238 to request further discussion and review with postal management. If a customer is not satisfied with the written response received, the customer may request in writing within 15 days from the date of the response to discuss the matter further with the Sectional Center Manager or an authorized representative. The Sectional Center Manager or an authorized representative must contact the customer and discuss the customer's concerns within 15 days of this written request.

.238 Interim Review.—a. If the customer remains dissatisfied after discussing the proposed changes with the Sectional Center Manager, or an authorized representative, the customer may request in writing that the Regional Director of Customer Services review the proposed action and the supporting record before a Final Determination is made. This request must be received by the Regional Director of Customer Services within 15 days of the discussion between the customer and the Sectional Center Manager or an authorized representative.

b. Upon receiving a written request for a review, the Regional Director of Customer Services shall obtain the file on the proposed action and the supporting record from the Sectional Center Manager, and shall review it with reference to the issues raised by the customer. The Regional Director shall consult with the Regional Counsel regarding the customer's comments and the supporting record, and shall mail a written response to the customer within 30 days. If the supporting record does not contain sufficient information to enable the Regional Director to respond to the customer's comments, the Regional Director shall return the file to the Sectional Center Manager with instructions for further action.

.24 Preparing the Record

.241 Other Steps. In addition to posting notice of a planned discontinuance and inviting public comment through a predetermination survey, the Sectional Center Manager should take any other steps that the manager considers necessary to ensure that the persons served by the affected post office understand the nature and implications of the recommended changes. Such additional actions may include meeting with community groups, and following up on customer comments which suggest corrective action. Note:

a. If oral comments contain views or information not previously documented, whether in favor of or against the proposal, the manager should encourage the customer to provide written comments which can be preserved for the record.

b. In making a decision, the manager may rely upon communications only when submitted for the record. However, the manager should document oral comments and discussions at any community meeting in the form of a narrative and include them in the record for consideration.

.242 Record. The Sectional Center Manager must maintain as part of the record all of the documentation that has been gathered concerning the proposed change. Note:

a. The record must include all information that the manager has considered, and the decision must stand on the record. No information relevant to a decision may be excluded, whether or not it tends to support the recommendation.

b. The docket number assigned to the record must be the ZIP Code of the office recommended for closing or consolidation.

c. The record must contain a chronological index in which each document included is identified and numbered as filed.

d. Any written communications which respond to the public notice and predetermination questionnaires must be included in the record.

e. A complete copy of the record must be made available for public inspection during normal office hours at the post office where the Final Determination is posted, beginning on the date the Final Determination is posted and extending through the appeal period.

f. Copies of documents in the record must be provided upon request and the payment of fees prescribed by 352.6 of the Administrative Support Manual.

Fees will be waived for the Final Determination, initial notice, and predetermination survey form.

.25 Preparing the Written Final Determination

.251 Reevaluation of Recommendation. After completing the analysis of comments under 113.236, the Sectional Center Manager must review the initial recommendation and reevaluate it thoroughly in light of the additional information and public comments included in the record.

a. Closing or Consolidation not Warranted. If the manager decides not to proceed with the closing or consolidation, notice that the closing or consolidation has been determined not to be warranted must be posted in the post office considered for discontinuance.

b. Closing or Consolidation Warranted. If the manager decides that the proposed discontinuance is justified, a response to the comments received from the public must be incorporated into the written Final Determination.

.252 Drafting the Written Final Determination. If closing or consolidation appears warranted on the basis of the information obtained during the predetermination survey period, the Sectional Center Manager should prepare a document entitled, "Final Determination to (Close, Consolidate) the (Name) Post Office." This document must describe and analyze the nature of and justification for the changes to be made in the service. The written Determination must address each of the following matters in separate sections:

a. Responsiveness to Community Postal Needs. The Final Determination must take into account the policy of Title 39, United States Code, Section 101(b), that the Postal Service shall provide a maximum degree of effective and regular postal services to rural areas, communities, and small towns where post offices are not self-sustaining. The Determination should compare the services available before and after the recommended change; should describe how the changes respond to the postal needs of the persons served by the post office; and should highlight any particular aspects of service that might be less advantageous to the persons served, as well as those that would be more advantageous.

b. Effect on Community. The Final Determination must include an analysis of the social and economic effects that the closing or consolidation might have on the community served by the affected post office. The requirements in 113.22 must be discussed and taken into account.

c. Effect on Employees. The Final Determination must include a summary of the effect of the change on the postmaster and any supervisors or other employees of the post office to be closed or consolidated. (The Sectional Center Manager must comply with personnel regulations related to the closing and consolidation of post offices.)

d. Economic Savings. The Final Determination must include an analysis of the economic savings anticipated by the Postal Service from the closing or consolidation, including the cost or savings expected from each of the major factors contributing to the overall estimate.

e. Other Factors. The Final Determination should discuss any other factors that the Sectional Center Manager determines are necessary to complete evaluation of the Determination, whether they weigh in favor of or against the recommended change.

f. Summary. The Final Determination must include a summary that explains why the closing or consolidation is considered necessary, including an assessment of how the factors supporting the need for the change outweigh any negative factors. In evaluating competing factors, the need to provide regular and effective service must be paramount.

g. Notices. The Final Determination must include the following notices:

"(1) Supporting Materials. Copies of all materials upon which the Determination is based are available for public inspection at the (Name) Post Office during normal office hours."

"(2) Appeal Rights. This Final Determination to (Close, Consolidate) the (Name) Post Office, may be appealed by any person served by the office to the Postal Rate Commission at 2000 L Street NW., Washington, D.C. 20268. Appeals must be received at the Commission within 30 days after the date this Final Determination is posted in the (Name) post Office. Detailed information about the Commission's appeal procedure may be found in 39 CFR 3001.110–3001.116, or obtained by writing to the Secretary of the Commission at the above address. If an appeal is filed, copies of appeal documents issued by the Postal Rate Commission, or filed by parties to the appeal, will be made available for public inspection at the (Name) Post Office during normal office hours."

.253 Forwarding the File. After writing the draft Final Determination, the Sectional Center Manager must:

a. Forward the draft Determination, together with the entire record, through the District Manager to the Regional Postmaster General for final review.

b. Attach a signed certification that all documents included in the record are originals or true and correct copies of the originals.

.26 Final Determination

.261 Standard of Review. The District Manager and Regional Postmaster General must review the draft Final Determination on the basis of the record forwarded by the Sectional Center Manager. The record must fully support the decision of each reviewing authority. As necessary, each reviewing authority may provide instructions through appropriate channels to the Sectional Center to supplement the record. Each decision and instruction must be added to the record.

.262 Review by District and Regional Management. The District Manager must review the draft Determination, and may approve it with or without making revisions, and forward it with the record to the Regional Postmaster General; or may disapprove it and return it with the record to the Sectional Center Manager, stating the reasons for disapproval. Note:

a. If the District Manager disapproves and returns the written Determination, the Sectional Center Manager must post a notice in the affected post office that the recommendation to close to consolidate the facility was not appproved.

b. If the District Manager forwards the draft Final Determination, the Regional Postmaster General may,

(1) approve it, with or without making revisions, or,

(2) disapprove it and return it with the record, stating the reasons for disapproval, through the District Manager to the Sectional Center manager, who must post a notice of disapproval in the post office considered for discontinuance.

.263 Final Determination by Regional Postmaster General. Upon approving the Final Determination the Regional Postmaster General must:

(1) Notify the Assistant Postmaster General, Government Relations Department, Headquarters in writing that the Determination has been approved.

(2) Return a copy of the approved Final Determination and the supporting record to the Sectional Center Manager, with notice of the action to the District Manager.

(3) Place a copy of each Final Determination, and a copy of each

disapproval of a recommended action under this section, on public file as provided in 352.412 of the Administrative Support Manual (ASM).

.27 Implementation of Final Determination

.271 Notice of Final Determination to Discontinue Post Office.—a. The Sectional Center Manager will provide notice of the Final Determination by posting a copy prominently in the affected post office or offices. The date of posting must be noted on the first page of the posted copy as follows: "Date of Posting: (month, day, year)."

b. The Sectional Center Manager must ensure that a copy of the completed record is made available for public inspection during normal office hours at the post office or offices where the Final Determination is posted, beginning on the posting date and extending for 30 days.

c. Copies of documents in the record must be provided upon request and payment of the fees prescribed by 352.6 of the ASM.

.27 Implementation of Determinations Not Appealed. If no appeal is filed under 39 U.S.C 404 (b)(5), the Sectional Center Manager will schedule an appropriate date for the approved closing or consolidation. However, the post office may not be discontinued sooner than 60 days after the posting of the notice required by 113.271.

.273 Actions During Appeal.—a. Implementation of Discontinuance. If an appeal is filed, the affected post office may be discontinued before the final disposition of the appeal only by direction of the Senior Assistant Postmaster General, Operations Group. However, the post office may not be discontinued sooner than 60 days after the posting of the notice required by 113.271.

b. Upon being advised that a posted Final Determination has been appealed to the Postal Rate Commission, the Regional Postmaster General must immediately send by Express Mail, the original and one copy of the entire administrative record of the closing or consolidation to the Office of Rates and Mail Classification Law, Headquarters.

c. Display of Documents. The Regional Counsel will provide the Sectional Center Manager with copies of each pleading, notice, order, brief, and opinion filed in the appeal proceeding.

(1) The Sectional Center Manager must assure that a copy of each of these documents is prominently displayed and made available for inspection by the public in the post office to be discontinued, or if it has already been discontinued or its operations have been suspended in the post office or post offices serving the customers affected.

(2) All documents must be displayed until the Commission's final order and opinion are issued. The final order and opinion must be displayed for 30 days.

.274 Actions Following Appeal Decision.—a. Determination Affirmed. If the Commission dismissed the appeal or affirms the Postal Service's Determination, the Sectional Center Manager will schedule an appropriate date to implement the approved closing or consolidation. However, the post office may not be discontinued sooner than 60 days after the posting of the notice required under 113.271.

b. Determination Returned for Further Consideration. If the Commission returns the matter for further consideration, the Regional Postmaster General must direct either (1) that the notice be provided in accordance with 113.262 that the proposed discontinuance was not approved or (2) that the matter be returned to an appropriate stage under these regulations for further action.

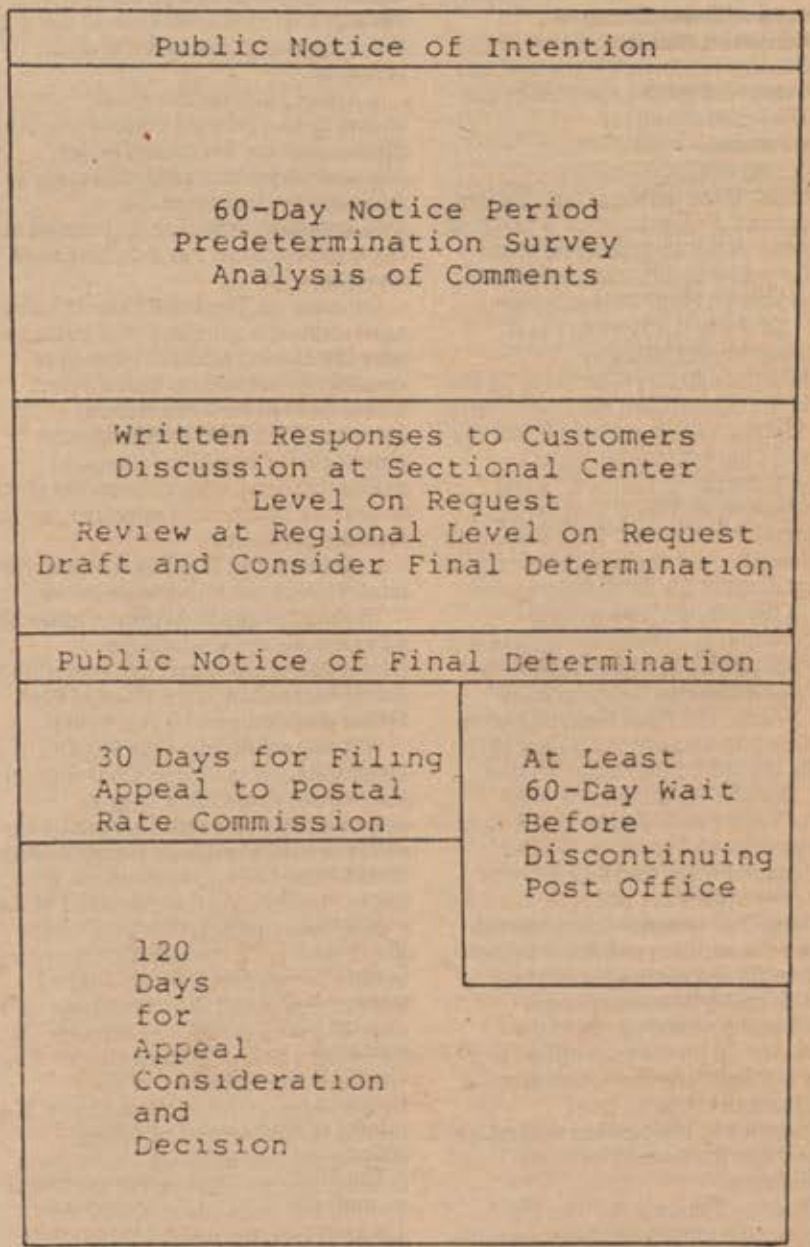


Exhibit 113.712

An appropriate amendment to 39 CFR 111.3 to reflect these changes will be published if the proposal is adopted.

(39 U.S.C. 401, 404 (b))

W. Allen Sanders,

Associate General Counsel, Office of General Law and Administration.

[FR Doc. 83-23973 Filed 8-31-83; 8:45 am]

BILLING CODE 7710-12-M

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 52

[A-5-FRL 2426-5]

Approval and Promulgation of Implementation Plans; Illinois

AGENCY: Environmental Protection Agency.

ACTION: Proposed rulemaking.

SUMMARY: On February 21, 1982 (45 FR 11472) USEPA conditionally approved a revised Part D sulfur dioxide control strategy as part of the Illinois State Implementation Plan (SIP). The SIP approval condition required that the SIP include a reanalysis of the Pekin, Illinois, area; a submittal of the analysis results to USEPA; the proposal of any necessary, additional regulations to the Illinois Pollution Control Board to ensure attainment and maintenance of the sulfur dioxide standard; and the promulgation of any necessary regulations. Any promulgated regulations must be submitted to USEPA. On March 24, 1983, the Illinois Environmental Protection Agency (IEPA) submitted information which satisfies this SIP approval condition for a portion of the Pekin, Illinois area. USEPA is today proposing that this condition to USEPA's approval has been satisfied for all but a portion of the Peoria and Tazewell Counties.

DATE: Comments on this revision and on the proposed EPA action must be received by October 3, 1983.

ADDRESSES: Copies of the SIP revision are available at the following addresses for review. (It is recommended that you telephone Randolph O. Cano, at (312) 886-6035, before visiting the Region V office).

Environmental Protection Agency, Region V, Air Programs Branch, 230 South Dearborn Street, Chicago, Illinois 60604

Illinois Environmental Protection Agency, Division of Air Pollution Control, 2200 Churchill Road, Springfield, Illinois 62706

Comments on this proposed rule should be addressed to: Gary Gulezian, Chief, Regulatory Analysis Section, Air and Radiation Branch (5AR-26), USEPA, Region V, 230 South Dearborn, Chicago, Illinois 60604.

FOR FURTHER INFORMATION CONTACT: Randolph O. Cano, Air and Radiation Branch, Environmental Protection Agency, Chicago, Illinois 60604, (312) 886-6035.

SUPPLEMENTARY INFORMATION: In a March 24, 1983, submittal, IEPA submitted a proposed revision to the Illinois SIP which meets the requirements of USEPA's conditional approval of the Illinois sulfur dioxide SIP for the Pekin, Illinois, area. It also requested USEPA to redesignate Peoria and Tazewell Counties as attainment for the pollutant sulfur dioxide. IEPA requested, on May 3, 1983, that USEPA incorporate recently adopted IPCB Rule 204(f)(2) into the Illinois SIP for sulfur dioxide.

This proposed rulemaking is limited to IEPA's submittal concerning the conditional approval of the Illinois Part D SIP relating to sulfur dioxide in the Pekin, Illinois, area. Separate **Federal Register** notices propose the redesignation of Peoria and Tazewell counties and propose to incorporate IPCB Rule 204(f)(2) into the Illinois SIP for sulfur dioxide.

USEPA has analyzed the information provided by the State of Illinois and determined that redesignations to attainment for SO_2 are warranted at this time for Cincinnati, Pekin, and Elm Grove Townships in Tazewell County and Logan and Limestone Townships in Peoria County. USEPA determined that redesignations to attainment for SO_2 are not warranted for Hollis and Peoria Townships in Peoria County and Groveland Township in Tazewell County until sufficient information is made available to demonstrate that the existing SO_2 SIP will assure attainment and maintenance of the SO_2 NAAQS. The State's request to redesignate Tazewell and Peoria Counties is the subject of a separate **Federal Register** action.

The State has completed the required re-analysis. The re-analysis indicates that redesignations to attainment are warranted for Cincinnati, Pekin, and Elm Grove Townships in Tazewell County and for Logan and Limestone Townships in Peoria County. No further action is required to satisfy this conditional approval since the townships are attainment. USEPA proposed that SO_2 control strategy approval condition, therefore, has been satisfied for these attainment townships. USEPA's conditional approval will remain in effect for the areas USEPA is not proposing to redesignate.

All interested persons are invited to submit written comments on the proposed satisfaction of this control strategy approval condition. Written comments received by the date specified above will be considered in the development of USEPA's final determination. After review of all comments submitted, the Administrator will publish in the **Federal Register** USEPA's final action on the satisfaction of this control strategy approval condition.

Under 5 U.S.C. 605(b), the Administrator has certified that SIP approvals do not have a significant economic impact on a substantial number of small entities. (See 46 FR 8709).

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

List of Subjects in 40 CFR Part 52

Air pollution control, Ozone, Sulfur oxides, Nitrogen dioxide, Lead, Particulate matter, Carbon monoxide, Hydrocarbons, Intergovernmental relations.

(Secs. 110, 172 and 301(a) of the Clean Air Act, as amended (42 U.S.C. 7410, 7502, and 7601(a))

Dated: June 15, 1983.

Valdas V. Adamkus,

Regional Administrator.

[FR Doc. 83-24003 Filed 8-31-83; 8:45 am]

BILLING CODE 6560-50-M

40 CFR Part 52

[A-5-FRL 2367-3]

Approval and Promulgation of Implementation Plans; Indiana

AGENCY: Environmental Protection Agency.

ACTION: Proposed rulemaking.

SUMMARY: On November 29, 1982, the State of Indiana submitted amended rule 325 IAC 11-4 as a revision to the Total Suspended Particulates (TSP) portion of its State Implementation Plan (SIP). This regulation contains site specific emission limitations for Knauf Fiber Glass in Shelby County, Indiana, which consists of an alternative emission

control program (bubble). EPA has designated Shelby County as an attainment area for TSP. Knauf Fiber Glass is using emission reduction credits obtained by a prior permanent shut down of one operation line and by reduction in the allowable emissions at another line to offset increases in allowable emissions at other sources. The regulation also contains procedures which allow emission limits contained in future operation permits to supersede emission limitations contained in this regulation. These revised limits must be submitted to and approved by EPA as a site-specific revision before they become part of the SIP.

EPA has reviewed this regulation and has determined that it has more stringent emission limits than the present SIP, conforms with EPA's emission trading policy, and will have an insignificant impact on the TSP National Ambient Air Quality Standards (NAAQS) in Shelby County. Therefore, EPA is proposing to approve this regulation.

DATE: Comments on this revision and on the proposed EPA action must be *received* by October 3, 1983.

ADDRESSES: Copies of the SIP revision and other materials relating to this rulemaking are available for inspection at the following addresses:

U.S. Environmental Protection Agency, Air and Radiation Branch, Region V, 230 South Dearborn Street, Chicago, Illinois 60604.

Indiana Air Pollution Control Division, Indiana State Board of Health, 1330 West Michigan Street, Indianapolis, Indiana 46206.

Comments on this action should be addressed to: Gary Gulezian, Chief, Regulatory Analysis Section, Air and Radiation Branch, Region V (5AR-26), U.S. Environmental Protection Agency, 230 South Dearborn Street, Chicago, Illinois 60604.

FOR FURTHER INFORMATION CONTACT: Anne E. Tenner, (312) 886-6036.

SUPPLEMENTARY INFORMATION: On April 7, 1982 (47 FR 15076), the EPA issued a proposed Emissions Trading Policy Statement (ETPS). This statement indicates that it is the policy of EPA to encourage use of emissions trades to achieve more flexible, rapid, and efficient attainment of the NAAQS. This policy statement describes emissions trading, sets out general principles EPA will use to evaluate emissions trades under the Clean Air Act, and expands opportunities for states and industry to use these less costly control approaches. The April 7, 1982 notice indicates that until EPA takes final action on its policy statement, state actions involving emission trades will be evaluated under the provisions set forth in the proposed policy statement.

The State of Indiana, on November 29, 1982, submitted amendments to 325 IAC 11-4 as a revision to the Indiana TSP SIP. The State submitted technical information to support the amended rule on December 19, 1982. The amendments add a new section (325 IAC 11-4-3.5) and change/delete particulate emission limitations for six facilities operated by Knauf Fiber Glass Company in Shelby County, Indiana. The emission limit changes are contained in 325 IAC 11-4-4 (Appendix A: Shelby County). EPA has designated Shelby County as an attainment area for TSP under Section 107 of the Act (March 3, 1978 43 FR 8962).

New section 325 IAC 11-4-3.5 allows the State to change emission limitations for specific facilities from those limits contained in 325 IAC 11-4. This is done by issuing, after notice and public hearing, an operating permit containing the new limits and submitting these revised limits to EPA as a revision to the SIP. This procedure has been previously approved by EPA for Indiana in the SIP TSP regulation, 325 IAC Article 6; the SIP sulfur dioxide regulation, 325 IAC Article 7; and the SIP permit regulation, APC 19 (47 FR 30972, July 16, 1982; 47 FR 10813, March 12, 1982; and 47 FR 6621, February 16, 1982, respectively). The SIP emission limits do not change until EPA approves the revised limits. EPA proposes to approve this provision in 325 IAC 11-4.

The changes for the particulate emission limitations for the six facilities operated by Knauf Fiber Glass Company are summarized below:

Facility description	Emission rate (pounds per hour)		
	Old	New	Change
204 oven	2.4	8.00	+5.6
204 furnace	13.78	10.00	−3.78
204 forming	18.82	15.00	−3.82
205 oven	2.44	0	−2.44
205 furnace	8.82	0	−8.62
205 forming	18.16	0	−18.16

In addition to a decrease in plant emission rate (lbs/hr), annual allowable emissions should decrease by 136.9 tons/year.

EPA proposes to approve the revised emission limitations for Knauf Fiber Glass. Knauf Fiber Glass is using emission reduction credits obtained by permanent shutdown of one operation line and by reduction in allowable emissions from the 204 line furnace and forming operations. (The shutdown had already occurred by the date in 1981 that the company submitted its application for revised limitations to Indiana). Consequently, the revision was reviewed with respect to EPA's proposed ETPS. The emission credits involve only particulate matter and are enforceable, permanent and quantifiable. The credits are surplus based on the use of an allowable emission baseline for the trade. The proposed ETPS allows use of an allowable (rather than actual) baseline in attainment areas if proper consideration is given to increment usage for prevention of significant deterioration (PSD). In Shelby County, the baseline date for PSD has not yet been triggered; therefore, the revised emission limits for Knauf will not result in consumption of PSD increment.

It should be noted that actual emissions at the line 204 furnace and forming units have been at a lower level historically than the old allowable emissions level used as the baseline for calculating the emission reduction credits generated at those facilities. This in turn means that the credits from those facilities represent the degree to which their actual emissions were already below their allowable emissions, rather than some new emission reduction below those allowable levels. This should not cause concern here, however, because the real emissions reduction brought about by the shutdown of line 205 creates more than enough emission reduction credits to offset the increase in allowable emissions at the line 204 oven, even without the credits from the line 204 forming and furnace units.

EPA notes that the revised limits represent a new decrease in actual as well as allowable emissions. In addition, an ambient equivalence demonstration was performed consistent with the Level II modeling analysis requirements in the proposed ETPS. That is, the Knauf sources involved in the trade were modeled with MPTER, the appropriate reference model, and one year of meteorological data.

MPTER modeling predicts that under worst case conditions there is a maximum increase in the 24-hour concentrations of 8.4 $\mu g/m^3$, which is below the 10 $\mu g/m^3$ significance level specified in the proposed ETPS. The highest annual TSP concentration increase of any receptor was 0.4 $\mu g/m^3$, which is below the 5 $\mu g/m^3$ significance level.

EPA has concluded that the amended 325 IAC 11-4-4 will not result in a significant degradation of air quality in Shelby County. Therefore, EPA proposes to approve the source specific emission

limits, because the revision will not interfere with the attainment and maintenance of the TSP NAAQS in Shelby County and fulfills the requirements of the proposed ETPS.

EPA is providing a 30-day comment period on this notice of proposed rulemaking. Public comments revised on or before October 3, 1983 will be considered in EPA's final rulemaking. All comments will be available for inspection during normal business hours at the Region V office listed at the front of this notice.

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

Under 5 U.S.C. 605(b), I certify that this SIP approval will not have significant economic impact on a substantial number of small entities.

List of Subjects in 40 CFR Part 52

Air pollution control, Ozone, Sulfur oxides, Nitrogen dioxides, Lead, Particulate matter, Carbon monoxide, Hydrocarbons, Intergovernmental relations.

This notice is issued under authority of Section 110 of the Clean Air Act, as amended (42 U.S.C. 7410).

Dated: August 8, 1983.

Valdas V. Adamkus,

Regional Administrator, Region V.

[FR Doc. 83-24004 Filed 8-31-83; 8:45 am]

BILLING CODE 6560-50-M

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40 CFR Part 81

[A-5-FRL 2426-6]

Designation of Areas for Air Quality Planning Purposes; Attainment Status Designations: Illinois

AGENCY: Environmental Protection Agency.

ACTION: Proposed rule.

SUMMARY: This revision is based on a request from the State of Illinois to redesignate Peoria and Tazewell Counties as attainment for Sulfur Dioxide and on the supporting data the State submitted. Under the Clean Air Act, designations can be changed if sufficient data are available to warrant such change.

ADDRESSES: Copies of the redesignation request, technical documents and the supporting air quality data are available at the following addresses:

Environmental Protection Agency, Region V, Air and Radiation Branch, 230 S. Dearborn Street, Chicago, Illinois 60604

Illinois Environmental Protection Agency, Division of Air Pollution Control, 2200 Churchill Road, Springfield, Illinois 62706

Comments on this proposed rule should be addressed to: Gary Gulezian, Chief, Regulatory Analysis Section, Air and Radiation Branch (5AR-26), USEPA, Region V, 230 South Dearborn, Chicago, Illinois 60604.

FOR FURTHER INFORMATION CONTACT: Randolph O. Cano, Air and Radiation Branch (5AR-26), Environmental Protection Agency, Region V, Chicago, Illinois 60604, (312) 886-6035.

SUPPLEMENTARY INFORMATION: Under Section 107(d) of the Act, the Administrator of USEPA has promulgated the national ambient air quality standards (NAAQS) attainment status for each area of every State. See 43 FR 8962 (March 3, 1978) and 43 FR 45993 (October 5, 1978). These area designations may be revised whenever the data warrant.

On March 24, 1983, the Illinois Environmental Protection Agency (IEPA) submitted a proposed revision to the Illinois State Implementation Plan (SIP) which responded to USEPA's conditional approval of the Illinois sulfur dioxide SIP for the Pekin area, and it requested redesignation of Peoria and Tazewell Counties to attainment for the pollutant sulfur dioxide. On May 3, 1983, IEPA additionally requested that USEPA take action to incorporate newly revised Illinois Pollution Control Board (IPCB) Rule 204(f)(2) into the Illinois SIP. This proposed rulemaking only concerns the proposed redesignation of Peoria and Tazewell Counties to attainment for sulfur dioxide. The State's other two requests are addressed in separate notices of proposed rulemaking.

IEPA's requested redesignation concerns Hollis, Limestone, Logan and Peoria Townships in Peoria County and Cincinnati, Elm Grove, Pekin and Groveland Townships in Tazewell County which are currently designated primary and/or secondary nonattainment for SO_2. The remaining townships in these counties are presently designated attainment for SO_2.

USEPA's criteria for designations are summarized in an April 21, 1983, memorandum, Section 107 Designation Policy Summary, from Sheldon Meyers, Director, Office of Air Quality Planning and Standards, to Air Management Division Directors. For SO_2 non-attainment designations originally based on modeling, redesignations to attainment can be approved provided that a reference modeling analysis considering the sources' legal emission limits shows attainment of the standards. Information must also be presented showing that the sources, which could cause non-attainment if they violated the emission limits, are in fact in compliance with enforceable SIP measures. The State has certified that the major SO_2 sources located within these townships proposed for redesignation are in compliance with the emission limits contained in the Illinois SO_2 SIP.

The available SO_2 monitor data for Peoria and Tazewell Counties indicate that there have been no monitored exceedances or violations of the SO_2 NAAQS in Peoria or Tazewell Counties during the 1980-1982 period. USEPA's Section 107 designation policy, however, recognizes that a small number of ambient monitors, as in Peoria and Tazewell Counties, is usually not representative of the air quality for the entire area if the area is dominated by point sources. Dispersion modeling employing the legally enforceable SO_2 SIP limits is generally necessary to comprehensively evaluate the sources impacts as well as to identify the areas of highest concentration.

IEPA has submitted the results of several modeling studies which assess SO_2 air quality in these counties. The details of these analyses are available for inspection at the addresses listed in the front of this notice. They are briefly summarized in the technical support document which is available at the USEPA Region V Office.

These modeling analyses employing USEPA reference methodology, clearly indicate that the current federally approved SO_2 SIP and the proposed 5.5 lbs/MMBTU emission limit for Pekin Energy (proposed in a separate rulemaking) will not cause or contribute to SO_2 NAAQS violations in Logan and Limestone Townships in Peoria County or Cincinnati, Pekin and Elm Grove Townships in Tazewell County. In addition, the only major SO_2 sources in the above townships (Commonwealth Edison Powerton and Pekin Energy) will not cause or contribute to potential NAAQS violations in Hollis and Peoria Townships, Peoria County or Groveland Township, Tazewell County.

Based on the available reference modeling and monitoring data, USEPA proposes to designate Peoria and Tazewell Counties as attainment for the SO_2 NAAQS with the exceptions of Hollis and Peoria Townships in Peoria County and Groveland Township in Tazewell County. USEPA takes no action at this time on these three townships until sufficient information is available to demonstrate that the existing SO_2 SIP will assure attainment

and maintenance of the SO_2 NAAQS in these areas. Illinois has certified that the major SO_2 sources in the township proposed for redesignation are in compliance with their federally approved emission limits (and that Pekin Energy is in compliance with their proposed limit which was used as input to the modeling analyses).

All interested persons are invited to submit written comments on the proposed redesignation. Written comments received by the date specified above will be considered in determining whether EPA will approve the redesignation. After review of all comments submitted, the Administrator of USEPA will publish in the **Federal Register** the Agency's final action on the redesignation.

Under 5 U.S.C. 605(b), the Administrator has certified that redesignations do not have a significant economic impact on a substantial number of small entities (See 46 FR 8709).

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

List of Subjects in 40 CFR Part 81

Air pollution control, National Parks, Wilderness areas.

(Sec. 107(d) of the Act, as amended (42 U.S.C. 7407))

Dated June 15, 1983.

Valdas V. Adamkus,

Regional Administrator.

[FR Doc. 83-24008 Filed 8-31-83; 8:45 am]

BILLING CODE 6560-50-M

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40 CFR Part 799

[OPTS—42033A; TSH-FRL # 2427-1]

Cresols; Proposed Test Rule; Extension of Comment Period

AGENCY: Environmental Protection Agency (EPA).

ACTION: Proposed rule; extension of comment period.

SUMMARY: EPA is extending the comment period for the proposed test rule for cresols published in the **Federal Register** of July 11, 1983. The extension is in response to a request by the Cresols Task-Force and the Natural Resources Defense Council for additional time for comment. The date for the public meeting on the proposed rule has also been changed.

DATES: Written comments on the proposed rule should be submitted on or before October 10, 1983. EPA will hold a public meeting on October 25, 1983, on this proposed rule in Washington, D.C., if persons request time for oral comment by September 30, 1983.

ADDRESS: Address written comments identified by the document control number (OPTS-42033A) in triplicate to: TSCA Public Information Office (TS-793), Office of Pesticides and Toxic Substances, Environmental Protection Agency, Rm. E-108, 401 M St. SW., Washington, D.C. 20460.

The administrative record supporting this action is available for public inspection at the above address from 8:00 a.m. to 4:00 p.m. Monday through Friday, except legal holidays.

FOR FURTHER INFORMATION CONTACT: Jack P. McCarthy, Director, TSCA Assistance Office (TS-799), Office of Toxic Substances, Environmental Protection Agency, Rm. E-545, 401 M St. SW., Washington, D.C. 20460, Toll Free: (800-424-9065), In Washington, D.C.: (554-1404), Outside the USA: (Operator-202-554-1404).

For exact time and place of meeting contact Jack P. McCarthy.

SUPPLEMENTARY INFORMATION: EPA issued a notice of proposed rulemaking published in the **Federal Register** of July 11, 1983 (48 FR 31812) to consider for testing under section 4(a) of the Toxic Substances Control Act for cresols including the ortho, meta, and para isomers and mixtures of these isomers.

In response to a request by the Cresols Task Force and the Natural Resources Defense Council, the Agency is extending the comment period to October 10, 1983. Additionally, the public meeting for those interested in presenting oral comments will be held October 25, 1983.

Information on the exact time and place of the meeting will be available from the TSCA Assistance Office at the telephone numbers given above. Persons who wish to attend or present comments at the meeting should call the TSCA Assistance Office by September 30, 1983. While the meeting will be open to the public, active participation will be limited to those persons who have arranged to present comments and to designated EPA participants. Attendees should call the TSCA Assistance Office before making travel plans, because the meeting will not be held if members of the public do not wish to make oral comments.

The Agency will transcribe the meeting and will include the written transcript in the public record of the test rule. Participants are invited, but not required, to submit copies of their statements prior to or on the day of the meeting. All such written materials will become part of EPA's record for this rulemaking.

(Sec. 4, Pub. L. 94-469, 90 Stat. 2003 (15 U.S.C. 2601))

Dated: August 23, 1983.

Edwin L. Johnson,

Acting Assistant Administrator for Pesticides and Toxic Substances.

[FR Doc. 83-24001 Filed 8-31-83; 8:45 am]

BILLING CODE 6560-50-M

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 68

[CC Docket No. 81-216; RM Nos. 3206, 3227, 35 et al.]

Connection of Telephone Equipment, Systems and Protective Apparatus to the Telephone Network and; Standards for Inclusion of One and Two-Line Business and Residential Service

AGENCY: Federal Communications Commission.

ACTION: Proposed rule; extension of comment/reply comment period.

SUMMARY: In *Third Notice of Proposed Rulemaking*, CC Docket 81-216, FCC 83-268, 48 FR 29014, June 24, 1983, Concerning Telephone equipment connection and One and Two-Line Business and Residential Service of the Commission ordered the unbundling of digital network channel terminal equipment and sought comments on the establishment of technical standards to permit the attachment of such equipment to the telephone network. Comments are currently due on August 26, 1983 and reply comments on September 19, 1983. In response to a motion for extension of time filed by the United Telephone System, Inc., the Commission has extended the date for filing comments and reply comments.

DATES: Comments are due on September 26, 1983 and reply comments on October 19, 1983.

ADDRESS: Federal Communications Commission, Washington, D.C. 20554.

FOR FURTHER INFORMATION CONTACT: Patrick Donovan, Esq., Domestic Services Branch, Common Carrier Bureau, Federal Communications Commission, Washington, D.C. 20554 (202) 634-1832.

In the Matter of Petitions Seeking Amendment of Part 68 of the Commission's Rules Concerning Connection of Telephone Equipment, Systems and Protective Apparatus to the Telephone Network and Notice of Inquiry into Standards for Inclusion of One and Two-Line Business and

Residential Service in Part 68 of the Commission's Rules; CC Docket No. 81-216, RM-3206, RM-3227, RM-3283, RM-3316,RM-3329, RM-3348, RM-3501, RM-3526, RM-3530, RM-4054, RM-2845, RM-2930, RM-3195.

Order

Adopted: August 23, 1983.
Released: August 24, 1983.
By the Chief, Common Carrier Bureau.

1. Before the Chief, Common Carrier Bureau is a motion for extension of time in the above-captioned proceeding filed by United Telephone System, Inc. (UTS). It requests an extension for comments and reply comments to September 26, 1983, and October 19, 1983, respectively. Comments are currently due on August 26, 1983, and reply comments on September 19, 1983.[1]

2. In support of the requested extension UTS states that in this proceeding in *Third Notice of Proposed Rulemaking*, CC Docket No. 81-216, FCC 83-268, released June 14, 1983, the Commission ordered the unbundling of digital network channel terminal equipment (NCTE) and sought comments on the establishment of technical standards to permit the attachment of such equipment to the telephone network under the Part 68 registration program. UTS states that pending the adoption of final standards by the Commission the American Telephone and Telegraph Co. (AT&T) was directed to file tariffs to become effective August 23, 1983 accomplishing such unbundling based on interim technical standards. *Third Notice of Proposed Rulemaking, supra*, paragraphs 45-46. UTS points out that the effective date for these tariffs will now be deferred until October 25, 1983,[2] and that the technical data supporting AT&T's unbundling of NCTE will not be available prior to the date for submitting comments on final standards to be adopted by the Commission in this proceeding. UTS claims that review of AT&T's technical publications in connection with the interim tariff will be necessary in order to sufficiently address the complex technical issues involved in adopting final standards.

3. We find that the requested opportunity to review AT&T's technical publications to be submitted in connection with its proposed tariff to unbundle NCTE will not unduly delay the adoption of final standards by the Commission. Accordingly, we will grant UTS's motion.

4. Accordingly, it is ordered, that the date for filing comments is extended until September 28, 1983 and for reply comments until October 19, 1983.

James R. Keegan,
Chief, Domestic Facilities Division, Common Carrier Bureau.

[FR Doc. 83-23864 Filed 8-31-83; 8:45 am]
BILLING CODE 6712-01-M

[1] *See* Order of the Common Carrier Bureau released July 27, 1983 granting in part a motion for extension of time filed by GTE Service Corporation. Comments had originally been due on July 29, 1983 and reply comments on August 17, 1983.

[2] *See* letter from Chief, Tariff Division to AT&T dated August 15, 1983.

NATIONAL TRANSPORTATION SAFETY BOARD

49 CFR Part 821

Rules of Practice in Air Safety Proceedings; Request for Comments

AGENCY: National Transportation Safety Board.

ACTION: Notice of proposed rulemaking (NPRM).

SUMMARY: The purpose of this notice is to request comments on certain proposals that would revise and update portions of the Board's Rules of Practice in Air Safety Proceedings.

The Safety Board conducts three types of proceedings under Part 821 of its Rules of Practice. These are: (1) The review of denials of requests for certification made under Section 602 of the Federal Aviation Act of 1958, as amended (49 U.S.C. 1422 et seq.) (the Act) which deal almost exclusively with denials of airman medical certification; (2) the review of suspension and revocation actions, among others, taken by the FAA against airman and other aviation certificates pursuant to section 609 of the Act; and (3) the expedited review of suspensions and revocations taken by the FAA under its emergency authority.

Recommendations for changes to our procedural rules have been received from both the FAA and from counsel for persons who have sought relief through the Safety Board's administratie review procedures. The Board has weighed and considered the recommendations that have been made and now proposes to adopt amendments to its rules that would enhance the Board's ability to accord parties to its appeal procedures a more favorable forum for the just and expeditious resolution of the issues.

DATES: Comments must be received on or before November 1, 1983.

ADDRESS: Comments and requests for further information should be addressed to: Office of General Counsel, National Transportation Safety Board, 800 Independence Avenue, S.W., Washington, D.C. 20594; Telephone [(202) 382-6540].

FOR FURTHER INFORMATION CONTACT: Mr. John N. Stuhldreher, General Counsel, (202) 382-6540.

SUPPLEMENTARY INFORMATION:

Comments Invited

Interested persons are invited to participate in the making of the proposed rules by submitting such written data, views, or arguments as they may desire. All comments received on or before the closing date for comments will be considered by the Board before taking action on any of the proposed changes. The proposals contained in this notice may be changed in the light of the comments received. All comments submitted will be available, both before and after the closing date for comments, in the Rules Docket, for examination by interested persons.

Background

The Board's Rules of Practice in Air Safety Proceedings were originally promulgated in 1967 as Part 421 of Title 14 (14 CFR Part 421) and were instituted when the Board was assigned the function of reviewing appeals from the safety enforcement actions taken by the FAA that, until adoption of the Department of Transportation Act (49 U.S.C. 1651), had been exercised by the Civil Aeronautics Board. Amendments to the Rules of Practice have been few and, generally, the procedural rules have been a workable tool in the administration of the Board's review function. The Rules were intended to provide the Board's administrative law judges with a framework for the orderly performance of their review functions without depriving them of the necessary flexibility afforded by the exercise of discretion. The changes proposed in this notice are intended to continue the Board's practice of encouraging its law judges to exercise discretion when the needs of justice are served thereby, while concurrently providing both the Government and the petitioner seeking review with the certainty that an orderly procedural framework can provide. Major matters that, the Board concludes, are in need of revision are: first and foremost, the matter of discovery and prehearing preparation; secondly, the identification of the evidence that can be considered by an administrative law judge and, hence, that becomes part of the record in an airman medical proceeding; third, recognition of the right to judicial review of Board Orders; and, finally, use of the U.S. Government

franked envelope, and the certificate of service as evidence of the date of service. Other areas of concern are also dealt with in the proposal. Noteworthy is the fact that the Board has, for the time being, decided not to propose amendments to its rule refecting the recommendation that has been made that it adopt the provisions of the Federal Rules of Civil Provedure that pertain to depositions and discovery. Nevertheless, we encourage reference to the Federal Rules as general guidelines, and especially to the principles developed in the case law that has emerged in their application, by our law judges and by counsel who appear before them, and are proposing an amendment to § 821.19 to reflect that policy.

Section-by-Section Analysis

Section 821.1 Definitions

In response to a recommendation, a definition of the term "interrogatory" is proposed as an addition to the terms defined in Section 821.1. Moreover, in light of the Board's express intention to enlarge the pre-hearing discovery process, it is proposed to amend § 821.19(a) to clarify the fact that the testimony of any person may be obtained either by deposition or by the submission of a written interrogatory. Moreover, the Board is proposing to dispense with the current requirement that permission to begin discovery be obtained.

Section 821.2—The Board proposes a change to the section to clarify the fact that proceedings under Part 821 also include proceedings involving airman medical certification.

Section 821.6—Although a recommendation was made to limit representation at Board hearings to attorneys of record, the Board believes that the non-attorney representative has not presented an identifiable problem in Board proceedings. Moreover, a non-attorney representative could be useful in dealing with lanuage communication or technical problems. The need for an administrative procedure to ensure attorney qualification has not yet surfaced. The Board is proposing a change, however, to require that the attorney of record be identified at every point in the proceedings. If any party, including the FAA, substitutes an attorney at any stage in the proceedings, particularly on appeal from an initial decision, the name of the attorney of record should be forwarded to the Board in writing.

Section 821.7/812.8—Concerns surrounding the filing of documents with the Board to evidence compliance with a filing date and service of documents on opposing parties have surfaced, especially with respect to the use by the Government of the franked envelope, a use that precludes the availability of a postmark as evidence of the date of mailing. Since the U.S. Post Office no longer provides a category of service designated "air mail", that term has been removed from the various provisions as have references to the so-called "800 mile rule."

As proposed, all provisions that deal with filing of documents will be revised to permit the use of the franked envelope thereby causing the certificate of service that accompanies each document and that contains a certified statement of the date the document was mailed to be evidence of the date of mailing. As proposed, the use of the certificate of mailing as evidence will extend to government and non-government parties alike. In case a party may inadvertently omit the certificate of service, the postmark will serve as evidence of the date of mailing.

Sections 821.9 and 821.16—On the matter of intervenors and the extent to which intervenors may participate, the Board renews and restates its policy of encouraging its law judges to exercise their discretion on the matter at any stage of the proceedings prior to appeal from an initial decision. As in other interlocutory matters, the Board's Rules provide the right to an interlocutory appeal at the discretion of the law judge. Although a recommendation has been made that the rules require a stay in any proceeding from which an interlocutory appeal has been taken, we believe that this is also a matter well within the discretion of the law judge.

Section 821.12—A recommendation has been made to permit settlement of cases without Board or law judge approval. We are not proposing adoption of the recommendation for two reasons:

(1) After having provided a forum for the resolution of issues, the Board is entitled to be apprised that the matter has been resolved by settlement; and

(2) Settlements do not necessarily bring an end to the matter of Board or even judicial review when applications for attorney fees and other issues later emerge; consequently, it is well within the Board's oversight responsibility to determine that cases are settled with reasonable fairness in order to ensure that review of claims for fees can be conducted properly, among other reasons.

Section 821.17—The Board is proposing to amend § 821.17 to provide for a motion for judgment on the pleadings after all pleadings have been filed and before the case has gone to hearing. The law judge may grant such a motion at his discretion.

Section 821.18—The recommendation has been made that the section entitled, "Motion for more definite statement," be expanded to include the use of such a motion to clarify pleadings that do not require a response. In the event that an answer fails to clearly respond either to the complaint in a Section 609 proceeding or to the petition for review in a Section 602(b) proceeding, the Board is proposing to permit the opposing party to file a motion for a more definite statement. The law judge may grant the motion at his discretion.

Section 821.19—Numerous recommendations have been made to amend § 821.19 to permit parties to initiate discovery proceedings without filing the motion requesting permission to conduct a deposition or to serve an interrogatory that the Board's Rules currently require. In response, the Board is proposing to amend the current § 821.19 to permit the taking of testimony by deposition or the service of an interrogatory by either party after a petition for review or a complaint is filed. Similarily we are proposing that the parties pursue other discovery on their own initiative. If disputes arise, they may be referred to the law judge assigned to the case for resolution.

Although the Board is not proposing the recommendation that has been made to adopt the deposition and discovery rules of the Federal Rules of Civil Procedure, we continue to endorse reference to those Rules by both administrative law judges and parties in their pleadings and motions. The Board is also proposing a revision to § 821.19 to encourage the use of pre-hearing discovery to minimize the element of surprise at Board hearings and to accord parties a more favorable opportunity for preparing their cases. We are also proposing to add a provision to the section to encourage use of the Federal Rules and the principles enunciated in

their application in matters that pertain to discovery.

Section 821.20—Although the recommendation has been made that subpoenas be issued routinely without approval of a law judge upon a showing of relevance, it is the Board's view that the issuance of subpoenas, especially if they are to be enforceable, requires that they be issued upon s showing of relevance. In the event that a party wishes to gauge the availability of a prospective witness, he can do so by use of a letter that indicates that a subpoena will be obtained.

Section 821.24—The matter of submission by a party of medical evidence not yet seen and evaluated by the Federal Air Surgeon has been a cause for concern in numerous proceedings, especially when an individual has undergone medical evaluation in the interim period between final denial by the Administrator, and Board review. Depending on the nature of the medical evidence submitted, the entire matter of medical qualification may require reevaluation by the Federal Air Surgeon and his staff. An example of this would be a case in which final denial was based upon a structural defect or condition that was subsequently corrected by surgery. In that event, a review of a petitioner's post-surgical medical circumstances might well lead to issuance of a certificate without Board review. In most Board Cases, however, the petitioner merely wishes to submit the results of further medical evaluation that attest to his continued medical fitness. In cases where the new medical evidence is developed and a petitioner plans to offer it into evidence at the hearing, the Board is proposing to add a new paragraph (e) to § 821.24 to require that the new medical evidence be submitted to the FAA at least 30 days in advance of the date hearing.

Section 821.31—A recommendation has been made that affirmative defenses, such as timely filing under the Aviation Safety Reporting Program or the mistaken identity of the pilot in command, be specifically pleaded in the answer or be made a matter of record at some time prior to hearing. In this way, all parties will be apprised of the matters that will be at issue at the hearing and can make preparations to properly address them. Accordingly, the Board is proposing to amend § 821.31(c) to require that affirmative defenses be specifically pleaded at some time prior to hearing. In the discretion of the law judge, an affirmative defense not so pleaded may be ruled inadmissible.

Section 821.37—The Board proposes to revise the provisions that pertain to the setting of a time and place for hearing to provide that parties are given at least 30 days' notice, that the need for pre-hearing discovery be taken into consideration, and that the availability of witnesses and other concerns of both parties be taken into consideration insofar as such concerns are compatible with the language of Section 602(b) of the Act which states, "The Board shall thereupon assign such petition for hearing at a place convenient to the applicant's place of residence or employment."

Section 821.48—As proposed herein, an additional 10 days would be added to the period of time permissible for the filing of a brief on appeal from an oral initial decision. Although one contributor recommended that the Rules be amended to provide for the filing of a brief in reply to the reply brief, the Board believes that § 821.48(e) provides sufficient flexibility for the filing of additional briefs, in the event that they are needed.

Section 821.57—A few recommendations have been made for amendments to the rules that apply to emergency proceedings. These have been evaluated in light of the fact that Section 609 of the Act requires that the entire emergency proceeding, including Board review, be completed within 60 days of the Administrator's written notice of an emergency. The Board proposes to add a sentence to clarify the fact that the time limitations are not affected by the unavailability of the hearing transcript but require that they be met in order for the Board to meet the 60-day completion date. Despite the rigid time restraints that must be met in emergency proceedings, the Board proposes to extend the period for filing a brief in reply to the appeal brief from 5 to 10 days.

Subpart K—A new Subpart K will be added to the regulations to recognize expressly that the statutory scheme in aviation safety enforcement proceedings provides for judicial review. (Section 1006 of the Act; 49 U.S.C. 1486).

Editorial Changes

In proposing this revision of Part 821, a review has been made of each Section for clarity. Some Sections have been updated in light of changes made to its services by the U.S. Post Office. Changes have been made to reflect the change in title of the FAA's Office of General Counsel to the Office of Chief Counsel.

Regulatory Flexibility

Under the criteria of the Regulatory Flexibility Act, these proposed rules at promulgation will not impose any kind of regulatory burden on any entity. The proposed rules are procedural and are intended to simplify and clarify the Board's procedures in exercising an administrative review function authorized by statute.

Paperwork Reduction

The rules that are proposed herein do not alter in any way the amount of paperwork involved in pursuit of an appeal to the Board.

Authority

Title VI, Federal Aviation Act of 1958, as amended, 49 U.S.C. 1421 et seq., and Sec. 304(a)(9) of the Independent Safety Board Act of 1974, as amended (49 U.S.C. 1903).

List of Subjects in 49 CFR Part 821

Administrative practice and procedure, Airmen, Aviation safety.

The Proposed Regulation

PART 821—[AMENDED]

In consideration of the foregoing, the Safety Board proposes to amend its Rules of Practice in Air Safety Proceedings (49 CFR Part 821) as follows:

1. By adding a definition for the term "interrogatory" to § 821.1 between the terms "initial decision" and "law judge" to read as follows:

§ 821.1 Definitions

* * * * *

"Interrogatory" means a written question directed to any person, including a party to the proceeding, to be answered under oath.

* * * * *

2. By revising § 821.2 to read as follows:

§ 821.2 Applicability and description of part.

The provisions of this part govern all air safety proceedings, including proceedings involving airman medical certification, before a law judge upon petition for review, or upon appeal from any order of the Administrator amending, modifying, suspending, or revoking any certificate, and upon appeal to the Board from any order or decision of a law judge.

3. By adding a new paragraph (d) to § 821.6 to read as follows:

§ 821.6 Appearances and rights of witnesses.

* * * * *

(d) Any party to a proceeding who is represented by an attorney shall notify the Board of the name and address of that attorney. In the event of a change in

counsel of record, each party shall notify the Board, in the manner provided in § 821.7(a), and the other parties to the proceeding prior to participating in any way, including the filing of documents, in any proceeding.

4. By revising § 821.7(a) to read as follows:

§ 821.7 Filing of documents with the Board.

(a) Filing address, date and method of filing.

Documents to be filed with the Board shall be filed with the following:

Office of Administrative Law Judges,
National Transportation Safety Board,
Washington, D.C. 20594,

by personal delivery or by mail (including U.S. Government franked envelope) and shall be deemed to be filed on the date of actual personal delivery, on the mailing date shown on the certificate of service, or the date shown on the postmark if there is no certificate of service.

* * * * *

5. By revising § 821.8 (a), (c), (e), and (h) to read as follows:

§ 821.8 Service of documents.

(a) *Service by the Board.* The Board will serve orders, notices of hearing, initial decisions, and rulings on motions upon all parties to the proceeding by certified mail. Other documents will be served by certified mail or by regular mail.

* * * * *

(c) *How service may be made.* Service may be made by personal delivery, by certified mail, or by regular mail (including U.S. govenment franked envelope).

* * * * *

(e) *Where service may be made.* Service by regular or certifed mail shall be made at the address of the person designated in accordance with §821.7(f) to receive service, or, if no such person is designated, at the usual residence or principal place of business of the party, or, if not know, at the address last furnished by him to the Federal Aviation Administration, except that an agent designated by an air carrier under section 1005(b) of the Act shall be served only at his office or usual place of residence. Service by mail on the Administrator shall be made at the office of his designee to receive service, or if none, at the Federal Aviation Administration, Office of the Chief Counsel, Washington, D.C. 20591. Personal service may be made on any of the persons described in paragraph (d) of this section wherever they may be found, except that an agent designated by an air carrier under section 1005(b) of the Act may be served only at his office or usual place of residence.

* * * * *

(h) *Date of service.* Whenever proof of service by mail is made, the date of service shall be the mailing date shown of the certificate of service, the mailing date shown by the postmark if there is no certificate of service, or the mailing date as shown by other evidence if there is no certificate of service and no postmark. Where personal delivery is made, the date of service shall be the date of personal delivery.

6. By revising §821.9 to read as follows:

§ 821.9 Intervention.

Any person may move for leave to intervene in a proceeding and may become a party thereto, if the law judge finds that such person may be bound by the order to be entered in the proceeding, or that such person has a property, financial, or other legitimate interest which may not be adequately represented by existing parties, and that such intervention will not unduly broaden the issues or delay the proceedings. Except for good cause shown, no motion for leave to intervene will be entertained if filed less than 10 days prior to hearing. The extent to which an intervenor may participate in the proceedings is a matter within the discretion of the law judge.

7. By revising § 821.17 to read as follows:

§ 821.17 Motion to dismiss and for judgment on the pleadings.

(a) *General.* A motion to dismiss may be filed within the time limitation for filing an answer, except as otherwise provided in paragraph (d) of this section. In case the motion is not granted in its entirety, the answer shall be filed within 10 days of service of the law judge's order on the motion.

(b) *Judgment on the Pleadings.* The party that carries the burden of proof may file a motion for judgment on the pleadings where no answer has been filed or where there are no issues to be resolved.

(c) *Appeal of dismissal orders and grants of motions for judgment on the pleadings.* Where a law judge grants a motion for judgment on the pleading or a motion to dismiss in lieu of an answer and terminates the proceeding without a hearing, an appeal of such order to the Board may be filed pursuant to the provisions of § 821.47. Where a law judge grants a motion to dismiss in part, § 821.16 is applicable.

(d) *Motions to dismiss for lack of jurisdiction.* A motion to dismiss on the ground that the Board lacks jurisdiction may be made at any time.

8. By revising § 821.18 to read as follows:

§ 821.18 Motion for more definite statement.

(a) A party, in lieu of an answer, may file a motion requesting that the allegations in the complaint of the petition be made more definite and certain. Such motion shall point out the defects complained of and the details desired. If the motion is granted and the law judge's order is not complied with within 15 days after notice, the law judge shall strike the allegation or allegations in any complaint or petition to which the motion is directed. If the motion is denied, the moving party shall file his answer within 10 days after the denial.

(b) A party may file a motion to clarify an answer in the event that it fails to respond clearly either to complaint or to the petition for review. The law judge may grant such a motion at his discretion.

9. By revising § 821.19 to read as follows:

§ 821.19 Depositions and other discovery.

(a) *Initiation of discovery.* After a petition for review or a complaint is filed, any party may take the testimony of any person, including a party, by deposition or by means of a written interrogatory without seeking prior approval. Reasonable notice shall be given in writing to the other parties of record stating the name of the witness and the time and place of the taking of his deposition. Similarly, a copy of any written interrogatory shall be served on other parties of record in sufficient time to permit them to object. A copy of any notice of deposition or written interrogatory shall be served on the Office of Administrative Law Judges. In other respects, the taking of any deposition shall be in compliance with the provisions of section 1004 of the Act.

(b) *Exchange of information by parties.* At any time before hearing, after the assignment of a proceeding to a law judge has been made in accordance with § 821.35(a), at the instance of either party or at the direction of the law judge, the parties or their representatives may exchange information, such as witness lists, exhibit lists, curricula vitae and bibliographies of expert witnesses, and other data. In the event of a dispute, the law judge may issue an order directing

compliance with any ruling he has made in respect to discovery.

(c) *Use of the Federal Rules of Civil Procedure.* Those portions of the Federal Rules of Civil Procedure that pertain to depositions and discovery may be used as a general guide for discovery practice in proceedings before the Board where appropriate. The Federal Rules and the case law that construes them shall be considered by the Board and its law judges as instructive rather than controlling.

10. By revising paragraph (b) and by adding a new paragraph (e) to § 821.24 to read as follows:

§ 821.24 Initiation of proceedings.

* * * * *

(b) *Filing petition with the Board.* The petition for review shall be filed with the Board and the date of filing shall be determined in the same manner as prescribed by § 821.7(a) for other documents.

* * * * *

(e) *New evidence.* In the event that a petitioner has undergone medical testing and evaluation, in addition to the evaluation that has already been submitted to the Federal Air Surgeon, and wishes to introduce the results of that further evaluation into the record, he/she may do so provided that the newly developed medical evidence is served upon the Administrator at least 30 days prior to the date of hearing.

* * * * *

11. By revising the title and text of paragraph (c) of § 821.31 to read as follows:

§ 821.31 Complaint procedure.

* * * * *

(c) *Answer to complaint.* The respondent shall file an answer to the complaint within 20 days of service of the complaint upon him by the Administrator. Failure to deny the truth of any allegation or allegations in the complaint may be deemed an admission of the truth of the allegation or allegations not answered. Respondent's answer shall also include any affirmative defense that he intends to raise at the hearing. A respondent may amend his answer to include any affirmative defense at any time prior to the date of hearing. In the discretion of the law judge, any affirmative defense not so pleaded may be deemed waived.

12. By revising § 821.37(a) to read as follows:

§ 821.37 Notice of hearing.

(a) *Notice.* The chief law judge or the law judge to whom the case is assigned shall set the date, time, and place for the hearing, at a reasonable date, time and place, and shall give the parties adequate notice at least 30 days in advance thereof, and of the nature of the hearing. Due regard shall be given to the convenience of the parties with respect to the place for the hearing. The location of the majority of the witnesses and the suitability of a site served by a scheduled air carrier are factors to be considered in setting the place for the hearing. Due regard shall be given to any need for discovery in setting the hearing date.

* * * * *

13. By revising § 821.48(a) to read as follows:

§ 821.48 Briefs and oral argument.

(a) *Appeal briefs.* Each appeal must be perfected within 50 days after an oral initial decision has been rendered, or 30 days after service of a written initial decision, by filing with the Board and serving on the other party of a brief in support of the appeal. Appeals may be dismissed by the Board on its own initiative or on motion of the other party, in cases where a party who has filed a notice of appeal fails to perfect his appeal by filing a timely brief.

* * * * *

14. By revising § 821.57 (a) and (b) to read as follows:

§ 821.57 Procedure on appeal.

(a) *Time within which to file a notice of appeal and content.* Within 2 days after the initial decision has been orally rendered, either party to the proceeding may appeal therefrom by filing with the Board and serving upon the other parties a notice of appeal. The time limitations for the filing of documents are not extended by the unavailability of the hearing transcript.

(b) *Briefs and oral argument.* Within 5 days after the filing of the notice of appeal, the appellant shall file a brief with the Board and serve a copy upon the other parties. Within 10 days after service of the appeal brief, a reply brief may be filed with the Board in which case a copy shall be served upon the other parties. The briefs shall comply with the requirements of § 821.48 (b), (c), (d), (e), (f), and (g), covering contents, waiver of objections on appeal, reply brief, other briefs, number of copies, and oral argument. Appeals may be dismissed by the Board on its own initiative or on motion of the other party, in cases where a party who has filed a notice of appeal fails to perfect his appeal by filing a timely brief. Where oral argument is granted, the Board will give 3 days' notice of such oral argument.

* * * * *

15. By adding a new Subpart K to read as follows:

Subpart K—Judicial Review of Board Orders

§ 821.64 Judicial review.

Judicial review of a final decision of the Board may be sought as provided in section 1006 of the Act (49 U.S.C. section 1486) by the filing of a notice of appeal within 60 days of the date of entry of the Board Order. The date of entry of the Board Order is the date on which the order was served.

Signed in Washington, D.C. on August 23, 1983.

Jim Burnett,

Chairman.

[FR Doc. 83-23558 Filed 8-31-83; 8:45 am]

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DEPARTMENT OF THE INTERIOR

Fish and Wildlife Service

50 CFR Part 26

Public Access, Use and Recreation; Back Bay National Wildlife Refuge, Virginia

AGENCY: Fish and Wildlife Service, Interior.

ACTION: Proposed rule; denial of petition.

SUMMARY: The Fish and Wildlife Service proposed to issue revised regulations concerning public access, use and recreation for the Back Bay National Wildlife Refuge, Virginia. These proposed regulations will replace the public access, use and recreation regulations published on May 28, 1980 (45 FR 35823), and extended on January 13, 1983 (48 FR 1501). These regulations propose to increase vehicular access through the Back Bay National Wildlife Refuge by revising 50 CFR 26.34, which will effectively increase the total number of permanent resident beach permits from 39 to approximately 49. At the same time the Fish and Wildlife Service denies a petition for rulemaking by the Virginia Wildlife Federation and the Pacific Legal Foundation requesting the extension of access privileges through the Back Bay National Wildlife Refuge to part-time residents of the Outer Banks.

DATE: Comments must be received on or before October 3, 1983.

ADDRESSES: Comments may be addressed to Howard N. Larsen, Regional Director, Attn: AWR, U.S. Fish and Wildlife Service, One Gateway Center, Suite 700, Newton Corner, Massachusetts 02158.

FOR FURTHER INFORMATION CONTACT: Howard N. Larsen, Regional Director, Attn: AWR, U.S. Fish and Wildlife Service, One Gateway Center, Suite 700, Newton Corner, Massachusetts 02158 (Telephone 617–965–5100, Ext. 222).

SUPPLEMENTARY INFORMATION: Edward S. Moses, U.S. Fish and Wildlife Service, Newton Corner, Massachusetts 02158 (617–965–5100, Ext. 222), is the primary author of this proposed rule.

General

For many years the Back Bay Refuge was open to the public for a number of purposes, and free access to the beach by vehicles was permitted. In 1961, less than 10,000 persons used the refuge for various purposes. During the late 1960's the development of lands south of the refuge for recreational/residential purposes and the increase in the availability and popularity of off-road recreational vehicles resulted in sharply accelerated use. By 1970, the number of persons using the refuge had increased to 235,000 and in 1971, to 348,000. All but a small fraction of this increase involved off-road vehicular use across the beach portion of the refuge. By 1969, it became evident that total public use had resulted in environmental degradation to the extent that a serious conflict existed with respect to the administration of the entire refuge for its intended purposes. Following careful analysis it was determined that certain controls of vehicular uses of the beach were required to reverse the trend of refuge habitat destruction. On January 12, 1972, the Fish and Wildlife Service provided notice in the **Federal Register** (37 FR 447) that the Back Bay National Wildlife Refuge would be closed to use by unauthorized vehicles. An Environmental Impact Statement assessing the impacts of this restriction was prepared (FES 72–33, 1973). A final rule was published in March 1973, that required authorized users to obtain permits for access. Recreational vehicle traffic was prohibited. Permits were issued to property owners in the proposed False Cape State Park area, permanent, full-time residents of the Outer Banks in North Carolina and their visitors, commercial fishermen, emergency service and utility vehicles and school buses. Implementation of the rulemaking was followed by legal action in a suit against the Service in the District Court for the Eastern District of Virginia. A final decision was handed down by Judge John MacKenzie on February 28, 1975 (Civil Action No. 145–73–N), fully upholding the authority of the Secretary of the Interior to control vehicular access across the Back Bay Refuge. This order was ultimately upheld by the Fourth Circuit Court of Appeals in a decision issued July 7, 1975.

The matter of regulating beach use at Back Bay National Wildlife Refuge continued to be the subject of considerable discussion by the many persons denied vehicular access to recreational properties in North Carolina. On July 29, 1976, following the preparation of an Environmental Assessment on May 4, 1976, a liberalized rulemaking (41 FR 31537) was issued which provided limited access eligibility to all persons who as of October 6, 1975, owned improved property on the Outer Banks of Currituck County, North Carolina, from the Virginia State line south to and including the village of Corolla, North Carolina, and not just permanent residents of the area as the previous rule had provided.

In order to mitigate the impact of travel on the beach by these additional permittees, it was necessary to place more restrictions and limit the number of round trips per day for permanent, full-time residents living between the south boundary of the refuge and the village of Corolla, North Carolina. Based on the restricted access imposed on the permanent, full-time residents by the 1976 regulations (41 FR 22361) and the permit program management experience gained during 1976 and 1977, the 1978–79 rulemaking (43 FR 26314) continued to provide access to qualified permanent, full-time and part-time residents. These special regulations provided notice that the refuge beach would be closed to vehicular traffic after December 31, 1979. Subsequently, in an effort to avoid undue hardship on permanent residents who had established residency prior to December 31, 1976, on the Outer Banks, an interim rule was published on December 13, 1979 (44 FR 72161), which provided for access for those permanent residents only.

Public comments on the interim rulemaking were invited. All comments submitted by January 31, 1980 were given consideration. In summary, of the 247 comments received, 151 supported the adoption of the interim proposed regulations or more restrictive regulations and opposed increased access, and 96 opposed the interim regulations and favored making them more liberal allowing more access.

The final rule on Back Bay National Wildlife Rufuge access, as published on May 28, 1980 (45 FR 35823), provided access for those permanent, full-time residents who could provide adequate proof of continuous residence commencing prior to December 31, 1976, on the Outer Banks from the refuge boundary south to and including the village of Corolla, North Carolina. The May 28 rulemaking also denied a petition for rulemaking received from the Outer Banks Civic League and Pacific Legal Foundation to allow access through Back Bay National Wildlife Refuge for part-time residents of the Outer Banks and False Cape State Park.

On July 25, 1980, President Carter signed into law Pub. L. 96–315 which provided that any time regulations limiting access to the refuge are issued, the Secretary of the Interior shall issue to any "eligible applicant" a permit to enable the applicant to commute across the refuge. The term eligible applicant was defined to include "all full time residents who can furnish * * * adequate proof of residence commencing prior to December 31, 1979, on the Outer Banks from the refuge boundary south to and including the village of Corolla, North Carolina * * *". The south boundary was defind as a "straight east-west line extending from Currituck Sound to the Atlantic Ocean and passing through a point one thousand and six hundred feet due south of the Currituck Lighthouse." On August 7, 1980 (45 FR 53291), the Back Bay access regulations were modified to reflect the legislation.

On September 18, 1981, the Assistant Secretary published in the **Federal Register** (46 FR 46358) a Notice of a Petition for Rulemaking submitted by the Virginia Wildlife Federation and the Pacific Legal Foundation seeking the extension of access privileges through the refuge to part-time residents of the Outer Banks. On January 13, 1983, the Fish and Wildlife Service published in the **Federal Register** (48 FR 1501), an extension of the duration of regulations governing access which were previously promulgated until revised rules are issued so that orderly management of the Back Bay National Wildlife Refuge would not be compromised.

The amendments proposed in this rule would change the date of "continuous and continuing residence commencing prior to December 31, 1979," to July 1, 1982, with the stipulation that the resident held a valid Fish and Wildlife Service access permit during the period from July 29, 1976, through December 31, 1979. Also, the south boundary of the area for access consideration remains

1,600 feet due south of the Currituck Lighthouse, but now includes anyone in continuous residency since 1976 through a point on the east-west prolongation of the centerline of Albacore Street, Whaleshead Club Subdivision, Currituck County, North Carolina. Other minor changes have been made to the existing regulations to further clarify eligibility for access permits.

Conformance with Statutory and Regulatory Authorities

The National Wildlife Refuge System Administration Act, 16 U.S.C. 668 dd, authorizes the Secretary of the Interior to permit the use of any area of the Refuge System for any purpose, including access, whenever he determines that such uses are compatible with the major purposes for which the area was established. The Back Bay National Wildlife Refuge was established by Executive Order No. 7907, June 6, 1933, "as a refuge and breeding ground for migratory birds and other wildlife".

The limited use permitted by these proposed regulations is compatible with the major purposes for which the Back Bay National Wildlife Refuge was established. This determination is based upon consideration of among other things, Environmental Impact Statement FES 72-33 (1973), the Environmental Assessment completed December 12, 1975, the Service's Final Environmental Statement on the Operation of the National Wildlife Refuge System published in November 1976, the Service's Final Environmental Impact Statement on the Proposed State-Federal Land Exchange Involving Portions of False Cape State Park and Back Bay National Wildlife Refuge, and the Environmental Assessment prepared on this proposed rulemaking.

Information Collection Requirements

Information collection is required for obtaining a vehicular access permit. This information collection has been approved by the Office of Management and Budget (OMB) under number 1018-0053. This proposed rule will not increase the information collection burden authorized by OMB.

Environmental Effects

An environmental assessment was prepared on this proposed rulemaking and denial and is available for public inspection at: Back Bay National Wildlife Refuge Headquarters, Pembroke Office Park, Pembroke No. 2 Building, Suite 218, Virginia Beach, Virginia, and Virginia Beach Public Library, Operations Building, Room 300, Courthouse Complex, Virginia Beach, Virginia. Copies of the environmental assessment can be obtained by addressing Howard N. Larsen, Regional Director, Attn: AWR, U.S. Fish and Wildlife Service, One Gateway Center, Suite 700, Newton Corner, Massachusetts 02158.

Statement of Effects and Certification of Effects on Small Entities

This rule and petition denial involve local, private residents only. Small entities will not be significantly affected. Accordingly, the Department of the Interior has determined that this rule is not a "major rule" within the meaning of Executive Order 12291 and would not have a significant economic effect on a substantial number of small entities within the meaning of the Regulatory Flexibility Act.

Authority: 16 U.S.C. 668 dd, 44 U.S.C. 3501 *et seq.*

Public comments are solicited on the proposed regulations. Interested persons may submit written comments, suggestions or objections regarding the proposed rule. All relevant comments will be considered by the Department prior to the issuance of a final rule.

Denial of Petition for Rulemaking

On September 18, 1981, the Assistant Secretary published in the **Federal Register** (46 FR 46358) a Notice of a Petition for Rulemaking submitted by the Virginia Wildlife Federation and the Pacific Legal Foundation. The Notice requested comments from the public on the content of the petition. Comments were to be accepted until November 17, 1981. The comment period was subsequently extended until December 11, 1981 (46 FR 58122).

Generally, the Petition sought to have the Back Bay National Wildlife Refuge access regulations amended to permit access for owners of improved property as of September 15, 1981. After a thorough review of the Petition and letters of comment on the Petition, the Service has found a general lack of substantial evidence. The evidence cited is inadequate and unsubstantiated scientifically. Observations by Fish and Wildlife Service personnel have indicated that permanent resident permit use has an appreciably lower level of impact on the affected environment than part-time resident use because of both numerical and temporal differences.

Thus, the Petitioners have advanced no persuasive rational for expanding access to the degree requested. Moreover, this Petition simply revises the petition previously filed and denied on May 28, 1980, which sought essentially the same relief. Accordingly, the petition is hereby denied.

These proposed rules will supplement the general regulations that govern recreation on wildlife refuge areas, that are set forth in Title 50 Code of Federal Regulations. The refuge, comprising approximately 4,600 acres, is delineated on a map available from either the Refuge Manager or Regional Director.

List of Subjects in 50 CFR Part 26

National Wildlife Refuge System, Recreation, Wildlife refuges.

PART 26—[AMENDED]

Accordingly, it is proposed to revise the special regulations governing public access, use and recreation on Back Bay National Wildlife Refuge by revising § 26.34 as follows:

§ 26.34 Special regulations concerning public access, use and recreation for individual national wildlife refuges.

VIRGINIA

Back Bay National Wildlife Refuge

Access

(a) Who can qualify for access?
(b) Routes of travel.
(c) How many trips are allowed?
(d) Medical emergencies.
(e) Military, fire, or emergency vehicles.
(f) Public utility vehicles.
(g) False Cape State Park employees.
(h) Commercial fishermen and their employees.
(i) Suspension or waiver of rules.
(j) Violation of rules.
(k) Other access rules.

General Rules

(l) Entry on foot, bicycle, or motor vehicle.
(m) Swimming and surfing.
(n) Parking.
(o) Fishing and boating.
(p) Fires.
(q) Dogs.
(r) Other general rules.

Access

(a) *Who can qualify for access?*

(1) Permanent, full-time residents who can furnish to the Refuge Manager, Back Bay National Wildlife Refuge, adequate proof of continuous and continuing residence, commencing prior to July 1, 1982, and who held a valid Fish and Wildlife Service access permit for improved property owners at any time during the period from July 29, 1976, through December 31, 1979, on the Outer Banks from the refuge boundary south to and including the village of Corolla, North Carolina, as long as they remain

permanent, full-time residents, are authorized beach access. The south boundary of the area for access consideration is defined as a straight, east-west line extending from Currituck Sound to the Atlantic Ocean and passing through a point sixteen hundred (1,600) feet due south of the Currituck Lighthouse, or for anyone in continuous residency since 1976, through a point on the east-west prolongation of the centerline of Albacore Street, Whaleshead Club Subdivision, Currituck County, North Carolina. Residence is defined as the place of general abode; the place of general abode of a person means his principal, actual dwelling place in fact, without regard to intent. For the purposes of this section, a dwelling shall mean a residential structure occupied on a year-round basis by the permit applicant and shall not include seasonal or part-time dwelling units such as beach houses, vacation cabins, or structures which are intermittently occupied. The burden of proof showing that the prospective permittee meets these criteria shall be on the applicant by presentation of appropriate documentation. Only one permit will be issued per family.

(2) All permits issued to full-time residents will be terminated in the event that alternate access is provided during the permit period.

(b) *Routes of travel.* Access to, and travel along, the refuge beach by motorized vehicles may be allowed between the dune crossing at the field headquarters and the south boundary of the refuge only after a permit has been issued or authorization provided by the Refuge Manager. Travel along the refuge beach by motorized vehicle shall be below the high tide line, within the intertidal zone to the maximum extent practicable.

(c) *How many trips are allowed?* Permitted vehicles of permanent, full-time residents shall be limited to a total of two round trips per day. Travel is restricted to the designated route of travel between the hours of 5:00 am and 12:00 midnight.

(d) *Medical emergencies.* Private vehicles used in a medical emergency will be granted access. A medical emergency is defined as any condition that threatens human life or limb unless medical treatment is immediately obtained. When evidence of the emergency is not readily apparent, the vehicle operator will be required to provide the refuge office with a doctor's statement confirming the emergency within two working days (Mondays through Fridays) after access is granted.

(e) *Military, fire, or emergency vehicles.* Military, fire, emergency or law enforcement vehicles when used for emergency purposes will be granted access. Vehicles used by an employee/agent of the Federal, state or local government in the course of official duty other than above may be granted access upon advance request to the Refuge Manager.

(f) *Public utility vehicles.* Public utility vehicle used on official business will be granted access. A public utility vehicles is described as any vehicle owned or operated by a public utility company enfranchised to supply Outer Banks residents with electricity or telephone service.

(g) *False Cape State Park Employees.* False Cape State Park employees who are residents in the Park will be considered as permanent, full-time residents as defined in 26.34(a)(1) with access privileges identical to those permittees.

(h) *Commercial fishermen and their employees.* (1) Commercial fishermen who have verified that their fishing operations on the Outer Banks of Virginia Beach, Virginia, or Currituck County, North Carolina, have been dependent since 1972 on ingress and egress to or across the refuge will be granted permits for access. Travel through the refuge by commercial fishermen from Currituck County, North Carolina, will be permitted only when directly associated with commercial fishing operations. Drivers and passengers on trips through the refuge will be limited to commercial fishing crew members. A commercial fisherman is described as one who harvests finfish by gill net or haul seine in the Atlantic Ocean, and who has owned and operated a commercial fishing business since 1972.

(2) Each commercial fisherman may be granted a maximum of five designated employees to travel the refuse beach for commercial fishing purposes. These employees may carry only other commercial fishing employees as passengers. Employees of commercial fishermen engaged in travel directly associated with commercial fishing operations or for the purpose of traveling to and from their homes in Virginia to fishing sites in North Carolina will be granted access.

(i) *Suspension or waiver of rules.* (1) In an emergency, the Refuse Manager may suspend any or all of the foregoing restrictions on vehicular travel and announce each suspension by whatever means are available. In the event of adverse weather conditions, the Refuge Manager may close all or any portion of the refuge to vehicular travel for such period as deemed advisable in the interest of public safety.

(2) The Refuge Manager may make exceptions to access restrictions if they are compatible with refuge purposes for qualified permittees who have demonstrated to the satisfication of the Refuge Manager a need for additional access relating to health or livelihood.

(3) The Refuge Manager may grant one-time use authorization for vehicular access through the refuge to individuals, not otherwise qualified above, who have demonstrated to the satisfaction of the Refuge Manager that there is no feasible alternative to the access requested. Authorization for access under this provision will not be based on convenience to the applicant.

(4) The Regional Director may grant access to non-eligible permanent residents and improved property owners who can show proof that their physical health is such that life-threatening situations may result from more arduous travel conditions. The submission of substantiating medical records will be required to be considered for a medical access waiver.

(j) *Violation of rules.* Violators of these special regulations or any regulations pertaining to Back Bay National Wildlife Refuge will be subject to legal action as prescribed by 50 CFR 25.43 and 50 CFR Part 28, including suspension or revocation of all permits issued to the violator or responsible permittee. The Refuge Manager may deny access permits to applicants, who during the two years immediately preceding date of applications, have been formally charged and successfully prosecuted for three or more violations of these or other regulations in effect at Back Bay National Wildlife Refuge. Individual whose vehicle access privileges are suspended, revoked, or denied may within 30 days file a written appeal of the action to the Regional Director, One Gateway Center, Suite 700, Newton Corner, Massachusetts 02158, in accordance with 50 CFR 25.44(c).

(k) *Other access rules.* (1) No permit will remain in effect beyond December 31 of the year in which it was issued. Permits may be renewed upon the submission of updated information on vehicle drivers and a signed, notarized statement that conditions of the previous permit have changed.

(2) Permitted vehicles shall be operated on the refuge beach only by the permittee or immediate family members residing with the permittee. Permit holders shall not tow vehicules and/or trailers owned by non-permit holders through the refuge. Any towed vehicles or trailer must have advance

approval from the Refuge Manager prior to being brought through the refuge.

(3) The Refuge Manager may prescribe restrictions as to the types of vehicles to be permitted to ensure public safety and adherence to all applicable rules and regulations.

General Rules

(l) *Entry on foot, bicycle, or motor vehicle.* Entry on foot, bicycle, or by motor vehicle on designated routes is permitted during daylight hours for the purpose of nature study, wildlife observation, photography, hiking, surf fishing, swimming, and bicycling.

(m) *Swimming and surfing.* Swimming and surfing are permitted on the entire refuge beach unless designated otherwise by signs. No lifeguards are provided. Swimming and surfing will be at the visitor's own risk.

(n) *Parking.* The parking lot at the end of the paved road is available on a first-come first-served basis.

(o) *Fishing and boating.* Surf fishing from the beach and freshwater fishing in the bay are permitted in accordance with state laws. Vehicular launching of trailered boats and bank fishing from the refuge bay shoreline are prohibited. Boat launching into the bay at field headquarters is limited on non-trailered canoes and small boats.

(p) *Fires.* Open fires are prohibited. Portable grills with a contained fuel supply are permitted on the beach.

(q) *Dogs.* Dogs on a hand-held leash not exceeding ten feet in length are permitted in designated areas.

(r) *Other general rules.* (1) Pedestrains and vehicular traffic in the sand dunes are prohibited.

(2) Registered motor vehicles and motorized bicycles (mopeds) are permitted on the pave refuge access road and on the parking lot at field headquarters. All other motorized vehicular use is prohibited except as specifically authorizes pursuant to this rule.

(3) The information collection requirement contained in the proposed rule has been approved by the Office of Management and Budget under 44 U.S.C. 3501 *et seq* and has been assigned the clearance number 1018–0053. The information is being collected and used to determine eligibility for issuing a vehicular access permit, and a response is required to obtain a benefit.

Dated: August 17, 1983.

G. Ray Arnett,

Assistant Secretary for Fish and Wildlife and Parks.

[FR Doc. 83-23062 Filed 8-31-83; 8:45 am]

BILLING CODE 4310-55-M

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 681

[Docket No. 30824–172]

Western Pacific Spiny Lobster Fisheries

AGENCY: National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Proposed rule.

SUMMARY: NOAA issues this proposed rule for Amendment 1 to the Fishery Management Plan for the Spiny Lobster Fisheries of the Western Pacific Region (FMP). The FMP amendment and proposed regulations will establish Federal management measures for the spiny lobster fishery in the fishery conservation zone (FCZ) off of the main Hawaiian Islands that are identical to State of Hawaii management meaures for the territorial sea.

Two technical and clarifying changes are also proposed for existing regulations governing this fishery: (1) Changing the number to be used for vessel identification to simplify vessel identification requirements, and (2) rewriting the recordkeeping and reporting requirements to make it clear that there are two separate reports and two separate time tables for submission of the reports. The intended effect of this action is to make management of the spiny lobster fishery more effective.

DATE: Comments are invited until October 14, 1983.

ADDRESSES: Comments should be addressed to Floyd S. Anders, Jr., Acting Regional Director, National Marine Fisheries Service (NMFS), Southwest Region, 300 South Ferry Street, Room 2016, Terminal Island, California 90731. Copies of the amendment are available by writing to either Floyd S. Anders or Kitty Simonds, Acting Executive Director, Western Pacific Fisheries Management Council, 1164 Bishop Street, Suite 1608, Honolulu, Hawaii 96813.

FOR FURTHER INFORMATION CONTACT: James J. Morgan (NMFS, Southwest Region), 213–548–2518.

SUPPLEMENTARY INFORMATION: Amendment 1 establishes Federal regulations for the spiny lobster fisheries in the FCZ off of the main Hawaiian Islands which are identical to State regulations for the fishery in the territorial sea around the main islands. This action will reduce confusion for fishermen and conflicts that may arise and simplify enforcement throughout the fishery. To make Federal management identical to State management, six State measures are adopted for the FCZ. These measures are (1) all spiny lobsters with a carapace less than 8.26 cm must be released; (2) all spiny lobsters carrying eggs must be released; (3) no spiny lobsters may be taken in June, July, and August; (4) no spiny lobsters may be taken using spears, chemicals, poisons, or expolsives; (5) traps must not exceed 6 feet × 6 feet × 10 feet in size; and (6) spiny lobsters must be landed whole.

The FMP for the spiny lobster fishery (February 7, 1983, at 49 FR 5560) established Federal regulations for the management of the commercial fishery in he Northwestern Hawaiian Islands (NWHI). Federal management of the NWHI includes conservation and reporting requirements; however, the FMP only established reporting requirements for the FCZ off of the main Hawaiian Islands.

On September 30, 1981, the Hawaii Department of Planning and Economic Development notified the Council that the FMP was not consistent with Hawaii's Coastal Zone Management Plan "to the maximum extent praticable" as required by subsection 307(c)(1) of the Coastal Zone Management Act. The Council then reached an agreement with the State of Hawaii by which the State would implement State regulations for the NWHI territorial sea identical to Federal regulations for the FCZ, and the Council would prepare an amendment to the FMP adopting managment measures for the FCZ off of the main Hawaiian Islands that are identical to State regulations.

By the time the FMP received final approval by the Assistant Administrator for Fisheries, NOAA had notified the State of Hawaii that the FMP was consistent with Hawaii's Coastal Zone Management Plan to the maximum extent practicable, and regulations implementing the FMP were published in the **Federal Register** on February 7, 1983. Nevertheless, the State of Hawaii's position continues to be that the FMP needs to be amended. The State has argued that failure to adopt regulations in the FCZ that are identical to its regulations would impair its ability to enforce its regulations. Because differences on the consistency issue persisted, the Council decided to proceed with Amendment 1 and held a hearing on the amendment in Honolulu, Hawaii on March 14, 1983 (48 FR 7608).

Measures

The State of Hawaii adopted State regulations identical to Federal regulations for the NWMI (where most of the fishery takes place in the FCZ) which were effective on June 6, 1983. Amendment 1 to the FMP adopts the following Federal measures for the FCZ off of the main Hawaiian Islands (where most of the fishing occurs in State waters) which are identical to State regulations for the territorial sea off of the main islands.

Minimum Size of 8.26 cm

The FMP established a minimum carapace length of 7.7 cm for lobster caught by commercial fishermen in the NWHI fishery. The FMP considered size limits for the NWHI of carapace lengths between 7.50 and 9.00 cm. This range is thought to include all of the reasonable alternatives available to management from the present information. The size limit included in the paln was adopted following an analysis by the Southwest Center, Honolulu Laboratory, of recent information from that area on reproductive capacity. Prior to the analysis, the Council had been considering adopting the State's main Hawaiian Islands size limit of 8.26 cm.

Amendment 1 established an 8.26 cm carapace length size limit for the FCZ off of the main Hawaiian Islands. This is identical to the State size limit for the trerritorial sea off of the main islands.

There is no rational for changing the minimum size limit from that adopted by the State because comercial landings have been relatively stable since the 8.26 cm size limit has been in effect. The heavy recreational fishery around the main islands takes most legal lobster (8.26 cm) when they first become available to the fishery. In addition, other factors not applicable to the main islands fisheries, such as distance to the fishing grounds and the 10-fathom area closures, tend to restrict fishing pressure in the NWHI. For the above reasons, the risk from establishing a size limit smaller than 8.26 cm in the main Hawaiian Islands is much greater than in the NWHI. Also, adopting a size limit for the FCZ off of the main islands that is different from the State of Hawaii's size limit would negate any benefit that is to be gained from Amendment 1 and would cause encorcement problems.

Release of Lobsters Carrying Eggs

Amendment 1 requires that all female lobsters carrying eggs caught in the FCZ off of the main Hawaiian Islands be released. The FMP established this measure for the NWHI and the State regulations have the same requirement for the territorial sea. This measure is expected to contribute to production of the resource.

Closed Season for the FCZ off of the Main Hawaiian Islands

Amendment 1 adopts a closed season on the harvesting of lobster in the FCZ off of the main Hawaiian Islands during the months of June, July, and August. This closure is the same as the State's regulation for the territorial sea which was adopted to maintain some control over the amount of fishing effort directed at spiny lobster. Most of the fishing pressure around the main islands is from recreational fishermen and this effort increases substantially during the summer months. The measure mainly affects recreational fishermen in the territorial sea because the fishery is primarily a recreational fishery; however, implementation in the FCZ will prevent commercial fishermen from claiming that lobsters caught in the territorial sea were caught in the FCZ.

Prohibition Against the Use of Spears, chemicals, Poisons, and Explosives

Amendment 1 adopts restrictions on the use of spears, chemicals, poisons, and explosives for the taking of lobsters in the FCZ off of the main Hawaiian Islands. The FMP established this measure in the FCZ off of the NWHI and it is the same as the State's requirement for the territorial sea off of the main islands.

Prohibiting spears prevents lobsters from being killed before they are measured to determine if they are of legal size. Prohibiting chemicals, posions, and explosives protects lobster of all sizes and the surrounding habitat.

Trap Size Limitation

Amendment 1 adopts for the FCZ off of the main Hawaiian Islands the State regulation that prohibits traps for the multispecies fishery (which also harvests lobster incidentally) larger than 6 feet x 6 feet x 10 feet. The State adopted the rule to regulate the trap fishery for species other than lobster, but the rule applies to lobster as well.

Spiny Lobster Must Be Landed Whole

The Federal regulations for managing the lobster fishery in the FCZ off of the NWHI allow removing the tails from spiny lobsters so that the catch can be frozen on board the fishing vessel.

State rules require lobsters to be landed whole. This is a common practice in lobster fisheries so that the catch can be properly measured by enforcement authorities. Also, there is not as much of a need to allow removal of tails so that they can be frozen on board the fishing vessel in the main islands fishery, because the fishery takes place close to port and it is easier to land live lobster.

Amendment 1 will require that spiny lobsters taken in the FCZ off of the main Hawaiian islands be landed whole.

Other Matters

In addition to proposing a new Subpart C to the spiny lobster regulations to implement the provisions of Amendment 1, § 681.5 on recordkeeping and reporting requirements is revised to clarify exactly what reports are required and when they must be submitted. Some of these reports are renamed but they require the same information as under existing regulations.

Section 681.6 on vessel identification is revised to require that the permit number issued by the NMFS be displayed on the vessel rather than the official number of the vessel. This change was necessary because the official number is too long to be displayed on the vessel in the required size.

The requirement that the approximate fish-hold capacity of a vessel be included on the application for a permit was omitted from the original regulations. It is therefore included in the revised regulations.

Classification

Section 304(a)(1)(C)(ii) of the Magnuson Fishery Conservation and Management Act (Magnuson Act), as amended by Pub. L. 97-453, requires the Secretary of Commerce (Secretary) to publish regulations proposed by a Council within 30 days of receipt of an FMP amendment and regulations. At this time the Secretary has not determined that the amendment these rules would implement is consistent with the national standards, other provisions of the Magnuson Act, and other applicable law. The Secretary, in making that determination, will take into account the data, views, and comments received during the comment period.

The Council prepared an environmental assessment for this amendment and concluded that there will be no significant impact on the environment as a result of this rule. You may obtain a copy of the environmental assessment, which is included in the amendment, from the Council at the address listed above.

Based upon the analysis in the amendment, which serves as a regulatory impact review, the Administrator of NOAA has determined

that the regulations implementing this amendment are not major under Executive Order 12291 and that they do not require a regulatory impact analysis. The main reason for this is that while the commercial fishery extends into the FCZ, this area accounts for only a small portion of the total catch, and the reglations therefore will have a limited economic impact. This rule will have the following economic effects:

1. Economic and social benefits will improve for the recreational fishery because the resource will receive additional protection.

2. The incomes, costs and profits of the commercial fishery will not be affected.

3. The employment impacts will be negligible.

You may obtain a copy of this regulatory impact review, which is included in the Amendment, from the Council at the address listed above.

This proposed rule is exempt from the procedures of E.O. 12291 under section 8(a)(2) of that order. Deadlines imposed under the Magnuson Act, as amended by Pub. L. 97–453, require the Secretary to publish this proposed rule 30 days after its receipt. The proposed rule is being reported to the Director, Office of Management and Budget, with an explanation of why it is not possible to follow procedures of the order.

The General Counsel of the Department of Commerce certified to the Small Business Administration that this proposed rule, if adopted, will not have a significant economic impact on a substantial number of small entities because the amendment adopts existing State regulations and therefore imposes no additional regulatory impact. As a result, a regulatory flexibility analysis was not prepared.

This rule contains collection of information requirements subject to the Paperwork Reduction Act. A request for approval to collect this information has been submitted to the Office of Management and Budget. This action merges the requirements of § 681.4 Permits and § 681.5 Recordkeeping and Reporting into approved collections 0648–0013, 0648–0016 and 0648–0097. Comments on the collection of information requirements should be directed to the Office of Information and Regulatory Affairs of OMB, Attention Desk Officer for Department of Commerce.

In response to a letter from the Council stating that this proposed rule will be implemented to the maximum extent practicable with the approved coastal zone management programs of Hawaii, in accordance with § 307 of the Coastal Zone Management Act, the Hawaii Department of Planning and Economic Development, on June 24, 1983, informed the Council that Amendment 1 is consistent with the Hawaii Coastal Zone Management Plan.

List of Subjects in 50 CFR Part 681

Fish, Fisheries, Reporting requirements.

Dated: August 29, 1983.

William G. Gordon,

Assistant Administrator for Fisheries, National Marine Fisheries Service.

For the reasons stated in the preamble, 50 CFR Part 681 is proposed to be amended as follows:

PART 681—WESTERN PACIFIC SPINY LOBSTER FISHERIES

1. The authority citation of 50 CFR Part 681 reads as follows:

Authority: 16 U.S.C. 1801 *et seq.*

2. In § 681.1, paragraph (b) is revised to read as follows:

§ 681.1 Purpose and scope.

* * * * *

(b) These regulations govern commercial fishing for spiny lobsters by fishing vessels of the United States, within the U.S. fishery conservation zone (FCZ) seaward of American Samoa, Guam, and Hawaii. The management measures specified in Subpart B apply only in the FCZ seaward of the Northwestern Hawaiian Islands (Permit Area 1). The management measures specified in Subpart C apply only in the FCZ seaward of the main Hawaiian Islands (Permit Area 2).

3. In § 681.2, the definition of *Permit Area 2* is revised and three new definitions, one for *Permit Number*, one for *Permit Area 3*, and one for *Processor* are added in appropriate alphabetical order to read as follows:

§ 681.2 Definitions.

Permit Area 2 means the FCZ of the Hawaiian Islands Archipelago lying to the east of 161°00' W. longitude, commonly known as the main Hawaiian Islands;

Permit Area 3 means the FCZ of the Territory of Guam and the FCZ of the Territory of American Samoa.

Permit Number means the number issued to a vessel under this part by the NMFS.

Processor means any person that changes the form of a lobster through such methods as freezing, cleaning, or removing tails. It does not include a person that only boxes or packages lobsters or lobster parts. It also does not include a person that catches lobsters and processes them at sea.

4. In § 681.4, paragraphs (a)(2) and (b)(2)(ix) are revised to read as follows:

§ 681.4 Permits.

(a) * * *

(2) Each permit is valid for fishing only in the area specified in the permit. Permit areas are defined in § 681.2.

* * * * *

(b) * * *

(2) * * *

(ix) The approximate fish-hold capacity of the vessel;

* * * * *

5. Section 681.5 is amended by revising paragraphs (a), (b) (1) and (2), (c) and by adding paragraph (d) to read as follows:

§ 681.5 Recordkeeping and reporting.

(a) *Reports.* The operator of any vessel engaged in commercial fishing for spiny lobster subject to this part must—

(1) Maintain on board the fishing vessel, while fishing for spiny lobster, an accurate and complete NMFS Daily Lobster Catch Report in English. All information specified in paragraph (b) of this section must be recorded within 24 hours after the completion of the fishing day.

(2) Within 72 hours of each landing of spiny lobster, submit to the Regional Director the NMFS Daily Lobster Catch Report for that fishing trip.

(3) Maintain an accurate and complete NMFS Trip Processing and Sales Report in which is recorded the information specified in paragraph (c) of this section.

(4) Within 72 hours of each landing of spiny lobsters, submit to the Regional Director the NMFS Trip Processing and Sales Report covering all lobsters that have been sold. For any lobsters that have not been sold within 72 hours of landing, the operator must submit a supplemental NMFS Trip Processing and Sales Report within 72 hours of each subsequent sale of the remaining lobsters.

(5) Make the Daily Lobster Catch Report and the Trip Processing and Sales Report available for inspection by an authorized officer or any employee of NMFS designated by the Regional Director to make such an inspection.

(b) *Daily Lobster Catch Report.* The Daily Lobster Catch Report must contain the following information for all spiny lobster taken under this part:

(1) Vessel information—

(i) Name of vessel;

(ii) Call sign of vessel;

(iii) Permit number of vessel;

(iv) Size of crew; and

(v) Number of traps.

(2) Fishing information—

(i) Location of lobster catch by statistical area as depicted in the NMFS Daily Lobster Catch Report form;

(ii) Date and time of trap deployment and number of traps deployed;

(iii) Date and time of trap retrieval and number of traps retrieved;

(iv) Number and species of legal spiny lobsters per trap deployment;

(v) Number and species of sublegal spiny lobsters per trap deployment;

(vi) Number and species of berried female spiny lobsters per trap deployment; and

(vii) Number of slipper lobster and Kona crabs per trap deployment.

(3) * * *

(c) *Trip Processing and Sales Report.* The Trip Processing and Sales Report must contain the following information for all spiny lobsters taken under this part:

(1) Vessel information—

(i) Name of vessel; and

(ii) Permit number.

(2) Landing information—

(i) Date of landing; and

(ii) Port of landing.

(3) Processing information—

(i) Weight of whole lobsters frozen at sea;

(ii) Weight of lobster tails frozen at sea;

(iii) Weight of whole lobsters to be frozen on land; and

(iv) Weight of lobster tails to be frozen on land.

(4) Sales information—

(i) Number, weight, and revenue from sale of live lobsters;

(ii) Number, weight, and revenue from sale of whole, frozen lobsters;

(iii) Number, weight, and revenue from sale of frozen lobster tails; and

(iv) Weight and revenue from sale of lobster byproducts.

(d) *Processor annual report.* Processors of lobster products harvested in the management area must submit an annual report covering the period January 1 to December 31 to the Regional Director on a form which can be obtained from the Regional Director. This report is due by April 1 of the following year and must specify the following:

(1) Source (by FCZ surrounding each State) of lobsters processed;

(2) Poundage of lobsters processed by species;

(3) Number of individual lobsters processed by species;

(4) Method of processing;

(5) Form of final product; and

(6) Current actual lobster-processing capacity.

6. Section 681.6 is revised to read as follows:

§ 681.6 Vessel identification.

(a) *Permit number.* Each fishing vessel subject to this part must display its permit number on the port and starboard sides of the deckhouse or hull, and on an appropriate weather deck so as to be visible from enforcement vessels and aircraft.

(b) *Numerals.* The permit number must be affixed to each vessel subject to this part in block Arabic numerals at least 18 inches in height for fishing vessels of 65 feet in length or longer, and at least ten inches in height for other vessels. Markings must be legible and of a color that contrasts with the background.

(c) *Duties of operator.* The operator of each fishing vessel subject to this part must—

(1) Keep the displayed permit number clearly legible and in good repair; and

(2) Ensure that no part of the vessel, its rigging, or its fishing gear obstructs the view of the permit number from an enforcement vessel or aircraft.

7. In § 681.7, a new paragraph (c) is added to read as follows:

§ 681.7 Prohibitions.

* * * * *

(c) In permit Area 2, in addition to the prohibition in paragraph (a) of this section, it is unlawful for any person to—

(1) Fish for, take, or retain spiny lobsters—

(i) By methods other than lobster traps or by hand, as specified in § 681.34; or

(ii) In the months of June, July, and August, as specified in § 681.33.

(2) Retain or possess on a fishing vessel any spiny lobster taken in Permit Area 2 which is less than the minimum size specified in § 681.31;

(3) Possess on a fishing vessel any spiny lobster or spiny lobster part taken in Permit Area 2 in a condition where the lobster is not whole and undamaged as specified in § 681.35; or

(4) Retain or possess on a fishing vessel, or remove the eggs from, any egg-bearing spiny lobster, as specified in § 681.32.

8. In § 681.8, paragraphs (a) and (b)(3) are revised to read as follows:

§ 681.8 Enforcement.

(a) *General.* The owner or operator of any fishing vessel subject to this part must immediately comply with instructions issued by an authorized officer to facilitate safe boarding and inspection of the vessel, its gear, equipment, logbook, reports, permit, and catch, for purposes of enforcing the Magnuson Act and this part

(b) * * *

(3) "AA AA AA etc." is the call to an unknown station, to which the signaled vessel should respond by identifying his vessel by radio, visual signals, or by lighting his permit number; and

* * * * *

9. The table of contents for this part is amended by adding the sections for a new Subpart C and by placing the existing authority line after this new subpart to read as follows:

Subpart C—Management Measures for Permit Area 2 (the Main Hawaiian Islands)

Sec.

681.30 General.
681.31 Size restrictions.
681.32 Reproductive condition restrictions.
681.33 Closed season.
681.34 Gear restrictions.
681.35 Lobster condition.

* * * * *

Subpart C—Management Measures for Permit Area 2 (the Main Hawaiian Islands)

§ 681.30 General.

The management measures specified in this subpart govern fishing for spiny lobster in the FCZ seaward of the main Hawaiian Islands (Permit Area 2).

§ 681.31 Size restrictions.

Only spiny lobsters with a carapace length of 8.26 cm or greater may be retained.

§ 681.32 Reproductive condition restrictions.

A female spiny lobster of any size may not be retained if it is carrying eggs externally. Eggs may not be removed from female spiny lobsters.

§ 681.33 Closed season.

Spiny lobster fishing is not allowed in Permit Area 2 during the months of June, July, and August.

§ 681.34 Gear restrictions.

(a) Spiny lobsters may be taken only with lobster traps or by hand. Lobsters may not be taken by means of posions, drugs, other chemicals, spears, nets, hooks, or explosives.

(b) A trap may measaure no greater than the following size dimensions: 6 feet × 6 feet × 10 feet.

§ 681.35 Lobster condition.

Any spiny lobster with a punctured or mutilated body, or a separated carapace and tail, may not be retained.

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Notices

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This section of the FEDERAL REGISTER contains documents other than rules or proposed rules that are applicable to the public. Notices of hearings and investigations, committee meetings, agency decisions and rulings, delegations of authority, filing of petitions and applications and agency statements of organization and functions are examples of documents appearing in this section.

DEPARTMENT OF AGRICULTURE

Cooperative State Research Service

Cooperative Forestry Research Advisory Council Meeting

According to the Federal Advisory Committee Act of October 6, 1972 (Public Law 92-463, 86 Stat. 770-776), U.S. Department of Agriculture announces the following meeting:

Name: Cooperative Forestry Research Advisory Council
Date: September 26-28, 1983
Time: 8:00 a.m.-5:00 p.m.
Place: University Hall, Room 205, The University of Montana, Missoula, Montana 59812

Type of Meeting: Open to the Public. Persons may participate in the meeting as time and space permit.

Comments: The public may file written comments before or after the meeting with the contact person below.

Purpose: The Council will be deliberating the McIntire-Stennis Forestry Research program with particular emphasis on the forest research priorities, annual distribution of funds and administration of McIntire-Stennis Cooperative Forestry Research programs. Tuesday, September 27, 1983, will be devoted to a review in the field of the regional and State forestry research programs.

Contact Person for Agenda and More Information: Dr. John D. Sullivan, Executive Secretary, Cooperative Forestry Research Advisory Council, Cooperative State Research Service, Room 119, West Auditors Building, U.S. Department of Agriculture, Washington, D.C. 20250

Done in Washington, D.C., this tenth day of August, 1983.

C. I. Harris,

Acting Administrator, Cooperative State Research Service.

[FR Doc. 83-24062 Filed 8-31-83; 8:45 am]

BILLING CODE 3410-03-M

Federal Grain Inspection Service

Agency Designation Actions; Request for Applicants To Perform Official Services in the Geographic Area Currently Assigned to Columbus Grain Inspection, Inc. (OH)

AGENCY: Federal Grain Inspection Service, USDA.

ACTION: Notice.

SUMMARY: Pursuant to the provisions of the U.S. Grain Standards Act, as amended (Act), official agency designations shall terminate not later than triennially and may be renewed in accordance with the criteria and procedures prescribed in the Act. This notice announces that the designation of one agency will terminate, in accordance with the Act, and requests applications from parties, including the agency currently designated, interested in being designated as the official agency to conduct official services in the geographic area currently assigned to the specified agency. The official agency is Columbus Grain Inspection, Inc.

DATE: Applications to be postmarked on or before October 3, 1983.

ADDRESS: Applications must be submitted to James R. Conrad, Chief, Regulatory Branch, Compliance Division, Federal Grain Inspection Service, U.S. Department of Agriculture, 1400 Independence Avenue, SW., Room 1647 South Building, Washington, DC 20250. All applications received will be made available for public inspection at the above address during regular business hours.

FOR FURTHER INFORMATION CONTACT: James R. Conrad, telephone (202) 447-8525.

SUPPLEMENTARY INFORMATION: This action has been reviewed and determined not to be a rule or regulation as defined in Executive Order 12291 and Secretary's Memorandum 1512-1; therefore, the Executive Order and Secretary's Memorandum do not apply to this action.

Section 7(f)(1) of the Act (7 U.S.C. 71 *et seq.*, at 79(f)(1)) specifies that the Administrator of the Federal Grain Inspection Service (FGIS) is authorized, upon application by any qualified agency or person, to designate such agency or person to perform official services after a determination is made that the applicant is better able than any other applicant to provide such official services in an assigned geographic area.

Columbus Grain Inspection, Inc. (Columbus), P.O. Box 167, Circleville, Ohio 43113, was designated as an official agency under the Act for the performance of inspection functions on September 30, 1978.

The agency's designation will terminate on February 28, 1984. This date reflects administrative extensions of official agency designations, as discussed in the July 16, 1979, issue of the **Federal Register** (44 FR 41275). Section 7(g)(1) of the Act states generally that official agencies' designation shall terminate no later than triennially and may be renewed according to the criteria and procedures prescribed in the Act.

The geographic area presently assigned to Columbus, in Ohio, pursuant to Section 7(f)(2) of the Act, and which is the area that may be assigned to the applicant selected for designation is the following:

Bounded: on the North by U.S. Route 30 east to State Route 154; State Route 154 east to the Ohio-Pennsylvania State line;

Bounded: on the East and South by the Ohio-Pennsylvania State line south to the Ohio River; the Ohio River south-southwest to the western Scioto County line; and

Bounded: on the West by the western Scioto County line north to State Route 73; State Route 73 northwest to U.S. Route 22; U.S. Route 22 west to U.S. Route 68; U.S. Route 68 north to Clark County; the northern Clark County line west to State Route 560; State Route 560 north to State Route 296; State Route 296 west to Interstate 75; Interstate 75 north to State Route 47; State Route 47 northeast to U.S. Route 68; U.S. Route 68 north to U.S. Route 30.

Interested parties, including Columbus, are hereby given opportunity to apply for designation as the official agency to perform the official services in the geographic area, as specified above, under the provisions of Section 7(f) of

the Act and § 800.196(b) of the regulations issued thereunder. Designation in the specified geographic area is for the period beginning March 1, 1984, and ending February 28, 1987. Parties wishing to apply for designation should contact the Regulatory Branch, Compliance Division, at the address listed above for appropriate forms and information. Applications must be postmarked not later than October 3, 1983, to be eligible for consideration.

Applications submitted and other available information will be considered in determining which applicant will be designated to provide official services in a geographic area.

(Sec. 8, Pub. L. 94-582, 90 Stat. 2873 (7 U.S.C. 79))

Dated: August 17, 1983.

Neil E. Porter,

Acting Director, Compliance Division.

[FR Doc. 83-23797 Filed 8-31-83; 8:45 am]

BILLING CODE 3410-02-M

Agency Designation Actions; Renewals of Fostoria Grain Inspection (OH), Louisiana Department of Agriculture (LA), and North Carolina Department of Agriculture (NC)

AGENCY: Federal Grain Inspection Service, USDA.

ACTION: Notice.

SUMMARY: This notice announces the designation renewals of Fostoria Grain Inspection, Louisiana Department of Agriculture, and North Carolina Department of Agriculture as official agencies responsible for providing official services under the U.S. Grain Standards Act, as amended (7 U.S.C. 71 *et seq.)* (Act).

EFFECTIVE DATE: October 1, 1983.

ADDRESS: James R. Conrad, Chief, Regulatory Branch, Compliance Division, Federal Grain Inspection Service, U.S. Department of Agriculture, 1400 Independence Avenue, SW., Room 1647 South Building, Washington, DC 20250.

FOR FURTHER INFORMATION CONTACT: James R. Conrad, telephone (202) 447-8525.

SUPPLEMENTARY INFORMATION: This action has been reviewed and determined not to be a rule or regulation as defined in Executive Order 12291 and Secretary's Memorandum 1512-1; therefore, the Executive Order and Secretary's Memorandum do not apply to this action.

The April 1, 1983, issue of the **Federal Register** (48 FR 14016) contained a notice from the Federal Grain Inspection Service (FGIS) announcing that Fostoria's, Louisiana's, and North Carolina's designations terminate on September 30, 1983, and requesting applications for designation as the agency to provide official services within each specified geographic area. Applications were to be postmarked by May 2, 1983.

Fostoria, Louisiana, and North Carolina were the only applicants for each respective designation.

FGIS announced the names of these applicants and requested comments on same in the June 1, 1983, issue of the **Federal Register** (48 FR 24401). Comments were to be postmarked by July 18, 1983.

No comments were received regarding designation renewal of these three agencies.

FGIS has evaluated all available information, regarding the designation criteria in Section 7(f)(1)(A) of the Act and in accordance with Section 7(f)(1)(B), and has determined that Fostoria, Louisiana, and North Carolina are able to provide official services in the geographic areas for which their designations are being renewed. Each assigned area is the entire geographic area, as previously described in the April 1 **Federal Register** issue.

Effective October 1, 1983, and terminating September 30, 1986, the responsibility for providing official inspection services in their respective specified geographic areas are assigned to Fostoria and North Carolina; for providing official inspection, official weighing, and supervision of weighing services in its specified geographic area is assigned to Louisiana.

A specified service point, for the purpose of this notice, is a city, town, or other location specified by an agency to conduct official inspection and where the agency and one or more of its licensed inspectors are located. In addition to the specified service points within the assigned geographic area, the agencies will provide official services not requiring a licensed inspector to all locations within their geographic area.

Interested persons may contact the Regulatory Branch, specified in the address section of this notice, to obtain a list of the specified service points. Interested persons also may obtain a list of the specified service points by contacting the agencies at the following addresses:

Fostoria Grain Inspection, P.O. Box 864, Fostoria, OH 44830

Louisiana Department of Agriculture, P.O. Box 44456, Baton Rouge, LA 70804

North Carolina Department of Agriculture, P.O. Box 27647, Raleigh, NC 27611

(Sec. 8, Sec. 9, Pub. L. 94-582, 90 Stat. 2873, 2875 (7 U.S.C. 79, 79a))

Dated: August 17, 1983.

Neil E. Porter,

Acting Director, Compliance Division.

[FR Doc. 83-23794 Filed 8-3-83; 8:45 am]

BILLING CODE 3410-02-M

Agency Designation Actions; Applicants in the Areas Currently Assigned to Alva Grain Inspection Department (OK) and Connecticut Department of Agriculture (CT); Request for Comments

AGENCY: Federal Grain Inspection Service, USDA.

ACTION: Notice.

SUMMARY: This notice requests comments from interested parties on the applicants for official agency designation in the areas currently assigned to Alva Grain Inspection Department and Connecticut Department of Agriculture.

DATE: Comments to be postmarked on or before October 16, 1983.

ADDRESS: Comments must be submitted in writing, in duplicate, to Lewis Lebakken, Jr., Regulations and Directives Management Unit, Resources Management Division, Federal Grain Inspection Service, U.S. Department of Agriculture, Room 0667, South Building, 1400 Independence Avenue, SW., Washington, D.C. 20250. All comments received will be made available for public inspection at the above address during regular business hours (7 CFR 1.27(b)).

FOR FURTHER INFORMATION CONTACT: Lewis Lebakken, Jr., telephone (202) 382-1738.

SUPPLEMENTARY INFORMATION: This action has been reviewed and determined not to be a rule or regulation as defined in Executive Order 12291 and Secretary's Memorandum 1512-1; therefore, the Executive Order and Secretary's Memorandum do not apply to this action.

The July 1, 1983, issue of the **Federal Register** (48 FR 30417) contained a notice from the Federal Grain Inspection Service requesting applications for designation to perform official services under the U.S. Grain Standards Act, as amended (7 U.S.C. 71 *et seq.)* (Act), in the areas currently assigned to the official agencies. Applications were to be postmarked by August 1, 1983.

Alva Grain Inspection Department (Alva), the only applicant, requested designation for the entire geographic area currently assigned on an interim basis to that agency. Connecticut

Department of Agriculture, the only applicant, requested a designation renewal for the entire geographic area currently assigned to that agency.

In accordance with § 800.206(b)(2) of the regulations under the Act, this notice provides interested persons the opportunity to present their comments concerning the applicants for designation. All comments must be submitted to the Regulations and Directives Management Unit, Resources Management Division, specified in the address section of this notice, and postmarked not later than October 16, 1983.

Comments and other available information will be considered before a final decision is made in this matter. Notice of the final decision will be published in the **Federal Register**, and the applicants will be informed of the decision in writing.

(Sec. 8, Pub. L. 94–582, 90 Stat. 2873 (7 U.S.C. 79)).

Dated: August 17, 1983.

Neil E. Porter,

Acting Director, Compliance Division.

[FR Doc. 83–23796 Filed 8–31–83; 8:45 am]

BILLING CODE 3410–02–M

Forest Service

Land and Regional Management Plan; Bridger-Teton National Forest, Resource Wyoming; Revised Notice of Intent to Prepare an Environmental Impact Statement

This Notice revises previously issued Notices of Intent published in the **Federal Register** dated May 1, 1980, page 29107 and March 12, 1982, page 16285.

This Notice is being issued because 36 CFR 219.17 is being revised to allow the reevaluation of roadless areas during the Forest planning process. Public participation in the reevaluation permits data collection and analysis activities to proceed pending release of the final regulations.

The proposed revision to 36 CFR 219.17 (issued 4/18/83) will allow further evaluation of the Forest roadless areas. The results of the reevaluation of roadless areas will be included in the Environmental Impact Statement and Bridger-Teton National Forest Land and Resource Management Plan.

The first steps involving initial public participation, inventory, and analysis of the management situation have been completed. The scoping for the roadless area reevaluation portion of the land management planning process will be initiated by explaining the roadless area reevaluation to all individuals interested and wanting to become involved in the planning process for the Forest. Significant issues relating to reevaluation will be identified and included with those issues already identified for the Forest.

Detailed information on the roadless areas and reevaluation processes will be available for individuals and organizations requesting the information. In addition, there will be a public meeting beginning in October to further explain, discuss, and gather information about the roadless areas and reevaluation process. The specific time and schedule of the meeting will be published in the local newspaper.

The Bridger-Teton National Forest Plan will select from a range of alternatives which will include at least:

(1) The "no-action" alternative, which represents continuation of present levels of activity.

(2) One or more alternatives which represent levels of activity that will result in elimination of all backlogs of needed treatment for restoration of renewable resources and ensure that a major portion of planning intensive multiple-use and sustained-yield management procedures are operating on an environmentally sound basis.

(3) One or more alternatives formulated to resolve the identified major public issues and management concerns, including roadless areas.

The Draft Environmental Impact Statement and proposed Land and Resource Management Plan for the Bridger-Teton National Forest are scheduled for a draft review by March 1985. The final documents are scheduled for filing with the Environmental Protection Agency in September 1985.

During the reevaluation process, current management and protection policies and activities in the roadless areas may be continued. Wilderness values will be protected in the areas recommended in RARE II for Wilderness, and management for other uses may continue in areas recommended for non-Wilderness.

J. S. Tixier, Regional Forester, Intermountain Region, USDA Forest Service, is the responsible official for the Forest Management Plan and Environmental Impact Statement. Reid Jackson, Forest Supervisor, is responsible for preparation of the Forest Plan and Environmental Impact Statement.

Written comments, suggestions, and/or requests for information during this process should be sent to Carl Pence, Forest Planner, Bridger-Teton National Forest, P.O. Box 1888, Jackson, Wyoming 83001, phone (307) 733–2752.

Dated: August 19, 1983.

Richard K. Griswold,

Director, Planning and Budget.

[FR Doc. 83–23079 Filed 8–31–83; 8:45 am]

BILLING CODE 3410–11–M

Land and Resource Management Plan; Challis National Forest, Idaho; Revised Notice of Intent to Prepare an Environmental Impact Statement

This Notice revises a previously issued Notice of Intent published in the **Federal Register** dated February 12, 1981, page 12038.

This Notice is being issued because 36 CFR 219.17 is being revised to allow the reevaluation of roadless areas during the Forest planning process. Public participation in the reevaluation permits data collection and analysis activities to proceed pending release of the final regulations.

The proposed revision to 36 CFR 219.17 (issued 4/18/83) will allow further evaluation of the Forest roadless areas. The results of the reevaluation of roadless areas will be included in the Environmental Impact Statement and Challis National Forest Land and Resource Management Plan.

The first steps involving initial public participation, inventory, and analysis of the management situation have been completed. The scoping for the roadless area reevaluation portion of the land management planning process will be initiated by explaining the roadless area reevaluation to all individuals interested and wanting to become involved in the planning process for the Forest. Significant issues relating to reevaluation will be identified and included with those issues already identified for the Forest.

Detailed information on the roadless areas and reevaluation processes will be available for individuals and organizations requesting the information. In addition, there will be a media announcement and contact with respondents to previous planning activities will be made to further explain, discuss, and gather information about the roadless areas and reevaluation process. These contacts are scheduled to begin 30 days from the date of the publication in the **Federal Register**.

The Challis National Forest Plan will select from a range of alternatives which will include at least:

(1) The "no-action" alternative, which represents continuation of present levels of activity.

(2) One or more alternatives which represent levels of activity that will

result in elimination of all backlogs of needed treatment for restoration of renewable resources and ensure that a major portion of planning intensive multiple-use and sustained-yield mangement procedures are operating on an environmentally sound basis.

(3) One or more alternatives formulated to resolve the identified major public issues and management concerns, including roadless areas.

The Draft Environmental Impact Statement and proposed Land and Resource Management Plan for the Challis National Forest are scheduled for filing with the Environmantal Protection Agency review by August 1985. The final documents are scheduled for filing with the Environmental Protection Agency in January 1986.

During the reevaluation process, current management and protection policies and activities in the roadless areas may be continued. Wilderness values will be protected in the areas recommended in RARE II for Wilderness, and management for other uses may continue in areas recommended for non-Wilderness.

J. S. Tixier, Regional Forester, Intermountain Region, USDA Forest Service, is the responsible official for the Forest Management Plan and Environmental Impact Statement. Jack E. Bills, Forest Supervisor, is responsible for preparation of the Forest Plan and Environmental Impact Statement.

Written comments, suggestions, and/or requests for information during this process should be sent to Jack E. Bills, Forest Supervisor, Challis National Forest, P.O. Box 404, Challis, Idaho 83226, phone 308/879–2285.

Dated: August 19, 1983.

Richard K. Griswold,

Director, Planning and Budget.

[FR Doc. 83-23960 Filed 8-31-83; 8:45 am]

BILLING CODE 3410-11-M

COMMISSION ON CIVIL RIGHTS

District of Columbia Advisory Committee; Agenda and Public Meeting

Notice is hereby given, pursuant to the provisions of the Rules and Regulations of the U.S. Commission on Civil Rights, that a meeting of the District of Columbia Advisory Committee to the Commission will convene at 4:00 p.m. and will end at 6:00pm, on September 12, 1983, at the National Housing Center, Lower Level, 15th & M Streets, NW., Washington DC. The purpose of the meeting is to brief Committee members on plans for a hearing on fair housing to be held by the U.S. Commission on Civil Rights.

Persons desiring additional information or planning a presentation to the Committee, should contact the Chairperson, Mr. Walter E. Washington, 1025 15th Street, NW., Washington DC 20005, (202) 659–3300; or the Mid-Atlantic Regional Office, 2120 L Street, NW., Washington DC 20037, (202) 254–6717.

The meeting will be conducted pursuant to the provisions of the Rules and Regulations of the Commission.

Dated at Washington, D.C., August 26, 1983.

John I. Binkley,

Advisory Committee Management Officer.

[FR Doc. 83-24025 Filed 8-31-83; 8:45 am]

BILLING CODE 6335-01-M

Illinois Advisory Committee; Agenda and Public Meeting

Notice is hereby given, pursuant to the provisions of the Rules and Regulations of the U.S. Commission on Civil Rights, that a meeting of the Illinois Advisory Committee to the Commission will convene at 10:00 am and will end at 2:00 pm, on September 23, 1983, at the John C. Klucaynski Building, Room 3280, 230 South Dearborn Street, Chicago, Illinois. The purposes of the meeting are to hear a report on the National Chairpersons' Conference and discuss progress on two Chicago projects, one on industrial revenue bonds and another on the effectiveness of contract compliance enforcement.

Persons desiring additional information or planning a presentation to the Committee, should contact the Chairperson, Mr. Thomas J. Pugh, 500 West Melbourne Avenue, Peoria, Illinois 61604, (309) 686–3121; or the Midwestern Regional Office, 230 South Dearborn Street, 32nd Floor, Chicago, Illinois 60604, (312) 353–7371.

The meeting will be conducted pursuant to the provisions of the Rules and Regulations of the Commission.

Dated at Washington, D.C., August 26, 1983.

John I. Binkley,

Advisory Committee Management Officer.

[FR Doc. 83-24022 Filed 8-31-83; 8:45 am]

BILLING CODE 6335-01-M

Louisiana Advisory Committee; Agenda and Public Meeting

Notice is hereby given, pursuant to the provisions of the Rules and Regulations of the U.S. Commission on Civil Rights, that a meeting of the Louisiana Advisory Committee to the Commission will convene at 9:00 am and will end at 1:00 pm, on September 24, 1983, at the Warwick Hotel, Somerset Room, 1315 Gravier Street, New Orleans, Louisiana. The purpose of the meeting will be to orient new Committee members and plan programs for FY 84.

Persons desiring additional information or planning a presentation to the Committee, should contact the Chairperson, Dr. Louis C. Pendleton, 1514 Grey, Sharveport, Louisiana 71103, (318) 424–1297; or the Southwestern Regional Office, Heritage Plaza, 418 South Main, San Antonio, Texas 78204, (512) 730–5570.

The meeting will be conducted pursuant to the provisions of the Rules and Regulations of the Commission.

Dated at Washington, D.C., August 26, 1983.

John I. Binkley,

Advisory Committee Management Officer.

[FR Doc. 83-24023 Filed 8-31-83; 8:45 am]

BILLING CODE 6335-01-M

Virginia Advisory Committee; Agenda and Public Meeting

Notice is hereby given, pursuant to the provisions of the Rules and Regulations of the U.S. Commission on Civil Rights, that a conference of the Virginia Advisory Committee to the Commission will convene at 5:00 pm and end at 10:00 pm, on September 25; the Committee will also convene at 8:00 am and will end at 5:00 pm, on September 26, 1983, at the Sheraton-Fredericksburg Inn, Conference Center, I–95 and Virginia Route 3, Fredericksburg, Virginia. The purposes of the conference are to gather information about civil rights complaints and enforcement in the State, and to discuss the possible utility of establishing a State human rights agency.

Persons desiring additional information or planning a presentation to the Committee, should contact the Chairperson, Rev. Curtis W. Harris, 209 Terminal Street, Hopewell, Virginia 23860, (804) 458–7404; or the Mid-Atlantic Regional Office, 2120 L Street, NW., Room 510, Washington, DC 20037, (202) 254–6717.

The meeting will be conducted pursuant to the provisions of the Rules and Regulations of the Commission.

Dated at Washington, D.C., August 26, 1983.

John I. Binkley,

Advisory Committee Management Officer.

[FR Doc. 83-24024 Filed 8-31-83; 8:45am]

BILLING CODE 6335-01-M

DEPARTMENT OF COMMERCE

International Trade Administration

[A-588-028]

Roller Chain, Other Than Bicycle, From Japan; Preliminary Results of Administrative Review of Antidumping Finding and Tentative Determination To Revoke in Part

AGENCY: International Trade Administration, Commerce.

ACTION: Notice of preliminary results of administrative review of antidumping finding and tentative determination to revoke in part.

SUMMARY: The Department of Commerce has conducted an administrative review of the antidumping finding on roller chain, other than bicycle, from Japan. The review covers Tsubakimoto Chain Company and the period December 1, 1979 through March 31, 1981. The review indicates a *de minimis* margin for the period.

As a result of the review, the Department has preliminarily determined to assess dumping duties equal to the calculated differences between United States price and foreign market value on each of the sales by Tsubakimoto Chain Company during the period of review. The Department has also tentatively determined to revoke the finding with respect to this firm.

Interested parties are invited to comment on these preliminary results and tentative determination to revoke in part.

EFFECTIVE DATE: September 1, 1983.

FOR FURTHER INFORMATION CONTACT: J. Linnea Bucher, or Robert Marenick, Office of Compliance, International Trade Administration, U.S. Department of Commerce, Washington, D.C. 20230, telephone: (202) 377-5255.

SUPPLEMENTARY INFORMATION:

Background

On September 4, 1981, the Department of Commerce ("the Department") published in the **Federal Register** (46 FR 44488) the final results of its last administrative review of the antidumping finding on roller chain, other than bicycle, from Japan (38 FR 9926, April 12, 1973), and announced its intent to conduct the next administrative review. On October 8, 1982, the Department published in the **Federal Register** (47 FR 44597) the preliminary results of the latter review, covering 117 firms but deferring publication of preliminary results with regard to Tsubakimoto Chain Company. As required by section 751 of the Tariff Act of 1930 ("the Tariff Act"), the Department has now conducted the administrative review with respect to Tsubakimoto for the period December 1, 1979 through March 31, 1981.

The substantive provisions of the Antidumping Act of 1921 ("the 1921 Act") and the appropriate Customs Service regulations apply to all unliquidated entries made prior to January 1, 1980.

Scope of the Review

Imports covered by the review are shipments of roller chain, other than bicycle, from Japan. The term "roller chain, other than bicycle" as used in the review includes chain, with or without attachments, whether or not plated or coated, and whether or not manufactured to American or British standards, which is used for power transmission and/or conveyance. Such chain consists of a series of alternately assembled roller links and pin links in which the pins articulate inside the bushings and the rollers are free to turn on the bushings. Pins and bushings are press fit in their respective link plates. Chain may be single strand having one row of roller links, or multiple strand having more than one row of roller links. The center plates are located between the strands of roller links. Such chain may be either single or double pitch and may be used as power transmission or conveyor chain.

The review also covers leaf chain which consists of a series of link plates alternately assembled with pins in such a way that the joint is free to articulate between adjoining pitches. The review further covers chain models #25 and #35. Roller chain, other than bicycle, is currently classifiable under various provisions of the Tariff Schedules of the United States Annotated, ranging from item numbers 652.1300 through 652.3800.

The review covers Tsubakimoto, one of the 119 known manufacturers and/or exporters of Japanese rollers, chain, other than bicycle, to the United States, and the period December 1, 1979 through March 31, 1981. In the preliminary results published on October 8, 1982, we preliminarily determined that certain types of chain manufactured by Tsubakimoto are not within the scope of the finding. We will publish our final determination on those types of chain with final results for the 117 firms. We have not included those types of chain in this review.

United States Price

In calculating United States price Department used exporter's sales price the ("ESP"), as defined in section 772 of the Tariff Act or section 204 of the 1921 Act, as appropriate. Exporter's sales price was based on the packed delivered price to unrelated purchasers in the United States. Where applicable, deductions were made for ocean freight, insurance, freight forwarders' fees, U.S. and foreign inland freight, loading charges, and the U.S. subsidiary's selling expenses, in accordance with § 353.10 of the Commerce Regulations. No other adjustments were claimed or allowed.

Foreign Market Value

In calculating foreign market value the Department used home market price, as defined in section 773 of the Tariff Act or section 205 of the 1921 Act, where sufficient quantities of such or similar merchandise were sold in the home market to provide a basis for comparison. When there were no sales or insufficient quantities of such similar merchandise sold in the home market, and because there were no sales of such or similar merchandise to third countries, the Department used constructed value, as defined in section 773(e) of the Tariff Act or section 206 of the 1921 Act.

The home market prices were based on packed prices to unrelated parties. Deductions were made, where applicable, for discounts, inland freight, direct selling expenses, credit costs, and indirect selling expenses up to the amount of U.S. indirect selling expenses, in accordance with § 353.15 of the Commerce Regulations and § 153.10 of the Customs Regulations. Further adjustments were made for differences in merchandise in accordance with § 353.16 of the Commerce Regulations and § 153.11 of the Customs Regulations and for differences in packing. No other adjustments were claimed or allowed. Constructed values were calculated as the sum of materials, fabrication costs, general expenses, profit, and the cost of packing. For general expenses the Department used the actual general expenses because they were higher than the statutory minimum of ten percent of the sum of materials and fabrication costs. Because the actual profit was less than eight percent of the sum of materials, fabrication costs, and general expenses, the Department added the statutory minimum of eight percent for profit.

Preliminary Results of the Review and Tentative Determination to Revoke in Part

As a result of our comparison of the United States price to foreign market value, we preliminarily determine that a 0.14 percent margin exists for

Tsubakimoto for the period December 1, 1979 through March 31, 1981.

The Department shall determine, and the U.S. Customs Service shall assess, dumping duties on all appropriate entries made with export dates during the time period involved. Individual differences between United States price and foreign market value may vary from the percentage stated above. The Department will issue appraisement instructions on Tsubakimoto directly to the Customs Service.

We concluded in our last review of Tsubakimoto that the company had a zero percent margin for the period April 1, 1979 through November 30, 1979. When combined with the current review, the firm has had a zero or *de minimis* margin for a two year period.

As provided for in § 353.54(e) of the Commerce Regulations, Tsubakimoto has agreed in writing to an immediate suspension of liquidation and reinstatement of the finding (as an order) if circumstances develop which indicate that roller chain, other than bicycle, manufactured and exported to the United Stated by Tsubakimoto is being sold by the firm at less than fair value.

Therefore, we tentatively determine to revoke the finding on roller chain, other than bicycle, from Japan with respect to Tsubakimoto. If this partial revocation is made final, it will apply to all shipments of roller chain, other than bicycle, manufactured and exported by Tsubakimoto entered, or withdrawn from warehouse, for consumption on or after the date of publication of this notice.

Interested parties may submit written comments on these preliminary results within 30 days of the date of publication of this notice and may request disclosure and/or a hearing within 10 days of the date of publication. Any hearing, if requested, will be held 45 days after the date of publication or the first workday thereafter. Any request for an administrative protective order must be made no later than five days after the date of publication. The Department will publish the final results of the administrative review including the results of its analysis of any such comments or hearing.

This administrative review, tentative determination to revoke in part, and notice are in accordance with sections 751 (a)(1) and (c) of the Tariff Act (19 U.S.C. 1675 (a)(1), (c)) and §§ 353.53 and 353.54 of the Commerce Regulations (19 CFR 353.53 353.54).

Dated: August 25, 1983.

Alan F. Holmer,

Deputy Assistant Secretary for Import Administration.

[FR Doc. 83-24056 Filed 8-31-83; 8:45 am]

BILLING CODE 3510-25-M

National Technical Information Service

Government-Owned Inventions; Availability for Licensing

The inventions listed below are owned by agencies of the U.S. Government and are available for licensing in the U.S. in accordance with 35 U.S.C. 207 to achieve expeditious commercialization of results of federally funded research and development. Foreign patents are filed on selected inventions to extend market coverage for U.S. companies and may also be available for licensing.

Technical and licensing information on specific inventions may be obtained by writing to: Office of Government Inventions and Patents, U.S. Department of Commerce, P.O. Box 1423, Springfield, Virginia 22151.

Please cite the number and title of inventions of interest.

Douglas J. Campion,

Program Coordinator, Office of Government Inventions and Patents, National Technical Information Service, Department of Commerce.

Department of the Air Force

SN 6-399,567 Tubular Singlet Delta Oxygen Generator
SN 6-439,493 Acoustically Tuned Optical Filter System
SN 6-505,166 Machining a Cooled Cylindrical Optic to Compensate for Pressure Distortion
SN 6-511,060 Void Detection and Composition Measurements in Composite Wires
SN 6-511,689 Fire Control Apparatus for a Laser Weapon
SN 6-511,591 Multibeam Lens Antennas
SN 6-511,697 Radio Frequency Lens Antenna

Department of the Army

SN 6-445,405 Ground Contact Area Measurement Device
SN 6-484,326 Phase Scanned Microstrip Array Antenna
SN 6-490,266 Self-Regulating Air Driven Power Supply
SN 6-492,120 Fluidic Absolute-To-Differential Pressure Converter
SN 6-517,607 Stripline Transformer Adapted for Inexpensive Construction
SN 6-519,154 Three Diode Balanced Mixer

Department of Health and Human Services

SN 6-481,934 Cell Matrix Receptor System and Use in Cancer Diagnosis and Management

[FR Doc. 83-23958 Filed 8-31-83; 8:45 am]

BILLING CODE 3510-04-M

Government-Owned Inventions; Availability for Licensing

The inventions listed below are owned by agencies of the U.S. Government and are available for licensing in the U.S. in accordance with 35 U.S.C. 207 to achieve expeditious commercialization of results of federally funded research and development. Foreign patents are filed on selected inventions to extend market coverage for U.S. companies and may also be available for licensing.

Technical and licensing information on specific inventions may be obtained by writing to: Office of Government Inventions and Patents, U.S. Department of Commerce, P.O. Box 1423, Springfield, Virginia 22151.

Please cite the number and title of inventions of interest.

Douglas J. Campion,

Program Coordinator, Office of Government Inventions and Patents, National Technical Information Service, Department of Commerce.

Department of Agriculture

SN 6-311,587 (4,395,959) Hand Apparatus for Continuous Injection of Chemically-Impregnated Filament
SN 6-506,482 Method for Obtaining a Purified Fraction from a Mixture Using Magnetic Fluid

Department of the Air Force

SN 6-486,125 Method of Making a High Stability Quartz Crystal Oscillator
SN 6-470,749 Vertical Launch Alignment Transfer Apparatus
SN 6-471,078 Eccentrically Tightened Latch Device
SN 6-475,417 Storage Cabinet Travel Lock
SN 6-484,107 Method and Apparatus for Signalling On-Line Failure Detection
SN 6-486,127 Scanning Beam Beamrider Missile Guidance System
SN 6-486,130 Liquid Reactant Chemical Pump
SN 6-488,249 Amine Salts as Bonding Agents
SN 6-490,948 Pulse Code Modulation Rate Converter
SN 6-499,581 Porous Catalytic Metal Plate Degeneration Bed in a Gas Generator

SN 6–499,593 Non-Obstructing Laser Beam Sampling Meter
SN 6–499,735 Integrated Dielectric Waveguide Radar Front End Device
SN 6–502,419 Method and Apparatus for Using a Photoacoustic Effect for Controlling Various Processes Utilizing Laser and Ion Beams, and the Like
SN 6–502,907 Recoil Transducer Fixture
SN 6–504,767 An Efficient Optical Design for a Matched Filter Correlator
SN 6–506,934 Waveform Design for Optimized Ambiguity Response
SN 6–507,886 Dual Gunn Diode Self-Oscillating Mixer
SN 6–508,791 Impulse Autocorrelation Function Communications System
SN 6–508,957 Method of Protecting Optical Fibre Against Stress Corrosion
SN 6–511,423 Optical Fiber Splice Sled
SN 6–51,811 Radiatiion Scanning and Detection System

Department of Health and Human Services

SN 6–228,681 (4,395,635) Gamma Bay Coincidence Analysis System
SN 6–352,599 (4,396,628) Antiviral Activities of Dansylcadaverine and Closely Related Compounds

[FR Doc. 83-23802 Filed 8-31-83; 8:45 am]
BILLING CODE 3510-04-M

COMMITTEE FOR PURCHASE FROM THE BLIND AND OTHER SEVERELY HANDICAPPED

Procurement List 1983; Addition

AGENCY: Committee for Purchase from the Blind and Other Severely Handicapped.

ACTION: Additon to Procurement List.

SUMMARY: This action adds to Procurement List 1983 a service to be provided by workshops for the blind and other severely handicapped.

EFFECTIVE DATE: September 1, 1983.

ADDRESS: Committee for Purchase from the Blind and Other Severely Handicapped, Crystal Square 5, Suite 1107, 1755 Jefferson Davis Highway, Arlington, Virginia 22202.

FOR FURTHER INFORMATION CONTACT: C. W. Fletcher, (703) 557–1145.

SUPPLEMENTARY INFORMATION: On June 24, 1983, the Committee for Purchase from the Blind and Other Severely Handicapped published a notice (48 FR 29038) of proposed addition to Procurement List 1983, November 18, 1982 (47 FR 52101).

After consideration of the relevant matter presented, the Committee has determined that the service listed below is suitable for procurement by the Federal Government under 41 U.S.C. 46–48c, 85 Stat. 77.

I certify that the following action will not have a significant impact on a substantial number of small entities. The major factors considered were:

a. The action will not result in any additional reporting, recordkeeping or other compliance requirements.

b. The action will not have a serious economic impact on any contractor for the service listed.

c. The action will result in authorizing small entities to provide a service procured by the Government.

Accordingly, the following service is hereby added to Procurement List 1983:

SIC 7349

Janitorial/Custodial Base and Survival School Buildings, 2249C, 1224, 1302, 1306, 1336, 1344, 1348, 2248D, 2301, and 2451A, Fairchild Air Force Base, Washington.

C. W. Fletcher,

Executive Director.

[FR Doc. 83-24028 Filed 8-31-83; 8:45 am]
BILLING CODE 6820-33-M

DEPARTMENT OF EDUCATION

National Advisory Council on Continuing Education; Meeting

AGENCY: National Advisory Council on Continuing Education, Fd.

ACTION: Notice of meeting.

SUMMARY: This notice sets forth the schedule and proposed agenda of a meeting of the National Advisory Council on Continuing Education. It also describes the functions of the Council. Notice of meetings is required under Section 10(a)(2) of the Federal Advisory Committee act. This document is intended to notify the general public of their opportunity to attend.

DATES: September 14, 15, and 16, 1983.

ADDRESS: The Capitol Hill Hotel, Washington, D.C. 20003.

FOR FURTHER INFORMATION CONTACT: Dr. William G. Shannon, Executive Director, National Advisory Council on Continuing Education, 425 Thirteenth Street, N.W.; Suite 529, Washington, D.C. 20004, Telephone: (202) 376–8888.

SUPPLEMENTARY INFORMATION: The National Advisory Council on Continuing Education is established under Section 117 of the Higher Education Act (20 U.S.C. 1009), as amended. The Council is established to advise the President, the Congress, and the Secretary of the Department of Education on the following subjects:

(a) An examination of all federally supported continuing education and training programs, and recommendations to eliminate duplication and encourage coordination among these programs;

(b) The preparation of general regulations and the development of policies and procedures related to the administration of Title I of the Higher Education Act; and

(c) Activities that will lead to changes in the legislative provisions of this title and other Federal laws affecting Federal continuing education and training programs.

The meetings of the Council are open to the public. However, because of limited space, those interested in attending are asked to all the Council's office to reserve space and to confirm locations of specific sessions.

The Council meeting will be held from 2:00 p.m. until 5:00 p.m., and from 7:00 p.m. until 9:00 p.m. on September 14: from 9:00 a.m. until 5:00 p.m. on September 15; and from 9:00 a.m. until 12:00 Noon on September 16, 1983.

The proposed agenda includes:

—Final review of Council's annual report
—Plans for circulation of Report;
—Installation of new members;
—Discussion of priorities for coming year;
—Other business.

Records are kept of all Council proceedings and are available for public inspection at the office of the National Advisory Council on Continuing Education, 425 Thirteenth Street, N.W., Room 529, Washington, D.C.

Singed at Washington, D.C. on August 29, 1983.

Richard F. McCarthy,

Aseociate Director.

[FR Doc. 83-23990 Filed 8-31-83; 8:45 am]
BILLING CODE 4000-01-M

Office of Postsecondary Education

Undergraduate International Studies and Foreign Language Program; Application Notice for New and Non-Competing Continuation Projects for Fiscal Year 1984

Applications are invited for new and non-competing continuation projects under the Undergraduate International Studies and Foreign Language Program.

Authority for this program is contained in Title VI, Section 604, of the Higher Education Act of 1965, as amended (20 U.S.C. 1124).

The Undergraduate International Studies and Foreign Language Program

issues awards to institutions of higher education and public and non-profit private agencies and organizations, including professional and scholarly associations. The purpose of the awards is to:

(a) Assist institutions of higher education and consortia of such institutions, to plan, develop, and carry out a comprehensive program to strengthen and improve undergraduate instruction in international studies and foreign languages; and

(b) Assist associations and organizations to develop projects that will make an specially significant contribution to strengthening and improving undergraduate instruction in international studies and foreign languages.

Closing Date for Transmittal of Applications: (1) An application for a new grant must be mailed or hand-delivered by October 31, 1983. (2) An application for a non-competing continuation grant, to be assured of consideration for funding, should be mailed or hand-delivered by January 10, 1984. If the application for a non-competing continuation grant is late, the Department of Education may lack sufficent time to review it with other non-competing continuation applications and may decline to accept it.

Applications Delivered by Mail: An application sent by mail must be addressed to the U.S. Department of Education, Application Control Center, Attention: 84.016 (Undergraduate International Studies Program), Washington, D.C. 20202.

An applicant must show proof of mailing consisting of one the following:

(1) A legibly dated U.S. Postal Service postmark;

(2) A legible mail receipt with the date of mailing stamped by the U.S. Postal Service;

(3) A dated shipping label, invoice, or receipt from a commercial carrier; or

(4) Any other proof of mailing acceptable to the Secretary of Education.

If an application is sent through the U.S. Postal Service, the Secretary does not accept either of the following as proof of mailing: (1) a private metered postmark, or (2) a mail receipt that is not dated by the U.S. Postal Service. An applicant should note that the U.S. Postal Service does not uniformly provide a dated postmark. Before relying on this method, an applicant should check with its local post office.

An applicant is encouraged to use registered or at least first class mail. Each late applicant for a new grant will be notified that its application will not be considered.

Applications Delivered by Hand: An application that is hand-delivered should be taken to the U.S. Department of Education, Application Control Center, (Room 5673, Regional Office Building 3), 7th and D Streets, SW., Washington, D.C. 20202.

The Application Control Center will accept a hand-delivered application between 8:00 a.m. and 4:30 p.m. (Washington, D.C. time) daily, except Saturdays, Sundays and Federal holidays.

An application for a new grant that is hand-delivered will not be accepted after 4:30 p.m. on the closing date.

Program Information: Information regarding this program is set forth in the Undergraduate International Studies and Foreign Language Program Regulations, 34 CFR Parts 655 and 658. Information regarding the continuation of non-competing continuation awards is set forth in the Education Department General Administrative Regulations, EDGAR, 34 CFR 75.253.

Application Topics for New Projects: Applications will be accepted in Fiscal Year 1984 for new projects in all categories included in the program regulations. The Secretary encourages applications designed to promote excellence in education and provide leadership in developing more effective learning strategies in international education and modern foreign language training. The Secretary further encourages applications which demonstrate the active involvement of the institution's administration in program design and implementation, and provide evidence that the project will continue without Federal assistance after the grant terminates. More specifically, the Secretary encourages new projects in the following categories:

(1) Projects initiated by institutions of higher education and consortia of such institutions, which can serve as exemplary or model projects for other higher education institutions, particularly in the field of teacher education;

(2) Projects initiated by organizations and associations which will make a significant contribution to strengthening and improving undergraduate instruction in international studies and foreign languages;

(3) Projects that use Federal dollars in partnership with institutional and private sector funding;

(4) Projects that strengthen the acquisition of basic and higher level skills in modern foreign languages, and in disciplines such as history, anthropology, economics, and the geography of the areas where such foreign languages are spoken;

(5) Projects that strengthen the acquistion of knowledge and skills in professional fields with an international component, such as agriculture, business, education, and journalism, or that develop skills for the analysis of critical issues such as economic development, technology utilization, national security, or international trade; and

(6) Projects that utilize computers to implement more effective means of teaching modern foreign languages, and for the collection and analysis of information about critical international issues.

Because of the planning time required to develop and implement new curricula in modern foreign languages, and to develop curricula that strengthen skills in international fields of study, the Secretary of Education is accepting applications for new projects of up to two years for a single institution, and up to three years for consortia.

Available Funds: The Administration's budget for Fiscal Year 1984 does not include funds for the Undergraduate International Studies and Foreign Language Program. However, applications are being invited to allow for sufficient time to evaluate applications and complete the grant process, should Congress decide to appropriate funds for this program. In Fiscal Year 1983, Congress appropriated $21,000,000 for the International Education and Foreign Language Studies domestic programs, of which $2,300,000 was allocated to the Undergraduate International Studies and Foreign Language Program. If this funding level is maintained for Fiscal Year 1984, it is anticipated that approximately 40 non-competing continuation applications would be funded at an approximate cost of $1,550,000 and approximately $750,000 would be allocated to new projects. Awards to single institutions usually average around $42,000 and consortia awards generally range between $50,000 and $65,000. Using these average figures, we anticipate that between 16 and 20 new awards could be made in Fiscal Year 1984.

Application Forms: Application forms and program information packages are expected to be ready for mailing by September 7, 1983. They may be obtained be writing to Mrs. Susanna C. Easton, International Studies Branch, International Education Programs, U.S. Department of Education (Room 3916, Regional Office Building 3), 7th and D Streets, SW., Washington, D.C. 20202.

Applications must be prepared and submitted in accordance with the regulations, instructions, and forms included in the program information package. The Secretary suggests that the narrative portion of the application not exceed 35 pages in length. The Secretary further urges that applicants not submit information that is not requested.

The program information is intended to aid applicants in applying for assistance under this competition. Nothing in the program information package is intended to impose any paperwork, application content, reporting, or grantee performance requirement beyond those specifically imposed under the statute and regulations governing the competition.

Applicable Regulations: Regulations applicable to this program include the following:

(a) Regulations governing the Undergraduate International Studies and Foreign Language Program, 34 CFR Parts 655 and 658; and

(b) Education Department General Administrative Regulations (EDGAR) (34 CFR Parts 74, 75, 77 and 78).

Further Information: For further information, contact Mrs. Susanna C. Easton, International Studies Branch, International Education Programs, U.S. Department of Education (Room 3916, Regional Office Building 3), 7th and D Streets., SW., Washington, D.C. 20202. Telephone: (202) 245–2794.

(20 U.S.C. 1124).

(Catalog of Federal Domestic Assistance Number 84.016—Undergraduate International Studies and Foreign Language Program).

Dated: August 23, 1983.

T. H. Bell,

Secretary of Education.

[FR Doc. 83-24026 Filed 8-31-83; 8:45 am]

BILLING CODE 4000-01-M

National Direct Student Loan, College Work-Study, and Supplemental Educational Opportunity Grant Programs

AGENCY: Department of Education.

ACTION: Notice of closing date for filing the Fiscal-Operations Report and application to participate in the National Direct Student Loan (NDSL), College Work-Study (CWS), and Supplemental Educational Opportunity Grant (SEOG) Programs.

The Secretary gives notice to institutions of higher education of the deadline for an institution of higher education to apply for fiscal year 1984 funds—for use in the 1984–85 award year—under the National Direct Student Loan, College Work-Study, and Supplemental Educational Opportunity Grant Programs. Under these programs, the Secretary allocates funds to institutions for students who need financial aid to meet the cost of postsecondary education. Institutions of higher education do not have to be eligible to submit an application for funds. Institutions will be notified of the closing date for establishing institutional eligibility to participate in the NDSL, CWS and SEOG programs through the **Federal Register.**

The Secretary further gives notice that an institution that had a NDSL fund or expended CWS or SEOG funds during the 1982–83 award year is required to report its program expenditures as of June 30, 1983 to the Secretary.

The NDSL, CWS, and SEOG programs are authorized by Parts E, C, and Subpart A–2, respectively, of title IV of the Higher Education Act of 1965.

(20 U.S.C. 1087aa–1087ii; 42 U.S.C. 2751–2756b; and 20 U.S.C. 1070b–1070b–3)

Closing Date For FISAPs: An institution must submit the Fiscal-Operations Report and Application to Participate in the National Direct Student Loan, Supplemental Educational Opportunity Grant, and College Work-Study Programs (FISAP) by October 3, 1983. Institutions that do not submit the FISAP by the closing date will not be considered for 1984–85 funds.

FISAPs Delivered by Mail: A FISAP sent by mail must be addressed to the Department of Education, Office of Student Financial Assistance, Division of Program Operations, Campus and State Grants Branch, 400 Maryland Avenue SW., (Room 4621, Regional Office Building 3), Washington, D.C. 20202.

An institution must show proof of mailing its FISAP. Proof of mailing consists of one of the following: (1) A legible mail receipt with the date of mailing stamped by the U.S. Postal Service, (2) a legibly dated U.S. Postal Service Postmark, or (3) any other proof of mailing acceptable to the Secretary of Education.

If a FISAP is sent through the U.S. Postal Service, the Secretary does not accept either of the following as proof of mailing:

(1) A private metered postmark, or (2) a mail receipt that is not dated by the U.S. Postal Service. An institution should note that the U.S. Postal Service does not uniformly provide a dated postmark. Before relying on this method, an institution should check with its local post office. An institution is encouraged to use certified or at least first-class mail.

FISAPs Delivered by Hand: A FISAP that is hand-delivered must be taken to the Department of Education, Office of Student Financial Assistance, Division of Program Operations, Campus and State Grants Branch, 7th and D Streets, SW., Room 4621, Regional Office Building 3, Washington, D.C. The Campus and State Grants Branch will accept hand-delivered FISAPs between 8:00 a.m. and 4:30 p.m. daily (Washington, D.C. time), except Saturdays, Sundays and Federal holidays.

A FISAP that is hand-delivered will not be accepted after 4:30 p.m. on the closing date.

FISAP Information: FISAPs have been mailed by the program office. An institution shall prepare and submit its FISAP in accordance with the instructions included in the package.

The program information is intended to aid applicants in applying for assistance under this competition. Nothing in the program information package is intended to impose any paperwork, application content, reporting, or grantee performance requirement beyond those specifically imposed under the statute and regulations governing the competition.

Applicable Regulations: The following regulations are applicable to these programs:

National Direct Student Loan—34 CFR Parts 674 and 668.

College Work-Study—34 CFR Parts 675 and 668.

Supplemental Educational Opportunity Grant—34 CFR Parts 676 and 668.

The final regulations governing the awarding of funds under each of the above campus-based programs were published in the **Federal Register** of August 2, 1982 (47 FR 33398).

Further information: For further information, contact Mr. Robert Coates, Chief, Campus and State Grants Branch, Division of Program Operations, Office of Student Financial Assistance, U.S. Department of Education, 400 Maryland Avenue, S.W., (Room 4621, ROB–3), Washington, D.C. 20202, Telephone (202) 245–2320.

(Catalog of Federal Domestic Assistance Nos. 84.038, National Direct Student Loan Program; 84.033, College Work-Study Program; and 84.007, Supplemental Educational Opportunity Grant Program)

Dated: August 28, 1983.

Edward M. Elmendorf,

Assistant Secretary for Postsecondary Education.

[FR Doc. 83-24027 Filed 8-31-83; 8:45 am]

BILLING CODE 4000-01-M

DEPARTMENT OF ENERGY

Bonneville Power Administration

Washington; Lynch Creek Substation and 115-kV Transmission Service; Finding of No Significant Impact

AGENCY: Bonneville Power Administration (BPA), DOE.

ACTION: Finding of No Significant Impact (FONSI) for BPA's proposed Lynch Creek Substation and 115-kV Transmission Line Project.

SUMMARY: This project is located near the town of Eatonville about 25 miles south of Tacoma, Washington. Steadily growing loads in the area are expected to exceed the capacity of distribution lines which serve the town of Eatonville and the nearby Ohop Valley area. Also, the quality and reliability of service is reduced because the length of the heavily loaded feeder lines is causing a significant voltage drop at the load centers of both the town of Eatonville and Ohop Mutual Light. Additions to the present electrical system are needed to avoid the consequences of overloads, to reduce system losses which increase as lines approach their rated capability, and to improve operating efficiency.

In order to meet electrical needs in this area, BPA proposes to construct a 3.2-mile, 115-kV wood-pole transmission line from a tap point on Tacoma City Light's Cowlitz-LaGrande 115/kV line to a new 115/12.5kV, 15/20/25 MVA substation about 1 mile northwest of Eatonville.

Alternatives considered for this project are: (1) Five alternative plans of service for the project area; (2) four location alternatives for BPA's proposed plan, as well as two alternative substation sites; (3) conservation; and (4) no action. For a further discussion of the purpose of and need for the project, the proposal, and alternatives, see pages 1-8 of the enviromental assessment (EA) (DOE/EA-0212) which was prepared for this proposal. No other documents are related to this finding.

Following are impacts which would be caused by construction and/or operation of the proposed project, as well as mitigation which would be undertaken by BPA to assure that these impacts on the environment are minimal:

1. Short-term degradation of air quality in the area would result from burning of slash. BPA or its contractor would obtain necessary permits and comply with all requirements of the State of Washington. Merchantable timber would be sold. Unmerchantable material suitable for use as firewood may be salvaged.

2. Short-term disturbance of soils would occur during construction. BPA would avoid erosion of steep slopes and escarpments by spanning areas where they occur. Disturbed areas of the right-of-way would be restored following construction to prevent further erosion.

3. Minimum new access roads would be required. BPA would avoid building new access by following existing roads. Short spurs to structure sites may be necessary in a few locations. Construction of an access road to structures located in the valley may be necessary but would be minimized by locating structures near existing roads. Easements may be obtained for temporary access of equipment and vehicles across fields for construction, emergency repair, and maintenance

4. Approximately 17 acres of forested wildlife habitat would be converted to more open, low-growing vegetation.

5. Approximately 17 acres of timber would be cleared. BPA would use selective clearing criteria in selected areas. Trees within falling distance of the line which would normally be felled to maintain electrical clearance criteria would be left if they are healthy and there is little likelihood that they would fall into the line.

6. Short-term, temporary disturbance would occur in the Ohop Valley during construction. BPA would avoid construction activity in or near the Ohop Creek and its floodplain. The floodplain/wetland area would be spanned, requiring clearing of approximately 0.25 acre of red alder. Alternatives were evaluated in the floodplain/wetland assessment included in the EA. A determination has been made that there is no practicable alternative to clearing a small portion of right-of-way within Ohop Creek floodplain and that the proposed action includes all practicable measures to minimize harm to or within the floodplain/wetland. Construction mats and/or special vehicles would be used for construction activity in the valley to avoid rutting or compaction of soils during wet periods or in wet areas. If rutting or compaction occurs, soils would be restored.

7. Permanent impacts to the visual quality of the Ohop Valley would occur as a result of the line crossing and substation location. Nonspecular conductor would be used for the 1/4-mile portion of the line crossing the valley. The area around the substation would be landscaped in a manner consistent with the surrounding area.

8. Herbicides would be applied periodically on the right-of-way and in the substation yard. BPA would comply with all regulations for the use and disposal of herbicides.

9. A slight amount of Prime Farmland would be removed from potential agricultural use by location of structure(s) within the Ohop Valley BPA would avoid unnecessary conversion of farmland by minimizing structures used in crossing farmlands. Most uses within the right-of-way could continue and the proposal should not affect grazing operations. The loss of a slight amount of Prime Farmland is outweighed by the advantages of the proposed line route over the alternative route (Route B), which are discussed in more detail on pages 25-26 of the EA.

10. Approximately 1 acre of land would be permanently removed from any other potential uses for the life of the substation facility.

Route A-1-3 and Substation Site 2 (see Figure 2 of the EA) are BPA's preferred alternatives, as well as the environmentally preferred options, for this project. Selection of these options is prefered because environmental impacts would be less than along Route B.

BPA evaluated the proposal with respect to current legislation affecting Federal projects and found it to comply with those laws and regulations. A detailed discussion of this evaluation of legislation is on pages 9-25 of the EA.

The EA was distributed to affected landowners and governmental agencies for public review. BPA did not receive any comments during this review. In addition, two public meetings were held in the Ohop Grange in April 1982 and in May 1983. Comments made during the scoping meeting in April 1982 were addressed in the EA. BPA presented its preferred option and environmental conclusions as documented in the EA at the second meeting in May of 1983. No adverse comments were received.

Copies of this finding will also be distributed to those landowners and governmental agencies which received the EA and participated in the public meetings. Copies are available upon request from the Environmental Manager, Bonneville Power Administration, P.O. Box 3621-SJ, Portland, Oregon 97208, telephone (503) 230-5136.

Based upon information in the EA, and after consideration of comments from the public and other agencies, the

Department of Energy has determined that BPA's action will not significantly affect the quality of the human environment. Therefore, an environmental impact statement will not be prepared.

Issued in Washington, D.C., August 18, 1983.

William A. Vaughan,

Asistant Secretary, Environmental Protection, Safety and Emergency Preparedness.

[FR Doc. 83-23960 Filed 8-31-83; 8:45 am]

BILLING CODE 6450-01-M

Economic Regulatory Administration

[ERA Docket No. 83-CERT-278 et al.]

A. E. Staley Mfg. Co. et al; Certification of Eligible Use of Natural Gas To Displace Fuel Oil

The Economic Regulatory Administration (ERA) of the Department of Energy (DOE) has received the following applications for certification of an eligible use of natural gas to displace fuel oil pursuant to 10 CFR Part 595 (44 FR 47920, August 16, 1979). Notice of these applications, along with pertinent information contained in the applications, was published in the **Federal Register** and an opportunity for public comment was provided for a period of ten calendar days from the date of publication. No comments were received. More detailed information is contained in each application on file and available for inspection at the ERA Fuels Conversion Division Docket Room, RG-42, Room GA-093, Forrestal Building, 1000 Independence Avenue, SW., Washington, D.C. 20585, from 8:00 a.m. to 4:30 p.m., Monday through Friday, except Federal holidays.

Applicant and facility	Date filed	Docket No.	Federal Register notice of application
A. E. Staley Mfg. Co., Decatur Plant, Decatur, Ill	July 27, 1983	83-CERT-278	48 FR 36876, Aug. 15, 1983.
A. E. Staley Mfg. Co., Champaign Plant, Champaign, Ill	do	83-CERT-279	48 FR 36876, Aug. 15, 1983.
Lever Brothers Co., Baltimore Plant, Baltimore, Md	do	83-CERT-281	48 FR 36876, Aug. 15, 1983.
United States Steel Corp., Florence Plant, Florence, Ky	do	83-CERT-282	48 FR 36876, Aug. 15, 1983.

The ERA has carefully reviewed the above applications for certification in accordance with 10 CFR Part 595 and the policy considerations expressed in the Final Rulemaking Regarding Procedures for Certification of the Use of Natural Gas to Displace Fuel Oil (44 FR 47920, August 16, 1979). The ERA has determined that the applications satisfy the criteria enumerated in 10 CFR Part 595 and, therefore, has granted the certifications and transmitted those certifications to the Federal Energy Regulatory Commission.

Issued in Washington, D.C., on August 26, 1983.

James W. Workman,

Director, Office of Fuels Programs, Economic Regulatory Administration.

[FR Doc. 83-24034 Filed 8-31-83; 8:45 am]

BILLING CODE 6450-01-M

[ERA Docket No. 83-CERT-306]

Burlington Industries, Inc.; Application for Certification of Eligible Use of Natural Gas To Displace Fuel Oil

The Economic Regulatory Administration (ERA) of the Department of Energy has received the following application for certification of an eligible use of natural gas to displace fuel oil pursuant to 10 CFR Part 595 (44 FR 47920, August 16, 1979). End-users who have the capability to use natural gas in place of fuel oil at any of their facilities can arrange for direct purchases and transportation of the gas to those facilities under the Federal Energy Regulatory Commission's (FERC) fuel oil displacement program. The ERA certification is required by the FERC as a precondition to interstate transportation of fuel oil displacement gas in accordance with the procedures in 18 CFR Part 284, Subpart F.

Pertinent information regarding this application is listed below, while more detailed information is contained in the application on file and available for inspection at the ERA Fuels Conversion Division Docket Room, RG-42, Room GA-093, Forrestal Building, 1000 Independence Avenue, SW., Washington, D.C. 20585, from 8:00 a.m. to 4:30 p.m., Monday through Friday, except Federal holidays.

1. 83-CERT-306.

Applicant: Burlington Industries, Inc., Greensboro, N.C.

Date Filed: August 23, 1983.

Facility Location: Asheboro, N.C.

Gas Volume: 30,000 Mcf per year.

Oil Displacement: 205,000 gallons of No. 6 fuel oil (2.1% sulfur).

Eligible Seller: Oklahoma Natural Gas Co., Tulsa, Okla.

Transporters: Transcontinental Gas Pipeline Corp., Houston, Tex.; Northern Natural Gas Co., Omaha, Neb.; and Piedmont Natural Gas Co., Inc., Charlotte, N.C.

To provide the public with as much opportunity to participate in this proceeding as is practicable under the circumstances, we are inviting any person wishing to comment concerning this application to submit comments in writing to the Economic Regulatory Administration, Office of Fuels Programs, Fuels Conversion Division, RG-42, Room GA-093, Forrestal Building, 1000 Independence Avenue, SW., Washington, D.C. 20585, Attention: Richard A. Ransom, within ten calendar days of the date of publication of this notice in the **Federal Register**. The docket number of the case should be printed on the outside of the envelope.

An opportunity to make an oral presentation of data, views, and arguments either against or in support of the above application may be requested by any interested person in writing within the ten-day comment period. The request should state the person's interest and, if appropriate, why the person is a proper representative of a group or class of persons that has such an interest. The request should include a summary of the proposed oral presentation and a statement as to why an oral presentation is necessary.

If ERA determines that an oral presentation is necessary, further notice will be given to the applicant and any person filing comments and will be published in the **Federal Register**.

Issued in Washington, D.C., August 26, 1983.

James W. Workman,

Director, Office of Fuels Programs, Economic Regulatory Administration.

[FR Doc. 83-24032 Filed 8-31-83; 8:45 am]

BILLING CODE 6450-01-M

[Docket No. ERA-FC-83-017; OFP Case No. 55069-9235-20-24]

Container Corp. of America; Acceptance of Petition for Exemption and Availability of Certification

AGENCY: Economic Regulatory Administration, DOE.

ACTION: Notice of acceptance of petition for exemption and availability of certification by Container Corporation of America.

SUMMARY: On July 28, 1983, Container Corporation of America (CCA), Santa Clara, Calif., filed a petition with the Economic Regulatory Administration (ERA) of the Department of Energy (DOE) requesting a permanent cogeneration exemption for an electric powerplant from the prohibitions of Title II of the Powerplant and Industrial Fuel Use Act of 1978 (42 U.S.C. 8301 *et seq.*) ("FUA" or "the Act"). Title II of FUA prohibits both the use of petroleum and natural gas as a primary energy source in any new powerplant and the construction of any such facility without the capability to use an alternate fuel as a primary energy source. Final rules setting forth criteria and procedures for petitioning for exemptions from the prohibitions of Title II of FUA were published in the **Federal Register** at 46 FR 59872 (December 7, 1981). Final rules governing the cogeneration exemption were revised on June 25, 1982 (47 FR 29209, July 6, 1982).

CCA seeks an exemption for a proposed powerplant consisting of (1) A gas turbine generator capable of using natural gas or No. 2 distillate oil to produce electricity, (2) a supplementary-fired waste heat recovery system to generate process steam, (3) a duct burner to produce additional steam when the steam demand exceeds the heat capacity of the gas turbine exhaust, and (4) a backpressure extraction steam turbine that can generate additional electrical power at CCA's Santa Clara Mill in Santa Clara, California. It is expected that virtually all of the net annual electric power produced by the cogenerator will be sold to the Pacific Gas & Electric Company (PG&E), making the cogeneration facility an electric powerplant pursuant to the definitions contained in 10 CFR § 500.2. CCA will operate the facility.

ERA has determined that the petition appears to include sufficient evidence to support an ERA determination on the exemption request and it is therefore accepted pursuant to 10 CFR 501.3. A review of the petition is provided in the SUPPLEMENTARY INFORMATION section below.

As provided for in sections 701 (c) and (d) of FUA and 10 CFR 501.31 and 501.33, interested persons are invited to submit written comments in regard to this petition and any interested person may submit a written request that ERA convene a public hearing.

The public file containing a copy of this Notice of Acceptance and Availability of Certification as well as other documents and supporting materials on this proceeding is available upon request through DOE, Freedom of Information Reading Room, 1000 Independence Avenue, SW., Room 1E-190, Washington, D.C. 20585, Monday through Friday, 8:00 a.m. to 4:00 p.m.

ERA will issue a final order granting or denying the petition for exemption from the prohibitions of the Act within six months after the end of the period for public comment and hearing, unless ERA extends such period. Notice of any such extension, together with a statement of reasons therefor, would be published in the **Federal Register.**

DATES: Written comments are due on or before October 17, 1983. A request for a public hearing must be made within this same 45-day period.

ADDRESSES: Fifteen copies of written comments or a request for a public hearing shall be submitted to: Case Control Unit, Office of Fuels Programs, Room GA-093, Forrestal Building, 1000 Independence Avenue, SW., Washington, D.C. 20585.

Docket No. ERA-FC-83-017 should be printed on the outside of the envelope and the document contained therein.

FOR FURTHER INFORMATION CONTACT:

George G. Blackmore, Office of Fuels Programs, Economic Regulatory Administration, 1000 Independence Avenue, SW., Room GA-073L, Washington, D.C. 20585, Phone (202) 252-1774

Marya Rowan, Office of the General Counsel, Department of Energy, Forrestal Building, Room 6B-222, 1000 Independence Avenue, SW., Washington, D.C. 20585, Phone (202) 252-2967

SUPPLEMENTARY INFORMATION: CCA proposes to install a cogeneration system at its Santa Clara Mill, Santa Clara, California, which will (1) generate electric power for sale to PG&E, and (2) produce steam to meet the mill's process requirements. The proposed cogeneration system will be operated by CCA. The system will consist of a gas turbine generator which will produce electric power, a supplementary-fired waste heat recovery system, a duct burner, and a backpressure extraction steam turbine which will produce process steam and additional electric power for CCA's use in the milling process and sale to PG&E.

CCA expects to sell virtually all the net annual electric power generation to PG&E. The sale of more than 50 percent of the facility's net annual electric power-generation causes it to be classified as an electric powerplant under FUA (10 CFR 500.2). It is therefore subject to the Title II construction and fuel use prohibitions contained in the Act.

Section 212(c) of the Act and 10 CFR 503.37 provide for a permanent cogeneration exemption from the prohibitions of Title II of FUA. In accordance with the requirements of § 503.37(a)(1), CCA has certified to ERA that:

1. The oil or gas to be consumed by the cogeneration facility will be less than that which would otherwise be consumed in the absence of the cogeneration facility, where the calculation of savings is in accordance with 10 CFR 503.37(b); and

2. The use of mixture of petroleum or natural gas and an alternate fuel in the cogeneration facility, for which an exemption under 10 CFR 503.38 would be available, would not be economically or technically feasible.

In accordance with the evidentiary requirements of § 503.37(c) (and in addition to the certifications discussed above), CCA has also included as part of its petition:

1. Exhibits containing the basis for the certifications described above; and

2. An environmental impact analysis, as required under 10 CFR 503.13.

In processing this exemption request, ERA will comply with the requirements of the National Environmental Policy Act of 1969 (NEPA); the Council on Environmental Quality's implementing regulations, 40 CFR 1500 *et seq.*; and DOE's guidelines implementing those regulations, published at 45 FR 20694, March 28, 1980. NEPA compliance may involve the preparation of: (1) An Environmental Impact Statement (EIS); (2) an Environmental Assessment; or (3) a memorandum to the file finding that the grant of the requested exemption would not be considered a major Federal action significantly affecting the quality of the environment. If an EIS is determined to be required, ERA will publish a Notice of Intent to prepare an EIS in the **Federal Register** as soon as practicable. No final action will be taken on the exemption petition until ERA's NEPA compliance has been completed.

The acceptance of the petition by ERA does not constitute a determination that CCA is entitled to the exemption

requested. That determination will be based on the entire record of this proceeding, including any comments received during the public comment period provided for in this notice.

Issued in Washington, D.C. on August 26, 1983.

Robert L. Davies,

Deputy Director, Office of Fuels Programs, Economic Regulatory Administration.

[FR Doc. 83-24036 Filed 8-31-83; 8:45 am]

BILLING CODE 6450-01-M

[ERA Docket No. 83-CERT-090, as Amended, et al.]

G&M Finishing, Inc., et al.; Applications for Amended Certification of Eligible Use of Natural Gas to Displace Fuel Oil

The Economic Regulatory Administration (ERA) of the Department of Energy has received the following applications to amend existing certifications of an eligible use of natural gas to displace fuel oil pursuant to 10 CFR Part 595 (44 FR 47920, August 16, 1979).

Pertinent information regarding these applications is listed below, while more detailed information is contained in each application on file and available for inspection at the ERA Fuels Conversion Division Docket Room, RG-42, Room GA-093, Forrestal Building, 1000 Independence Avenue, SW., Washington, D.C. 20585, from 8:00 a.m. to 4:30 p.m., Monday through Friday, except Federal holidays.

1. 83-CERT-090, as amended.

Applicant: G&M Finishing, Inc.

Date Existing Certification Issued: July 24, 1983.

Date Amendment Filed: July 27, 1983.

Requested Change: Addition of Eligible Seller: Morgan-Pennington, Inc., Wooster, Ohio.

2. 83-CERT-154, as amended.

Applicant: W. R. Grace & Co., Davison Chemical Div.

Date Existing Certification Issued: July 19, 1983.

Date Amendment Filed: August 10, 1983.

Requested Change: Additional Gas Volume: 160,000 Mcf/yr. (for a total of 520,000 Mcf/yr.) Additional Oil Displacement: 28,000 bbls/yr. No. 2 fuel oil 0.3% sulfur.

To provide the public with as much opportunity to participate in this proceeding as is practicable under the circumstances, we are inviting any person wishing to comment concerning any of these applications to amend the existing certifications to submit comments in writing to the Economic Regulatory Administration, Office of Fuels Programs, Fuels Conversion Division, RG-42, Room GA-093, Forrestal Building, 1000 Independence Avenue, SW., Washington, D.C. 20585, Attention: Richard A. Ransom, within ten calendar days of the date of publication of this notice in the **Federal Register**. The docket number of the case should be printed on the outside of the envelope.

An opportunity to make an oral presentation of data, views, and arguments either against or in support of any of the above applications may be requested by any interested person in writing within the ten-day comment period. The request should state the person's interest and, if appropriate, why the person is a proper representative of a group or class of persons that has such an interest. The request should include a summary of the proposed oral presentation and a statement as to why an oral presentation is necessary.

If ERA determines that an oral presentation is necessary in a particular case, further notice will be given to the applicant and any person filing comments in that case and will be published in the **Federal Register**.

Issued in Washington, D.C., August 25, 1983.

James W. Workman,

Director, Office of Fuels Programs, Economic Regulatory Administration.

[FR Doc. 83-24031 Filed 8-31-83; 8:45 am]

BILLING CODE 6450-01-M

[ERA Docket No. 83-CERT-300]

Lancaster Osteopathic Hospital; Application for Certification of Eligible Use of Natural Gas To Displace Fuel Oil

The Economic Regulatory Administration (ERA) of the Department of Energy has received the following application for certification of an eligible use of natural gas to displace fuel oil pursuant to 10 CFR Part 595 (44 FR 47920, August 16, 1979). End-users who have the capability to use natural gas in place of fuel oil at any of their facilities can arrange for direct purchases and transportation of the gas to those facilities under the Federal Energy Regulatory Commission's (FERC) fuel oil displacement program. The ERA certification is required by the FERC as a precondition to interstate transportation of fuel oil displacement gas in accordance with the procedures in 18 CFR Part 284, Subpart F.

Pertinent information regarding this application is listed below, while more detailed information is contained in each application on file and available for inspection at the ERA Fuels Conversion Division Docket Room, RG-42, Room GA-093, Forrestal Building, 1000 Independence Avenue, SW., Washington, D.C. 20585, from 8:00 a.m. to 4:30 p.m., Monday through Friday, except Federal holiday.

Applicant: Lancaster Osteopathic Hospital, Lancaster, Pa.

Date Filed: August 12, 1983.

Facility: Lancaster, Pa.

Gas Volume: 35,000 Mcf per year.

Oil Displaced: 262,385 gallons of No. 2 fuel oil (1.2% sulfur).

Seller: Exxon U.S.A., Houston, Tex.

Transporter: Colombia Gas Transmission Corp., Charleston, W. Va., UGI Corp., Reading, Pa.

To provide the public with as much opportunity to participate in this proceeding as is practicable under the circumstances, we are inviting any person wishing to comment concerning this application to submit comments in writing to the Economic Regulatory Administration, Office of Fuels Programs, Fuels Conversion Division, RG-42, Room GA-093, Forrestal Building, 1000 Independence Avenue, SW., Washington, D.C. 20585, Attention: Richard A. Ransom, within ten calendar days of the date of publication of this notice in the **Federal Register**. The docket number of the case should be printed on the outside of the envelope.

An opportunity to make an oral presentation of data, views, and arguments either against or in support of the above application may be requested by any interested person in writing within the ten-day comment period. The request should state the person's interest and, if appropriate, why the person is a proper representative of a group or class of persons that has such an interest. The request should include a summary of the proposed oral presentation and a statement as to why an oral presentation is necessary.

If ERA determines that an oral presentation is necessary in a particular case, further notice will be given to the applicant and any person filing comments in that case and will be published in the **Federal Register**.

Issued in Washington, D.C., on August 26, 1983.

James W. Workman,

Director, Office of Fuels Programs, Economic Regulatory Administration.

[FR Doc. 83-24033 Filed 8-31-83; 8:45 am]

BILLING CODE 6450-01-M

Energy Information Administration

Agency Forms Under Review by the Office of Management and Budget

AGENCY: Energy Information Administration, DOE.

ACTION: Notice of submission of request for clearance to the Office of Management and Budget.

SUMMARY: Under provisions of the Paperwork Reduction Act (44 U.S.C. Chapter 35), Department of Energy (DOE) notices of proposed collections under review will be published in the Federal Register on the Thursday of the week following their submission to the Office of Management and Budget (OMB). Following this notice is a list of the DOE proposals sent to OMB for approval since Thursday, August 25, 1983. The listing does not contain information collection requirements contained in regulations which are to be submitted under 3504(h) of the Paperwork Reduction Act.

Each entry contains the following information and is listed by the DOE sponsoring office: (1) The form number; (2) Form title; (3) Type of request, e.g., new, revision, or extension; (4) Frequency of collection; (5) Response obligation, i.e., mandatory, voluntary, or required to obtain or retain benefit; (6) Type of respondent; (7) An estimate of the number of respondents; (8) Annual respondent burden, i.e., an estimate of the total number of hours needed to fill out the form; and (9) A brief abstract describing the proposed collection.

DATES: Last Notice published Thursday, August 25, 1983.

FOR FURTHER INFORMATION CONTACT:

John Gross, Director, Forms Clearance and Burden Control Division, Energy Information Administration, M.S. 1H-023, Forrestal Building, 1000 Independence Ave., NW., Washington, D.C. 20585, (202) 252-2308

Jefferson B. Hill, Department of Energy Desk Officer, Office of Management and Budget, 726 Jackson Place, NW., Washington, D.C. 20503 (202) 395-7340

Vartkes Broussalian, Federal Energy Regulatory Commission Desk Officer, Office of Management and Budget, 726 Jackson Place, NW., Washington, D.C. 20503 (202) 395-3087

SUPPLEMENTARY INFORMATION: Copies of proposed collections and supporting documents may be obtained from Mr. Gross. Comments and questions about the items on this list should be directed to the OMB reviewer, as shown in "For Further Information Contact." If you anticipate commenting on a form, but find that time to prepare these comments will prevent you from submitting comments promptly, you should advise the OMB reviewer of your intent as early as possible.

Issued in Washington, D.C., August 29, 1983.

Yvonne M. Bishop,

Director, Statistical Standards, Energy Information Administration.

DOE Forms Under Review by OMB

Form No.	Form title	Type of request	Response frequency	Response obligation	Respondent description	Estimated number of respondents	Annual respondent burden	Abstract
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
EIA-254	Quarterly Progress Report on Status of Reactor Construction.	Extension	Quarterly	Voluntary	Electric utilities	35	320 hrs.	Form EIA-254 requests cost and scheduling data on U.S. electric utility nuclear power generating units under construction and on order. The data track the progress and costs of nuclear construction. The data are used to forecast nuclear powerplant costs and are published by the Energy Information Administration.
EIA-821	Annual Sales of Fuel Oil and Kerosene Report.	Revise	Annually	Mandatory	Fuel oil refiners and distributors.	7,000	21,700 hrs.	Data are published in the EIA Report *Petroleum Supply Annual*. Data are used in energy policy activities in forecasting and consumption programs to determine current and projected fuel oil needs on a National, regional and State basis.
EP-411	Coordinated Regional Bulk Power Supply Program Report	Revise	Annually	Voluntary	Electric utilities	638	20,000 hrs.	The EP-411 provides the Department of Energy with a single, comprehensive source of information on current and planned electric power supply for the U.S. The data are used to evaluate the current and projected reliability of bulk electric power supply, and the effects of unforeseen changes in powerplant construction schedules.

[FR Doc. 83-24037 Filed 8-31-83; 8:45 am]

BILLING CODE 6450-01-M

Federal Energy Regulatory Commission

[Docket No. ER83-696-000]

Alabama Power Co.; Filing

August 29, 1983.

The filing company submits the following.

Take notice that Alabama Power Company, on August 25, 1983, tendered for filing a supplements contract executed between it and the Southeastern Power Administration ("SEPA") acting on behalf of the Department of Energy. The supplemental contract is filed with the Federal Energy Regulatory Commission by Alabama Power Company because one of its provisions would increase the transmission payment to be made by SEPA for transmission of capacity and energy to certain preference customers designated by SEPA.

Any person desiring to be heard or to protest said filing should file a motion to intervene or protest with the Federal Energy Regulatory Commission, 825 North Capitol Street, NE., Washington, D.C., 20426, in accordance with Rules 211 and 214 of the Commission's Rules of Practice and Procedure (18 CFR 385.211, 385.214). All such petitions or protests should be filed on or before September 23, 1983. Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceeding. Any person wishing to become a party must file a petition to intervene. Copies of this filing are on file with the

Commission and are available for public inspection.

Kenneth F. Plumb,

Secretary

[FR Doc. 83-24045 Filed 8-31-83; 8:45 am]

BILLING CODE 6717-01-M

[Docket No. ST83-559-000]

Cranberry Pipeline Corp.; Application for Approval of Rates

August 29, 1983

Take notice that on August 8, 1983, Cranberry Pipeline Corporation (Applicant), P.O. Box 3753, Charleston, West Virginia 25337, filed in Docket No. ST83-559-000 an application pursuant to § 284.123(b)(2) of the Commission's Regulations for approval of the rates and charges to be assessed by Applicant for transportation services to be provided for Cabot Corporation (Cabot), all as more fully set forth in the application which is on file with the Commission and open to public inspection.

Applicant states that Cabot has entered into an agreement to sell natural gas from supplies in West Virginia to United States Steel Corporation for the displacement of fuel oil consumption in Ohio. Applicant indicates that the sale is to commence on August 8, 1983, and is to continue for a period of two years or until the expiration of the Fuel Shortage Emergency Period under § 284.201(e) of the Commission's Regulations, whichever is earlier.

Pursuant to a transportation and storage agreement between Applicant and Cabot dated April 4, 1983, Applicant proposes to accept gas for Cabot's account from mutually agreeable wellhead delivery points in West Virginia and thereafter store, transport, condition, and redeliver such gas to Columbia Gas Transmission Corporation (Columbia) at Applicant's Bradley Compressor Station, Wyoming County, West Virginia, and Columbia's Lanham Compressor Station, Kanawha County, West Virginia, for subsequent delivery to United States Steel Corporation.

For such service, Applicant proposes to charge Cabot 60.0 cents per Mcf of gas redelivered for the account of Cabot. Applicant asserts that the rate is fair and equitable and that it is less than Applicant's transportation cost of service for its utility operations for the fiscal year ending September 30, 1982.

Any person desiring to be heard or to make any protest with reference to said application should on or before September 19, 1983, file with the Federal Energy Regulatory Commission, Washington, D.C. 20426, a motion to intervene or a protest in accordance with the requirements of the Commission's Rules of Practice and Procedure (18 CFR 385.214 or 385.211). All protests filed with the Commission will be considered by it in determining the appropriate action to be taken but will not serve to make the protestants parties to the proceeding. Any person wishing to become a party to a proceeding or to participate as a party in any hearing therein must file a motion to intervene in accordance with the Commission's Rules.

Kenneth F. Plumb,

Secretary.

[FR Doc. 83-24046 Filed 8-31-83; 8:45 am]

BILLING CODE 6717-01-M

[Docket No. ER83-695-000]

Florida Power Corp.; Filing

August 29, 1983.

The filing Company submits the following:

Take notice that on August 22, 1983, Florida Power Corporation ("Florida Power") tendered for filing a Contract for Interchange Service ("Contract") between Florida Power and Seminole Electric Cooperative, Inc., entered into on August 1, 1983, and an Interconnection Agreement dated March 28, 1980. The Contract for Interchange Service provides for the following interchange services: emergency energy, short-term and long-term firm capacity and energy, and economy energy, and backup and reserve power. The Interconnection Agreement provides for a Transmission Facilities Charge for use of certain facilities by Seminole.

Florida Power request waiver of the Commission's notice requirements so that the Contract for Interchange and the Interconnection Agreement, in accordance with their terms, may be permitted to become effective on August 1, 1983, and March 28, 1980, respectively.

Any person desiring to be heard or protest said filing should file a petition to intervene or protest with the Federal Energy Regulatory Commission, 825 North Capitol Street, NE., Washington, D.C. 20426, in accordance with Sections 211 and 214 of the Commission's Rules of Practice and Procedure (18 CFR 385.211, 385.214). All such motions or protests should be filed on or before September 13, 1983. Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceeding. Any person wishing to become a party must file a motion to intervene. Copies of this filing are on file with the Commission and are available for public inspection.

Kenneth F. Plumb,

Secretary.

[FR Doc. 83-24047 Filed 8-31-83; 8:45 am]

BILLING CODE 6717-01-M

[Docket No. ER83-688-000]

Idaho Power Co.; Filing

August 29, 1983.

The filing company submits the following:

Take notice that Idaho Power Company (Idaho) on August 19, 1983, tendered for filing proposed changes in its rates and charges for sales for resale to its wholesale customers. The proposed increase is $5,477,212 or approximately 39.4 percent, based on the 12 months ending December 31, 1982.

The filing proposes an increase in rates in its contract for sales of electric power and energy to C P National's Oregon Division, as filed with the Commission and designated as Idaho's Rate Schedule FPC No. 57 and to the City of Weiser, as filed with the Commission and designated as Idaho's Rate Schedule FPC No. 42. The proposed changes, requested to become effective on October 19, 1983, would increase revenues from jurisdictional sales and service by approximately $4,611,418 from C P National-Oregon and by $331,481 from the City of Weisser, based on the 12-month period ending December 31, 1982.

The filing also proposes an increase in rates in its contract for sales of electric power and energy to Sierra Pacific Power Company, as filed with the Commission and designated as Idaho's Rate Schedule FPC No. 30. The proposed changes, requested to become effective on October 19, 1983, would increase revenues from Sierra Pacific Power Company by 4534,312 based on the 12-month period ending December 31, 1982, or by $483,991 based on the 12-month period ending December 31, 1983, which reflects the rate for service which has been agreed to by Sierra Pacific Power Company and Idaho.

Idaho states that the proposed increase in rates is required to offset the effect of increased operating expenses, capital costs and plant additions.

Copies of the filing were served upon C P National, Sierra Pacific Power Company, the City of Weiser, the Public Utility Commissioner of Oregon, the Idaho Public Utilities Commission and the Nevada Public Services Commission.

Any person desiring to be heard or to protest said application should file a

petition to intervene or protest with the Federal Energy Regulatory Commission, 825 North Capitol Street, NE., Washington, D.C. 20426, in accordance with Rules 211 and 214 of the Commission's Rules of Practice and Procedure (18 CFR 385.211, 385.214). All such motions or protests should be filed on or before September 19, 1983. Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceeding. Any person wishing to become a party must file a motion to intervene. Copies of this filing are on file with the Commission and are available for public inspection.

Kenneth F. Plumb,

Secretary

[FR Doc. 83-24049 Filed 8-31-83; 8:45 am]

BILLING CODE 6717-01-M

[Docket No. ER83-692-000]

Iowa-Illinois Gas & Electric Co.; Filing

August 29, 1983.

The filing Company submits the following:

Take notice that on August 22, 1983, Iowa-Illinois Gas & Electric Company, tendered for filing an Interchange Agreement (Agreement) with Waverly Municipal Electric Utility, Waverly, Iowa (Waverly) dated June 13, 1983, containing schedules reflecting facilities and points of connection; metering; conditions of service and charges associated with emergency energy, short term firm power, and economic dispatch replacement energy (proposed effective on the date of commercial operation of Louisa Generating Station, in which each party has an interest, and to which this schedule relates); and transmission service schedules (including, as an addendum thereto, Transmission Service Schedule No. 1, dated June 13, 1983, proposed effective July 1, 1983).

Iowa-Illinois Gas & Electric states, except as so indicated, the Agreement (with its other schedules) is proposed effective as of its execution date, and therefore requests waiver of the Commission's notice requirements.

Iowa-Illinois states a complete copy of the filing has been mailed to Waverly, the Iowa State Commerce Commission, and the Illinois Commerce Commission.

Iowa-Illinois also states that the various schedules, including those in respect of the exchange or furnishing of power and energy, were negotiated by the parties based upon cost reflective and comparable rates or rate methodologies, or reflective of Waverly's requirements for replacement energy from, or of transmission capacity related to, Louisa Generating Station, that the parties have incorporated into the Agreement, and affected rate schedules, reference to Iowa-Illinois's effective Office of Settlement rates from Docket No. ER80-592, *et al.*, consolidated *sub nom.* Allegheny Power System, *et al.*; and that the rate schedules in respect of exchanges of power and energy include, if applicable, reimbursement for wheeling charges assessed by third parties, since Iowa-Illinois notes Waverly contemplates arrangements with others for further delivery of power and energy to its load center.

It is further stated that Transmission Service Schedule No. 1 provides for utilization by Waverly, in respect to its share of Louisa Generating Station capacity of Iowa-Illinois' 345 kV facilities from Substation 92 to Hills Substation, and incorporates transmission rates, charges and a loss responsibility factor designed to compensate Iowa-Illinois for reflected costs of facilities provided, as the scheduling path, and associated operation and maintenance, and, for transmission losses for which compensation in kind is provided. Iowa-Illinois notes that a related, but independent, filing will be made in respect of the operation of Louisa Generating Station outlet transmission facilities of which Substation 92 is a part.

Any person desiring to be heard or protest said application should file a motion to intervene or protest with the Federal Energy Regulatory Commission, 825 North Capitol Street, NE., Washington, D.C. 20426, in accordance with Rules 211 and 214 of the Commission's Rules of Practice and Procedure (18 CFR 385.211, 385.214). All such motions or protests should be filed on or before September 12, 1983. Protests will be considered by the Commission in determining the appropriate action to be taken but will not serve to make protestants parties to the proceeding. Any person wishing to become a party must file a motion to intervene. Copies of this filing are on file with the Commission and are available for public inspection.

Kenneth F. Plumb,

Secretary.

[FR Doc. 83-24048 Filed 8-31-83; 8:45 am]

BILLING CODE 6717-01-M

[Docket No. ER83-691-000]

Mississippi Power Co.; Filing

August 29, 1983.

The filing Company submits the following:

Take notice that on August 19, 1983, Mississippi Power Company tendered for filing a supplement contract executed between it and the Southeastern Power Administration ("SEPA") acting on behalf of the Department of Energy. The supplemental contract is filed with the Federal Energy Regulatory Commission by Mississippi Power Company because of its provisions would increase the transmission payment to be made by SEPA for transmission of capacity and energy to certain preference customers designated by SEPA.

Mississippi states that due to the general inapplicability of the Commission's regulations to the filing of supplemental contracts, they request waiver of any additional abbreviated filing requirements prescribed by §§ 35.12 and 35.13 that might be considered applicable to this filing.

Any person desiring to be heard or to protest said filing should file a motion to intervene or protest with the Federal Energy Regulatory Commission, 825 North Capitol Street, NE., Washington, D.C. 20426, in accordance with Rules 211 and 214 of the Commission's Rules of Practice and Procedure (18 CFR 385.211, 385.214). All such petitions or protests should be filed on or before September 9, 1983. Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceeding. Any person wishing to become a party must file a petition to intervene. Copies of this application are on file with the Commission and are available for public inspection.

Kenneth F. Plumb,

Secretary.

[FR Doc. 83-24050 Filed 8-31-83; 8:45 am]

BILLING CODE 6717-01-M

[Docket No. ER83-689-000]

The Montana Power Co.; Compliance

August 29, 1983.

The filing Company submits the following:

Take notice that on August 19, 1983, The Montana Power Company ("Montana") tendered for filing in accordance with Section 35 of the Commission's Regulations, a Letter Agreement dated April 1, 1983 between Montana and Western Area Power

Administration (WAPA) providing for sale of nonfirm energy.

Montana states that under the terms of this Letter Agreement, it will make available to WAPA nonfirm energy, and that the terms of the Letter Agreement have been agreed to by the parties.

Montana states further that the rate for nonfirm energy sold to WAPA under this Letter Agreement shall be 9 mills per kilowatt hour.

Montana requests an effective date of April 1, 1983, and therefore requests waiver of the Commission's notice requirements.

Any person desiring to be heard or to protest said filing should file a motion to intervene or protest with the Federal Energy Regulatory Commission, 825 North Capitol Street, NE., Washington, D.C. 20426, in accordance with Rules 211 and 214 of the Commission's Rules of Practice and Procedure (18 CFR 385.211, 385.214). All such motions or protests should be filed on or before September 13, 1983. Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceeding. Any person wishing to become a party must file a motion to intervene. Copies of this filing are on file with the Commission and are available for public inspection.

Kenneth F. Plumb,

Secretary

[FR Doc. 83-24051 Filed 8-31-83; 8:45 am]

BILLING CODE 6717-01-M

[Docket No. CP83-450-000]

Northwest Central Pipeline Corp.; Application

August 29, 1983.

Take notice that on August 3, 1983, Northwest Central Pipeline Corporation (Applicant), P.O. Box 25128, Oklahoma City, Oklahoma 73125, filed in Docket No. CP83-450-000 an application pursuant to Section 7(b) of the Natural Gas Act for permission and approval: (1) to abandon the exchange of gas with Zenith Natural Gas Company (Zenith); (2) to abandon by sale in place to Zenith of certain facilities in Barber County, Kansas, and Woods County, Oklahoma; (3) to abandon and reclaim or to abandon in place the Zenith No. 1 Compressor Station; and (4) to abandon the sale of gas to The Gas Service Company for resale to one right-of-way customer. Applicant also proposes the total or partial assignment to Zenith of 11 of Applicant's gas purchase contracts. The proposals are more fully set forth in the application which is on file with the Commission and open to public inspection.

Applicant states that since 1954, Applicant and Zenith have executed several agreements providing for the gathering, delivery and exchange of gas produced in certain areas of Kansas and Oklahoma and that the instant facilities are used to perform those activities. Applicant states that, due to their age, the facilities now require considerable maintenance and personnel to keep them operational and that as production from the effected area has declined, Applicant's gas purchases have been substantially reduced. Such gas is currently delivered into Zenith's system, pursuant to the exchange agreement now in effect, it is explained.

Due to the increased maintenance and the decreased production mentioned above, Applicant states that its existing exchange arrangement with Zenith is no longer economical. Therefore, Applicant proposes to terminate its existing exchange arrangement with Zenith, to sell to Zenith certain facilities which are connected to Zenith's pipeline system, and to assign totally or partially to Zenith 11 contracts for the purchase of gas in Barber County, Kansas, and Woods County, Oklahoma, since gas currently being purchased from the assigned portion of these contracts is delivered into Zenith's facilities. It is stated that the facilities proposed to be sold to Zenith would be sold at their depreciated value of $55,137.45 plus applicable Kansas and Oklahoma state sales taxes.

Applicant also seeks authority to abandon by reclaim and in place its 230 horsepower Zenith Compressor Station located on the pipeline proposed to be sold to Zenith, and to abandon the sale to The Gas Service Company for resale to one right-of-way customer. Zenith has agreed to continue to service this customer, it is explained.

Any person desiring to be heard or to make any protest with reference to said application should on or before September 19, 1983, file with the Federal Energy Regulatory Commission, Washington, D.C. 20426, a motion to intervene or a protest in accordance with the requirements of the Commission's Rules of Practice and Procedure (18 CFR 385.214 or 385.211) and the Regulations under the Natural Gas Act (18 CFR 157.10). All protests filed with the Commission will be considered by it in determining the appropriate action to be taken but will not serve to make the protestants parties to the proceeding. Any person wishing to become a party to a proceeding or to participate as a party in any hearing therein must file a motion to intervene in accordance with the Commission's Rules.

Take further notice that, pursuant to the authority contained in and subject to the jurisdiction conferred upon the Federal Energy Regulatory Commission by Sections 7 and 15 of the Natural Gas Act and the Commission's Rules of Practice and Procedure, a hearing will be held without further notice before the Commission or its designee on this application if no motion to intervene is filed within the time required herein, if the Commission on its own review of the matter finds that permission and approval for the proposed abandonment are required by the public convenience and necessity. If a motion for leave to intervene is timely filed, or if the Commission on its own motion believes that a formal hearing is required, further notice of such hearing will be duly given.

Under the procedure herein provided for, unless otherwise advised, it will be unnecessary for Applicant to appear or be represented at the hearing.

Kenneth F. Plumb,

Secretary.

[FR Doc. 83-24052 Filed 8-31-83; 8:45 am]

BILLING CODE 6717-01-M

[Docket No. CP83-465-000]

Transcontinental Gas Pipe Line Corp.; Application

August 29, 1983.

Take notice that on August 12, 1983, Transcontinental Gas Pipe Line Corporation (Transco), P.O. Box 1396, Houston, Texas 77251, filed in Docket No. CP83-465-000 an application pursuant to Section 7(c) of the Natural Gas Act for a certificate of public convenience and necessity authorizing service revision requests of certain Transco customers, all as more fully set forth in the application which is on file with the Commission and open to public inspection.

Transco states that United Cities Gas Company—North and South Carolina Division (United Cities-N.C. & S.C.), a Rate Schedule CD-2 customer of Transco, has served the natural gas needs of the City of Hendersonville, Henderson County, North Carolina (Hendersonville), through its distribution system. It is stated that Transco has been advised that the Public Service Company of North Carolina, Inc. (Public Service), has purchased the Hendersonville gas distribution facilities from United Cities-N.C. & S.C.

Due to the sale of such facilities, both Public Service and United Cities-N.C. & S.C. have requested the following

changes in allocation and service agreements:

1. A reduction of 3,200 dt equivalent of gas per day in the present 9,900 dt equivalent per day contract demand allocation of United Cities-N.C. & S.C. and a transfer of that 3,200 dt equivalent per day, representing the requirements of Hendersonville, to Public Service, resulting in new contract demand allocations of 6,700 dt equivalent per day for United Cities-N.C. & S.C. and 154,600 dt equivalent per day for Public Service (up from the current daily 151,400 dt equivalent allocation). Upon such transfer, the Mill Spring delivery point would be eliminated from the service agreement with United Cities-N.C. & S.C.

2. United Cities-N.C. & S.C. presently has a contracted Washington Storage Service (WSS) storage capacity quantity with Transco of 370,485 dt equivalent of gas. Due to the Hendersonville sale, that customer requests a reduction of 118,819 dt equivalent in its WSS quantity and a transfer of that quantity to its affiliate, United Cities Gas Company–Georgia Division (United Cities-Ga.), a Rate Schedule CD–1 and WSS customer of Transco, resulting in new storage capacity quantities of 251,666 dt equivalent for United Cities-N.C. & S.C. and 385,574 dt equivalent for United Cities-Ga. Again, upon such transfer, the Mill Spring delivery point would be eliminated from the WSS service agreement with United Cities-N.C. & S.C.

3. Finally, after the Hendersonville sale, United Cities-N.C. & S.C. no longer has any facilities in North Carolina, and it would therefore be renamed United Cities Gas Company—South Carolina Division. It has requested and Transco has agreed subject to certificate approval that its reduced pipeline service from Transco be changed from Rate Schedule CD–2 to Rate Schedule G–2. All other service to Transco's customers referenced herein would remain the same.

Any person desiring to be heard or to make any protest with reference to said application should on or before September 19, 1983, file with the Federal Energy Regulatory Commission, Washington, D.C. 20426, a motion to intervene or a protest in accordance with the requirements of the Commission's Rules of Practice and Procedure (18 CFR 385.214 or 385.211) and the Regulations under the Natural Gas Act (18 CFR 157.10). All protests filed with the Commission will be considered by it in determining the appropriate action to be taken but will not serve to make the protestants parties to the proceeding. Any person wishing to become a party to a proceeding or to participate as a party in any hearing therein must file a motion to intervene in accordance with the Commission's Rules.

Take further notice that, pursuant to the authority contained in and subject to jurisdiction conferred upon the Federal Energy Regulatory Commission by Sections 7 and 15 of the Natural Gas Act and the Commission's Rules of Practice and Procedure, a hearing will be held without further notice before the Commission or its designee on this application if no motion to intervene is filed within the time required herein, if the Commission on its own review of the matter finds that a grant of the certificate is required by the public convenience and necessity. If a motion for leave to intervene is timely filed, or if the Commission on its own motion believes that a formal hearing is required, further notice of such hearing will be duly given.

Under the procedure herein provided for, unless otherwise advised, it will be unnecessary for Transco to appear or be represented at the hearing.

Kenneth F. Plumb,

Secretary.

[FR Doc. 83-24060 Filed 8-31-83; 8:45 am]

BILLING CODE 6717-01-M

[Docket No. CP78-336-004]

Trunkline Gas Co.; Petition To Amend

August 29, 1983.

Take notice that on August 9, 1983, Trunkline Gas Company (Petitioner), P.O. Box 1642, Houston, Texas, 77001, filed in Docket No. CP78-336-004 a petition to amend the order issued October 18, 1978, in Docket No. CP78-336 pursuant to Section 7 of the Natural Gas Act by authorizing the transportation and redelivery of natural gas in accordance with an amendment to a transportation contract between Petitioner and Panhandle Eastern Pipe Line Company, all as more fully set forth in the petition to amend which is on file with the Commission and open to public inspection.

Specifically, Petitioner proposes to reduce the transportation quantity from 6,000 Mcf of gas per day to 3,000 Mcf per day beginning December 2, 1983, and reduce the associated monthly charge on Petitioner's system at that time from $38,668 to $19,334 and on the High Island Offshore System, U T Offshore System and Natural Gas Pipeline Company of America systems from $45,240 to $22,620.

Any person desiring to be heard or to make any protest with reference to said petition to amend should on or before September 19, 1983, file with the Federal Energy Regulatory Commission, Washington, D.C. 20426, a motion to intervene or a protest in accordance with the requirements of the Commission's Rules of Practice and Procedure (18 CFR 385.214 or 385.211) and the Regulations under the Natural Gas Act (18 CFR 157.10). All protests filed with the Commission will be considered by it in determining the appropriate action to be taken but will not serve to make the protestants parties to the proceeding. Any person wishing to become a party to a proceeding or to participate as a party in any hearing therein must file a motion to intervene in accordance with the Commission's Rules.

Kenneth F. Plumb

Secretary.

[FR Doc. 83-24064 Filed 8-31-83; 8:45 am]

BILLING CODE 6717-01-M

[Docket No. ER83-694-000]

West Texas Utilities Co.; Filing

August 29, 1983.

The filing company submits the following:

Take notice that on August 22, 1983, West Texas Utilities Company ("WTU") tendered for filing proposed changes in its FERC Electric Service Tariff, Original Volume No. 1, unexecuted letter amendments to its electric service agreement with Texas-New Mexico Power Company (formerly Community Public Service Company) and unexecuted letter amendments to contracts for electric service with the Cities of Brady and Coleman, Texas. WTU has proposed a phased rate increase based upon a rate base which includes construction work in progress (CWIP) to the extent permitted under the Commission's regulations, as amended by Order No. 298. Level C Rates, proposed to be effective on October 23, 1983, would increase revenues from jurisdictional sales by $3,034,579 based on calendar year 1984. Level D Rates, proposed to be effective on October 24, 1983, would increase revenues from jurisdictional sales by $3,883,812, based on calendar year 1984. The only difference between the two sets of rates is the return on common equity which the rates are designed to produce. WTU requests that both the Level C Rates and the Level D Rates be suspended until January 1, 1984, in accordance with the terms of settlement in the Company's last rate case.

WTU has also proposed Level A Rates and Level B Rates. The Level A

Rates reflect the addition of construction work in progress, other than pollution control CWIP, to Period II revenues generated under present rates. Level A Rates, proposed to be effective on October 21, 1983, would increase revenues from jurisdictional sales by $2,258,734, based on calendar year 1984. The Level B Rates reflect projected Period II increase in cost of service but are premised upon a rate base which includes only pollution control related CWIP. WTU proposes that the Level B Rates become effective on October 22, 1983 but, pursuant to the terms of settlement in the Company's last rate case, requests that the Level B Rates be suspended until January 1, 1984. The Level B Rates would increase revenues from jurisdictional sales by $1,930,996, based on calendar year 1984.

WTU states that it seeks to increase its rates for jurisdictional service in order to earn a fair return on its investment in utility property and thereby attract the capital it needs in order to complete construction of new generating and transmission capability.

Copies of the filing have been served on the customers of WTU affected by the filing and upon the Public Utility Commission of Texas.

Any person desiring to be heard or to protest the filing should file a motion to intervene or protest with the Federal Energy Regulatory Commission, 825 North Capitol Street, NE., Washington, D.C. 20426, in accordance with Rules 211 and 214 of the Commission's Rules of Practice and Procedure (18 CFR 385.211, 385.214). All such motions or protests should be filed on or before September 20, 1983. Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceeding. Any person wishing to become a party must file a motion to intervene. Copies of this filing are on file with the Commission and are available for public inspection.

Kenneth F. Plumb,

Secretary.

[FR Doc. 83-24055 Filed 8-31-83; 8:45 am]

BILLING CODE 6717-01-M

Southeastern Power Administration

Correction of Rate Schedule CR-1-E, Under Order Confirming and Approving Power Rates on an Interim Basis

AGENCY: Southeastern Power Administration (SEPA), DOE.

ACTION: Correction of Rate Schedule CR-1-E, Approved on an Interim Basis in the Cumberland Basin Projects' Rates.

SUMMARY: On May 31, 1983, the Assistant Secretary for Conservation and Renewable Energy confirmed on an interim basis, replacement rate schedule, CR-1-E, for the Cumberland Basin Project. This rete schedule, published in the **Federal Register** Notice of June 8, 1983, 48 FR 26531, has an error in column 3, paragraph A. The monthly installment of $1,573,000 is hereby corrected to read $1,365,000.

FOR FURTHER INFORMATION CONTACT:

Leon Jourolmon, Jr., Chief, Division of Fiscal Operations, Southeastern Power Administration, Department of Energy, Samuel Elbert Building, Elberton, Georgia 30635.

Fred Sheap, Office of Power Marketing Coordination, Department of Energy, James Forrestal Building—Room 6B104, 1000 Independence Avenue, SW., Washington, D.C. 20585

Issued in Washington, D.C., this 24th day of August, 1983.

Joseph J. Tribble,

Assistant Secretary, Conservation and Renewable Energy.

Wholesale Power Rate Schedule

CR-1-E

Unless otherwise mutually agreed, the annual unregulated flow of water into the Wolf Creek Reservoir will be established from a consideration of the unadjusted discharge registered at Rowena Gauging Station as determined by the U. S. Geological Survey, adjusted for changes in storage at all reservoirs upstream from said station, in accordance with capacity ratings by the owners thereof, and for other possible factors which may be mutually agreed upon by the parties.

TVA shall pay the applicable annual charge to Energy in monthly installments as follows:

A. For each of the months July through December, the monthly installment payment shall be $1,365,000.

B. For the month of January and for each succeeding month through June, the installment payment for each month shall be the amount computed for that month as follows:

1. The estimated applicable annual charge will first be computed using an estimated average flow for the year determined by combining the inflow from the beginning of the fiscal year through the month for which the installment is being computed with the minimum probable inflow for the remainder of the fiscal year as listed in Table 1 below opposite the month for which said payment is being computed.

2. The installment payment will then be determined by taking the difference between the estimated applicable annual charge for the fiscal year as determined under 1. and the total of the installment payments for the preceding months in that fiscal year and multiplying said difference by the percentage listed in Table 11 opposite the month for which the installment payment is being computed.

Month	Table 1 (second-foot days)	Table 11 (percentage)
January	800,000	20
February	700,000	25
March	290,000	30
April	50,000	40
May	7,800	50
June	0	100

[FR Doc. 83-23959 Filed 8-31-83; 8:45 am]

BILLING CODE 6450-01-M

ENVIRONMENTAL PROTECTION AGENCY

[A-6-FRL 2426-3]

Air Pollution Control Grants; Continuing Eligibility Level for Fiscal Year 1983; State of Oklahoma

AGENCY: Environmental Protection Agency.

ACTION: Notice and opportunity for public hearing.

SUMMARY: The U.S. Environmental Protection Agency (EPA), Region 6 announces an opportunity for public hearing and comment on a request from the Oklahoma State Department of Health (OSDH), Air Quality Service (AQS) for a waiver from the continuing elgibility level (CEL) requirement of Section 105(b) of the Clean Air Act (CAA) in fiscal year 1983.

DATES: Hearing Opportunity: If written requests for a public hearing are received by October 3, 1983, the Agency will hold a hearing at Oklahoma City, Oklahoma.

FOR FURTHER INFORMATION CONTACT: Dolores S. Johnson, State Programs Section, Air and Waste Management Division, EPA, Region 6, 1201 Elm Street, Dallas, Texas 75270, (214) 767-2742, (FTS) 729-2742.

SUPPLEMENTARY INFORMATION: Section 105(b) of the CAA specifies that no Agency shall receive any grant under this section during any fiscal year when its expenditures of non-federal funds for other than nonrecurrent expenditures for air pollution control programs will be less than its expenditures were for such programs during the preceding fiscal year, unless the Administrator, *after notice and opportunity for public hearing*, determines that a reduction in

expenditures is attributable to a non-selective reduction in expenditures in the programs of all executive branch agencies of the applicable unit of government.

On August 20, 1982, the AQS submitted an application for a grant under Section 105 of the Clean Air Act. At that time, it was determined that the AQS would meet the CEL requirement of the CAA since the State appropriations to the AQS for fiscal year 1983 were equal to fiscal year 1982 and would allow the AQS to expend at least as much in fiscal year 1983 as was expended in fiscal year 1982 on other than nonrecurrent expenditures. However, due to a shortfall in State revenues, the Oklahoma Legislature reviewed the appropriations and made non-selective reductions in expenditures in the programs of all executive branch agencies to maintain a balanced State budget. These adjustments were accomplished by S.B. No. 69. As a result, the AQS' fiscal year 1983 budget of $385,000 was reduced by 6 percent or $23,100.

The OSDH, AQS has requested that the Administrator grant a waiver from the CEL requirement for fiscal year 1983 as a result of this reduction. The waiver, if granted, would allow the AQS to expend up to $23,100 less, in other than nonrecurrent expenditures, in fiscal year 1983 than was expended in fiscal year 1982. If the short fall in the AQS' fiscal year 1983 expenditures exceeds $23,100, the AQS will be required to pay EPA the amount in excess of $23,100.

This notice provides an opportunity for a public hearing as required by the Clean Air Act. EPA will hold the hearing only if actual requests for a public hearing are received. Unless written requests for a hearing on this request for a waiver of the CEL requirement for fiscal year 1983 are received by EPA, Region 6 (Dallas) by October 3, 1983 we will proceed to make a determination on the requested waiver.

Dated: August 17, 1983.

Frances E. Phillips,

Acting Regional Administrator.

[FR Doc. 83-24015 Filed 8-31-83; 8:45 am]

BILLING CODE 6560-50-M

Science Advisory Board, Environmental Health Committee; Open Meeting

[SA—FRL 2426-4]

Under Public Law 92-463, notice is hereby given that a two-day meeting of the Environmental Health Committee of the Science Advisory Board will be held on September 22-23, 1983, in Conference Room 3906-3908, Waterside Mall, U.S. Environmental Protection Agency, 401 M Street, Southwest, Washington, D.C. The meeting will start at 9:00 a.m. on September 22, and adjourn no later than 4:30 p.m. on September 23, 1983.

A principal purpose of the meeting will be to review and comment on the scientific adequacy of three draft health assessment documents prepared by the Office of Health and Environmental Assessment of EPA's Office of Research and Development. The titles and publication numbers of the three documents are:

Title	EPA No.
Health Assessment Document for Inorganic Arsenic.	EPA-600/8-83-021A, June 1983.
Updated Mutagenicity and Carcinogenicity Assessment of Cadmium.	EPA-600/8-83-025A, June 1983.
Health Assessment Document for Nickel.	EPA-600/8-83-012, May 1983

For information on how to obtain copies of the draft corp document, contact: ORD Publications Office, Center for Environmental Research Information, U.S. Environmental Protection Agency, Cincinnati, Ohio 45268, telephone: (513) 684-7562. Requestors should be sure to cite the EPA number assigned to the document.

Another principal purpose of the meeting will be to review and comment on the scientific adequacy of draft revisions (dated September 1983) of the Carcinogen Assessment of Coke Oven Emissions (Revised Draft, EPA-600/6-82-003, November 1982).

For information on how to obtain copies of the revised portions of the Carcinogen Assessment of Coke Oven Emissions please call or write to Ms. Judy B. Theisen, Office of Health and Environmental Assessment, Office of Research and Development, RD-689, U.S. Environmental Protection Agency, Washington, D.C. 20460, telephone: (202) 382-7317.

The agenda will also include brief reports, discussions, and informational items of current interest to the Members.

The meeting will be open to the public. Any member of the public wishing to attend, participate, submit a paper, or wishing further information should contact the Executive Secretary, Environmental Health Committee, Science Advisory Board (A-101), U.S. Environmental Protection Agency, Washington, D.C. 20460 by c.o.b. September 16, 1983. Please ask for Mrs. Patti Howard or Mr. Ernst Linde. The telephone number is (202) 382-2552.

FOR FURTHER INFORMATION CONTACT: Patti Howard 382-2552.

Dated: August 25, 1983.

Terry F. Yosie,

Staff Director Science Advisory Board.

[FR Doc. 83-24014 Filed 8-31-83; 8:45 am]

BILLING CODE 6560-50-M

[SA-FRL 242 7-3]

Science Advisory Board, Subcommittee on the Biological Effects of Radiofrequency Radiation; Open Meeting

Under Public Law 92-463, notice is hereby given of a meeting of the Science Advisory Board's Subcommittee on the Biological Effects of Radiofrequency Radiation. The meeting will be held on September 22-23, 1983 in Room 2123, EPA Headquarters, 401 M Street, SW., Washington, D.C. The meeting will begin at 9:15 a.m. on both days and will adjourn at approximately 12:00 p.m. on September 23.

The Subcommittee was formed by the Science Advisory Board at the request of EPA's Office of Research and Development and Office of Radiation Programs to review and evaluate the available scientific information on the biological effects of radiofrequency radiation as it is assessed in EPA's review draft entitled "Biological Effects of Radiofrequency Radiation." Copies of this document may be obtained by calling or writing to Office of Research and Development Publication-CERI-FR, U.S. EPA, Cincinnati, Ohio 45268 (513) 684-7562.

The meeting is open to the public. Any member of the public wishing to attend, obtain information or submit comments to the Subcommittee should contact Dr. Terry F. Yosie, Director, Science Advisory Board (202) 382-4126 or Dr. Douglas Seba, Executive Secretary, Science Advisory Board (202) 382-2552 by close of business September 15, 1983.

Terry F. Yosie,

Director, Science Advisory Board.

August 26, 1983.

[FR Doc. 83-24016 Filed 8-31-83; 8:45 am]

BILLING CODE 6560-50-M

[SAB-FRL 2425-7]

Science Advisory Board, High-Level Radioactive Waste Disposal Subcommittee; Open Meeting

Under Public Law 92-463, notice is hereby given that a two-day meeting of the High-Level Radioactive Waste Disposal Subcommittee of the Science Advisory Board will be held in the Regional Administrator's Conference Room, Ninth Floor, Region VIII, U.S. Environmental Protection Agency, 1860

Lincoln Street, Denver, CO on September 20–21, 1983. The meeting will begin at 9:00 a.m. and last until 5:00 p.m. each day. The purpose of the meeting will be to continue the review of the scientific and technical basis of the Agency's proposed rules for the management and disposal of high-level radioactive wastes. The members of the Subcommittee, and the principal issues for the Subcommittee's consideration, were announced in the Federal Register, Wednesday, January 5, 1983, page 509.

The agenda for the meeting, which will be the ninth in a series of meetings on the proposed rules, will include discussion of Subpart A requirements, a briefing on environmental pathways modeling, finalizing of subgroup reports, and discussion of the Subcommittee's draft final report.

The meeting is open to the public. Any member of the public wishing to attend or obtain further information about the meeting should contact Harry C. Torno, Executive Secretary, at (202) 382–2552 or Terry F. Yosie, Staff Director, Science Advisory Board, at (202) 382–4126. Public comment will be accepted at the meeting. Written comment will be accepted in any form, and there will be opportunity for brief oral statements. Anyone wishing to make such comment must contact Mr. Torno prior to September 14, 1983, in order to be placed on the agenda.

Dated: August 24 , 1983.

Terry F. Yosie,

Staff Director, Science Advisory Board.

[FR Doc. 83-24012 Filed 8-31-83; 8:45 am]

BILLING CODE 6560-50-M

[OPTS-51482; TSH-FRL 2427-7]

Certain Chemicals; Premanufacture Notices

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice.

SUMMARY: Section 5(a)(1) of the Toxic Substances Control Act (TSCA) requires any person who intends to manufacture or import a new chemical substance to submit a premanufacture notice (PMN) to EPA at least 90 days before manufacture or import commences. Statutory requirements for section 5(a)(1) premanufacture notices are discussed in EPA statements of interim policy published in the Federal Register of May 15, 1979 (44 FR 28558) and November 7, 1980 (45 FR 74378). This notice announces receipt of twenty-four PMNs and provides a summary of each.

DATES: Close of Review Period:

PMN 83–1062, 83–1063, 83–1064 and 83–1065: November 19, 1983

PMN 83–1066, 83–1067, 83–1068, 83–1069, 83–1070, 83–1071, 83–1072, 83–1073, 83–1074, 83–1075, 83–1076, 83–1077, 83–1078, 83–1079, 83–1080, 83–1081: November 20, 1983

PMN 83–1082 and 83–1083: November 21, 1983

PMN 83–1084 and 83–1085: November 22, 1983

Written comments by:

PMN 83–1062, 83–1063, 83–1064 and 83–1065: October 20, 1983

PMN 83–1066, 83–1067, 83–1068, 83–1069, 83–1070, 83–1071, 83–1072, 83–1073, 83–1074, 83–1075, 83–1076, 83–1077, 83–1078, 83–1079, 83–1080 and 83–1081: October 21, 1983

PMN 83–1082 and 83–1083: October 22, 1983

PMN 83–1084 and 83–1085: October 23, 1983

ADDRESS: Written comments, identified by the document control number "[OPTS–51482]" and the specific PMN number should be sent to: Document Control Officer (TS–793), Office of Toxic Substances, Office of Pesticides and Toxic Substances, Environmental Protection Agency, Rm. E–409, 401 M St., SW., Washington, DC 20460; (202–382–3532).

FOR FURTHER INFORMATION CONTACT: Margaret Stasiskowski, Acting Chief, Notice Review Branch, Chemical Control Division (TS–794), Office of Toxic Substances, Environmental Protection Agency, Rm. E–216, 401 M St., SW., Washington, DC 20460; (202–382–3729).

SUPPLEMENTARY INFORMATION: The following notice contains information extracted from the non-confidential version of the submission provided by the manufacturer on the PMNs received by EPA. The complete non-confidential document is available in the Public Reading Room E–107.

PMN 83–1062

Importer. Confidential.

Chemical. (G) Polycarboxylic acid.

Use/Import. (G) 100% as a manufacturing intermediate. Import range: Confidential.

Toxicity Data. Acute oral: > 5,000 mg/kg; Irritation: Skin—Minimal, Eye—Minimal.

Exposure. Processing: Dermal and inhalation, a total of 16 workers, up to 2 hrs/da, up to 20 da/yr.

Environmental Release/Disposal. 4 kg released to air.

PMN 83–1063

Manufacturer. Ashland Chemical Company.

Chemical. (G) Reaction product of melamine, formaldehyde and polyol.

Use/Production. (G) Open, non-dispersive use. Prod. range: .3–1 M kg.

Toxicity Data. No date submitted.

Exposure. Confidential.

Enviornmental Release/Disposal. No data submitted.

PMN 83–1064

Manufacturer. Confidential.

Chemical. (G) Cyanoacetate ester

Use/Production. Confidential. Prod range: Confidential.

Toxicity Data. Acute oral: Male—4.7 gm/kg. Female—4.3 gm/kg Irritation: Skin—Mild.

Exposure. Confidential.

Environmental Release/Disposal. Little release to environment.

PMN 83–1065

Manufacturer. Confidential.

Chemical. (G) Cyanoacrylate ester.

Use/Production. Confidential. Prod. range: Confidential.

Toxicity Data. No date on the PMN substance submitted.

Exposure. Confidential.

Environmental Release/Disposal. Minimal environmental impact.

PMN 83–1066

Manufacturer. The Dow Chemical Company.

Chemical. (S) Magnesium aluminum hydroxy phosphate-monobasic form.

Use/Production. Confidential. Prod. range: 1,000–100,000 ky/yr.

Toxicity Data. No data submitted.

Exposure. Manufacture and use: dermal and possible inhalation, a total of 25 workers, up to 5 hrs/da, up to 120 da/yr.

Environmental Release/Disposal. Minimal release anticipated. Disposal by landfill and on-site industrial waste treatment plant.

PMN 83–1067

Manufacturer. The Dow Chemical Company.

Chemical. (S) Magnesium aluminum hydroxy phosphate-dibasic form.

Use/Production. Confidential. Prod. range: 1,000–100,000 kg/yr.

Toxicity Data. No data submitted.

Exposure. Manufacture and use: Dermal and possible inhalation, a 25 total of workers, up to 5 hrs/da, up to 120 da/yr.

Environmental Release/Disposal. Minimal release anticipated. Disposal by landfill and on-site industrial waste treatment plant.

PMN 83–1068

Manufacturer. The Dow Chemical Company.

Chemical. (S) Magnesium aluminum hydroxy phosphate-tribasic form.

Use/Production. Confidential. Prod. range: 1,000–100,000 kg/yr.

Toxicity Data. No data submitted.

Exposure. Manufacture and use: Dermal and possible inhalation, a total of 25 workers, up to 5 hrs/da, up to 120 da/yr.

Environmental Release/Disposal. Minimal release anticipated. Disposal by landfill and on-site industrial waste treatment plant.

PMN 83–1069

Manufacturer. Confidential.

Chemical. (G) Ethylene, polymer with mixed alpha olefins.

Use/Production. (S) Film, blow molding, etrusions. Prod. range: Confidential. Prod. range: Confidential.

Toxicity Data. No data on the PMN substance submitted.

Exposure. Manufacture and use: Dermal, a total of 10,210 workers, up to 40 hrs/wk.

Environmental Release/Disposal. Minimal release anticipated. Disposal by incineration and landfill.

PMN 83–1070

Manufacturer. Confidential.

Chemical. (G) Ethylene, polymer with mixed alpha olefins.

Use/Production. (S) Film, blow molding, etrusions. Prod. range: Cofidential.

Toxicity Data. No data on the PMN substance submitted.

Exposure. Manufacture and use: Dermal, a total of 10,210 workers, up to 40 hrs/wk.

Environmental Release/Disposal. Minimal release anticipated. Disposal by incineration and landfill.

PMN 83–1071

Manufacturer. Confidential.

Chemical. (G) Ethylene, polymer with mixed alpha olefins.

Use/Production. (S) Film, blowing molding, etrusions. Prod. range: Confidential.

Exposure. Manufacture and use: Dermal, a total of 10,210 workers, up to 40 hrs/wk.

Environmental Release/Disposal. Minimal release anticipated. Disposal by incineration and landfill.

PMN 83–1072

Manufacturer. Confidential.

Chemical. (G) Ethylene, polymer with mixed alpha olefins.

Use/Production. (S) Film, blow molding, etrusions. Prod. range: Confidential.

Toxicity Data. No data on the PMN substance submitted.

Exposure. Manufacture and use: Dermal, a total of 10,210 workers, up to 40 hrs/wk.

Environmental Release/Disposal. Minimal release anticipated. Disposal by incineration and landfill.

PMN 83–1073

Manufacturer. Confidential.

Chemical. (G) Ethylene, polymer with mixed alpha olefins.

Use/Production. (S) Film, blow molding, etrusions. Prod. range: Confidential.

Toxicity Data. No data on the PMN substance submitted.

Exposure. Manufacture and use: Dermal, a total of 10,210 workers, up to 40 hrs/wk.

Environmental Release/Disposal. Minimal release anticipated. Disposal by incineration and landfill.

PMN 83–1074

Manufacturer. Confidential.

Chemical. (G) Ethylene, polymer with mixed alpha olefins.

Use/Production. (S) Film, blow molding, etrusions. Prod. range: Confidential.

Toxicity Data. No data on the PMN substance submitted.

Exposure. Manufacture and use: Dermal, a total of 10,210 workers, up to 40 hrs/wk.

Environmental Release/Disposal. Minimal release anticipated. Disposal by incineration and landfill.

PMN 83–1075

Manufacturer. Confidential.

Chemical. (G) Reaction products of triglycerides and polyethylene glycol.

Use/Production. (G) Lubricant additive. Prod. range: 10,000–100,000 kg/yr.

Toxicity Data. No data submitted.

Exposure. Manufacture: Dermal, a total of 2 workers, up to 2 hrs/da, up to 75 da/yr.

Environmental Release/Disposal. 2 kg/batch released to water. Disposal by publicly owned treatment works (POTW).

PMN 83–1076

Manufacturer. Confidential.

Chemical. (G) Polyester urethane—isocyanate terminated.

Use/Production. (S) Industrial component for flexible polyurethane foam for high resiliency seating applications. Prod. range: Confidential.

Toxicity Data. No data submitted.

Exposure. Manufacture: Dermal, a total of 18 workers, up to 1 hr/da, up to 10 da/yr.

Environmental Release/Disposal. 1–5 kg/batch released. Disposal by incineration.

PMN 83–1077

Manufacturer. Confidential.

Chemical. (G) Polyester urethane—isocyanate terminated.

Use/Production. (S) Industrial applications to manufacture elastomeric cast parts or abrasion resistant thick coatings. Prod. range: Confidential.

Toxicity Data. No data submitted.

Exposure. Manufacture: Dermal, a total of 18 workers, up to 1 hr/da, up to 18 da/yr.

Environmental Release/Disposal. 1–5 kg/batch released. Disposal by incineration.

PMN 83–1078

Manufacturer. Confidential.

Chemical. (G) Unsaturated polyester.

Use/Production. (S) Industrial base crosslinking resin for electrical varnish. Prod. range: Confidential.

Toxicity Data. No data submitted.

Exposure. Manufacture and processing: dermal, a total of 24 workers, up to 1 hr/da, up 51 da/yr.

Environmental Release/Disposal. 5–10 kg/ batch released. Disposal by incineration

PMN 83–1079

Importer. Haarmann & Remier Corporation.

Chemical. (S) 2–(3-heptyloxy) acetic acid.

Use/Import. (S) Industrial fragrance compounding. Import range: 100–100,000 kg/yr.

Toxicity Data. Acute oral: 1.600 ml/kg; Irritation: Skin—Non-irritant, Eye—Non-irritant; Photosensitization: Negative.

Exposure. No data submitted.

Environmental Release/Disposal. No data submitted.

PMN 83–1080

Manufacturer. Confidential.

Chemical. (G) Silylated silica gel.

Use/Production. (S) Catalyst. Prod. range: Confidential.

Toxicity Data. Acute oral: 324 mg/kg; Acute dermal: >2,000 mg/kg; Irritation: Skin—Very slight, Eye—Severe; Ames Test: Non-mutagenic.

Exposure. Manufacture: Dermal, a total of 1 worker.

Environmental Release/Disposal. No release. Disposal by incineration.

PMN83-1081

Manufacturer. Confidential.
Chemical. (G) Quaternary ammonium chloride.
Use/Production. (S) Intermediate. Prod. range: Confidential.
Toxicity Data. Acute oral: 324 mg/kg: Acute dermal: >2,000 mg/kg: Irritation: Skin—Slight, Eye—Slight; Ames Test: Non-mutagenic.
Exposure. Manufacture: Dermal, a total of 1 worker.
Environmental Release/Disposal. No release. Disposal by incineration.

PMN83-1082

Manufacturer. ALCOLAC Incorporated.
Chemical. (S) Docosyl methacrylate.
Use/Production. (G) Crude oil additive. Prod. range: Confidential.
Toxicity Data. No data submitted.
Exposure. Manufacture: Dermal, a total of 4 workers, up to 3 hrs-da, up to 18 da/yr.
Environmental Release/Disposal. 10kg/batch released to land. Disposal by landfill.

PMN 83-1083

Importer. Confidential.
Chemical. (G) Modified polyurethane from substituted alkanopolyols and an aromatic diisocyanate.
Use/Production. (S) Industrial adhesive for metal to foam. Production range: 1,000-50,000 kg-yr.
Toxicity Data. No data submitted.
Exposure. Manufacturer and processing: Dermal and inhalation, a total of 8 workers, up to 8 hrs/da, up to 50 da/yr.
Environmental Release/Disposal. No release.

PMN 83-1084

Manufacturer. Confidential.
Chemical. (G) Hydrocarbon novolac.
Use/Production. (G) Site-limited intermediate. Prod. range: Confidential.
Toxicity Data. Acute oral: >2,000 mg/kg: Acute dermal: >2,000 mg/kg: Irritation: Skin—Not a primary irritant, Eye—Non- irritant.
Exposure. Manufacture and use: Dermal, a total of 20 workers, up to 8 hrs/da, up to 75 da/yr.
Environmental Release/Disposal. Incidental release. Disposal by incineration and approved landfill.

PMN 83-1085

Importer. Confidential.
Chemical. (G) Substituted phenylacetamide.
Use/Import. (G) Destructive use intermediate. Import range: Confidential.
Toxicity Data. Acute oral: Male—2,593 mg/kg. Female—2,610 mg/kg: Acute dermal: >2,000 mg/kg: Irritation: Skin—Mild, Eye—Non-irritant: Inhalation: 10.34 mg/L.
Exposure. Import: Dermal, a total of 2 workers.
Environmental Release/Disposal. Confidential.

Dated August 29, 1983.

V. Paul Fuschini,

Acting Director, Management Support Division.

[FR Doc. 83-24009 Filed 8-31-83; 8:45 am]

BILLING CODE 6560-50-M

FEDERAL COMMUNICATIONS COMMISSION

[Report No. 1422]

Petitions for Reconsideration of Actions in Rule Making Proceedings

August 25, 1983.

The following listings of petitions for reconsideration filed in Commission Rulemaking proceedings is published pursuant to 47 CFR 1.429(e). Oppositions to such petitions for reconsideration must be filed within 15 days after publication of this Public Notice in the Federal Register. Replies to an opposition must be filed within 10 days after the time for filing oppositions has expired.

Subject: Amendment of § 73.606(b) to Effect Changes in the Television Table of Assignments. (MM Docket No. 83-190, RM-4262)

Filed by: Marvin Rosenberg & David G. Rozzelle Attorneys for Griffin Television, Inc. on 7-19-83.

Subject: Amendment of Part 97 of the Commission's Rules to Revise the Procedures for Determining Eligibility for the Novice Class Amateur Radio Operator License. (PR Docket No. 82-727, RM 4044)

Filed by: Christopher D. Imlay Attorney for The American Radio Relay League, Incorporated on 8-10-83.

Subject: Definition and Measurement of Transmitting Power in the Amateur Radio Service. (PR Docket No. 82-624)

Filed by: Donald B. Chester, K4KYV on 8-16-83. F. A. Dunlap, President The American Radio Relay League on 8-17-83. Kevin Alfred Strom on 8-19-83.

Subject: Business communications in the Amateur Radio Service. (FCC 83-298)

Filed by: David B. Popkin on 8-9-83.

William J. Tricarico,

Secretary, Federal Communications Commission.

[FR Doc. 83-23983 Filed 8-31-83; 8:45 am]

BILLING CODE 6712-01-M

[File No. 26023-CL-P (15)-82 et al.]

Advanced Mobile Phone Service, Inc., et al.; Hearing

Memorandum Opinion and Order Granting Application, Dismissing Application, and Designating Applications for Hearing

In re applications of Advanced Mobile Phone Service, Inc., File No. 26023-CL-P (15)-82; GTE Mobilnet of Dallas, Inc., File No. 26056-CL-P-(11)-82; for a construction permit to establish a new cellular system operating on frequency block B in the Domestic Public Cellular Radio Telecommunications Service to serve the Dallas-Fort Worth, Texas, Standard Metropolitan Statistical Area (SMSA). In re applications of D/FW Signal, Inc., CC Docket No. 83-945, File No. 26039-CL-P-(20)-82; LIN Cellular Communications Corp., File No. 26143-CL-P-(28)-82; MCI Cellular Telephone Co., File No. 26106-CL-P-(23)-82; Cellular Mobile Systems of Texas, Inc., File No. 26185-CL-P-(35)-82; Mid-American Cellular Systems, Inc., File No. 26158-CL-P-(5)-82; for a construction permit to establish a new cellular system operating on frequency block A in the Domestic Public Cellular Telecommunications Service to serve the Dallas-Fort Worth, Texas, Standard Metropolitan Statistical Area (SMSA).

Adopted August 24, 1983.
Released August 26, 1983.
By the Common Carrier Bureau.

1. Presently before the Chief, Common Carrier Bureau, under delegated authority are (a) the captioned applications of Advanced Mobile Phone Service, Inc. (AMPS), GTE Mobilnet of Dallas, Inc. (GTE), D/FW Signal, Inc. (D/FW), LIN Cellular Communications Corp. (LIN), MCI Cellular Telephone Co. (MCI), Cellular Mobile Systems of Texas, Inc. (CMS), and Mid-America Cellular System, Inc. (MACS), to construct cellular radio systems to serve the Dallas-Fort Worth SMSA, and (B) various petitions and pleadings related to the applications. AMPS and GTE, applicants for the wireline frequency block B, have filed a Joint Request for Approval of Limited Partnership Agreement and a Limited Partnership Agreement for this SMSA.

2. As discussed below, after carefully reviewing the applications and related pleadings, we find that the public interest will be served by our approving the AMPS/GTE settlement agreement and granting the AMPS application. Concerning the nonwireline applications, we find all applicants except for MACS and D/FW, to be fully qualified to construct and operate a cellular system in Dallas-Fort Worth. Since the proposals of D/FW, LIN, MCI, CMS, and MACS, to use the same frequencies in the same geographical area are mutually exclusive, a

comparative proceeding will be held to determine which of the applicants would best serve the public interest.

DF/W Application

3. *Financial qualifications.* Petitioners question whether D/FW has demonstrated the availability of funds to finance the projected construction and operating costs of $15.6 million. D/FW relies on $7 million of equity capital, a $4 million loan commitment from the Republic Bank, Dallas, Texas, and projected revenues from first-year operations. CMS questions the availability of the $4 million loan, arguing that the commitment was not made to the applicant D/FW but rather to Rotan, an investor which has not formally joined D/FW, but which retains the option to join. After reviewing the application, however, we conclude that these funds are available. D/FW has submitted (Exhibit 12, Attachment F) a letter from the Republic Bank, Dallas, extending $4 million in credit, not to the investor Rotan, but to D/FW. The letter specifies an interest rate of 1% above the bank's prime rate. This letter provides reasonable assurance that the $4 million funding is available to the applicant.[1]

4. MACS questions the availability of the $7 million of equity capital, arguing that D/FW relies on letters of credit rather than dedicated funds. We conclude, however, that these funds are available. D/FW has submitted (Exhibit 12, attachments A–E) irrevocable letters of credit from various banks. Each letter refers to a particular shareholder under whose name the account was opened. The letters of credit are addressed to D/FW and give D/FW (rather than the shareholder) the right to make drafts upon the accounts, up to the amount specified under each credit letter. We conclude, therefore, that these funds are irrevocably committed to D/FW and thus are available for the proposed cellular venture.

5. The petitioners further question the applicant's financial qualifications because D/FW relies on projected subscriber revenues. D/FW has obtained $11,005,000 in financing and projects expenses of $15,635,000 through the first year of operation. The applicant relies on projected revenues to cover the $4,630,000 deficit. To support its revenue projections, D/FW submits a detailed analysis, prepared by Peat, Marwick, Mitchell & Company. Application Exhibit 12, attachment G. In *Advanced Mobile Phone Service, Inc. (Buffalo Order),* CC Mimeo 1320, released December 14, 1982, at para. 17, we recognized that cellular systems may generate revenues to offset construction and operating expenses even as construction progresses. However, without the benefit of a hearing, we are unable to determine the validity of the methodology used by D/FW to arrive at its projected revenues. *Advanced Mobile Phone Service, Inc. (New York Order)* CC Mimeo 2418, released February 18, 1983, at para. 34. Thus, we cannot credit D/FW with any projected revenues. Accordingly, we will designate a financial issue against D/FW to the extent of these funds.[1a] Even though we cannot credit D/FW with any specific amounts for projected revenues, we recognize that it is likely that D/FW will be able to substantiate some or all of its projections. Therefore, we will permit D/FW to amend its application to provide additional information to the Administrative Law Judge (ALJ) concerning these revenue projections. The ALJ may use our summary procedures to resolve the financial issue if D/FW submits amendments showing reasonable assurance. *Id.*

6. *Accuracy of cost estimates.* The petitioners question the reliability of the D/FW cost estimates, alleging a failure to specify pre-operational expenses such as personnel costs, training expenses, advertising costs, interest expenses, insurance fees, taxes, overhead, and the purchase of mobile units. In its application, D/FW provides a detailed listing of its various start-up costs, categorizing them as either construction costs or first year operational costs. Exhibit 11, Attachment B. D/FW further provides an item-by-item cost estimate, totalling $12,335,000 in construction costs and $3,300,000 in operation costs. Many of the items which the petitioners allege to be omitted from the applicant's estimates are in fact included. For example, advertising costs are listed as "promotion" expenses, and interest expenses are listed as "debt service." Further, Section 22.917 of the rules does not require that the cost of mobile equipment be included in an applicant's financial projections. LIN also faults the D/FW application for failing to provide a cell-by-cell break-down of cost estimates. Section 22.913(a)(8) does not, however, require that cost estimates for the proposed system be itemized for each particular cell. *See* Buffalo Order, *supra* at para. 9. We find that the petitoners have failed to raise any serious questions concerning the D/FW cost estiamtes. Because the estimates submitted by D/FW do not appear unreasonable on their face, we will not designate an issue. *Advanced Mobile Phone Service, Inc. (Chicago Order),* 91 FCC 2d 512 (1982), at para. 13. *See also Buffalo Order,* at para. 9 and n. 7.

7. *Undue concentration of ownership.* MACS contends that the D/FW application should be denied because it involves undue concentration of ownership in the Dallas/Fort Worth mobile radio market. MACS maintains that D/FW is composed of a large group of local, existing mobile radio licensees which already serve a substantial portion of the current mobile telephone market in the Dallas/Fort Worth SMSA. MACS questions whether a grant of the single nonwireline authorization to D/FW would unduly concentrate control of facilities in the hands of these shareholders. MACS also refers to a pending lawsuit brought by one of the D/FW shareholders, Radio Relay, against the remaining stockholders, alleging anti-copetitive conduct and breach of contract,[2] as reflecting adversely on D/FW's qualifications. We conclude, however, that designation of an issue is not warranted on either count. First, as we stated in *Advanced Mobile Phone Service, Inc. (New Orleans Order)* CC Mimeo 5139, released July 11, 1983, at para. 14, the Commission has nowhere indicated that a carrier's participation in the conventional mobile telephone market has any bearing on its eligibility for a cellular license. *Cf. Report and Order,* at 487. Second, we have already declined to designate an issue against D/FW or its principals based on the pending litigation cited by MACS *Celcom Communications Corp. of Georgia (Atlanta Order),* CC Mimeo 1988, released January 26, 1983, at para. 16. However, consistent with prior decisions, we will condition any grant to D/FW on the outcome of the pending litigation. We repeat, however, that it would be premature to examine this matter in a cellular comparative proceeding. *See Peoples Broadcasting Corporation* 68 FCC 2d 1569, 1573–74 (1978); *Atlanta Order, supra.*

8. *Inconsistent application.* LIN contends that the D/FW application is

[1] D/FW filed a petition for Reconsideration of the Mobile Services Division action returning an August 10, 1982 amendment supplementing the Republic Bank commitment letter. Because we find that the Republic Bank funding is available and the amendment only provides clarifying information we will grant reconsideration and accept the amendment.

[1a] In cellular proceedings, we have determined that adding a financial issue to the comparative hearing, when we are unable to find a nonwireline applicant financially qualified, is the most efficient method of resolving the issue.

[2] Radio Relay Corp.—Texas v. D/FW Signal, Inc. et al., No. CA3 82-0877 G (N.D. Texas, filed June 7 1982).

defective for violating § 22.21 of the rules, which forbids applicants to file conflicting or inconsistent applications. Specifically, LIN refers to the fact that one of ten D/FW shareholders, Radio Relay is also a subsidiary of Graphic Scanning, which has filed a cellular application in Dallas/Fort Worth through its subsidiary CMS. LIN argues that Graphic Scanning is the same applicant with respect to the CMS application and the D/FW application. We conclude, however that its applications are not conflicting or inconsistent. Radio Relay is a minority shareholder (10%) in D/FW. However, in an amendment filed on July 28, 1982, D/FW indicates that if a grant is made to D/FW, the corporation will be reconstructed and Radio Relay's share will be reduced to 1.33%.[3] The mere fact that Graphic Scanning has an ownership interest in D/FW and owns CMS does not in itself establish common control or an identity of interests so as to render D/FW's application defective. In order to find that Graphic Scanning has filed inconsistent applications, there must be evidence that Graphic Scanning exercises control over D/FW. *See Comark Television*, FCC 82-212, released May 7, 1982. LIN has presented no factual materials that point to any such exercise of control by either Radio Relay or Graphic Scanning and no factual materials that indicate an identity of interest between D/FW and CMS. The mere fact that Graphic Scanning has a small ownership interest in D/FW is not a violation of § 22.21 *See Everett G. Peace, Jr.*, 60 FCC 2d 1087, 1089–1090 (1976). Accordingly, we reject petitioner's arguments and will not designate an issue on this matter.

9. *Rates.* MACS contends that the rates proposed by D/FW are unjustified and unreliable because the need survey used is invalid and the application does not contain a revenue requirements study to support the proposed rates. The rules, however, do not require that a study be submitted, and MACS has provided no factual materials to support its allegations of unreasonable rates. Moreover, relative demand forecasts and proposed rates are not qualifying issues but will instead be examined in hearing on a comparative basis. *See Advanced Mobile Phone Service, Inc. et al. (Philadelphia Order)*, CC Mimeo 1882, released January 27, 1983, at paras. 19 and 22. Also as we have stated repeatedly, the rates charged to the public for cellular service are a state matter, rather than within the jurisdiction of the Commission. *See generally Morrison Radio Relay Corp.*, 31 FCC 2d 612 (1971); *Buffalo Order, supra* at para. 4.

10. *Site availability.* LIN questions the availability of the proposed sites in the D/FW application, contending that D/FW has submitted only letters of intent from the site owners. After reviewing the application, however, we conclude that the proposed sites have shown to be available. In its application (Exhibit 9, Attachments A–T), D/FW submits letters from site owners. The letters specify the location of the sites and state each owner's intent to permit D/FW to use the particular site as an antenna and equipment location. This information provides reasonable assurance that the proposed cell sites are available for the applicant's use. The cellular rules do not require that copies of lease agreements or deeds of ownership be furnished. *See Sampson Broadcasting, Inc.*, 52 FCC 2d 954, 959 (1975), *Silver Beehive Telephone Company*, 35 FCC 2d 333, 336 (Rev. Bd. 1972), *Philadelphia Order, supra*, at para. 21.

11. *Hand-off capability (cellular design issue).* LIN contends that the D/FW proposal includes major gaps within the SMSA where no cells are proposed and that, consequently, no cell-to-cell hand-off can take place. LIN argues that D/FW has in effect failed to design a cellular system, since subscribers will be unable to receive service as they drive through certain sections of the SMSA. In its reply (Attachment H), D/FW submits an engineering statement which explains that cell-to-cell hand-off will in fact take place throughout the SMSA and that no gaps exist within the service area where service will be provided. D/FW states that the signal level can be adjusted so that a wider service range is possible and no subscribers will travel out of service range within the CGSA. D/FW also replies that as demand increases in the parts of the SMSA not presently included in the D/FW CGSA, the applicant will add cell sites. We conclude that this information fully responds to the matters raised by the petitioner and that D/FW has conformed its proposal to our rules. Moreover, whether hand-off between certain cells is possible is not a qualifying issue because it relates to system design which may be examined during the comparative portion of this proceeding. *See New York Order supra*, at paras. 9–10.

12. *System expansion.* CMS argues that D/FW has not made a proper showing of the basis upon which it will determine when system expansion is warranted. We are not persuaded by these arguments. The D/FW application and reply fully explain the proposed method for system expansion and the grade of service criteria to be applied. We find this showing meets the requirements of § 22.913(a)(4) of the rules. Additionally, these matters may be examined in the comparative portion of this proceeding. *See Cellcom Inc. (Minneapolis Order)*, CC Mimeo 1573, released December 30, 1982, at para. 13.

LIN Application

13. *Financial qualifications.* Petitioners CMS and MACS argue that LIN has failed to establish its financial qualifications. Specifically, the petitioners maintain that LIN has underestimated projected system costs and interest charges, overestimated projected demand and revenues, and failed to provide reasonable assurance of the financial resources necessary to fund the $32 million needed to construct and operate the proposed cellular system in Dallas/Fort Worth.

14. Similar issues were raised against the LIN application filed in the New York market. The Common Carrier Bureau designated a financial issue to examine the LIN proposals for all four markets, including Dallas, in which LIN applied. *See New York Order, supra*, at para. 32. The petitioners have not raised additional matters not covered in the proceeding.[3a]

15. *Need survey.* MACS contends that the market survey submitted by LIN is unreliable and cannot be used to justify the proposed CGSA. MACS argues that the application is consequently defective. We reject that contention, however The Commission's rules do no require applicants to submit need surveys Moreover, the validity of the market survey of need is not a qualifying issue but may be examined in a hearing on a comparative basis. *See Philadelphia Order, supra* at paras. 19 and 22.

16. *Site Availability.* MACS questions whether the sites proposed by LIN are in fact available, arguing that the application includes only general letters of intent from site owners. We conclude however, that the sites have been shown to be available. The letters from site owners specify the location of the sites and state that the sites are available to

[3] Radio Relay will reduce its ownership interests by selling its shares in D/FW to other shareholders and will not participate in any way in the management of D/FW's cellular system

[3a] In the *New York* proceeding, the Administrative Law Judge found LIN financially qualified in all four markets Memorandum Opinion and Order CC Docket No 83-101 FCC 83M-1398, released April 29 1983. The decision is, of course subject to Commission review

the applicant for use as cellular sites. This showing complies with our rules, which do not require that copies of lease agreements of deeds of ownership be furnished. *See Sampson Broadcasting, supra; Silver Beehive, supra;* and *Philadelphia Order, supra,* at para. 21.

17. *Tariff issue.* MACS argues that the LIN application is defective for proposing to provide mobile equipment under tariff. MACS cites language in the application (Vol. 1, Exhibit 4, Attachment A, at pp. 15 and 21), where the applicant states, "* * * [C]ustomers shall pay monthly in advance all charges for equipment furnished by the Company * * *. Equipment provided by the Company will be maintained and repaired by it subject to the charges specified in this tariff." LIN's reply does not address these allegations. The Commission has prohibited tariffing of cellular mobile equipment as part of a common carrier communication service. *See Memorandum Opinion and Order on Reconsideration,* 89 FCC 2d 58 at para. 59. Since it is unclear from the language contained in the application that LIN will not provide mobile units pursuant to a tariff, we will require LIN to file with the ALJ a statement that the applicant will comply with the rules in this respect.

MCI Application

18. *Financial qualifications.* MCI's financial qualifications to construct cellular systems in 12 of the top 30 markets, including Dallas/Fort Worth, were resolved in *Advanced Mobile Phone Service, Inc. (Pittsburgh Order),* CC Mimeo 1169, released December 6, 1982, at para. 5, and no new issues on this point have been raised here. Hence, our prior findings control and we find that MCI is financially qualified.

19. *Congestion determination, expansion method, need survey, rates.* The petitioners attack the MCI application for failing to adequately detail its method for determining system congestion, for failing to fully explain how it plans to expand its proposed system, and for failing to furnish a statistically valid need survey. MACS further contends that MCI's proposed rates are unjustified and unreliable because they are not based on a revenue requirements study. Our rules do not require submission of either a need survey or a revenue requirements study. MCI has submitted exhibits describing its system design, expansion plans and projected costs which meet our requirements. *See* Exhibits 13 and 16–25 of MCI's application. System design, proposed system expansion and proposed rates are issues to be examined in the comparative portion of this proceeding. *Report and Order,* 86 FCC 2d 469 at 592–03 (1981). Accordingly, we decline to designate a basic qualifying issue with respect to these matters. *See Buffalo Order* at para. 20.

20. *Technical (hand-off capability).* LIN and MACS contend that the MCI application is defective for failure to comply with the Commission's cellular design concept of continuous geographic coverage of the proposed service area. Specifically, they allege that MCI cell 7 is isolated from the remainder of the cellular system and that cells 10, 12, 21 and 23, do not provide complete overlapping coverage. MCI replies that hand-off between all cells will take place because the signal does not stop at the 39 dBu contour. While it is unclear whether MCI's proposed cellular system will permit hand-off between all cells, there is no need to designate for hearing a basic qualification issue on this matter because this question relates to system design which will be examined during the comparative portion of this proceeding. *See New York Order* at para. 10.

21. *Site availability* . MACS questions whether the sites proposed by MCI are in fact available. MACS contends that the proposals for at least eight of the sites are supported only by general letters of intent from site owners and that such letters fail to show that the sites are available. The application (Exhibit 12) contains letters for which the site owners specify the exact location of each proposed site and state that the site is available to MCI for its use as an antenna site. This information provides reasonable assurance that the proposed cell sites are available for the applicant's use. The cellular rules do not require that copies of lease agreements or deeds of ownership be furnished. *See also Sampson Broadcasting, supra; Silver Beehive Telephone Company, supra;* and *Philadelphia Order, supra,* at para. 21.

CMS Application

22. *Financial qualifications.* LIN, MACS, and D/FW question CMS' financial qualifications in the Dallas/Fort Worth market. The Commission considered CMS' financial qualifications and the financial qualifications of its parent corporation, Graphic Scanning, in the Chicago market, and found the applicant qualified in all 30 top markets. *Chicago Order, supra* at para. 6. Since no new issues regarding CMS' financial qualifications have been raised here, those findings control disposition of the petitioners' arguments here.

23. *Rates, costs estimates, revenue requirement, study CGSA size, method of expansion, market survey.* The petitioners question the validity of various portions of the CMS application such as proposed rates, cost estimates, size of CGSA, and method of expansion. The petitioners object that these portions of the application are invalid and unreliable because they are not based on a valid revenue requirement study and market study. As noted above, our rules do not require submission of either a need survey or revenue requirements study. CMS has submitted exhibits describing its system design and rates and projected costs which meet our requirements. These issues may be examined in the comparative portion of this proceeding. *Report and Order,* 86 FCC 2d 469 at 502–03 (1981). CMS has also submitted, in Exhibits III and IV of its application, a proposed method of expansion which meets the requirements of our rules. *Report and Order,* 86 FCC 2d 469 at 502–03 (1981). Accordingly, we decline to designate a basic qualifying issue with respect to these matters. *See Buffalo Order, supra,* at para. 20.

24. *Technical (hand-off capability).* LIN objects that the CMS proposal contains noncontiguous cells with no "hand-off" capability, thus violation the cellular rules. In its reply, CMS explains that its proposed cellular equipment is designed so as to carry a signal beyond the cell's dBu contours sufficiently to permit "hand-off" between all cells, including those which may be noncontiguous. As indicated at para. 21, *supra,* this is not a basic qualifying issue but CMS' "hand-off" capability will be examined during the comparative portion of this proceeding.

25. *Inconsistent application.* LIN contends that the CMS application is defective for being in conflict with the D/FW application. Specifically, LIN refers to the fact that Radio Relay , a D/FW shareholder, is also a subsidiary of CMS' parent corporation Graphic Scanning. These same allegations were raised against the D/FW application. *See* our discussion on that issue, *supra* at para. 8, in which we rejected these arguments.

26. *Abuse of process.* D/FW requests the Commission either to designate an abuse of process issue against CMS or to deny the CMS application. D/FW refers to a lawsuit brought against D/FW by Radio Relay, a CMS subsidary. D/FW alleges that Radio Relay filed the suit for the purpose of pressuring D/FW not to prosecute it cellular application and that Radio Relay was in effect action on behalf of CMS, which (like Radio Relay) is also a subsidiary of Graphic Scanning. In its petition, D/FW

submits a chronology of the disagreements which have taken place between Radio Relay and the other shareholders of D/FW, concerning the filling of the D/FW cellular application. The complaint appears to be not that CMS abused the Commission's processes but rather that CMS has abused the processes of a court of law by filing its civil action. The materials submitted in the D/FW petition do not present a matter bearing on the basic qualifications of CMS to be a licensee. Accordingly, we will not designate an issue on this basis. Additionally, we have already discussed the impact of that litigation on this proceeding in our examination of the D/FW application, *supra*, para. 7.

27. *Site availability.* LIN questions whether CMS has adequately demonstrated that its proposed sites are available. LIN alleges that three letters of site availability submitted in the CMS application are inconsistent with respect to coordinates or addresses. In its reply, CMS explains that these discrepancies are clerical in nature and CMS has since filed amendments to correct any such inconsistencies. This responds fully to the objections. MACS and LIN further object that the letters of intent submitted by CMS are inadequate to demonstrate site availability . We have previously rejected this same argument with respect to the MACS, LIN, and D/FW applications and similary reject it here. LIN further objects that the CGSA map submitted by CMS contains a "phantom" cell number 36 which is not otherwise accounted for in the application. CMS has submitted an amendment, dated August 2, 1982, deleting the cell from the CGSA map. In its reply, CMS explains that just prior to the June 7, 1982, filing of the application, CMS had decided not to include cell number 36 and deleted it from Exhibit X of the application but that the CGSA map was inadvertently not modified. This change in no way improves CMS' comparative position and we conclude that this explantion responds fully to the matters raised by the petitioner

MACS Application

28. *Accuracy of cost estimates.* Petitioners LIN and CMS raise various objections as to whether the MACS application fully and accurately sets forth the projected costs of constructing and operating. LIN faults the application for not providing a cell-by-cell projection of costs and for failing to include costs for mobile units. CMS contends that the applicant's cost estimates cover only a five-cell system, which will be operational the first year, whereas MACS contemplates a 23-cell system by the fifth year of operation. CMS argues that the rules require the MACS application to include cost estimates and show available financing for the fully developed system. The petitioners also object that the applicant's cost estimates are not sufficiently detailed to demonstrate that all pertinent expenses have been included. CMS specifically objects that MACS has not included in its cost estimates such categories as pre-operating cost, advertising and promotional expenses.

29. After reviewing the application and MACS' consolidated reply to the petitioners' pleadings, we have concluded that the cost estimates provided by MACS comply with the requirements of the cellular rules. Initially, we reject the contention that the applicant's cost estimates are insufficiently detailed. Sections 22.917(a)(1) and (2) of the rules require applicants to set forth their proposed costs of construction and operation for one year. The MACS application lists these costs by categories in Exhibit 5, Tables No. 5–1 and 5–9, of the application. These tables also include similar projections through five years of operation. These showings satisfy the requirements of our rules; MACS is not required to demonstrate the itemized costs for each cell. *See Buffalo Order, supra* para. 9. Also, cellular applicants are not required to include the cost of mobile equipment in their financial projections. *See Metrocom of St. Louis (St. Louis Order)*, CC Mimeo 2045, released January 28, 1983, at para. 10. Lastly, we find that the petitioners have failed to raise any serious questions concerning MACS' cost estimates that have not been adequately explained by MACS in its reply. Moreover, MACS' estimates do not appear unreasonable on their face. *See Buffalo Order, supra* at para. 9.

30. *Financial qualifications.* The petitioners raise various objections as to whether MACS has sufficient funds available to construct and operate its proposed system for one year. In the *Kansas City Order* [4] the Bureau examined similar arguments and found them to raise a substantial and material question of fact about MACS' financial ability. In view of this conclusion, the Bureau designated for hearing an issue concerning MACS' overall financial package. As we indicated there, we will not designate a identical issue here because we want to avoid duplicative litigation. However, we will consider the ultimate finding as to the MACS' financial qualifications in the Kansas City proceeding to be dispositive of the issue, and we reserve the right to reexamine and reconsider any authorization to MACS in the event that MACS' Dallas application is granted as a result of the comparative hearing.[5]

31. *CGSA Coverage.* MACS failed to provide coverage of at least 75% of its proposed CGSA in violation of Rule § 22.903(a). By amendment, MACS attempted to cure this patent defect by uniformly shrinking its proposed CGSA so as to comply with § 22.903(a). The amendment was returned as "major" and unacceptable for filing. MACS filed an application for review. In the *Kansas City Order, supra*, at para. 55, the Bureau addressed this problem and upon further review accepted the amendment there shrinking the CGSA.[6] For the same reasons, we will direct MACS to refile the original, returned amendment with the ALJ. Due to these circumstances, brief extensions of time may be granted at the discretion of the Administrative Law Judge (ALJ).

32. *Maintenance, repair, operation, complaints.* LIN alleges that MACS has not sufficiently set forth its proposals for maintenance, repair, and operation of the cellular system. MCI further alleges that MACS has not sufficiently explained how it will handle complaints from subscribers. Similar arguments were raised against the MACS application in the Kansas City market, where we declined to designate a qualifying issue with respect to these matters. *See Kansas City Order, supra*, at para. 51. No new arguments were raised by LIN or MCI which persuade us to designate an issue against MACS' Dallas application.

AMPS Application

33. AMPS is the only remaining applicant for Block B (wireline) in the Dallas/Fort Worth market under the terms of a Limited Partnership Agreement submitted on November 2, 1982.[7] This Agreement is one of a series

[4] Advanced Mobile Phone Service, Inc., (Kansas City Order), CC Mimeo 5086, released July 6, 1983. In addition, in the Kansas City Order at nn. 19 and 20, the Bureau accepted two financial amendments to MAC's application. See Mid-America Cellular Systems, Inc. FCC 83-286, released June 24, 1983. MACS filed the same two amendments in this proceeding and we will accept them for the same reasons.

[5] The Kansas City Order stated that petitioners in the instant proceeding may file motions for limited intervention in the Kansas City proceeding on the financial issue.

[6] *See* Mid America Cellular Systems, Inc., *supra*, and § 22.23(c)(1).

[7] The participants in the agreement are: AMPS, general and limited partner 72.56%; GTE, limited partner, 27% and Lake Dallas Telephone Co., Inc., limited partner, 0.44%.

of similar agreements by which AMPS and GTE, which had filed in 15 of these markets, together with 18 other wireline companies, proposed to settle their electrically mutually exclusive applications in 18 of the top 30 markets. Pursuant to the terms of the Agreements, AMPS will operate cellular systems in twelve markets, including Dallas/Fort Worth, and GTE will operate cellular systems in six markets. Each partner will continue to prosecute its cellular applications in its specified markets, while the other partners to the agreements will withdraw any applications in those sites. An agreement identical in all material aspects to the Dallas/Fort Worth Agreement was approved by the Commission in *Advanced Mobile Phone Service, Inc. (Los Angeles Wireline Order)*, FCC 83-124, released April 26, 1983. We find the Commission's decision to be dispositive of all objections to the Dallas/Fort Worth Agreement itself.[8] To the extent the objections raise the head-start issue, *i.e.*, an alleged anticompetitive effect of allow AMPS to commence service before a nonwireline licenseee can be selected, we will defer action for reasons stated in the *Chicago Order, supra*, at para. 16.

34. D/FW and MCI filed petitions to deny the AMPS application. MCI filed a virtually identical petition against AMPS' application in Pittsburgh. We rejected MCI's arguments there and will not repeat the discussion here. *See Pittsburgh Order, supra* at para. 13. Likewise, D/FW has not raised an issue in its petition that we have not rejected previously. For the most part, D/FW challenges policies adopted and reaffirmed by the Commission in the *Report and Order, supra*. These arguments constitute the untimely request for reconsideration and must be rejected. *Pittsburgh Order, supra* at para. 12; *Advanced Mobile Phone Service, (Atlanta Order)* CC Mimeo 4567, released June 6, 1983, para. 8. To the extent D/FW raises the issue of a head start, we find that it is premature to rule on that issue now, for the reasons stated by the Commission in deferring action on similar petitions in the Chicago market. *See Chicago Order, supra*, at para. 16.; *Atlanta Wireline Order, supra*, at para. 8. In addition, D/FW alleges a history of anticompetitive behavior of wireline carriers generally. This argument has already been rejected as a basis for adverse action. D/FW has raised no specific allegations against any of the wireline applicants here, and we find no reason to designate an issue regarding anticompetitive behavior.

35. Also, D/FW argues that: AMPS' engineering showing is deficient; AMPS has failed to provide a schedule of proposed charges; and AMPS has not disclosed its financial qualifications. Again, we have previously rejected these objections and for the reasons previously stated we do so here. *See Kansas Order, supra*, at para. 5 (proposed rates); *Los Angeles Wireline Order, supra*, at para. 38 (financial qualifications) and *Advanced Mobile Phone Service, Inc. (Denver Order)*, CC Mimeo 4779, released June 17, 1983, at para. 40 and n. 12 (system engineering).

Conclusions

36. Based on our analysis of the applications and our resolution of the contested issues in this order, we find that, except for D/FW and MACS the applicants are legally, technically, financially and otherwise qualified to construct and operate their proposed cellular systems. We are designating a financial issue against D/FW and conditioning any grant made to CMS, D/FW or MACS as set forth below. Finally, we are requiring LIN to submit a statement to the SAJ, as set forth below.

37. Accordingly, it is ordered, pursuant to Section 22.29 of the Commission's Rules, that the Joint Request for Approval of Limited Partnership Agreement filed by GTE Mobilnet of Dallas, Incorporated, Lake Dallas Telephone Co., Inc. and Advanced Mobile Phone Service, Inc., is granted and the accompanying Limited Partnership Agreement is approved.[9]

38. It is further ordered that the request for withdrawal of the application filed by GTE Mobilnet of Dallas, Inc., File No. 26056-CL-P-(11)-82, is granted and the application is dismissed.

39. It is further ordered that the authorization is conditioned upon AMPS' filing an amendment to the Limited Partnership Agreement which eliminates the language contained in Section 11.1 of the Agreement, imposing restraints on the alienation of partnership interests.[10]

40. It is further ordered, pursuant to Section 309 of the Communications Act of 1934, as amended, that the applications of D/FW Signal, Inc., LIN Cellular Communications Corp., MCI Cellular Mobile Systems of Texas Inc., and Mid-America Cellular Systems, Inc., are designated for hearing in a consolidated proceeding, upon the following issues:[11]

(a) To determine whether D/FW is financially qualified to construct and operate for one year its proposed cellular system;

(b) to determine on a comparative basis the geographic area and population that each applicant proposes to serve;[12] to determine and compare the relative demand for the services proposed in said areas; and to determine and compare the ability of each applicant's cellular system to accommodate the anticipated demand for both local and roamer service;

(c) to determine on a comparative basis each applicant's proposal for expanding its system capacity in a coordinated manner within its proposed CGSA in order to meet anticipated increasing demand for local and roamer service;[13]

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[8] The Commission required the deletion of one provision of the Los Angeles Agreement which restrained alienation of partnership interests. We also require deletion of that provision here.

[9] This authorization will be conditioned upon AMPS obtaining antenna structure clearance. Also AMPS will not be authorized to render service to the public during service tests even after it files FCC Form 403 for a license. Service to the public cannot commence until the covering license becomes effective. Equipment tests, however, may be conducted. AMPS' authorization (FCC Form 403) will reflect these conditions.

[10] The Commission will hold issuance of AMPS' authorization until the amendment is received by the Mobile Services Division, Common Carrier Bureau. We also remind the partners that, pursuant to Section 212 of the Communications Act, officers or directors of more than one carrier are required to have authorizations to hold interlocking directorships.

[11] There are two issues that are not to be considered in the comparative hearing. The first is the financial qualifications of the applicants other than D/FW. Financial ability is a basic rather than a comparative qualification for cellular licensing. Cellular Communications Systems, 86 FCC 2d 469, 501-02 (1981). Except as noted, we have found the applicants included in the comparative hearing to be financially qualified. The second issue not to be considered is the qualifications of Cellular Mobile Systems of Texas, Inc. or its parent Graphic, to the extent that such qualifications may be affected by the issues included in the Commission's order designating certain 35 and 43 MHz paging applications for hearing, A.S.D. Answer Service, Inc. *et al* (ASD), FCC 82-391, released August 24, 1982. Those issues will be thoroughly reviewed in that separate proceeding and should not be reargued in the context of a cellular hearing. As set forth in para. 50, *infra*, the Commission reserves the right to reexamine and reconsider the qualifications of Cellular Mobile Systems of Texas, Inc. to hold a cellular license should *ASD* be resolved adversely to any of CMS' affiliate or parent companies or to any of their principals.

[12] For purposes of comparison, the geographic area that an applicant proposes to serve includes that area within the proposed 39 dBu contours which, in turn, falls within the proposed Cellular Geographic Service Area and the relevant Standard Metropolitan Statistical Area. Consideration should be given to the presence of densely populated regions, highways and areas likely to have high mobile usage characteristics, as well as indications of a substantial public need for the services proposed. *See* 86 FCC 2d at 502.

[13] In making this comparison, preference should be given to designs entailing efficient frequency use including not only the applicant's plan with regard to cell-splitting and additional channels, but also the degree of frequency reuse the system will be

(d) to determine on a comparative basis the nature and extent of the service proposed by each applicant, including each applicant's proposed rates, charges, maintenance, personnel, practices, classifications, regulations and facilities (including switching capabilities);[14] and

(e) to determine, in light of the evidence adduced under the foregoing issues, what disposition of the referenced applications would best serve the public interest, convenience and necessity.

41. It is further ordered that the burden of proceeding with the introduction of evidence upon the financial qualification issue, and the burden of proof, shall be upon D/FW. Procedures to decide the issue designated against D/FW shall be determined by the Administrative Law Judge (ALJ) in the ALJ's discretion.

42. It is further ordered that the Petition for Reconsideration filed by D/FW is granted.

43. It is further ordered that LIN submit a statement to the ALJ judge certifying that charges for cellular mobile equipment are not included in its tariff. The statement shall be submitted within fifteen days after publication of this order in the **Federal Register**. The date for filing rebuttal cases under § 22.916(b)(4) of the rules is deferred pending establishment of procedural dates by the ALJ.

44. It is further ordered that any authorization granted to D/FW shall be conditioned on, and without prejudice to, reexamination and reconsideration of that company's qualifications to hold a cellular license following final disposition of the litigation cited in para. 7, *supra.*

45. It is further ordered that MACS is directed to file the conforming amendment specified in this order within 15 days after publication of this order in the **Federal Register** and that the date for filing rebuttal cases under § 22.916(b)(4) of the Rules is deferred pending establishment of procedural dates by the Administrative Law Judge. Procedures for deciding the issues designated against MACS shall be determined by the Judge in the Judge's discretion.

46. It is further ordered that the Separated Trial Staff (the Hearing Division and other individuals specifically designated) of the Common Carrier Bureau is made a party to the proceeding.[15]

47. It is further ordered that the applicants shall file written notices of appearances under § 22.916(b)(3) of the Commission's rules within 10 days after publication of this order in the **Federal Register.**

48. It is further ordered that the hearing shall be held according to the procedures specified in § 22.916 of the rules, except as otherwise noted herein, at a time and place and before an Administrative Law Judge to be specified in a later order.

49. It is further ordered that exceptions to the initial decision of the Administrative Law Judge under § 1.276 of the Commission's Rules shall be taken directly to the Commission.

50. It is further ordered that any authorization granted to MACS as a result of the comparative hearing shall be conditioned on, and without prejudice to, reexamination and reconsideration of that company's financial qualifications as determined in *Advanced Mobile Service, Inc.* (*Kansas City Order*), CC Mimeo 5086, released July 8, 1983.

51. It is further ordered that any authorization granted to CMS as a result of the comparative hearing shall be conditioned on, and without prejudice to reexamination and reconsideration of that company's basic qualifications to hold a cellular license following a final decision in the hearing designated in *A.S.D. Answering Service, Inc., et al.*, FCC 82-391 released August 24, 1982, and shall be specifically conditioned upon the outcome of that proceeding.

52. It is further ordered that the AMPS authorization and any other authorization granted as a result of this proceeding shall be conditioned upon the obtaining of the appropriate antenna structure clearances.

53. This Order is issued under § 0.291 of the Commission's Rules and Order Delegating Authority, FCC 82-435, released October 6, 1982, and is effective on its release date. Petitions for reconsideration under § 1.106 or applications for review under § 1.115 of the rules may be filed within the time limits specified in those sections. See also Rule 1.4(b)(2).

54. The Secretary shall cause a copy of this order to be published in the **Federal Register.**

Kenneth A. Levy,

Acting Deputy Chief/Operations, Common Carrier Bureau.

[FR Doc. 83-23985 Filed 8-31-83; 8:45 am]

BILLING CODE 6712-01-M

capable of, and the applicant's ability to coordinate the use of channels with adjacent or nearby cellular systems. *See* 86 FCC 2d at 502-03.

[14] *See* 86 FCC 2d at 503 for a discussion of the relative importance of the evidence submitted under this issue.

[15] Members of the Separated Trial Staff are non-decision making personnel and they will not participate in decision-making or agency review on an *ex parte* basis in this case, either directly or through contact with other Common Carrier Bureau personnel. Any investigative or prosecuting functions will be performed by the Separated Trial Staff in connection with its role as a party to the adjudication of these cellular radio applications. All other personnel of the Common Carrier Bureau, unless identified in a subsequent order as required to be separated, are designated as decision-making and they may advise the Commission as to the proceeding. *See* Communications Act of 1934 as *amended* section 409(c) [47 U.S.C. section 409(c)]; Administrative Preocedure Act section 554(d) [5 U.S.C. 554(d)]; Section 1.221 of the Commission's Rules.

[BC Docket No. 82-536]

Amendment of the Commission's Rules Concerning the Use of the Subsidiary Communications Authorizations; Order Extending Time for Filing Oppositions to Petition for Reconsideration

AGENCY: Federal Communications Commission.

ACTION: Petition for reconsideration; extension of time for filing oppositions.

SUMMARY: Action taken herein grants Telocator Network of America's motion for an extension of time for filing comments in opposition to petitions for reconsideration which concerns the use of the Subsidiary Communications Authorizations.

DATE: Oppositions must now be filed by August 31, 1983.

ADDRESS: Federal Communications Commission, Washington, DC 20554.

FOR FURTHER INFORMATION CONTACT: Brian F. Fontes, Mass Media Bureau, (202) 632-6302.

SUPPLEMENTARY INFORMATION:

In the matter of an amendment of Parts 2 and 73 of the Commission's Rules concerning the use of the Subsidiary Communications Authorizations; BC Docket 82-536; order entending time for filing oppositions to petitions for reconsideration.

Adopted: August 23, 1983.

Released: August 26, 1983.

By the Chief, Policy and Rules Division.

1. On April 7, 1983, the Commission adopted the *First Report and Order* in BC Docket No. 82-536. The *Report and Order* amended Parts 2 and 73 of the Commission's rules thereby eliminating restrictions on the use and availability of subcarrier signals in the transmission of FM broadcast stations.

2. On August 22, 1983, Telocator Network of America, the national council of independent, non-wireline radio common carriers, filed a motion with the Commission requesting an extension of time for filing oppositions to petitions for reconsideration.

Telocator requested a one week extension of time from August 24, 1983, to August 31, 1983. Public notice of the filing of petitions for reconsideration of the *Report and Order* in BC Docket No. 82–536 was published in the **Federal Register** on August 9, 1983 (48 FR 36193) and oppositions are due to be filed on August 24, 1983. Telocator in their motion indicated that due in part to transition problems experienced in connection with the relocation of Downtown Copy Center's operations, they did not obtain copies of those petitions for reconsideration until August 19, 1983.

3. Accordingly, it is ordered, that the time for filing oppositions to petitions for reconsideration in BC Docket 82–536 is extended to and including August 31, 1983.

4. This action is taken pursuant to authority found in Sections 4(i), 5(d)(1) and 303(r) of the Communications Act of 1934, as amended, and §§ 0.61, 0.204 and 0.283(b) of the Commission's Rules.

5. For further information concerning this proceeding, contact Brian F. Fontes, Mass Media Bureau, (202) 632–6302.

Federal Communications Commission.

Roderick K. Porter,

Chief, Policy and Rules Division, Mass Media Bureau.

[FR Doc. 83-23986 Filed 8-31-83; 8:45 am]

BILLING CODE 6712-01-M

FEDERAL RESERVE SYSTEM

Acquisition of Bank Shares by a Bank Holding Company; Banks of Iowa, Inc.

The company listed in this notice has applied for the Board's approval under section 3(a)(3) of the Bank Holding Company Act (12 U.S.C. 1842(a)(3)) to acquire voting shares or assets of a bank. The factors that are considered in acting on the application are set forth in section 3(c) of the Act (12 U.S.C. 1842(c)).

The application may be inspected at the offices of the Board of Governors, or at the Federal Reserve Bank indicated. With respect to the application, interested persons my express their views in writing to the address indicated. Any comment on the application that requests a hearing must include a statement of why a written presentation would not suffice in lieu of a hearing, identifying specifically any questions of fact that are in dispute and summarizing the evidence that would be presented at a hearing.

A. **Federal Reserve Bank of Chicago** (Franklin D. Dreyer, Vice President) 230 South LaSalle Street, Chicago, Illinois 60690:

1. *Banks of Iowa, Inc.*, Des Moines, Iowa; to acquire at least 90 percent of the voting shares or assets of Henry County Savings Bank, Mount Pleasant, Iowa. Comments on this application must be received not later than September 23, 1983.

Board of Governors of the Federal Reserve System, August 6, 1983.

William W. Wiles,

Secretary of the Board.

[FR Doc. 83-23978 Filed 8-31-83; 8:45 am]

BILLING CODE 6210-01-M

Formation of Bank Holding Companies; First City Bancorp, Inc., et al.

The companies listed in this notice have applied for the Board's approval under section 3(a)(1)) of the Bank Holding Company Act (12 U.S.C. 1842(a)(1) to become bank holding companies by acquiring voting shares or assets of a bank. The factors that are considered in acting on the applications are set forth in 3(c) of the Act (12 U.S.C. 1842(c)).

Each application may be inspected at the offices of the Board of Governors, or at the Federal Reserve Bank indicated for that application.With respect of each application, interested persons may express their views in writing to the address indicated for that application. Any comment on an application that requests a hearing must include a statement of why a written presentation would not suffice in lieu of a hearing, identifying specifically any questions of fact that are in dispute and summarizing the evidence that would be presented at a hearing.

A. **Federal Reserve Bank of Atlanta** (Robert E. Heck, Vice President) 104 Marietta Street, N.W., Atlanta, Georgia 30303:

1. *First City Bancorp, Inc.*, Gainesville, Florida; to become a bank holding company by acquiring 80 percent or more of the voting shares of First City Bank, Gainesville, Florida. Comments on this application must be received not later than September 23, 1983.

B. **Board of Governors of the Federal Reserve System** (William W. Wiles, Secretary) Washington, D.C. 20551:

1. *New Mexico Bank Holding Company*, Ruidoso, New Mexico; to become a bank holding company by acquiring 100 percent of the voting shares of Security Bank, Ruidoso, New Mexico. This application may be inspected at the offices of the Board of Governors or the Federal Reserve Bank of Dallas. Comments on this application must be received not later than September 23, 1983.

Board of Governors of the Federal Reserve System, August 26, 1983.

William W. Wiles,

Secretary of the Board.

[FR Doc. 83-23977 Filed 8-31-83; 8:45am]

BILLING CODE 6210-01-M

Acquisition of Bank Shares by Bank Holding Companies, First Community Bancshares, Inc. et. al.; Correction

This notice corrects a previous **Federal Register** Document (FR Doc. 83-23276), published at page 38676 of the issue for August 25, 1983. First Community Bancshares, Inc.; One Valley Bancorp of West Virginia, Inc.; Midwest Financial Group, Inc.; State Exchange Bancshares, Inc.; Ellis Banking Corporation, Inc.; Falcon Bancorporation, Inc..; and First Bancshares Corporation of Illinois; have each applied for the Board's approval under section 3(a)(3) of the Bank Holding Company Act (12 U.S.C. 1842 (a)(3)) to acquire voting shares or assets of various banks.

Board of Governors of the Federal Reserve System, August 26, 1983.

James McAfee,

Associate Secretary of the Board.

[FR Doc. 83-23965 Filed 8-31-83; 8:45 am]

BILLING CODE 6210-01-M

Acquisition of Bank Shares by a Bank Holding Company; First Golden Bancorporation

The company listed in this notice has applied for the Board's approval under section 3(a)(3) of the Bank Holding Company Act (12 U.S.C. 1842(a)(3)) to acquire voting shares or assets of a bank. The factors that are considered in acting on the application are set forth in section 3(c) of the Act (12 U.S.C. 1842(c)).

The application may be inspected at the offices of the Board of Governors, or at the Federal Reserve Bank indicated. With respect to the application, interested persons may express their views in writing to the address indicated. Any comment on the application that requests a hearing must include a statement of why a written presentation would not suffice in lieu of a hearing, identifying specifically any questions of fact that are in dispute and summarizing the evidence that would be presented at a hearing.

A. **Federal Reserve Bank of Kansas City** (Thomas M. Hoenig, Vice President) 925 Grand Avenue, Kansas City, Missouri 64198:

1. *First Golden Bancorporation*, Golden, Colorado; to acquire 100 percent

of the voting shares of First Interstate Bank of Arvada, N.A., Arvada, Colorado and First Interstate Bank of Westminster, N.A., Broomfield, Colorado. Comments on this application must be received not later than September 26, 1983.

Board of Governors of the Federal Reserve System, August 26, 1983.

James McAfee,

Associate Secretary of the Board.

[FR Doc. 83-23907 Filed 8-31-83; 8:45 am]

BILLING CODE 6210-01-M

Formation of Bank Holding Companies; Farmers National Bancorp of Cynthiana, Inc., et. al.

The companies listed in this notice have applied for the Board's approval under section 3(a)(1) of the Bank Holding Company Act (12 U.S.C. 1842 (a)(1)) to become bank holding companies by acquiring voting shares or assets of a bank. The factors that are considered in acting on the applications are set forth in section 3(c) of the Act (12 U.S.C. 1842 (c)).

Each application may be inspected at the offices of the Board of Governors, or at the Federal Reserve Bank indicated for that application. With respect to each application, interested persons may express their views in writing to the address indicated for that application. Any comment on an application that requests a hearing must include a statement of why a written presentation would not suffice in lieu of a hearing, identifying specifically any questions of fact that are in dispute and summarizing the evidence that would be presented at a hearing.

A. **Federal Reserve Bank of Cleveland** (Lee S. Adams, Vice President) 1455 East Sixth Street, Cleveland, Ohio 44101:

1. *Farmers National Bancorp of Cynthiana, Inc.*, Cynthiana, Kentucky; to become a bank holding company by acquiring at least 84 percent of the voting shares of Farmers National Bank of Cynthiana, Cynthiana, Kentucky. Comments on this application must be received not later than September 26, 1983.

B. **Federal Reserve Bank of Atlanta** (Robert E. Heck, Vice President) 104 Marietta Sreet, N.W., Atlanta, Georgia 30303:

1. *Community Banking Corporation*, Bradenton, Florida; to become a bank holding company by acquiring 100 percent of the voting shares of Community Bank of Manatee, Bradenton, Florida. Comments on this application must be received not later than September 26, 1983.

2. *Florida Community Banks, Inc.*, Bonifay, Florida; to become a bank holding company by acquiring 97.8 percent of the voting shares of First Bank of Holmes County, Bonifay, Florida. Comments on this application must be received not later than September 26, 1983.

3. *FN BanCorp, Inc.*, Tullahoma, Tennessee; to become a bank holding company by acquiring 100 percent of the voting shares of First American National Bank of Tullahoma, Tullahoma, Tennessee. Comments on this application must be received not later than September 26, 1983.

C. **Federal Reserve Bank of Minneapolis** (Bruce J. Hedblom, Vice President) 250 Marquette Avenue, Minneapolis, Minnesota 55480:

1. *Kittson Investment Company*, Grygla, Minnesota; to become a bank holding company by acquiring 99.2 percent of the voting shares of American State Bank of Grygla, Grygla, Minnesota. Comments on this application must be received not later than September 26, 1983.

D. **Federal Reserve Bank of Kansas City** (Thomas M. Hoenig, Vice President) 925 Grand Avenue, Kansas City, Missouri 64198:

1. *American Exchange Bancorp, Inc.*, Norman, Oklahoma; to become a bank holding company by acquiring at least 80 percent of the voting shares of American Exchange Bank & Trust Company, Norman, Oklahoma. Comments on this application must be received not later than September 26, 1983.

Board of Governors of the Federal Reserve System, August 26, 1983.

James McAfee,

Associate Secretary of the Board.

[FR Doc. 83-23906 Filed 8-31-83; 8:45 am]

BILLING CODE 6210-011-M

Proposed Acquisition of Walter E. Heller & Co.; The Fuji Bank, Limited

The Fuji Bank, Limited, Tokyo, Japan, has applied, pursuant to section 4(c)(8) of the Bank Holding Company Act (12 U.S.C. 1843(c)(8)) and 225.4(b)(2) of the Board's Regulation Y (12 CFR 225.4(b)(2)), for permission to acquire all of the voting shares of Walter E. Heller & Company, Chicago, Illinois.

Applicant proposes to engage, through Walter E. Heller & Company, in all of the activities in which Walter E. Heller & Company is currently authorized to engage, including commercial finance and servicing, factoring, real estate lending and servicing, construction finance, real estate appraisal and investment advisory services, leasing activities, and the sale of credit-related life, accident and health, and property and casualty insurance related to extensions of credit. Applicant contends that the insurance activities are permissible under section 4(c)(8) (A) and (D) of the Bank Holding Company Act as amended by the Garn-St Germain Act. Applicant has also proposed to engage *de novo* in arranging for income-producing properties. Although arranging equity financing has not been added to the list of permissible activities specified by the Board in Section 225.4(a) of Regulation Y, the Board has determined by order that this activity is closely related to banking. *E.g., Trust Company of Georgia*, 69 *Federal Reserve Bulletin* 225 (1983). The insurance activities will be conducted primarily from offices in Chicago, Illinois and in Puerto Rico and will serve Puerto Rico. The other activities will be conducted from a total of 67 offices throughout the United States, serving the entire United States.

Interested persons may express their views on the question whether consummation of the proposal can "reasonably be expected to produce benefits to the public, such as greater convenience, increased competition, or gains in efficiency, that outweigh possible adverse effects, such as undue concentration of resources, decreased or unfair competition, conflicts of interests, or unsound banking practices." Any request for a hearing on this question must be accompanied by a statement of the reasons a written presentation would not suffice in lieu of a hearing, identifying specifically any questions of fact that are in dispute, summarizing the evidence that would be presented at a hearing, and indicating how the party commenting would be aggrieved by approval of the proposal.

The application may be inspected at the offices of the Board of Governors or the Federal Reserve Bank of New York.

Any views or requests for hearing should be submitted in writing and received by William W. Wiles, Secretary, Board of Governors of the Federal Reserve System, Washington, D.C., not later than September 26, 1983.

Board of Governors of the Federal Reserve System, August 26, 1983.

James McAfee,

Associate Secretary of the Board.

[FR Doc. 83-23908 Filed 8-31-83; 8:45 am]

BILLING CODE 6210-01-M

Proposed Acquisition of Bankers Leasing Services, Inc., Union Bancorp, Inc.

Union Bancorp, Inc., Grand Rapids, Michigan, has applied, pursuant to section 4(c)(8) of the Bank Holding Company Act (12 U.S.C. 1843(c)(8)) and

§ 225.4(b)(2) of the Board's Regulation Y (12 CFR 225.4(b)(2)), for permission to acquire voting shares of Bankers Leasing Services, Inc., Southfield, Michigan.

Applicant states that the proposed subsidiary would engage in the activity of leasing various types of furniture and equipment. These activities would be performed from offices of Applicant's proposed subsidiary in Southfield, Michigan, and the geographic area to be served is the entire United States. Such activities have been specified by the Board in § 225.4(a) of Regulation Y as permissible for bank holding companies, subject to Board approval of individual proposals in accordance with the procedures of § 225.4(b).

Interested persons may express their views on the question whether consummation of the proposal can "reasonably be expected to produce benefits to the public, such as greater convenience, increased competition, or gains in efficiency, that outweigh possible adverse effects, such as undue concentration of resources, decreased or unfair competition, conflicts of interests, or unsound banking practices." Any request for a hearing on this question must be accompanied by a statement of the reasons a written presentation would not suffice in lieu of a hearing, identifying specifically any questions of fact that are in dispute, summarizing the evidence that would be presented at a hearing, and indicating how the party commenting would be aggrieved by approval of the proposal.

The application may be inspected at the offices of the Board of Governors or at the Federal Reserve Bank of Chicago.

Any person wishing to comment on the application should submit views in writing to the Reserve Bank to be received not later than September 26, 1983.

Board of Governors of the Federal Reserve System, August 26, 1983.

James McAfee,

Associate Secretary of the Board.

[FR Doc. 83-23369 Filed 8-31-83; 8:45 am]

BILLING CODE 6210-01-M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. 83F-0254]

Schenectady Chemicals, Inc.; Filing of Food Additive Petition

AGENCY: Food and Drug Administration.

ACTION: Notice.

SUMMARY: The Food and Drug Administration (FDA) is announcing that Schenectady Chemicals, Inc., has filed a petition proposing that the food additive regulations be amended to provide for the safe use of 2,6-bis(1,1-dimethylethyl)-4-(1-methylpropyl) phenol, as an antioxidant and/or stabilizer for adhesives used in food-contact articles.

FOR FURTHER INFORMATION CONTACT: Anthony P. Brunetti, Bureau of Foods (HFF-334), Food and Drug Administration, 200 C St. SW., Washington, D.C. 20204; 202-472-5690.

SUPPLEMENTARY INFORMATION: Under the Federal Food, Drug, and Cosmetic Act (sec. 409(b)(5), 72 Stat. 1786 (1 U.S.C. 348(b)(5))), notice is given that a petition (FAP 3B3734) has been filed by Schenectady Chemicals, Inc., 2750 Balltown Rd., Schenectady, NY 12309, proposing that § 175.105 *Adhesives* (21 CFR 175.105) be amended to provide for the safe use of 2,6-bis(1,1-dimethylethyl)-4-(1-methylpropyl) phenol, as an antioxidant and/or stabilizer in adhesives used in food-contact articles.

The potential environmental impact of this action is being reviewed. If the agency finds that an environmental impact statement is not required and this petition results in a regulation, the notice of availability of the agency's finding of no significant impact and the evidence supporting that finding will be published with the regulation in the **Federal Register** in accordance with 21 CFR 25.40(c) (proposed December 11, 1979; 44 FR 71742).

Dated: August 24, 1983.

Sanford A. Miller,

Director, Bureau of Foods.

[FR Doc. 83-23972 Filed 8-31-83; 8:45 am]

BILLING CODE 4160-01-M

Health Resources and Services Administration

Application Announcement and Final Funding Preferences for the Health Careers Opportunity Program (HCOP)

The Bureau of Health Professions, Health Resources and Services Administration, announces that applications for Fiscal Year 1984 Health Careers Opportunity Program (HCOP) grants are now being accepted under the authority of section 787 of the Public Health Act.

Section 787 authorizes the Secretary to make grants to schools of medicine, osteopathy, public health, dentistry, veterinary medicine, optometry, pharmacy, podiatry and allied health and other public or private non-profit health or educational entities to carry out programs which assist individuals from disadvantaged backgrounds to enter and graduate from health professions schools. The assistance authorized by this section includes: identification and recruitment, retention, counseling and advice on financial aid.

Based on the President's budget request and projected commitments for currently active projects requiring continued support, an estimated $16 million will be available for competitive HCOP awards in Fiscal Year 1984. This amount may be changed by final action on the Fiscal Year 1984 appropriation.

At least 80 percent of the funds appropriated in any fiscal year must be obligated for grants or contracts to institutions of higher education. Also, no more than five percent of the funds appropriated in any fiscal year can be awarded to projects having information dissemination as their primary purpose.

To receive support, applicants must meet the requirements of the program regulations which are located at Title 42 of the Code of Federal Regulations, Part 57, Subpart S.

Requests for grant application materials and questions regarding grants policy should be directed to: Grants Management Officer (D18), Bureau of Health Professions, Health Resources and Services Administration, Parklawn Building, Room 8C-22, 5600 Fishers Lane, Rockville, Maryland 20857, Telephone: (301) 443-6857

For specific information regarding the programmatic aspects of this program, direct inquires to: Mr. Arthur Testoff, Chief, Program Coordination Branch, Division of Disadvantaged Assistance, Bureau of Health Professions, Health Resources and Services Administration, Parklawn Building, Room 8A-09, 5600 Fishers Lane, Rockville, Maryland 20857, Telephone: (301) 443-4493.

To be considered for Fiscal Year 1984 funding, applications sent by mail must be postmarked no later than November 4, 1983, and received no later than November 14, 1983. Materials postmarked after November 4 will not be included in the review process. The term "postmark" means a printed, stamped, or otherwise placed impression exclusive of a postage meter machine impression, that is readily identifiable as having been affixed on the date of mailing by an employee of the U.S. Postal Service. All hand delivered applications must be received by November 4.

This program is listed at 13.822 in the Catalog of Federal Domestic Assistance. It is not subject to the provisions of Exective Order 12372, Intergovernmental

Review of Federal Programs or 45 CFR, Part 100.

Fiscal Year 1984 Funding Preferences for the Health Careers Opportunity Program (HCOP)

The Division of Disadvantaged Assistance announces the final funding preferences which will govern the distribution of grant awards to approved HCOP grant applications for Fiscal Year 1984.

These preferences were published for public comment in the **Federal Register** of May 26, 1983 (48 FR 23711), and 17 comments were received during the 30 day comment period. These comments and their responses are discussed below:

Definitions

Feeder Institution: Eight respondents objected to the definition of Fedder Institution, which requires a school to:

(a) Have a student body more than 20 percent of which are individuals from disadvantaged backgrounds; and

(b) Have 10 or more graduates annually (as averaged over the last three years) who are disadvantaged and who are accepted into health professions schools.

Generally, these respondents expressed concern that the definition was too stringent and that few institutions could meet both of the proposed requirements. One respondent proposed that Feeder Institution be defined solely as junior or four-year colleges with student bodies comprised of 30 percent or more of individuals from disadvantaged backgrounds.

The concept of "fedder institution" is introduced in these funding preferences because experience has shown that many undergraduate institutions are relatively unsuccessful in getting their students into health professions schools. This lack of success may be caused by: inadequate identification of promising students; poor counseling; deficiencies in the curriculum; or weak linkages with health professions schools. The Department must use its limited funds to support those institutions with demonstrated capability. Therefore, the Department has not modified the requirements of this definition.

However, the Department has eased the difficulty of meeting the requirement of Fedder Institution for purposes of the first funding preference. This preference has been modified to change the requirement of having an Educational Assistance Agreement (EAA) with *one or more feeder institutions*, to having an EAA with one to five schools which *separately or collectively* satisfy the definition of a feeder institution.

As a result a greater number of health professions schools and undergraduate institutions will be able to participate in the development of educational pathways providing continuity of support to students, and at the same time the focus of providing support to undergraduate institutions with a demonstrated capability of developing applicant pools will not be lost.

Training Center For Allied Health: One respondent proposed expanding the list of the training programs provided by a training center for allied health to include training needed to practice as a nutritionist with a Bachelor's Degree.

The Department wishes to retain the definition of training center for allied health as it is for consistency with the definition used in the regulations for grants for allied health projects at 42 CFR 58.401 *et seq.* It should be noted, however, that a training center for allied health is not precluded from providing training for a Bachelor's Degree in nutrition, in addition to the listed programs.

Individual from a disadvantaged background: One respondent objected to parental income being used as a determinent for being economically disadvantaged.

The Department points out that the purpose of HCOP programs is to assist persons from disadvantaged *backgrounds*, as opposed to individuals who are, by themselves, in need of financial assistance. This definition, therefore, has not been revised.

General Comments: Seven respondents expressed concern that community organizations and professional associations wee not given funding preferences, and suggested adding an additional preference. In addition, they expessed concern that participation of certain disadvantaged students in some geographical areas of the country would be excluded.

The Department did not include community organizations and professional associations in the funding preferences for reasons, as explained below, which it believes are important to the development of the HCOP grant program; therefore, the preferences have not been expanded. The Department has established the preferences in accordance with the Congressional emphasis in supporting institutions of higher education, as expressed by section 787(b) of the Public Health Service Act which directs no less than eighty percent of the funds appropriated for HCOP grants to be awarded to institutions of higher education. The funding preferences do not include participation of community organizations and professional associations; however all eligible entities are invited to submit applications and will be funded as the quality of applications and appropriations permit.

Secondly, the Department wishes to encourage institutions to enter into Educational Assistance Agreements (EAA's) that will identify and support promising disadvantaged students along an educational pathway to successful completion of their preparation for a professional health career. The EAA's result in the establishment of inter-institutional communications to strengthen academic programs and improve the admissions process, and the retention of matriculated students to successful completion of the health professions education.

One respondent expressed concern that the preferences did not address the need for direct student financial assistance. The Department cannot provide for such assistance, since the authorizing legislation does not provide for direct student financial aid.

The intent of the authorizing legislation is to increase the number of disadvantaged persons admitted to and graduated from health professions shools and as such, those states that do not have health profession schools must continue to rely on schools in other states to provide health professions training to their eligible students.

The definitions used in the funding preferences are as follows:

"Health Professions Schools" means schools of medicine, dentistry, osteopathy, pharmacy, optometry, veterinary medicine, podiatry, public health, or graduate programs in health administration, as defined in Section 701(4) of the Public Health Service Act.

"Training Center for Allied Health Professions" means a junior college, or college, or university, as defined in Section 795 of the Public Health Service Act which:

a. Provides educational programs leading to an associate, baccalaureate, or higher degree needed to practice as one of the following:

Doctoral Degree:
- Clinical Psychologist

Master's Degree:
- Speech Pathologist/Audiologist

Associate Degree:
- Clinical Dietetic Technician
- Cytotechnologist
- Dental Assistant

Bachelor's Degree:
- Dental Hygienist
- Dietitian (Coordinated undergraduate program)
- Community Health Educator
- Health Services Administrator

Medical Records Administrator
Medical Technologist
Occupational Therapist
Physical Therapist
Primary Care Physician Assistant
Sanitarian (Environmental Health)
Dental Hygienist
Dental Laboratory Technician
Medical Assistant
Medical Laboratory Technician
Medical Records Technician
Occupational Therapy Assistant
Ophthalmic Medical Assistant
Optometric Technician
Physical Therapy Assistant
Radiologic Technologist
Respiratory Therapist
Sanitarian Technician

b. Provides training for no fewer than 20 persons in the substantive health portion, including clinical experience as required for employment, in three or more of the disciplines listed in paragraph (a) of this definition and has a minimum of six full-time students in that portion of each curriculum by October 15 of the fiscal year of application.

c. Has a teaching hospital as part of the grantee institution or is affiliated with a teaching hospital by means of a formal written agreement. The term "teaching hospital" includes other settings which provide clinical or other health services if they fulfill the requirement for clinical experience specified in an allied health curriculum.

"Feeder institution" means an institution of higher education meeting the requirements of Section 435 of the Higher Education Act, as amended, P.L. 89-239 (20 U.S.C. 1085(b)), which:

a. Has a student body more than 20 percent of which are individuals from disadvantaged backgrounds; and

b. Has 10 or more graduates annually (as averaged over the last three years) who are disadvantaged and who are accepted into health professions schools.

"Educational Assistance Agreement (EAA)" means a formal agreement between the grantee and another school or entity to assure continuity of training through health or allied health professions schools. This agreement must provide for financial or other support (excluding direct student aid) for this purpose and support may include funds from the grant awarded under this program, also joint use of facility, staff, and faculties. An EAA must:

a. Contain the names of the participating institutions;

b. Identify the prime grantee, subcontractors, and other participating institutions;

C. State the HCOP purposes addressed by each participating institution;

d. Identify the specific activities to be performed by the grantee, including a description of program activities and administrative responsibilities;

e. Identify the specific activities to be performed by all collaborating institutions, including a description of program activities;

f. Contain a detailed description of proposed expenditures for each participating institution;

g. Contain a description of how facilities, faculty, and staff will be shared, including times, places, and dates;

h. State the duration of the EAA;

i. Contain the terms for amending the EAA; and

j. Be signed by the President, Chancellor, Dean, or equivalent official from all participating institutions and health or educational entities.

For this program, an "individual from a disadvantaged background" means an individual who (a) comes from an environment that has inhibited the individual from obtaining the knowledge, skill and abilities required to enroll in and graduate from a health professions school or from a program providing education or training in an allied health profession or (b) comes from a family with an annual income below a level based on low income thresholds according to family size, published by the U.S. Bureau of the Census, adjusted annually for changes in the Consumer Price Index and adjusted by the Secretary for use in all health professions programs, 42 CFR 57.1804(b)(2).

The following income figures determine what constitutes a low income family for purposes of these Health Careers Opportunity Program grants for Fiscal Year 1984:

Size of parents' family [1]	Income level [2]
1	6,500
2	8,400
3	10,000
4	12,600
5	15,100
6 or more	17,100

[1] Includes only dependents listed on Federal income tax forms.
[2] Adjusted gross income for calendar year 1982, rounded to $100.

The funding preferences are final as follows:

Funding Preferences

An applicant may request consideration in one of the following five funding preferences:

(1) Health professions school(s) which have Education Assistance Agreement (EAA) with no more than five undergraduate institutions that separately or collectively satisfy the definition of a feeder institution and who are requesting HCOP support only for:

a. The feeder institution(s) or equivalent to provide individuals from disadvantaged backgrounds with preliminary education; and

b. Either the health professions school or the feeder institution to facilitate the entry of individuals from disadvantaged backgrounds into health professions schools; and

c. The health professions school(s) to provide individuals from disadvantaged backgrounds who are enrolled in their institution(s) with counseling or other retention services.

(2) A feeder institution requesting HCOP support only for:

a. Providing individuals from disadvantaged backgrounds with preliminary education; and

b. Facilitating the entry of individuals from disadvantaged backgrounds into health professions schools.

(3) A health professions school requesting HCOP support only for:

a. Facilitating the entry of individuals from disadvantaged backgrounds into its health professions school; and

b. Providing the students who are individuals from disadvantaged backgrounds with counseling or other retention services.

(4) A joint application from two to five institutions of higher education, which, as a group: (1) Has a student body more than 20 percent of which are individuals from disadvantaged backgrounds; (2) has 20 or more graduates annually (as averaged over the last three years) who are disadvantaged individuals and who are accepted into health professions schools; and (3) is requesting HCOP support only for:

a. Providing individuals from disadvantaged backgrounds with preliminary education; and

b. Facilitating the entry of individuals from disadvantaged backgrounds into health professions schools.

(5) A training center for allied health professions requesting HCOP support only for:

a. Facilitating the entry of individuals from disadvantaged backgrounds into allied health training centers; and

b. Providing its students who are individuals from disadvantaged backgrounds with counseling or other retention services.

Greatest weight will be given to applicants in funding preference Number 1, decreasing, respectively, to funding preference Number 5.

The five preferences, however, do not preclude funding of other eligible approved applications as appropriations permit. Therefore, entities which do not qualify for the preferences are also invited to submit applications.

The applicant must indicate on the upper right-hand corner of page one of the application the funding preference in which the applicant wishes consideration. However, the final determination of the category of funding preference will be based on a staff assessment of the contents of the proposal. An applicant may apply for consideration under only one preference. A feeder institution which is identified in an EAA may not apply as a primary grantee to support the same type of HCOP activities.

[FR Doc. 83-24065 Filed 8-31-83; 8:45 am]

BILLING CODE 4160-16-M

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

[CA 13093]

Conveyance of Public Land; Humboldt County, California

August 23, 1983.

Under the exchange provisions of the Act of October 21, 1970 (16 U.S.C. 460y), which provides for the establishment of the King Range National Conservation Area, a Patent has been issued to Jay Sooter, c/o Humboldt Land Title Company, Post Office Box 102, Eureka, California 95501, for the following described public lands:

Humboldt Meridian, California

T. 5 S., R. 2 E.,
Sec. 19, Lot 35.
Containing 0.16 acre.

Under this exchange, the Federal Government acquired title to 0.16 acre of equal value private land located in the same county and described as follows:

Humboldt Meridian, California

T. 5 S., R. 2 E.,
Sec. 19, Parcel A of the NE¼SE¼.

Eleanor Wilkinson,

Chief, Land and Locatable Minerals Section, Branch of Lands and Minerals Operations.

[FR Doc. 83-23961 Filed 8-31-83; 8:45 am]

BILLING CODE 4310-84-M

[C-0124534]

Colorado; Proposed Withdrawal and Reservation of Public Minerals; Pinon Canyon Site, Fort Carson Military Reservation

August 23, 1983.

The United States Army Corps of Engineers has filed application to withdraw these Federally owned minerals which are under the jurisdiction of the Secretary of the Interior, and lie within the boundries of the Fort Carson Military Reservation, Pinon Canyon Site, as authorized by 10 U.S.C. 2231 et seq. These areas are more particularly described as follows:

References to the rim of Purgatorie River Canyon mean the boundry of the Pinion Canyon Site as defined by metes and bounds along the northwesterly or left rim of the canyon, facing downstream.

Sixth Principal Meridian

T.28 S., R. 55 W.,
Sec. 4, those portions of Lots 2, 3, 4, and SW¼NW¼, northwesterly of the rim;
Secs. 5 and 6;
Sec. 7, lots 1 and 2.
T. 28 S., R. 56 W.,
Secs. 1 through 12;
Sec. 13, NE¼NW¼;
Sec. 14, those portions of the SE¼SE¼, northwesterly of the rim;
Secs. 21 and 22;
Sec. 23, W½, and those portions of the W½NE¼ and SW¼SE¼, northwesterly of the rim;
Sec. 26, NW¼NW¼;
Secs. 27, 28, 29, 31, and 32.
T.29 S., R. 56 W.,
Sec. 4, lots 3 and 4 and those portions of the S½NW¼ northwesterly of the rim;
Sec. 5, lots 3 and 4;
Sec. 6;
Sec. 7, lots 1, 2, 3, 4, E½NW¼, and NW¼NE¼, and those portions of the S½NE¼, SE¼SW¼, and W½SE¼ westerly of the rim;
Sec. 19, lot 1, that portion westerly of the rim.
T. 28 S., R. 57 W.,
Secs. 1 through 15;
Sec. 18,
Secs. 22 through 34.
T. 29 S., R 57 W.,
Secs. 2, 3, 5, 15;
Secs. 17 through 23;
Sec. N½NE¼, S½N½, N½S½ and S½SW¼, and that portion of S¼SE¼ northerly of the rim;
Sec. 25, those portions of the NW¼NE¼, N½NW¼, and SW¼NW¼ northwesterly of the rim;
Sec. 26, N½, and SW¼, and that portion of the SE¼ northwesterly of the rim;
Sec., 27 through 34;
Sec. 35, those portions of the NW¼ and S½SW¼ northwesterly of the rim;
T. 30 S., R. 57 W.,
Secs. 3 through 9;
Sec. 17, those portions of N½ and S½ lying northerly of rim;
Sec. 18;
Sec. 19, lots 2, 3, and SE¼NW¼, and those portions of NE¼SW¼ and NW¼SE¼ northwesterly of rim;
Sec. 30, lot 1 and those portions of Lot 2 and E½NW¼ northwesterly of rim.
T. 28 S., R. 58 W.,
Secs. 11, 12, 13, and 14;
Sec. 20 through 35.
T. 29 S., R. 58 W.,
Secs. 1 through 15;
Secs. 17 through 35.
T. 30 S., R. 58.,
Secs. 2 through 15;
Secs. 17 through 24;
T. 30 S., R. 58.,
Secs. 2 through 15;
Secs. 17 through 24;
Secs. 25, NE¼NE¼, NW¼NW¼, S½NW¼, SW¼, and those portions of S½NE¼ and W½SE¼ westerly of rim;
Secs. 26 through 30;
Secs. 32 through 34;
Sec. 35, N½ and SW¼, and those portions of NW¼SE¼ northwesterly of rim.
T. 31 S., R. 58 W.,
Sec. 2, SE¼NW¼, SW¼, and those portions of SW¼NE¼ and W½SE¼ westerly of rim;
Secs. 3, 4, 5, 6, 7, and 8;
Sec. 9, N½NE¼, SE¼NE¼, and E½NW¼;
Sec. 10, NE¼NE¼, and those portions of E½E½, SW¼NE¼ and NW¼SE¼ northeasterly and northwesterly from rim;
Sec. 11, those portions of NW¼NE¼ and NE¼NW¼ northerly of rim.
T. 28 S., R. 59 W.,
Sec. 24, E½, E½NW¼, and SW¼;
Sec. 25.
T. 29 S., R. 59 W.,
Secs. 1 through 5;
Secs. 7 through 15;
Secs. 17 through 35.
T. 30 S., R. 59 W.,
Secs. 1 through 15;
Secs. 18 through 21;
Secs. 23 through 32;
Secs. 34 and 35.
T. 31 S., R. 59 W.,
Secs. 1 through 6,
Sec. 7, E½NE¼, NW¼NE¼, NW¼, and those portions of Lots 1 and 2, SW¼NE¼, SE¼NW¼, and W½SE¼ lying northeasterly of a line 10 feet northerly of and parallel to the centerline of Las Animas County road No. 54;
Sec. 8, E½NE¼, SW¼NE¼, and N½S½, and those portions of S½SW¼ and SW¼SE¼ lying northerly of a line 10 feet northerly of and parallel to the centerline of Las Animas County Road No. 54;
Secs. 9 through 12;
Sec. 14, N½NW¼, and SW¼NW¼;
Sec. 15, N½N½, and SW¼NE¼;
Sec. 17, those portions of the NW¼NE¼ lying northeasterly of a line 10 feet northerly of and parallel to the centerline of Las Animas County Road No. 54.
T. 29 S., R. 60 W.,
Sec. 9, SE¼SE¼, and those portions of SE¼NE¼ and NE¼SE¼ lying southeasterly of the southeasterly right-of-way line of U.S. Highway 350;
Secs., 10 through 15;

Sec. 17, that portion of the S½SE¼ lying southeasterly of the southeasterly right-of-way line for U.S. Highway 350;
Secs. 21 through 26;
Secs. 33, 34, and 35.
T. 30 S., R. 60 W.,
Secs. 1, 2, and 3;
Secs. 10 through 15;
Secs. 19 through 28;
Secs. 33, through 35.
T. 31 S., R. 60 W.,
Sec. 1, those portions of the S½ lying northeasterly of a line 10 feet northerly of and parallel to the centerline of Las Animas County Road No. 54;
Sec. 2; those portions of the S½NW¼, NE¼SW¼, and NE¼SE¼ lying northeasterly of a line 10 feet northerly of and parallel to the centerline of Las Animas County Road No. 54;
Sec. 3, lot 2, and those portions of the S½NE¼ lying northeasterly of a line 10 feet northerly of and parallel to the centerline of Las Animas County Road No. 54.

The areas described aggregate approximately 130.139 acres in Las Animas County, Colorado. These lands are intermingled with lands in which the Corps of Engineers has acquired the entire estate, this entire area being within the boundaries of the Fort Carson Military Reservation.

The Department of the Army requests that exploration for, and disposition of, these Federally owned minerals shall only be made when the Secretary of Defense, after consultation with the Secretary of the Interior, determines that such exploration or disposition is consistent with the mission of the Fort Carson Military Reservation.

Effective on the date of publication of this notice, the Federal minerals contained in the lands described by this order shall be segregated from operation of the U.S. mining laws to prevent any form of disposal or appropriation under such laws. This segregation shall continue until May 25, 1985, unless terminated sooner by administrative action and publication in the **Federal Register**. Administrative jurisdiction over these minerals will not be affected by this temporary segregation.

Department of the Interior regulations provide that an authorized officer of the Bureau of Land Management undertake the necessary investigations to determine the existing and potential demands for the mineral resources in this area. The Bureau will also determine that the area requested is the absolute minimum essential to meet the needs of the applicant agency and reach an agreement on management of these resources. If this application is approved, the withdrawal will be made for a minimum of 20 years.

This withdrawal will be authorized under the Act of February 28, 1958 (43 U.S.C. 155–158), and requires legislative action by Congress.

Pursuant to section 204(h) of the Federal Land Policy and Management Act of 1976, notice is hereby given that an opportunity for a public hearing is afforded in connection with the proposed withdrawal. Any persons who desire to be heard on the proposed withdrawal must submit a written request for a hearing to the State Director, at the address shown below, within 90 days of publication date. If a hearing is scheduled, notice of public hearing will be published in the Federal Register giving the time and place of such hearing. The hearing will be scheduled and conducted in accordance with BLM Manual, Section 2351.16B.

All communications in connection with this proposed withdrawal should be addressed to State Director, Colorado State Office, Bureau of Land Management, 1037—20th Street, Denver, Colorado 80202.

Robert D. Dinsmore,
Chief Branch of Lands and Minerals Operations.

[FR Doc. 83-23963 Filed 8-31-83; 8:45 am]
BILLING CODE 4310-84-M

Sale of Public Lands in Powell County, Montana

This Notice modifies the original Notice of Realty Action for M57661, M57662, published on June 23, 1983 (48 FR 28740). No bids were received before or on the sale date and the tract will now be offered on a continuing basis during regular office hours until December 8, 1983. The tract will be sold on a first-come, first-served basis. Buyers must comply with the requirements of the original Notice. Minimum acceptable price is $6,000 for Tract A and $30,000 for Tract B. Bids will be accepted by mail or in person at the Butte District Office, P.O. Box 3388, Butte, Montana 59702.

Dated: August 23, 1983.

Jack A. McIntosh,
District Manager.

[FR Doc. 83-23956 Filed 8-31-83; 8:45 am]
BILLING CODE 4310-84-M

[AA-37846]

Alaska Native Claims Selection; Cook Inlet Region, Inc.

In accordance with departmental regulation 43 CFR 2650.7(d), notice is hereby given that a decision to issue conveyance under the provisions of Sec. 14 of the Alaska Native Claims Settlement Act of December 18, 1971 (43 U.S.C. 1601, 1611 (1976) (ANCSA)), issued to Cook Inlet Region, Inc. June 30, 1982 is hereby amended to include all lands extending Seward to the line of mean high tide. The lands involved are within the Seward Meridian, Alaska:

T. 4 S., R. 22 W.
T. 6 S., R. 24 W.
T. 6 S., R. 25 W.

This amendment does not change the original approximation of acres to be charged contained in the decision of June 30, 1982. If any additional acreage is to be charged, it will be determined at the time of survey.

Except as amended by this decision, the decision of June 30, 1982, stands as written.

The amended decision to issue conveyance will be published once a week, for four (4) consecutive weeks, in the ANCHORAGE TIMES upon issuance of the decision. For information on how to obtain copies, contact Bureau of Land Management, Alaska State Office, 701 C Street, Box 13, Anchorage, Akaska 99513.

Any party claiming a property interest in lands affected by this decision an agency of the Federal Government, or regional corporation may appeal the decision to the Interior Board of Land Appeals, Office of Hearings and Appeals, in accordance with the regulations in Title 43 Code of Federal Regulations (CFR), Part 4, Subpart E, as revised.

If as appeal is taken, the notice of appeal must be filed in the Bureau of Land Management, Alaska State Office, Division of ANCSA and State Conveyances (960), 701 C Street, Box 13, Anchorage, Alaska 99513. Do not send the appeal directly to the Interior Board of Land Appeals. The appeal and copies of pertinent case files will be sent to the Board from this office. A copy of the appeal must be served upon the Regional Solicitor, 701 C Street, Box 34, Anchorage, Alaska 99513.

The time limits for filing an appeal are:

1. Parties receiving service of the decision by personal service or certified mail, return receipt requested, shall have thirty days from the receipt of the decision to file an appeal.

2. Unknown parties, parties unable to be located after reasonable efforts have been expended to locate, parties who failed or refused to sign their return receipt, and parties who received a copy of the decision by regular mail which is not certified, return receipt requested, shall have until October 3, 1983 to file an appeal.

Any party known or unknown who is adversely affected by the decision shall

be deemed to have waived those rights which were adversely affected unless an appeal is timely filed with the Bureau of Land Management, Alaska State Office, Division of ANCSA and State Conveyances.

To avoid summary dismissal of the appeal, there must be strict compliance with the regulations governing such appeal. Further information on the manner of and requirements for filing an appeal may be obtained from the Bureau of Land Management, Alaska State Office, 701 C Street, Box 13, Anchorage, Alaska 99513.

If an appeal is taken, the parties to be served with a copy of the notice of appeal are:

Cook Inlet Region, Inc., P.O. Drawer 4–N, Anchorage, Alaska 99509
Ninilchik Native Association, Inc., P.O. Box 173, Ninilchik, Alaska 99639
Salamatof Native Association, Inc., P.O. Box 2682, Kenai, Alaska 99611
Seldovia Native Association, Inc., P.O. Box 185, Seldovia, Alaska 99663
Tyonek Native Corporation, 445 East Fifth Avenue, Suite 9, Anchorage, Alaska 99501
Knikatu, Inc., P.O. Box 2130, Wasilla, Alaska 99687
Alexander Creek, Inc., 8126 Tri-Lake Road, Anchorage, Alaska 99502
Chickaloon Moose Creek Native Associaiton, Inc., 2600 Fairbanks Street, Anchorage, Alaska 99501
State of Alaska, Land Exchange & Entitlement Unit, Land Management Section, Division of Land & Water Management, Alaska Department of Natural Resources, Pouch 7–005, Anchorage, Alaska 99510.

Doris Diakakis,

Section Chief, Branch of ANCSA Adjudication.

[FR Doc. 83–24019 Filed 8–31–83; 8:45 am]

BILLING CODE 4310–84–M

[F–70029]

Alaska Native Claims Selection; Cook Inlet Region, Inc.

In accordance with departmental regulation 43 CFR 2650.7(d), notice is hereby given that a decision to issue conveyance under the provisions of Secs. 12(b)(6) of the act of January 2, 1976 (89 Stat. 1151), and I.C. (2) of the Terms and Conditions for Land Consolidation and Management in the Cook Inlet Area, as clarified August 31, 1976 (90 Stat. 1835), will be issued to Cook Inlet Region, Inc. for approximately 1,597.50 acres. The lands involved are within T. 1 S., R. 2 E., Seward Meridian, Alaska.

The decision to issue conveyance will be published once a week, for four (4) consecutive weeks, in the FAIRBANKS DAILY NEWS-MINER upon issuance of the decision. For information on how to obtain copies, contact Bureau of Land Management, Alaska State Office, 701 C Street, Box 13, Anchorage, Alaska 99513.

Any party claiming a property interest in lands affected by this decision, an agency of the Federal Government, or regional corporation may appeal the decision to the Interior Board of Land Appeals, Office of Hearings and Appeals, in accordance with the regulations in Title 43 Code of Federal Regulations (CFR), Part 4, Subpart E, as revised.

If an appeal is taken, the notice of appeal must be filed in the Bureau of Land Management, Alaska State Office, Division of Conveyance Management (960), 701 C Street, Box 13, Anchorage, Alaska 99513. Do not send the appeal directly to the Interior Board of Land Appeals. The appeal and copies of pertinent case files will be sent to the Board from this office. A copy of the appeal must be served upon the Regional Solicitor, 710 C Street, Box 34, Anchorage, Alaska 99513.

The time limits for filing an appeal are:

1. Parties receiving service of the decision by personal service or certified mail, return receipt requested, shall have thirty days from the receipt of the decision to file an appeal.

2. Unknown parties, parties unable to be located after reasonable efforts have been expended to locate, parties who failed or refused to sign their return receipt, and parties who received a copy of the decision by regular mail which is not certified, return receipt requested, shall have until October 3, 1983 to file an appeal.

Any party known or unknown who is adversely affected by the decision shall be deemed to have waived those rights which were adversely affected unless an appeal is timely filed with the Bureau of Land Management, Alaska State Office, Division of Conveyance Management.

To avoid summary dismissal of the appeal, there must be strict compliance with the regulations governing such appeal. Further information on the manner of and requirements for filing an appeal may be obtained from the Bureau of Land Management, Alaska State Office, 701 C Street, Box 13, Anchorage, Alaska 99513.

If an appeal is taken, the parties to be served with a copy of the notice of appeal are: Cook Inlet Region, Inc., P.O. Drawer 4–N, Anchorage, Alaska 99509.

Doris Diakakis,

Acting Section Chief, Branch of ANCSA Adjudication.

[FR Doc. 83–24020 Filed 8–31–83; 8:45 am]

BILLING CODE 4310–84–M

[AA–8103–5]

Alaska Native Claims Selection; Doyon, Limited

On September 29, 1980, a Decision to Issue Conveyance (DIC) was issued to Doyon, Limited and published in the **Federal Register** (45 FR 64741–64742, September 30, 1980).

The DIC of September 29, 1980, included those water bodies determined to be navigable as recommended in the Alaska State Director (SD) BLM memorandum dated April 18, 1980, as amended by SD BLM memorandum dated August 29, 1980, concerning final easements and navigability determinations for certain lands in the vicinity of Anvik.

On May 3, 1983, a further amendment to the SD memorandum of April 18, 1980, was issued which contained an administrative redetermination of Paradise Creek, locally known as Lower Sandstrom Creek, in Sec. 36, T. 28 N., R. 60W., Seward Meridian, Alaska.

Paradise Creek is identified on the attached navigability map, the original of which will be found in easement case file AA–16630–5.

The DIC of September 29, 1980, approved for conveyance the surface and subsurface estates of the bed of Paradise Creek to Doyon, Limited. As Paradise Creek is now considered to be navigable, the submerged land beneath it is not public land and is not available for conveyance to the Native corporation under the Alaska Native Claims Settlement Act of December 18, 1971 (43 CFR 2650.0–5(g)).

Therefore, the DIC of September 29, 1980, is hereby modified to exclude the submerged lands beneath Paradise Creek from the approval for conveyance to Doyon, Limited. Approximately 23 acres will not be charged toward the regional corporation's entitlement.

In accordance with Departmental regulation 43 CFR 2650.7(d), notice of this decision is being published once in the **Federal Register** and once a week, for four (4) consecutive weeks, in the TUNDRA TIMES.

Except as modified by this decision, the decision of September 29, 1980, stands as written.

Ruth, Stockie,

Section Chief, Branch of ANCSA Adjudication.

[FR Doc. 83-24021 Filed 8-31-83; 8:45 am]

BILLING CODE 4310-84-M

Nominations; California Desert District Advisory Council

AGENCY: Bureau of Land Management, Interior.

ACTION: Call for Nominations for the California Desert District Advisory Council.

SUMMARY: The purpose of this notice is to solicit public nominations to fill five positions which will become vacant this year on the Bureau of Land Management's California Desert District Advisory Council.

The Council comprises 15 members. Under the staggered-term arrangement instituted by the Secretary of the Interior in 1981, the terms of five members on the Council will expire on December 31, 1983. Current council members may be reappointed or new members may be appointed. Appointments made by the Secretary pursuant to this call will assure continued representation of specific categories of interest on the Council. The new terms will expire December 31, 1986.

To ensure Council membership that is balanced in terms of categories of interest represented and functions performed, nominees must be qualified to provide advice in one of the following areas:

Non-Renewable Resources (mining, oil and gas, extractive industries)
Recreation
Public-at-Large.

The purpose of the Council is to provide informed advice to the California Desert District Manager on the management of the public lands within the California Desert District. Members will serve without salary, but will be reimbursed for travel and per diem expenses at current rates for Government employees.

The Council normally will meet at least twice annually. Additional meetings may be called by the District Manager or his designee in connection with special needs for advice.

Persons wishing to nominate individuals or to be nominated to serve on the Council should provide the District Manager with the names, addresses, professions, and other biographic data of qualified nominees.

DATE: All nominations should be received by October 1, 1983.

ADDRESS: The mailing address of the District Manager is as follows: California Desert District Manager, Bureau of Land Management, 1695 Spruce Street, Riverside, California 92507.

James M. Parker,

Acting Director.

Dated: August 25, 1983.

[FR Doc. 83-24029 Filed 8-31-83; 8:45 am]

BILLING CODE 4310-84-M

INTERSTATE COMMERCE COMMISSION

[Docket No. AB-6 (Sub-No. 160F)]

Rail Carriers; Burlington Northern Railroad Co.—Abandonment—in Stillwater and Yellowstone Counties, MT; Notice of Findings

The Commission has issued a certificate authorizing Burlington Northern Railroad Company to abandon its 38.16-mile rail line near Hesper at milepost 0.0 and the end of the line near Rapelje at milepost 38.16 in Stillwater and Yellowstone Counties, MT. The abandonment certificate will become effective 30 days after this publication unless the Commission also finds that: (1) A financially responsible person has offered financial assistance (through subsidy or purchase) to enable the rail service to be continued; and (2) it is likely that the assistance would fully compensate the railroad.

Any financial assistance offer must be filed with the Commission and the applicant no later than 10 days from publication of this Notice. The following notation shall be typed in bold face on the lower left-hand corner of the envelope containing the offer: "Rail Section, AB-OFA." Any offer previously made must be remade within this 10-day period.

Information and procedures regarding financial assistance for continued rail service are contained in 49 U.S.C. 10905 and 49 CFR 1152.27.

Agatha L. Mergenovich,

Secretary.

[FR Doc. 83-23998 Filed 8-31-83; 8:45 am]

BILLING CODE 7035-01-M

[AB 18 SDM et al.]

Rail Carriers; Chessie System Railroads; Amended System Diagram Map

Notice is hereby given that, pursuant to the requirements contained in Title 49 of the Code of Federal Regulations, Part 1121.23, that the Chessie System Railroads has filed with the Commission its amended color-coded system diagram map in docket No. AB 18 SDM et al. The Commission on August 24, 1983, received a certificate of publication as required by said regulation which is considered the effective date on which the system diagram map was filed.

Color-coded copies of the map have been served on the Governor of each state in which the railroad operates and the Public Service Commission or similar agency and the State designated agency. Copies of the map may also be requested from the railroad at nominal charge. The maps also may be examined at the office of the Commission, Section of Dockets, by requesting docket No. AB 18 SDM et al.

Agatha L. Mergenovich,

Secretary.

[FR Doc. 83-23997 Filed 8-31-83; 8:45 am]

BILLING CODE 7035-01-M

[AB 31 SDM]

Rail Carriers; Grand Trunk Western Railroad Co.; Amended System Diagram Map

Notice is hereby given that, pursuant to the requirements contained in Title 49 of the Code of Federal Regulations, Part 1121.23, that the Grand Trunk Western Railroad Company has filed with the Commission its amended color-coded system diagram map in docket No. AB 31 SDM. The Commission on August 22, 1983, received a certificate of publication as required by said regulation which is considered the effective date on which the system diagram map was filed.

Color-coded copies of the map have been served on the Governor of each state in which the railroad operates and the Public Service Commission or similar agency and the State designated agency. Copies of the map may also be requested from the railroad at a nominal charge. The maps also may be examined at the office of the Commission, Section of Dockets, by requesting docket No. AB 31 SDM.

Agatha L. Mergenovich,

Secretary.

[FR Doc. 83-23999 Filed 8-31-83; 8:45 am]

BILLING CODE 7035-01-M

[Finance Docket No. 30227]

Rail Carriers; Seaboard System Railroad, Inc.—Abandonment Exemption—Between Sanford and Forest City, FL

AGENCY: Interstate Commerce Commission.

ACTION: Notice of exemption.

SUMMARY: The Interstate Commerce Commission exempts Seaboard System Railroad, Inc. from the requirements of 49 U.S.C. 10903, *et seq.* in connection with abandonment of 13.76 miles of rail lines from Sanford to Forest City in Seminole County, FL, subject to conditions for protection of employees.

DATES: This exemption is effective on October 3, 1983. Petitions to stay must be filed by September 12, 1983; and petitions for reconsideration must be filed by September 21, 1983.

ADDRESS: Send pleadings referring to Finance Docket No. 30227 to:

(1) Office of the Secretary Interstate Commerce Commission Washington, DC 20423

(2) Petitioner's representative: Charles M. Rosenberger Seaboard System Railroad, Inc. 500 Water Street Jacksonville, FL 32202

FOR FURTHER INFORMATION CONTACT: Louis E. Gitomer, (202) 275–7245.

SUPPLEMENTARY INFORMATION: Additional information is contained in the Commission's decision. To purchase a copy of the full decision, write to T.S. InfoSystems, Inc., Room 2227, Interstate Commerce Commission, Washington, DC 20423 or call 289–4357 (D.C. Metropolitan area) or toll free (800) 424–5403.

Decided: August 23, 1983.

By the Commission, Chairman Taylor, Vice Chairman Sterrett, Commissioners Andre and Gradison. Vice Chairman Sterrett and Commissioner Andre would not impose a deadline on consummation of the exempted transaction.

Agatha L. Mergenovich,

Secretary.

[FR Doc. 83-23909 Filed 8-31-83; 8:45 am]

BILLING CODE 7035-01-M

[Ex Parte No. 347 (Sub-1)]

Coal Rate Guidelines—Nationwide

AGENCY: Interstate Commerce Commission.

ACTION: Notice of final scope for environmental impact statement.

SUMMARY: The Commission recently issued (48 FR 8362, February 28, 1983) proposed freight rate guidelines governing railroad movements of coal throughout the United States, for which an environmental impact statement is to be prepared. A notice of proposed scope for the environmental study was published (48 FR 9706, March 8, 1983) and comment was invited. In response to comments submitted, and following further analysis of the issues, modifications to the proposed scope of the environmental study (see **"SUPPLEMENTAL INFORMATION,"** below) have been made.[1]

FOR FURTHER INFORMATION CONTACT: Carl Bausch or Robert Maestro at (202) 275–0800.

SUPPLEMENTARY INFORMATION: Briefly, our proposed scope of environmental analysis for this proceeding contemplated examination, using predictive computer models, of electric-generating utility industry responses to coal freight rate fluctuations. Responses might include relying to a greater extent on fuel sources other than coal, such as nuclear power, and converting or delaying conversion to coal-fired generating facilities, among others. These in turn could affect the quality of the physical, social, and economic environment within the United States. We envisioned a regional as well as a national analysis. Additionally, we proposed to consider the effects of the guidelines on potential overseas demand for domestic coal.

Notwithstanding some criticism, we believe that the basic structure of analysis announced in our proposed scope is sound. In response to certain comments, however, we intend to expand somewhat the scope of the study. We also plan to compare, if possible, at least one plausible alternative not previously considered.

The Nation's major coal-hauling railroads maintain that an environmental impact statement and statement of energy impact are not required for this proceeding. We disagree.

There can be little doubt that the proposal we are advancing is a "major Federal action." See 40 CFR 1508.18. Compare *Aberdeen & Rockfish R. Co.* v. *SCRAP*, 422 U.S. 289 (1975). Notwithstanding preliminary threshold inquiries, the question remains whether our proposal will affect significantly the quality of the human environment. NEPA compliance is particularly appropriate in situations where the possible effects of a proposal on the human environment are highly uncertain. See 40 CFR 1508. 27(b)(5). Under the circumstances of this case we believe that NEPA requires preparation of an environmental impact statement for this proceeding. Moreover, even if an environmental impact statement were not required, the Commission would not be prohibited from developing one.

It has been suggested that the proposed scope of study is too narrow in that it focuses exclusively on the electric-generating utility industry. Although that industry is by far the largest consumer of coal in the United States, we recognize that there are other major industrial users of coal. Their predictive responses to the proposed guidelines will be considered in the environmental document.

Commenters also have suggested that the study examine the potential effects of the proposed action on consumers of electricity within the United States. The omission of consumer interests from the proposed scope was inadvertent. The effects of the proposed action on consumers of electricity within the United States will be examined on a regional basis in the environmental document.

The environmental impact statement will consider, as feasible, the effect of the proposed guidelines and alternatives on other modes of transportation and other fuel sources, as several commenters have requested.

Many commenters believe that other actions pending before the Commission [2] may ultimately influence coal freight rate fluctuations. These commenters contend that consideration of the potential effects of these actions must be considered together with the potential effects of the coal freight rate guidelines proceeding.

Other actions pending before the Commission will be addressed in the environmental analysis to the extent they may influence coal freight rate fluctuations. See 40 CFR 1502.16(c). However, we will not prepare a programmatic environmental impact statement evaluating simultaneously the potential impacts of all pending Commission preceedings that arguably could affect coal rates. We believe that one massive cumulative or programmatic environmental impact statement would neither be feasible nor practical to undertake. The diverse actions identified by commenters—*i.e.*, decisions involving the adoption of depreciation accounting principles for railroads, new standards for determining carrier revenue adequacy, the exemption from regulation of coal destined for export and the policy statement involving implementation of the Long-Cannon Amendment—involve significantly different subject matters and differ markedly in their potential environmental effects. We have and will continue to consider the environmental

[1] The environmental document prepared for this proceeding will also serve as the basis for the Statement of Energy Impact. See 49 CFR Part 1106.

[2] See e.g., Docket No. 36988, *Alternative Methods of Accounting for Railroad Track Structures*, and Ex Parte No. 393 (Sub-No. 1), *Standards for Railroad Revenue Adequacy*.

effects of each proposed action, to the extent required by NEPA. But this is not a case where different proceedings are so interrelated to be, in effect a single course of action that should be evaluated in one environmental impact statement. See 40 CFR 1502.4(a); 1508.25(a). Accordingly, it would not be feasible or worthwhile to consider all of their environmental consequences together. See *Kleppe* v. *Sierra Club*, 427 U.S. 390, 398–402 (1976).

Similarly, we decline at this time to consider the environmental and energy consequences of applying the methodology developed in this proceeding to commodities other than coal. If the standards are in fact applied to other commodities, we will consider the environmental consequences of that action at that time.

As for the suggestion that we consider the potential impacts of this proceeding at 5, 10, 15, and 20 year intervals, we point out that we will use 1985 as the base year on our computer runs and that our computer models will analyze projected data for 1990 and 1995. While we believe that computer runs directed beyond 1995, if available, would be too speculative to be useful, we intend to address qualitatively likely consequences of the proposed action and alternatives in the year 2000. We believe that this course of action will allow consideration of both the long- and short-term consequences of the proposed coal rate guidelines.

Some commenters believe that the environmental document should confine its analysis to the potential effects of freight rate fluctuations only for coal traffic which would be affected by the proposed guidelines. It is suggested that coal traffic: (a) Moving over non-market dominant lines, (b) destined for export, (c) moving under contract, and (d) presently within the zone of rate flexibility, not be included in the evaluation. To the extent possible, we will attempt such an analysis for comparative purposes.

We recognize, as pointed out by some commenters, that the computer models which we plan to use in our analysis are not without imperfections. Nevertheless, we are persuaded that, properly qualified, the computer models' predictive capabilities are well suited to analyzing the potential impacts of the proposed action. Every precaution will be taken to assure accuracy of results.

Finally, a number of commenters have proffered counter-proposals to the proposed action, many of which have been cast as alternatives. None of these so-called alternatives, however, has been designed to accomplish the stated objectives of the policymaking endeavor. Accordingly, they will not be considered in the environmental documentation.

Decided: August 26, 1983.

Agatha L. Mergenovich,

Secretary.

[FR Doc. 83-23995 Filed 8-31-83; 8:45 am]

BILLING CODE 7035-01-M

DEPARTMENT OF JUSTICE

Office of the Attorney General

Pollution Control; Union Corp. et al.; Lodging of Stipulation Pursuant to the Resource Conservation and Recovery, the Toxic Substances Control, and the Refuse Acts

In accordance with Departmental policy, 28 CFR 50.7, notice is hereby given that on August 16, 1983, a proposed Stipulation in *United States of America* v. *Union Corporation, Metal Bank of America, Irvin G. Schorsch, Jr., and John B. Schorsch*, Civil Action No. 80–1589, was lodged with the United States District Court for the Eastern District of Pennsylvania. The proposed Stipulation concerns recovery, treatment, and disposal of PCB-contaminated oil and water at Metal Bank of America's site in Philadelphia, Pennsylvania.

The Department of Justice will receive for a period of thirty (30) days from the date of this publication comments relating to the proposed consent decree. Comments should be addressed to the Assistant Attorney General of the Land and Natural Resources Division, Department of Justice, Washington, D.C. 20530, and should refer to *United States* v. *Union Corp. et al.*, D.J. Ref. 90–7–1–17.

The proposed Stipulation may be examined at the office of the United States Attorney for the Eastern District of Pennsylvania, 3310 U.S. Courthouse, Independence Mall West, 601 Market Street, Philadelphia, Pennsylvania; at the Region III Office of the Environmental Protection Agency, Curtis Building, Sixth and Walnut Streets, Philadelphia, Pennsylvania; and at the Environmental Enforcement Section, Land and Natural Resources Division of the Department of Justice, Room 1517, Ninth Street and Pennsylvania Avenue, NW., Washington, D.C. 20530. A copy of the proposed Stipulation may be obtained in person or by mail from the Environmental Enforcement Section, Land and Natural Resources Division of the Department of Justice. In requesting a copy, please enclose a check in the amount of $2.50 (10 cents per page reproduction cost) payable to the Treasurer of the United States.

F. Henry Habicht, II,

Acting Assistant Attorney General, Land and Natural Resources Division.

[FR Doc. 83-23957 Filed 8-31-83; 8:45 am]

BILLING CODE 4410-01-M

NATIONAL AERONAUTICS AND SPACE ADMINISTRATION

[Notice 83-73]

Intent To Grant An Exclusive Patent License; HealthMate, Inc.

AGENCY: National Aeronautics and Space Administration.

ACTION: Notice of Intent to Grant an Exclusive Patent License.

SUMMARY: NASA hereby gives notice of intent to grant to HealthMate, Inc., of Northbrook, Illinois a limited, exclusive, revocable license to practice the Nonradioactive Isotope version of the invention described in claims 4–6, 10–14, 20–28, 30, 31, 36 and 37 of U.S. Patent No. 4,142,101 for a "Low Intensity X-Ray and Gamma-Ray Imaging Device" which issued on February 27, 1979 to the Administrator of the National Aeronautics and Space Administration on behalf of the United States of America. The proposed exclusive license will be for a limited number of years and will contain appropriate terms and conditions to be negotiated in accordance with the NASA Patent Licensing Regulations, 14 CFR 1245.2. NASA will negotiate the final terms and conditions and grant the exclusive license unless, within 60 days of the date of this Notice, the Director of Patent Licensing receives written objections to the grant, together with supporting documentations. The Director of Patent Licensing will review all written responses to the Notice and then recommend to the Assistant General Counsel for Patent Matters whether to grant the exclusive license.

DATE: Comments to this notice must be received by October 31, 1983.

ADDRESS: National Aeronautics and Space Administration, Code GP–4, Washington, D.C. 20546.

FOR FURTHER INFORMATION CONTACT: Mr. John G. Mannix, (202) 755–3954.

Dated: August 24, 1983.

Gary L. Tesch,

Acting General Counsel.

[FR Doc. 83-23953 Filed 8-31-83; 8:45 am]

BILLING CODE 7510-01-M

NATIONAL TRANSPORTATION SAFETY BOARD

Collapse of I-95 Bridge, Mianus River, Greenwich CT, Hearing

In conection with its investigation of the collapse of a section of the I-95 bridge over the Mianus River, Greenwich, Connecticut, on June 28, 1983, the Safety Board will convene a hearing at 9 a.m. (local time) on September 19, 1983, in the Nutmeg Room of the Sheration-Greenwich Inn, Greenwich, Connecticut.

H. Ray Smith, Jr.,

Federal Register Liaison Officer.

August 25, 1983.

[FR Doc. 83-23739 Filed 8-31-83; 8:45 am]

BILLING CODE 4910-58-M

NUCLEAR REGULATORY COMMISSION

[Docket No. 50-289]

Metropolitan Edison Co. et al.; Issuance of Amendment to Facility Operating License and Final No Significant Hazards Consideration Determination (Partial)

The U.S. Nuclear Regulatory Commission (the Commission) has issued Amendment No. 86 to Facility Operating License No. DPR-50, issued to Metropolitan Edison Company, Jersey Central Power and Light Company, Pennsylvania Electric Company, and GPU Nuclear Corporation (the licensees), which revised the license and the Technical Specification (TSs) for operation of the Three Mile Island Nuclear Station, Unit No. 1 (the facility) located in Dauphin County, Pennsylvania. The amendment is effective as of the date of issuance.

The amendment revises the TSs to recognize and approve the steam generator tube kinetic expansion repair technique as an alternative to plugging of defective tubes, only for purposes of steam generator hot functional testing using pump heat (non-nuclear), and permits such testing. As such, it addresses a portion of the Notice of Consideration of Issuance of Amendment and Proposed No Significant Hazards Consideration Determination and Opportunity for Hearing identified below.

The application for amendment complies with the standards and requirements of the Atomic Energy Act of 1954, as amended (the Act), and the Commission's rules and regulations. The Commission has made appropriate findings as required by the Act and the Commission's rules and regulations in 10 CFR Chapter I, which are set forth in the license amendment.

Notice of Consideration of Issuance of Amendment and Proposed No Significant Hazards Consideration Determination and Opportunity for Hearing in connection with this action was published in the **Federal Register** on May 31, 1983 (48 FR 24231), and corrected June 14, 1983 (48 FR 27328). That notice covers a requested amendment which would: recognize steam generator repair techniques other than plugging, provided such techniques are approved by the Commission; approve the kinetic expansion repair technique; and authorize subsequent operation (both non-nuclear and nuclear) of the facility with the repaired steam generators. This notice addresses a portion of, and is encompassed by, that May 31, notice.

In response to the May 31, notice, request for hearing were filed by TMIA on May 19, 1983, as amended on June 23, 1983, and by Lee, Molholt, and Aamodt on June 30, 1983, as amended on July 13, 1983. Comments were made by six other persons and the Commonwealth of Pennsylvania.

Under its regulations, the Commission may issue and make an amendment immediately effective, notwithstanding the pendency before it of a request for a hearing from any person, in advance of the holding and completion of any required hearing, where it has determined that no significant hazards consideration is involved.

The Commission has applied the standards of 10 CFR 50.92 and has made a final determination that the amendment involves no significant hazards consideration. The basis for this determination is contained in the Safety Evaluation related to this action. Accordingly, as described above, the amendment has been issued and made immediately effective and any hearing in connection with this amendment will be held after issuance. A final determination regarding significant hazards considerations on the remainder of the subject matter of the May 31 notice, i.e., nuclear operation with the repaired steam generators, has not yet been made.

The Commission has determined that the issuance of the amendment will not result in any significant environmental impact and that pursuant to 10 CFR 51.5(d)(4) an environmental impact statement or negative declaration and environment impact appraisal need not be prepared in connection with issuance of the amendment.

For further details with respect to the action see (1) the application for amendment dated May 9, 1983, (2) Amendment No. 36 to Facility Operating License No. DPR-50, and (3) the Commission's related Safety Evalation. All of these items are available for public inspection at the Commission's Public Document Room, 1717 H Street, N.W., Washington, D.C., and at the Government Publications Section, State Library of Pennsylvania, Education Building, Commonwealth and Walnut Streets, Harrisburg, Pennsylvania 17126.

A copy of items (2) and (3) may be obtained upon request addressed to the U.S. Nuclear Regulatory Commission, Washington, D.C. 20555, Attention: Director, Division of Licensing.

Dated at Bethesda, Maryland this 25th day of August, 1983.

For the Nuclear Regulatory Commission.

John F. Stolz,

Chief, Operating Reactors Branch No. 4, Division of Licensing.

[FR Doc. 83-24042 Filed 8-31-83; 8:45 am]

BILLING CODE 7590-01-M

International Atomic Energy Agency Draft Safety Guide; Avialability of Draft for Public Comment

The International Atomic Energy Agency (IAEA) is completing development of a number of internatinally acceptable codes of practice and safety guides for nuclear power plants. These codes and guides are in the following five areas: Government Organization, Design, Siting, Operation, and Quality Assurance. All of the codes and most of the proposed safety guides have been completed. The purpose of these codes and guides is to provide guidance to countries beginning nuclear power programs.

The IAEA codes of practice and safety guides are developed in the following way. The IAEA receives and collates relevant existing information used by member countries in a specified safety area. Using this collation as a starting point, and IAEA working group of a few experts develops a preliminary draft of a code or safety guide which is then reviewed and modified by an IAEA Technical Review Committee corresponding to the specified area. The draft code of practice or safety guide is then sent to the IAEA Senior Advisory Group which reviews and modifies as necessary the drafts of all codes and guides prior to their being forwarded to the IAEA Secretariat and thence to the IAEA Member States for comments. Taking into account the comments received from the Member States, the Senior Advisory Group then modifies the draft as necessary to reach

agreement before forwarding it to the IAEA Director General with a recommendation that it be accepted.

As part of this program, Safety Guide SG–010, "Core Management and Fuel Handling for Nuclear Power Plants," has been developed. The working group consisting of Mr. A. Recalde from Argentina; Mr. D. B. Upendra from India; and Mr. F. L. Langford (Westinghouse Electric Corporation) from the U.S.A., developed the initial draft of this guide from an IAEA collation. This draft was subsequently modified by the IAEA Technical Review Committee for Operation and the Senior Advisory Group, and we are now soliciting public comment on a modified draft (Rev. 7, dated November 20, 1982). Comments received by the Director, Office of Nuclear Regulatory Research, U.S. Nuclear Regulatory Commission, Washington, D.C. 20555, by September 23, 1983, will be particularly useful to the U.S. representatives to the Technical Review Committee and the Senior Advisory Group in developing their positions on its adequacy prior to their next IAEA meetings.

Single copies of this draft Safety Guide may be obtained by a written request to the Director, Office of Nuclear Regulatory Research, U.S. Nuclear Regulatory Commission, Washington, D.C. 20555.

(5 U.S.C. 522(a))

Dated at Washington, D.C. this 26th day of August 1983.

For the Nuclear Regulatory Commission.

Robert B. Minogue,

Director, Office of Nuclear Regulatory Research.

[FR Doc. 83-24044 Filed 8-31-83; 8:45 am]

BILLING CODE 7590-01-M

[Docket No. 50-354A]

Public Service Electric & Gas Company and Atlantic City Electric Company; Receipt of Antitrust Information

The Public Service Electric and Gas Company and the Atlantic City Electric Company have submitted antitrust information accompanying their application for an operating license for a boiling water nuclear reactor known as Hope Creek Generating Station, located in Lower Alloways Creek Township, Salem County, New Jersey. The data submitted contains antitrust information for review pursuant to NRC Regulatory Guide 9.3 necessary to determine whether there have been any significant changes since the completion of the antitrust review at the construction permit stage.

S-A01093 0042(02)(31-AUG-83-14:37:56)

On Completion of the staff's antitrust review, the Director of Nuclear Reactor Regulation will issue an initial finding as to whether there have been "significant changes" under section 105c(2) of the Atomic Energy Act. A copy of this finding will be published in the **Federal Register** and will be sent to the Washington, D.C. and local public document rooms and to those persons providing comments or information in response to this notice. If the initial finding concludes that there have not been any significant changes, requests for reevaluation may be sumitted for a period of 30 days after the date of the **Federal Register** notice. The results of any reevaluation that is requested will also be published in the **Federal Register** and copies sent to the Washington, D.C. and local public document rooms.

A copy of the general information portion of the application for an operating license and the antitrust information submitted is available for public examination and copying for a fee at the Commission's Public Document Room, 1717 H Street, NW., Washington, D.C. 20555, and at the local public document room at the Salem Free Public Library, 112 West Broadway, Salem, New Jersey 08079.

Any person who desires additional information regarding the matter covered by this notice or who wishes to have his views considered with respect to significant changes related to antitrust matters which have occurred in the applicants' activities since the construction permit antitrust review should submit such requests for information or views to the U.S. Nuclear Regulatory Commission, Washington, D.C. 20555, Attention: Section Leader, Antitrust and Economic Analysis Section, Site Analysis Branch, Office of Nuclear Reactor Regulation, on or before October 6, 1983.

Dated at Bethesda, Maryland this 25th day of August 1983.

For the Nuclear Regulatory Commission.

A. Schwencer,

Chief, Licensing Branch No. 2, Division of Licensing.

[FR Doc. 83 24043 Filed 8-31-83; 8:45 am]

BILLING CODE 7590-01-M

SECURITIES AND EXCHANGE COMMISSION

[File No. 81-683]

Citicorp Homeowners, Inc., Application and Opportunity for Hearing

August 26, 1983.

Notice is hereby given that Citicorp Homeowners, Inc. (the "Applicant"), as seller and servicer under a number of Pooling and Servicing Agreements (the "Agreements") providing for the issuance of Mortgage Pass-Through Certificates (the "Certificates"), has filed an application pursuant to Section 12(h) of the Securities Exchange Act of 1934, as amended (the "Act"), for exemption from certain reporting requirements under Section 13 of the Act and from the operation of Section 16 of the Act.

The application states in part:

In the absence of an exemption, Applicant would be required to file reports adhering to all the item requirements of Form 10–K, 10–Q and 8–K under the 1934 Act.

Applicant believes that the exemptive order requested by it is appropriate in that Form 10–Q and certain items or Form 10–K under the 1934 Act are inapplicable to its pass-through mortgage pool arrangement, and the requirements of Section 16 of the 1934 Act are inapplicable to holders of its mortgage pass-through certificates.

For a more detailed statement of the information presented, all persons are referred to said application, which is on file in the Office of the Commission at the Public Reference Room 450 Fifth Street, N.W., Washington, DC 20549.

Notice is further given that any interested persons may submit to the Commission in writing, not later than September 20, 1983, his views on any substantial facts bearing on the application or the desirability of a hearing thereon. Any such communication or request should be addressed: Secretary, Securities and Exchange Commission, 450 Fifth Street, N.W., Washington, D.C. 20549, and should state briefly the nature of the interest of the person submitting such information or requesting the hearing, the reason for such request, and the issues of fact and law raised by the application which he desires to controvert.

Persons who request a hearing or advice as to whether a hearing is ordered will receive any notices and orders issued in this matter, including the date of the hearing (if ordered) and any postponements thereof. At any time after said date, an order granting the application may be issued upon request or upon the Commission's own motion.

For the Commission, by the Division of Corporation Finance, pursuant to delegated authority.

George A. Fitzsimmons,

Secretary.

[Fr Doc. 83-23971 Filed 8-31-83; 8:45 am]

BILLING CODE 8010-01-M

DEPARTMENT OF STATE

[Public Notice CM-8-656]

Advisory Committee on International Investment, Technology, and Development; Meeting

The Department of State will hold a meeting of the Working Group on Transborder Data Flows (TBDF) of the Advisory Committee on International Investment, Technology, and Development on Friday, September 23, 1983, from 10:00 a.m. to noon in Room 1912, Department of State, 2201 C Street, NW., Washington, D.C.

An agenda for the meeting will include a report on the OECD Committee for Information, Computer and Communications Policy (ICCP) Working Group on TBDF meeting held last June and preparations for the ICCP committee meeting in October and the ICCP Symposium on TBDF in November/December.

Members of the public wishing to attend the meeting must contact Mr. Lincoln's office (202-632-2728) in order to arrange admittance to the State Department. Please use the "C" Street entrance.

The Chairman of the Working Group will, as time permits, entertain oral comments from members of the public attending the meeting.

Dated: August 23, 1983.

Philip T. Lincoln, Jr.,

Executive Secretary.

[FR Doc. 83-23954 Filed 8-31-83; 8:45 am]

BILLING CODE 4710-01-M

[Public Notice CM-8/655]

Modem Working Party of Study Group D of the U.S. Organization for the International Telegraph and Telephone Consultative Committee (CCITT); Meeting

The Department of State announces that the Modem Working Party of Study Group D of the U.S. Organization for the International Telegraph and Telephone Consultative Committee (CCITT) will meet on September 22 and 23, 1983 at the Sheraton-Tara Hotel, Braintree, Massachusetts. Meetings on both days will begin at 8:30 a.m. This Working Party deals with matters in telecommunications relating to the development of international digital data transmission.

The agenda for the meetings is as follows:

1. To act on certain V.aa (9600 bits-per-second two-wire full duplex modem) modifications proposed during the Working Party's last meeting in Boulder, Colorado;

2. To review the proposed 14,400 bits-per-second modem draft recommendations and prepare a U.S. paper on areas of mutual agreement.

Members of the general public may attend the meeting and join in the discussion subject to the instructions of the Chairman. Requests for further information may be directed to Mr. Earl Barbely, State Department, telephone 202 632-3405 or Mr. T. de Haas, Chairman of U.S. Study Group D, Department of Commerce, Boulder, Colorado, telephone 303 497-3728.

Dated: August 18, 1983.

Richard E. Shrum,

Acting Director, Office of International Communications Policy.

[FR Doc. 83-23955 Filed 8-31-83; 8:45 am]

BILLING CODE 4710-07-M

DEPARTMENT OF TRANSPORTATION

Office of the Secretary

Reports, Forms, and Recordkeeping Requirements: Submittals to OMB August 3-August 23, 1983

AGENCY: Office of the Secretary, DOT.

ACTION: Notice.

SUMMARY: The notice lists those forms, reports, and recordkeeping requirements, transmitted by the Department of Transportation, during the period Aug. 3-Aug. 23, 1983, to the Office of Management and Budget (OMB) for its approval. This notice is published in accordance with the requirements of the Paperwork Reduction Act of 1980 (44 U.S.C. Chapter 35).

FOR FURTHER INFORMATION CONTACT: John Windsor, John Chandler, or Annette Wilson, Information Requirements Division, M-34, Office of the Secretary of Transportation, 400 7th Street, SW., Washington, D.C. 20590, (202) 426-1887 or Gary Waxman or Wayne Leiss, Office of Management and Budget, New Executive Office Building, Room 3001, Washington, D.C. 20503, (202) 395-7313.

SUPPLEMENTARY INFORMATION:

Background

Section 3507 of Title 44 of the United States Code, as adopted by the Paperwork Reduction Act of 1980, requires that agencies prepare a notice for publication in the **Federal Register**, listing those information collection requests submitted to the Office of Management and Budget (OMB) for approval under that Act. OMB reviews and approves agency submittals in accordance with criteria set forth in that Act. In carrying out its responsibilities, OMB also considers public comments on the proposed forms, reporting and recordkeeping requirements.

On Mondays and Thursdays, as needed, the Department of Transportation will publish in the **Federal Register** a list of those forms, reporting and recordkeeping requirements that it has submitted to OMB for review and approval under the Paperwork Reduction Act. The list will include new items imposing paperwork burdens on the public as well as revisions, renewals and reinstatements of already existing requirements. OMB approval of an information collection requirement must be renewed at least once every three years. The published list also will include the following information for each item submitted to OMB:

(1) A DOT control number.

(2) An OMB approval number if the submittal involves the renewal, reinstatement or revision of a previously approved item.

(3) The name of the DOT Operating Administration or Secretarial Office involved.

(4) The title of the information collection request.

(5) The form number used, if any.

(6) The frequency of required responses.

(7) The persons required to respond.

(8) A brief statement of the need for, and uses to be made of, the information collection.

Information Availability and Comments

Copies of the DOT information collection requests submitted to OMB may be obtained from the DOT officials listed in the "**For Further Information Contact**" paragraph set forth above.

Comments on the requests should be forwarded, as quickly as possible, directly to the OMB officials listed in the "**For Further Information Contact**" paragraph set forth above. If you anticipate submitting substantive comments, but find that more than 5 days from the date of publication is needed to prepare them, please notify

the OMB officials of your intent immediately.

Items Submitted for Review by OMB

The following information collection requests were submitted to OMB from Aug. 3–Aug. 23, 1983.

- DOT No: 2196
- OMB No: None (new)
- By: Federal Aviation Administration
- Title: Indirect Air Carrier security—FAR 109
- Forms: None
- Frequency: On occasion
- Respondents: Each air carrier, including each air freight forwarder and each cooperative shippers' association engaged indirectly in air transportation of property.

Need/Use: To ensure that the property received by an air carrier from an indirect air carrier does not contain bombs or other explosive or incendiary devices. Security programs required by FAR 109 set forth procedures to be used by indirect air carriers in carrying out their responsibilities involving the protection of persons and property against acts of criminal violence and aircraft piracy in the forwarding of air cargo.

- DOT No: 2197

OMB No: 2127–0009
By: National Highway Traffic Safety Administration
Title: Monthly Report of Motor Vehicle Traffic Fatalities
Forms: HS–251
Frequency: Monthly
Respondents: State Agencies

Need/Use: The Report gives the total fatalities involving motor vehicles each month.

- DOT No: 2198

OMB No: 2125–0092
By: Federal Highway Administration
Title: Preparation of the 1985 Estimate of the Cost of Completing the Interstate System
Forms: None
Frequency: Biennually
Respondents: State Highway Agencies

Need/Use: To provide Congress with a detailed estimate of the cost of completing the Interstate System, and for FHWA to determine the allocation of Federal funds authorized as a result of the withdrawal of Interstate routes in favor of substitute projects.

- DOT No: 2199

OMB No: 2120–0065
By: Federal Aviation Administration
Title: Airport Aid Program—FAR 152 (Airport Layout Plan)
Forms: FAA Forms 5100–100 and FAA 5100–60, 61, 62, 63
Frequency: On occasion, Quarterly, Annually
Respondents: Airport sponsors (State and Local Governments)

Need/Use: The FAA collects information from airport sponsors and planning agencies in order to administer the Airport Grants Programs. Data is used to determine eligibility, proper use of Federal funds and project accomplishment.

- DOT No: 2200

OMB No: 2125–0040
By: Federal Highway Administration
Title: Annual Interstate Maintenance Program
Forms: None
Frequency: Annually
Respondents: State Highway Agencies

Need/Use: To meet the requirements contained in 23 CFR Subpart E, which requires each State to certify that the Interstate System is being maintained in accordance with an approved Interstate Maintenance Program.

- DOT No: 2201

OMB No: To be assigned
By: Maritime Administration
Title: Application for Excess or Surplus Property
Forms: None
Frequency: On Occasion
Respondents: Maritime Educational Agencies or Institutions

Need/Use: Excess or surplus vessels and marine equipment may be applied for by certain approved Maritime training institutions to upgrade Maritime training.

- DOT No: 2202

OMB No: To be assigned
By: Research and Special Programs Administration
Title: Approval of Sampling and Test Procedures Used to Determine if A Gas is Flammable (49 CFR 173.300(b)(1)
Forms: None
Frequency: Occasionally (as produced)
Respondents: Packagers (bottlers) of a new gas

Need/Use: The Materials Transportation Bureau retains in the regulations the criteria for determining the flammability of a gas so that when a new gas is developed the procedures for documenting its flammability will exist. Compressed gas packaging, handling and transportation safety requirements are based on the hazard class of a material. Once tested and documented, the criteria for shipment is established indefinitely.

- DOT No: 2203

OMB No: 2135–0003
By: St. Lawrence Seaway Development Corporation
Title: Transit Declaration
Forms: S/VM 755–11–77 (Canadian form)
Frequency: On occasion
Respondents: Businesses or for-profit sole proprietors

Need/Use: Used to assess toll charges in accordance with the St. Lawrence Seaway Tariff of Tolls.

- DOT No: 2204

OMB No: 2135–0004
By: St. Lawrence Seaway Development Corporation
Title: Seaway Explosives Permit
Forms: SLSDC–LO–7–1–6200.31
Frequency: On Occasion
Respondents: Businesses or for-profit sole proprietors

Need/Use: To provide for safe guards in transiting the Seaway system.

- DOT No: 2205

OMB No: 2135–0002
By: St. Lawrence Seaway Development Corporation
Title: Application for preclearance
Forms: S/VM 429–01–80 (Canadian form)
Frequency: On occasion
Respondents: Businesses or for-profit sole proprietors

Need/Use: Used by the St. Lawraence Seaway Development Corporation to determine whether a vessel is properly fitted to allow it to safely transit through the St. Lawrence Seaway System.

Issued in Washington, D. C. on August 25, 1983.

Karen S. Lee,

Deputy Assistant Secretary for Administration.

[FR Doc. 83-24006 Filed 8-31-83; 8:45 am]
BILLING CODE 4910-62-M

Maritime Administration

Maritime Advisory Committee—Working Group on Tanker Operations; Meeting

AGENCY: Maritime Administration, DOT.

ACTION: Notice.

SUMMARY: The Maritime Advisory Committee's Working Group on Tanker Operations will meet on September 14, 1983, at 10 a.m. The meeting will be held in Room 8334, Department of Transporation, 400 7th Street, SW., Washington, D.C. The Committee will discuss the probable size and composition of the American tanker fleet in 1988, with a view toward advising the Secretary of Transportation in this regard. This meeting will be open to the public on a space available basis.

By order of the Maritime Administrator.

Dated: August 30, 1983.

Georgia P. Stamas,

Secretary.

[FR Doc. 83-24184 Filed 8-31-83; 8:45 am]

BILLING CODE 4910-81-M

[Docket No. S-740]

Application; Delta Steamship Lines, Inc.

Notice is hereby given that, by application dated August 23, 1983, Delta Steamship Lines, Inc. (Delta) has requested all necessary approvals and consents under the Merchant Marine Act, 1936, as amended (Act), and its Operating-Differential Subsidy Agreements (ODSAs), including such approval under section 605(c) of the Act as may be necessary, for the substitution of two and possibly three new containerships on a one-for-one basis for the three C9-S-81d LASH type vessels presently operated on Delta's Trade Route (TR) 20 service (U.S. Gulf/East Coast South America). Delta proposes to acquire the new containerships from a West German shipyard, pursuant to the Maritime Subsidy Board's September 30, 1982 authorization to Delta under section 615 of the Act.

Until recently, Delta provided service with three LASH vessels on TR 20 with one sailing approximately every 14 days. Since November 1982, as a result of a sharp cargo decline in the trade, Delta has been operating only two LASH vessels with one sailing every 21 days. Assuming that Delta exercises the option to acquire three vessels, sailings will be provided once every 14 days. If only two new vessels are acquired, sailings will be provided every 21 days, supplemented as necessary by other Delta vessels if and when the trade picks up sufficiently to require additional service. The new container vessels will call at essentially the same ports as the LASH vessels. Delta has not requested any change in the maximum number of subsidized sailings on the route presently permitted under its ODSA. Delta does not at this time request any transfer or interchange privileges for the new vessels but reserves the right to request such privileges in the future.

Delta's C9-S-81d LASH vessels have a deadweight tonnage of 40,710 metric tons and capacity for 60 barges and 559 TEU's. The new container vessels, which are self-sustaining have a deadweight tonnage of 25,500 metric tons and 1265 TEU's. Delta advises that the container vessels also will have the capability to be enlarged to an approximate 1650 TEU capacity by insertion of a mid-body, should increases in the trade warrant an increase in capacity. Delta indicates that the new vessels will be able to compete for all cargoes. Cargoes which are containerizable will be carried in containers, while non-containerizable cargoes will be carried using lift capability and liquid cargoes can be carried in tanks.

Delta indicates that the C9 vessels proposed to be replaced will be used in non-liner operations on an unsubsidized basis or laid up unless they can be utilized for military or emergency deployment. Delta advises that the subject application is not dependent on the outcome of its application in Docket No. S-738 for a settlement and early termination of its ODSAs.

The application may be inspected during normal business hours in the Office of the Secretary, Maritime Subsidy Board/Maritime Administration, Room 7300, Department of Transportation, 400 Seventh Street, SW., Washington, D.C. 20590. Interested parties who desire to comment on Delta's application may submit their views thereon to the Secretary, Maritime Subsidy Board/Maritime Administration, in triplicate, on or before 5:00 p.m. on September 14, 1983. Any request for a hearing shall specify the issues for such a hearing. All timely responses will be considered in MarAd's evaluation of Delta's application. MarAd will take such action as may be deemed appropriate with respect thereto, which may or may not include a hearing.

(Catalog of Domestic Assistance Program No. 11.504 Operating-Differential Subsidy (ODS)).

By Order of the Maritime Subsidy Board/Maritime Administration.

Dated: August 29, 1983.

Georgia P. Stamas,

Secretary.

[FR Doc. 83-24056 Filed 8-31-83; 8:45 am]

BILLING CODE 4910-81-M

[Docket S-739]

Lykes Bros. Steamship Co., Inc.; Application

Notice is hereby given that Lykes Bros. Steamship Co., Inc. has filed an application dated August 26, 1983, to amend its present Operating-Differential Subsidy Agreement, Contract MA/MSB-451, so as to increase the maximum number of sailings permitted from 48 to 56 sailings for calendar year 1983 only on its subsidized Trade Route 13—Freight Service (Line C—Mediterranean Line).

Any person, firm, or corporation having any interest in such application and desiring to offer views and comments thereon for consideration by the Maritime Subsidy Board should submit them in writing, in triplicate, to the Secretary, Maritime Subsidy Board, Washington, D.C. 20590 by close of business on September 14, 1983.

The Maritime Subsidy Board will consider these views and comments and take such action with respect thereto as may be deemed appropriate.

(Catalog of Federal Domestic Assistance Program No. 20.804 Operating-Differential Subsidies (ODS))

By order of the Maritime Subsidy Board.

Dated: August 29, 1983.

Georgia P. Stamas,

Secretary.

[FR Doc. 83-24057 Filed 8-31-83; 8:45 am]

BILLING CODE 4910-81-M

National Highway Traffic Safety Administration

[Docket No. IP83-3; Notice 2]

General Motors Corp.; Grant of Petition for Determination of Inconsequential Noncompliance

This notice grants the petition by General Motors Corporation of Warren, Michigan, to be exempted from the notification and remedy requirements of the National Traffic and Motor Vehicle Safety Act (15 U.S.C. 1381 *et seq.*) for an apparent noncompliance with 49 CFR 571.115, *Vehicle Identification Number.* The basis of the grant is that the noncompliance is inconsequential as it relates to motor vehicle safety.

Notice of receipt of the petition was published on May 2, 1983, and an opportunity afforded for comment (48 FR 19163).

GM determined that 61 of its 1982-model Chevrolet C-10 and K-10 trucks, and GMC C-15 and K-15 trucks had an incorrect gross vehicle weight rating designator in the vehicle identification number, required by Motor Vehicle Safety Standard No. 115. The designator incorrectly given was "C", indicating a GVWR of 4001 to 5000 pounds, while the correct letter was "E", as the trucks actually had a GVWR of 6200 pounds.

Petitioner argued that the noncompliance was inconsequential as it related to motor vehicle safety since it would not result in a potential overloading, nor did it jeopardize traceability of the vehicles in the event of a recall. The trucks are intended to carry a load greater than was indicated in the erroneous character, and the uniqueness of the VIN's assured traceability of the trucks. Nevertheless, GM intends to provide the owners of the

61 trucks with a letter informing them of the error to minimize possible difficulties with State registration. The National Auto Theft Bureau will also be informed.

No comments were received on the petition.

NHTSA believes that the incorrect GVWR designator poses no risk to motor vehicle safety. The information present in the designator is sufficient to identify vehicles in the event of a recall campaign and does not affect information retrieval. The agency views with approval petitioner's willingness to notify owners of the trucks concerned as well as the National Auto Theft Bureau. General Motors has met its burden of persuasion that the noncompliance herein described is inconsequential as it relates to motor vehicle safety, and its petition is herewith granted.

The engineer and attorney primarily responsible for this notice are Nelson Erickson and Taylor Vinson, respectively.

(Sec. 102, Pub. L. 88 Stat. 1470 (15 U.S.C. 1417); delegations of authority at 49 CFR 1.50 and 49 CFR 501.8)

Issued on August 24, 1983.

Kennerly H. Digges,

Acting Associate Administrator for Rulemaking.

[FR Doc. 83-24070 Filed 8-31-83; 8:45 am]

BILLING CODE 4910-59-M

[Docket No. Ex 83-3; Notice 1]

Jaguar Cars, Inc.; Petition for Temporary Exemption From Federal Motor Vehicle Standard No. 108

Jaguar Cars, Inc. of Leonia, N.J., has petitioned for a temporary exemption of its XJ-S model from the headlighting requirements of Federal Motor Vehicle Safety Standard No. 108 on the basis that it will facilitate the "field evaluation of a styled, aerodynamic headlamp fitted with an externally mounted wash and wipe system."

This notice of receipt of petition for temporary exemption is published in accordance with NHTSA regulations on this subject (49 CFR 555.7) and does not represent any agency decision or other exercise of judgment concerning the merits of the petition.

Under 49 CFR 555.6(b), a motor vehicle manufacturer may petition for an exemption from a Federal motor vehicle safety standard for a period up to two years, covering no more than 2500 vehicles for any 12-month period the exemption is in existence on the basis that the exemption would facilitate the development or field evaluation of a new motor vehicle safety feature which provides a level of safety which is equivalent to or exceeds the level of safety established in the standard from which an exemption is sought. Jaguar seeks a two-year exemption from the headlighting requirements of 49 CFR 571.108 Motor Vehicle Safety Standard No. 108 *Lamps, Reflective Devices, and Associated Equipment*. The exemption would cover the XJ-S model, approximately 1000 of which (accounting for about 50% of total production) were sold in the United States in 1982.

Jaguar would fit the exempted models with styled, aerodynamic headlamps equipped with an externally mounted wash and wipe system. The headlamps are identical to those non-sealed beam headlamps used on the XJ-S model destined for markets other than the United States. The headlamp and wash/wipe system will be fitted as standard equipment on 1984 model XJ-S cars intended for the Canadian market. According to the petitioner, the system will enable the headlamps to function without a deterioration in performance under a wide variety of extreme operating conditions, such as exist in North America and nowhere else in the world: temperatures ranging from −30 degrees Celsius to +50 degrees Celsius, high and low humidity, high and low altitude, sea spray, dust, sand and road salt. Jaguar believes that its ordinary mileage-accumulation fleets are too small to provide "the field evaluation we envision for the wipe/wash system." The company intends to survey owners of cars with wash/wipe systems. It will also provide spare bulbs with each car.

The headlamps do not comply with current requirements of Standard No. 108 for all headlamps in that they are not mechanically aimable, possess a maximum design wattage that slightly exceeds that specified for upper and lower beams of Type 2B1 headlamps (the US headlamp to which it is most similar in size), and when installed have an object in front of the lens, i.e., a wiper blade. However, Jaguar avers that the "driving beam" is "only minimally affected by the presence of the wiper blade." The status of compliance of these non-sealed headlamps with respect to the recently adopted environmental test procedures for semi-sealed replaceable bulb headlamp systems (48 FR 24690, June 2, 1983) is not known.

Jaguar argues that an exemption would be in the public interest because of the unique cleaning feature of the wipe/wash system, and the contribution of aerodynamic headlamps to fuel economy.

Interested persons are invited to submit comments on the petiton for exemption for exemption of Jaguar Cars, Inc. Comments should refer to the docket number and be submitted to: Docket Section, National Highway Traffic Safety Administration, room 5109, 400 Seventh Street, SW, Washington, D.C., 20590. It is requested but not required that five copies be submitted.

All comments received before the close of business on the comment closing date indicated below will be considered. The application and supporting materials, and all comments received, are available for examination in the docket both before and after the closing date. Comments received after the closing date will also be filed and will be considered to the extent practicable. Notice of final action on the petition will be published in the **Federal Register.**

Comment closing date: October 3, 1983.

(Sec. 3, Pub. L. 92-548, 86 Stat. 1159 (15 U.S.C.1410); delegation of authority at 49 CFR 1.50 and 49 CFR 501.8)

Issued on August 29, 1983.

Kennerly H. Digges,

Acting Associate Administrator for Rulemaking.

[FR Doc. 83-24069 Filed 8-31-83; 8:45 am]

BILLING CODE 4910-59-M

Sunshine Act Meetings

Federal Register
Vol. 48, No. 171
Thursday, September 1, 1983

This section of the FEDERAL REGISTER contains notices of meetings published under the "Government in the Sunshine Act" (Pub. L. 94-409) 5 U.S.C. 552b(e)(3).

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1

FEDERAL RESERVE SYSTEM

(Board of Governors)

TIME AND DATE: 10 a.m., Wednesday, September 7, 1983.

PLACE: 20th Street and Constitution Avenue NW., Washington, D.C. 20551.

STATUS: Closed.

MATTERS TO BE CONSIDERED:

1. Legislative proposals relating to banking structure.
2. Personnel actions (appointments, promotions, assignments, reassignments, and salary actions) involving individual Federal Reserve System employees.
3. Any items carried forward from a previously announced meeting.

CONTACT PERSON FOR MORE INFORMATION: Mr. Joseph R. Coyne, Assistant to the Board (202) 452-3204.

Dated: August 31, 1983.

James McAfee,

Associate Secretary of the Board.

[S-1242-83 Filed 8-30-83; 3:39 pm]

BILLING CODE 6210-01-M

2

NATIONAL COMMISSION ON LIBRARIES AND INFORMATION SCIENCE

Blue Ribbon Panel on the Information Policy Implications of Archiving Satellite Data

DATE AND TIME: September 12, 1983, 9 a.m.–4 p.m.

PLACE: The Capitol Holiday Inn, 550 C Street SW., Washington, D.C. 20024.

STATUS: Open.

MATTERS TO BE DISCUSSED: Description of the work of the Department of Commerce's Source Evaluation Board (SEB); SEB's need for General Policy Guidance on Archiving Requirements of data from LandSat and MetSat; the Satellite Data System; current Archiving Systems and Practices; and Discussion of Issues and Preliminary Recommendations.

CONTACT PERSON FOR MORE INFORMATION: Toni Carbo Bearman, Executive Director.

Toni Carbo Bearman,

Executive Director, National Commission on Libraries and Information Science.

August 25, 1983.

[S-1240-83 Filed 8-30-83; 10:19 am]

BILLING CODE 7527-01-M

3

NATIONAL TRANSPORTATION SAFETY BOARD

[NM-83-22]

A majority of the Board determined by recorded vote that the business of the Board required holding this meeting on less-than-normal notice and that no earlier announcement was possible.

TIME AND DATE: 11:30 a.m., Friday, August 26, 1983.

PLACE: NTSB Board Room, eighth floor, 800 Independence Avenue SW., Washington, D.C. 20594.

STATUS: Open.

MATTERS TO BE CONSIDERED:

1. *Request for Depositions* in connection with the accident involving Landry Aviation Lockheed 18, N116CA, Arlington, Washington, August 21, 1983.
2. *Request for Depositions* in connection with the accident involving Las Vegas Airlines, Inc., Piper PA 31-350 Chieftain, N88LV, near Peach Springs, Arizona, August 17, 1983.

CONTACT PERSON FOR MORE INFORMATION: Sharon Flemming (202) 382-6525.

August 30, 1983.

[S-1241-83 Filed 8-30-83; 10:10 am]

BILLING CODE 4910-58-M

4

POSTAL SERVICE

(Board of Governors)

Amendment to Notice of a Meeting

"FEDERAL REGISTER" CITATION OF PREVIOUS ANNOUNCEMENT: 48 FR 38948, August 26, 1983.

PREVIOUSLY ANNOUNCED DATE OF MEETING: September 7–8, 1983.

CHANGE: On August 26, 1983, the Postal Rate Commission issued a Recommended Decision on Bulk Third-Class Nonprofit Rates (Docket R80-1). By telephone vote on August 26 the board voted to add consideration of the commission's Recommended Decision to the agenda for the closed session on Wednesday, September 7.

The Board determined that pursuant to section 552b(c)(3) of title 5, United States Code, and § 7.3(c) of title 39, Code of Federal Regulations, the consideration of this matter is exempt from the open meeting requirement of the Government in the Sunshine Act (5 U.S.C. 552b) because it is likely to disclose information in connection with proceedings under chapter 36 of title 39 (having to do with postal ratemaking) which is specifically exempted from disclosure by section 410(c)(4) of title 39, United States Code. The Board determined further that pursuant to section 552b(c)(10) of title 5 United States Code, and § 7.3(j) of title 39 Code of Federal Regulations, the discussions are exempt, because they are likely to specifically concern the participation of the Postal Service in a civil action or proceeding or the litigation of a particular case involving a determinationon the record after opportunity for a hearing.

In accordance with section 552b(f)(1) of title 5, United States Code, and § 7.6(a) of title 39, Code of Federal Regulations, the General Counsel of the United States Postal Service has certified that in his opinion the consideration by the Board of the Commission's Recommended Decision may properly be closed to public observation, pursuant to section 552b(c)(3) and (10) of title 5 United States Code and section 7.3 (c) and (j) of title 39, Code of Federal Regulations.

CONTACT PERSON FOR MORE INFORMATION: David F. Harris (202) 245-3734.

David F. Harris,

Secretary.

[S-1239-83 Filed 8-30-83; 10:19 am]

BILLING CODE 7710-12-M

federal register

Thursday
September 1, 1983

Part II

Department of Health and Human Services

Health Care Financing Administration

Medicare Program; Payment for Physician Services Furnished in Hospitals, Skilled Nursing Facilities, and Comprehensive Outpatient Rehabilitation Facilities; Combined Billing; Final Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Part 405

Medicare Program; Payment for Physician Services Furnished in Hospitals, Skilled Nursing Facilities, and Comprehensive Outpatient Rehabilitation Facilities; Combined Billing

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

ACTION: Final rule.

SUMMARY: This document announces our decisions on the new issues raised in the final rule on Medicare reimbursement of physicians' services furnished in providers published March 2, 1983. The decisions are based on public comments and our analysis of them. Specifically, we are eliminating combined billing procedures.

EFFECTIVE DATE: October 1, 1983.

FOR FURTHER INFORMATION CONTACT: Leonard Peshkin, (301) 594–1115.

SUPPLEMENTARY INFORMATION: This document responds to comments to rules published on March 2, 1983. We decided not to make any changes in the text of the rules.

I. Background

On March 2, 1983, we published in the **Federal Register** (48 FR 8902) a final rule with comment period that set forth regulations governing Medicare reimbursement of physicians' services furnished in providers. The March 1983 final rule incorporated our decisions on the proposed rule published October 1, 1982 (47 FR 43578) and the public comments we received as a result of publishing the proposed rule. In addition, the final rule contained issues that had not been addressed in the October 1982 proposed rule.

In the preamble to the October 1982 proposal, we had proposed to extend the combined billing option to all physicians' services furnished to hospital patients regardless of specialty. Since April 1, 1968, the combined billing procedure has been available to hospitals and physicians for radiology and pathology services furnished to hospital inpatients and all physicians' services (except psychiatric) furnished in hospital outpatient departments. Its availability to only two inpatient specialties was based on a provision of the 1967 Amendments to the Social Security Act (the Act) that specified Medicare payment at 100 percent of the Part B reasonable charge for pathology and radiology services. Beneficiaries bore no liability for copayment for those services. Since the Part A component of the services was also reimbursable at 100 percent, a single bill could be submitted to the fiscal intermediary, thus eliminating the need for two bills. In order to use the procedure, a physician had to have a salary or percentage arrangement with a hospital, and the procedure had to be used for all services furnished within a hospital medical specialty department.

Section 112 of the Tax Equity and Fiscal Responsibility Act of 1982 (Pub. L. 97–248) eliminated the special provision regarding 100 percent payment for radiology and pathology services effective October 1, 1982. This change in the law meant that henceforth, such physicians' services would be payable on the same basis as the services of other physicians. Therefore, there was no need to restrict combined billing for services to hospital inpatients to the two specialties, and the October 1982 regulations proposed to expand the availability of this billing option. A key consideration in this expansion proposal was the proposed application of Reasonable Compensation Equivalent (RCE) limits to the full range of services for which a physician is compensated by a hospital.

However, in the March 1983 final rule, we decided not to apply at that time the RCE limits to Part B reasonable charge payments. In addition, that publication solicited comments on the total elimination of combined billing (except for all-inclusive-rate hospitals that charge patients a single rate for all hospital and physicians' services), since the test of reasonableness of the charges was being eliminated. Also, we requested comments on the delayed implementation of 42 CFR 405.550(e) concerning lease arrangements.

To afford the public the opportunity to comment on new issues in the March 1983 final rule, we provided an additional 30-day comment period. Also, we indicated that we would publish an additional notice announcing our decision on these issues based on our analyusis of the public comments in response to the March 1983 final rule.

Subsequent to the publication of the March 1983 final rule, Congress enacted Pub. L. 98–21, the Social Security Amendments of 1983. Title VI of Pub. L. 98–21 amends section 1886 and related provisions of the Social Security Act to establish a prospective payment system for hospitals under Medicare. Due to the close relationship of provisions of Pub. L. 98–21 and the March 1983 regulations, on May 31, 1983 (48 FR 24308) we delayed th effective date of those regulations unit October 1, 1983.

II. Discussion

A. Combined Billing

We have decided to eliminate the combined billing procedure under which we have permitted physicians' services to individual patients to be billed using forms HCFA–1453 and HCFA–1483. However, we will allow all-inclusive-rate hospitals that charge patients a single rate that covers hospital and physicians' services to continue to use the provider billing forms for all-inclusive-rate billing (HCFA–1453 and HCFA–1483) that include physicians' services. We believe such hospitals will be almost exclusively composed of governmental providers. We will allow these all-inclusive-rate hospitals to use a form of combined billing because it may be difficult for these hospitals to identify specific physician services, since they do not use a fee-for-service charge structure. Also, it might be overly burdensome and costly for these hospitals to begin to identify specific physician services. Further, the form used in the past for such type of billing (HCFA–1554) is being eliminated. Therefore, we believe that it is appropriate to enter these per diem amounts on the provider billing forms (HCFA–1453 and HCFA–1483). For a description of the combined billing procedure and our rationale for eliminating the procedure, refer to section VI. E. of the March 1983 final rule (48 FR 8915).

With the elimination of the combined billing procedure, all physicians' services to individual patients, including those physicians' services furnished in providers, must, beginning on the effective date of these regulations, be billed on the HCFA–1500 billing form. The comments received on this issue are discussed in section III. B. of this final rule.

B. Other Issues

Subsequent to publication of the March 1983 rule and in regard to the prospective payment legislation, some individuals inquired about the payment policy for anesthesia services where they are personally furnished by the anesthesiologist versus the situation where the anesthesiologist directs concurrent procedures.

In the March 1983 rule, we discussed at some length our considerations in distinguishing between anesthesiologists' "medical direction" and supervision of concurrently furnished services (48 FR 8927). We also

drew certain parallels between personally furnished anesthesiology services and those that are "medically directed". Anesthesiologists' "medical direction" exists both when the individuals directed are employees of the physician (and the services of such individuals are "incident to" the physician's own services) and when they are not, e.g., the individuals are certified registered nurse anesthetists employed by a hospital. The primary issue, as we viewed it at that time was a decrease of physician involvement in the care furnished to an anesthesia patient and Medicare payment where concurrent anesthesia procedures occurred. We indicated that "One commenter pointed out that the NPRM did not discuss payment for personal performance by a physician of a single anesthesia procedure." (48 FR 8928). We responded that * * * "the NPRM was sufficiently clear that such a service would be reimbursable on a reasonable charge basis as a physician's service to an individual patient (47 FR 43588). We were concerned to make provision for circumstances that required special and explicit treatment. The proposed section 405.552(a) was unambiguous in this matter." Since there still appears to be a question regarding this matter, and because we must further deal with Medicare payment for anesthesia services furnished to hospital inpatients as a result of the amendments adding sections 1862(a)(14) and 1866(a)(1)(h) in section 602 of Pub. L. 98–21, we address the issue in rules that implement the Medicare prospective payment system that are located elsewhere in this issue of the **Federal Register.**

In the March 1983 rule, we also provided special dates of application for the provisions on lease arrangements (in which a physician assumes some or all of the operating costs of a hospital department) set forth at 42 CFR 405.550(e). However, the "unbundling" provision of section 1862(a)(14) of the Social Security Act (discussed below) as added by section 602(e) of Pub. L. 98–21, in effect superseded those provisions as they affect inpatient hospital services and moot all comments on this issue resulting from the March 1983 rule. (The "unbundling" provision provides for payment of nonphysician services furnished in an inpatient setting as hospital services only and will be effective on October 1, 1983 as mandated by Pub. L. 98–21.) As a result, we are amending § 405.550(e) in the interim final regulations implementing the prospective payment system for Medicare inpatient hospital services to eliminate the provisions on its dates of application and to make other changes. These regulations are published elsewhere in this issue of the **Federal Register.** Because these further changes in our provisions on lease arrangements are necessary to implement the prospective payment system, and an additional opportunity for comment is provided in those interim rules, we are not discussing comments on § 405.550(e) in this document.

III. Major Comments and Responses

We requested comments on the new issues raised in the preamble to the March 2, 1983 final rule. These are discussed below. Although we received some comments on other issues, we are responding only to comments on the new issues identified in the March 1983 document. A period for public comment on the original issues was allowed in connection with the October 1, 1982 proposed rule, and we already have responded to the comments raised in response to that rulemaking.

A. Combined Billing

In response to our proposal to eliminate the use of combined billing for physicians' services, we received approximately 60 comments. The majority of the comments were from individual physicians and the remainder were from hospitals and associations.

Following are specific comments received and our responses.

Comment (1). Although many commenters either favored the elimination of combined billing, or did not oppose it as long as adequate time was allowed for implementing its elimination, the majority of the commenters, specifically pathologists, opposed the proposal to eliminate combined billing. The principal objection was that the proposal would increase the cost of billing for physicians' services by requiring separate itemized bills for physicians' services.

Response (1). We realize that the elimination of combined billing will increase the cost of billing for physicians' services where the combined billing method has been used. However, we believe this consideration must be viewed against the advantage of desirable uniformity in billing and reimbursement practices that the elimination of combined billing permits. All physicians' services to individual patients will be billed to the carrier or the beneficiary and be reimbursed by the carrier on an itemized basis. An accurate prevailing charge screen is especially important because with the elimination of RCE limits from Part B charge payments, there will be no other tests of reasonableness of payments.

Physicians' whose services were previously combined billed may continue their relationships with hospitals and have the hospitals bill for their services or make other billing arrangements.

We do not have any data that identifies the costs that hospitals currently incur for combined billed services. Any increase in billing costs that hospitals may incur as a result of the elimination of combined billing is not measurable. Moreover, the existence of any increase is conditioned to a large extent on whether hospitals, rather than outside billing entities, bill for those physicians' services. In spite of these quantitative problems, we estimate that hospitals, either collectively or individually, should not experience a significant increase in their billing costs.

This is based on the fact that there will not be a significant shift from combined billing to HCFA–1500 billing by the two types of specialists who have been the principal beneficiaries of combined billing. Nearly 70 percent of hospital radiologists currently do not use combined billing. Moreover, the great bulk of services furnished in hospital laboratories supervised by hospital pathologists will not qualify for reasonable charge reimbursement. We will continue to pay the hospital for these services on a reasonable cost basis or as an element of prospective payment, as appropriate. We will, however, consider any studies that are submitted that quantify the cost of billing for physician services that previously were combined billed.

The elimination of combined billing allows us to more properly determine program reimbursement as mandated by section 1842(b) of the Act, which specifies that we should, in determining reasonable charges for services, consider among other things the customary charges for similar services, as well as the prevailing charges for similar services in the locality and that reasonable charges should not exceed the charge applicable for comparable services in the locality. Under combined billing, data would be lost in the carrier screens because specific charges cannot be determined from combined billing and, therefore, would be excluded from prevailing charge screens. The result would not be equitable to those who bill on the HCFA–1500 or the Medicare program because the screens would not be totally representative.

Further, physicians had to have salary or percentage arrangements with hospitals to be eligible to use combined

billing. Recently there have been many changes in the financial arrangements between physicians and hospitals that resulted in some physicians losing their eligibility for combined billing. However, in some cases, intermediaries allowed physicians to continue to use combined billing even though the physicians were not eligible for purposes of combined billing. By eliminating combined billing, physicians who were erroneously utilizing combined billing will no longer be able to do so.

We believe the advantages of eliminating combined billing far outweigh the disadvantages of maintaining the procedure.

Physicians' services currently billed using the combined billing method must be billed on the HCFA–1500 billing form beginning on October 1, 1983. Carriers will be responsible for determining the compensation-related customary charge for services furnished by physicians who are compensated by or through a provider to furnish services to individual patients. The compensation-related customary charge data will be used in the calculation of the prevailing charge screens for physicians' services in the locality.

If a physician who has been compensated by or through a provider or other entity for physicians' services to individual patients ends his or her compensation agreement and instead bills all patients, that is, the physician no longer receives any compensation from the hospital for his or her services, the physician's customary charge will be determined on the basis of the former compensation agreement until the carrier has accumulated charge data from at least three months of the calendar year preceding the annual reasonable charge update. Any changes in charges will be reflected in his or her customary charges at the next update.

Comment (2). Some physicians stated that the proposal would prevent them from using the hospital as a billing and collection agent for their services.

Response (2). This is not intended. Physicians are not prohibited by the regulations from having the hospital or another entity provide billing services for them, nor are they required to do so. Physicians may give hospitals the right to bill for them either as agents or as a term of their employment. (See section 1842(b)(5) of the Act and 42 CFR 405.1680.) This is a matter for agreement between physicians and hospitals. Further, the hospital, if authorized by various compensated physicians, could bill Medicare for their services on the same form HCFA–1500. For example, if the hospital compensates its cardiologists and radiologists for furnishing physicians' services and is authorized to claim Medicare payments for the physicians' services, the hospital could bill for the services of both on the same claim form HCFA–1500. There are currently procedures in place under which a single signature on a billing form is sufficient for the services of all physicians for whom the hospital is authorized to bill. However, when the hospital bills as a billing agent for a physician or physician group, it can only include on the same form those services furnished by that physician or group. While the HCFA–1500 billing form can be used in the above situation to bill for multiple physicians' services, the same form cannot be used to bill for more than one patient. A separate HCFA–1500 form must be used for each patient.

Comment (3). A few commenters, both physicians and organizations, proposed various ways to continue combined billing, including prior approval of charge schedules by intermediaries, application of carrier screens by intermediaries, and sending a copy of the hospital billing form to the carrier for processing. Another commenter requested that combined billing be continued for outpatient services if the physician's compensation level is reasonable.

Response (3). Our purpose in eliminating combined billing is twofold. First, our previous decision not to apply the RCE limits to the compensation the physician receives from the hospital for physicians' services to individual patients means that if intermediaries continue to process combined bills, they would do so without testing the reasonableness of their payments for physicians' services that are reimbursed under Part B because the services are not itemized. Secondly, the simplification in reimbursement procedures and claims processing envisioned in the 1967 Amendments for both providers and intermediaries under combined billing never materialized because the option was never widely used and section 112 of Pub. L. 97–248 eliminated the special provision regarding 100 percent payment for radiology and pathology services. Thus, the additional special processing routines necessary for combined billing have not been justified. (See discussion in section VI. E. 3. of the preamble of the March 2, 1983 (48 FR 8915) rule for further discussion of combined billing.)

Also, we do not believe the recommendation to continue combined billing subject to the condition that the intermediary approve the physician's charge schedule is workable. The intermediary does not have the expertise or data needed to evaluate reasonable charges for physicians' services (that is, the intermediary would not have data to transfer to the carrier reflecting the frequency with which each service was rendered). Under combined billing, services are not itemized and the intermediary would not be able to evaluate the reasonableness of payment for the unknown quantity of services. These data would be necessary to compute prevailing charge screens.

In addition, it should be noted that in all of these suggestions, there would be no identification of the individual services furnished. Itemization of physician services is necessary if carrier screens are to reflect the actual going rate for physicians' services furnished in providers. Also, the discrete charge for the physician's service alone is necessary for implementation of the "unbundling" provision of the prospective payment system that is effective October 1, 1983. Under section 1862(a)(14) of the Act, "unbundling" will be prohibited; that is (with one exception), all nonphysician services provided in an inpatient setting will be paid only as hospital services. Physician direction of certain hospital services; e.g., anesthesiology, will continue to be reimbursed under Part B as indicated in the response to comments on other issues in this preamble. Regulations implementing the "unbundling" provision are published as part of the final rule implementing prospective payment for inpatient hospital services, elsewhere in this issue of the **Federal Register.**

Comment (4). Several commenters noted that elimination of combined billing will add to the beneficiaries' copayment burden, and that the separate bill would confuse beneficiaries.

Response (4). Since the enactment of section 112 of Pub. L. 97–248 on October 1, 1982, beneficiaries have been liable for copayment in connection with inpatient pathology and radiology services and have received bills for copayment amounts. There is no reason for these amounts to increase unless the charges for such services increase. Thus, these services are now treated the same as other physician services reimbursed under Part B of Medicare.

Comment (5). Some commenters suggested that combined billing be phased out over one year or that more time be permitted to help assure a smooth transition. Others asked that the change be delayed to coincide with the implementation of certain provisions of the Social Security Amendments of 1983 (effective October 1, 1983) that affect

payment for items and services furnished to hospital inpatients.

Response (5). As previously mentioned, subsequent to our publishing the final regulations on March 2, 1983, Congress passed the Social Security Amendments of 1983. These amendments require some further modification in the way Medicare pays for certain items and services, generally nonphysician services, furnished to hospital inpatients. Therefore, in order to assure a smooth transition and to assure that the effective dates here are consistent with the provisions of the Social Security Amendments of 1983, the effective dates applicable to the March 1983 final rule were uniformly changed to October 1, 1983.

Also, we stated in the March 1983 final rule, that we would, if feasible, publish an announcement of our decision on the elimination of the combined billing procedure before the regulations become effective in order to implement the elimination of combined billing at the same time as the provisions of the March 1983 final rule. The elimination of combined billing will be effective October 1, 1983. We are allowing 30 days notice before these regulations are effective. We believe this is ample time because no changes in agreements between physicians and hospitals are required by this rule. Also, we gave notice in the March 1983 rule that this change was likely to occur.

B. Comments on Other Issues

Comment. A number of commenters noted that while 42 CFR 405.552(a)(1)(vii) requires that an anesthesiologist, as a condition for payment on the basis of charges, provide indicated postanesthesia care, the general discussion in the preamble of the March 1983 final rule (48 FR 8928, column 3) states ". . . checking or discharging patients in the recovery room and handling scheduling matters is not compatible with our reimbursing the physician on a reasonable charge basis for directing concurrent anesthesia procedures." The commenters requested clarification.

Response. Implicit in the payment of charges for the medical direction of concurrent anesthesiology services is that the physician is directing services furnished by others. As a condition for charge payment for direction of up to four concurrent services, the physician must furnish or assure that a qualified individual furnishes indicated care in the recovery room. We did not mean to suggest otherwise.

However, if a physician is directing four concurrent surgical procedures and devotes extensive time to checking or discharging other patients in the recovery room or handling scheduling matters, this could unduly diminish physician involvement in the surgical cases. If significantly reduced, a physician's involvement in the surgical cases would become "supervision" rather than "medical direction". Also, a physician cannot *personally* be extensively involved in recovery room or scheduling matters of significant duration, because such personal services would diminish the scope of control necessary for "medical direction".

The carrier will review medical records and operating room logs to assure that the requirements for medical direction are met. Any questions regarding these issues as they apply in individual cases will be resolved by the carrier's medical director.

IV. Impact Analysis

A. Executive Order 12291

Executive Order 12291 requires us to prepare and make available to the public a regulatory impact analysis for any regulations likely to result in an annual effect on the economy of $100 million or more, cause a major increase in costs or prices, or meet other threshold criteria specified in section 1(b) of the Order.

1. Combined Billing. Combined billing has been used by providers to include charges for certain physician services, especially radiology and pathology services, on the provider's bill. Charges billed by this method have not been subject to prevailing charge screens. We believe that elimination of combined billing will enable us to test the reasonableness of all charges for physicians' services furnished to Medicare beneficiaries. This will avoid creating incentives for physicians or hospitals to shift to combined billing to escape the effects of reasonable charge determinations made by carriers using prevailing charge screens.

As noted in the March 1983 final rule, we expect that eliminating combined billing will result in additional one-time start-up costs of $6 million in FY 1984, and will generate ongoing operational costs as well as some program savings. As a result of decisions made in the final rule, we estimate ongoing operational costs of $18 million in FY 1984. These costs will result from increased costs for processing claims formerly included in combined billing coupled with the higher average cost, as compared to combined bills, to process the HCFA-1500 billing form, which will now be used for almost all physician services reimbursed on a reasonable charge basis. However, these operational costs will be offset by administrative savings from other features in the hospital-based physician regulation published March 2, 1983. If we do not eliminate combined billing, we can expect our billing costs to be significantly higher, since maintaining parallel optional billing methods entails the additional costs of changes between billing methods.

We believe that this provision will also realize some program savings resulting from the use of the itemized HCFA-1500 billing form. Carriers will be able to make the necessary comparisons of actual amounts billed to customary and prevailing charges for similar services. This will assure that payment amounts for physician services furnished in providers do not exceed what we would otherwise have paid for comparable services and will allow us to retain control over Medicare program expenditures. However, because we do not have data on the extent to which this now occurs, we cannot quantify the expected savings of this provision. However, we expect that this will result in savings that are greater than the anticipated costs. There is no indication, at this time, that any savings would exceed the $100 million threshold.

2. Anesthesiologists' Services. We are not making any changes to the regulations concerning physician direction of concurrent anesthesia procedures while a physician is checking and discharging patients in the recovery room. We included the effect of these regulations in our analysis published in the March 1983 rule (48 FR 8943).

B. Regulatory Flexibility Act

The Secretary certifies under 5 U.S.C. 605(b), enacted by the Regulatory Flexibility Act of 1980 (Pub. L. 96-354), that this rule will not result in a significant impact on a substantial number of small entities.

1. Combined Billing. Some physicians may experience revenue losses because of the application by carriers of the regular prevailing charge screens. However, we are unable to estimate the extent to which this may occur, although any loss should not be significant given the average income for most physicians.

Hospitals or physicians previously subject to combined billing will also experience some increase in operating expenses to comply with this new billing procedure, although some of these costs can be recovered through various means.

2. Anesthesiologists' Services. We are not making any changes to the

regulations concerning physician direction of concurrent anesthesia procedures while a physician is checking and discharging patients in the recovery room. We included the effect of these regulations in our analysis published in the March 1983 rule (48 FR 8943).

C. Information Collection Requirements

This final rule does not contain information collection requirements that are subject to Executive Office of Management and Budget review under the Paperwork Reduction Act of 1980, Pub. L. 96–511.

List of Subjects in 42 CFR Part 405

Administrative practice and procedure, Certification of compliance, Clinics, Contracts (agreements), End-stage renal disease (ESRD), Health care, Health facilities, Health maintenance organizations (HMO), Health professions, Health suppliers, Home health agencies, Hospitals, Inpatients, Kidney diseases, Laboratories, Medicare, Nursing homes, Onsite surveys, Outpatient providers, Reporting requirements, Rural areas, X-rays.

(Secs. 1102, 1814(b), 1815, 1832, 1833(a), 1842(b), 1861(b), 1861(v), 1871, 1881, 1886, and 1887 of the Social Security Act, as amended (42 U.S.C. 1302, 1395f(b), 1395g, 1395k, 1395l(a), 1395u(b), 1395x(b), 1395x(v), 1395hh, 1395rr, 1395ww, and 1395xx))

(Catalog of Federal Domestic Assistance Program No. 13.773, Medicare—Hospital Insurance Program, No. 13.774, Medicare—Supplementary Medical Insurance Program)

Dated: August 17, 1983.

Carolyne K. Davis,

Administrator, Health Care Financing Administration.

Approved: August 25, 1983.

Margaret M. Heckler,

Secretary.

[FR Doc. 83-23802 Filed 8-31-83; 8:45 am]

BILLING CODE 4120-03-M

federal register

Thursday
September 1, 1983

Part III

Department of Health and Human Services

Health Care Financing Administration

Medicare Program; Schedule of Target Rate Percentages for Limits on the Rate of Hospital Cost Increases and Updating Factors for Transition Prospective Payment Rates; Interim Final Notice With Comment Period.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

Medicare Program; Schedule of Target Rate Percentages for Limits on the Rate of Hospital Cost Increases and Updating Factors for Transition Prospective Payment Rates

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

ACTION: Interim final notice with comment period.

SUMMARY: This interim notice sets forth target rate percentages needed to limit the rate of increase of hospital inpatient operating costs and related updating factors for use in computing the hospital-specific portions of transition payment rates under the prospective payment system. The notice also explains which hospitals are subject to the ceiling on the rate of hospital cost increases (as established by the Tax Equity and Fiscal Responsibility Act of 1982, and amended by the Social Security Amendments of 1983), and describes how the calendar year target rate percentages are applied to cost reporting periods that span two calendar years.

EFFECTIVE DATE: See the text of this notice for an explanation of the application of these target rate percentages to particular cost reporting periods.

COMMENT DATE: To assure consideration, comments should be received by October 16, 1983.

ADDRESS: Address comments in writing to: Health Care Financing Administration, Department of Health and Human Services, Attention: BERC-264-FNC, P.O. Box 26676, Baltimore, Maryland 21207.

In commenting, please refer to BERC-264-FNC.

If you prefer, you may deliver your comments to Room 309-G Hubert H. Humphrey Building, 200 Independence Ave., SW., Washington, D.C., or to Room 132, East High Rise Building, 6325 Security Boulevard, Baltimore, Maryland.

Comments will be available for public inspection as they are received, beginning approximately three weeks after publication, in Room 309-G of the Department's offices at 200 Independence Ave., S.W., Washington, D.C. 20201, on Monday through Friday of each week from 8:30 a.m. to 5:00 p.m. (200-245-7890).

FOR FURTHER INFORMATION CONTACT: Terence Skelly, (301) 594-9343.

SUPPLEMENTARY INFORMATION:

I. Background

Section 101(a)(1) of the Tax Equity and Fiscal Responsibility Act of 1982, or TEFRA (Pub. L. 97-248, enacted September 3, 1982), added two new sections 1886(a) and 1886(b) to the Social Security Act (the Act), supplementing section 1861(v) of the Act by providing for a limit on the amount of inpatient operating cost per discharge and a new three-year control on the rate of increase of operating costs of inpatient hospital services. (This rate of increase limit is separate and different from the type of limit established under section 1861(v) (as amended by section 223 of Pub. L. 92-603) and section 1886(a), which were applied to the level of costs, rather than to their rate of increase.) This new provision requires that we establish a ceiling on the rate of increase of operating costs per case for inpatient hospital services and provides for both incentive payments for hospitals that keep their cost below the target, and a reduction in the amount of reimbursement for hospitals that incur costs greater than the target.

On September 30, 1982, we published interim final regulations (47 FR 43282) implementing section 1886(b) of the Act for hospital cost reporting periods beginning on or after October 1, 1982 (42 CFR 405.463). The interim rules had a 60-day comment period, ending November 29, 1982, during which we received approximately 100 comments on the regulations.

As a result of review of comments on and further analysis of the interim regulations, we published final regulations making certain amendments to the interim rules and establishing them as permanent program regulations (FR Doc. 83-23800, Part V of the issue of August 30, 1983). In those final rules, we amended the interim rate of increase regulations (42 CFR 405.463) in two ways. First, we excluded certain kidney acquisition costs from those inpatient operating costs subject to the rate of increase ceiling. Second, we decided to revise the method of updating and providing notice of target rate percentages included in the interim regulations. Instead of requiring intermediaries to use the most recent percentage published in the annual cost limits notice, we decided to publish appropriate percentages quarterly. Those amendments provided that intermediaries use the most recent percentage available as of the close of the hospital's cost reporting period, and that HCFA publish revised market basket percentages each quarter in the Provider Reimbursement Manual (HCFA Pub. 15-1), and also publish the updated percentages in an appropriated **Federal Register** notice.

However, amendments to section 1886(b) made by Title VI of Pub. L. 98-21, enacted April 20, 1983, which also established the prospective payment system, require us to further amend the regulation on the rate of increase ceiling.

We are implementing the amendments made to section 1886(b) by section 601 of Pub. L. 98-21 by amending our regulations at 42 CFR 405.463 as part of the conforming changes made in the interim rules implementing the prospective payment system, published elsewhere in this issue of the **Federal Register**. The changes are as follows:

- We are deleting all references to the inapplicability of the rate of increase limits to cost reporting periods beginning on or after October 1, 1985. Section 405.463 will now apply indefinitely (section 1886(b)(2) of the Act, as repealed by section 601(b)(4)).
- We are clarifying the costs subject to the ceiling, specifying that for cost reporting periods beginning on or after October 1, 1983, capital-related costs (including the return on equity which is treated like a capital-related cost), and the direct costs of approved medical education programs will be excluded from the ceiling (sections 1886(a)(4) and (b)(4)(A) of the Act, as amended by sections 601(a)(2) and 601(b)).
- Hospitals must treat such costs consistently with treatment in their base period.
- We are providing for adjustment of base period costs to account for FICA taxes incurred by a non-profit hospital that had not incurred such taxes for all its employees in its base period (section 1886(b)(6) of the Act, as amended by section 601(b)(9)).
- Hospitals engaged in kidney transplantation encounter a unique set of circumstances with respect to their cost experience because of special provisions of the law applicable to end stage renal disease (ESRD). Kidney acquisition costs are reimbursed pursuant to section 1981 of the Act, under which the Secretary reimburses: (1) the hospital for obtaining kidneys from Organ Procurement Agencies (OPA) in amounts not to exceed the costs incurred by OPAs and histocompatability laboratories; and (2) the reasonable expenses incurred by an individual donor. In view of the unique characteristics of organ procurement activities and the desirability of maintaining an adequate supply of kidneys, certain kidney acquisition costs will not be subject to the rate of increase control.

• We are providing that the target rate percentages by which target amounts will be determined will be established prospectively and published in a quarterly **Federal Register** notice. Target rate percentages will still be prorated for cost reporting periods that span portions of two calendar years. Further, we have made it explicit in the regulations that we will apply the appropriate target rate percentage prospectively, and will not retroactively adjust the prospectively set target rate percentages if the actual increase in the market basket differs from the prospective estimate.

II. How the Rate of Increase Ceiling Works

The regulations, as amended, establish a target rate percentage system to be applied to control the rates of increase of total hospital inpatient operating costs per case effective for 12-month cost reporting periods beginning on or after October 1, 1982 (see our regulations at 42 CFR 405.463(b)). The target rate percentage equals the market basket index plus one percentage point. In the first year, this target rate percentage will be applied to each hospital's allowable inpatient operating cost per discharge for its immediately preceding cost reporting period (§ 405.463(c)). In the case of a hospital whose first reporting period subject to the rate-of-increase control begins October 1, 1982, the target rate percentage would be applied to the allowable inpatient operating cost per discharge for the period beginning October 1, 1981. The resulting amount will be that hospital's target amount for inpatient operating cost per discharge in the first cost reporting period subject to this provision (§ 405.463(b)). The rules provide that in each subsequent cost reporting period, the target amount will be computed by applying the applicable target rate percentage to the previous period's target amount (§ 405.463(c)(4)(ii)).

If a hospital's costs in a subject cost reporting period are below its target amount, we will pay the hospital its actual costs per case plus the lower of 50 percent of the difference between the hospital's cost per case and the target amount, or 5 percent of the target amount. If a hospital's cost in a subject period is higher than its target amount, we will pay, in the first two years, the target amount plus 25 percent of the excess costs, and, in the third year, the target amount (§ 405.463(d)). For periods beginning on or after October 1, 1982 and before October 1, 1983, the maximum payment is limited by the TEFRA limits on total inpatient operating cost established under section 1886(a).

New hospitals, risk-basis health maintenance organizations, and hospitals paid under the prospective payment system are exempt from the rate of increase ceiling (§ 405.463(f)). A hospital subject to the ceiling may request an exception to it on the basis of a change in case mix or extraordinary circumstances that are beyond the hospital's control and which have substantial cost effects (§ 403.463(g)). The ceiling will not apply to a cost reporting period of less than 12 months that occurs along with a change in operations of the facility as a result of changes in ownership, merger or consolidation (§ 405.463(b)(3)). In addition, HCFA may adjust a hospital's cost per case to take into account factors, such as a decrease in the inpatient hospital services, that would otherwise distort the comparison of costs between reporting periods (§ 405.463(h)).

III. Hospitals Subject to the Rate of Increase Ceiling

Under the rules implementing TEFRA, only new hospitals and risk-basis health maintenance organizations (HMOs) were exempt from the rate of increase ceiling. All other hospitals participating in Medicare were subject to this new limit on inpatient operating costs for cost reporting periods beginning on or after October 1, 1982.

Under Pub. L. 98–21, most participating short-term acute care hospitals will be paid under the prospective payment system and will not be subject to the rate of increase ceiling for cost reporting periods beginning on or after October 1, 1983. Rather, this ceiling will apply to hospitals and hospital units (that is, distinct part psychiatric and rehabilitation units) that are excluded from the prospective payment system and paid on a reasonable cost basis under our regulations at 42 CFR Part 405, Subpart D. The criteria for identifying these hospitals and units are set forth in the interim regulations published elsewhere in this issue, at § 405.471(c).

In summary, the following classes of hospitals will be subject to the rate of increase ceiling for cost reporting periods beginning on or after October 1, 1983:

- Psychiatric hospitals;
- Rehabilitation hospitals;
- Psychiatric and rehabilitation distinct part units;
- Children's hospitals;
- Long-term hospitals; and
- Hospitals outside the 50 States and the District of Columbia (for example, Puerto Rico).

IV. Inpatient Operating Costs Subject to the Rate of Increase Ceiling

The rate of increase ceiling applies to operating costs incurred by a hospital in furnishing inpatient hospital services. These operating costs *include* the operating costs related to routine services, such as nursing services and room and board, ancillary services, and special care units.

For cost reporting periods beginning on or after October 1, 1982 and before October 1, 1983, inpatient operating costs *exclude* capital-related costs, the direct costs of medical education, malpractice insurance costs, and certain costs of kidney acquisition. However, section 601(a)(2) of Pub. L. 98–21 amended section 1886(a)(4) of the Act, which defines inpatient operating costs, effective for cost reporting periods beginning on or after October 1, 1983. For those cost reporting periods, costs *excluded* from operating costs are capital-related costs, direct medical education costs, and certain kidney acquisition costs. A new regulation section describing capital-related costs is included in the interim rules implementing the prospective payment system, at § 405.414. Those interim rules also amend the regulations describing direct medical education costs, at § 405.421, as explained in the preamble to the interim rules.

V. Application of Target Rate Percentages

As mentioned above, we are, beginning with this notice, publishing quarterly notices of target rate percentages. Each of these notices will include tables (see below) of target rate percentagers set at the market basket index plus one percentage point, in accordance with section 1886(b)(3)(B) of the Act. The market basket index is an estimate of the annual rate of increase in the costs of certain goods and services used by hospitals in the production of inpatient care. The items and services used in the market basket index have been selected and weighted to reflect the effect that general price changes have on hospital inpatient operating costs.

The calculation of the market basket index is explained in the interim rules on prospective payment. We have revised the market basket index to take into account the inclusion of malpractice insurance among inpatient operating costs. For administrative simplicity, and because the minimal increase in the

market basket estimates resulting from this change will not disadvantage any hospitals, we have decided to use the same market basket index for all cost reporting periods subject to this notice.

When a hospital's cost reporting period spans two calendar years (i.e., begins in one calendar year and ends in another), the hospital's target rate percentage will be determined by prorating the applicable percentages for the calendar years the period spans.

For 12-month cost reporting periods beginning on or after October 1, 1982, and before October 1, 1983, the applicable target rate precentages will be taken from the notice published for the quarter in which the hospital's cost reporting period ends. Thus, the percentages published in this notice will be used to determine the rate of increase ceilings for hospital cost reporting periods *ending* on or after September 30, 1983 and *before* January 1, 1984. These percentages will not be adjusted later if the actual rates of increase differ from the market basket estimates.

Cost reporting periods of other than 12 months that *do not* occur along with a change in operations of the facility as a result of changes in ownership, merger, or consolidation, are subject to the rate of increase limit. In such cases, the applicable target rate percentage must be obtained from HCFA. We will adjust the target percentage rate to reflect fewer months in the case of a short reporting period, using a monthly factor corresponding to the annual percentage rate and apply the ceiling. (We will also use such a monthly factor to make adjustments for cost reporting periods longer than 12 months.)

As noted above, Pub. L. 98–21 specified that, effective for cost reporting periods beginning on or after October 1, 1983, the target rate percentages must be established prospectively. Therefore, the target rate percentages published in this notice will also be applied to 12-month cost reporting periods *beginning* on or after October 1, 1983 and before January 1, 1984. Again, these percentage rates will not be revised later based on actual market basket experience.

A hospital's intermediary will prorate the appropriate calendar year percentages from Table A to determine the target rate percentage for a hospital with a cost reporting period that spans two calendar years. The intermediary will compute a prorated target rate percentage as follows:

1. The intermediary will determine the number of months in each calendar year covered by the hospital's cost reporting period.

2. The number of months for each calendar year will be divided by twelve and multiplied by the applicable target rate percentage for that year.

3. The two resulting percentages are added, yielding the hospital's target rate percentage for that cost reporting period.

Example A: Hospital A has a cost reporting period beginning October 1, 1982 and ending September 30, 1983. Therefore, there are 3 months of the period in 1982 and 9 months of the period in 1983.

The applicable calendar year target rate percentages are:

1982.....10.3 (0.103)
1983.....7.2 (0.072)

Hospital A's rate percentage is calculated as follows:

$$\frac{(3\times 0.103)}{12} + \frac{(9\times 0.072)}{12} = 8.0\%$$

Example B:

Hospital B has a cost reporting period beginning November 1, 1983 and ending October 31, 1984. Therefore, there are 2 months of the period in 1983 and 10 in 1984.

The applicable calendar year target rate percentages are:

1983.....7.2 (0.072)
1984.....6.8 (0.068)

Hospital B's target rate percentage is calculated as follows:

$$\frac{(2\times 0.072)}{12} + \frac{(10\times 0.068)}{12} = 6.9\%$$

Note that in Example A, in which the cost reporting period begins *before* October 1, 1983, the resulting percentage will be applied retrospectively. In Example B, the resulting percentage will be applied prospectively, since the cost reporting period begins *after* October 1, 1983.

VI. Updating Factors for Determining Transition Payment Rates Under the Prospective Payment System

The preamble to the interim final rules implementing the prospective payment system established by Title VI of Pub. L. 98–21 and amending the regulations governing the rate of increase ceiling, which are published elsewhere in this issue of the **Federal Register**, explains how prospective payment rates during the initial three-year transition period will be determined using a blend of Federal prospective payment rates (based on standardized payment amounts) and rates based on each hospital's cost experience. The hospital-specific portion of the transition payment rates will be based on per case target amounts computed generally in the same way as are amounts for hospitals subject to the rate of increase ceiling. This computation is described in the interim regulations published elsewhere in this issue at 42 CFR 405.474. The differences will be that, for hospitals paid under the prospective payment system:

- The target amounts will be standardized to take a hospital's historical case mix into account;
- The case-mix adjusted base year costs will be reduced to take into account outlier payments; and
- The applicable updating factors will be based on the rate of increase target rate percentage as adjusted for budget neutrality, in accordance with section 1886(e)(1)(A) of the Social Security Act.

Therefore, for cost reporting periods beginning on or after October 1, 1983, we are publishing in Table B, below, updating factors for computing the hospital-specific portion of transition period prospective payment rates. The updating factors are computed by adjusting the calendar year target rate percentages by an actuarily estimated factor. This adjustment is necessary to implement the budget neutrality provisions of the statute. The factor is computed to ensure that the estimated amount of aggregate Medicare payments made based on the hospital-specific portion of the transition payment rates for Federal fiscal year 1984 is neither greater nor less than 75 percent of the payment amounts that would have been payable for the inpatient operating costs incurred by those same hospitals for fiscal year 1984 under the Social Security Act as it was in effect on April 19, 1983.

VII. Tables of Target Rate Percentages and Hospital-Specific Portion Updating Factors

TABLE A.—TARGET RATE PERCENTAGES

[Applicable to hospitals subject to the rate of increase ceiling]

Calendar year	Estimated market basket index (percent) [1]	Target rate percentage
1982	9.3	10.3
1983	6.2	7.2
1984	5.8	6.8
1985	6.2	7.2

[1] This market basket index includes malpractice insurance costs.

TABLE B.—UPDATING FACTORS

[Applicable to hospitals under the prospective payment system]

If base year cost reporting period ends	And first cost reporting period under PPS ends	Updating factor[1]
Sept. 30, 1982	Sept. 30, 1984	1.13570
Oct. 31, 1982	Oct. 31, 1984	1.13265
Nov. 30, 1982	Nov. 30, 1984	1.12961
Dec. 31, 1982	Dec. 31, 1984	1.12658
Jan. 31, 1983	Jan. 31, 1985	1.12658
Feb. 28, 1983	Feb. 28, 1985	1.12658
Mar. 31, 1983	Mar. 31, 1985	1.12658
Apr. 30, 1983	Apr. 30, 1985	1.12658
May 31, 1983	May 31, 1985	1.12658
June 30, 1983	June 30, 1985	1.12658
July 31, 1983	July 31, 1985	1.12658
Aug. 31, 1983	Aug. 31, 1985	1.12658

[1] If a hospital's base year cost reporting period ends on a date other than as specified above, the fiscal intermediary will contact HCFA for the appropriate adjustment factor.

VIII. Impact Analysis

Executive Order 12291 requires us to prepare and publish a regulatory impact analysis for any regulations that are likely to have an annual effect on the economy of $100 million or more, cause a major increase in costs or prices, or meet other threshold criteria that are specified in that order. In addition, the Regulatory Flexibility Act (Pub. L. 96–354) requires us to prepare and publish a regulatory flexibility analysis for regulations unless the Secretary certifies that the regulations will not have a significant economic impact on a substantial number of small entities. (For purposes of the Regulatory Flexibility Act, small entities include all nonprofit and most for-profit hospitals.) Under both the Executive Order and the Regulatory Flexibility Act, such analyses must, when prepared, show that the agency issuing the regulations has examined alternatives that might minimize unnecessary burden or otherwise ensure the regulations to be cost-effective.

Although this notice implements two regulatory provisions, its primary purpose is to publish the target rate percentages for purposes of determining the rate-of-increase ceiling for hospitals subject to our regulations at 42 CFR 405.463. The effect of the updating factors used to determine the hospital-specific portion of transition payment rates under the prospective payment system is included in the cost and impact estimates of the impact analysis of the interim rules implementing that system. Therefore, in this section, we address only the rate of increase ceiling provisions implemented through this notice.

In previous documents implementing the rate of increase ceiling, we noted that although the estimated effect of the rate of increase ceiling clearly exceeded the $100 million annual threshold of the Executive Order, we determined that impact to be caused by section 1886(b) of the Social Security Act, rather than by our regulations, now codified at 42 CFR 405.463. (See interim rules at 47 FR 43282, published September 30, 1982 and final rules in FR Doc. 83–23800, Part V of the issue of August 30, 1983. With the implementation of the prospective payment system, the rate of increase ceiling will be applied to many fewer hospitals, since hospitals paid on a prospective rate basis are not subject to the ceiling. Further, our prior estimates for the rate of increase ceiling were stated as savings in addition to savings achieved by the hospital cost limits, which will not apply to cost reporting periods beginning on or after October 1, 1983.

As established under TEFRA, the rate of increase ceiling was expected to substantially reduce Medicare expenditures for inpatient hospital services, resulting, according to our re-estimate in February 1983, in savings for the Part A Trust Fund of $480 million in Fiscal Year 1983 and $780 million in Fiscal Year 1984. However, nearly all of these savings were the result of the effect of the ceiling on hospitals that will be subject to the prospective payment system. This notice will not result in a change of Fiscal Year 1983 savings, or savings related to cost reporting periods phased in during Fiscal Year 1983. However, due to the implementation of the prospective payment system, the rate of increase ceiling will apply to only a very small proportion of Medicare expenditures for inpatient hospital services furnished in cost reporting periods beginning on or after October 1, 1983.

We estimate that only about two percent of such expenditures have been made historically to hospitals that will be excluded from the prospective payment system. However, we have not previously collected special data on these groups of hospitals, and cannot determine whether their rates of cost increase have been similar to those of hospitals as a whole. It is possible that their costs have increased significantly less rapidly than those of short-term acute-care hospitals. If this is so, then the rate of increase ceiling may have little effect on them. In any event, the savings attributable directly to the rate of increase ceiling will be much smaller than would have been attributed to the ceiling if the prospective system had not been established.

Any savings would be the direct result of implementation of section 1886(b), which clearly specifies the major features of the rate of increase ceiling. The discretionary features with respect to the ceiling, such as the decision to publish updated target rate percentages quarterly, will not have an impact of $100 million or more, or meet the other threshold criteria of the Executive Order. Therefore, we have determined that this notice is not a major rule and that a regulatory impact analysis is not required.

For similar reasons, we have determined, and the, Secretary certifies, under the Regulatory Flexibility Act, that this notice will not, in itself, result in a significant economic impact on a substantial number of small entities.

Nearly all hospitals participating in Medicare will, as a result of implementation of section 1886 of the Social Security Act, be subject to the rate of increase ceiling, the prospective payment system, or a State cost control system. As regards the rate of increase ceiling, we have exercised discretionary authority affecting the impact on small entities primarily in developing criteria for excluding certain hospitals from the prospective payment system. However, the categories for which we developed such criteria are prescribed by statute (section 1886(d)(1)(B)), and we do not believe that our criteria have resulted in subjecting a substantial number of hospitals to the rate of increase ceiling that would otherwise have been subject to the prospective payment system. Since the impact of the ceiling is attributable to the effect of the statute, rather than our regulations, we have determined that a regulatory flexibility analysis is not required.

IX. Other Required Information

A. Public Comments on This Interim Notice

Because the updating factors included in this notice will be used to implement interim rules published elsewhere in this issue of the **Federal Register**, this notice must be published on an interim basis also. We are providing a 45-day comment period on both this interim notice and the interim rules implementing the prospective payment system. We expect to respond to comments on those rules and this notice in the final rules on prospective payment. Because this is the first of a series of notices that we plan to publish quarterly, those final rules and responses to comments on this notice may not be published before the next quarterly notice. Quarterly notices will be published on an interim basis until final rules on the prospective payment system are promulgated.

Because of the large number of comments we receive, we cannot

acknowledge them individually. Although the target rate percentages and updating factors published in this interim notice will take effect as described above before the close of the comment period on [45 days from date of publication], we will review all comments received by that date and respond to them in a future publication.

B. Paperwork Reduction Act

This final notice with comment period does not contain information collection requirements that are subject to review by the Executive Office of Management and Budget under the Paperwork Reduction Act of 1980 (Pub. L. 96–21).

C. Waiver of Prior Public Comment Period and 30-Day Delay in Effective Date

The Administrative Procedure Act (5 U.S.C. 553) provides for a period of public comment and for a 30-day delay in the effective date of rulemaking documents, unless there is good cause to waive the requirements.

The target rate percentages and updating factors published in this interim notice are necessary for three purposes:

- To compute appropriate rate of increase ceilings under our regulations at 42 CFR 405.463 for hospital cost reporting periods ending during the quarter from September 30, 1983 through December 31, 1983;
- To compute appropriate rate of increase ceilings under § 405.463 for hospital cost reporting periods beginning on or after October 1, 1983 and before January 1, 1983; and
- To update the cost data used to determine the hospital-specific portion of transition payment rates under the prospective payment system.

The first purpose requires a retroactive application of percentages to cost reporting periods beginning as long ago as October 1, 1982. As explained above, we provided in the final rules concerning the rate of increase limit (FR Doc. 83–23800, Part V of the issue of August 30, 1983) that we would publish quarterly notices of target rate percentages. The purpose of quarterly publication is to ensure the availability of timely and accurate estimates. Less frequent publication (for example, annual notices of percentages, as originally provided under the interim rules published September 30, 1982) would result in accidental accrual of unintended and unnecessary advantages or disadvantages to affected hospitals, depending on how their cost reporting periods related to the publication schedule and how the percentages varied. Therefore, although generally there are no other changes in the methodology by which target rate percentages are derived, we have decided to publish revised estimates as often as feasible. (The basis for retroactive application of these estimates is explained more fully in the final rules concerning the rate of increase limit referred to above.)

Regarding the updating factors, section 604(c) of Pub. L. 98–21 provides that we must publish interim regulations and rates implementing the prospective payment system no later than September 1, 1983. These updating factors are necessary for the calculation of the transition payment rates that we will pay during the first year of that payment system.

Similarly, since the methodology used to compute the rates of increase contained in this notice is essentially the same as provided in the original interim rate of increase rules, we believe it would be inappropriate to use a different, outdated, and less accurate market basket estimate to compute rate of increase ceiling target amounts for cost reporting periods already begun. If we were required to submit the rates of increase for public comment and to provide a delayed effective date, the alternative to using these quarterly estimates would be to use the market basket estimate published September 30, 1982 for all cost reporting periods beginning before October 1, 1983.

To summarize, section 604(a) of Pub. L. 98–21, enacted on April 20, 1983, provides that the prospective payment system, to which this notice conforms and which it in part implements, is effective for cost reporting periods beginning on or after October 1, 1983. In addition, section 604(c) of Pub. L. 98–21 mandates that final rules to implement the prospective payment system be published in the **Federal Register** by September 1, 1983 without the benefit of a prior period for public comment.

For the reasons stated above, and in view of the time frames for implementation of the prospective payment system required by Pub. L. 98–21, we believe that it is not practicable, necessary, or in the public interest to publish this notice as a proposal for public comment or to provide for a delay in the effective date. However, we are offering an opportunity for comment on both this interim notice and the interim rules implementing the prospective payment system, including the amendments to the regulations governing the rate of increase ceiling.

(Secs. 1102, 1871, and 1886(b) and (d) of the Social Security Act (42 U.S.C. 1302, 1395hh, and 1395ww(b) and (d)); 42 CFR 405.463 and 405.474)

(Catalog of Federal Domestic Assistance Program No. 13.773, Medicare-Hospital Insurance)

Dated: August 17, 1983.

Carolyne K. Davis,

Administrator, Health Care Financing Administration.

Approved: August 25, 1983.

Margaret M. Heckler,

Secretary.

[FR Doc. 83–23800 Filed 8–31–83; 8:45 am]

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federal register

Thursday
September 1, 1983

Part IV

Department of Health and Human Services

Health Care Financing Administration

Medicare Program; Prospective Payments for Medicare Inpatient Hospital Services; Interim Final Rule With Comment Period

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 405, 409, and 489

Medicare Program; Prospective Payments for Medicare Inpatient Hospital Services

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

ACTION: Interim final rule with comment period.

SUMMARY: This interim final rule sets forth the revised conditions and procedures for making Medicare payments to hospitals for inpatient services, effective with cost reporting periods that begin on or after October 1, 1983. It also contains certain provisions effective on October 1, 1983 for all providers. This rule is needed to implement the Social Security Amendments of 1983 (Pub. L. 98–21), which change the method of payment for inpatient hospital services from a cost-based, retrospective reimbursement system to a diagnosis specific prospective payment system. The new system will be phased in over a three-year period and is primarily intended to provide incentives to hospitals to manage their operations in a more cost-effective manner. The attached addendum sets forth the schedule of standardized amounts and relative weights applicable for cost reporting periods beginning on or after October 1, 1983 and before October 1, 1984.

DATES: Effective Date: In general, these regulations are effective on October 1, 1983. They will be applied with cost reporting periods beginning on or after October 1, 1983, with the following exceptions. The amendments to §§ 405.310(m), 489.21, and 489.23 will be applied for services furnished on or after October 1, 1983 irrespective of cost reporting periods. The amendments to § 405.429 will be applied for cost reporting periods beginning on or after April 20, 1983. The amendments to § 405.455 will be applied for cost reporting periods beginning on or after October 1, 1982. The amendments to §§ 405.1837, 405.1841, and 405.1877 concerning group appeals will be applied as of April 20, 1983. The amendments to § 405.453(f)(3) are effective September 1, 1983.

Comment Date: To assure consideration, comments should be received by October 17, 1983.

ADDRESS: Address comments in writing to: Health Care Financing Administration, Department of Health and Human Services, Attention: BERC–263–IFC, Room 132, East High Rise Building, 6325 Security Boulevard, Baltimore, Maryland 21207.

Please address a copy of any comments relating to information collection requirements to: Office of Information and Regulatory Affairs, Office of Management and Budget, Room 3208, New Executive Office Building, Washington, D.C. 20503, Attention: Desk Officer for HCFA.

If you prefer, you may deliver your comments to Room 309–G Hubert H. Humphrey Building, 200 Independence Ave., SW., Washington, D.C., or to Room 132, East High Rise Building, 6325 Security Boulevard, Baltimore, Maryland. When commenting, please refer to file code BERC–263–IFC.

Comments will be available for public inspection as they are received, beginning approximately three weeks after today, in Room 309–G of the Department's offices at 200 Independence Ave., SW., Washington, D.C., on Monday through Friday of each week from 8:30 a.m. to 5:00 p.m. (phone: 202–245–7890).

FOR FURTHER INFORMATION CONTACT:

Paul Olenick, (301) 594–9349; Determination of Federal Rates; Exceptions and Adjustments; Addendum

Barbara Wynn, (301) 597–1869; Determination of Hospital-Specific Rates; Excluded Costs; 602(k) Waivers; Interim Payments

Sheridan Gladhill, (301) 594–9441; Excluded Hospitals

Tom Hoyer, (301) 594–9446; Medical Review Activities; Exclusions From Coverage

George Cray, (301) 594–9755; Provider Appeals

Ed Roth, (301) 594–9437; Charges to Beneficiaries; Secondary Liability

William Morse, (301) 594–1160; Definition of and Payment for Physician Services

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ADDENDUM

Schedule of Standardized Amounts and Relative Weights Effective with Cost Reporting Periods Beginning on or after October 1, 1983

I. BACKGROUND

A. Medicare Reimbursement—General Discussion

The Social Security Amendments of 1965 (Pub. L. 89-97) established Title XVIII of the Social Security Act (the Act), which authorized the establishment of the Medicare program to pay part of the costs of health care services furnished to eligible beneficiaries. Part A of the program (Hospital Insurance) provides basic health insurance protection against the costs of inpatient hospital care and other inpatient or home health care. Part B of the program (Supplementary Medical Insurance) provides voluntary supplementary insurance covering most physicians' services and certain other

items and services not covered under Part A.

Generally, there are two bases for payment under the Medicare program. The first is "reasonable cost" and the second is "reasonable charge". Essentially, reasonable costs include all direct and indirect costs that are necessary and proper for the efficient delivery of needed health services to beneficiaries. Within this general framework, there are numerous rules regarding the reasonableness of certain categories of cost, how they are to be calculated, and how they are to be reported.

Section 1861(v)(1)(A) of the Act defines, subject to certain limitations, reasonable costs of any services as the costs actually incurred excluding any part of incurred costs found to be unnecessary in the efficient delivery of needed health services. The principles of reasonable cost reimbursement are further described and clarified in regulations in Subpart D of 42 CFR Part 405. Because actual reasonable costs cannot be determined until the end of the provider's cost reporting period, interim reimbursement amounts, approximating actual costs are determined by the fiscal intermediary serving each provider and paid to the provider throughout the year.

Providers are required to maintain sufficient financial records and statistical data for proper determination of costs payable under the program. Cost reports must be submitted to the intermediary on an annual basis. Upon receipt of the cost report, the intermediary makes a tentative adjustment based on the report as submitted. Final settlement is made following further review and/or audit of the cost report and records.

The second basis of payment, "reasonable charge", is for physicians' services and other medical and health services that are not furnished directly by a provider of services or by others under an arrangement with the provider. The principles of reasonable charge reimbursement are described in section 1842(b)(3) of the Act and further described and clarified in regulations at 42 CFR Part 405, Subpart E.

B. Social Security Amendments of 1972

The Social Security Amendments of 1972 (Pub. L. 92-603) contained numerous provisions affecting the Medicare program. Two sections, however, are particularly relevant to changes in Medicare reimbursement.

Section 222 of the 1972 Amendments authorized the Secretary to engage in experiments and demonstration projects in order to determine the advantages and disadvantages of making payments to Medicare providers on a prospective basis. Resulting studies on prospective payment have primarily been aimed at discovering methods of determining rates that would have long-term constraining effects on total payment without concurrently reducing quality of care.

Section 223 of the Social Security Amendments of 1972 amended section 1861(v)(1) of the Act to authorize the Secretary to set prospective limits on the costs that are recognized as reasonable under Medicare. Section 223 authorized the Secretary to apply limits to direct and indirect overall costs or to costs incurred for specific items or services furnished by a Medicare provider and to base these limits on estimates of the cost necessary for the efficient delivery of needed health services. Regulations implementing this authority are at 42 CFR 405.460. Under this authority, we published limits on hospital inpatient general routine per diem costs annually from 1974 through 1981.

C. Tax Equity and Fiscal Responsibility Act of 1982

On September 3, 1982, the President signed into law the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), Pub. L. 97-248. Section 101(a) of that legislation added section 1886 to the Act. This new section included two provisions that limited Medicare reimbursement for costs of inpatient hospital services. Section 1886(a) of the Act provided for the extension of the section 223 hospital cost limits, which had previously been applied only to inpatient general routine operating costs, to the total operating costs of inpatient hospital services. The expanded limits were to apply on a per discharge or per admission basis, and were to take into account the mix of types of Medicare cases treated by the hospital. Section 1886(b) of the Act provided for a new three-year limitation on payment for hospital costs that was separate from the type of limit established under section 223. This provision required that we limit for the allowable rate of increase in a hospital's inpatient operating costs per case through reductions in the amounts of reimbursement to hospitals that incur costs greater than the target amount. Section 1886(b) provided for incentive payments to hospitals that keep their costs below a target amount. The regulations implementing this provision were set forth at 42 CFR 405.463.

On September 30, 1982, we published in the **Federal Register** an interim final notice and an interim final rule that implemented sections 1886 (a) and (b) of the Act (47 FR 43296 and 47 FR 43282). The reader is referred to those documents for a more detailed explanation of the cost limit provisions and for a description of our implementation of them.

Additionally, section 101(b)(3) of Pub. L. 97-248 further required the Secretary to develop, in consultation with the Senate Committee on Finance and the House of Representatives Committee on Ways and Means, a legislative proposal for Medicare payment to hospitals, skilled nursing facilities, and to the extent feasible, other providers, on a prospective basis. In response to this requirement, the Secretary submitted, on December 27, 1982 the Department's proposal in a Report to Congress titled Hospital Prospective Payment for Medicare. A proposal on prospective payment for skilled nursing facilities will be issued in the near future.

II. SUMMARY OF TITLE VI OF THE SOCIAL SECURITY AMENDMENTS OF 1983

On April 20, 1983, the President signed Pub. L. 98-21, the Social Security Amendments of 1983. Title VI of Pub. L. 98-21 provides for Medicare payment for hospital inpatient services under a prospective payment system, rather than on a reasonable cost basis. Essentially, Medicare payment will be made at a predetermined, specific rate for each discharge. All discharges are classified according to a list of diagnosis-related groups (DRGs). This list contains 470 specific categories. The prospective payment rate will not include capital-related costs (e.g., depreciation, taxes, rent, etc.) or direct medical education costs, which will continue to be reimbursed under a reasonable cost-based system.

The statute provides for a 3-year transition period during which a declining portion of the total prospective payment will be based on hospitals' historical costs in a given base year and a gradually increasing portion will be based on a regional and/or national Federal rate per discharge. Beginning with the fourth year and continuing thereafter (i.e., cost reporting periods beginning on or after October 1, 1986), Medicare payment for hospital inpatient services will be determined fully under a national DRG payment methodology.

The statute excludes several types of hospitals and hospital units from the prospective payment system. These include psychiatric, long-term, children's, and rehabilitation hospitals as well as psychiatric and rehabilitation units operating as distinct parts of acute

care hospitals. Hospitals located outside the 50 States and the District of Columbia are also excluded. The excluded facilities and units will continue to be reimbursed on the basis of reasonable costs subject to the target rate of increase limits. In addition to the above categorical exclusions from prospective payment, the statute provides for other special exclusions, such as hospitals that are covered under approved State reimbursement control systems.

The Federal payment rates are determined based on the mean urban or rural standard amount per discharge. This amount is then adjusted to account for area differences in hospital wages. The standard amounts per discharge will be updated annually. For FY 84 and FY 85, the prospective payment system must be "budget neutral." That is, payments may not be greater than, nor less than, the payments that would have been paid under the law previously in effect. Beginning with FY 86, the Secretary will determine the update factor taking into consideration recommendations made by a commission of independent experts appointed by the Director of the Office of Technology Assessment.

Additional payments will be made to hospitals for discharges meeting specified criteria as "outliers". Outliers are cases that have an extremely long length of stay or unusually high cost when compared to most discharges classified in the same DRG. Additional payments will also be made for indirect costs of approved graduate medical education programs.

Beneficiaries may be charged only for deductibles, coinsurance amounts, and non-covered services (e.g., phone, television, etc.). They may not be charged for differences between the hospital's cost of providing covered care and the Medicare payment amount.

Under the prospective payment system, payment will be made to the hospital on a per discharge basis. Therefore, hospitals may have incentives to increase admissions or reduce services. To safeguard against such practices, the statute requires the establishment of a monitoring system to review admission practices and quality of care. If an abuse of the prospective payment system is discovered (e.g., unnecessary multiple admissions of the same beneficiary or inappropriate medical practices), payment may be partially or totally denied to the hospital.

In addition to the general Medicare demonstration authority, Pub. L. 98-21 requires that certain research projects be conducted related to Medicare program costs and payment methods. The statute also requires a large number of reports to the Congress on specified areas of study, including recommendations for legislative changes.

III. MAJOR FEATURES OR PROSPECTIVE PAYMENT SYSTEM

A. Applicability

The prospective payment system will apply to all inpatient hospital services furnished by all hospitals participating in the Medicare program except for those hospitals, or units excluded as discussed below. A hospital's status as to whether it is subject to, or excluded from, prospective payment will generally be determined at the beginning of each cost reporting period and this status, for reimbursement purposes, will continue throughout the period, which is normally one year. An exception to this general rule is when a hospital comes under prospective payment after a cost reporting period has begun, or is excluded at some time during its cost reporting period because of its participation in an approved demonstration project or State reimbursement control program, or regional demonstration.

1. Excluded Hospitals and Hospital Units Subject to Rate of Increase Limits

In accordance with section 1886(d)(1)(B) of the Act, hospitals or distinct part units categorized below are excluded from the prospective payment system. Medicare will continue to pay for services furnished to inpatients of these hospitals or units on the basis of reasonable costs. These payments will, however, be subject to the rate of increase ceiling in the amended regulations at § 405.463.

a. Psychiatric Hospitals

In accordance with section 1886(d)(1)(B)(i) of the Act, hospitals that meet the definition of psychiatric hospitals in section 1861(f) of the Act are excluded from the prospective payment system. Section 1861(f) of the Act defines a psychiatric hospital as an institution that:

(i) Is primarily engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill persons;

(ii) Satisfies the requirements of paragraphs (3) through (9) of section 1861(e) (i.e., the statutory requirements of a "hospital", which are implemented by regulations set forth at 42 CFR 405.1020 through 405.1035);

(iii) Maintains clinical records on all patients and maintains such records as the Secretary finds necessary to determine the degree and intensity of the treatment provided to individuals entitled to hospital insurance benefits under Part A (i.e., meets the special medical records requirements for psychiatric hospitals set forth in 42 CFR 405.1036 and 405.1037);

(iv) Meets the staffing requirements that the Secretary finds are necessary for the institution to carry out an active program of treatment for individuals who are furnished services in the institution (i.e., meets the special staff requirements for psychiatric hospitals set forth in 42 CFR 405.1038); and

(v) Is accredited by the Joint Commission on Accreditation of Hospitals.

Section 1861(f) further specifies that, in the case of an institution that satisfies the first two items above and that contains a distinct part that also satisfies the third and fourth items above, the distinct part will be considered to be a "psychiatric hospital" if the institution is accredited by the Joint Commission on Accreditation of Hospitals or if the distinct part meets requirements equivalent to the accreditation requirements, as determined by the Secretary.

The regulations implementing section 1886(d)(1)(B)(i) of the Act are set forth at § 405.471(c)(1). Compliance with the requirements in the statute and regulations for psychiatric hospitals is demonstrated by having a provider agreement in effect to participate in the Medicare program and HCFA's assignment of a special provider number indicating participation as a psychiatric hospital. Institutions meeting the above requirements will be paid on a reasonable cost basis, subject to the rate of increase provisions of § 405.463. It should be noted, as a matter of clarification, that the distinct part referred to in the section 1861(f) definition of a psychiatric hospital is not the same as a section 1886(d)(1)(B) distinct part psychiatric unit in a general hospital (see section 1.c. below).

There are approximately 410 hospitals or distinct parts currently participating as psychiatric hospitals.

b. Rehabilitation hospitals

While section 1886(d)(1)(B)(ii) of the Act specifies that rehabilitation hospitals (as defined by the Secretary) are excluded from the prospective payment system, neither that section nor the Conference Committee report (H.R. Rep. No. 98-47, 98th Cong., 1st Sess. 193

(1983)) accompanying Pub. L. 98–21 provide explicit guidance on how the term "rehabilitation hospital" is to be defined for purposes of this exclusion. However, the report of the Committee on Ways and Means, U.S. House of Representatives, on the House bill that was considered by the Conference Committee (H.R. 1900) in recommending enactment of Pub. L. 98–21 does provide some recommendations regarding this definition (H.R. Rep. No. 98–25, 98th Cong., 1st Sess. 147 (1983)). This report states that the Committee understands that there are currently extensive rules pertaining to rehabilitation hospitals, and suggests that the Secretary use such regulations, and consult with the Joint Commission on Accreditation of Hospitals (JCAH) in order to define a rehabilitation hospital.

To comply with these recommendations, we reviewed our current regulations at 42 CFR 405.1031(d). Those regulations establish standards that must be met by rehabilitation, physical therapy, and occupational therapy departments in hospitals that participate in Medicare. (Hospitals accredited by the JCAH are ordinarily deemed to meet those requirements.) Those standards apply to all hospitals participating in Medicare that furnish rehabilitation services through the use of organized departments, without regard to the extent of the hospitals' involvement with rehabilitation. Thus, the regulations are not useful in determining the extent of a particular hospital's involvement in rehabilitation.

Moreover, we have recently proposed, in a separate **Federal Register** document, to apply new, less prescriptive requirements to all hospitals, including those that provide rehabilitation, physical therapy, occupational therapy, audiology, or speech pathology services (48 FR 299 January 4, 1983). These would apply without regard to whether the services are provided in organized departments (48 FR 299). We are currently analyzing the public comments we received on this proposal.

Because the current regulations on hospital rehabilitation services are not specific to those hospitals primarily engaged in rehabilitation, and are likely to be replaced by revised regulations in the near future, we have decided not to use those regulations as a basis for the definition of "rehabilitation hospital."

In addition, we consulted the JCAH and other accrediting bodies to identify features of their standards that could be used as a basis for our definition of rehabilitation hospitals. We have incorporated elements of these accreditation requirements in our definition. However, due to the unique nature of the prospective payment system, we found it necessary to include other criteria that are not common to the accreditation requirements. We believe the comprehensive definition that has been developed meets the legislative intent as to the application of the exclusion of rehabilitation hospitals and rehabilitation units of general hospitals from the prospective payment system.

To distinguish rehabilitation hospitals from other hospitals that offer general medical and surgical services but also provide some rehabilitation services, it was necessary to develop and include in the new regulations provisions that describe the criteria that hospitals must meet to be excluded from the prospective payment system as rehabilitation hospitals. These provisions are at § 405.471(c)(2). In summary, the criteria are as follows:

- The hospital must have in effect a provider agreement to participate in Medicare as a hospital;
- The hospital must be primarily engaged in furnishing intensive rehabilitation services as demonstrated by patient medical records showing that, during the hospital's most recently completed 12-month cost reporting period, at least 75 percent of the hospital's inpatients were treated for one or more conditions specified in these regulations that typically require intensive inpatient rehabilitation;
- The hospital must have in effect a preadmission screening procedure under which each patient's condition and medical history are reviewed to determine whether the patient is likely to benefit significantly from an intensive inpatient hospital rehabilitation program or assessment;
- The hospital must ensure close medical supervision, and furnish rehabilitation nursing, physical therapy, and occupational therapy, plus, as needed, speech therapy, social services or psychological services, and orthotic and prosthetic services;
- The hospital must have a full-time Director of Rehabilitation who is a Doctor of Medicine or Osteopathy, is licensed under State law, and either has experience in the medical management of rehabilitation patients, or is Board-certified in one of a number of rehabilitation-related medical specialties;
- The hospital must have a plan of treatment for each inpatient that is established, reviewed, and revised as needed by a physician in consultation with other professional personnel who provide services to the patient;
- The hospital must use a coordinated multidisciplinary team approach in the rehabilitation of each inpatient. This must be documented by periodic clinical entries made in the patient's medical record noting the patient's status in relationship to goal attainment, and by team conferences held at least every 2 weeks to determine the appropriateness of treatment.

The first criterion that the provider have an agreement in effect to participate in Medicare as a hospital is an administrative requirement that we are imposing to ensure that hospitals are properly classified for purposes of exclusion from the prospective payment system.

We require the second criterion because we believe that examining the types of conditions for which a hospital's inpatients are treated, and the proportion of patients treated for conditions that typically require intensive inpatient rehabilitation, will help distinguish those hospitals in which the provision of rehabilitative services is a primary, rather than secondary, goal. To develop the specific list of medical conditions set forth in the new regulations at § 405.471(c)(2), and the requirement that 75 percent of a hospital's patients be treated for one or more of these conditions, we relied on HCFA Technical Assistance Document No. 24 ("Sample Screening Criteria for Review of Admissions to Comprehensive Medical Rehabilitation Hospitals/Units"). This document was developed by the Committee on Rehabilitation Criteria for PSRO of the American Academy of Physical Medicine and Rehabilitation and the American Congress of Rehabilitation Medicine.

The project that produced the sample screening criteria was funded under a purchase order with HCFA. The project built on work performed by the American Academy of Physical Medicine and Rehabilitation in 1975 under subcontract to the American Medical Association, and on the efforts of PSROs that had previously developed and implemented criteria for review of admissions to comprehensive medical rehabilitation hospitals and units. The project was intended primarily to provide a basis for reviewing the medical necessity of admission to, and continued stay in, these hospitals and units, and for assessing the quality of care furnished in them. The seven medical conditions for which sample screening criteria were developed accounted for approximately 75 percent of the admissions to comprehensive medical rehabilitation hospitals and units. These conditions are:

- Stroke;

- Dorsal or lumbar spinal cord injury with paraparesis/paraplegia;
- Cervical spinal cord injury with quadriparesis/quadriplegia;
- Congenital deformity or amputation of the leg or lower limb;
- Polyarthritic, rheumatoid, or acquired deformity of the leg or lower limb;
- Fracture of femur; or
- Head injury.

In addition, we obtained advice from the National Association of Rehabilitation Facilities (NARF) and from the American Hospital Association (AHA) regarding the types of medical conditions most often treated by hospitals and hospital units that specialize in rehabilitation. We also consulted HCFA staff physicians who had been involved in developing the Technical Assistance Document. Based on information received from these groups and physicians, we developed the list of medical conditions set forth in the new regulations at § 405.471(c).

We plan to use the second criterion as a test of whether a hospital provides specialized rehabilitation services to such an extent that it incurs costs significantly different from those of a general medical/surgical hospital and, therefore, should be excluded from the prospective payment system.

The remaining criteria for rehabilitation hospitals relate to the preadmission screening of prospective inpatients, to the types of services that must be furnished by or made available in the hospital, and to the hospital's management of the rehabilitative services it furnishes. Except for the criterion relating to a full-time director of rehabilitation, these criteria are based on similar requirements for the coverage of rehabilitation services under Medicare (see section 211 of Medicare's Hospital Manual).

In the context of these regulations, however, we plan to use these criteria, in conjunction with those described above, to determine whether particular hospitals furnish the type and intensity of rehabilitation services necessary to warrant exclusion from the prospective payment system as rehabilitation hospitals. We wish to note that we recognize that some of these criteria (e.g., the plan of treatment requirement) may also be met by hospitals in which rehabilitation is secondary to general medical/surgical treatment. However, we believe only those hospitals that primarily engage in rehabilitation could meet all of these criteria.

In addition to the general rationale set forth above, we have additional reasons for requiring each of the criteria in paragraphs (iii) through (vii) of § 405.471(c)(2).

These are as follows:

- *Preadmission screening procedure.* We believe this procedure is needed to help demonstrate that a hospital specializes in the treatment of patients who primarily require intensive impatient rehabilitation, rather than patients who primarily require medical/surgical treatment.
- *Provision of specified services.* The types of services listed are those that are typically required for the rehabilitation of patients. While some of the services listed are also available in other settings, we believe provision of all of these services would help to demonstrate that a hospital is extensively engaged in rehabilitation.
- *Director of rehabilitation.* We selected this criterion because we believe an intensive hospital inpatient rehabilitation program will require the full-time direction of a physician with special expertise in the medical management of patients who require rehabilitation services. Meeting this requirement would help a hospital to document the extent of its involvement in rehabilitation.
- *Plan of treatment.* We selected this criterion because we believe the existence of a plan of treatment for each hospital impatient who receives rehabilitation services will help to demonstrate the existence of an intensive impatient rehabilitation program. In addition, the presence of a plan of treatment in each patient's medical record would simplify the administration of the exclusion provision, since it would help HCFA or its agents determine the frequency and intensity of the rehabilitation services furnished by particular hospitals.
- *Coordinated multidisciplinary team approach.* This type of approach is currently required for the coverage of rehabilitation services. Use of this approach for all rehabilitation patients treated in the hospital would help document the primacy of rehabilitation in the hospital.

c. Distinct Part Psychiatric and Rehabilitation Units

(i) General Criteria for Distinct Part Units

Section 1886(d)(1)(B) specifies that the prospective payment system will not be applied to a psychiatric or rehabilitation unit of a hospital which is a distinct part of the hospital (as defined by the Secretary). Units that qualify for this exclusion will be paid on a reasonable cost basis, subject to the rate of increase provisions of 42 CFR 405.463.

To implement this exclusion, we have developed general criteria that will apply to both types of excluded units and additional, more specific, criteria for psychiatric and for rehabilitation units, respectively. The general criteria for distinct part units are set forth in § 405.471(c)(3)(i), and are discussed in the following paragraphs. The specific criteria for psychiatric units are set forth in a new § 405.471(c)(3)(ii), and are discussed in item (ii) below. The specific criteria for rehabilitation units are set forth in § 405.471(c)(3)(ii), and are discussed in item (iii).

All excluded units must meet the general criteria in new § 405.471(c)(3)(i). The first criterion is an administrative requirement that an institution has in effect an agreement under Part 489 for participation as a hospital under Medicare. We are imposing this requirement to ensure that all units are properly classified for purposes of exclusion from the prospective payment system. The second criterion, which requires uniform application of written admission criteria to all patients, both Medicare and non-Medicare, is designed to discourage hospitals from placing patients in excluded units for reasons related to the hospital's reimbursement rather than to the type of services the patients need. We do not believe it would be appropriate for these units to be set up primarily for reimbursement reasons, rather than for reasons related to patient needs. To prevent this result, we are requiring each unit to have written policies for admission, and to apply these policies uniformly to all patients, both Medicare and non-Medicare. In addition, to ensure that all units are operated in compliance with applicable State law, we are requiring that psychiatric and rehabilitation units meet applicable State licensing laws.

The remaining criteria are administrative requirements that are necessary to enable Medicare intermediaries to distinguish costs incurred for the unit from costs of other parts of the hospital, and to measure and reimburse unit costs accurately. These criteria are based on the long standing requirements for reimbursement of separate cost entities in multiple-facility hospitals, as set forth in section 2336 of the Medicare Provider Reimbursement Manual (HCFA Pub. 15-1).

(ii) Specific Criteria for Psychiatric Units

In developing specific criteria for the exclusion of distinct part psychiatric units, we wish to ensure that the exclusion is available only to a unit that

predominantly provides psychiatric services. To identify and exclude these units, we have developed the criteria set forth in § 405.471(c)(3)(ii). Our specific reasons for selecting each of these criteria are as follows:

• *Treatment of patients with psychiatric diagnoses.* This requirement is necessary to ensure that patients are not improperly placed in the psychiatric unit for financial rather than medical reasons.

• *Direction by qualified psychiatrist.* This requirement is necessary to ensure professional oversight of policies and procedures in the unit (e.g. to assure appropriateness of admission criteria). Patients with a psychiatric diagnosis will normally require such direction. Consequently this is an appropriate identifier of this type of facility.

• *Provision of specified services: supervising nurse.* The provision of these services and use of a qualified supervising nurse is typical of units which treat patients whose characteristics are like those in psychiatric hospitals. Consequently, the provision of these services is an identifier of such a patient population.

• *Plan of treatment.* This requirement is necessary to ensure proper placement of patients. A unit which treats a patient population similar to that in a psychiatric hospital would routinely have a plan of treatment and would routinely use a multidisciplinary team approach. As such, this is an identifier of a unit whose patient population and services differ sufficiently as to warrant exclusion.

(iii) Specific Criteria for Rehabilitation Units

As in the case with the specific criteria for psychiatric units, our rehabilitation unit criteria are designed to enable us to identify those units in which the costs are sufficiently different from those of the hospitals in which the units are located to warrant exclusion of the units from the prospective payment system. We believe that the patients treated, and the types of services furnished, in units of this type are likely to be more similar to those of rehabilitation hospitals than to those of hospitals in which the primary concern is the provision of general medical/surgical services. Therefore, we are applying the same criteria in excluding rehabilitation units as in excluding rehabilitation hospitals.

d. Children's Hospitals

Section 1886(d)(1)(B) of the Act also excludes from the prospective payment system hospitals whose inpatients are predominantly individuals under 18 years of age. Generally, this includes all children's hospitals. For purposes of this exclusion children's hospital is defined at § 405.471(c)(4) of these regulations as a hospital having a provider agreement, meeting applicable requirements in subpart J, and furnishing services to inpatients who are predominantly individuals under the age of 18.

e. Long-term Hospitals

The statute (section 1886(d)(1)(B)(iv) of the Act) excludes from the prospective payment system hospitals with an average length of stay (as determined by the Secretary) greater than 25 days. The average length of stay is calculated by dividing the total number of inpatient days (excluding leave of absence or pass days) for all patients by the total number of discharges for a cost reporting period. We will make this determination based on the hospital's most recently filed cost report, except where these data may not accurately reflect a hospital's current classification. In this case, data for the most recent 6-month period will be used. Section 405.471(c)(5) of these regulations sets forth the requirements regarding long-term hospitals.

f. Hospitals Outside the 50 States and the District of Columbia

Initially, hospitals in Puerto Rico, Guam, the Virgin Islands, American Samoa, and the Northern Marianas will be excluded from the prospective payment system. However, the statute mandates that the Secretary complete a study before April 1, 1984, and make recommendations to the Congress regarding the possible inclusion of these hospitals.

2. Excluded Hospitals Paid Under Alternative Reimbursement Programs

Section 402 of the Social Security Amendments of 1967 (Pub. L. 90–248) and Section 222(a) of the Social Security Amendments of 1972 (Pub. L. 92–603) authorize demonstrations and studies for various purposes, primarily to analyze alternative methods of payment. For the most part these authorities were not altered by Pub. L. 98–21, therefore, the demonstrations and studies that are currently approved may continue unaffected.

Additionally, section 1886(c) of the Act was amended by Pub. L. 98–21 to permit approval by HCFA of State reimbursement control systems for Medicare reimbursement purposes if the systems meet certain conditions prescribed by the statute relating to applicability and administrative matters. Hospitals covered by these systems will also be excluded from the prospective payment system. The regulations implementing section 1886(c) of the Act will be published separately in the **Federal Register.**

3. Other Special Cases

Discussed below are additional special cases where the prospective payment system would be inappropriate.

a. Nonparticipating Hospitals Furnishing Emergency Services

Sections 1814(d) and 1835(b) of the Act authorize Medicare payments to hospitals not participating in the Medicare program, for emergency services (i.e., both inpatient and outpatient) provided to eligible beneficiaries under special circumstances. These statutory sections provide the basis of payment for emergency services, and Pub. L. 98–21 did not amend them. Therefore, payment for emergency services to nonparticipating hospitals will not be made under the prospective payment system. Regulations providing for payments to nonparticipating hospitals are set forth at § 405.152 and § 405.249.

b. Veterans Administration Hospitals

Veterans Administration (VA) hospitals are generally excluded from participation in the Medicare program as required by sections 1814(c) and 1835(d) of the Act. However, in some limited situations, special provisions are made for services not otherwise available in the community to be furnished by a VA hospital to the general public, including Medicare beneficiaries. When this is the case (generally for renal services) the payment mechanism will not be the prospective payment system. Rather, payment will be determined, as it has in the past, in accordance with 38 U.S.C. 5053(d).

There is authority contained in section 1814(h) of the Act, as amended by section 602(c) of Pub. L. 98–21, for applying the prospective payment system for certain hospital services provided in VA hospitals. This authority allows for payment in such circumstances to be an amount equal to the charges imposed by the VA or the prospective payment rate as established by section 1886, whichever is lower. Rather than establish a complete system by which the VA hospitals can be reimbursed under the prospective payment system for a situation which virtually never occurs, we believe the VA charges (i.e., the rates prescribed by the Secretary after consultation with the

VA Administrator) should be paid if this situation should exist.

c. Services Furnished by Risk-Basis HMOs and CMPs

At its election, a health maintenance organization (HMO) or a competitive medical plan (CMP) that receives Medicare payments on a risk basis may choose to have payment made by HCFA directly to hospitals for inpatient hospital services furnished to Medicare enrollees of the HMO or CMP. If the HMO does not exercise the option, it may negotiate its own rate with the hospital. If the HMO exercises the option, the hospital will be paid either under the prospective payment system or on a reasonable cost basis if the hospital is excluded. If the hospital is paid directly by HCFA, the payment for inpatient hospital services to Medicare HMO/CMP enrollees and administrative costs for paying hospitals directly is deducted from the Medicare capitation payments otherwise paid to the HMO or CMP.

B. Basis of Payment Under the Prospective Payment System

1. General Description

Unless excluded from prospective payment, all Medicare participating hospitals will be paid, for inpatient services provided, a specific amount for each discharge based on the case's classification into one of 468 Diagnosis-Related Groups (DRGs).

2. Discharges and Transfers

The terms "discharge" and "transfer" are defined, for purposes of prospective payment, at § 405.470(c) of these regulations. These definitions are essentially the same as they were under the hospital cost limits established as a result of TEFRA except that in cases where a patient is transferred to another hospital paid under the prospective payment system, the transfer will not be considered a discharge. A patient on a leave of absence from a hospital will not be considered discharged. In summary, a patient will be considered discharged when he or she:

- Is formally released from the hospital (Release of the patient to another hospital as described in § 405.470(c)(2) of these regulations will not be recognized as a discharge for the purpose of determining payment under the prospective payment system.);
- Dies in the hospital; or
- Is transferred to another hospital or unit that is excluded from the prospective payment system.

It was necessary to distinguish between discharges where the patient has received complete treatment and discharges where the patient is transferred to another institution for related care. The prospective payment system was intended to provide full payment, less deductibles and coinsurance, for all inpatient services associated with a particular diagnosis.

It is emphasized that discharges and transfers will be subject to medical review to assure that patients are properly categorized.

a. Transfers to Hospitals Paid Under Prospective Payment

The policy set forth in this section and contained in these regulations at § 405.470(c)(4) is intended as an interim policy. It should be noted that our ultimate goal is to pay a single rate to one hospital for a given service. Therefore, we will be reviewing discharge/transfer patterns following implementation of the prospective payment system and will revise this policy as appropriate.

When patients are transferred between hospitals receiving payment under the prospective payment system full payment will be made to the final hospital from which the patient is released. The transferring hospital will be paid a per diem for each day of the hospital stay.

The prospective payment rate paid to each hospital will be the rate specific to each hospital. That is, the rate will be composed of the Federal portion and the hospital-specific portion for each hospital. Similarly, the wage indexes and any adjustments will be those which are appropriate for each hospital, and in cases where treatment is provided under different DRGs, payment will be based on the DRG under which the patient was treated at each hospital.

Since the final discharging hospital will generally provide the greatest portion of the patient's treatment, payment to this hospital will be made at the full prospective payment rate. The transferring hospital, generally providing a limited amount of treatment to the transferred patient, is not entitled to payment at the full prospective payment rate. Therefore, payment to the transferring hospital will be made based on a per diem rate (i.e., the prospective payment rate divided by the average length of stay for the specific DRG into which the case falls) and the patient's length of stay at the transferring hospital. Payment to the transferring hospital may not exceed the full prospective payment rate.

Example 1: A patient stays at Hospital A for 2 days and is subsequently transferred to Hospital B. The prospective payment rate is $10,000 at each hospital, with an average length of stay of 10 days for the DRG. Hospital A would be paid $2,000 (2/10 × $10,000) and Hospital B would be paid $10,000, the full prospective payment rate. Total payment is $12,000.

Example 2: A patient stays at Hospital A for 8 days and is subsequently transferred to Hospital B. The prospective payment rate is $10,000 at Hospital A and $12,000 at Hospital B. The average length of stay for the DRG is 5 days. The payment to Hospital A would be limited to $10,000, the full prospective payment rate, since the length of stay exceeds the average length of stay for the DRG. Hospital B would be paid the full prospective payment rate of $12,000. Total payment is $22,000.

Example 3: A patient stays at Hospital A for 2 days under DRG X, which has an average length of stay of 10 days. The prospective payment rate is $10,000 for the hospital for X. He is subsequently transferred to Hospital B under DRG Y. The prospective payment rate at Hospital B is $16,000 for DRG Y. Hospital A would be paid $2,000 (2/10 × $10,000). Hospital B would be paid $16,000, the full prospective payment rate for DRG Y at Hospital B. Total payment is $18,000.

Example 4: A patient stays at Hospital A for 4 days under DRG X, which has an average length of stay of 8 days. The prospective payment rate at Hospital A is $16,000 for DRG X. He is subsequently transferred to Hospital B for 4 days under DRG Y which has an average length of stay of 10 days. The prospective payment rate is $10,000 for DRG Y. He is finally transferred to Hospital C. The prospective payment rate for DRG Y in this hospital is $15,000. Hospital A would be paid $8,000 (4/8×$16,000). Hospital B would be paid $4,000 (4/10×$10,000). Hospital C would be paid $15,000, the full prospective payment rate for DRG Y at Hospital C. Total payment is $27,000.

Payment to a transferring hospital is based on a per diem rate and is limited to the full prospective payment rate. Therefore, outlier payments may not be made to the transferring hospital. The criteria for making outlier determinations for the receiving hospital (i.e., the final discharging hospital) in cases involving transfers between hospitals would be the same as for any other outlier (i.e., length of stay or charges adjusted to cost for the DRG in the hospital receiving the transferred patient exceeds a certain level). In determining outlier payment in transfer cases, only the length of stay or costs in the discharging hospital, rather than combining the total period of hospitalization, will be considered.

b. Transfers to Hospitals or Units Excluded From Prospective Payment

When patients are transferred to hospitals or units excluded from the prospective payment system (e.g., psychiatric, rehabilitation, children s hospitals), the transfers will be considered discharges and the full

prospective payment will be made to the transferring hospital. Hospitals and units excluded from the prospective payment system are organized for treatment of conditions distinctly unlike treatment encountered in short-term acute care facilities. Therefore, the services obtained in excluded facilities would not be the same services obtained in transferring hospitals (i.e., paid under the prospective payment system), and payment to both facilities would be appropriate.

When patients are transferred to hospitals that would ordinarily be paid under the prospective payment system, but, for reasons listed below, are not, payment to the transferring hospital will be a per diem amount based on the prospective payment rate for the number of days of care delivered (i.e., in the same manner as when the patient is transferred to another hospital paid under the prospective payment system). These cases are:

- When the receiving hospital is excluded from prospective payment because of participation in a statewide cost control program or demonstration; or
- When the receiving hospital's first cost reporting period (i.e., bringing it under prospective payment) has not yet begun

3 DRG Classification

A system has been developed for classifying patients into groups that are clinically coherent and homogenous with respect to resource use. Over the past several years, a case classification system called Diagnosis Related Groups (DRGs) has been developed at Yale University. The latest series of Yale DRGs is based on records of patients discharged during the last half of 1979.

Using a universe of over 1.4 million records selected from a nationally representative sample of 332 hospitals participating in the hospital discharge abstract service of the Commission on Professional and Hospital Activities, the Yale researchers created a stratified sample of 400,000 medical records, classified into 23 Major Diagnostic Categories (MDCs). Each MDC represents a broad clinical category that is differentiated from all others based on body system involvement and disease etiology. The specification of the MDCs was developed by a committee of clinicians using the following guidelines:

- Clinical consistency
- A sufficient number of patients.
- Coverage of the complete range of diagnoses represented in the *International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)*, without overlay

The patient records in each MDC were then partitioned using a classification algorithm called AUTOGRP and a prespecified set of variables to suggest subgroups of cases that were expected to be distinct in terms of length of stay. The variables used to split the MDCs were intentionally limited to those that are descriptive of the patient's clinical condition and that are readily available on most discharge abstracts, such as principal diagnosis, secondary diagnoses, surgical procedures, age, sex, and discharge status. Suggested subgroups of cases within the MDCs were examined by physicians to determine whether the proposed distinctions were clinically sensible and whether the cases in each group were medically similar. These purely statistical subgroups were modified if they were not supported clinically.

For example, in MDC 11 (Diseases and Disorders of the Kidney and Urinary Tract), the initial statistical grouping of medical (i.e., nonsurgical) cases suggested three subgroups that were different in terms of length of stay. Each of these subgroups, however, contained several different kinds of cases (e.g., urinary tract infections, signs and symptoms, renal failure, and neoplasms). Clinical judgment suggested that the major clinical subsets of these three groups should be revised to form seven more clinically coherent initial groups: kidney stone, infection, renal failure, neoplasms, signs and symptoms, urethral stricture, and other

This process ultimately resulted in the development of the set of 470 mutually exclusive and comprehensive case classfication categories called diagnosis-related groups. Under the prospective payment system, each Medicare discharge will be classified into one of these DRGs, which are listed in section VII, Table 5, of the addendum to this document. For 468 of the DRGs, we have established weighting factors that reflect the relative resources used for furnishing inpatient services to that classification of cases. Generally, this weighting factor will be applied to determine the amount that will be paid for each DRG-discharge, regardless of the individual services furnished or the number of days of care (except for "outlier" cases discussed below). However, classification of a discharge under DRG numbers 468 through 470 require special consideration as follows:

- *DRG No. 468* represents a discharge with an operating room procedure unrelated to a given MDC. This does not necessarily represent an invalid record. For example, a patient may be admitted for cataract surgery, but have a coronary bypass operation rather than the cataract procedure, or may be hospitalized for treatment of pneumonia and be given an appendectomy during the same stay. In such instances, intermediaries will return the claims to the provider for clarification. If the accuracy of the discharge data is affirmed, the prospective payment rate will be paid as for any other DRG classification. Otherwise, the case will be reassigned to the appropriate DRG using corrected data.
- *DRG No. 469* represents discharges with a valid diagnosis in the principal diagnosis field, but not acceptable as a principal diagnosis. Examples of such cases may include a diagnosis of diabetes mellitus during pregnancy or a diagnosis of an infection of the genitourinary tract during pregnancy, both unspecified as to episode of care. These diagnoses may be valid, but they are not sufficient to determine the principal diagnosis for DRG assignment purposes. In these instances, intermediaries will return the claim to the provider in order to enter the correct principal diagnosis for proper DRG assignment. The provider will resubmit the claim for payment.
- *DRG No. 470* represents discharges with invalid data. In these instances, the intermediary will return the claim to the provider for correction of data elements affecting proper DRG assignment. The provider will resubmit the claim for payment.

Because the assignment of a case to a particular DRG determines the amount that will be paid for the case, it is important that this assignment be done systematically and uniformly. Therefore, we have established an automated classification algorithm (that is, the Grouper Program) that will be used in all cases to assign discharges to their proper DRGs using essential information abstracted from the inpatient bill. The process will work as follows:

- The hospital will submit a bill for a particular case, using classifications and terminology consistent with *ICD-9-CM* and the Uniform Hospital Discharge Data Set (UHDDS) prescribed by the National Committee on Vital and Health Statistics (*Uniform Hospital Discharge Data: Minimum Data Set*, National Center for Health Statistics, DHEW Pub No. (PHS) 80—1157, April, 1980).
- The fiscal intermediary will assign a DRG to the discharge using the Grouper program.

—The Grouper program screens the essential information from the inpatient bill against the criteria that distinguish the DRGs.

—The DRG criteria include the patient's age, sex, principal diagnosis (that is, the condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital), secondary diagnoses, procedures performed, and discharge status.

• If the discharge is assigned to DRG numbers 1 to 467, the intermediary will determine the appropriate prospective payment and pay the hospital.

• If the discharge is assigned to DRG number 468, 469, or 470, the intermediary will initiate appropriate special consideration, as described above.

We wish to point out that the definitions of principal diagnosis and other criteria for the UHDDS are not HCFA requirements. (Principal diagnosis is defined on page 12 of the minimum data set criteria published in April, 1980, cited above.) The UHDDS was developed for the U.S. National Committee on Vital and Health Statistics. It has been used as a standard for the development of policies and programs related to hospital discharge statistics by both governmental and non-governmental sectors for quite some time. In particular, it was used by Yale University in creating the DRG classification.

Interested parties may order the DHEW Pub. No. (PHS) 80–1157 from the Government Printing Office, and may purchase Grouper program software and ICD–9–CM DRG user manuals from the following: Health Systems International, 345 Whitney Avenue, New Haven, Connecticut 06511.

It has been suggested that the use of "principal diagnosis" and the Grouper program would in some cases result in paying a hospital based on DRG classification that does not reflect the most resource-intensive services furnished to a patient. For example, assume a hypothetical case in which a patient leaves a hospital with diagnoses A, B, C, and D. The official UHDDS definition of principal diagnosis is "the condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care" (*Uniform Hospital Discharge Data, Minimum Data Set*, April 1980, p. 12.). Under this standard, the patient *must be* assigned to a particular DRG, once it is determined which one of the four diagnoses caused the admission. If diagnosis A caused the admission, even though diagnosis C required the most resource-intensive treatment, the case will be assigned to a DRG related to diagnosis A.

Because of this occasional result, it has been suggested that we revise the definition of principal diagnosis, permitting hospitals to report the most-resource intensive condition of a patient as the principal diagnosis rather than the current "diagnosis established after study to be chiefly responsible for occasioning the hospitalization." Adoption of this revision presumably would result in the case being accurately assigned to a more costly DRG, yielding an appropriately greater prospective payment rate.

We have decided not to make such a change for the following reasons. First, as noted above, the definition of "principal diagnosis" is part of the UHDDS definitions. As such, it has been used to develop the current DRG classification system. (An earlier DRG system used a definition of "primary diagnosis" very similar to the proposal. This definition was one of the deficiencies in the old DRGs, as discussed in December, 1982 Report to Congress, *Hospital Prospective Payment for Medicare*, pages 66 to 75.) Second, modification as proposed of the "principal diagnosis" definition would introduce subjectivity into the process of classifying cases into DRGs. Patients with identical diagnoses could be assigned to different DRGs solely because of differing hospital and/or physician judgments as to the most resource intensive condition. This would result in our inability to definitely assign a case with multiple diagnosis to a specific DRG because of our requirement to accept the hospital's judgment as to which diagnosis was the most resource intensive.

Hospitals would determine this for us by selecting the principal diagnosis which resulted in assignment to the DRG with the highest prospective payment rate. Third, in the absence of data demonstrating relatively frequent occurrence, we question whether there are frequent multiple diagnosis cases in which the most resource-intensive diagnosis is not also the principal diagnosis. To the extent such cases do occur, we believe the costs associated with them have already been taken into account in the data base used to construct the average standardized cost amounts and the DRG relative weights. Finally, the provision of outlier payments, as required by law, will ensure additional payment in some cases in which the resources required for treatment of comorbidities and complications exceed the resources required by the principal diagnosis, and also ensures that there will be no reduction in reimbursement for cases that are unusually short lengths of stay, or for cases that are unusually inexpensive to treat. Presumably, a hospital has at least as much chance of encountering one of these cases as it does of encountering a case of the other type discussed.

Example:

To make clear the effect of our use of the "principal diagnosis" definition, let us consider the following case.

A patient age 65 is admitted for skin graft of a skin ulcer. Under normal circumstances, this case would be assigned to DRG 264, which has a weighting factor of 2.2031. However, during the stay a hip and femur procedure (except major joint procedure) is performed. Disregarding the skin ulcer, this surgical procedure would normally be assigned to DRG 211, with a weighting factor of 1.9530.

There would be an obvious inconsistency between the principal diagnosis (skin ulcer) and the operating room procedure (hip and femur procedure). In such a situation, the bill would be returned to the hospital for validation and re-verification. If the apparently inconsistent diagnosis and procedure are affirmed, this would result in the case being assigned to DRG 468 (Operating Room Procedure Unrelated to Principal Diagnosis). This DRG has a comparatively high weighting factor of 2.1037.

4. Costs Included Under the Prospective Payment System

a. Inpatient Operating Costs for Routine, Ancillary, and Special Care Services

The statute requires that the prospective payment rate serve as total Medicare payment for inpatient operating costs for all items and services furnished other than physicians' services (as defined in regulations) associated with each discharge. These include the Part A operating costs for routine services, ancillary services, and intensive care type unit services. Although we excluded the costs of malpractice insurance from the definition of total inpatient operating costs under TEFRA, these costs will be included in the definition of inpatient operating costs under prospective payment. Malpractice insurance costs allowable under the Medicare program are associated with providing inpatient care and, therefore, are included as operating costs.

We believe that by including all inpatient operating costs, the system maintains financial incentives which will permit hospitals to plan the most efficient use of resources given their unique operating circumstances. Thus, the decisions concerning the allocation of all resources rest with the managers

responsible for planning care. It is only in this manner that the most effective use of health care funds can be achieved.

b. Nonphysician Services

Other than services furnished under waivers as discussed in section c. below, effective October 1, 1983, the only services provided in an inpatient hospital setting that may be billed by an entity other than the hospital are physicians' services to individual patients reimbursable on a reasonable charge basis. (These services are defined in § 405.550(b) (published March 2, 1983 at 48 FR 8937), as discussed below. Note that physician services to providers, defined in § 405.480 (48 FR 8935), are provider services for which payment may be made only to the provider. Payment for a physician's services to the provider, rather than to an individual patient, is included in the prospective payment. These services may not be billed separately.) Therefore, all nonphysician services furnished to hospital inpatients must be payable only to the hospital regardless of whether the hospital is subject to the prospective payment system. (See Sections 1862(a)(14) and 1866(a)(1)(H) of the Act.) This includes "incident to" physician services, medical items, supplies, and services, etc. See section IV of this preamble for additional details on this provision.

c. Waivers

Section 602(k) of Pub. L. 98–21 permits waivers to be granted under special circumstances for cost reporting periods beginning prior to October 1, 1986 (the 3-year transition period), allowing continued separate direct billing under Part B by suppliers or other providers of services to hospital inpatients. This waiver is restricted to situations where this practice was in effect prior to October 1, 1982 and was so extensively used that immediate compliance would threaten the stability of patient care. If hospitals have been granted this waiver, the reasonable charges for the nonphysician services billed under Part B will be subtracted from the Part A payment amount. Hospitals that believe they would qualify and wish to request a waiver should apply to the HCFA Regional Office through their intermediary. See section V.C. of this preamble for a detailed explanation of this waiver.

5. Costs Excluded From the Prospective Payment System

Section 1886(a)(4) of the Act, as amended, excludes capital-related costs and costs of direct medical education from the definition of inpatient operating costs. Therefore, payment for these costs will continue on a reasonable cost basis.

a. Capital-Related Costs

The rules applying to capital-related costs for purposes of the prospective payment system also will apply for purposes of determining such costs under the rate of increase limit at § 405.463 and the SNF cost limits issued under § 405.460 of the regulations.

As a result, all hospitals reimbursed under Subpart D will need to identify their capital-related costs. Therefore, we are establishing in these interim final rules a new section 405.414 of Subpart D, which identifies in detail costs that are includable in a hospital's capital-related costs. Generally, the following items are treated as capital-related costs and will be reimbursed under the reasonable cost method.

- Net depreciation expense.
- Leases and rentals (including license and royalty fees) for the use of assets that would be depreciable if the provider owned them outright (except in certain cases).
- Betterments and improvements that extend the estimated useful life of an asset at least 2 years beyond its original estimated useful life or increase the productivity of an asset significantly over its original productivity.
- The cost of minor equipment that are capitalized rather than charged off to expense.
- Interest expense incurred in acquiring land or depreciable assets (either through purchase or lease) used for patient care.
- Insurance on depreciable assets used for patient care or insurance that provides for the payment of capital-related costs during business interruption.
- Taxes on land or depreciable assets used for patient care.
- For proprietary providers, a return on equity capital.

If services, facilities, or supplies are provided to the hospital by a supplying organization related to the hospital within the meaning of § 405.427, then the hospital must include in its capital-related costs, the capital-related costs of the supplying organization. However, if the supplying organization is not related to the provider within the meaning of § 405.427, no part of the charge to the provider may be considered a capital-related cost (unless the services, facilities, or supplies are capital-related in nature) and:

- The capital-related equipment is leased or rented by the provider;
- The capital-related equipment is located on the provider's premises; and
- The capital-related portion of the charge is separately specified in the charge to the provider.

All hospitals, whether paid under the prospective payment system or excluded, must treat capital-related costs in a manner consistent with the way identical or similar costs were treated in the base period. This is necessary since the target amount is established on the basis of a hospital's base year costs. If costs were included as inpatient operating costs for purposes of the target amount computation and considered as capital-related costs in a subsequent year, there would be an unfair and inaccurate distortion in the year-to-year comparison.

Section 603(a)(1) of Pub. L. 98–21 requires that the Secretary study, develop, and report to the Congress within 18 months after the date of enactment of Pub. L. 98–21 on proposals for legislation by which capital-related costs associated with inpatient hospital services can be included within the prospective payment amounts.

b. Direct Medical Education Costs

The direct costs (including appropriate overhead costs) of approved education programs will be excluded from prospective payment. These costs will be reimbursed separately in accordance with regulations at § 405.421. (Costs of interns and residents hired to replace anesthetists will not be included. This adjustment is being adopted to preclude reimbursement for medical education programs instituted for the purpose of maximizing medical reimbursements.) Generally, approved educational activities mean formally organized or planned programs of study usually engaged in by providers in order to enhance the quality of care in an institution. Those programs may also include nursing schools and medical education of paraprofessionals (e.g., radiologic technicians). These programs do not include on-the-job training or other activities which do not involve the actual operation or support except through tuition or similar payments of an approved education program. Also, they do not include patient education or general health awareness programs offered as a service to the community at large.

6. Cost Reporting Periods

Hospitals subject to prospective payment will be paid under the new payment system for inpatient services effective with the hospital's first cost reporting period beginning on or after

October 1, 1983. The appropriate blend of the hospital's target amount and the DRG-rate will be paid for each discharge occurring on or after the first day of the cost reporting period. It is likely that a number of patients will be admitted and receive services before the beginning of the new period, but will be discharged after the period begins. Because the prospective payment rate is intended to cover an entire hospital stay, this situation would result in duplicate payment for a portion of the inpatient stay. Section 604(b) of Pub. L. 98-21 requires that, in this situation, an appropriate reduction in the prospective payment rate will be made to take into account amounts payable for items and services furnished before the cost reporting period begins. Therefore, the amounts payable on a reasonable cost basis for the portion of a hospital stay occurring before the beginning of the first cost reporting period on or after October 1, 1983 (i.e., the effective date for prospective payment) will be subtracted from the prospective payment rate for the applicable discharge. However, the prospective payment rates will not be reduced below zero; that is, if reasonable cost payments exceed the prospective payment rate, no additional payment will be made but pass through costs will not be reduced.

Section 604(a)(1) of Pub. L. 98-21 states that a change in a hospital's cost reporting period made after November 1982 will be recognized, for purposes of the effective date of the prospective payment system, only if the Secretary finds good cause for the change. We are implementing this requirement through regulations at § 405.453(f)(3), which are effective for cost reporting periods ending on or after the date of publication of these interim rules. We considered applying this requirement to all changes since November, 1982. However, a number of hospitals have had changes approved for cost reporting periods that have already closed. We decided that retroactive application of the requirements of § 405.453(f)(3) was not feasible, but that making them effective as soon as possible was necessary, since we did not wish to afford hospitals an additional 30-day or more period in which to effectuate such changes before the rules take effect. Therefore, even if our fiscal intermediaries have approved such changes, we will not recognize them for purposes of a hospital's entry into the prospective payment system unless the period for which the change is approved has already closed. Under this policy, a hospital will be required to adhere to the cost reporting period initially selected unless a change is authorized in writing by the hospital's fiscal intermediary.

To establish good cause for a change, the hospital must show that there are specific circumstances that support its request for the change. The hospital's written request must be received by the intermediary 120 days prior to the reporting period to be changed. Good cause would be found to exist, for example, if a hospital that is part of a multi-hospital system requests that its cost reporting period be changed to coincide with the periods used by all other components of the system. However, good cause would not be found to exist where the effect of the change is to change the date by which the provider becomes subject to, or is excluded from, the prospective payment system.

7. Publication of Standardized Amounts and Relative Weights

a. Initial Rates

Section 604(c) of Pub. L. 98-21 requires that a notice of the interim final DRG prospective payment rates effective with cost reporting periods beginning on or after October 1, 1983, be published in the **Federal Register** no later than September 1, 1983. Additionally, while a period for public comment is required, the rates as published will be effective on October 1, without consideration of comments received. However, by notice published in the **Federal Register** not later than December 31, 1983, the payment amounts must be affirmed or modified after consideration of those comments. Section 604(c) also requires that if a modification is made reducing payment rates, this modification will apply only to discharges occurring after 30 days from the date the notice of modification is published in the **Federal Register**. The above requirements are included in regulations at § 405.470(d)(1).

b. Annual Publication of Standardized Amounts and Relative Weights

Beginning in 1984, HCFA will publish in the **Federal Register** annual notices setting forth amounts and factors necessary to determine prospective payment rates applicable to discharges occurring during the Federal fiscal year. See the regulations at 405.470(e)(2) that establish dates by which the notices will be published.

C. Determination of the Prospective Payment Rates

This section contains a detailed explanation of how the final DRG-based prospective payment rates are determined, adjusted, and updated. An explanation of applicable rates during the 3-year transition period is presented in section C.4. of this preamble.

1. Calculation of Adjusted Standardized Payment Amounts

The statute requires that the Secretary determine national and regional adjusted DRG prospective payment rates for each DRG to cover the operating costs of inpatient hospital services. The methodology for arriving at the appropriate rate structure is essentially prescribed in the Act in section 1886(d)(2). It requires that certain base period cost data be developed and modified in several specified ways (i.e., inflated, standardized, grouped, and adjusted) resulting in 20 average standard amounts per discharge according to urban/rural designation in each of the nine census divisions and the nation. Table 1, section VII of the addendum contains the 18 regional standardized amounts (further divided into labor/nonlabor portions). The national standardized amounts are not included in the table because, for FY 84, Federal rates are based on regional averages. (In FY 85, Federal rates will be based on a combination of regional and national averages.) For the interested reader, the national standardized amounts for FY 84 have been calculated to be $2,837.91 as the urban average ($2,206.22 for the labor share and $631.69 for the nonlabor share) and $2,264.00 as the rural average ($1,847.42 for the labor share and $416.58 for the nonlabor share). These amounts are only estimates that, for comparison purposes, have been computed in the same manner as the regional amounts contained in Table 1 section VII of the addendum.

a. Base Year Cost Data

Section 1886(d)(2)(A) of the Act requires that, in determining allowable costs for the base period, the most recent cost reporting period for which data are available be used. Therefore, we have used Medicare hospital cost reports for reporting periods ending in 1981.

In calculating standardized amounts, we gathered cost reports from nearly all hospitals participating in Medicare, manually extracted necessary information, and prepared the information in computer-readable form. Because this process required a great deal of staff time, there was considerable lag time between the filing

of cost reports and the availability of complete data for use by HCFA. Thus, calendar year 1981 cost data were the most recent cost reporting period data available for use.

As explained in section III.B. of this preamble, prospective payment is intended to cover all hospital inpatient operating costs for treating Medicare beneficiaries. The base year cost data include all allowable hospital costs incurred in treating Medicare patients except, to the extent possible, the following:

(i) Costs from psychiatric, rehabilitation, children's, and long-term hospitals, and subproviders;

(ii) Capital-related costs, as recorded in the depreciation cost centers of the Medicare cost reports and return on equity capital, if applicable;

(iii) Direct medical education costs;

(iv) Nursing differential costs, which were previously reimbursable but are now disallowed under section 1861(v)(1)(J) of the Act, effective with services furnished on or after October 1, 1982. (The reported hospital operating costs were adjusted to reflect a zero nursing salary differential.)

Since only Medicare allowable inpatient operating costs were used in the data base, routine costs in excess of the routine cost limits provided for in section 223 of Pub. L. 92-603 were not included in the calculation of the standardized amounts.

The resulting Medicare cost was then divided by the number of Medicare discharges during the year, resulting in total Medicare allowable inpatient operating costs per discharge, for each hospital included in the data base. To determine discharges we relied on a monthly tabulation of Medicare discharges covering the same periods represented in the cost report. These final amounts represent the base year cost data.

b. Updating for inflation

Section 1886(d)(2)(B) of the Act requires that the base year cost data be updated. This requires a two-step process.

(i) The base year cost data, representing allowable costs per Medicare discharge (per hospital), are inflated through fiscal year 1983 using actuarial estimates of the rate of increase in hospital inpatient operating costs nationwide. The estimated actual rates of inflation for the hospital industry are as follows:

Calendar year	Inflation rate (percent)
1981	15.9
1982	15.0
1983	11.7

(ii) The resulting amounts are further inflated through fiscal year 1984 by using the estimated annual rates of increase in the hospital market basket, plus 1 percentage point, in accordance with section 1886(b)(3)(B) of the Act. (See the notice of target rate percentages published elsewhere in this issue of the **Federal Register.**)

Since July 1, 1979, the hospital cost limit schedules have incorporated a "market basket index" to reflect changes in the prices of goods and services that hospitals use in producing general inpatient services. We developed the current market basket by identifying the most commonly used categories of hospital inpatient operating expenses and by weighting each category to reflect the estimated proportion of hospital operating expenses attributable to each category. We then obtained historical and projected rates of increase in the resource prices for each category. Based on the rate of increase and the weight of each category, we developed an overall annual rate of increase in the hospital market basket. The categories of expenses used to develop the revised market basket are based primarily on those used by the American Hospital Association in its analysis of costs, and by the U.S. Department of Commerce in publishing price indices by industry.

In developing the market basket index used in establishing the prospective payment rates, we have revised in two ways the market basket previously used under the hospital cost limits, which were published in the **Federal Register** (47 FR 43313) on September 30, 1982. First, we have added malpractice insurance to the categories of expenses included in the market basket. We made this change because malpractice insurance premiums, which were excluded from the hospital cost limits, are included in the prospective payment rates. Second, we have revised the proportions assigned to each expense category to reflect the estimated proportion of total inpatient operating costs, including malpractice insurance attributable to each category.

The price variables used to predict price changes for each category of expenses are specified in Table 2, section VII of the attached addendum. For further background on the development of the market basket index, see Freeland, Anderson and Schendler, "National Hospital Input Price Index", *Health Care Financing Review*, Summer 1979, pp. 37-61.

c. Standardization

Section 1886(d)(2)(C) of the Act requires that each hospital's updated base year cost per discharge be standardized. Standardization means the removal of the effects of certain variable costs from the cost data.

i. Variations in Case Mix Among Hospitals

Section 1886(d)(2)(c)(iii) of the Act requires that the updated amounts be standardized to adjust for variations in case mix among hospitals. The methodology used for determining the appropriate adjustment factor (i.e., the case-mix index) is similar to that used for the hospital cost limits published in the **Federal Register** on September 30, 1982 (47 FR 43303). Essentially, a case-mix index has been calculated for each hospital (based on 1981 cost and billing data) reflecting the relative costliness of that hospital's mix of cases compared to a national average mix of cases. Standardization, necessary to neutralize the effects of variations in case mix among hospitals, is accomplished by dividing each hospital's average cost per Medicare discharge by that hospital's case-mix index. Table 3, section VII of the addendum contains the case-mix index values used for this purpose.

While the case-mix indexes used to develop the prospective payment rates are similar to those previously published (see 47 FR 43314), they differ in one respect. The weights used in their construction are not limited to the DRGs represented in the 1981 MEDPAR data set. The case-mix indexes have been calculated using weighting factors derived for all DRGs. Section III.B.3. of this preamble contains an explanation of the development of the DRG weighting factors. We computed each hospital's case-mix index by multiplying the weighting factor for each DRG by the number of MEDPAR cases classified in that DRG and dividing that result by the hospital's total number of MEDPAR discharges.

ii. Indirect Medical Education Costs

After adjusting each hospital's inpatient operating cost per discharge for inflation and case-mix complexity, we divided each cost by 1.0 plus the product of double the education adjustment factor (11.59 percent) and the individual hospital's adjusted intern-and-resident to bed ratio. (Section III.D.4. of this preamble contains a

detailed explanation of the education adjustment factor and ratio.) We determined that adjusted ratio by dividing the number of FTE interns and residents for the cost reporting period to which the average cost per discharge applies by the hospital's bed size determined at the beginning of that period to obtain the hospital's intern-and-resident to bed ratio, and dividing that ratio by .1. In order to appropriately standardize base year data for indirect medical education costs, it is necessary to use the same education adjustment factor in standardization as is used in making additional payments to teaching hospitals. Since the statute requires that the education adjustment factor be doubled in determining the amount of additional payments, we must also double the factor for standardization.

Example: After adjusting for inflation and standardizing for case-mix, the cost per discharge of a hospital with 686 beds available for use in Queens County, New York, is $1646.09. The hospital employed 77 FTE interns and residents in approved teaching programs.

The cost per case is adjusted for education costs as follows:

77 divided by 686 = .11224, which is the intern-and-resident to bed ratio for this hospital.

.11224 divided by .1 = 1.12240—Adjusted Ratio.

$1646.09 divided by [1 + (.1159 × 1.12240)] = $1456.61, Education-adjusted cost per discharge.

iii. Adjustments for Variation in Hospital Wage Levels (Federal Portion)

Section 1886(d)(2)(C)(ii) of the Act requires that the updated amounts be standardized by adjusting for area variations in the hospital wage levels. This adjustment requires the division of the average cost per discharge into labor-related and nonlabor-related portions. To determine the labor-related portion, we summed the percentages of the labor-related items (i.e., wages and salaries, employee benefits, professional fees, business services, and miscellaneous items) from the market basket. Using the most current market basket, the labor-related portion is 79.15 percent. Under the operating cost limits, the labor-related portion equaled 80.77 percent.

However, as mentioned in section C.1.b. of this preamble, the market basket applicable for the prospective payment system has been revised to include malpractice insurance. Therefore, the resulting labor-related percentage has also been revised.

To remove the effects of local wage differences from hospital costs, the labor-related portion is then divided by the appropriate wage index for the geographic area in which the hospital is located. The wage index reflects the average hospital wage level in the geographic area in which the hospital is located compared to the national average. The index is calculated based on wage and employment data maintained by the Bureau of Labor Statistics (BLS) of the U.S. Department of Labor. Specificially, the source file is the 1981 ES 202 Employment, Wages, and Contributions File for hospital workers (Standard Industrial Classification code 806).

The data used to develop the wage index were supplied by BLS, and are the most reliable national data available. If we discover that we, or BLS, have made any error that results in an incorrect wage index for any area, we will direct the Medicare intermediaries to recalculate the payment rates. However, BLS has advised us that they are unable to correct any inaccuracies in the wage index that may result from a hospital's failure to report the required wage and employment data. Moreover, any revisions in wage indexes will only apply to the adjustment of the standardized amounts as described in section C.2.a. of this preamble. We will not recalculate the standardized amounts themselves based on revised wage indexes.

In developing the wage index, we used approximate values for certain areas because BLS confidentiality requirements prohibit the disclosure of actual data or indexes for areas that include fewer than three reporting units. (A reporting unit is the smallest unit for which data are recorded on the employer's contribution report. Therefore, two or more hospitals owned by one organization could appear as one reporting unit.) The BLS has identified the areas having wage index values closest to, but not less than, the wage index for those areas where actual disclosure is prohibited. Additionally, data from Federal hospitals (e.g., VA hosptials) are excluded in determing wage indexes because these hospitals typically use national pay scales. Therefore, the amounts paid to employees do not necessarily reflect area wage levels.

Previously, we have published wage indexes for each Standard Metropolitan Statistical Area (SMSA), New England County Metropolitan Area (NECMA), and State rural area. On June 30, 1983, the Executive Office of Management and Budget (EOMB) began using Metropolitan Statistical Areas (MSAs) in lieu of SMSAs (see section III.C.1.d. of this preamble).

An example of standardization for wages follows:

Assume a hospital has an average cost per Medicare discharge of $3,000 and the wage index for the area is 1.0293.

$3000 × 79.15% (labor-related portion) = $2374.50 (labor share).

$2374.50 = $2306.91 (wage adjusted labor share) 1.0293.

The wage indexes are listed in Table 4, section VII of the addendum.

iv. Cost-of-Living Factor for Alaska and Hawaii

Section 1886(d)(5)(C)(iv) of the Act authorizes the Secretary to provide for such adjustments to the payment amounts as the Secretary deems appropriate to take into account the unique circumstances of hospitals located in Alaska and Hawaii. Generally, these two States have higher levels of cost in comparison to other States in the nation. The high cost of labor is accounted for in the wage index adjustments discussed above. However, the high cost-of-living in the States also affects the cost of nonlabor items (e.g., supplies and equipment). Under the Amendments, hospitals in Alaska and Hawaii will be entitled to an increased prospective payment rate because of the generally higher cost of living in those States. The effect of this higher cost of living is to increase Alaska and Hawaii hospital nonlabor costs from the levels generally prevalent in the rest of the country. Therefore, we believe it is desirable to reduce, as much as possible, the effect of the higher nonlabor costs in deriving each hospital's standardized cost per discharge. Accordingly, we divided the nonlabor-related portion of the average Medicare cost per discharge for hospitals located in Alaska and Hawaii by an appropriate cost-of-living adjustment factor. We point out that aside from being technically desirable, the effect of standardizing nonlabor hospital costs in Alaska and Hawaii is to decrease the reduction for budget neutrality stemming from the requirements in section 1886(e)(1)(B) of the Act. The adjustment factors contained in the table below are based on data obtained from the U.S. Office Of Personnel Management as published in their FPM-591 letter series.

Table.—Cost-of-Living Adjustment Factors, Alaska and Hawaii Hospitals

Alaska: All areas	1.25
Hawaii:	
Oahu	1.20
Kauai	1.175
Maui	1.20
Molokai	1.20
Lanai	1.20
Hawaii	1.10

As explained above, the average labor-related portion of hospital costs (i.e., based on the market basket) equals 79.15 percent of total costs. Therefore, the nonlabor portion equals 20.85 percent. The formula used to make the standardization adjustments for the nonlabor related costs in Alaska and Hawaii is as follows:

$$\frac{(\text{Average Cost Per Medicare Discharge}) \times (20.85\%)}{(\text{Cost-of-Living Adjustment Factor})}$$

d. Urban/Rural Averages Within Geographic Areas

Section 1886(d)(2)(D) of the Act requires that average standardized amounts (i.e., per discharge) be determined for hospitals located in urban and rural areas of the nine census divisions and the nation. The statute further specifies that the term "urban area" means an area within a Standard Metropolitan Statistical Area (SMSA), as defined by EOMB, or within such similar area as the Secretary has recognized by regulation. The term "rural area" means any area outside of urban areas.

On June 30, 1983, EOMB began using Metropolitan Statistical Areas (MSAs) in lieu of SMSAs. MSAs are designated and defined following a set of new standards prepared by the Federal Committee on MSAs, which advises EOMB on metropolitan area definitions. Under these standards, an area qualifies for recognition as an MSA in one of two ways: (1) if a city of at least 50,000 population is located in the area, or (2) if it is an urbanized area of at least 50,000 with a total metropolitan population of at least 100,000. In addition to the county containing the main city, an MSA may also include additional counties that have close economic and social ties to the central county. MSAs are defined in terms of entire counties, except in the six New England States. In most cases, there is little difference between the SMSA designations and the MSA designations beyond the change in title. For example, the Los Angeles SMSA is now the Los Angeles MSA. Therefore, we are using MSA designations for purposes of the prospective payment system because this is the classification system currently used by EOMB, and the new designations recognize area changes reflecting 1980 census data. The MSA designations announced by EOMB on June 27, 1983 and effective June 30, 1983 are contained in Table 4, section VII of the addendum.

Section 601(g) of Pub. L. 98–21 requires that any hospital located in New England will be classified as being in an urban area if the hospital was classified as being in an urban area under the classification system in effect in 1979. As a result of this provision, the following counties are deemed to be urban areas: Litchfield County, Connecticut; York County, Maine; Sagadahoc County, Maine; Merrimack County, New Hampshire; and Newport County, Rhode Island.

As a result of the adjustments explained above, we have calculated 18 average adjusted standardized amounts per Medicare discharge. In summary, these amounts: are adjusted for inflation; are standardized to remove the effects of area wage differences, indirect medical education, case mix, and cost-of-living in Alaska and Hawaii; and are grouped by urban/rural and geographic designations.

e. Calculation of Adjustments to Standardized Amounts

The various calculations explained in the sections above resulted in a determination of 18 separate average standardized amounts. These amounts were further adjusted taking into consideration various provisions of Pub. L. 98–21.

i. Part B Costs

As explained above, the prospective payment rates are intended to cover all costs associated with inpatient hospital services for Part A beneficiaries except physicians' services to individual patients. Because many of these services have previously been billed under Part B of the program, the standardized costs per discharge do not include these amounts.

Section 602(e) of Pub. L. 98–21 added section 1862(a)(14) to the Act to prohibit payments for nonphysician services furnished to hospital inpatients unless the services are furnished either directly by the hospital or furnished by an entity under arrangements (as defined in section 1861(w)(1) of the Act) made by the hospital. Section 1861(w)(1) of the Act defines the term "arrangements" as "arrangements under which receipt of payment by the hospital (whether in its own right or as agent), with respect to services for which an individual is entitled to have payment made under this title discharges the liability of such individual or any other person to pay for the services." Because the term "arrangements" is defined in a way that satisfies all beneficiary liability for the services (except for the Part A cost-sharing provisions), Part B billing by an entity other than the hospital for nonphysician services furnished to hospital inpatients is essentially prohibited, effective October 1, 1983. This prohibition applies to all hospitals participating in the Medicare program, not just those subject to prospective payment.

In order to adjust the standardized amounts per discharge so that the Federal rate payable in FY 84 includes an approximation of costs previously billed under Part B, they must be increased based on estimates that have been made by HCFA's Office of Financial and Actuarial Analysis.

Since 1980 and 1981 data are used to set the prospective payment rates, the estimated amounts for inpatient services billed to Part B of Medicare should be consistent with policies and practices existing in 1980 and 1981. The amounts for inpatient services billed to Part B were derived from Part B billing data and then projected to FY 1984 consistent with estimated-growth and with 1980–81 policies and practices. (Most of those amounts are attributable to lab tests sent out to independent labs.) The effect of the hospital based physician regulations is excluded from this adjustment since section 1886(d)(5)(D) specifies adjustment only for the effects of section 1862(a)(14). The projections of the FY 84 amounts were divided by HCFA's estimate of FY 84 Medicare inpatient costs to derive the adjustment factor of 0.13%. Therefore, the standardized amounts have been increased by this percentage. Because section 1886(d)(5)(D)(ii) provides that an adjustment to the Federal payment rates will be made in each fiscal year for nonphysician inpatient hospital services previously billed under Part B, we will estimate the amount of this percentage adjustment to the standardized amounts on an annual basis.

ii. FICA Taxes

Section 102 of Pub. L. 98–21 requires that certain hospitals (i.e., non-profit organizations) enter the Social Security system and begin paying FICA taxes for employees beginning January 1, 1984. Section 1886(b)(6) of the Act is also amended by Pub. L. 98–21, requiring that adjustments be made in the rate of increase base period costs in recognition of these higher payroll costs. The conference committee report accompanying Pub. L. 98–21 expressed the intent that the Federal rate also be adjusted to reflect this change. (H.R. Rep. No. 98–47, 98th Cong. 1st Sess. 184 (1983).) Our actuaries have estimated the amount of the adjustment to the

standardized amounts necessary to account for increased payroll taxes for hospitals entering the Social Security system.

The Office of the Actuary (OACT) in the Social Security Administration (SSA) supplied us with an estimate of the 1984 payroll of non-profit hospitals not covered by the FICA tax in 1981. IRS data were combined with SSA internal data to identify which of the health services employers with fifty or more employees were not covered by the FICA tax 1981. (Since hospitals are not identified in the data, health services employers with fifty or more employees are used as a proxy.) The OACT estimated that the 1984 payroll for hospitals not covered by FICA in 1981 was about $2.7 billion.

The $2.7 billion payroll was multiplied by 87% to derive the inpatient share and further multiplied by 36% to derive Medicare's share of the inpatient share. The result was multiplied by the 1981 FICA tax rate of 6.65% to derive Medicare's share of the employer portion of the FICA taxes. Medicare's share of the FICA taxes was divided by the 1981 Medicare hospital costs to derive the adjustment factor of 0.18%. Therefore, the standardized amounts were increased by this percentage.

The 87% ration of inpatient costs to total costs was derived from American Hospital Association data and verified by analysis of Medicare hospital cost report data. The 36% Medicare share of inpatient cost was derived from analysis of Medicare hospital cost reports for non-profit—non-government hospitals.

iii. Outliers

Section 1886(d)(5)(A) of the Act requires that payments, in addition to the basic prospective payment rates, be made for discharges involving day or cost outliers as explained in section III.D.1 of this preamble. Section 1886(d)(2)(E) of the Act correspondingly requires that the standardized amounts be reduced by a proportion that is estimated to reflect additional payments for outlier cases.

The statute further requires that outlier payments may not be less than 5 percent or more than 6 percent of total payments projected to be made based on the prospective payment rates in any year. In accordance with this requirement, we estimate that outlier payments for FY 84 will be 6.0 percent of total payments (including both prospective and outlier payments). Therefore, we have reduced the standardized amounts by multiplying by .943, which is a factor computed to achieve the result. Prior to each fiscal year, an estimate of outlier payments for that year will result in an adjustment to the standardized amounts used in calculating Federal rates. The methodology for determining the adjustment factor needed to actualize that estimate is closely related to the method for determining the budget neutrality adjustment factor discussed in the next section, and is explained in section VIII of the addendum along with the derivations of the budget neutrality adjustments.

iv. Budget Neutrality

Section 1886(e)(1) of the Act requires that the prospective payment system result in aggregate program reimbursement equal to "what would have been payable" under the reasonable cost provisions of prior law; that is, for fiscal years 1984 and 1985, the prospective payment system should be "budget neutral."

Under the Amendments the prospective payment rates are a blend of a hospital-specific portion and a Federal portion. Section 1886(e)(1)(A) of the Act requires that projected aggregate payments for the hospital specific portion should equal the comparable share of estimated reimbursement under prior law. Similarly, section 1886(e)(1)(B) of the Act requires that projected aggregate reimbursement for the Federal portion of the prospective payment rates should equal the corresponding share of estimated amounts payable prior to the passage of Pub. L. 98–21. Thus, for FY 84, 75 percent of projected payment for inpatient operating costs based on the hospital-specific portion should equal 75 percent of the amount projected to be payable for inpatient operating costs under the law in effect before enactment of Pub. L. 98–21. Likewise, total estimated prospective payments incurred deriving from the 25 percent Federal portion, including outlier payments and adjustments and special treatment of certain classes of hospitals, should equal 25 percent of projected payments incurred under the prior reasonable cost reimbursement system. (Note that this does not apply to payments such as payments of a return on equity capital, made in addition to prospective payments.)

This adjustment of the Federal portion was determined as follows:

- *Step 1*—Estimate total incurred payments for inpatient hospital operating costs (for FY 84 and FY 85) that would have been made on a reasonable cost basis under Medicare prior to Pub. L. 98–21.
- *Step 2*—Multiply total incurred payments by 25 percent (for FY 84) and 50 percent (for FY 85), i.e., the Federal portions of the total payment amounts for each year.
- *Step 3*—Estimate Federal portion of total payments that would have been made without adjusting for budget neutrality, but with the adjustment for outlier payments.
- *Step 4*—Add an estimate of total adjustments and payments made under the special treatment provisions of § 405.476 (e.g., outliers, indirect medical education) to the Federal portion.
- *Step 5*—The difference between amounts calculated in Step 4 and Step 2 is divided proportionally among the standardized amounts resulting in the budget neutrality adjusted (standardized) amounts.

The resulting adjustment factor for the FY 84 Federal portion is .969. Payment amounts of hospitals excluded from the prospective payment system (for example, psychiatric and children's hospitals) and of hospitals not participating in prospective payment because of their participation in demonstrations and studies were not included in the calculations above. For a more detailed explanation of budget neutrality, see section VIII of the addendum.

f. Summary of Calculations Resulting in Adjusted Standardized Amounts

In summary, we began our calculations by developing base year cost data for individual hospitals; we updated these amounts to account for inflation through fiscal year 1984; we standardized the data; we grouped the data from individual hospitals resulting in average standardized amounts for urban and rural hospitals located in the nine census divisions; and we adjusted the resulting 18 standardized amounts in accordance with requirements of the Act. Throughout the remainder of this discussion, when we refer to "adjusted standardized amounts", we are referring to the 18 separate average amounts calculated as described above.

2. Adjustments for Area Wage Levels and Cost-of-Living in Alaska and Hawaii

This section contains and explanation of two types of adjustments that will be made by the fiscal intermediaries to the adjusted standardized amounts. For discussion purposes, it is necessary to present the adjusted standardized amounts divided into labor and non-labor portions. See Table 1, section VII of the addendum, which contains the actual divided amounts which will be used for calculation of prospective payment rates.

a. Adjustment for Area Wage Levels

Section 1886(d)(2)(H) of the Act requires that an adjustment be made to the labor-related portion of the national and regional Federal rates to account for area differences in hospital wage levels. This adjustment will be made by the fiscal intermediaries by multiplying the labor-related protion of the adjusted standardized amount (i.e., 79.15 percent of the total amount) by the appropriate wage index for the area in which the hospital is located. The wage indexes, applicable for fiscal year 1984, are presented in Table 4, section VII of the addendum.

b. Adjustment for Cost-of-Living in Alaska and Hawaii

As explained in section III.C.1.c.iv. of this preamble, the statute provides for an adjustment to take into account the unique circumstances of hospitals in Alaska and Hawaii. Higher labor-related costs for these two States were included in the adjustment explained in section a. above. The adjustment necessary for nonlabor-related costs for hospitals in Alaska and Hawaii will be made by the fiscal intermediaries by multiplying the nonlabor portion (i.e., 20.85 percent) of the standardized amounts by the appropriate adjustment factor contained in the table in section III.C.1.c.iv.

3. Federal DRG Prospective Payment Rates

a. DRG Classification

As explained in section III.B. of this preamble, all Medicare discharges will be classified according to one of 467 DRGs. (Note that DRG No. 468 may also be assigned when valid discharge records contain an operating room procedure unrelated to the Major Diagnostic Category.)

b. Weighting Factors

The actual DRG Federal payment rates are determined by multiplying the standardized amounts by weights appropriate to each discharge. These weights are intended to reflect the relative resource consumption associated with each DRG. That is, each weight reflects the relative cost, across all hospitals, of treating cases classified in that DRG. To establish these weights, we used data from the MEDPAR file (MP) (a statistical file containing coded clinical information and billed charge data based on a 20 percent sample of all Medicare claims), from the Medicare cost reports (MCR), and from non-MEDPAR discharge records for Maryland and Michigan hospitals (NMP). Maryland and Michigan discharge records were used to calculate the weights for 109 DRGs that either contained no MEDPAR cases or had too few cases to provide a reasonably precise estimate of the average cost of care. Because the prospective payment system requires the establishment of a rate for all DRGs, Maryland and Michigan records were used to calculate the weighting factors for DRGs which were not prevalent in the 1981 MEDPAR file. Discharges falling within the 109 DRGs for which non-MEDPAR records were used to construct the prospective payment weighting factors represent less than .3 percent of all Medicare discharges.

In addition, of the 468 categories which required the determination of prospective payment weighting factors, the DRG assignment program (i.e., the MEDPAR grouper) collapsed 25 into 16 more general categories because specific clinical information essential for the assignment of Medicare discharges to these DRGs was not available in the MEDPAR data set. For example, DRGs 106 and 107, corresponding to coronary bypass with and without cardiac catheterization, are not distinguished in the MEDPAR file. Instead, there is a single group (labeled DRG 107) containing coronary bypass patients with or without catheterization. To derive prospective payment weighting factors for DRGs that had been combined in the MEDPAR data set, we relied on the same non-MEDPAR discharge records from Maryland and Michigan used to construct the weights for the 109 empty or low volume DRGs.

Based on the Maryland and Michigan records, we first computed weighting factors for all 468 categories. For example, assume relative weights for DRGs 106 and 107 as shown in the following table:

DRG	Maryland	Michigan
106	1.3862 (30)	1.2418 (80)
107	1.4722 (20)	1.3162 (50)

The numbers in parentheses represent the number of discharges on which each weight is based. The weighting factor for DRGs 106 and 107 combined (i.e. weighted by the number of discharges in each DRG) is 1.3121.

We then divided the weighting factor for the combined DRGs in the MEDPAR data set by the combined Maryland-Michigan weight for the corresponding DRGs to yield an adjustment ratio. Using our hypothetical example, if the weighting factor for DRG 107 in the MEDPAR file (representing DRGs 106 and 107 combined) is 1.2600, we computed the adjustment ratio 1.2600 divided by 1.3121 or .9603. We then multiplied all of the original Maryland and Michigan weighting factors by this ratio. Using our example, the revised weights would be:

DRG	Maryland	Michigan	Combined
106	1.3312 (30)	1.1925 (80)	1.2303
107	1.4138 (20)	1.2639 (50)	1.3067

The combined column, the weighted average of the adjusted original State weights, represents the weighting factors for the MEDPAR DRGs that were collapsed or otherwise combined. Thus, in our example the hypothetical prospective payment weighting factors for DRGs 106 and 107 would be 1.2303 and 1.3067, respectively.

The calculation below illustrates the use of the data in constructing the weighting factors. The source of the data items is given in parentheses for each step of the calculation.

i. Computation of Adjusted Cost for Each Case

To derive DRG weights, we first calculated an adjusted cost for each case by: (1) Multiplying the number of days the patient spent in a regular room (MP or NMP) by the hospital's routine cost per day (MCR); (2) Multiplying the number of days the patient spent in a special care unit (MP or NMP) by the hospital's special care unit cost per day (MCR); and (3) Multiplying the ancillary charges for services to the patient (MP or NMP) by the relevant departmental ancillary cost to charge ratios (MCR) to determine the cost of ancillary services. All hospital routine and special care per diem costs were standardized to July 1, 1981 to coincide with the mid-point of the period represented in the MEDPAR file (i.e. calendar year 1981 records). Example 1 depicts the hypothetical calculation of the adjusted cost per case for a patient who spent 10 days in a hospital in New York City. Two of the 10 days were spent in a special care unit. During the stay, the patient incurred charges for radiology, laboratory and pharmacy services.

EXAMPLE 1.—Calculation of Adjusted Cost Per Case for Cases Classified Within a DRG

Routine care cost per diem (MCR)	×	Routine care days (MP or NMP)	=	Routine care cost
$150		8		$1,200

Special care cost per diem (MCR)	×	Special care days (MP or NMP)	=	Special care cost
$200		2		$400

Ancillary department	Cost to charge ratio (MCR)	×	Ancillary charges (MP or NMP)	=	Ancillary cost
Radiology	$0.80		$55		$44
Laboratory	.85		175		149
Pharmacy	1.20		80		96
Total					289

NOTE.—Adjusted Cost Per Case $1,200 + $400 + $289 = $1,889.

ii. Standardization of Adjusted Cost Per Case for Variation Due to Teaching Activity and Hospital Wage Levels

The next step was to standardize each adjusted cost per case for the effects of variations in the level of hospital specific teaching activity and area-specific hospital wage levels, so that the cost values would be comparable across hospitals. The method for standardizing adjusted costs per case for differences in teaching activity is as follows. First, for each hospital with an approved internship and residency program, we determine the ratio of full-time equivalent (FTE) interns and residents per bed. We compute this ratio for each hospital from data contained on Medicare institutional certification surveys where available, and from data submitted directly by the intermediary. We then multiply the FTE intern and resident to bed ratio by 5.795 percent, the indirect education cost adjustment factor, and add the product to 1.0. This results in a teaching activity adjustment factor which we then use to divide the hospital's adjusted cost per case. The result of this division is a cost value for each case adjusted for hospital differences in teaching activity.

Next, we divided each hospital's adjusted cost per case into labor related and non-labor components. The labor related component was derived from the market basket and represents a fixed share (79.15 percent) of cost per case. This share represents the sum of the 1981 market basket relative importance weights for wages and salaries, employee benefits, professional fees, business services, and miscellaneous expenses (see Table 2, section VII of Addendum). The labor related component of adjusted cost per case was then divided by the hospital's applicable wage index from Tables 4A and 4B. This result was added to the non-labor component of the adjusted cost per case to yield a revised cost per case that is standardized for hospital differences in teaching activity and area wage levels. The resulting adjusted cost values for the cases from each hospital represent estimates of the treatment costs that would prevail if the hospital had no teaching programs, and paid the prevailing national average wage rates. Example 2 depicts the hypothetical calculation of this standardized cost per case.

Example 2

Calculation of Standardized Cost Per Case
Adjusted cost per case = $1889
Hospital intern and resident to bed ratio (based on 686 bed facility with 77 FTE interns and residents)
(77 divided by 686) divided by .1 = 1.1224
Education adjustment factor = 5.795 percent
Adjusted cost per case, standardized for differences in teaching activity
$1,889 divided by (1.0 + (1.1224) (.05795) = $1,773.64)
Labor-related portion of adjusted cost per case, standardized for differences in teaching activity
$1773.64 × .7915 = $1403.84
Non-labor portion of adjusted cost per case, standardized for differences in teaching activity
$1773.64 − $1403.84 = $369.80
Adjusted cost per case, standardized for area wage differences
$1403.84 divided by 1.3979 (Wage index) + $369.80 = $1374.05

We did not use every case included in the MEDPAR file and from the non-MEDPAR discharge records for Maryland and Michigan hospitals in constructing the DRG weighting factors. We were concerned that those cases of a typically long or short duration would distort the results. Therefore, we eliminated all cases in each DRG for which the standardized cost values were outside three standard deviations from the geometric mean of the values for the DRG.

The average standardized cost for each of the 468 DRGs was calculated by summing the standardized adjusted costs for all cases in the DRG and dividing that amount by the number of cases classified in the DRG. The average standardized cost for each DRG was then divided by the overall average standardized cost to determine the weighting factor.

We have depicted the construction of the DRG prospective payment weights and the case-mix indexes in the table below. The table has been structured to make DRGs 1 through 4 correspond to the 358 DRGs with sufficient Medicare cases in the 1981 MEDPAR data set. DRGs 5 and 6 correspond to the 109 DRGs with insufficient Medicare cases to which Maryland and Michigan non-MEDPAR records were added to derive the DRG weighting factors. Hospitals A through E correspond to the 5853 hospitals represented in the MEDPAR file and used to calculate the weights for the 358 DRGs with sufficient Medicare cases.

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CALCULATION OF MEDICARE PROSPECTIVE PAYMENT WEIGHTS

Standardized Cost Per Discharge, Classified By DRG[1/]

HOSPITAL	DRG 1	DRG 2	DRG 3	DRG 4	DRG 5	DRG 6	Expected Cost Per Discharge[2/]	Case Mix Index[8/]
A	1100 2000	3000	None	4000	--	--	2575	1.0210
B	None	2000 1000 5000	2000	4000 5000	--	--	3092	1.2259
C	1200 900	3000	2500 2000	3000	--	--	2367	.9384
D	2000 3000 2000	3200 2500 1900	1800 1600 1500	None	--	--	2067	.8194
E	1000	1800	1900 2300	6000	--	--	2510	.9952
Number of MEDPAR Discharges by DRG	8	9	8	5	--	--	--	--
MEDPAR Average Expected Cost Per Discharge (hospital weighted)	--	--	--	--	--	--	2522[3/]	--
DRG Cost Weight	1650	2600	1950	4400	3400[4/]	4000[4/]	--	--
MEDPAR Average DRG Cost Weight (DRG weighted)	--	--	--	--	--	--	2650[5/]	--
MEDPAR DRG Relative Cost Weights[5/]	.6226	.9811	.7358	1.6604	1.2143	1.4286	--	--
Prospective Payment DRG Relative Cost Weights[2/]	.6542	1.0309	.7732	1.7447	1.2760	1.5012	--	--

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1/ Structured to make these 6 DRGs represent all 468 DRGs. DRGs 5 and 6 correspond to the 109 low volume or empty MEDPAR DRGs for which primarily Maryland and Michigan non-MEDPAR records were used to compute the relative weights. Their weights are not derived from the national set of hospitals represented in the MEDPAR file. DRGs 1 through 4 correspond to the 358 MEDPAR DRGs with sufficient Medicare discharges.

2/ For hospital A, calculated as follows:

1/4 [2(1650) + 1(2600) + 0(1950) + 1(4400)] = 2575

3/ Computed as follows:

1/5 (2575 + 3092 + 2367 + 2067 + 2510) = 2522

4/ Based primarily on Maryland and Michigan non-MEDPAR records. MEDPAR cases were also included to the extent they were available for these DRGs.

5/ Computed as follows: 1/4 (1650 + 2600 + 1950 + 4400) = 2650

6/ For DRGs 1 through 4 (i.e. representing the 358 MEDPAR DRGs), computed by dividing each DRG cost weight by the arithmetic mean MEDPAR DRG cost weight. For DRG 1, this equals:

1650 divided by 2650 = .6226

For DRGs 5 and 6 (representing the DRGs for which primarily Maryland and Michigan non-MEDPAR discharges were used), computed by dividing each DRG cost weight by the arithmetic mean DRG cost weight for the 358 MEDPAR DRGs in the Maryland-Michigan data set. Assume, in this hypothetical example, an average of 2800, For DRG 5, this equals:

3400 divided by 2800 = 1.2143

Note that the resulting cost weights are "unweighted."

7/ For DRG 1, computed as follows:

.6226 (2650 divided by 2522) = .6542

The ratio 2650 divided by 2522 represents an adjustment factor required to properly transform the "unweighted" relative cost weights described in footnote 6. This transformation is necessary to obtain cost weights that reflect the relative cost of treatment of a case in DRG X compared to the cost of treatment of the typical Medicare discharge in the average hospital.

8/ For hospital D, computed as follows:

1/9 [3(.6542) + 3(1.0309) + 3(.7732)] = .8194

$\approx \frac{2067}{2522}$ (Numbers are not identical solely due to rounding.)

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iii. Adjustments to the Weighting Factors To Remove Kidney Acquisition Costs

Weighting factors were originally calculated including costs of kidney acquisition. To adjust the weighting factors in order to correct for treating kidney acquisition costs as a special payment under the prospective payment system, 1981 average cadaveric and live donor acquisition costs were used. These average costs were obtained from a survey of intermediaries conducted in preparation for a report to Congress on the End Stage Renal Diseases program. The average cadaveric and live donor costs were combined to obtain an overall average kidney acquisition cost. Further adjustments had to be made to this average cost since it included capital and medical education costs and it had not been standardized for area wage levels or indirect teaching costs. The adjustment for capital and direct medical education was made based on an estimate of the proportion of capital and medical education costs to inpatient operating cost. To adjust for the fact that the average costs was a hospital weighted average rather than a discharge weighted average and was not standardized, a ratio of the unweighted, unstandardized average kidney acquisition costs (after adjustment for capital and medical education) to the unstandardized, unweighted average transplant cost was calculated. The compliment of this ratio produces the portion of transplant costs unrelated to kidney acquisition and can be applied directly to the relative weight of DRG 302 to remove the value of kidney acquisition. This results in a revised weighting factor for DRG 302 of 4.2266. Once the revised weight was obtained, the weights for all DRG's were renormalized to assure the correct relative values and the case-mix index for all hospitals was recalculated. The final weight for DRG 302, after removing kidney acquisition cost and correcting the relative weights was 4.2279.

4. Calculation of Prospective Payment Rates

To ease the sudden impact of a completely new method of payment for hospital services, the statute provides for a three-year transition period. For the first three years under the prospective payment system, hospitals will be paid a prospective payment rate for each discharge that is a blend of a hospital-specific portion and a Federal portion. This section contains an explanation of how each is calculated and the formula for determining each hospital's appropriate prospective payment rate during the transition period.

a. Hospital-Specific Portion

The hospital-specific portion of the prospective payment rate is determined in a manner similar to the target amount under the rate of increase ceiling established by TEFRA. The conference committee report expresses the committee's expectation that the hospital-specific portion be based on the best data available at the time the rate is established for purposes of the transition period (H.R. Rep. No. 98–47 at p. 182). Therefore, fiscal intermediaries will be estimating the hospital-specific portion amounts using the best data for the base period cost reporting period available prior to the hospitals entry into the prospective payment system. Once the amounts have been calculated, they will be applied throughout the entire 3-year transition period, except as indicated below.

We believe that it is important for the effectiveness of the prospective payment system to ensure that payment rates are actually prospective in their effect and as accurate as possible based on available data. To meet these objectives, the hospital may submit additional adjustment data and request an informal reconsideration of the determination within 3 weeks of receipt of the intermediary's notice of base period costs/target amount. In addition, due to the short timeframes involved in the initial implementation of the prospective payment system, we are allowing hospitals which become subject to the prospective payment system on or after October 1, 1983, and before November 16, 1983 to request that their intermediary (up to November 15, 1983) recompute their base period costs to take into account inadvertent omissions in their previous submissions to the intermediary related to changes made by the prospective payment legislation for purposes of determining base period costs. After the initial 3-week period when the hospital can submit additional adjustment data pertaining to all base year costs, omissions that can be considered under this special provision are limited to those items specified in § 405.474(b)(1)(iii)(B), for example, capital-related costs, direct medical education costs, FICA taxes, and nonphysician services billed under Part B.

We are also allowing hospitals to notify their intermediaries of errors of calculation, and we will correct such errors when notified timely, that is, within 90 days of the date on which the intermediary notifies the hospital of its rates.

Medicare fiscal intermediaries may initiate revisions to the determination of the hospital's base period costs and hospital-specific amount as follows:

- For any reason up to the date the hospital is subject to the prospective payment system;
- To make adjustments for capital-related costs and direct medical education costs and adjustments specified in paragraphs (b)(1)(iii)(A) and (b)(2)(ii) of § 405.474 during the extended reconsideration period for hospitals beginning participation in the prospective payment system on or after October 1, 1983 and before November 16, 1983; and
- To correct errors in calculation within 90 days of the date on which the intermediary notifies the hospital of its rates.

When a hospital succeeds in appealing the disallowance of costs in its base period, we will adjust the costs used in determining the hospital-specific portion for hospital cost reporting periods beginning after the date of the favorable appeal decision. We will not retroactively adjust payment rates, or adjust rates in the middle of a cost reporting period because to do so would undermine the prospectivity of the rates and would undo the budget neutrality adjustments. Therefore, we will only allow prospective adjustments to reflect revisions in base year costs when a hospital successfully contests a disallowance of costs.

If a hospital's base year costs, as estimated for purposes of determining the hospital-specific portion, are determined, by criminal conviction, imposition of a civil money penalty or assessment, a civil judgment under the False Claims Act (31 U.S.C. 3729–3731), or a proceeding for exclusion from the Medicare program to include costs that were unlawfully claimed, the hospital's base period costs will be adjusted to remove the effect of the excess costs, and HCFA will recover both the excess costs reimbursed for the base period and the additional amounts paid due to the inappropriate increase of the hospital-specific portion of the hospital's transition payment rates. Similarly, we will adjust payments for the remaining portion of the transition period to account for the reduction in funds.

The hospital-specific portion is an amount derived from the following formula:

$$\frac{\text{(Base year costs)}}{\text{(Case-mix index)}} \times \text{Outlier adjustment} \times \text{Updating factor} \times \text{Transition period percentage} \times \text{DRG weight}$$

i. Base-Year Costs

Base year costs, necessary for calculating the hospital-specific portion of the prospective payment rates, are developed from cost data for the 12-month (or longer) reporting period ending on or after September 30, 1982 and before September 30, 1983. If the applicable period is less than 12 months, then preceding 12-month (or longer) period is used.

Costs in excess of the routine cost limits (i.e., the section 223 limits) will be excluded from base year costs in calculating the hospital-specific portion in the same manner as they are excluded when determining base period costs for the rate-of-increase ceiling under § 405.463. This is necessary for the following reasons.

- We wish to be consistent with respect to interpretation of the term "allowable operating costs" between the prospective payment system and the rate of increase ceiling.
- Inclusion of costs in excess of the limit, in determining base year costs, would result in recognition of costs which have been legitimately found to be unnecessary and unreasonable in the efficient delivery of hospital services under section 1861(v)(1)(A) of the Act.
- The method, specified in Pub. L. 98-21, of updating base period costs would carry forward those costs, recognized as unnecessary and unreasonable (inflated by the target rate percentage), into future years.
- Because of the budget neutrality provision of Pub. L. 98-21, the increased base period costs due to inclusion of costs in excess of the limits must be offset against all hospitals' costs. Therefore, inefficient hospitals would be advantaged at the expense of efficient hospitals.

Each hospital's total allowable Part A costs will be adjusted:

- To remove any capital-related costs;
- To remove any medical education costs;
- To remove the nursing differential previously permitted;
- To include allowable malpractice insurance costs;
- To include estimated FICA taxes for those hospitals that did not incur such costs for all their employees in the base period;
- To remove the kidney acquisition costs incurred by hospitals approved as renal transplantation centers; and
- To include the costs of services that were billed under Part B of the program by another provider or supplier during the base period but will be billed under Part A as inpatient hospital services effective October 1, 1983.
- To eliminate any higher costs resulting from changes in accounting principles initiated in the base period and to exclude any base year costs that were incurred for the purpose of increasing base year costs or that have the effect of distorting base year costs as an appropriate basis of the hospital-specific rate. This would involve, for example, a change in the hospital's accounting principles in pricing inventory or change from the cash to the accrual basis, or other actions taken to increase base period costs such as one-time salary bonuses and pension fund contributions. Any costs removed from the base period due to the operation of this provision would only be removed for purposes of the determination of the hospital-specific payment rates. Such costs, if otherwise allowable and reasonable in amount, would be reimbursed in the base period settlement.

In order to make some of these adjustments, the intermediary must receive documentation from the hospitals as outlined in PRM Chapter 2800 (Transmittal 291).

Total allowable Medicare inpatient operating costs for each hospital, resulting from the above adjustments, are divided by the number of Medicare discharges during the applicable base year. The amount resulting from this calculation will be used as the base year cost per case for purposes of calculating the hospital-specific portion (HSP) of the transition period prospective payment rates.

ii. Case-Mix Adjustment

In order to take into consideration the hospital's individual case mix, the base year cost amount is divided by the case-mix index applicable in FY 81 (See Table 3, section VII, of the Addendum which contains 1981 case-mix indexes.) Adjusted base period costs are divided by the hospital's case-mix index to neutralize them for the effects of the complexity of the mix of patients treated.

The effects of individual case complexity will be taken into account by multiplying the hospital-specific rate by the weighting factor for each discharge in determining the hospital-specific portion of payment for each case.

We have decided to adjust the hospital-specific rate for case-mix for the following reasons:

- It immediately protects hospitals from losses based on changes in current case mix under the prospective payment system compared to the base period, and eliminates disincentives to changes in services.
- It is conceptually consistent with the long term prospective payment approach, i.e., a specific rate for each type of discharge.
- It will facilitate the transition to the DRG prospective payment system by allowing all the planning, budgeting, and financial analysis of a hospital to be by diagnosis.
- It is responsive to concerns raised by major industry associations.

Current HCFA policy permits a hospital with a statistically unreliable case-mix index to use the higher of its published index or the average index for its classification cell under the case-mix adjusted hospital cost limits published September 30, 1982. Under those limits, the higher a provider's case-mix index, the greater its reimbursement. Under the prospective payment system transition period, the incentives are reversed. The lower the case-mix index, the greater the hospital-specific portion (HSP), since the HSP is deflated by the case-mix index. The methodology used for determining case-mix indexes is comparable to that used for the hospital cost limits published in the **Federal Register** on September 30, 1982 (47 FR 43303). A case-mix index has been calculated for each hospital based on 1981 cost and billing data. At least 50 discharges are required for a hospital's case-mix index to be considered statistically reliable. For those hospitals whose case-mix index may be statistically unreliable (i.e., indicated by an asterisk in Table 3a), there is also an issue of deriving an appropriate case-mix index for the prospective payment system.

We have decided, for prospective payment purposes, when the case-mix index is statistically unreliable, to use the lower of either the published questionable case-mix index or the average index for the hospital's TEFRA cost limits classification cell, shown in Table 3b. This revises the current policy to conform with the changed incentive for a hospital to seek a lower case-mix index in view of our decision to

calculate the HSP by DRG. We believe this is a fair alternative absent sufficient data to construct a statistically reliable case-mix index. Table 3a, section VII of the addendum, contains the case-mix indexes for each hospital. The indexes based on insufficient data are indicated by an asterisk. In determining the case-mix adjustment to the hospital-specific rate for hospitals so indicated, fiscal intermediaries will use either the case-mix index from Table 3a, section VII, or the appropriate average case-mix index from Table 3b, whichever is lower. Additionally, where a hospital is not included in Table 3a (e.g., in the case of new providers), the intermediary will use the appropriate average case-mix index from Table 3b.

iii. Outlier Adjustment

The intermediary will reduce the case-mix adjusted base year costs to take into account outlier payments under § 405.475. The case-mix adjusted base year costs are multiplied by a factor calculated to take into account outlier payments of 6.0 percent of total payments. This factor is .943.

iv. Budget Neutrality

The hospital-specific portion of the payment rates will be adjusted for cost reporting periods that begin between October 1, 1983 and October 1, 1985, to maintain budget neutrality in accordance with section 1886(e)(1)(A) of the Act. The hospital-specific portion of the rate is set at 75 percent in the first year and 50 percent in the second year.

An adjustment is made to the otherwise applicable target rate percentage to maintain budget neutrality of the hospital specific portion of the payment. To determine the necessary adjustment, we estimated expenditures for inpatient operating costs payable under the law as it was in effect on April 19, 1983, the latest date prior to enactment of the Social Security Amendments of 1983. The appropriate share of this estimate is compared to a projection of aggregate payments from the hospital-specific portion of the prospective payment amount. For example, if estimated outlays for inpatient operating payments under TEFRA would have been $10 billion, the total payments under the hospital-specific portion must equal $7.5 billion (75 percent of $10 billion) for FY 84. In making the above estimates, the statute specifies that payments made, or estimated to be made, for utilization review activities be excluded. See section VIII of the addendum which contains a detailed explanation of budget neutrality. The factor calculated to maintain budget neutrality for the FY 84 hospital-specific portion is .984. (This factor is included in the calculation of the updating factor below.)

v. Updating Factor

The case-mix adjusted base year cost is updated to apply to cost reporting periods beginning on or after October 1, 1983. To update, the base year costs are multiplied by an updating factor that is equal to be compounded applicable target rate percentage (as used for the rate of increase ceiling under revised § 405.463), multiplied by the adjustment factor for budget neutrality and added to 1.0.

The target rate percentages are based on the latest available calendar year market basket inflation rates plus one percentage point. Based on the most recent market basket data, the target rate percentages for calendar years 1982 through 1984 are as follows:

Calendar year	Target rate percentages (percent)
1982	10.3
1983 [1]	7.2
1984 [1]	6.8

[1] These rates will be updated regularly using the latest available data. The updated target rate percentages and the resulting budget neutrality adjusted updating factors will be published in a quarterly FEDERAL REGISTER notice.

In order to compute an updating factor, the above target rate percentages are compounded using the number of months in each calendar year and applying the adjustment factor for budget neutrality (.984 for FY 84). The chart below shows the updating factor for each base year month.

COMPOUNDED PROSPECTIVE PAYMENT, TARGET RATES OF INCREASE ADJUSTED FOR BUDGET NEUTRALITY FOR HOSPITAL-SPECIFIC PORTION (10/1/83 CYCLE)

If 12-month base year cost reporting period ends	And first cost reporting period under PPS ends	Updating factor
Sept. 30, 1982	Sept. 30, 1984	1.13570
Oct. 31, 1982	Oct. 31, 1984	1.13265
Nov. 30, 1982	Nov. 30, 1984	1.12961
Dec. 31, 1982	Dec. 31, 1984	1.12658 **
Jan. 31, 1983	Jan. 31, 1985	1.12658 **
Feb. 28, 1983	Feb. 28, 1985	1.12658 **
Mar. 31, 1983	Mar. 31, 1985	1.12658 **
Apr. 30, 1983	Apr. 30, 1985	1.12658 **
May 31, 1983	May 31, 1985	1.12658 **
June 30, 1983	June 30, 1985	1.12658 **
July 31, 1983	July 31, 1985	1.12658 **
Aug. 31, 1983	Aug. 31, 1985	1.12658 **

** These updating factors are subject to change depending on changes in the target rate percentages used to compute them. We will publish a quarterly notice in the FEDERAL REGISTER setting forth the percentages and factors to be used for cost reporting periods beginning in the subsequent calendar quarter.

If a hospital's base year cost reporting period ends on a day other than those listed above, the intermediary will use the nearest whole month to the date on which the hospital's cost reporting period actually ends. For example, if a hospital's base year cost reporting period ends on December 27, 1982, the inflation factor for cost reporting periods ending December 31, 1982 will be used.

If a hospital's base year cost reporting period is other than as specified above, the intermediary should contact HCFA for the appropriate updating factor.

In subsequent years, the hospital specific rate will be increased by multiplying the previous year's hospital-specific rate by the updating factor. This factor will be published annually in the **Federal Register.**

vi. Example of Calculation of Hospital Specific Rate

Assume that a hospital's base year costs equal $3,000, its case-mix index is 1.0235, the outlier adjustment is .943 (i.e., 1.0 − 0.057), and the prorated updating factor for its cost reporting period is 1.14258. The hospital specific rate would be computed as follows:

Base year costs / Case-mix index	×	Outlier adjustment	×	Updating factor	=	Hospital specific rate
3000 / 1.0235		.943		1.14258		$3,171.54

vii. Calculation of Hospital-Specific Portion

The hospital-specific portion of a hospital's transition payment rate for a given discharge is calculated by:

Step 1—Multiplying the hospital-specific rate by the appropriate percent (as explained in section 4.c. below). (Following the end of the 3-year transition period, the hospital-specific portion will no longer be determined for hospitals participating under the prospective payment system, except for sole community hospitals, which will continue to be paid a rate based on the first-year transition rates.)

Step 2—Multiplying the amount from Step 1 by the specific DRG weighting factor applicable to the discharge (see Table 5, section VII of the addendum).

viii. New Providers

A relatively small number of hospitals are likely to begin operation during the transition period. For these new providers there is no historical cost experience on which to base a target amount. The report of the Committee on Ways and Means, in considering H.R. 1900 H.R. Rep. No. 98–25, 98th Cong. 1st Sess, 137 (1983), expresses

Congressional intent that such hospitals be included under the prospective payment system. The Committee expects the Secretary to make "appropriate provision" for applying a prospective payment rate. Although the Committee report suggests that this might be accomplished by applying the average hospital operating cost limit for the classification group applicable to the new provider's location and bed size, we believe an alternative method of paying new providers is more appropriate in view of the other adjustments necessary in computing the hospital-specific rate, and because we have no historical data or experience that would justify such a policy.

For new providers, we will not apply the hospital-specific portion of the prospective payment rate. Instead, full payment to these providers will be based on a blend of regional and national Federal rates only. That is, rather than following the phase-in period as described in section III. C.4.c. of this preamble (i.e., blending a hospital-specific rate with a Federal rate), new providers will use a phase-in methodology combining regional and national Federal rates only, as described in section III. C.4.d. of this preamble.

b. Federal Portion

The Federal portion of the prospective rate, during the transition period, is a percentage of the Federal prospective rate. The applicable percentages for each year are presented in section c. below. During the first year of the transition period, the Federal rate will be derived from the regional urban and rural standardized amounts. During the second and third year of the transition period, the Federal rate will be comprised in part from regional urban and rural standardized amounts and in part from national urban and rural standardized amounts.

The Federal rates are determined by:

Step 1—Selecting the appropriate regional or national adjusted standardized amount considering the location and urban/rural designation of the hospital (see Table 1, section VII of the addendum);

Step 2—Multiplying the labor-related portion of the standardized amount by the appropriate wage index;

Step 3—For hospitals in Alaska and Hawaii, multiplying the nonlabor-related portion of the standardized amount by the appropriate cost-of-living adjustment factor;

Step 4—Summing the amounts from step 2 and the nonlabor portion of the standardized amount (adjusted if appropriate under step 3); and

Step 5—Multiplying the final amount from step 4 by the weighting factor corresponding to the appropriate DRG classification.

c. Phase-In Period

The total prospective payment rate containing the hospital-specific portion and the Federal portion for discharges in a given cost reporting period are calculated as described below.

i. For cost reporting periods beginning on or after October 1, 1983 and before October 1, 1984, the prospective payment rate is equal to the sum of:

(A) 75 percent of the hospital-specific rate, plus

(B) 25 percent of the appropriate Federal prospective rate. The Federal rate will be 100 percent of the regional rate for discharges occurring before October 1, 1984. After that date the Federal rate will be 75 percent of the regional rate and 25 percent of the national rate.

ii. For cost reporting period beginning on or after October 1, 1984 and before October 1, 1985, the prospective payment rate is equal to the sum of:

(A) 50 percent of the hospital-specific rate, plus

(B) 50 percent of the Federal prospective rate. The Federal rate will be 75 percent of the regional rate and 25 percent of the national rate for discharges occurring before October 1, 1985. After that date the Federal rate will be 50 percent of the regional rate and 50 percent of the national rate.

iii. For cost reporting periods beginning on or after October 1, 1985 and before October 1, 1986, the prospective payment rate is equal to the sum of:

(A) 25 percent of the hospital-specific rate, plus

(B) 75 percent of the Federal prospective rate. The Federal rate will be 50 percent of the regional rate and 50 percent of the national rate for discharges occurring before October 1, 1986. After that date the Federal rate will be 100 percent of the national rate.

iv. For cost reporting periods beginning on or after October 1, 1986, all hospitals (including hospitals that begin operation on or after that date) paid under the prospective payment system will be paid at the national Federal prospective payment rates, except for those hospitals eligible for special treatment as provided in § 405.476.

d. Phase-In Period for New Providers

As was stated in section III.C.4.a.viii. above, new providers will be paid prospective payment rates based entirely on the Federal rates. Therefore, in determining prospective payment rates for new providers, we will blend the regional and national Federal rates as follows:

i. For discharges occurring on or after October 1, 1983 and before October 1, 1984, the prospective payment rate is equal to the regional Federal prospective rate.

ii. For discharges occurring on or after October 1, 1984 and before October 1, 1985, the prospective payment rate is equal to the sum of:

(A) 75 percent of the regional Federal prospective rate, plus

(B) 25 percent of the national Federal prospective rate.

iii. For discharges occurring on or after October 1, 1985 and before October 1, 1986, the prospective payment rate is equal to the sum of:

(A) 50 percent of the regional Federal prospective rate, plus

(B) 50 percent of the national Federal prospective rate.

iv. For discharges occurring on or after October 1, 1986, the prospective payment rate will equal the national Federal prospective payment rates.

e. Annual Update of Schedule of Standardized Amounts

i. Update of Standardized Amounts for FY 85

For FY 85, the average standardized amount determined for FY 84 will be increased by the estimated applicable percentage change in the cost (excluding non-operating costs) of the mix of goods and services comprising routine, ancillary, and special care unit inpatient hospital services for FY 85 over those in FY 84 (i.e., market basket), plus 1 percentage point. HCFA will use the market basket index that appropriately weights indicators of changes in wages and prices that are representative of the mix of goods and services included in inpatient hospital operating services. Additionally, the updated standardized amounts for FY 85 will be adjusted for "outliers", for unbundling, and for adjustments that may be necessary to maintain budget neutrality. We will publish a notice in the **Federal Register** by September 1, 1984 announcing the updated standardized amounts.

ii. Update of Standardized Amounts Beginning—FY 86

For years beginning with FY 86 (i.e., applicable for cost reporting periods beginning on or after October 1, 1985), the Secretary will determine the update factor which will take into account amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality.

In determining the update factor, the Secretary will take into account such factors as changes in the market basket, productivity, technological and scientific advances, quality of health care, the long-term cost-effectiveness of the program, and recommendations of a commission of independent experts, the Prospective Payment Assessment Commission. This commission will be appointed by the Director of the Congressional Office of Technology Assessment to review the adequacy of the payment rates and to make recommendations to the Secretary.

The Secretary's proposed update factor and the recommendations of the commission will be published in the **Federal Register** for public comment by June 1 each year. The final percentage increase will be published by September 1 each year.

HCFA will adjust the DRG classification and weighting factors for FY 86 and at least once every four years thereafter to reflect changes in treatment patterns, technology, and other factors that may alter the consumption of hospital resources. Adjustments may be made to individual DRG classifications and would not necessarily involve rebasing the entire classification system. The Commission shall consult with and make recommendations to the Secretary with respect to the need for adjustments.

D. Additional Payment Amounts

In addition to prospective payment rates per discharge, payments will be made for items or services as specified below.

1. Outliers

Section 1886(d)(5)(A) of the Act requires that additional amounts be paid for atypical cases known as "outliners". These cases are those that have either an extremely long length of stay or extraordinarily high costs when compared to most discharges classified in the same DRG.

The regulations on outlier payments are at § 405.475. These regulations provide that a discharge will qualify as an outlier if the length of stay exceeds the average length of stay for discharges in the DRG by a fixed number of days or a fixed number of standard deviations, whichever is the fewer number of days. A per diem payment will be made for each covered day of care beyond the outlier threshold. Upon the request of a hospital, an extraordinarily high cost case, that does not qualify as an outlier based on length of stay, will qualify for an outlier payment if covered charges, adjusted to operating cost, exceed a fixed multiple of the Federal prospective payment rate or a fixed dollar amount whichever is greater. (See III.J.1.d.ii.C. of this preamble for a discussion of medical review of outlier claims).

Since total outlier payments must be between 5 and 6 percent of the total prospective payments estimated for the fiscal year, the specific criteria for determining whether a case qualifies for an outlier payment may change each fiscal year and will be published as part of the annual notice setting forth the standardized amounts and factors necessary to determine prospective payment rates. The FY 84 threshold criteria are published in the addendum to the regulations. These criteria should result in outlier payments approximating 6.0 percent of the estimated FY 84 total prospective payments (including outlier payments). As explained elsewhere in this preamble, we have adjusted the amount of basic prospective payment rates to achieve this result (section III.C.1.e.iii and III.C.4.a.iii).

We are providing that a discharge in FY 84 will be considered an outlier if the number of days in the stay exceeds the mean length of stay for discharges within that DRG by the lesser of 20 days or 1.94 standard deviations. The first criterion will primarily identify cases in the long-stay, resource intensive DRGs, whereas the second criterion should identify slightly less than 2 percent of the cases within primarily short-stay DRGs as outliers. In total, we estimate 5.1 percent of all cases will qualify as day outliers.

We established the day outlier criteria based on the geometric mean length of stay for each DRG. We used the geometric mean (the antilogarithm of the mean of the logarithms of length of stay) instead of the arithmetic mean because the length of stay data are highly skewed. That is, there are cases at the high end of the distribution which are not matched at the low end. This occurs because, while there is no limit to how long an inpatient stay can be, the number of days can never be below zero. By using the geometric mean, the percent of cases that will be outliers within each DRG is more predictable. Overall, the geometric criteria will identify a smaller percentage of total discharges as outliers. However, because the geometric mean is lower than the arithmetic mean, the per diem payment rate under the geometric criteria is higher.

For FY 84, we are also providing that a discharge that does not qualify as a day outlier will be considered a high cost outlier if the cost of covered services exceeds the greater of 1.5 times the Federal rate (regional) for the DRG or $12,000. Both criteria will be adjusted for area wage differences. The first criterion will operate only for the relatively few DRGs with a Federal rate of $8,000 or more. In most cases, the $12,000 criterion will operate. In total, we estimate .9 percent of all cases will qualify as high cost outliers.

We selected criteria that will result in substantially more cases being identified as day outliers than as cost outliers for two basic reasons. First, the identification and payment determination for day outliers will be an automatic feature of the intermediary bill processing system. Hospitals must identify and specifically request payment for cost outliers and the intermediary must review and make a payment determination in each case. Thus, cost outliers carry a greater administrative burden for both hospitals and HCFA. Second, because the application of the outlier criteria is sequential (a discharge cannot be considered a cost outlier if it meets the applicable day outlier criterion), the day outlier criteria would have to be set very high and the cost criteria would have to be set very low in order to obtain an even allocation of payments between types of outliers. A low threshold for cost outliers could result in outlier payments simply because the hospital is a high cost provider, and not as a direct consequence of extraordinary services provided an individual patient.

The statute specifies that the outlier payments should approximate the marginal cost of care beyond the cut-off criteria. Marginal cost is the change in total cost associated with a one unit change in output. Due to the presence of fixed costs, the marginal cost of care is generally less than the average cost. In the short run, marginal cost is usually low since hospitals cannot respond to volume changes by immediately adjusting costs such as labor. Depending on the measure of output (days, admissions or services) and the time interval examined, estimates of marginal cost have ranged from 21 percent to over 90 percent of average cost. The analyses suggest that the short-run marginal cost to average cost ratio is less than .58 and with patient days as the measure of output, as low as .22. (J. Lipscomb, I. Raskin, and J. Eichenholz, "The Use of Marginal Cost Estimates in Hospital Cost-Containment Policy," *Hospital Cost Containment: Selected Notes for Future Policy*, ed. M. Zubkoff, I. Raskin, and R. Hanft (New York: Prodist, 1978), pp. 527–532.)

To date, the estimates of the ratio of marginal cost to average cost have been based on total costs, including capital-related and medical education costs. We

believe an estimate of marginal cost to average operating costs would be somewhat higher.

Therefore, the regulations provide that the marginal cost of outlier care will be based on a 60 percent factor.

For day outliers, an additional per diem payment will be made for each covered day of care beyond the threshold (including SNF-level days of care when a SNF bed is not available). The per diem payment will be based on 60 percent of the average per diem Federal rate for the DRG. The average per diem payment is determined by dividing the wage-adjusted Federal rate for the DRG by the mean length of stay for that DRG. For cost reporting periods beginning on or after October 1, 1983, and before October 1, 1984, the Federal rate will be 100 percent of the regional prospective payment rate. During the remainder of the transition period, it will be a combination of the Federal national and regional prospective payment rates.

For high cost outliers, the regulations provide that the additional payment will be based on 60 percent of the difference between the hospital's adjusted cost for the discharge and the threshold. The cost of the discharge will be determined by multiplying the billed charges for covered services by .72. This figure represents a national ratio of Medicare inpatient operating costs to Medicare inpatient charges and was derived from an analysis of the cost and billing data used to establish the DRG relative weights. We are removing the non-operating costs since payment for these costs will be made on a reasonable cost basis. The cost will be further adjusted to exclude an estimate of indirect medical education costs. This adjustment is necessary since payment for indirect teaching costs is separately determined based on total federal DRG revenue. If these costs were not removed, we would be paying for them twice. For those few hospitals who receive a Section 602(K) waiver (see Part V of this preamble), the cost will also be adjusted to include the reasonable charges for non-physician services billed by the outside supplier.

The following is an example of how the additional payment will be determined for a high cost outlier:

Step 1—Determination of the Hospital's Cost:

Billed Charges = $35,000	
National Ratio of Cost to Charges	.72
Educational Adjustment Factor	1.1924

$$\text{Hospital's cost} = \frac{\$35{,}000 \times .72}{1.1924} = \$21{,}134$$

Step 2—Determination of Outlier Threshold:

Federal DRG Rate = $3800	
Wage Index	1.10
Labor-Related Portion	.7915
Non-Labor Related Portion	.2085

Since 1.5 times the DRG rate would be less than $12,000, the threshold will be based on $12,000

Wage-Adjusted Threshold = ($12,000 × .7915 × 1.10) + (12,000 × .2085) = $12,949.

Step 3—Determination of Outlier Payment: Outlier Payment = ($21,134 − $12,949) × 60% = $4,911.*

*This payment will be included in total Federal DRG revenue for puposes of the educational adjustment.

The relationship between the educational adjustment factor and outlier payments is as follows:

- The additional payment for indirect medical education costs is intended to account for a variety of factors which may legitimately increase costs in teaching institutions. Since many of these factors are as applicable to the outlier portion of an inpatient stay as they are applicable to the non-outlier portion, an additional payment will be made for the indirect medical education costs associated with the marginal cost of outlier care.
- The additional payment for indirect medical education costs associated with length of stay outliers will be determined by applying the educational adjustment factor to the outlier payment. In the case of a high cost outlier, the hospital's costs include indirect teaching costs that must be removed before determining the amount of the outlier payment. Once the outlier payment has been determined, the additional payment will be made for the associated indirect medical education costs by applying the educational adjustment factor to the outlier payment.

2. Alternate Placement Days

Medicare provides for continued coverage when a beneficiary who no longer requires an acute level of hospital care remains hospitalized because medically necessary skilled nursing facility (SNF) services are not available. Until the 1980 and 1981 Reconciliation Acts, reimbursement for these alternate placement days was at the regular hospital rate. In order to reduce program expenditures and encourage the conversion of excess hospital beds into long-term care beds, Congress passed section 1861(v)(1)(G) of the Social Security Act which provides that alternate placement days must be reimbursed at the estimated Medicaid SNF rate if there are excess hospital beds in the facility or in the area. If there are no excess hospital beds, reimbursement is at the regular acute care hospital rate.

The reimbursement provisions of section 1861(v)(1)(G) have not been implemented. As a result, the SNF-level alternate placement days have not been distinguished from other inpatient hospital days and are included at full cost in the data bases used to establish the prospective payment rate. Given the presence of the alternate placement days in the data base and in view of the incentive hospitals will have under the prospective payment system to reduce the incidence of alternate placement days by locating available SNF beds in the area or converting excess capacity to SNF beds, we are continuing to treat alternate placement days the same as other inpatient hospital days. No separate payment will be made for the alternate placement days occurring in a regular inpatient stay. However, medically necessary SNF-level days of care will continue to constitute covered inpatient hospital services and will qualify for an outlier payment when the outlier threshold is crossed.

3. Additional Payments on Reasonable Cost Basis

a. Capital-Related Costs

In accordance with the statute, payment for capital-related costs (as described in § 405.414) will be determined on a reasonable cost basis. During the transition period, the capital-related costs must be determined consistently with the treatment of such costs for purposes of determining the hospital-specific portion of the hospital's prospective payment rate.

b. Direct Medical Education

In accordance with the statute, the direct costs of medical education programs will be reimbursed on the basis of reasonable cost subject to applicable regulations in Subpart D.

c. Direct Medical and Surgical Services of Teaching Physicians

Payment for direct medical and surgical services of physicians in teaching hospitals will be made on a reasonable cost basis under § 405.465 where the hospital exercises the election as provided for in § 405.521(d).

4. Bad Debts

An additional payment will be made to each hospital in accordance with

§ 405.420 for bad debts attributable to deductibles and coinsurance amounts related to covered services received by beneficiaries.

5. Indirect Medical Education

Section 1886(d)(5)(B) of the Act provides for additional payments to be made to hospitals under the prospective payment system for the indirect costs of medical education. This payment is computed in the same manner as the indirect teaching adjustment under the notice of hospital cost limits published September 30, 1982 (47 FR 43310), except that the educational adjustment factor is to equal twice the factor computed under that method.

If a hospital has a graduate medical education program approved under 42 CFR 405.421, an additional payment will be made equal to 11.59 percent of the aggregate payments made to the hospital, based on the Federal portion of prospective payments and outlier payments related to those portions, for each .1 increase (above zero) in the hospital's ratio of full-time equivalent (FTE) interns and residents (in approved programs) to its bed size. The number of full-time equivalent interns and residents is the sum of:

1. Interns and residents employed for 35 hours or more per week, and

2. One half of the total number of interns and residents working less than 35 hours per week (regardless of the number of hours worked).

For purposes of this adjustment, a hospital will be allowed to count only interns and residents in teaching programs approved under 42 CFR 405.421 who are employed at the hospital. Interns and residents in unapproved programs and those who are on the hospital's payroll but furnish services at another site will not be taken into account in making this adjustment nor will interns and residents employed to replace anesthetists. In determining the amount of the adjustment, the fiscal intermediary will use the number of interns and residents employed at the end of the immediately preceding cost reporting period.

The teaching adjustment does not apply to any hospital not paid under the prospective payment system, such as those hospitals or distinct part psychiatric and rehabilitation units that are paid on a reasonable cost basis, since the payments to those facilities already include the indirect costs of medical education. Therefore, the number of beds in an excluded psychiatric and rehabilitation unit, as well as interns and residents assigned those units, may not be included in calculating the ratio of interns and residents to beds. However, due to the way in which the adjustment factor was originally computed, interns and residents working in outpatient areas and emergency rooms should be included in the calculation of the ratio. In the original computation of the adjustment factor, interns and residents working in these areas were included in the analysis, even though the costs were excluded. Further, these areas would not affect the bed count assigned to the facility. Therefore, if we were to exclude these interns and residents in applying the factor, the amount of the adjustment would be incorrect because we would be altering only one element of the variable and failing to maintain comparability between the methodology used for developing the adjustment factor and subsequently standardizing hospital costs based on that factor.

Congress was particularly concerned that the prospective payment system not have an adverse impact on teaching hospitals because these hospitals provide an essential service in that they assure a continuing supply of essential health care personnel. As a result, the statute requires that the teaching adjustment factor under the prospective payment system be computed in a manner similar to the adjustment in effect on January 1, 1983, except the adjustment factor shall equal twice the factor determined under that method.

In computing the education adjustment for the prospective payment system, we calculated the adjustment factor from 1981 base year cost data using the same methodology used to calculate the indirect medical adjustment figure from 1980 cost data for the cost limits in effect on January 1, 1983. We used this method, rather than simply multiplying the previous adjustment factor by 2, because we wanted to relate the payment rate and the adjustments to the same data base, 1981 cost data, before doubling the adjustment factor.

The teaching adjustment factor is computed by comparing the inpatient operating costs of all hospitals. Using the ratio of FTE interns and residents to beds as a variable to measure relative intensity of teaching activity, we estimated the effect of teaching activity on operating costs through regression analysis in the same manner as used previously. Since the 1980 data base used to calculate the teaching adjustment factor in effect on January 1, 1983, did not include malpractice insurance as an operating cost, while the prospective payment system includes malpractice insurance as an operating cost, it is inappropriate to update the data before doubling the adjustment factor. Additionally we have a new series of case-mix indexes and wage indexes (i.e., based on 1981 data) to be included. Therefore, we have recomputed the adjustment factor using the same data used to calculate the standardized amounts and doubled that result.

The resulting teaching adjustment factor is 11.59 percent. The adjustment factor is applied only to revenue under the Federal portion of the payment rates. Since the hospital-specific portion of the rates is based on the hospital's actual allowable costs, this portion already includes the higher costs of indirect education in an individual hospital. Therefore, it would not be appropriate to increase this portion of the prospective payment rates further.

An example of the application of indirect teaching adjustment payment follows:

A 686-bed hospital in Queens County, New York has a total revenue from the Federal portion of the prospective payments of $1.32 million. The hospital employed 77 FTE interns and residents in approved teaching programs on September 30, 1983 (their cost reporting period ending date).

77 divided by 686 = .11224 (ratio of interns and residents to beds) divided by .1 = 1.1224 (adjusted ratio).

Federal portion of DRG revenue × teaching adjustment factor × adjusted ratio = additional payment amount
$1,320,000 × .1176 × 1.1224 = $174,232.

The indirect teaching adjustment payment is an annual lump sum additional payment to teaching hospitals. However, to alleviate cash flow problems for these hospitals, the intermediary may include estimated teaching adjustment amounts in the periodic payment to the hospital. If a hospital does not have a graduate medical education program approved under 42 CFR 405.421, the education adjustment will not apply.

E. Interim Payments

1. General

The prospective payments for inpatient hospital operating costs (a blend of hospital-specific and Federal payment rates during a 3-year transition period), including amounts for outlier cases, are intended to represent final payment for services rendered. Excluded from inpatient operating costs are capital-related costs and direct medical education costs. (See § 405.2102(e)(1) regarding kidney acquisition costs in hospitals approved as renal transplantation centers.) These costs and the costs of services rendered to inpatients under Part B when Part A benefits are not payable and outpatient

services continue to be reimbursed on a reasonable cost basis. In addition, payments to hospitals and distinct part hospital units which are exempt from the prospective payment system continue to be made on a reasonable cost basis.

Prior to implementation of the prospective payment system, hospitals may receive interim payments for their costs of covered inpatient and outpatient services furnished to Medicare beneficiaries as described in 42 CFR 405.454(a) through (j). Those interim payments are computed to approximate as closely as possible actual reimbursement which will be determined at year end based on the hospital's submitted cost report. There are two methods of interim reimbursement for inpatient hospital services.

One method is based on actual bills submitted by the hospital. Under this method, interim payments are calculated by applying a predetermined per diem amount to the number of days reflected on actual bills or by applying a predetermined percentage to the charges reflected on the actual bills submitted. The predetermined per diem amount or percentage factor applied to billed patient days or charges represents an estimate of the hospital's costs as related to days or charges which will be incurred.

Under the second method, referred to as the periodic interim payment (PIP) method, interim payments are not made based on individual bills. Instead, total reimbursable cost for the year is estimated and periodic level payments are made to hospitals without regard to the submission of individual bills. Under either interim reimbursement method, any over or under estimation of the hospital's actual costs, to the extent not adjusted during the year, is adjusted at the time of cost report settlement.

Effective with cost reporting periods beginning on or after October 1, 1983, hospitals subject to the prospective payment system for Part A inpatient services will be paid a prospectively determined amount for each discharge based on actual bills submitted. Such payment constitutes final payment for each discharge claimed. On the other hand, hospitals meeting the qualifications for PIP in § 405.454(j) may elect to receive level biweekly payments representing their estimated annual prospective amounts. Only in this circumstance would year-end reconciliation be required.

Payments for costs of capital-related and direct medical education costs and for kidney acquisition costs in hospitals approved as renal transplantation centers, which are payable on a reasonable cost basis, continue to require interim payments and a year-end reconciliation based on a submitted cost report. In addition, the indirect teaching adjustment, if appropriate, will be paid on an interim basis subject to final settlement.

Interim payment for all services under the prospective payment system are specifically addressed in a new § 405.454(m). Cost of services rendered to inpatients under Part B when Part A benefits are not payable and rendered to outpatients continue to be reimbursed as currently addressed in § 405.454.

2. Methodology for Determining Payments Under PPS

Except for hospitals qualifying to receive payments under the PIP method, prospective payments for Part A inpatient operating costs will be made on the basis of a submitted bill. Such payments represent final payments and are not subject to retroactive adjustment at the end of the hospital's fiscal year. Payment for outlier cases may be computed and paid only after the intermediary is assured that the outlier claim is justified. Payment for outliers resulting from extraordinary costs, i.e., cost outliers, must be requested by the hospital and are payable after approval, subject to a medical review determination. Payment for day outliers, i.e., outliers resulting from length of stay exceeding the day outlier threshold criteria for the DRG, need not be specifically requested by the hospital and can be paid after a medical necessity determination is made, along with the prospective payment for the discharge.

We recognize that errors can be made, and adjustment bills to correct errors will be submitted after the initial bill is submitted. Such adjustment bills will be scrutinized closely to ensure correctness and completeness. Copies of medical records or other evidence may be requested to document procedures, diagnoses, etc.

Hospitals (including hospitals not previously on PIP) that meet the qualifications in § 405.454(j) may elect to receive their prospective payments in the form of level payments. They may convert to payments on a per discharge basis at any time. For hospitals making the election to receive level payments, the interim payment amount will be based on the total estimated discharges for the reporting period multiplied by the hospital's estimated average prospective payment amount. This amount is the blended sum of the hospital-specific rate and the Federal rate multiplied by the hospital's case-mix index. The total estimated annual amount will be paid in 26 equal biweekly payments. The payments will be reviewed and adjusted at least twice during the reporting period and are subject to final settlement at year end. For hospitals making this election, payment for outliers will not be included in the biweekly payments. Rather, the payments for both day and cost outliers, after medical review approval, will be paid based on submitted bills. These additional payments will be final with no retroactive year end adjustment.

During the early period that a hospital first becomes subject to the prospective payment system, some patients discharged will have been admitted in the prior period. Prospective payments must be adjusted for the portion of the stay occurring in the prior period which was reimbursed on a reasonable cost basis. The adjustment will be made by subtracting from the prospective payment rate (made either on the basis of a bill or on level payments) the hospital's interim reimbursement for inpatient operating costs applicable to the days in the prior period. The interim reimbursement applicable to the prior period must be adjusted to exclude costs related to capital and direct medical education.

Accelerated payments will be available only to hospitals not electing to receive level payments and which demonstrate the existence of cash flow problems caused by a temporary delay in preparing and submitting bills to the intermediary beyond its normal billing cycle.

For items applicable to inpatient hospital services not reimbursable on a prospective basis (capital-related and direct medical education costs and for kidney acquisition costs in hospitals approved as renal transplantation centers, and the indirect teaching adjustment), interim payments will be made subject to final settlement. Interim payments for capital-related and direct medical education costs and for kidney acquisition costs in hospitals approved as renal transplantation centers will be determined by estimating the reimbursable amount for these costs for the year, using Medicare principles of cost reimbursement, and dividing it into 26 equal biweekly payments. If appropriate, these payments will be combined with the biweekly interim payments for inpatient services subject to the prospective payment system. The estimated amount may be based on the previous year's experience and on additional substantiated information for the current year. The interim payments will be reviewed and adjusted at least

twice annually by the intermediary with final settlement based on a submitted cost report.

Level payments on a biweekly basis for capital-related and direct medical education costs are required and are not at the hospital's option. Interim payment on the basis of a percentage of billed charges or on an average cost per diem will no longer be available to hospitals subject to prospective payment for Part A inpatient services.

The indirect teaching adjustment is calculated based on the Federal portion of the prospective payment amount. To estimate the adjustment, the hospital's total discharges for the reporting period and the ratio of full time equivalent (FTE) interns and residents to the number of hospital beds must be estimated and multiplied by the education adjustment factor. The total estimated annual amount of the adjustment will be divided into 26 biweekly payments and combined with inpatient costs reimbursed on a reasonable cost basis. This estimate is subject to year end adjustment.

To reflect these changes, § 405.454(a) has been revised and a new paragraph (m) has been added to § 405.454, "Payments to providers".

F. Change of Ownership

The circumstances under which a change of ownership is recognized are described in 42 CFR 489.18. Under prior law, which reimbursed reasonable costs and required that providers file cost reports, the last cost reporting period ended and a new one began on the date a provider changed ownership. Costs were accumulated, reported, and reimbursed accordingly. Under the new law, Medicare prospective payments for inpatient operating costs are to be made on a discharge basis, so that the correct amount of the payment cannot be known until the beneficiary is discharged from a hospital. Further, the payment represents full payment for the entire patient stay.

In accordance with regulations at § 405.477(f), payment for inpatient operating costs, including outlier payments and payments for indirect teaching costs, will be made to the legal owner or operator of the hospital as of the date of discharge, without proration between the buyer and seller. It is the intent of the Medicare program that any adjustments to any prospective payments be negotiated by the former and new owners as they see fit, without Government involvement or interference. The capital-related costs and the direct costs of approved medical education programs will continue to be reimbursed on a reasonable cost basis. As such, each party to the sale will be reimbursed for these costs in accordance with the costs incurred and the return on equity capital in the case of for-profit hospitals during each party's respective period of participation.

There is no change to our rules and policies with respect to revaluation of assets, treatment of goodwill, etc., upon the sale, transfer or other change of ownership. The direct capital-related costs and costs of approved medical education programs will continue to be paid on the basis of reasonable costs, and there will continue to be a need to accumulate costs and charges separately for the pre- and post-change of ownership so that those costs can be properly allocated.

G. Special Treatment of Sole Community Hospitals, Christian Science Sanitoria, Cancer Hospitals, Referral Centers, and Certain Kidney Acquisition Costs Incurred by Renal Transplantation Centers

Section 1886(d)(5)(C) of the Act authorizes the Secretary to make certain exceptions and adjustments to the prospective payment rates under circumstances as he or she deems appropriate. The Secretary is authorized to make adjustments for:

- Regional and national referral centers,
- Hospitals with disproportionate numbers of low income and/or Medicare beneficiaries,
- Sole community hospitals,
- Hospitals extensively involved in treatment for and research on cancer,
- Hospitals in Alaska and Hawaii (addressed in section III.C. of this preamble), and
- Other exceptions and adjustments as the Secretary deems appropriate.

1. Sole Community Hospitals (SCHs)

Section 1886(d)(5)(C)(ii) of the Act requires the Secretary to take into account the special needs of SCHs by using a special payment formula for hospitals so classified. The law defines SCHs as those that, by reason of factors such as isolated location, weather conditions, travel conditions, or absence of other hospitals (as determined by the Secretary), are the sole source of inpatient hospital services reasonably available to individuals in a geographic area who are entitled to benefits under Part A of the program. Regulations regarding SCH exceptions are set forth at § 405.476.

a. Criteria for SCH Status

A hospital will be classified as an SCH for purposes of the prospective payment system and receive payment adjustments if the hospital has an approved exemption from hospital cost limits (see § 405.460) as an SCH prior to October 1, 1983. However, if there is a change in circumstances affecting this classification under the cost limits, the classification for purposes of adjustments under prospective payment will be reevaluated in accordance with other criteria explained below.

Hospitals which have not been approved for an exemption prior to the effective date of these regulations must be located in a rural area and meet one of the following criteria in order to be classified as a SCH.

i. The hospital is located more than 50 miles from other like hospitals; or

ii. The hospital is located between 25 and 50 miles from other like hospitals and either:

- No more than 25 percent of the residents in the hospital's service area are admitted to other like hospitals for care, or
- Because of local topography, weather, etc., the other hospitals are generally not accessible for more than one month during a 12-month period; or

iii. The hospital is located between 15 and 25 miles of other like hospitals and because of local topography, weather, etc., the other hospitals are generally not accessible for more than one month during a 12-month period.

We recognize that it might be to a hospital's advantage in certain instances to give up its SCH classification and elect to be reimbursed under the prospective payment system as other hospitals in the region. Although Congress did make special provisions for SCHs, we do not believe it was the Congressional intent to permit hospitals to continually alter the method under which they are reimbursed solely to maximize reimbursement. Therefore, we are permitting hospitals to voluntarily give up their SCH classification at any time.

However, this decision is irrevocable unless all other hospitals within 50 miles close.

A SCH classification is not available for those hospitals located within 15 miles of another hospital nor for those located in an urban area unless they qualify under paragraph i. above. Since EOMB considers local commuting patterns in establishing urban designations, we presume that residents in urban areas have access to hospital services either by living in close proximity to a hospital or by establishing a heavy commuting pattern to an area in which a hospital is located

For purposes of evaluating whether a hospital meets the criteria for aSCH classification, HCFA will measure the distance between hospitals using "improved road miles." We have decided to use improved road miles rather than radius miles because this is the actual distance that must be traveled in order to reach alternative hospital services. An improved road is a road which is maintained for regular use by a governmental entity (i.e., local, State, or Federal) and which is available for use by the general public.

HCFA will consider "like" hospitals as those hospitals furnishing short-term acute care. A hospital may not qualify for a SCH classification on the grounds that neighboring hospitals do not offer comparable specialty services. Thus, a hospital that has an intensive care unit but is located only 12 miles from another acute care hospital without such specialty services would not be granted a SCH classification.

For the purpose of evaluating utilization outside of the service area, the service area would be defined as the geographical area from which the hospital draws or expects to draw its patients. Optimally, the boundaries of the service area would be defined by a statewide planning agency. If not, the hospital would determine the service area based on where it draws at least 75 percent of its admissions. A hospital must submit admissions data documenting the boundaries of its service area if such boundaries are not established by a statewide planning agency. In order to document that no more than 25 percent of the residents of the service area utilize services outside of the area, hospitals must also gather and submit applicable admissions data from all surrounding hospitals located within 50 miles of the requesting hospital.

Finally, those hospitals requesting an SCH classification on the grounds that alternative hospitals were inaccessible for more than one month each year must submit data to document a history of such inaccessibility. For example, reports of a State Highway Department or local public safety officials specifying the locations of road closure and periods of time the road was inaccessible over the past three years would be necessary to substantiate the request. The fact that alternative hospital services were not available during one month of a single 12-month period is not sufficient evidence to substantiate the prolonged and predictable inaccessibility intended in this criterion.

b. Procedures for SCH Classification

Hospitals may submit a written request to be designated as an SCH to the appropriate intermediary at any time during their cost reporting period. The intermediary, based on the information submitted, will send its recommendation regarding the request to HCFA. HCFA will make the final determination and will respond in writing to the intermediary. The hospital will receive notification of the decision from its intermediary. The new payment rates for an SCH as described in c. below, will be effective 30 days after the date of HCFA approval. There will be no retroactive effective dates on SCH designations.

Once a hospital is classified as an SCH, at its option it retains that classification indefinitely until there is a change in circumstances suggesting a need for reevaluation (for example, if there is a change in MSA designations).

c. Payment to SCHs

Hospitals, that are classifed as SCHs, will be paid in accordance with the methods of establishing rates for the first year of the transition period (i.e., effective with the first cost reporting period on or after October 1, 1983). Use of the methods for rates established for the first year of the transition period (i.e., 75 percent of the hospital-specific rate and 25 percent of the Federal rate) will continue to be the basis of payment to SCHs indefinitely.

In addition to the payment rates calculated as explained above, SCHs may also receive an additional amount if the hospital has experienced a decrease of more than five percent in its total number of inpatient cases, due to circumstances beyond its control. However, this additional payment only applies during the transition period.

i. Criteria for Determining Eligibility for Additional Payments

Effective for cost reporting periods beginning on or after October 1, 1983 and before October 1, 1986, if an SCH experiences more than a 5 percent decrease in its total number of inpatient cases, i.e., discharges, compared to the immediately preceding cost reporting period, HCFA will provide for a payment adjustment.

The basic test for evaluating a hospital's request for special payment due to extraordinary circumstances is that the decrease in volume is the result of an unusual situation or occurrence externally imposed on the hospital and beyond its control. Such situations may include, but are not limited to, strikes, fires, earthquakes, floods, inability to recruit essential physician staff, unusual prolonged severe weather conditions, or similar unusual occurrences with substantial cost effects.

In making the comparision of dicharges, the number of discharges in a cost reporting period is compared to the immediately preceding cost reporting period only. This pollicy is based on the language in section 1886(d)(5)(C)(ii) which states that this additional payment is available "in the case of a sole community hospital that experiences, in a cost reporting period * * * compared to *the previous* cost reporting period, a decrease of more than 5 percent in its total number of inpatient cases * * *" (emphasis added). Thus, if a hospital experiences an occurrence that results in a sustained decrease in cases, an adjustment would be made for the cost reporting period where the change occurred but would not be made during subsequent periods unless dicharges decreased another 5 percent.

Example: Hospital A loses its community physician during its cost reporting period ending September 30, 1984. This results in sustained lower case load until June 1986 when the physician is replaced.

- Discharges for cost reporting period ended September 30, 1983—5,000
- Discharges for cost reporting period ended September 30, 1984—3,000
- Discharges for cost reporting period ended September 30, 1985—3,500

An adjustment is available only for the cost reporting period ending September 30, 1984, even though discharges for the period ending September 30, 1985 were more than 5 percent less than the year immediately preceding the onset of prospective payments.

(ii) Amount of Payment Adjustment

The statute requires that the payment adjustment be made to compensate the hospital for the fixed costs it incurs in the period in providing inpatient hospital services including the reasonable cost of maintaining necessary core staff and services.

Fixed costs are defined as those over which management has no control. Most true fixed costs such as rent, interest, and depreciation are capital-related costs and would be paid on a reasonable cost basis, regardless of volume. Variable costs, on the other hand, are those costs for items and services that vary directly with utilization. However, in a hospital setting many costs are neither perfectly fixed nor perfectly variable, but are semifixed. Semifixed costs are those costs for items and services that are essential for the hospital to maintain operation but will also vary with volume. For purposes of this adjustment,

many semifixed costs, such as personnel related costs, may be considered as fixed on a case by case basis. An adjustment will not be made for truly variable costs, such as food and laundry services.

In evaluating semifixed costs, such as personnel, HCFA will consider the length of time the hospital has experienced a decrease in utilization. For a short period of time, most semifixed costs would be considered fixed. As the period of decreased utilization continues, we would expect that a cost-effective hospital would take some action to reduce unnecessary expenses. Therefore, if a hospital did not take such action, we would not include such costs in determining the amount of the adjustment.

The statute also requires that the adjustment amount include the reasonable cost of maintaining necessary core staff and services. HCFA will review the determination of core staff and services based on an individual hospital's needs and circumstances; e.g., minimum staffing requirements imposed by State agencies.

iii. Procedures for Requesting Special Adjustments

Sole community hospitals that believe they qualify for an adjustment as explained above must submit a written request for an adjustment to HCFA through the intermediary. The request must clearly document the extraordinary circumstances causing the decrease in patient volume and its effect on costs.

The hospital's request must be made to its intermediary within 180 days of the date on the intermediary's notice of program reimbursement. The intermediary will make a recommendation on the hospital's request to HCFA, which will make the decision. We will respond to the request, through the intermediary, within 180 days of the date we receive the request from the intermediary. HCFA's decision will be reviewable under the provisions of Subpart R of 42 CFR Part 405.

The Secretary is required to study and make legislative recommendations to the Congress by April 1, 1985, with respect to an equitable method of reimbursing SCHs which takes into account their unique vulnerability to substantial variations in occupancy.

2. Christian Science Sanitoria

There are approximately 22 Christian Science Sanitoria participating in Medicare. Patients in these institutions are allowed to determine whether the services they receive constitute hospital or SNF services. The basic prospective payment system clearly would be inappropriate for these facilities since they do not furnish the kind of medical services, particularly ancillary services, that are generally provided in acute care hospitals.

Therefore, if a Christian Science Sanitorium is not excluded from the prospective payment system under § 405.471 (e.g., by meeting criteria as a long-term hospital), HCFA will pay for inpatient hospital services furnished to a beneficiary by that sanitorium on the basis of a predetermined fixed amount per discharge based on the sanitorium's historical inpatient operating costs per discharge (see § 405.476(e)). For cost reporting periods beginning on or after October 1, 1983, the sanitorium's prospective payment rate will be equal to the amount that would constitute the sanitorium's target amount under § 405.463(c)(4) if the institution were subject to the rate of increase ceiling (at § 405.463) instead of the prospective payment system. This amount will not be adjusted for the DRG weighting factor. Additionally, a sanitorium is not eligible for outlier payments under § 405.475.

3. Hospitals Involved Extensively in Treatment for and Research on Cancer

Congress specifically mentioned hospitals extensively engaged in cancer treatment and research as a class of hospitals for which some exception might be provided. It is clear that the concern was limited to a few hospitals that are primarily devoted to cancer treatment and research. We could not identify hospitals engaged extensively in cancer treatment based on Medicare records because we do not approve hospitals based on the particular types of cases they treat.

We are able, however, to identify certain characteristics which need to exist in a hospital setting for it to fit the category described in the law. First, the primary mission of the hospital must be restricted to cancer care. Second, most of the cases treated by the hospital must be cancer cases, i.e., involvement must be extensive. Third, the hospital must have a substantial commitment to research on cancer.

Therefore we will define cancer hospitals as follows:

- The hospital must have been recognized by the National Cancer Institute of the National Institutes of Health as a comprehensive cancer center or clinical cancer research center as of April 20, 1983 (i.e., the date of Pub. L. 98-21 was enacted).
- The hospital must demonstrate that the entire facility is organized primarily for treatment of and research on cancer.
- 80 percent or more of the hospital's total discharges must be classified in those DRGs reflecting the condition of cancer as the principal diagnosis.

Hospitals meeting the above criteria will be given an opportunity, before their first cost reporting period begins under the prospective payment system, to opt for reimbursement on a reasonable cost basis subject to the target rate ceiling. If this option is chosen, they will have an additional option of converting to the prospective payment system at a future date. No further options will be allowed.

A number of hospitals have over the course of time devoted a major share of their attention to cancer treatment and research. These facilities, which play a significant role in the development of cancer treatment, represent an existing concentration of resources in the area of cancer care.

We believe Congress was concerned that the prospective payment system might produce an unintended disincentive for current programs if those institutions involved extensively in treatment of and research on cancer were found to be legitimately more costly than typical short-term general hospitals. Since the standardized amounts are based on expenditures in short-term general hospitals, a hospital could, under the circumstances, be encouraged to reduce its commitment to cancer treatment in order to operate within the prospective rate. Such a diminution of existing cancer programs would be an unintended negative consequence.

Additionally, we believe it is desirable to avoid the opposite effect. That is, we do not think it is appropriate for the system to become the chief determinant of whether existing resources will be shifted among broad classes of illness. We recognize the power of the prospective payment system to create incentives for particular actions and realize that hospitals might be encouraged to create duplicative programs if the system provided financial incentives.

In order to assure that cancer treatment and research are maintained while avoiding incentives for artificial expansion, we believe it is appropriate to focus our policy on current programs which might be limited or curtailed. This is, we think, consistent with the evident desire of the Congress to afford some level of protection to hospitals whose involvement in cancer treatment and

research over the years has been extensive.

Therefore, as stated in the first criteria above, we are restricting the special provision for cancer centers to those hospitals whose programs were recognized as of April 20, 1983.

4. Referral Centers

Section 1886(d)(5)(C)(i) of the Act states that "the Secretary shall provide for such exceptions and adjustments to the payment amounts established under this subsection as the Secretary deems appropriate to take into account the special needs of regional and national referral centers (including those hospitals of 500 or more beds located in rural areas) . . ." The Conference Committee Report accompanying Pub. L. 98-21 contains little additional language clarifying what the Congress intended by "regional and national referral centers." The Report does state, however, that they include very large acute care hospitals in rural areas. In addition, since the law specifies "regional and national" referral centers it appears that Congress intended that such referral centers would serve a substantial number of patients outside the local area.

There is no commonly accepted definition of a referral center. However, we have developed criteria that we believe fulfill the intent of the law, and have included them at § 405.476(g) of these interim regulations.

To be considered a referral center, a hospital must be a short-term acute care hospital with a provider agreement in effect under Part 489 to participate in the Medicare program; and

a. The hospital must be located outside of any Metropolitan Statistical Area (MSA) or the New England County Metropolitan Area (NECMA) recognized by the EOMB and have at least 500 beds as defined in section 2510.5 of the Provider Reimbursement Manual; or

b. The hospital must have a patient population such that at least 60 percent of all Medicare patients reside out-of-State or more than 100 miles from the hospital (whichever is more stringent) and at least 60 percent of all services received by Medicare beneficiaries must be provided to Medicare beneficiaries residing out-of-State or more than 100 miles from the hospital.

The above criteria are considered appropriate as they clearly distinguish hospitals that are predominant for the purpose of referrals from other institutions. We wish to encourage comments on these criteria.

We believe that the few rural referral centers with 500 or more beds clearly require some recognition in their payments, and that they are not comparable to other rural hospitals. Generally, these hospitals offer a variety of specialized services, employ many specially trained personnel, and have a medical staff composed of many different types of specialists. In these factors and in the services they furnish, they are similar to urban acute care centers, and pay salaries and have costs comparable to those hospitals. Therefore, we will determine prospective payments to these hospitals on the basis of the urban, rather than rural, adjusted standardized amounts. (These amounts will be adjusted appropriately, as for any other hospital, by the applicable DRG weighting factor and the hospital's area wage index.)

Except for rural referral centers with 500 or more beds, there will be no adjustments made for referral centers during the first year of the transition period. We must first determine which facilities are affected. We do not believe that this interim period will present difficulties for referral centers for the following reasons.

- During the first year, 75 percent of the prospective payment rate will be based on the hospital's own experience (i.e., the hospital-specific portion).
- Hospitals may request additional payment for "cost-based" outliers.
- We expect that virtually all referral centers will be teaching hospitals which will benefit from the doubling of the teaching adjustment.

During the first six months of the first transition year, hospitals must submit written requests, including all data necessary for a determination based on the above criteria, to their fiscal intermediaries. The intermediaries will make a recommendation to HCFA which will make the final determination.

During the second six months of the first transition year, HCFA will, after analyzing all data submitted, make a judgement regarding any adjustments that may be appropriate for referral centers beginning with the second year of the transition period.

5. Hospitals with Disproportionate Numbers of Low Income Patients or Medicare Beneficiaries or Both

The statute authorizes the Secretary to make adjustments to the prospective payment rates in consideration of the special needs of certain classes of hospitals, including public or other hospitals that incur additional costs because they serve a significantly disproportionate number of low income patients or Medicare Part A beneficiaries. We have not made special provision for these hospitals in the regulations because our current data do not show that such an adjustment is warranted.

To date, we have conducted a preliminary analysis of Medicare inpatient operating costs per case adjusted for case-mix and, after considering other factors already recognized in the prospective payment amounts, have not found a significant association between higher Medicare cost per case and either public ownership or the proportion of low-income patients. (Using a ratio of Medicaid utilization as an indicator of low-income patients, we found no significant influence on costs per case.) Likewise, we have no indication that the volume of Medicare patients significantly affects a hospital's costs.

We have been consulting with representatives from the health care field on this issue and, in a joint effort with them, are conducting a review of the available data. Therefore, adjustments will not be made initially for hospitals with disproportionate numbers of low income or Medicare patients. If, after more detailed study, we find that adjustments are appropriate we will publish a notice in the **Federal Register** informing the public of the change.

6. Kidney Acquisition Costs Incurred by Renal Transplantation Centers

Kidney acquisition costs incurred by Renal Transplantation Centers (RTC) will be treated as an adjustment to prospective payment. Hospitals engaged in kidney transplantation encounter a unique set of circumstances with respect to their cost experience because of special provisions of the law applicable to End Stage Renal Disease (ESRD). Kidney acquisition costs are reimbursed under section 1881 which requires the Secretary to: (1) Reimburse the hospital for obtaining kidneys from Organ Procurement Agencies (OPA) in amounts not to exceed the costs incurred by OPAs and histocompatability laboratories; and (2) Reimburse the reasonable expenses incurred by an individual donor. In view of the unique characteristics of organ procurement activities and the desirability of maintaining an adequate supply of kidneys, we believe these costs should be handled outside of the prospective payment system. Therefore, payments to a hospital will be adjusted in each reporting period to compensate hospitals for reasonable expenses of kidney acquisition, and costs of this type will not be included in determining the prospective payments rates.

Kidney acquisition costs have been removed from the standardized amounts

and from the cost weight for DRG 302 (Kidney Transplant). An adjustment will be made to the RTC's base year costs to remove the estimated cost of kidney acquisition. Interim reimbursement for kidney acquisition costs incurred by RTCs will continue to be based on the average acquisition costs of the hospital. Final settlement will be made based on the hospital's cost report. Other hospitals that excise kidneys for transplant will no longer be paid for this activity directly by Medicare. They must receive payment from the OPA or RTC.

An adjustment to the RTC's operating costs, used to compute the average standardized amount, was made by estimating the kidney acquisition costs in the RTC using the unweighted average kidney acquisition costs. This average was first adjusted for area wages and indirect teaching costs. This standardized average kidney acquisition cost was multiplied by the number of kidney transplants for the RTC to obtain the kidney acquisition costs for the RTC. The operating ocsts were reduced by the kidney acquisition cost.

7. Other Exceptions and Adjustments

While the statute authorizes the Secretary to provide for exceptions and adjustments for any class of hospitals deemed appropriate by the Secretary, we are initially providing exceptions and adjustments only as discussed above. At the present time, we have no reason to believe that any other exceptions or adjustments are appropriate.

H. Appeals

For the most part, disputes that arise in connection with the prospective payment system will be resolved under the administrative and judicial appeals procedures and authorities already established under the Medicare program.

1. Beneficiaries

Pub. L. 98–21 left undisturbed those provisions of title XVIII of the Act that set forth processes for beneficiaries who pursue appeals of determinations with respect to matters such as entitlement to benefits or coverage of health care services under the Medicare program. Thus, the procedures described in Subparts G and H of 42 CFR Part 405 for beneficiary appeals will remain in effect under the prospective payment system.

In addition, the waiver of liability provisions of section 1879 of the Act, as implemented through regulations at §§ 405.330–405.332, continue to apply. In this regard, under section 1866(a)(1)(G) of the Act, hospitals that are receiving payment under the prospective payment system must agree not to charge beneficiaries for inpatient hospital services that are furnished to beneficiaries under the system but for which the hospital is denied payment under section 1886(f)(2) of the Act. Under this latter section, if HCFA makes a determination that a hospital has taken an action that results in an unnecessary admission of a Medicare Part A beneficiary or unnecessary multiple admissions of the same individual or other inappropriate practice with respect to the individual in order to circumvent the prospective payment system, HCFA may deny part or all of the payment for the services furnished by the hospital in connection with the unnecessary admission. HCFA may also require the hospital to take corrective action to prevent or correct the inappropriate practices. Whatever action is taken by HCFA in either of these circumstances, the hospital will already have agreed not to hold the beneficiary liable for the costs of the services, and the beneficiary may not be charged regardless of fault.

2. Hospitals.

With regard to appeals by hospitals, the jurisdiction of the Provider Reimbursement Review Board (hereafter referred to as "the Board") under section 1878 of the Act will apply generally to questions concerning payments to hospitals arising under prospective payment. For other types of questions, different appeal procedures will apply. In addition, we have determined that the waiver of liability regulations at §§ 405.330–405.332 will apply if an entire patient stay, a "day outlier", or a "cost outlier" (as discussed in section III.H. of this preamble), is denied under section 1862(a)(1) or (9) of the act because health care services were found to be not medically reasonable and necessary or to constitute custodial care. Section 1879 waiver of liability considerations will also apply if a PSRO/PRO or FI finds that services are not payable. Therefore, we changed the regulations in 42 CFR Part 405, Subpart G (which contains procedures for appeals under Part A of Medicare) to govern appeals stemming from individual claims determinations, accordingly.

Essentially, there are three areas of hospital appeal procedures that must be addressed in this final rule.

a. The Board

To be reimbursed for services covered by the Medicare program, providers generally have been required to file cost reports with their fiscal intermediaries. These reports are used by the intermediaries to determine the amount of program reimbursement due to the provider for health care items and services furnished to beneficiaries. If a provider is dissatisfied with the amount of reimbursement (or if the intermediary does not make its determination within 12 months after receiving a cost report), and the amount in controversy is $10,000 or more, the provider has the right under section 1878 of the Act to request a hearing before the Board. The provider must meet specified time limits for filing an appeal. In addition, the Administrator and Deputy Administrator of HCFA have been delegated the authority by the Secretary under section 1878(f) of the Act to reverse, affirm, or modify a decision of the Board on his or her own motion.

If a provider is dissatisfied with the Board's decision or, if the decision has been reviewed by the Administrator or Deputy Administrator and the provider is dissatisfied with that decision, the hospital may request judicial review of the final decision by a U.S. District Court. (In certain cases, the hospital may appeal directly to a U.S. District Court when the Board determined that it does not have the authority to decide the questions appealed.)

In the exercise of its review authority, the Board decides all questions relating to its jurisdiction to grant a hearing.

Except for the restrictions (discussed below) contained in section 1886(g)(2) of the Act, as added by Pub. L. 98–21, appeal procedures for hospitals receiving payments under the prospective payment system are basically the same as for all providers being reimbursed on the basis of reasonable cost. Under section 1878(a) of the Act, as amended by section 602(h) of Pub. L. 98–21, hospitals receiving payment under the reasonable cost subject to the target rate system (section 1886(b) of the Act) and hospitals receiving payment under the prospective payment system may obtain a Board hearing with respect to the payments if—

- The hospital has submitted required reports;
- The amount in controversy is $10,000 or more; and
- The hospital files its appeal within 180 days after receiving notice of "the Secretary's final determination . . ."

Other amendments to section 1878 of the Act by Pub. L. 98–21 are as follows:

- Section 1878(f)(1) was amended to provide that in a civil action brought jointly by several providers, the suit may be brought in the judicial district in which the greatest number of such providers are located. This section was further amended to provide that an

appeal to the Board or the courts by providers that are under common ownership or control must be brought by the providers as a group with respect to any matter involving an issue common to the providers. Before Pub. L. 98–21 was enacted, providers were limited to bringing joint civil actions in the judicial district in which all the providers were located, or in the U.S. District Court in Washington, D.C.

• Section 1878(g)(2) was added to the Act to state that the determinations and decisions described in section 1886(d)(7) of the Act may not receive Board or judicial review. Section 1886(d)(7) of the Act precludes administrative and judicial review of the following:

—A determination of the requirement, or the proportional amount, of any "budget neutrality" adjustment effected under section 1886(e)(1) of the Act; or

—The establishment of DRGs, of the methodology for the classification of hospital discharges within DRGs, or of the appropriate weighting factors of DRGs under section 1886(d)(4) of the cost.

It was the clear intent of Congress that a hospital would not be permitted to argue that the level of the payment that it receives under the prospective payment system is inadequate to cover its costs. Thus, as discussed above, neither the definition of the different DRGs, their weight in relation to each other, nor the method used to assign discharges to one of the groups is to be reviewable. However, if there is an error in the coding of an individual patient's case, review would be permitted. (See the Report of the Committee on Ways and Means on H.R. 1900, H. Report No. 98–25, (98th Cong., 1st Sess.) 143 (1982).) As noted below, we believe the appropriate review concerning coding errors should be conducted by the entity (i.e., the PSRO/PRO or fiscal intermediary) which made the initial determination.

In order to implement these changes, we have included in this final rule amendments to 42 CFR Part 405, Subpart R, Provider Reimbursement Determinations and Appeals.

i. To implement the changes to sections 1878(a) and (g)(2) of the Act contained in Pub. L. 98–21, it was necessary to amend the following sections of the regulations:

• In § 405.1801, we expanded the definition of "intermediary determination" (and also made conforming changes in § 405.1803) to include a determination as to the total amount of payment under the reasonable cost subject to the target rate system or under the prospective payment system due a hospital for the cost reporting period covered by the determination. For purposes of appeal to the Board, the definition is synonymous with the "final determination of the Secretary," as that term is used in section 1878(a) of the Act.

• In § 401.1801(c), we stated that the prospective payment appeals regulations will be effective with a hospital's first cost reporting period under the Medicare program beginning on or after October 1, 1983.

• We added a new § 405.1804 (and also made conforming changes in § 405.1873 and § 405.1877) to describe the matters that are not reviewable by the Board or by the courts as provided in section 1886(d)(7) of the Act.

• For purposes of determining the amount in controversy in a particular period, we expanded § 405.1839 by providing that the amount will include amounts computed by deducting the total amount due the hospital under the target rate or prospective payment system from the total amount that would be payable to the hospital after taking into consideration any exemption, exception, exclusion, adjustment or additional payment originally denied the hospital under § 405.463 or §§ 405.470–405.477, as applicable, but disputed by the hospital in its request for a hearing.

• We made conforming changes in other sections of 42 CFR Part 405, Subpart R as necessary to incorporate references to the intermediary's determination and notice about prospective payment.

ii. With certain changes, the regulations at § 405.1837 (Group appeal), § 405.1841 (Time, place, form, and content of request for Board hearing), and § 405.1877 (Judicial review) are consistent with and can accommodate the Pub. L. 98–21 amendments to section 1878(f)(1) of the Act. These amendments were effective April 20, 1983, the date on which they were signed into law. The statute is self-implementing and our changes are merely conforming regulations. Thus, the regulations specify the effective date of the statute, and will apply to an appeal to the Board or an action for judicial review filed prior to the publication date of the final regulations, as well as those filed after the publication date. Under the amendment to section 1878(f)(1) of the Act concerning providers under common ownership or control, we have changed the regulations to state that effective April 20, 1983, an appeal to the Board or an action for judicial review by providers that are under common ownership or control, as that phrase is defined in § 405.427 of the regulations, must be brought by the providers as a group with respect to any matter involving an issue common to them. Section 405.427 states that common ownership exists if an individual or individuals possess significant ownership or equity in the provider and in the institution or organization serving the provider. Control exists if an individual or an organization has the power, directly or indirectly, to influence significantly or to direct the actions or policies of an organization or institution whether or not that power is actually exercised. Under the amendment concerning judicial review venue, we further changed § 405.1877 to add a third permissible venue, effective April 20, 1983, in the case of a civil action brought jointly, by several providers, that is, the judicial district in which the greatest number of the providers is located.

b. Errors in DRG Coding

As noted above, it is clear that Congress intended hospitals to be entitled to a review of DRG classifications if errors occur concerning the coding of an individual patient's case.

Intermediaries will assign discharges to DRGs initially. Where errors in coding occur, the hospital may resubmit the billing data with the revised coding for the case. Additionally, the hospital may request individual review of claims. The review would appropriately be conducted by the entity (i.e., the PSRO/PRO or fiscal intermediary) which made the initial determination. However, in general, the DRG classification system may not be appealed.

We are presently developing a proposed rule, to be issued in the **Federal Register** in the near future, to deal with PRO hearings and appeals.

c. Outlier claims

A hospital's claim for outlier payments will be subject to review by a peer review organization (PSRO/PRO) under Part B of Title XI of the Act, or in their absence, the hospital's fiscal intermediary, which will make appropriate coverage determinations. The PSRO/PRO or the intermediary will examine outlier cases and will deny claims for additional payment for those days of care in the outlier case that are not covered. (See the more detailed discussion of PSRO/PRO or intermediary review in section III. J. of this preamble.).

An adverse PSRO/PRO coverage determination may be challenged by the provider under the authority of section 1155 of the Act, which provides for a

reconsideration of the issue by the PRO. However, a provider may not appeal the PRO coverage determination beyond the reconsideration stage. On the other hand, for denials under section 1154, section 1879 of the Act gives the provider the same appeal rights as a beneficiary concerning whether it knew that the services were not covered. If section 1879 considerations are applicable, the provider may request, as part of the appeals process authorized under § 405.704(b)(12) of the regulations, a reconsideration, a hearing before the Office of Hearings and Appeals of the Social Security Administration, and judicial review. Accordingly, we amended § 405.704(b)(12) to provide that, if items or services for which payment could otherwise be made under section 1886(d)(5)(A) of the Act are excluded from coverage based on a determination that the services are not medically necessary, constitute custodial care, or are excluded under section 1154(a) (1) and (2), and a determination is made under section 1879 as to whether the hospital knew or could reasonably have been expected to know the items or services were excluded, the section 1879 determination is appealable.

I. Charges to Beneficiaries

Except as described below, a hospital may not charge a beneficiary for services covered under the Medicare program. However, Medicare Part A beneficiaries are responsible for payment of deductible and coinsurance amounts. The deductible is a set amount of inpatient hospital costs for which the beneficiary is liable when he or she first enters the hospital during a benefit period. Under Medicare, coinsurance is a daily charge for inpatient hospital care for which the beneficiary is liable after he or she has been hospitalized for 60 days. These amounts are changed each year as required by law.

Generally, a hospital paid under the prospective payment system must bill its intermediary, under Medicare Part A, for all inpatient hospital services furnished to a beneficiary. Except as described below, a hospital may not bill either a beneficiary or Medicare Part B for services for which payment is made under the prospective payment system. However, in cases in which no payment is made under the prospective payment system for inpatient hospital services (either because a beneficiary's Medicare Part A benefits were exhausted before admission to the hospital, or because the inpatient admission was denied as not covered), a hospital may seek payment for those specific services which can be covered under Medicare Part B, if the beneficiary is entitled to have the service paid for under Part B.

In addition, a hospital furnishing inpatient hospital services to a Medicare beneficiary for which it expects to receive payment under the prospective payment system may charge the beneficiary for certain items and services for which payment is not made by Medicare. These items and services include:

- Items and services, furnished at any time during the stay, which are excluded from coverage on some basis other than § 405.310(g), (k), and (m) (i.e., as custodial care, medically unnecessary items and services, and nonphysician services furnished to hospital inpatients by other than a hospital or a provider or supplier under arrangements made by the hospital).
- Days of care subsequent to a length-of-stay outlier (as described in § 405.475(a)(1)) which:

—Will not be paid for by Medicare because the patients' benefits under Medicare have been exhausted, or
—Are not covered under Medicare Part A for other reasons and waiver of liability under § 405.330 does not apply. When payment is considered for outlier days, the entire stay will be reviewed and days up to the number of days by which the total stay exceeds the day-outlier threshold may be denied. In applying this rule, the latest days of the stay will be denied first. However, unless the entire stay is denied, the basic prospective payment rate will not be affected.
—Items and services attributable to cost-outliers which will not be paid for by Medicare because the services are not covered and waiver of liability under § 405.330 does not apply. (Exhaustion of benefits during the stay will have no effect on cost-outliers.) When payment is considered for cost-outliers, the coverage of services throughout the stay will be reviewed. When payment for services is denied solely on the basis of § 405.310(g) or (k) (i.e., custodial care and medically unnecessary items and services), the amount which the beneficiary may be billed for the denied services is limited to an amount which, when added to the Medicare payment for the stay, results in a total payment for the stay no greater than the Medicare payment would have been had all the denied services been viewed as covered.

- The customary charge differential for a private room or other luxury item or service that is more expensive than is medically required and is furnished for the personal comfort of the beneficiary at his or her request (or that of the person acting on his or her behalf).

Under section 1866(a)(2)(B)(ii), a beneficiary could also be charged, if certain conditions were met, for costs in excess of the cost limits, established under section 405.460. Section 1866(a)(2)(B)(ii) was amended, however, by section 602(f)(2) of Pub. L. 98-21 to provide that these charges may not be imposed for services provided under the prospective payment system. Except as indicated above with respect to luxury items and services, a hospital may not charge a beneficiary for any services for which payment is made by Medicare, even if the hospital's costs of furnishing those services to that beneficiary are greater than the amount the hospital is paid under the prospective payment system.

As noted above in the discussion about beneficiary appeals, Congress provided in section 602(f)(1) of Pub L. 98-21 that beneficiaries may not be held responsible for charges for services furnished by a hospital in connection with unnecessary admissions, unnecessary multiple admissions, or inappropriate medical or other practices. To implement this provision, we have amended § 489.21 of the regulations. This section describes specific limitations on charges that a provider may impose on a beneficiary. We state in a new § 489.21(e) that, as part of its agreement with the Secretary under section 1866 of the Act, the provider (in this case, a hospital under prospective payment) may not charge a beneficiary for inpatient hospital services for which the beneficiary would be entitled to have payment made but for the improper practices of the provider with respect to admissions or other inappropriate medical practices.

J. Review Activities

1. Medical Review

a. Medical Review Agents.

The conforming amendments contained in Section 602 of Pub. L. 98-21 require hospitals receiving Medicare payments to enter into an agreement with a Utilization and Quality Control Peer Review Organization (PRO) by October 1, 1984. Until a PRO contract is awarded in an area, medical review will be conducted by existing Professional Standards Review Organizations (PSROs) or fiscal intermediaries, absent a federally funded PSRO in the area.

As a result of PRO contracts being awarded over the course of FY 84 (i.e., October 1, 1983 through September 30, 1984), the medical review role will be spread between the above mentioned

entities. Therefore, for the sake of clarity, we will use the term "medical review agent", which will encompass the entities listed above.

b. Background

The Social Security Amendments of 1983 did not modify the statutory provisions that prohibit Medicare from paying for certain care. For example, the law retains the following technical exclusions providing that Medicare will not pay:

- For hospital care when the patient has no legal obligation to pay (section 1862(a)(2) of the Act);
- When another government entity pays (section 1862(a)(3) of the Act); or
- When payment may be made under worker's compensation, an automobile medical liability, no fault insurance, or an employer's group health plan that is primary insurance for an ESRO beneficiary or an employed beneficiary or spouse age 65 to 69 (section 1862(b) of the Act).

Also, the law retains requirements that no payment be made for the following: services that are not certified by a physician as needed services (section 1814(a)(2) of the Act), services that are not reasonable and necessary (section 1862(a)(1) of the Act), services that constitute custodial care (section 1862(a)(9) of the Act), and services that are personal comfort items (section 1862(a)(6) of the Act).

We need to adjust our policies for excluding payment for such noncovered care to reflect Medicare's shift in reimbursement policy. Prior to the recent amendments, the financial incentives of cost-based reimbursement built in logical assumptions that there might be a tendency on the part of providers to overutilize services, thus leading to increases in their costs associated with treating Medicare patients. Now, however, aside from the potential for inappropriate admissions, the incentives work in the opposite direction in that, regarding inpatient operating costs for which payment is made under the prospective payment system, hospitals are benefited *only* if they provide solely those services needed to care for the patient in an appropriate manner. Therefore, it is essential that we reshape some of our approaches to identifying noncovered care so that they reflect the realities of the new system of payment.

It is our intent to describe review methods and policies necessary to avoid payment for noncovered care that will apply to all HCFA medical review agents. We are continuing to consider alternative proposals and we wish to encourage comments on these provisions.

c. General Policies and Assumptions

Specifically, we will apply the following coverage principles under prospective payment:

i. Technical Exclusions

We will not change our implementation of the statutory "technical" exclusions. Generally, those exclusions are absolute and not sensitive to fiscal incentives built into the new payment policies. Therefore, no changes will be made in provisions such as §§ 405.311–405.314.

ii. Physician Certification

Adjustments will be made to the implementation of physician certification requirements in section 1814(a)(3) of the Act so that physicians must certify at new "key" points where payment incentives could lead to inappropriate utilization (i.e., at what the hospital reasonably assumes to be the beginning of outlier status for a case and, as appropriate, during that outlier status).

iii. Medically Related Coverage

Adjustments will be made to the procedures for enforcement of medically-related coverage provisions in a way that focuses on whether admissions were appropriate and otherwise covered (i.e., reasonable and necessary and not for the purpose of delivering statutorily or otherwise excluded care), with further review being conducted only in outlier cases.

iv. Operational Assumptions

One operational assumption inherent in these adjustments and approaches is that once an admission has been found to be covered (i.e., it was a reasonable and necessary admission for the particular patient and it was not for the delivery of statutorily or otherwise excluded care, (e.g., for cosmetic or experimental care), *any* services or days needed by and provided to a beneficiary are included in the Medicare prospective payment rate and that it is these services which the hospital has provided. This based on the realities of the new fiscal incentives involved.

d. Review and Denials System

i. For Technical Exclusion

FIs will continue their current system of ensuring no Medicare payment where these exclusions apply. We are making no changes in §§ 405.311–405.314.

At present, we will continue to require FIs to review for care not reasonable and necessary based on *national* coverage policy and, where medical judgments are required to implement national coverage provisions, to use PSROs or PROs to make those judgments. For example, Medicare does not pay for procedures or services which have not been proven to be safe and effective (i.e., for services which are generally experimental in nature). The program denies such payment on "reasonable and necessary" grounds. This policy will continue and FIs will continue to be ultimately responsible for this enforcement (deferring to PSROs or PROs as noted above), although, as in the past, PSROs/PROs will be expected to consider such policies when performing their case-specific admission and outlier review.

Therefore, as in the case of PSRO/PRO review, payment for nonoutlier cases will be totally denied or totally approved based on a finding regarding the appropriateness of the admission. When an FI finds, in conducting retrospective review, that the sole or primary services provided to a patient above and beyond routine services were experimental and therefore noncovered (as enumerated in program instructions), the patient's admission will be found to have been inappropriate and payment for the entire stay will be denied.

Continuation of our current policy will generate a substantial incentive for providers to adhere to generally accepted medical practices in their treatment of Medicare patients. Therefore, to avoid potential payment loss, providers must remain sensitive to and cognizant of "nationally" noncovered care.

It should be noted in this regard that only if the *sole or primary* services (beyond routine care) provided to a patient are noncovered will the admission (and therefore prospective payment) be denied. This means that as long as an acceptable or proven diagnostic or treatment course (for the DRG) is present, even if noncovered care is also present, the payment will be made.

ii. Specific Review

We will specify in PRO contracts, the process by which PROs will meet the review requirements under prospective payment. Until a PRO contract is awarded in an area, the PSRO or FI will perform the following review functions.

A. Admission Review

After finding that an admission is appropriate, the medical review agent will not "carve out" days or services to affect the DRG rate portion of a prospective payment, based on findings of overutilization occurring in a nonoutlier case. This will be the

approach because the absence of such noncovered care will be presumed based on the fiscal incentives involved and the assumption that DRG rates are set at a level to pay only for care essential to treat the patient and delivered in the most appropriate setting.

If the medical review agent finds that the admission is inappropriate, it will deny the admission, and the hospital would not receive DRG payment.

B. Admission Pattern Monitoring

Under TEFRA, HCFA put in place an admission pattern monitoring (APM) plan which will continue under the prospective payment system. Based upon a file of all Medicare discharges, HCFA compares the number of discharges from a provider during a quarter to the number of discharges from the provider over the previous eight quarters. If the percent of increase in discharges exceeds a predetermined threshold, the information is sent to the medical review agent for analysis.

If the medical review agent's data analysis cannot justify the increase in discharges, then medical review of discharges during the quarter in question takes place. The review is performed at the hospital using, at a minimum, an accepted random sample technique. The purpose of the review is to determine if the admission was medically necessary and appropriate.

C. Outliers

Once a case becomes an outlier, medical review policy and systems will shift to a mode designed to carve out unnecessary services or days. For day outlier cases, the medical review agent would deny unnecessary days, not specific services. Should the medical review agent find that noncovered treatment occurred in an appropriately admitted outlier case, the appropriate prospectively determined payment will be made for that DRG, and the specific noncovered days or services will be carved out of the outlier payment or, if appropriate, the entire outlier payment will be denied.

1. Day Outliers

Day outliers constitute one of the two types of outliers recognized under prospective payment. They are cases involving unusually long stays and result in per diem payments beyond the DRG rate for each day exceeding a specified number of days (i.e., for each day exceeding the day-outlier threshold criteria for the DRG) on which covered care is provided. Day-outlier cases occur automatically when a stay exceeds a specified number of days for each DRG. The determination of eligibility for extra Medicare payment is "automatic" for outlier days (i.e., a hospital need not specifically request it) and, therefore, appropriate medical review agent review of the day-outlier cases must occur.

When medical review occurs for the purpose of affecting payment for day outlier cases, that review includes: (1) reviewing to determine that the admission was medically necessary and appropriate; (2) "looking back" at the days occurring prior to the day outlier threshold being met (particularly unnecessary preprocedure or pretesting delays occurring at the beginning of the hospital stay or just prior to outlier status); (3) reviewing for unnecessary or excessive days actually occurring after the case reaches the day outlier threshold criteria; and (4) ascertaining that the diagnostic and procedural coding area reflective of the information found in the medical records.

If the medical review agent finds the patient's entire hospitalization to be reasonable and necessary, the hospital will receive the outlier payment. If the medical review agent's finding is negative, it will appropriately deny days of outlier payment. These denials will be subject to waiver of liability considerations under section 1879 of the Act.

2. Cost Outliers

Cost outliers, the other type of "unusual" cases under prospective payment, are recognized as such only if they are not eligible for payment as day outliers. They are cases where payment can be made beyond the prospective payment rate because extraordinary costs are incurred in a short period of time in treating the patient. Medicare payment beyond the prospective rate for that DRG would not be made until a certain threshold of "excess" costs above the amount of the prospective payment rate is reached, and Medicare would then pay only a certain percentage of costs incurred *beyond* that threshold point. Review by a medical review agent for noncovered services would occur whenever a hospital requests cost outlier payment. (Note that cost outliers, unlike day outliers, are not paid automatically. Hospitals must request cost outlier payment.) That review would include the monitoring of outlier services and, like day outliers, also involve "looking back" at the medical necessity and appropriateness of the admission as well as the previously provided services to determine whether they were noncovered (including their appropriateness). The medical review agent would also validate that the diagnostic and procedural information listed was substantiated by the medical records and that all charged services were actually rendered, ordered by a physician, and not duplicatively billed. Costs of unnecessary and otherwise noncovered services would be excluded both for purposes of determining arrival at the cost outlier threshold (i.e., by excluding costs for noncovered services occurring between admission and the point at which the request is made) and determining the amount of outlier payment (i.e., by excluding costs for noncovered care occurring between the outlier threshold and the end of care).

For cost outliers, the medical review agent review will be for the purpose of denying unnecessary services, rather than days. If the medical review agent approves the services, outlier payment will be made. If, however, it finds the services unnecessary, payment would be denied for some or all of the services (i.e., for noncovered care provided before cost outlier status, as identified by the hospital, for noncovered services actually generating outlier costs, or both). These denials also will be subject to waiver of liability considerations under section 1879 of the Act.

D. DRG Validation

To assign a DRG to a case the following elements must be present: principal diagnosis, secondary diagnoses (if any), names of surgical procedures (if applicable), age, sex, and discharge destination of the beneficiary. As a requirement for prospective payment, we are requiring that, shortly before, at or shortly after discharge (but before a claim is submitted), the attending physician will attest in writing to the principal diagnosis, secondary diagnoses, and procedures performed, to be utilized when assigning the DRG.

The medical review agent will review, at the hospital, at a minimum a random sample of discharges every quarter. The purpose of the review will be to ascertain that the diagnostic and procedural coding used to assign the DRG are substantiated by the medical records.

iii. Waiver of Liability

It is important to note here that, as discussed above in section III. E. of this preamble, the waiver of liability regulations (§§ 405.330–405.332) will apply if an entire patient stay or a day or cost outlier is denied under section 1862(a) (1) or (9) or 1154(a) (1) and (2) of the Act.

iv. For Other Medically-Related Statutory Exclusions (e.g., Foot Care, Dental Services, Cosmetic Surgery, and Personal Comfort Items)

We will continue to hold FIs responsible for monitoring for the presence of these statutory exclusions. When these coverage rules require the use of a medical judgment in their application, a PRO/PSRO must be used to make the medical necessity decision.

However, for purposes of prospective payment, FI's will assume that the cost of any noncovered care identified in a nonoutlier case has already been excluded by the process by which the prospective payment rate was developed. They will make full payment of that rate, unless, as in the above discussion, that assumption is not a reasonable one because the primary or significant nonroutine care provided was noncovered; in which case the admission will be denied and total prospective payment is to be denied.

On the other hand, if these noncovered items (e.g., personal comfort items, foot care) are identified in the review of an outlier case, the intermediary is to carve out appropriately from the outlier payment, consistent with the amount of noncovered care identified. Again, this would be day denials in day outliers (when it is clear that the days were solely or primarily for the delivery of noncovered care) and services denials for cost outliers.

e. Provisions of Interim Regulations

Under the prospective payment system, we are concerned that hospitals may be able to circumvent the intent of the system by unnecessarily admitting or readmitting individuals. Sharing this concern, Congress provided in Pub. L. 98–21 a new section 1886(f)(2) of the Act, requiring that:

(2) If the Secretary determines, based upon information supplied by a utilization and quality control peer review organization under part B of title XI, that a hospital, in order to circumvent the payment method established under subsection (b) or (d) of this section, has taken an action that results in the admission of individuals entitled to benefits under part A unnecessarily, unnecessary multiple admissions of the same such individuals, or other inappropriate medical or other practices with respect to such individuals, the Secretary may—

(A) deny payment (in whole or in part) under part A with respect to inpatient hospital services provided with respect to such an unnecessary admission (or subsequent admission of the same individual), or

(B) require the hospital to take other corrective action necessary to prevent or correct the inappropriate practice.

Section 1886(f)(3) continues by specifying that the provisions of sections 1862(d) (2), (3), and (4), apply equally to determinations under section 1886(f)(2), and section 602(f)(1) of Pub. L. 98–21 adds a new paragraph (F) to section 1866(a)(1) of the Act.

Sections 1862(d) of the Act contains general provisions prohibiting fraudulent billing practices and provision of unnecessary services, or services that fail to meet professionally recognized standards and provides for notice to providers and suppliers, the public, and State Medicaid agencies when it is determined that such practices have occurred. Section 1866 sets forth the requirements of provider agreements, which must be complied with for a provider to participate in Medicare.

It is clear from these provisions that Congress wished to provide strong sanctions against circumventing the prospective payment system. However, section 1886(f)(2) determinations must, according to the statutory language, be based upon the findings of a PRO. We are implementing prospective payment under section 1886(d) before any PRO regulations become effective or any PRO contracts established. Nonetheless, it is clear that we must have regulations in place providing for admissions review at the very inception of the prospective payment system.

We are providing, in § 405.472(e), general regulations setting forth review requirements modeled after the requirements of sections 1862(a), 1862(d), and 1886(f)(2), establishing general authority for HCFA to impose sanctions based on this review, and cross-referring to appropriate regulations providing for notice and appeal.

In § 405.472(e)(2), we are providing for appropriate procedures when payment is denied in individual cases, depending on whether the denial was the result of review by a PRO, PSRO, or fiscal intermediary. In §§ 405.472(e) (3) to (5), we are providing appropriate procedures when review shows a pattern of inappropriate admissions or billings that have the effect of circumventing the prospective payment system. Such cases would come under the Medicare quality review regulations at 42 CFR Part 420, and could result in termination of a hospital's provider agreement.

We do not intend these interim regulations to implement section 1886(f)(2) (or the provisions of 1866(a)(1)(F) concerning agreements between hospitals and PROs and per case payment for PRO reviews). Those statutory requirements will be implemented at a later date under the PRO regulations. Rather, under the authority of sections 1102, 1862(d), and 1876 of the Act, we are establishing the regulatory authority that we believe, at a minimum, is required to ensure that timely implementation of payment under 1886(d) does not result in incentives, loopholes, and payment outcomes clearly contrary to the intent of Congress.

We expect, initially, that we will implement these regulations through fiscal intermediary and PSRO review. After PRO regulations, and regulations explicitly implementing section 1886(f)(2), are in place, we would expect these functions to be taken over by PROs.

2. Utilization Review

a. Discussion

For hospitals under prospective payment, Congress has retained the requirement that Medicare hospital providers have a utilization review (UR) committee, which operates in conformance with certain statutory provisions (section 1861(k) of the Act). For hospitals under PSRO review, this statutory requirement does not apply. In regulations now being developed for hospitals under PRO review, we plan to propose similar exceptions. Currently, another statutory provision, section 1866(d), further privides that no Medicare payment will be made beyond a certain point in "long stay" cases (i.e., no payment beyond 20 days) if the Secretary has found inadequate UR compliance (Also see section 1814(a)(6) of the Act). And, finally, section 1814(a)(7) of the Act provides that program payment cannot be made if a hospital UR committee has found that further care is not necessary, except that up to 3 grace days may be provided.

Hospitals covered by section 1861(k) of the Act must comply with the basic terms of the statute and a partial set of implementing regulations, parts of which have been permanently enjoined. (See *AMA et al. v. Weinberger*, 395 F. Supp. 515 (N.D. Ill., 1975), affd. 522 F. 2d 921 (7th Cir., 1975).) The proposed new UR regulations appearing in the proposed rule, *Conditions of Participation for Hospitals*, published in the January 4, 1983, **Federal Register** (48 FR 299), impose basic requirements which adhere closely to the statute. Essentially, the requirements that hospitals would have to meet include:

- Having an UR committee;
- Reviewing admissions and durations of stay;

• Reviewing extended stay cases no later than 7 days after specified time intervals; and

• Notifying parties of denials.

b. Changes to the Regulations

i. For purposes of prospective payment, we are revising 42 CFR Part 405, Subpart J, Conditions of Participation, Hospitals, by adding a new condition § 405.1042—Condition of Participation: Special Utilization Review Requirements for Hospitals Paid Under the Prospective Payment System. The changes contained in this new condition represent, for hospitals under the prospective payment system, a revision and adoption of the proposed § 482.30 on utilization review that appeared in our proposed regulations for hospital conditions published on January 4, 1983.

The comments we received on proposed § 482.30, and the changes in this provision that we made based on these comments, are discussed below. We are publishing this material in this interim final rule, rather than in a separate final rule on the hospital conditions of participation, because this will enable us to revise our utilization review requirements to reflect changes required by the prospective payment legislation. In addition, we believe prompt publication is justified because the new utilization review requirements will allow hospitals greater flexibility, and impose a lesser compliance burden, than our current regulations. This special condition becomes effective when each hospital begins participation in the prospective payment system. The current regulation at § 405.1035 on utilization review will continue to apply to all other hospitals participating in Medicare.

This special condition is an interim rule intended to contribute to the implementation of the prospective payment system. Comments on these interim rules will be responded to in the final rules on prospective payment that the law requires us to publish by December 1983.

Some comments received in response to the January, 1983 proposed rule are reflected in these special requirements. Therefore, a summary of our response to them is appropriate here.

Services for Which Review Is Required

Comment: Several commenters suggested that the opening paragraph of this section be revised to specify that services furnished by members of the medical staff of the institution, as well as by the institution, are subject to review. They also suggested that the term "individual" be changed to "patient," to avoid misunderstanding.

Response: We agree, and have revised this paragraph accordingly under § 405.1042.

Composition of Utilization Review Committee

Comment: Several commenters recommended that we require the utilization review (UR) committee to be composed of two or more fully licensed physicians (Doctors of Medicine or Osteopathy), rather than of two practitioners who meet the proposed definition of "physician." These commenters believe that only MDs and DOs are qualified to review the medical necessity of services to hospital patients, and that other practitioners included in the proposed definition of "physician" are not qualified to perform review responsibilities independently. One commenter suggested that if proposed § 480.30(b) and the proposed definition of physician were implemented without change, services furnished by MDs and DOs could be reviewed by other practitioners. Other commenters recommended that we require that at least one MD or DO be on each utilization review committee.

Response: This provision of our regulations implements section 1861(k) of the Act (42 U.S.C. 1395x(k)). Section 1861(k)(1) provides, in pertinent part, that the utilization review committee of a hospital or skilled nursing facility is to be "composed of two or more physicians (of which at least two must be physicians described in subsection (r)(1) of this section) * * *". Section 1861(r)(1) defines a physician as a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he performs such function or action. To comply with these statutory provisions, we have specified in the regulation that a hospital UR committee must be composed of two or more physicians, of whom at least two must be doctors of medicine or osteopathy. Thus, we have adopted the first comment. However, we have not specified the review responsibilities of various categories of practitioners. As explained more fully below, specificity on this issue is not required by section 1861(k) and could unnecessarily limit hospitals' flexibility in complying with the UR requirements.

Comment: Some commenters suggested that we require, rather than merely permit, participation by non-physician health care personnel on utilization review committees. These commenters argue that if services of these personnel are available in the hospital, the personnel should participate in review of those services. In particular, one commenter suggested that an RN be required on the utilization review committee.

Response: Section 1861(k)(1) permits, but does not require, participation on UR committees by non-physician personnel. We believe it would be inappropriate to restrict by regulation a hospital's discretion with regard to inclusion of these personnel on UR committees. Therefore, we have not modified this provision to require participation by non-physician health care personnel in UR committee decisions. For the same reason, we have not required RN participation on the UR committee.

Comment: Some commenters stated that the prohibition against conduct of reviews by a physician who is financially interested in the hospital is unnecessarily broad (proposed § 482.30(b)(3)(i)), since all physicians who practice in a hospital have a stake in its financial well-being. They suggested that we prohibit review by physicians with a direct financial interest, such as an ownership interest.

Response: We agree, and have specified this provision that reviews by physicians who have a direct financial interest (e.g., an ownership interest) in the hospital are prohibited.

Comment: One commenter suggested that the regulation be modified to ensure that services of practitioners in a particular category would be reviewed only by other practitioners in the same category.

Response: We have not adopted this comment. This type of review procedure is not specifically required by section 1861(k) of the Act, and we believe that requiring the procedure in regulations would unnecessarily limit hospitals' flexibility in conducting utilization review.

Final Determination Regarding Admissions or Continued Stays

Comment: One commenter stated that it is unnecessary to require the UR committee to consult the attending physician and give him or her the opportunity to present his or her view before making a final determination that an admission or continued stay is not medically necessary. This commenter suggested that such a consultation could lead the attending physician to order additional, unnecessary services in order to justify the admission or stay. This commenter also expressed the view that the procedures for making negative determinations is too burdensome and that, rather than providing for grace days, HCFA should put more emphasis on discharge planning. On the other hand, another commenter suggested that

we require the UR committee to notify the patient as well as the attending physician before making a final determination that a continued stay is not necessary. This commenter believes that this notice would help ensure that attending physicians present their views regarding the need for continued stay to the UR committee, and thus would be an important safeguard against premature discharge.

Response: We have not adopted either comment. While requiring the UR committee to consult the patient's attending physician before making a final determination may delay the determination somewhat, we believe this consultation is essential to ensure accurate medical decisions regarding the need for admissions or continued stays. On the other hand, we do not believe that it is necessary to require UR committees to give separate notice to the patient before making final determination that continued stay is not necessary. This decision is a medical judgment that is made by the UR committee after consultation with the patient's attending physician, and we believe requiring notice to the patient would not increase the accuracy of the judgment.

We do not believe there is any incentive for a physician to order unnecessary services in order to justify a stay to the UR committee. Part of the committee's function is to identify unnecessary services, and such an attempt would be readily identified during the course of review. Moreover, the physician does not stand to gain anything by such action.

Comment: One commenter objected to the proposed utilization review provisions, since they do not permit the patient's attending physician to make the final decision as to whether a continued stay is medically necessary.

Response: The utilization review provisions are needed to implement section 1861(k) of the Act. This section requires the utilization review committee to review the duration of stays in the hospital and to give notification if it finds that further stay is not medically necessary. We have provided in the interim final rule that this decision is to be made only after consultation with the attending physician. We believe this provision is adequate to ensure that the attending physician's views are taken into account before a decision is made.

Comment: Some commenters suggested that we require all decisions regarding admissions and continued stays to be made by a minimum number of MDs or DOs (i.e., either one or two).

Response: As noted earlier, section 1861(k) specifies that decisions regarding admissions and continued stays may be made by a staff committee composed of two or more physicians, of whom at least two are MDs or DOs. The statute does not further require that only MDs or DOs may make decisions regarding admissions or continued stays. We do not believe it would be either necessary under the statute, or consistent with hospital flexibility, to impose such a further requirement in our regulations.

Comment: One commenter stated that our proposal to remove many credentialling requirements from other areas of the hospital conditions would reduce the quality of UR in hospitals, since many of the affected personnel are involved in UR.

Response: We are continuing to analyze the issues raised with regard to credentialling, and have not yet made final decisions on these issues. However, we have not seen any evidence to indicate that our credentialling proposals would adversely affect UR activities in hospitals. Therefore, we have not adopted any changes based on this comment.

Comment: One commenter suggested that we require UR to be conducted to determine the "health care necessity" rather than "medical necessity" of services. This commenter, a State nursing association, stated that it is primarily the need for nursing services, rather than for physician services, that justifies hospital admissions. The commenter suggested that use of the term "health care necessity" would emphasize this point.

Response: We believe the proposed provision makes it clear that services provided by the hospital, including nursing services, are subject to UR, and that introducing a new term not contained in section 1861(k) or the current or proposed regulations would not clarify this provision. Therefore, we did not adopt this comment.

Comment: One commenter opposed the adoption of less restrictive UR requirements, and suggested that this could increase unnecessary utilization of services. This commentor suggested we retain the current UR requirements.

Response: As explained in the preamble to our January 4, 1983 NPRM, we believe it is essential to reduce the regulatory burdens on hospitals to the minimum level consistent with patient health and safety and statutory requirements. We have not seen any concrete evidence that our current UR requirements are more effective in preventing excessive utilization than our proposed special requirements. Moreover, we are enjoined (as discussed below) from implementing many of our current UR requirements. Therefore, we did not adopt this comment.

Comment: One commenter suggested that we make our UR requirements less restrictive by permitting a subgroup of the UR committee, or an individual designee, to conduct admission or continued stay reviews.

Response: While we support, in general, efforts to reduce unnecessary regulatory burdens on hospitals, we are unable to accept this comment. One of the benefits of UR is the educational aspect of committee review that comes from committee discussions of the proper use of expensive health care services, such as hospital services. To reduce decisions to a small component of the URC or an individual could markedly hamper this effort and could give the appearance of permitting one individual's judgment concerning care to override that of the attending physician. We believe that benefits of full committee participation far outweigh the benefits of a more streamlined approach.

Comment: One commenter suggested that we eliminate the current UR regulation and not replace it. This commenter believes this approach would enable hospitals to integrate UR activities into their overall quality assurance systems.

Response: Because of the specific requirements in section 1861(k), we do not believe it would be legally supportable to eliminate UR requirements entirely. However, hospitals would be free, under the UR requirements, to combine UR activities with other quality control measures.

Comment: Several commenters suggested that the reference to Professional Standards Review Organizations (PSROs) in proposed § 482.30 be changed to Peer Review Organizations (PROs), to reflect changes made by TEFRA.

Response: The statutory provisions for PROs have not yet been implemented. Therefore, we have decided to defer making this change until PROs are fully operational.

Additional comments were received regarding psychiatric hospitals. However, because such hospitals are excluded from the prospective payment system, related comments will not be discussed here.

Specifically, we are adding § 405.1042 to replace the current UR provisions for hospitals under prospective payment and avoid certain overly prescriptive and detailed specifics for those

hospitals. A more indepth discussion of the revisions can be found in the preamble to the proposal published on January 4, 1983. However, for purposes of these regulations, we are revising certain sections to reflect appropriate review under prospective payment. This review, in the way it is adjusted to the incentives created by prospective payment, should be similar to the approach taken with PSRO, PRO, and FI review under prospective payment. However, we must point out that the findings of such utilization review, particularly regarding approval of admissions and outlier care, do not substitute for FI review. These utilization review requirements are necessary to comply with current statutory requirements (e.g., 1861(k), 1814(a) (6) and (7)). As long as they are necessary, we believe it is important to conform them to the dominant incentives of the payment system, especially as it is inappropriate to continue existing requirements despite their diminished relevance and significance. We are concerned that the UR committee findings be appropriate and useful to the hospital. However, we cannot equate the activities of a hospital committee with FI review activities, and we will not be bound by UR committee approval of an admission or outlier case for purposes of Medicare payment under the prospective payment system.

Section 405.1042(c) requires that the UR plan provide for some type of admission review, either pre-admission, upon admission, or after admission. In appropriate admissions we will not recognize, for DRG rate payment purposes, any UR committee determinations regarding the appropriateness of individual days or services in non-outlier cases (§ 405.1042(d)).

As discussed above in the case of PSROs/PROs and FIs, days would be denied in day outliers and services would be denied in cost outliers. We will, in advance, determine the day and cost outlier points for each DRG. Hospital UR plans must include procedures under which the UR committee will automatically review day outliers (based on the hospital's reasonable estimate of the proper DRG) and will review the necessity for continued services in cases which the hospital believes will qualify for "extra" or outlier payment. Appropriate hospital personnel (e.g., those in the hospital finance office) should provide prompt notification to UR committees of cases which have reached or are about to reach the cost outlier point (§ 405.1042(e)), and retrospective review of such cases by UR committees will be permitted.

ii. We believe Medicare outlier payment should be denied or reduced if the quality of UR committee activities is inadequate. That should be reflected in the way in which the program adjusts its implementation of section 1866(d) of the Act, i.e., long stay cases. Current regulations (§405.163) prohibit payment after the 20th consecutive day if the Secretary determines the hospital has substantially failed to make timely utilization review decisions in long stay cases. However, under prospective payment, it is only when the 20th day occurs after the beginning of what the hospital reasonably estimates to be outlier status that we are interested in penalizing inadequate UR committee activities. We do not intend that the quality of UR committee long-stay review activities affect the DRG rate payment for an appropriate admission. Therefore, we are amending §405.163 to provide that, in non-outlier cases, the Secretary will not find that a UR committee failed to make timely utilization review based solely on its failure to conduct continued stay review after an appropriate admission. This retains the penalty for ineffective UR, when and if cases become day outliers and the day outlier point is at 20 days or beyond.

iii. Section 1814(a)(7) of the Act, which prohibits payment after a UR committee finding that further care is not necessary, will now be interpreted to include only those committee findings that relate to situations in which additional payment would be made on the basis of medical need and utilization, i.e., outliers. To accomplish this, we are revising §405.162. Similar changes will be included in PRO regulations.

Physician Certification and Recertification

a. Discussion

Section 1814(a)(3) of the Act requires that no Medicare payment be made where a physician has failed to certify and, as appropriate, recertify that care is needed. Under the statute, in hospitals that are not tuberculosis or psychiatric hospitals, the certification must be no later than the 20th day of an inpatient hospital stay. Implementing regulations at §405.1627 (1) set forth what certifications and recertifications should contain; (2) permit certifications and recertifications of the need for inpatient hospital care due to unavailability of covered needed care in a skilled nursing facility; (3) allow for UR committee continued stay review to substitute for recertifications; and (4) require certifications no later than the 12th day of hospitalization and the first recertification no later than the 18th day of hospitalization.

b. Changes to the Regulations

We are revising current § 405.1627(b) to reflect prospective payment changes. For hospitals under prospective payment, we are requiring certification at the beginning of what the hospital reasonably assumes to be an outlier (cost or day), or no later than 20 days into the stay, whichever is earlier. As is currently the case, we will accept delayed certifications and recertifications.

The content of the physician certification statement will remain substantially the same. However, we are amending § 405.1627(a) to require a showing as to the need for special or unusual services in cost outlier cases. The physician is still authorized to recertify the need for hospital care if other needed covered care in an SNF is unavailable.

We are making no substantive changes in § 405.1629, governing certification and recertification for inpatient psychiatric and tuberculosis hospital services, because we assume that these hospitals, for the most part, will be excluded from prospective payment. We are, however, making minor technical amendments to this section to conform its language and cross-references to related regulations. In addition, we are making similar minor technical amendments to § 405.1630, concerning certification and recertification requirements applicable when a beneficiary is not entitled to benefits at the time of admission.

4. Quality Review

Section 1866(a)(1)(F) of the Act, effective October 1, 1984, authorizes PROs to review the quality of care provided by a hospital. Specific guidelines and procedures for PRO quality review will be included in PRO regulations and contracts which will be developed at a later date.

IV. PAYMENT FOR NONPHYSICIAN SERVICES FURNISHED TO HOSPITAL INPATIENTS

A. Background

Prior to Pub. L. 98–21, nonphysician services provided to Medicare beneficiaries who are hospital inpatients have generally been billed by the hospitals under Part A of the Medicare program. However, under certain circumstances, payments have been made for nonphysician services which

are furnished by an outside supplier or another provider and which have been billed by the outside source as a Part B service even though furnished to a hospital inpatient. Thus, some nonphysician services may have been billed under Part A in one hospital and under Part B in another. The practice of billing under Part B for these services has been referred to in the legislative history as "unbundling" of Part A services.

Under the new law, effective October 1, 1983, "unbundling" will be prohibited; that is, all nonphysician services provided in an inpatient setting will be paid only as hospital services. This rule will apply to all participating hospitals as of that date, regardless of a hospital's fiscal period, or inclusion or exclusion from the prospective payment system.

Section 602(e) of Pub. L. 98–21 added a new paragraph (14) to section 1862(a) of the Act, which provides for certain exclusions from Medicare coverage. The new section 1862(a)(14) provides that payment may not be made under either Medicare Part A or Part B for any expenses incurred for items or services—

> (14) which are other than physicians' services (as defined in regulations promulgated specifically for purposes of this paragraph) and which are furnished to an individual who is an inpatient of a hospital by an entity other than the hospital, unless the services are furnished under arrangements (as defined in section 1861(w)(1)) with the entity made by the hospital.

Further, section 602(f)(1) of Pub. L. 98–21, in adding certain additional statutory requirements, in section 1866(a)(1) of the Act, to the basic commitments into which a hospital must enter in making a provider agreement to participate in Medicare (see section V., on provider agreements following this section), provided that a participating hospital must agree—

> . . . to have all items and services (other than physicians' services as defined in regulations for purposes of section 1862(a)(14)) (i) that are furnished to an individual who is an inpatient of the hospital, and (ii) for which the individual is entitled to have payment made under this title, furnished by the hospital or otherwise under arrangements (as defined in section 1861(w)(1)) made by the hospital.

Although most of the provisions of Title VI of Pub. L. 98–21 are effective for cost reporting periods beginning on or after October 1, 1983, these provisions, in accordance with section 604(a)(2), take effect on October 1, 1983. We wish to make it clear that these requirements do not apply only to hospitals under the prospective payment system, or even to hospitals reimbursed under our regulations at Part 405, Subpart D, but to all hospitals participating in Medicare, including those reimbursed under alternative arrangements such as demonstrations or State cost control systems, and to emergency hospital services furnished by nonparticipating hospitals. There is, however, a statutory provision for a waiver of this requirement, which could defer, for a time, application of these provisions to a hospital meeting certain criteria. Section 602(k) of Pub. L. 98–21 provides that, if a hospital has been extensively allowing Part B billing of inpatient services since before October 1, 1982, and if immediate compliance with these requirements would threaten the stability of patient care, the Secretary may waive these requirements for any cost reporting period beginning before October 1, 1986. The criteria for and terms of such waivers are discussed in the section V.C., below.

B. Part A Billing

The basic unbundling provision, section 1862(a)(14), provides that Medicare payment will not be made under Parts A or B if non-physician services are furnished to a hospital inpatient by anyone other than the hospital (that is, the hospital would have to furnish the services directly or under "arrangements", as defined in section 1861(w)(1). The term "under arrangements" refers to a manner of arranging to have services (other than physicians' services to individual patient) furnished by a supplier or provider outside the hospital. Under such arrangements, payment to the hospital for those services discharges the beneficiary's liability to pay for the services. Thus, the supplying organization must accept its payment from the hospital. The amount charged by the supplying organization and paid by the hospital is a cost to the hospital. If the hospital is not being paid under the prospective payment system, those costs are includable in its cost report. If the hospital is being paid on a prospective rate basis for the particular inpatient services, the prospective payment would include full payment for services furnished under arrangements.

In order to be paid under this provision, a hospital must bill under Medicare Part A for any service that falls within the scope of "inpatient hospital services" (see 1861(b)). Section 1833(d) prohibits Part B payment for services that may be paid for under Part A. The Senate Finance Committee report states that section 1862(a)(14) is intended to have the effect that payment under the prospective payment system be "payment in full for all covered items and nonphysician services to hospital inpatients." It further notes that this is done by providing that "all nonphysician services provided to hospital inpatients would be paid only as inpatient hospital services under Part A * * *" (S. Rept. No. 98–23, 98th Cong., 1st Sess. 50 (1983)).

Because Section 1862(a)(14) requires that, to qualify for Medicare payment, all services, with limited exceptions, provided to hospital inpatients must be provided directly or arranged for by the hospital, those services become "inpatient hospital services" payable under Part A for patients with Part A eligibility. Section 1833(d) then in turn requires that those services, to the extent that payment can be made for them under Part A, not be paid for under Part B. Therefore, it is essential that we require all services within the definition of inpatient hospital services to be billed under Part A, except when the patient is not eligible for Part A benefits, or if Part A benefits are exhausted before the patient is admitted or enters outlier payment status. Our interim final regulations include this requirement at § 405.470(b)(6).

C. Definition of Nonphysician Services

Section 1862(a)(14) excludes from Medicare coverage all items, supplies, and services furnished to an inpatient, "other than physicians' services (as defined in regulations promulgated specifically for purposes of this paragraph)" that are not directly furnished by the hospital or by others under arrangements. As a result, we must make clear for purposes of this section which services furnished to inpatients are "physicians' services" within the meaning of the Act.

The definition of physicians' services reimbursable on a reasonable charge basis has been a matter of great controversy since the beginning of the Medicare program. To resolve this issue, Congress added a new section 1887(a) for the Social Security Act (enacted September 3, 1982 under section 108 of Pub. L. 97–248, the Tax Equity and Fiscal Responsibility Act of 1982). This section requires the Secretary to establish criteria in regulations that distinguish between physicians' services that are professional medical services personally furnished to an individual patient by a physician, and which contribute to the diagnosis or treatment of that patient and physicians' services and those that are for the general benefit of patients, such as quality control activities, are furnished to the provider, and, as provider services, must be paid for on

the basis of provider costs. In so establishing section 108 of TEFRA, Congress confirmed our long-standing interpretation of the requirements of the Social Security Act.

On March 2, 1983, we published final rules (with a comment period) on payment for physician services furnished in providers (48 FR 8902), implementing section 108 of TEFRA. In those regulations, we established explicit distinctions between physician services to individual patients, which are reimbursable on a reasonable charge basis under Medicare Part B, and physician services to the provider, which are of general benefit to patients and are reimbursable only on a reasonable cost basis. These regulations apply to services furnished in hospitals, SNFs, and CORFs, and apply to outpatient services covered under Medicare Part B (and paid on a reasonable cost basis) as well as to Part A services.

Pub. L. 98–21 amended section 1887(a) only to provide that physician services to the provider may be paid for only on a reasonable cost basis or under prospective payments under section 1886(d). Therefore, a hospital under the prospective payment system will be paid in full for physicians' services to the hospital related to care of Medicare inpatients as part of its prospective payments, and will be paid on a reasonable cost basis for such services related to care of Medicare outpatients. This amendment also clearly implies that, for purposes of implementing prospective payment, criteria for identifying physicians' services to inpatients payable on a reasonable charge should be consistent with criteria implementing section 1887(a).

Under the March 2, 1983 rules, § 405.550(b) of our regulations provides that physicians' services are medical services to individual patients and payable on a Part B charge basis if—

- The services are personally furnished to an individual patient by a physician;
- The services contribute directly to the diagnosis or treatment of an individual patient;
- The services ordinarily require performance by a physician; and
- If applicable, the services meet certain special rules that apply to services of certain physician specialties. (It was necessary to develop special distinguishing criteria for physicians' services furnished by anesthesiologists, radiologists, and pathologists (§§ 405.552, 405.554, and 405.556, respectively).)

We believe that we can best implement section 1862(a)(14) by identifying nonphysician services as those services furnished to hospital inpatients that do not meet the criteria of § 405.550(b), including the special criteria for anesthesiologists, radiologists, and pathologists. Therefore, we have added a new § 405.310(m) governing exclusions from coverage under section 1862(a). This new provision will ensure the greatest consistency and simplicity throughout the program. As a result, for the services a beneficiary receives as an inpatient of a hospital, we will be making separate and mutually exclusive payments for either physicians' services or hospital services. This new provision will minimize inconsistencies of coverage and payment between hospitals, and will greatly limit the opportunities for duplicate payments.

D. Services "Incident to" Physicians' Services

Another issue in implementing section 1862(a)(14) involves whether we should classify services furnished "incident to" physicians' services as physicians' or nonphysicians' services when they are furnished to a hospital inpatient for purposes of determining coverage under Medicare Part A or Part B. Section 1861(s) of the Act lists the medical and health services covered under Part B. Section 1861(s)(1) is "physicians' services" and section 1861(s)(2)(A) is "services and supplies . . . furnished as an incident to a physican's professional service." For coverage of the services furnished by nonphysicians as "incident to" services, Medicare requires an employer-employee relationship between the physician and the nonphysician (common law definition), that the physician be present when the service is furnished, and that the services be of the type commonly furnished in physicians' offices. Over the years, the "incident to" provision has been used as a basis for coverage of the services in hospitals of certain nurse anesthetists and various nonphysician therapists, such as physical and occupational therapists, employed by physicians. It is also the basis for coverage of items and supplies physicians furnish to patients, such as pacemakers, lenses, and artificial hip and knee joints.

However, many items and services paid for as incident to a physician's services have also been paid for under Part A as inpatient hospital services. For example, services of nurse anesthetist have been covered as inpatient hospital services when an anesthetist is employed by or contracts with a hospital. Thus, under current payment procedures, services and supplies furnished to inpatients in some hospitals are reimbursed under Part A while, in other hospitals, the same services and supplies are payable on a reasonable charge basis under Part B. The trend toward the provision of supplies and services by individuals and entities other than hospitals has contributed to higher program expenditures and a higher copayment burden on beneficiaries.

We believe that it is vital to the success of the prospective payment system that the services and supplies included in the payment be essentially the same in every hospital. Further, there is a strong statutory basis for discontinuing the use of "incident to" billing for services and supplies furnished to hospital inpatients. Section 1862(a)(14) states explicitly that only physicians' services are exempt from the requirement that all items and services furnished to hospital inpatient be provided directly or under arrangement. We could only exempt services incident to a physician's services if we determined that they were included within the definition of "physicians' services". The definition of such services in section 1861(q) of the Act, and our regulations at 42 CFR 405.550(b), both specify that physicians' services are performed by a physician. Thus, it is clear that services incident to a physician's services, which by definition are not performed by a physician, are subject to the exclusion from coverage under section 1862(a)(14). Therefore, we have included inpatient hospital services furnished incident to a physician's services, with one exception, in the new § 405.310(m), as services subject to that coverage exclusion.

The single, time-limited exception to this policy is the inpatient hospital services of anesthetists, such as certified registered nurse anesthetists, employed by physicians. During the prospective payment transition period, we will permit physicians who have customarily employed and billed on a reasonable charge basis for the services of anesthetists to continue this practice. The practice of physician-employer and anesthetist-employee is so wide spread, and the relationship of anesthesiologist to anesthetist is so unique, that we believe that it would be disruptive of medical practice and adverse to the quality if patient care to require all such contracts to be renegotiated in the limited time available before the implementation of the prospective payment system.

Therefore, we are providing, in § 405.553(b)(4), that, if a physician's practice was to employ anesthetists as

of the last day of a hospital's most recent 12-month or longer cost reporting period ending before September 30, 1983, then the physician may continue that practice through subsequent cost reporting periods beginning before October 1, 1986. However, if the physician chooses to continue this practice the hospital may not add the costs of the anesthetists' services to its base period costs for purposes of determining the hospital-specific portion of its transition payment rates.

E. Payment for Physician Radiology Services Furnished to Hospital Inpatients

The final rules published March 2, 1983 established a special test of reasonableness for charges for radiology services furnished in providers; that is, § 405.555(c)(2) provided that a carrier could not pay a physician, for any radiology service furnished in a provider, an amount exceeding 40 percent of the prevailing charge for a similar service furnished in a nonprovider setting. This limit ensured that payment for such services does not inappropriately include amounts reflecting the overhead costs associated with producing such services. However, that provision did not expressly apply to services furnished to provider inpatients outside the provider setting. (For example, since many hospitals do not own equipment for performing computed tomography (CT) scans, their patients may be transported to another hospital or a physician's office for such services.)

Under section 1862(a)(14) of the Act, we must pay the hospital for nonphysician services, such as overhead and operating costs, associated with furnishing radiology services to hospital inpatients. We may pay a physician (or other entity) only for the physician radiology services. We believe the best way to accomplish this is to apply the test we developed for services furnished in providers, thus ensuring consistent payment for all physician radiology services furnished to hospital inpatients. The nonphysician services associated with furnishing such radiology services will be paid for through the hospital since they must be furnished either directly or under arrangements. Therefore, we are amending § 405.555(c)(2) to ensure that the reasonable charge for any physician radiology service furnished to a hospital inpatient, regardless of the site at which the service is furnished, does not exceed 40 percent of the prevailing charge in a nonprovider setting.

F. Payment for Physicians' Services Furnished Through Independent Laboratories

Independent laboratories may furnish a variety of services to hospitals and their inpatients. Historically, these services have sometimes been paid for under Medicare Part B, in accordance with section 1861(s)(3), and have sometimes been furnished under arrangements and covered under Medicare Part A. These practices have not taken into consideration whether the service furnished through the independent laboratory included any services that qualified as physicians' service under section 1861(s)(1). In implementing section 1862(a)(14), however, we must distinguish between independent laboratory services which are nonphysician services for purposes of this provision, and which therefore must be furnished under arrangements, and any independent, laboratory services which qualify as physicians' services reimbursable on a reasonable charge basis under Part B.

In the March 2, 1983, regulations on payment for physicians' services furnished in providers, we established criteria for identifying physician laboratory services that are reimbursable on a reasonable charge basis. We believe that these criteria afford the most appropriate and consistent basis for distinguishing physicians' services reimbursable on a reasonable charge basis furnished by independent laboratories. These regulations, at 42 CFR 405.556, provide that physician laboratory services, to be reimbursable on a reasonable charge basis, must meet the requirements of § 405.550(b) (see discussion in paragraph V.C. of this preamble), and are—

- Anatomical pathology services;
- Services performed by a physician in personal administration of test devices, isotopes, or other materials to an individual patient; or
- Consultative pathology services that—
- Are requested by the patient's attending physician;
- Relate to a test result that lies outside the clinically significant normal or expected range in view of the condition of the patient;
- Result in a written narrative report included in the patient's medical record; and
- Require the exercise of medical judgment by the consultant physician.

In order to ensure that these criteria are applied to independent laboratory services furnished to hospital inpatients, we are amending § 405.556 in these interim rules by adding a paragraph explaining this application.

V. HOSPITAL PROVIDER AGREEMENTS

A. Background

Part 489 of Title 42 of the Code of Federal Regulations implements section 1866 of the Act, which specifies the terms of provider agreements and the providers that may enter into such agreements. Provider agreements are the basic legal instrument by which a provider enters into participation in the Medicare program. In these agreements providers agree to comply with the requirements of the Act, Title XVIII and related programs. If we find that a provider has not complied with those requirements and the implementing regulations, we may terminate the provider agreement, and thus terminate the provider's participation in the Medicare program.

Section 602(f) of Pub. L. 98-21 added three new paragraphs to section 1866(a)(1) of the Act. All three of these paragraphs refer explicitly to hospitals, rather than providers in general. They provide, in addition to the other requirements of section 1866, that in order to participate in Medicare and receive Medicare payment, a hospital must file an agreement with the Secretary—

(F) in the case of hospitals which provide inpatient hospital services for which payment may be made under subsection (c) or (d) of section 1886, to maintain an agreement with a utilization and quality control peer review organization (if there is such an organization which has a contract with the Secretary under part B of title XI for the area in which the hospital is located) under which the organization will perform functions under that part with respect to the review of the validity of diagnostic information provided by such hospital, the completeness, adequacy, and quality of care provided, the appropriateness of admissions and discharges, and the appropriateness of care provided for which additional payments are sought under section 1886(d)(5), with respect to inpatient hospital services for which payment may be made under part A of this title (and for purposes of payment under this title, the cost of such agreement to the hospital shall be considered a cost incurred by such hospital in providing inpatient services under part A, and (i) shall be paid directly by the Secretary to such organization on behalf of such hospital in accordance with a rate per review established by the Secretary, (ii) shall be transferred from the Federal Hospital Insurance Trust Fund, without regard to amounts appropriated in advance in appropriation Acts, in the same manner as transfers are made for payment for services provided directly to beneficiaries, (iii) shall be not less than an amount which reflects the rates per review

established in fiscal year 1982 for both direct and administrative costs (adjusted for inflation), and (iv) shall not be less in the aggregate for a fiscal year than the aggregate amount expended in fiscal year 1982 for direct and administrative costs (adjusted for inflation)] of such reviews.

(G) in the case of hospitals which provide inpatient hospital services for which payment may be made under subsection (b) or (d) of section 1886, not to charge any individual or any other person for inpatient hospital services for which such individual would be entitled to have payment made under part A but for a denial or reduction of payments under section 1886(f)(2), and

(H) in the case of hospitals which provide inpatient hospital services for which payment may be made under this title, to have all items and services (other than physicians' services as defined in regulations for purposes of section 1862(a)(14)) (i) that are furnished to an individual who is an inpatient of the hospital, and (ii) for which the individual is entitled to have payment made under this title, furnished by the hospital or otherwise under arrangements (as defined in section 1861(w)(1)) made by the hospital.

In addition to these new provisions, section 1866 was amended to conform generally to the prospective payment system established by Pub. L. 98–21. As a result, we must also make conforming changes in our regulations at Part 489.

B. Changes Affecting Basic Provider Agreement Commitments

In these interim regulations, we are amending Part 489 to eliminate inappropriately restrictive references to reasonable cost reimbursement (see § 489.3), and are amending § 489.20 (dealing with the basic commitments providers must make in their agreements) to add specific reference to the new commitments hospitals must make under sections 1866(a)(1) (F), (G) and (H).

Further, we are adding new language to § 489.21 (Specific limitations on charges) to reflect the requirements of the prospective payment system in general. This will take the form of a new paragraph (e), referring to inpatient hospital services paid for under the prospective payment system, and a new paragraph (f), referring to nonphysician services furnished to hospital inpatients. The new § 489.21(e) specifies that a hospital may not charge a beneficiary for inpatient hospital services for which the beneficiary would be entitled to have prospective payment made but for a denial or reduction in payments as a result of admissions or quality review. (See § 405.47 of this chapter or section 1886(f) of the Act.)

A new § 489.20(d) specifies that all Medicare covered services furnished to hospital inpatients, other than physician services reimbursable on a reasonable charge basis under § 405.550(b), must be furnished by the hospital or by others under arrangements made with them by the hospital. A new § 489.21(f) specifies that the hospital may not charge or permit others to charge for these services.

C. Waiver of Requirements of Section 1866(a)(1)(H)

Section 602(k) of Pub. L. 98–21 temporarily authorizes waiver, in certain circumstances, of the requirement that nonphysician inpatient hospital services be furnished either directly or under arrangements. Section 602(k) reads as follows:

(k) The Secretary of Health and Human Services may, for any cost reporting period beginning prior to October 1, 1986, waive the requirements of sections 1862(a)(14) and 1866(a)(1)(H) of the Social Security Act in the case of a hospital which has followed a practice, since prior to October 1, 1982, of allowing direct billing under part B of title XVIII of such Act for services (other than physician services) so extensively, that immediate compliance with those requirements would threaten the stability of patient care. Any such waiver shall provide that such billing may continue to be made under part B of such title but that the payments to such hospital under part A of such title shall be reduced by the amount of the billings for such services under part B of such title. If such a waiver is granted, at the end of the waiver period the Secretary may provide for such methods of payments under part A as is appropriate, given the organizational structure of the institution.

Since we are implementing section 1866(a)(1)(H) through amendments to our regulations governing provider agreements, we are also implementing this waiver authority through regulations in Part 489. This also ensures applicability of these requirements and waivers to all hospitals participating in Medicare, including not only hospitals paid under the prospective payment system, but those paid under reasonable cost reimbursement (regulations at 42 CFR Part 405, Subpart D), demonstrations, or the new regulations (published elsewhere in this issue of the **Federal Register** in 42 CFR Part 403 on State cost control systems implementing section 1886(c) of the Act.

We are establishing in these final rules a new § 489.23 that sets forth criteria for a waiver under section 602(k), specifies how a hospital must apply, and gives the terms that a hospital and its suppliers must meet under a waiver agreement. Essentially, to qualify for a waiver, a hospital must have allowed extensive billing under Part B for services furnished to inpatients before October 1, 1982, and must demonstrate that certain criteria we have established to determine whether this practice was so extensive that the hospital's immediate compliance with section 1862(a)(14) is impossible and that a sudden change in attempting to so comply would threaten the stability of patient care.

The first criterion is that a hospital must show that the outside suppliers' reasonable charges for nonphysician services in the hospital's base period must have been at least 125 percent of the reasonable cost of the nonphysician ancillary services furnished to Medicare inpatients by the hospital, exclusive of the costs for operating room, recovery room, labor and delivery room, and drugs and medical supplies charged to patients. Second, the hospital must show that at least three ancillary services furnished for its inpatients have been provided by outside suppliers and billed directly under Medicare Part B.

In developing these criteria, we relied on the clear intent expressed in the Senate Finance Committee Report (S. Rept. No. 98–23, 98th Congress, 1st Session, 50 (1983)) and the House Committee on Ways and Means Report (H. Rept. No. 98–25, 98th Congress, 1st Session, 138 (1983)). Congress intended that the waiver of the requirements of sections 1862(a)(14) and 1866(a)(1)(F) be granted in relatively few cases, that the administrative burden be limited, and yet that flexibility be provided for hospitals that currently do permit extensive Part B billing for inpatient services furnished to their inpatients.

We believe the 125 percent criterion is a reasonable measure of whether a significant proportion of services have been billed under Part B. By excluding from the comparison those ancillary services that generally are not reimbursable under Part B for hospital inpatients, the criterion recognizes that certain ancillary services must be furnished by the hospital and, at the same time, assures that the Part B billings are extensive for those services that can be billed by an outside supplier. The second criterion is based on the expectation expressed in the House Report that a change in billing arrangements for one or two services would not create hardship (H. Rept. 98–25, page 138).

The regulations also require that a hospital must show that its suppliers have agreed to certain conditions. First, the suppliers must agree to bill only for services for which payment may be made under Part B. This condition has the effect of limiting the waiver only to services that are covered under Part B and of protecting the beneficiary from being billed for services, such as drugs,

which would be covered under Part A if furnished by the hospital but cannot be covered under Part B when billed by an outside supplier.

Other requirements are necessary to enable us to make the required reduction in the hospital's prospective payment amounts to reflect Part B billings. Under section 602(K), we must reduce Medicare Part A payments to a hospital for the amount of Part B billings for nonphysician services furnished to the hospital's inpatients. To implement this requirement, we are requiring a hospital to show that its suppliers have agreed to the following practices:

- To bill the program directly (even if assignment is not taken) for services furnished to Medicare beneficiaries;
- To submit a bill within 30 days of a beneficiary's discharge;
- To specify on the bill that the services were furnished to an inpatient of a particular hospital; and
- To identify the nonphysician services that were furnished and the charge for each service.

VI. CONFORMING CHANGES

A. Explanation

The preamble to this interim final rule discusses many amendments, additions, and changes to our regulations as published in 42 CFR Chapter IV. There are a number of other changes that must be made in the CFR to make it consistent with the prospective payment system and the statutory changes made by Pub. L. 98–21.

In order to make clear the actual changes we are making in HCFA regulations as codified in the CFR, we are providing the following discussion, including some brief explanations of additions, deletions, and amendments to the regulations that are not discussed elsewhere in this document, but which are necessary and appropriate for the consistent implementation of Pub. L. 98–21. We are also including some technical corrections not directly related to the prospective payment system.

B. Introduction to Subpart D—§ 405.401

Because we have decided to incorporate the main prospective payment regulations in Subpart D, it is necessary to revise § 405.401, which serves as a general introduction to the entire Subpart. In addition, we are amending the table of contents of Subpart D by adding center headings designed to ease finding of the applicable sections of the regulations.

As revised, § 405.401 summarizes the applicability, structure, and scope of the provisions of Subpart D. In this section, we point out which providers and which cost will be reimbursed on a reasonable cost basis, and which will be paid on a prospective basis. We also point out special rules applying to ESRD facilities, teaching hospitals, and the costs of physician services to hospitals.

C. Methods of Apportionment Under Title XVIII—§ 405.404

The apportionment regulations set forth in § 405.404 are either obsolete or repetitive of regulations in §§ 405.452 (Cost related to patient care) and 405.453 (Adequate cost data and cost finding). Therefore, we are deleting this section.

D. Cost of Educational Activities—§ 405.421

Under section 1886(a)(4) of the Social Security Act, costs of approved educational activities will continue to be reimbursed on a reasonable cost basis. We have defined approved educational activities as those meeting the criteria of and within the scope of 42 CFR 405.421, Cost of Educational Activities. However, § 405.421(d) distinguishes only orientation and on-the-job training as not being within the scope of this regulation. Prior to the prospective payment system, this distinction was not significant, since training costs not within the scope of § 405.421, as well as costs of approved educational activities, were reimbursed on a reasonable cost basis.

This is no longer true for hospitals paid under the prospective payment system, since any training costs incurred by a hospital which are within the scope of § 405.421 will continue to be reimbursed on a reasonable cost basis, while costs not within the scope of the regulation will be considered part of inpatient operating costs to be included in the prospective payment rates. As the regulation now stands, costs of many types of training activities, which we do not consider within the scope of the regulation, will nonetheless qualify for separate reasonable cost reimbursement in addition to the prospective payments.

Therefore, it is important that we clearly differentiate between approved educational activities in which a hospital may be engaged and other training costs a hospital may incur. Approved educational activities are already adequately addressed. These activities are defined in § 405.421(b), while § 405.421(e) (and § 405.116(f)) list recognized approved medical and paramedical programs. Further, § 405.421(f) recognizes there may be additional approved training programs in which a provider is engaged.

On the other hand, other training activities are not adequately addressed in the regulations at §§ 405.421(d) and 405.451. To better define these activities, we are listing common examples of such training, currently listed in the Provider Reimbursement Manual section 416 (i.e., costs of a medical library, refresher and post-graduate programs, part-time education, educational workshops and training in use of medical appliances), in the regulations in § 405.421(d).

E. Grants, Gifts, and Income From Endowments—§ 405.423

Medicare policy concerning the treatment of grants and gifts has been in a state of transition for some time. As a general rule, grants and gifts that have been restricted by the donor to pay for a specific operating cost (or group of costs) have been used to reduce that cost. However, a number of exceptions to the general rule on the treatment of restricted contributions have been administratively established and implemented over time. The exceptions (which represent a liberalization of the rule) have resulted from situations where strict application of the general rule would not yield an equitable or desirable effect. These exceptions have included:

- Seed money grants;
- Deficit financing grants;
- Grants for primary care education programs;
- Contributions which benefit only non-Medicare patients; and
- Capital assets purchased with donated funds.

Except for grants for primary care education programs, the exceptions are not contained in the regulations, although they are being applied by the Medicare intermediaries.

The Omnibus Reconciliation Act of 1980 (Pub. L. 96–499) contained a provision dealing specifically with hospital philanthropy. Section 901 set out the same general rule pertaining to those contributions which shall not be offset as our regulations contain. In addition, the section reaffirmed the Secretary's authority not to offset those types of donor-restricted grants and gifts which the Secretary finds, in the best interests of needed health care, should be encouraged.

The intent behind the general rule pertaining to restricted contributions is to prevent providers from receiving double payment for a given cost—once from the contribution and once from Medicare—and to permit the Medicare program to derive the same benefit from the contribution as do others. We believe the general rule no longer has a significant impact on Medicare program outlays.

Hospitals are the largest beneficiary of restricted grants and contributions. Under the prospective payment system, the treatment of the grants and contributions for purposes of determining reasonable cost will not affect Medicare reimbursement for inpatient operating services.

Since the offset of donor restricted contributions appears to dilute the effect of the contribution, it may discourage private philanthropy. Because we believe it is in the best interests of needed health care to increase private sector support of health care institutions, we are eliminating § 405.423. As a result, restricted grants and gifts will no longer be used to offset costs effective with cost reporting periods beginning on or after October 1, 1983.

F. Compensation of Owners—§ 405.426

Existing regulations at § 405.426(d) state payment requirements that do not need to be incorporated in such regulations. Paragraph (d)(1) includes requirements concerning sole proprietorships that are implicit in other regulations at § 405.426(c)(2). Paragraph (d)(2) sets forth special rules on the compensation paid corporate "owners".

However, our program instructions in section 2305 of the Provider Reimbursement Manual (HCFA Pub. 15–1) provide rules applicable to liquidation of short-term liabilities that are sufficient to safeguard against abuse in this area. Therefore, we are deleting paragraph (d) from § 405.426.

G. Allowance in Lieu of Specific Recognition of Other Costs—§ 405.428

The provisions of this regulation have not been applicable to cost reporting periods beginning after June 30, 1969. It has long been obsolete, and we are therefore repealing it.

H. Return on Equity Capital—§ 405.429

Currently, we allow proprietary providers (as described in § 405.429(a)(2)) a reasonable return on equity capital invested and used in the provision of patient care. For these providers, we allow the amount of such a return as an amount in addition to the reasonable cost of covered services. This return on equity capital is being treated as a capital-related cost for the rate of increase ceiling (§ 405.463), and the prospective payment system.

Under regulations at § 405.429, we have, since 1966, determined the amount of the allowable return on equity "by applying to the provider's equity capital a percentage equal to one and one-half times the average of the rates of interest on special issues of public debt obligations issued to the Federal Hospital Insurance Trust Fund for each of the months during the provider's reporting period or portion thereof covered under the program". (§ 405.429(a)(1))

However, section 1886(g)(2) of the Act, added to title XVIII by Pub. L. 98–21, enacted April 20, 1983, provides that the amount of allowable return on equity capital related to inpatient hospital services shall "be equal to amounts otherwise allowable under regulations in effect on March 1, 1983, except that the rate of return to be recognized shall be equal to the average of the rates of interest, for each of the months any part of which is included in the reporting period, on obligations issued for purchase by the Federal Hospital Insurance Trust Fund." This provision is effective for cost reporting periods beginning on or after the date of enactment, that is, April 20, 1983.

We issued appropriate instructions revising chapter 12 of the Provider Reimbursement Manual (HCFA Pub. 15–1, Transmittal 292) in July, 1983. In addition, we are making conforming changes to our regulations at § 405.429(a)(1), in order to make clear that the rate of return on equity capital related to inpatient hospital services, as calculated for cost reporting periods beginning before April 20, 1983, is calculated in an identical manner, but set at a reduced level, for cost reporting periods beginning on or after April 20, 1983. No other regulatory changes are necessary to implement section 1886(g)(2) of the Act.

I. Inpatient Routine Nursing Salary Differential—§ 405.430

Section 103 of TEFRA eliminated this differential effective with services furnished on or after October 1, 1982. As a result, § 405.430 does not affect cost reporting periods ending on or after September 30, 1983. Therefore, we are eliminating this section effective October 1, 1983.

J. Physical and Other Therapy Services Furnished Under Arrangements—§ 405.432

Section 1861(v)(5) of the Act specifies that the reasonable cost of therapy services furnished under arrangements shall not exceed the amount that would be payable on a salary-related basis. The statutory provision is intended to control program expenditures and to prevent abuse. This abuse generally occurs by therapists contracted by other providers who have little or no financial incentive to control therapy costs. Since the costs of providing therapy services under arrangement are operating costs, the salary equivalency guidelines will not be applicable to inpatient hospital services covered under the prospective payment system. With respect to hospitals that are excluded from the prospective payment system, we believe that the rate of increase limitation under § 405.463 establishes a definite incentive to provide services in a prudent and cost-conscious manner and that the guidelines are unnecessary to assure that the requirement of Section 1861 (v)(5) is met with respect to inpatient hospital services. Therefore, effective with cost reporting periods beginning on or after October 1, 1983, inpatient hospital services will be excepted, under a new provision at § 405.432(f)(4), from the guidelines if the costs of the therapy services furnished under arrangements are subject to the provisions of §§ 405.463 or 405.470. The guidelines will continue to apply to services furnished to outpatients and to patients of a hospital-based SNF or hospital-based HHA, as well as for other providers reimbursed on a reasonable cost basis.

K. Swing-Bed Hospitals—§§ 405.434 and 405.452

On July 20, 1982, we published interim final regulations (with a comment period), implementing section 904, the "swing-bed" provision, of Pub. L. 96–499 (47 FR 31518).

This provision allowed certain small rural hospitals to use their inpatient facilities to furnish skilled nursing facility (SNF) services to Medicare and Medicaid beneficiaries, and intermediate care facility (ICF) services to Medicaid beneficiaries. These hospitals are reimbursed for SNF and ICF services at rates appropriate to those services, which are generally lower than hospital rates. Special Medicare reimbursement rules for swing-bed hospitals were established at § 405.434, and special provisions for determining the appropriate cost of hospital and SNF services for purposes of Medicare reimbursement were added to § 405.452, Determination of cost of services to beneficiaries.

Those regulations governing Medicare reimbursement for swing-bed hospital services were based on reasonable cost reimbursement principles. However, under the prospective payment system, swing-bed hospitals are not excluded from prospective payment for the inpatient hospital services they furnish, and therefore we must change our method for paying swing-bed hospitals for inpatient hospital services. Since the prospective payment system applies only to payment for inpatient hospital services, the swing-bed regulations on

Medicare reimbursement for SNF-type routine and SNF-type ancillary services furnished in a swing-bed hospital will not change. That is, routine SNF-type services will continue to be reimbursed based on the prior calendar year Statewide Medicaid rate, and ancillary services furnished to swing-bed patients will continue to be reimbursed on a cost basis.

Under the present system, routine service costs applicable to swing-bed patients are subtracted (that is, carved-out) from total inpatient general routine service costs before computing the cost of furnishing routine services to hospital inpatients. The carve-out calculation is not appropriate under the prospective payment system because Medicare reimbursement for inpatient hospital services will not be based on cost. Swing-bed hospitals subject to the prospective payment system will be paid like any other hospital and the carve-out provision will not be applied.

Therefore, in these interim final regulations, we are amending existing swing-bed regulations as follows:

- § 405.434(c)(3) is revised to provide that the cost of swing-bed ancillary services will be determined in the same manner as the reasonable cost of other ancillary services furnished by the hospital which are not inpatient services.
- The provisions of § 405.452(b)(3) (now located at § 405.452(b)(2)) are being revised to stipulate that the carve-out method for computing general routine inpatient hospital service costs does not apply to swing-bed hospitals that are subject to prospective payment.

L. Costs of Services to Beneficiaries—§ 405.452

Most of the provisions of § 405.452 have become obsolete. We are deleting those provisions and reorganizing the rest of the regulation.

M. Private Room Cost Differential—§ 405.452

We are amending the Medicare regulations on cost apportionment (42 CFR 405.452) to revise the methodology for computing reimbursement for inpatient general routine service costs. The regulations now provide that for cost reporting periods beginning October 1, 1982, or later, that in computing reimbursement for inpatient routine services, the difference in costs between private and semiprivate accommodations will be reimbursed only when private rooms are furnished to Medicare beneficiaries for medically necessary reasons. For hospitals subject to the prospective payment system, it will no longer be necessary to determine the higher costs of private rooms since the same amount per discharge will be paid regardless of whether private or semiprivate accommodations are provided. (Hospitals will, however, continue collecting the private room charge differential when private rooms are requested and are not medically necessary.)

N. Cost Data and Cost Finding—§ 405.453

Section 405.453(g) sets forth rules on outstanding current financing payments. All such cases involving current financing are now referred to either the General Accounting Office or to the Department of Justice for collection. Removal of this provision for future cost reporting periods will not affect the status of existing overpayment cases.

O. Lower of Cost or Charges—§ 405.455

We are revising the regulations at 42 CFR 405.455 to provide that the lower of cost or charges (LCC) provision will not apply to the determination of payment for Part A Medicare inpatient hospital services under either the rate of increase or the prospective payment system. With respect to the rate of increase provision, section 1886(b) of the statute, enacted by section 101 of TEFRA effective for cost reporting periods beginning on or after October 1, 1982, provides that the rate of increase ceiling provisions are to be applied in determining payment for inpatient operating costs notwithstanding section 1814(b) which is the LCC provision. With respect to hospitals subject to the prospective payment system, payment for inpatient operating costs is to be made on the basis of a fixed amount per discharge rather than on the basis of the lower of reasonable costs or charges.

We are discontinuing application of the lesser of cost or charges rule with respect to all Part A Medicare inpatient hospital services, effective October 1, 1982, rather than suspending application of the rule for only the operating costs of inpatient hospital services. "Operating costs of inpatient hospital services" are defined under the statute as "all routine operating costs, ancillary services operating costs and special care unit operating costs with respect to inpatient hospital services." Operating costs exclude capital-related costs, and costs allocated by a hospital to approved medical education programs, such as nursing school or approved intern and resident programs, on its Medicare cost report. In order to apply the lesser of cost or charges rule to capital-related costs, and costs of medical education programs, we would have to identify separate charges for these costs. However, hosptials generally do not establish separate charges for these types of costs. Therefore, we would be imposing a significant new recordkeeping burden on hospitals if we were to apply the lesser of cost or charges rule to these costs. For this reason, we have chosen to discontinue application of the lesser of cost or charges rule with respect to all Part A Medicare inpatient hospital services furnished in cost reporting periods beginning on or after October 1, 1982.

We do not permit any unreimbursed costs from a prior cost reporting period to be recovered in any cost reporting period in which the allowable costs for that cost reporting period will exceed the cost limits established for inpatient hospital operating costs under 42 CFR 405.460. Therefore, we are also revising 42 CFR 405.455(d)(1) to state that we will not permit unreimbursed costs from a prior cost reporting period to be recovered in a current cost reporting period if the allowable costs of the current cost reporting period will exceed the rate of increase ceiling under 42 CFR 405.463.

P. Hospital Cost Limits–§ 405.460

Pub. L. 98–21 enacted section 1886(a)(1)(D) of the Act to provide that cost limits on hospital inpatient operating costs established under section 1886(a) would not apply to hospital cost reporting periods beginning on or after October 1, 1983. We had implemented section 1886(a) by amending our regulations at 42 CFR 405.460, which had been established to implement the cost limits authorized by section 1861(v)(1)(A) of the Act, as amended by section 223 of Pub. L. 92–603.

We are now further amending § 405.460 to provide that it does not apply to the operating costs of inpatient hospital services furnished in cost reporting periods beginning on or after October 1, 1983. With this one qualification, section 405.460 continues in effect unchanged, and we will continue to issue cost limits on SNF and HHA services under its authority. Further, we could at a future date, issue limits on hospitals' reimbursable costs, such as outpatient or capital-related costs, under the authority of § 405.460 and section 1861(v)(1) of the Act.

Q. Rate of Increase Limit—§ 405.463

In addition to establishing the prospective payment system, Title VI of Pub. L. 98–21 amended section 1886(b) of the Act which is implemented by regulations at § 405.463. Section 601(b) of Pub. L. 98–21 provided that:

- The rate of increase limit would continue indefinitely instead of being limited to 3 years duration;
- The target rate percentage must be based on a prospective estimate of the market basket increase;
- The rate of increase ceiling applies to all hospitals excluded from the prospective payment system under section 1886(d) of the Act; and
- The existing provisions on the FICA adjustment, which had not been implemented, were repealed, and a new paragraph 1886(b)(6) was added to the Act providing for adjustment of base period costs to account for FICA taxes incurred by a hospital that had not incurred such taxes in its base period.

In addition, section 601(a) of Pub. L. 98-21 amended the definition of inpatient operating costs for all hospitals under Medicare (see amended section 1886(a)(4) of the Act); therefore, changes are required in the rate of increase ceiling regulations.

As a result of these statutory amendments, we are amending § 405.463 in several ways:

- We are deleting all references to the inapplicability of the rate of increase limits to cost reporting periods beginning on or after October 1, 1985. Section 405.463 will now apply indefinitely.
- We are clarifying the costs subject to the ceiling, representing that for cost reporting periods beginning on or after October 1, 1983, only capital-related costs and the direct costs of approved medical education programs will be excluded from the ceiling. Hospitals must treat such costs consistently with treatment in their base period.
- We are providing that the target rate percentages by which target amounts will be determined will be published in a quarterly **Federal Register** notice. Target rate percentages will still be prorated for cost reporting periods that span portions of two calendar years. Further, we have made it explicit in the regulations that we will not retroactively adjust the prospectively set target rate percentages if the actual increase in the market basket differed from the estimate.

R. Physician Compensation Limits—§ 405.482

On March 2, 1983, we published in the **Federal Register** (48 FR 8902) final regulations on payment for physician services furnished in providers. (On May 31, 1983, we also published a notice (48 FR 24308) delaying the effective date of those rules from May 31, 1983, to October 1, 1983, coinciding with the effective date of these regulations.) Among other provisions, those regulations established reasonable compensation equivalent (RCE) limits on the amount of physician compensation allowable under Medicare for furnishing services to providers, implementing section 1887(a)(2) of the Act, enacted by section 108 of TEFRA.

Since March 2, 1983, Pub. L. 98-21 established the prospective payment system implemented in these regulations. Conforming changes made to section 1887(a)(1) by section 602(i) of Pub. L. 98-21 ensured that payment for physician services to included would be in prospective payments for inpatient hospital services. However, section 1887(a)(2) was not amended and applies only to cost reimbursement. As a result, RCE limits do not apply to the operating costs of inpatient hospital services paid for under the prospective payment system.

Therefore, we are amending § 405.482 to provide that the RCE limits do not apply to physician compensation related to inpatient hospital services paid for under the prospective payment system. As a result, we will apply these limits to inpatient operating costs, beginning October 1, 1983, only to hospital cost reporting periods, or portions thereof, that are not subject to the prospective payment system. However, even after a hospital comes under the prospective payment system, the RCE limits will apply to the hospital's outpatient costs.

S. Physician's Assumption of Provider Operating Costs—§ 405.550(e).

This provision was also added by the March 2, 1983 rules on payment for physician services furnished in providers. This paragraph had differing effective dates as set forth in § 405.550(e)(2) due to the impact of its provisions on lease arrangements, particularly the long-established relationships. Generally, these rules were to be effective June 30, 1983, but for such arrangements that predated the Medicare program, application of these rules was delayed until March 2, 1985. The rules made no provision for separate treatment of services based on the inpatient or outpatient status of provider patients.

As noted above, Pub. L. 98-21 established a new section 1862(a)(14), affecting services furnished to hospital inpatients, including those furnished by leased departments. In order to evaluate the relationships between the prospective payment legislation and the March 2, 1983 rules, the effective date of the entire package was delayed until October 1, 1983. The May 31 **Federal Register** notice (48 FR 24308) that announced this delay was not specific on the application of the rules to providers which would have qualified for the March 2, 1985 effective date.

The question now being addressed is whether the rules in § 405.550(e) should be applied with respect to services furnished to outpatients in those hospitals in which lease arrangements were established before July 1, 1966. We have decided that in view of the requirement of section 1862 (a)(14) and the exception to that requirement made available under section 602(k) of Pub. L. 98-21, we are deleting paragraph (e)(2). Thus, the March 2, 1985 effective date is not applicable to any hospital services. Hospitals that are granted the special waiver for the 3-year transition period under section 602(k) of Pub. L. 98-21 may continue to have such arrangements for outpatient services as well. No requests for exceptions from compliance with section 405.550(e) for services to outpatients will be considered.

In addition, we are making minor changes in the language of the other provisions of paragraph (e) to conform to the prospective payment system.

T. Payment for Anesthesia Services Furnished Directly by a Physician

Medicare policy has permitted payment for a physician's personally furnished anesthesiology services and anethetist services furnished "incident to" a physician's service in the same way, that is, on a reasonable charge basis under Part B, and in the same amount, that is, the reasonable charge for such service has been the same for an individual physician whether the service was personally furnished or furnished by an anesthetist in his or her employ. The final rules published on March 2, 1983, limited the number of concurrent services furnished by anesthetists that would qualify for reasonable payment. This limitation applied to services furnished "incident to" a physician's service. (We also, for the first time, provided for payment on a reasonable charge basis for a physician's medical direction of CRNAs not in his or her employ, but this change is not pertinent to this discussion.) Further, we provided a specific method for determining the reasonable charge for a physician's concurrent service.

We assumed that generally it would be understood that the method established in §§ 405.552 and 405.553 would apply when the carrier determined the reasonable charge for an anesthesiology service that was personally furnished by a physician. However, we did not explicitly provide this in our regulations. It is, of course, necessary to determine reasonable

charges for similar services in the same way. The carrier considers, in determining a reasonable charge, both the physician's customary charge for the service and the prevailing charge for the service in the locality. The prevailing charge is intended, among other things, to cover 75 percent of the customary charges made for similar services in the same locality during a specified period. It is only possible to do this if our carriers use a single system.

In the case of anesthesia, since physicians generally vary their charge for anesthesia services based on the duration of the surgery, the system we (and many Blue Shield Plans) use recognizes this factor. The majority of anesthesiologists bill charges that are derived from procedure-specific base units to which they add units for time intervals, e.g., 10, 12, or 15 minutes of elapsed time. They multiply the total units (e.g. base plus time) by a dollar amount to arrive at their charge for an individual service. Hence, our carriers base the customary and prevailing charges for anesthesiology services on the dollar amount multiplier because this is the sole constant factor used by most anesthesiologists nationwide. This is the applicable method for determining Medicare reasonable charges for personally furnished anesthesiology services, services of anesthetists that are "incident to" an anesthesiologist's services, and when applicable, for the "medical direction" an anesthesiologist furnishes to anesthetists who are not in his employ.

After publication of the March 2, 1983 final rules we received comments on how this would apply to physicians furnishing services directly, since there are some who do not set their charges this way. We have discussed those comments and our response to them in the notice on payment for physician services published elsewhere in this issue of the **Federal Register**. As a result, we are amending our regulations at §§ 405.552 and 405.553 to explicitly refer to services furnished by a physician without the assistance of an anesthetist. This conforms those provisions to our original intent, and ensures consistent payment for anesthesia services.

(Note: See section IV. D. of this preamble for other changes affecting payment for anesthesia services.)

U. Reimbursement of Health Maintenance Organizations (HMOs)—§ 405.2041(d)

We are amending paragraph (d) of § 405.2041 to delete inappropriate references to reasonable cost reimbursement. This regulation allows an HMO to elect to have providers of services that furnished covered services to the HMO's enrollees paid directly by Medicare. The HMOs will continue to have this election regarding hospitals paid under the prospective payment system.

V. Lifetime Reserve Days—§ 409.65(e)

Medicare provides coverage of up to 90 days of inpatient hospital services in a benefit period. Days of inpatient hospital services count toward this limit without regard to whether the beneficiary chooses to have Medicare pay for them. In addition, each beneficiary has a lifetime reserve of 60 additional days of inpatient hospital coverage to draw on after he or she uses the 90 days in a benefit period. Medicare payment is made for these additional days of hospital care after the 90 days of benefits have been exhausted, unless the beneficiary elects not to have such payment made (and thus save his or her reserve days for a later time). Under existing regulations at § 409.65, the beneficiary may, subject to certain restrictions, file an election not to use his or her lifetime reserve days for a particular hospital stay or part of a stay.

The option not to use lifetime reserve days for part of the nonoutlier portion of a stay, in conjunction with the prospective payment provisions, would give the beneficiary an advantage in the use of his or her lifetime reserve days not contemplated by the statute. Under § 405.470(b)(2) of the prospective payment regulations, the full prospective payment, exclusive of outliers, will be made for each stay during which the beneficiary receives at least one day of payable care. Thus, under the existing rules, a beneficiary would need to use only one lifetime reserve day for each hospital stay in order to have full prospective payment made on his or her behalf for the stay, not including outlier days, and could save the other reserve days to ensure full prospective payment for up to 59 additional hospital stays.

To avoid this unwarranted expansion of Medicare coverage, we are revising § 409.65(e) of the regulations to provide that if a beneficiary has exhausted his or her regular coverage in the benefit period, any election not to use lifetime reserve days under the prospective payment system must apply either to the entire stay, to all outlier days, or to all outlier days after a specified date. On the other hand, if a beneficiary has one or more days of regular coverage available upon entering the hospital, there will be no advantage in using lifetime reserve days, and he or she will be deemed not to use them, for days which are not outlier days. In this situation, the beneficiary may also elect not to use lifetime reserve days for outlier days but this election must apply either to all outlier days or to all outlier days after a specified date.

W. Technical Corrections

1. On April 5, 1983, we published final rules on coverage of services that are reimbursable under automobile medical, no-fault, or liability insurance, and services to ESRD beneficiaries covered under employer group health plans (48 FR 14802), adding new §§ 405.322 through 405.329 to Subpart C of our regulations. However, we did not at that time amend § 405.301, Scope of subpart, to reflect the new sections. Since we are amending Subpart C in these regulations, we are also correcting the oversight by adding appropriate language to § 405.301.

2. On March 2, 1983, we published in the **Federal Register** (48 FR 8902) final regulations on payment for physician services furnished in providers such as hospitals, skilled nursing facilities, and comprehensive outpatient rehabilitation facilities. Among other changes, those regulations established new §§ 405.550 to 405.556 to Subpart E, setting forth rules on payment on a reasonable charge basis for physicians' services to individual patients furnished in providers.

In these regulations, we are amending portions of those new sections of Subpart E, in order to implement the prospective payment system. However, since publication of those rules on March 2, 1983, we have also found the following technical errors in the regulations text published in that document, and are taking this opportunity to correct them. In § 405.550(d)(2), the word "applicable" was omitted before "conditions in §§ 405.552, 405.554, and 405.556". In § 405.554(b), a cross-reference to "§ 405.551(e)(2)" should have referred the reader to "§ 405.550(e)(2)". We erroneously stated in § 405.556(a) that certain rules would apply to "laboratory services furnished by a physician to an individual inpatient", when, in fact, it was clear from the preamble that we intended those rules to apply to all patients who received services in the provider, whether on an inpatient or outpatient basis. This document corrects that error by changing the term "inpatient" to "patient" in § 405.556(a).

VII. OTHER REQUIRED INFORMATION

A. Effective Dates

These interim final regulations are effective October 1, 1983.

In accordance with section 604(a)(1) of Pub. L. 98–21, these rules will generally apply to hospital cost reporting periods beginning on or after October 1, 1983. This is true of all the regulatory provisions, in particular §§ 405.470 through 405.477, that implement the prospective payment system for inpatient hospital services, and for other conforming changes except as specified.

The interim regulations implementing the "unbundling" provisions of Pub. L. 98–21, that is, sections 1862(a)(14) (added to Act by section 602(e)(3) of the 1983 amendments) and section 1866(a)(1)(H) (added to the Act by section 602(f)(1) of the 1983 amendments), are applied to items and services furnished on or after October 1, 1983, regardless of hospital cost reporting periods, in accordance with section 604(a)(2) of Pub. L. 98–21. This affects the amendments to §§ 405.301(m), 489.21, and 489.23.

In accordance with section 1886(g)(2) of the Act, enacted by section 601(e) of Pub. L. 98–21, the amendments to § 405.429 will be applied for cost reporting periods beginning on or after April 20, 1983.

The provisions of § 405.453(f)(3), relating to changes in cost reporting periods, implement section 604(a)(1) of Pub. L. 98–21 and are effective for cost reporting periods ending on or after the date of publication of these interim rules.

The amendments to § 405.455, referring to payment of the lesser of costs or charges, will be applied to all inpatient hospital services furnished in cost reporting periods beginning on or after October 1, 1982.

Section 602(h)(2) of Pub. L. 98–21 amended section 1878(f)(1) of the Act regarding group appeals. These statutory amendments are self-implementing and were effective April 20, 1983. Therefore, our conforming amendments to regulations in §§ 405.1837, 405.1841, and 405.1877 cite that effective date and will be applied to such appeals as of April 20, 1983.

B. Waiver of 30-day Delay of Certain Effective Dates

As noted above, certain provisions of these interim rules will take effect without a 30-day delay in effective date. The amendments to § 405.429, Return on equity capital of proprietary providers; § 405.1837, Group Appeal; § 405.1841, Time, place, form, and content of request for Board hearing; and § 405.1877, Judicial review, will be applied as of April 20, 1983. The amendments to §405.455, Amount of payments where customary charges for services furnished are less than reasonable cost, will be applied to cost reporting periods beginning on or after October 1, 1982. The provisions of § 405.453(f)(3) relating to changes in cost reporting periods will be applied to cost reporting periods ending on or after the date of publication of these interim rules.

Generally, the Administrative Procedure Act requires us to provide a 30-day delay of a substantive rule (except for a rule that grants or recognizes an exemption or relieves a restriction), unless we find good cause and publish it with the rule (5 U.S.C. 553(d)). We have found good cause to waive this 30-delay for each of the regulation sections cited above.

Regarding § 405.429, section 1886(g)(2) of the Act specifies the applicable date. That statutory requirement is clear and self-implementing. Our amendment to § 405.429 merely conforms our published regulation to existing law and practice. A 30-day delay in implementing this amendment is unnecessary and would violate the statute.

The amendments to section 1878(f)(1) of the Act, requiring conforming changes to §§ 405.1837, 405.1841, and 405.1877, are also effective on the date of enactment of Pub. L. 98–21, April 20, 1983. Further, these changes are procedural, rather than substantive, and the provisions of the law are clear and self-implementing. Therefore a 30-day delay in effective date is unnecessary and impracticable.

The amendment to § 405.453, adding paragraph (3) regarding changes in cost reporting periods, is necessary to implement section 604(a)(1) of Pub. L. 98–21. It is primarily procedural, is necessary to ensure appropriate entry of hospitals into the prospective payment system, and is consistent with the intent of the law. Therefore, a 30-day delay in effective date is unnecessary and not in the public interest.

We have also found a delay in the effective date of § 405.455 to be unnecessary and impracticable. In implementing section 101 of TEFRA, which established a new section 1886 of the Act effective October 1, 1982, we provided, in accordance with the law, that the rate of increase limit implemented by § 405.463 would apply to inpatient hospital services without regard to the lesser of costs or charges provisions of section 1814(b) of the Act, as implemented in § 405.455 (§ 405.463(d)(1)). However, we did not make conforming changes to § 405.455 at the time we implemented § 405.463. As a result, § 405.455 has lacked substantial effect on payments for inpatient hospital services furnished in cost reporting periods beginning on or after October 1, 1982. The amendments made in these interim rules are merely conforming changes that reflect existing law and practice.

C. Waiver of Proposed Rulemaking

The Administrative Procedure Act (5 U.S.C. 553) requires us to publish general notice of proposed rulemaking in the **Federal Register**, and afford prior public comment on proposed rules. Such notice includes a statement of the time, place, and nature of rulemaking proceedings, reference to the legal authority under which the rule is proposed, and the terms or substance of the proposed rule or a description of the subjects and issues involved. However, this requirement does not apply when an agency finds good cause that such a notice-and-comment procedure is impracticable, unnecessary, or contrary to the public interest, and incorporates a statement of the finding and its reasons in the rules issued.

These interim final rules include many amendments to our regulations. Generally, these amendments are necessary for the timely implementation of the prospective payment system established by section 1886(d) of the Act. As such, affording a proposed rulemaking process is impracticable, not in the public interest, and would violate the provisions of Pub. L. 98–21. Section 604(c) of Pub. L. 98–21 requires us to publish in the **Federal Register**, no later than September 1, 1983, interim final rules and an interim final notice of prospective payment rates for purposes of implementing section 1886(d) effective October 1, 1983. (The statute also requires us to afford a period of public comment on the interim final rules and rates, and to affirm or modify them, after considerations of comments, by December 31, 1983.) Therefore, we find good cause to waive proposed rulemaking for those regulatory provisions that are necessary to implement section 1886(d).

Section 1886(d) is primarily implemented by the new regulation provisions in §§ 405.414, 405.470 through 405.477, the amendments to various regulations such as those on utilization review, provider appeals, and lifetime reserve days necessary to avoid direct conflict with the prospective payment system, and the notice of prospective payment rates for hospital cost reporting periods beginning in Federal fiscal year 1984, which is published as an addendum to these interim rules. However, we believe that proper implementation of Pub. L. 98–21 and the prospective payment system

necessitates amendments to other regulations, both to prevent perverse interactions between existing rules and rules implementing prospective payment, and to ensure that the objectives of the prospective payment system are realized. As a result, we are including in these interim final rules a number of amendments to existing regulations that do not directly implement section 1886(d). In each case, however, we believe there is adequate justification for including these amendments with the prospective payment regulations, waiving proposed rulemaking and issuing them in interim final form.

The amendments to §§ 405.310(m), 489.21, and 489.23 implement provisions of sections 602 (e), (f), and (k) of Pub. L. 98–21 that have a statutory effective date of October 1, 1983 under section 604(a)(2) of Pub. L. 98–21. These provisions prohibit the "unbundling" of inpatient hospital services, as discussed in section IV of this preamble, and provide for waiver of that prohibition in certain circumstances. In addition, as also discussed in section IV, we have determined that it is necessary to amend §§ 405.550(e), 405.552, 405.553, 405.555, and 405.556, relating to reasonable charge payments for certain specialist physicians' services furnished in providers, to ensure that these charges appropriately exclude payment for inpatient hospital services furnished by nonphysicians. Implementation of these amendments as of October 1, 1983 is necessary to ensure that payments for inpatient hospital services under the prospective payment system is consistent from hospital to hospital. Because of the statutory effective date and the effect of these provisions on the implementation of section 1886(d) of the Act, we find that affording prior public comment before issuing these regulations in interim form is impracticable and not in the public interest.

Similarly, the amendments to § 405.463, Ceiling on rate of hospital cost increases, implement amendments to sections 1886 (a) and (b) of the Act made by sections 601 (a) and (b) of Pub. L. 98–21. Under section 604(a)(1) of Pub. L. 98–21, these amendments are effective for items and services furnished in cost reporting periods beginning on or after October 1, 1983. Further, since hospitals and distinct part units excluded from the prospective payment system will generally be subject to the rate of increase limits implemented by § 405.463, we believe it is necessary to implement these amendments concurrently with the implementation of the prospective payment system. Therefore, we have found that proposed rulemaking procedures are impracticable and not in the public interest.

We are also amending § 405.421 to clarify the definition of allowable costs for medical education, because certain medical education costs are excluded from payment under the prospective payment system. This was not necessary before, since all the costs were reimbursed on the same reasonable cost basis. However, under the prospective payment system, failure to properly define those medical education costs, for which payment in addition to prospective payments is permitted, could result in unnecessary and inappropriate payments. We have found that prevention of this adverse effect requires rulemaking on an interim basis concurrently with the prospective payment rules. Therefore, we find proposed rulemaking impracticable and not in the public interest.

Several other amendments implement recent statutory changes. These include § 405.429, Return on equity capital; § 405.430, Inpatient routine nursing salary cost differential; § 405.1837, Group appeal; § 405.1841, Time, place, form, and content of request for Board hearing; and § 405.1877, Judicial review. Since these statutory changes are clear and self-implementing, the amendments to these regulations are not necessary to implement section 1886(d). However, in view of the large number of changes we are making in payment practices, and the inevitable confusion that will occur during the initial implementaton of the prospective payment system, we do not believe that it is necessary or in the public interest to delay amending regulations to afford public comment when we have already changed our practices to implement the statute. Therefore, we have found good cause to include these technical and procedural (as opposed to substantive) amendments in these interim rules.

For similar reasons, we have decided to eliminate certain provisions of our Subpart D regulations that are outdated and no longer applied. These include § 405.404 Methods of apportionment under Title IVIII; the provisions of § 405.426(d), Compensation of owners, related to sole proprietorships; § 405.428, Allowance in lieu of specific recognition of other costs; most of the provisions of § 405.452, Costs of services to beneficiaries; and the provisions of paragraph (g) of § 405.453, Cost data and cost finding, relating to outstanding current financing payments. Since formal elimination of these provisions will have no adverse impact, and will not in fact result in changes in our payment practices, we find proposed rulemaking unnecessary.

Finally, we are also amending certain provisions of the Subpart D regulations in order to eliminate certain specialized limits on the costs of inpatient hospital services. We believe that these limits are contrary to the objectives of the prospective payment system. The sections affected by these amendments include § 405.423, Grants, gifts, and income from endowments; § 405.432, Physical and other therapy services furnished under arrangements; § 405.455, Amount of payments where customary charges for services furnished are less than reasonable cost; and the provisions of § 405.452, Determination of cost of services to beneficiaries, related to the private room cost differential. For reasons discussed above, we are eliminating § 405.423 entirely. We are amending the other sections in more limited ways: Sections 405.432 and 405.452 are being amended to ensure that they do not apply to hospitals paid under the prospective payment system, and § 405.455 is being amended to provide that the lesser of cost or charges provision does not apply to the costs of inpatient hospital services. We believe that the incentives established by the prospective payment system and rate of increase limits will appropriately restrain the costs of such services without the necessity for such intrusive rules on specific costs. Further, these amendments relieve existing restrictions and will simplify and improve program administration. Therefore, we find that delay of these amendments to afford comment before they take effect is unnecessary and contrary to the public interest.

For the above reasons, we find good cause to waive notice and public procedure before implementation of these interim final rules.

D. Paperwork Reduction Act

Certain sections of these regulations contain information collection requirements that are subject to the provisions of the Paperwork Reduction Act of 1980 (44 U.S.C. 3507). As required by that act, HCFA requested Office of Management and Budget (OBM) approval of these requirements. Under 44 U.S.C. 3507(g), OBM granted approval for 90 days after the date of publication of the regulations (September 1, 1983) under the following control numbers:

Section	Control Number
§ 405.476(d)(2)	0938-0308
§ 405.1042(c)	0938-0305
§§ 405.1627 and 405.1629	0938-0306
§ 489.23(b)(2) and (c)	0938-0304
§ 405-476(b)	0938-0309

We will submit a request for continued approval of the information collection requirements to OMB and will publish a notice in the **Federal Register** before the expiration of the interim OMB approval date when the continued approval is obtained.

The reporting requirements on base-year adjustments described in § 405.474(b)(2)(ii) and in section V. A.1. of the addendum are approved by EOMB. The control number is 0938–0288. The form that collects this data is the HCFA–1008, "Transmittal of Supplementary Information for Determination of the Target Amount Under the Medicare Prospective Payment System".

E. Public Comments

We are providing an opportunity for comment on these interim final rules in accordance with requirements in section 604(c)(1) of Pub. L. 98–21. Although these rules generally will be effective on October 1, 1983, regardless of comments received by that date, we will consider all comments received by the date specified in the "Dates" section of this preamble in the development of the final rules, which is to be published by December 31, 1983. Because of the large number of comments we receive, we cannot acknowledge or respond to them individually.

VIII. IMPACT ANALYSES

A. Executive Order 12291 and the Regulatory Flexibility Act

Executive Order 12291 requires that a regulatory impact analysis be performed on any major rule. A "major rule" is defined as one which would:

- Result in annual effect on the national economy of $100 million or more;
- Result in a major increase in costs or prices for consumers, any industries, any government agencies, or any geographic regions; or
- Have significant adverse effects on competition, employment, investment, productivity, innovation or on the ability of U.S.-based enterprises to compete with foreign-based enterprises in domestic or import markets.

The Regulatory Flexibility Act requires that a regulatory flexibility analysis be prepared when a notice of proposed rulemaking is utilized. For purposes of the Regulatory Flexibility Act, small entities include all nonprofit and most for-profit hospitals.

Under both the Executive Order and the Regulatory Flexibility Act, such analyses must, when prepared, examine regulatory alternatives which minimize unnecessary burden or otherwise assure that regulations are cost-effective.

We are treating these regulations as a major rule under Executive Order 12291. Although the statute requires that the prospective payment system be budget neutral in fiscal years 1984 and 1985, we anticipate that the changed incentives of the system will result in annual program savings exceeding $100 million in subsequent years. Accordingly, the Executive Order definition of a "major rule" is met. The major features of the prospective payment system are specified in the statute, and we do not have administrative discretion to develop alternatives to them. The statute does allow the Secretary some administrative discretion in the implementation of the prospective payment system, and we will examine these provisions in another part of this analysis.

Because of the extensive changes in our methods of paying for inpatient hospital services under this rule, we are providing the following discussion which, combined with the rest of this preamble, constitutes a preliminary regulatory impact analysis and a preliminary and voluntary regulatory flexibility analysis. We solicit comments and factual information that would enable us to describe and quantify in greater detail the effects of the rule in the final analyses.

B. Nature of the Problem of Increased Health Care and Hospital Costs

Numerous studies have highlighted the dynamic growth in health care spending in the United States, particularly the rapid increase in Medicare program hospital costs. These cost issues have been, for many years, a focal point of discussion and action on the part of all levels of government and various sections of the health care industry. Of concern to us is that these increasing Medicare expenditures constrain the ability of the Federal government to fund other needed programs.

Hospital care represents a significant portion of present and projected health care expenditures. The cost increases experienced by hospitals, and the Medicare program, appear to be caused by several factors. Primary among these is general inflation in the economy. Inflation contributes significantly to the rapid rise in hospital costs particularly with regards to employee salaries and hospital supplies and equipment. A second contributing factor is the absence of traditional supply and demand forces operating to curb excessive expenditures. As third-party payors of medical care, including Medicare, cover an increasing portion of consumer medical care costs, the normal restraints on utilization and price that in other sectors of the economy are provided, in part, by consumers' capacity to pay, have been weakened. Decreasing consumer financial risk when medical care decisions are made tends to increase consumer demand for medical care services; this further exacerbates excessive health care expenditures.

A third factor is Medicare's current cost reimbursement system, which by its very nature tends to aggravate this cost problem. The economic incentives of this system contribute to cost increases by rewarding hospitals and physicians who increase utilization and thus their allowable reimbursable costs. There is little incentive for hospitals and physicians to operate more efficiently as all allowable costs are fully reimbursed.

A fourth factor that contributes to cost increases is the growth and increasing age of the beneficiary population.

As the percentage of the aged rises in contrast to the general population, the intensity and the costs of services rise because of the increased prevalence of chronic conditions and the incidence of serious illness common to the elderly. This trend can be seen especially among persons aged 75 years and over, an ever-increasing portion of the beneficiary population.

The combined effect of these factors is the explosion of overall health care utilization and expenditures, and of particular interest to the Medicare program, its payments for hospital care provided to beneficiaries.

C. Prospective Payment System as the Best Response to Certain Problems Related to Medicare Hospital Rate of Increase

Prospective payment rates begin to address increased hospital utilization by providing hospitals with a fixed set of payment rates for each type of discharge. Prospective rates represent a set of prices with characteristics similar to the prices a hospital would face in a more conventional market. The hospital knows the amount it will be paid per discharge and that the payment rate will remain unchanged regardless of its own cost experience. Of importance to the Medicare program, is that a prospective payment system will tend to restructure

the current incentives that influence the use of hospital resources and, therefore, the amount of Medicare payments for inpatient hospital services. As a means of restraining hospital expenditure growth, prospective payment places hospitals at risk in terms of the management of their operations and the use of their resources. Thus, we believe that this system will begin to address some of the serious problems inherent in the present cost reimbursement payment methodology and, therefore, will allow us to better manage the Medicare program and preserve the integrity of the trust funds.

Under this rule, hospital payment will be related to the treatment provided to each patient. However, since patients have different diagnoses, require different treatments, are of different ages, and differ in other ways, it is important that the payment system explicitly adjust for these differences. The failure of any system to account for these differences would severely harm certain types of hospitals.

In recognition of these concerns, Congress has determined that these differences will be accommodated by the use of diagnosis related groups (DRG) as the basis of payment determinations. This patient classification system has been under development at Yale University since 1969 and has been used in New Jersey's hospital reimbursement system since 1979.

DRGs offer the following advantages that will allow us to make prospective payment in full to hospitals for services provided to Medicare beneficiaries:

- The category definitions cover virtually the entire patient population;
- The groupings have been extensively reviewed by physicians for clinical coherence throughout their development;
- The DRGs conform closely to the organization (by clinical specialty) of the delivery of inpatient care in the hospital;
- The DRGs group those inpatient cases together which are generally quite similar in use of resources; and
- The DRGs allow inpatient records to be easily classified by an efficient computer program using readily available discharge abstract data.

Congress concluded that, based on these considerations, the DRG prospective payment system is the best available response to the problems of increased hospital expenditures currently experienced by the Medicare program.

D. Economic Impacts

As noted above, this analysis constitutes a voluntary regulatory impact analysis and a voluntary regulatory flexibility analysis. This portion of the analysis will discuss our estimates of the various impacts that are likely to result from the prospective payment system. We will discuss the impact on hospitals and beneficiaries and also examine the effect of this system on Medicare program operations. Finally, we will discuss the impacts resulting from other provisions within this final rule.

- *Hospital Impact*—During its first two years, aggregate payments under the prospective payment system will be adjusted, in accordance with Section 1886(e)(1) of the Act, to be "budget neutral"; that is, so that aggregate payments under the prospective payment system, including outlier payments, exceptions, and adjustments, will be neither more nor less than the estimated payment amounts to affected hospitals that would have resulted under the Social Security Act as in effect before April 20, 1983. During the three years of the transition period, payment rates to about 5500 hospitals will be a blend of hospital-specific amounts based on each hospital's cost experience, and Federal amounts based on the averaged experience of hospitals. (See section III. C. of the preamble.) The initial impact of the prospective payment system will be like the impact that would have occurred to affected hospitals under the TEFRA provisions, because the hospital-specific portion of the first year's rate will be set at 75 percent of the TEFRA target amount. However, this impact will gradually change during the transition period, as the hospital-specific portion of the payment rate will be set at an increasingly lower percentage of each fiscal year's TEFRA target amounts. To correspond to the budget neutrality provision of the law, this estimated impact assumes no change in hospitals' economic behavior in response to this system.

However, prospective payment systems will change the economic incentives that influence a hospital's decisions in the use of resource inputs for each case. The profit potential inherent in this system alone should encourage hospitals to begin changing their behavior to decrease their operating costs. We believe that individual hospitals with lower current year operating costs per case will probably do better under this system than hospitals that cannot reduce or control these costs.

We also anticipate minimal differential impacts between hospitals in the first year, compared to the impact under the TEFRA provisions. Since we are required to use a transition period payment formula that blends both hospital-specific cost experience and Federal rates, the differential impact resulting from bed size or other economic factors, should not be significant between hospitals. This difference in impacts could be more pronounced in the long-run relative to each hospital's ability to respond to the incentives of this payment system.

The following provisions in the legislation seek to further moderate the impact of the prospective payment system.

- *Three-year Transition Period*—The phase-in process will not only reduce the possibility of a hospital experiencing extreme losses or profits during the initial years of this payment system, but it will also offer a financial incentive for improved hospital productivity throughout this period.
- *Blending of National and Regional Prospective Payment Rates*—During the second and third years of the transition period, the Federal portion of the prospective payment rates will be determined by using a blend of regional standardized amounts for urban and rural areas in addition to the national standardized amounts. This blending recognizes that there are some regional variations that exist in the cost of providing hospital care.
- *Other Provisions*—Other considerations aimed at moderating any impact include the exclusion of certain costs, wage adjustments, additional payments for the indirect costs of approved graduate medical education programs and additional payments for unusually long stay or costly cases.

We believe that hospitals can also temper any impact they experience resulting from this payment system. Several examples of management strategies that could be used by a hospital include:

- Management control systems that allow managers to formulate and monitor various efforts at improving the performance of individual cost centers. These control systems would provide information about the cost influencing variables that impact on a hospital's performance;
- Improving medical data processing and billing routines. The task of accurately coding and processing medical records is important in any hospital setting. Under prospective payment, medical records will become crucial because they indicate the

diagnoses, procedures, and factors used in determining which DRGs should be assigned and, therefore, how much a hospital is paid; and

• Examining the present relation of hospital management and attending physicians to determine the appropriate extent of physician involvement in the management control process. This is necessary because of the direct authority attending physicians have over inputs per case, which are key components of any hospital's costs. Also, there is demonstrable variation in treatment patterns among physicians according to various physician characteristics, such as specialty, Board certification, and age, which must be considered in selecting management strategies.

In the implementation of this system, we exercised some discretion in designing the following provisions with potential impact on hospitals. Alternative, non-selected criteria are discussed elsewhere in this preamble. Our rationale for these decisions is discussed below:

• *Criteria for Excluded Hospitals*—In establishing these criteria, we determined that a restrictive definition for excluded hospitals was preferred. A precise definition reduces potential administrative problems with intermediary billing determinations and ensures that appropriate payment is made to each hospital.

• *Exceptions and Adjustments Criteria*—We have adhered to the statute concerning exceptions and adjustments in developing these criteria. We believe that this decision preserves the integrity of the prospective payment system by limiting the number of hospitals that might receive an exception or an adjustment. To allow for numerous exceptions and adjustments could alter the payment amounts to other prospective payment hospitals in a manner not intended by Congress in requiring a budget neutral position. This definition will also cause hospitals to focus on ways to reduce operating costs instead of seeking ways to gain exceptions or adjustments.

• *Criteria for Waiver of Nonphysician Services Requirement*—Effective October 1, 1983, all non-physician inpatient services must be furnished under Part A directly by the hospital or billed to the hospital by the outside supplier. The statute gives the Secretary authority to waive this requirement and permit continued Part B billing during the transition period where the services have been so extensively billed under Part B that immediate compliance would threaten the stability of patient care. We selected a stringent approach in implementing this provision to ensure that a limited number of hospitals will operate under this waiver prior to October 1, 1986. To grant waiver status to others would result in administrative difficulties and increased costs in facilitating the billing requirements of such an arrangement.

• *Establishing Prospective Payment Prices*—The law is very specific regarding how prices shall be determined for operating costs of inpatient hospital services. However, some technical discretion is required to develop many of the technical features of the payment system. In developing this system we believe that we are using the best methodology available.

• *"Incident To" Provision*—Section 602(e)(3) of Pub. L. 98–21 establishes a new section 1862(a)(14) of the Act and provides the statutory authority, we believe, to include services "incident to" physicians' services furnished to hospital patients as hospital services paid for from the Part A trust fund instead of as Part B physicians' services. We are exercising our discretion in this manner to ensure consistency in determining which services are to be paid as hospital services and which services can be billed separately under Part B.

We believe that our discretion in all of these cases will result in cost-effective outcomes and will preserve the integrity of the prospective payment system.

• *Operational Impact*—To implement the prospective payment system, intermediaries will be required to make some changes in their claims processing system, increase auditing activities, and train providers to submit appropriate forms. The intermediaries will be reimbursed in full for their costs. The estimated incremental administrative costs for implementing and operating the prospective payment plan are: $27.5 million in FY 1983, $17 million in FY 1984, and $3.8 million in FY 1985.

• *Beneficiary Impact*—We believe that Medicare beneficiaries will be affected by the prospective payment system in several ways. First, their financial liability will remain limited to the coinsurance and deductible payments mandated by Congress. However, some beneficiaries will be advantaged by our prohibiting the "unbundling" of Part A services (as discussed in section IV of the preamble). Their previous Part B coinsurance payments for these services would now be eliminated as these services are now considered inpatient hospital services subject to the prospective payment methodology.

Second, we anticipate that quality of care for beneficiaries will be maintained or improved. Quality of care is protected in a number of ways separate from this regulation, and results of several recent studies indicate that prospective payment programs operating to date have not compromised the quality of care provided in hospitals, even while such programs generally reduce the intensity of care provided to patients. In addition, insofar as prospective payment encourages specialization in certain services, we believe treatment may be improved for beneficiaries and other patients. And insofar as prospective payment acts to constrain cost increases, it will contribute to maintaining the affordability and accessibility of quality care.

We intend to monitor admission and physician practice patterns to ensure that beneficiaries continue to receive care that is reasonable and necessary and of good quality.

• *Impact of Other Provisions*

—Section 1886(c) of the Social Security Act sets forth the conditions and procedures under which Medicare payment will be made for hospital services under State reimbursement control systems. This provision immediately impacts hospitals in four States (New York, Massachusetts, Maryland and New Jersey). The impact of this provision is examined in the Impact Analysis section of the "Recognition of State Reimbursement Control Systems" final rule published separately in another **Federal Register** issue.

—Section 601(b) of Pub. L. 98–21 amends section 1886(b) of the Act. This amendment sets forth target rate percentages needed to limit the rate of increase on hospital inpatient operating costs and related updating factors for use in computing the hospital-specific portions of transition payment rates under the prospective payment system. The impact resulting from this provision is examined in the final notice for "Schedule of Target Rate Percentages" published elsewhere in this **Federal Register** issue.

—We have noted several conforming changes in section VI. of the preamble. These changes must be made to make our existing regulations consistent with the objectives of the prospective payment system and the statutory changes made by Pub. L. 98–21. We are also including some technical corrections that have no economic impact.

We believe that apart from the return on equity capital provision (§ 405.429), these changes do not result in significant

economic impacts. We estimate that the amendment to the return on equity capital provision will generate $100 million in savings in FY 1984 and $115 million in FY 1985. However, this impact results from the statute (section 1886(g)(2) of the Act) and not this regulation, which merely implements the statute.

E. Benefits

This change in our payment methods will result in numerous net benefits to society and to the Medicare program. In the near term, these benefits will probably not result in a significant impact on the economy. Due to our phasing-in of the payment system, the full extent of the anticipated benefits will be realized when the system is fully operational and hospitals have implemented cost-effective management strategies in response to the system.

Included among these benefits are:

- Restructuring the economic incentives facing the health care system to establish market like forces;
- Restraining hospital cost increases which will preserve the integrity of the Medicare trust funds and the financial status of other payors;
- Adopting an active role on behalf of Medicare beneficiaries, in determining payment made for inpatient services. This will establish the Federal government as a prudent buyer of services;
- Payment being based upon the type of discharge will identify, more accurately than the present system, the product being purchased on behalf of Medicare beneficiaries. This approach over time will have desirable effects regarding hospitals' decisions on which services to provide.
- A strong link between payment and diagnosis, along with the ability for hospitals to retain any amounts by which their prospective payment rates exceed their costs. This will invite more active medical participation in the financial and operating routines of hospitals; and,
- Providers being able to identify, in terms of revenue to the institution, what services they deliver well and what services they do not provide efficiently.

F. Conclusion

Taken together, these statutory and regulatory provisions and the flexibility these rules provide hospitals mean that these rules meet the objectives of E. O. 12291 and the Regulatory Flexibility Act, including:

- Minimization of significant economic impact on small entities, including use of timetables, adjustments for geographic and other differences, and use of performance rather than design standards; and
- Choosing alternatives involving the least net cost to society, taking into account the conditions of the hospital industry.

List of Subjects

42 CFR Part 405

Administrative practice and procedure, Certification of compliance, Clinics, Contracts (Agreements), End-Stage Renal Disease (ESRD), Health care, Health facilities, Health maintenance organizations (HMO), Health professions, Health suppliers, Home health agencies, Hospitals, Inpatients, Kidney diseases, Laboratories, Medicare, Nursing homes, Onsite surveys, Outpatient providers, Reporting requirements, Rural areas, X-rays.

42 CFR Part 409

Blood, Health insurance, Home health, Hospitals, Inpatients, Medicare, Nursing homes.

42 CFR Part 489

Clinics, Health care, Health facilities, Medicare, Provider Agreements, Rural health clinics, Termination procedures.

42 CFR Chapter IV is amended as set forth below:

A. Part 405 is amended as follows:

PART 405—FEDERAL HEALTH INSURANCE FOR THE AGED AND DISABLED

1. Subpart A is amended as set forth below:

Subpart A—Hospital Insurance Benefits

a. The authority citation for Subpart A is revised to read as follows:

Authority: Secs. 1102, 1814, 1815, 1861, 1866(d), and 1871 of the Social Security Act (42 U.S.C. 1302, 1395f, 1395g, 1395x, 1395cc(d), and 1395hh).

b. Section 405.162 is revised to read as follows:

§ 405.162 Prohibition against payment for inpatient hospital services furnished after utilization review finding that further services are not medically necessary.

(a) *Hospital system of utilization review.* If a finding has been made under a hospital system of utilization review (see §§ 405.1035 and 405.1042) that further inpatient hospital services are not medically necessary, payment may be made only for those inpatient hospital services furnished before the fourth day following the day on which the hospital received notice of the finding.

(b) *PSRO and PRO system of review.* If a Professional Standards Review Organization (PSRO) or a Utilization and Quality Control Peer Review Organization (PRO) has assumed review responsibility in accordance with the applicable provisions of § 405.472 and of Part 463 of this chapter for the inpatient hospital services furnished by or in the hospital, the payment limitation described in § 463.17(a) applies to the inpatient hospital services furnished to a beneficiary and shall be in lieu of the payment limitation in paragraph (a) of this section.

(c) If a hospital is paid for inpatient hospital services under the prospective payment system established by §§ 405.470 through 405.477, the payment limitation in paragraph (a) of this section applies only in cases otherwise eligible for outlier payment under § 405.475 if the utilization review committee determines that—

(i) Excess days of care furnished in the case of a length of stay outlier are not necessary to furnish services covered under Medicare Part A; or

(ii) Additional items and services furnished in the case of a high cost outlier are either not covered or not necessary to furnish services covered under Medicare Part A.

c. Section 405.163 is amended by redesignating the previously uncoded paragraph as paragraph (a), revising it, and adding a new paragraph (b). As revised the section reads as follows:

§ 405.163 Prohibition against payment for inpatient hospital services furnished after 20th consecutive day by a hospital which has failed to make timely utilization review.

(a) When HCFA has determined that a hospital has substantially failed to make timely utilization review in long stay cases and has imposed the limitation on days of services provided in section 1866(d), no payment may be made under this Subpart A for inpatient hospital insurance services furnished by such hospital to any individual after the 20th consecutive day on which such services have been furnished to him if the individual is admitted after the effective date of such determination.

(b) HCFA will not make a finding of failure to make timely utilization review, as described in paragraph (a) of this section, that would have the effect of altering prospective payment amounts determined under §§ 405.473, 405.474, and 405.476.

2. Subpart C is amended as set forth below:

Subpart C—Exclusions, Recovery of Overpayment, Liability of a Certifying Officer and Suspension of Payment

a. The authority citation for Subpart C is revised to read as follows:

Authority: Secs. 1102, 1815, 1833, 1842, 1862, 1866, 1870, 1871, and 1879 of the Social Security Act (42 U.S.C. 1302, 1395g, 1395l, 1395u, 1395y, 1395cc, 1395gg, 1395hh, 1395pp), and 31 U.S.C. 3711.

b. Section 405.301 is revised to read as follows:

§ 405.301 Scope of subpart.

Sections 405.310 to 405.320 describe certain exclusions from coverage applicable to hospital insurance benefits (Part A of Title XVIII) and supplementary medical insurance benefits (Part B of Title XVIII). The exclusions in this subpart are applicable in addition to any other conditions and limitations in this Part 405 and in Title XVIII of the Act. Sections 405.322 to 405.325 relate to exclusion of services covered under automobile medical, no-fault, or liability insurance. Sections 405.326 to 405.329 relate to limitations on payment for services to ESRD beneficiaries who are covered under employer group health plans. Sections 405.330 to 405.332 relate to payments for expenses for certain items or services otherwise excluded from coverage. Sections 405.340 to 405.344 relate to limitation on payment for services furnished to employed aged and their spouses. Sections 405.350 to 405.359 relate to the adjustment or recovery of an incorrect payment, or a payment made under section 1814(e) of Part A of Title XVIII of the Act. Sections 405.370 to 405.373 relate to the suspension of payment to a provider of services or other supplier of services where there is evidence that such provider or supplier had been or may have been overpaid.

c. Section 405.310 is amended by reprinting the undesignated introductory material unchanged and adding a new paragraph (m) to read as follows:

§ 405.310 Types of expenses not covered.

Notwithstanding any other provisions of this Part 405, no payment may be made for any expenses incurred for the following items or services.

* * * * *

(m)(1) Except as provided under paragraph (m)(3) of this section, items, supplies and services furnished to hospital inpatients on or after October 1, 1983, that—

(i) Do not meet the criteria set forth in § 405.550(b) that describe services of physicians to provider patients that are reimbursable on a reasonable charge basis; and

(ii) Are not furnished by the hospital either directly or under arrangements as defined in § 409.3 of this chapter.

(2) Items, supplies, and services (other than physicians' services to individual patients) that are excluded if they are not furnished directly or under arrangements include, but are not limited to—

(i) Clinical laboratory services;

(ii) Pacemakers;

(iii) Artificial limbs, knees, and hips;

(iv) Intra-ocular lenses;

(v) Total parenteral nutrition; and

(vi) Services and supplies furnished incident to physicians' services (except for anesthetist services that continue to be billed for by a physician employer under § 405.553(b)(4)), as described in §405.231(b).

(3)(i) Except as provided in paragraph (m)(3)(ii) of this section, the items, supplies, and services described in paragraphs (m) (1) and (2) of this section—

(A) Are inpatient hospital services;

(B) May not be paid for under Medicare Part (B); and

(C) Must be billed by the hospital to its intermediary under Medicare Part A for the hospital to be paid for such services.

(ii) A hospital may seek payment under Medicare Part B for the items and services described in paragraphs (m) (1) and (2) of this section only if—

(A) No payment will be made for such items or services under Medicare Part A; and

(B) The beneficiary is entitled to have payment made for such services under Medicare Part B.

(4) HCFA may waive the requirements of paragraphs (m) (1), (2), and (3) of this section for any cost reporting period beginning before October 1, 1986, in accordance with § 489.23 of this chapter.

* * * * *

3. Subpart D is amended as set forth below:

a. The authority citation for Subpart D reads as follows:

Authority: Secs. 1102, 1814(b), 1815, 1833(a), 1861(v), 1871, 1881, 1886, and 1887 of the Social Security Act as amended (42 U.S.C. 1302, 1395f(b), 1395g, 1395l(a), 1395x(v), 1395hh, 1395rr, 1395ww, and 1395xx).

b. The table of contents of Subpart D is revised by adding undesignated center headings, removing §§ 405.404, 405.423, 405.428, and 405.430, adding a new § 405.414, and adding new § 405.470 through 405.477 to read as follows:

Subpart D—Principles of Reimbursement for Providers, Outpatient Maintenance Dialysis, and Services by Hospital-Based Physicians

Sec.
405.401 Introduction.

Reasonable Cost Reimbursement: General Rules

405.402 Cost reimbursement; general.
405.403 Apportionment of allowable costs.
405.405 Payments to providers; general.
405.406 Financial data and reports.

Specific Categories of Costs

405.414 Hospital capital-related costs.
405.415 Depreciation: Allowance for depreciation based on asset costs.
405.416 Depreciation: Optional allowance for depreciation based on a percentage of operating costs.
405.417 Depreciation: Allowance for depreciation on fully depreciated or partially depreciated assets.
405.418 Depreciation: Allowance for depreciation on assets financed with Federal or public funds.
405.419 Interest expense.
405.420 Bad debts, charity, and courtesy allowances.
405.421 Cost of educational activities.
405.422 Research costs.
405.424 Value of services of nonpaid workers.
405.425 Purchase discounts and allowances and refunds of expenses.
405.426 Compensation of owners.
405.427 Cost to related organizations.
405.429 Return on equity capital of proprietary providers.
405.432 Reasonable cost of physical and other therapy services furnished under arrangements.
405.433 Determining allowable cost for drugs.
405.434 Reasonable cost of extended care services furnished by a swing-bed hospital.
405.435 Nonallowable costs related to certain capital expenditures.
405.436 Reimbursement of independent organ procurement agencies and histocompatibility laboratories.

Payment for Outpatient Maintenance Dialysis and Related Services

405.438 Reasonable costs of home dialysis equipment furnished between October 1, 1978, and July 31, 1983.
405.439 Payments for covered outpatient maintenance dialysis treatments.
405.440 Target rate reimbursement for home dialysis services furnished between April 1, 1979 and July 31, 1983.
405.441 Recordkeeping and cost reporting requirements for outpatient maintenance dialysis.

Additional General Rules on Reasonable Cost Reimbursement

405.451 Cost related to patient care.
405.452 Determination of cost of services to beneficiaries.
405.453 Adequate cost data and cost finding.

Sec.
405.454 Payments to providers.
405.455 Amount of payments where customary charges for services furnished are less than reasonable cost.
405.456 Payment to a foreign hospital.

Limits on Cost Reimbursement

405.460 Limitations on reimbursable costs.
405.461 Limitations on coverage of costs; charges to beneficiaries where cost limits are applied to services.
405.463 Ceiling on rate of hospital cost increases.

Payments to Teaching Hospitals

405.465 Determining reimbursement for certain physician and medical school faculty services rendered in teaching hospitals.
405.466 Payment to a fund.

Prospective Payment for Inpatient Hospital Services

405.470 Prospective payment: general provisions
405.471 Hospitals and hospital services subject to and excluded from the prospective payment system.
405.472 Conditions for payment under the prospective payment system.
405.473 Basic methodology for determining Federal prospective payment rates.
405.474 Determining transition period payment rates.
405.475 Payment for outlier cases.
405.476 Special treatment of sole community hospitals, Christian Science sanitoria, cancer hospitals, referral centers, and renal transplantation centers.
405.477 Payments to hospitals under the prospective payment system.

Payment for Services of Physicians to Providers

405.480 Payment for services of physicians to providers: General rules.
405.481 Allocation of physician compensation costs.
405.482 Limits on compensation for services of physicians in providers.

c. Section 405.401 is revised to read as follows:

§ 405.401 Introduction.

(a) *Scope.*

(1) *General summary.* This subpart sets forth regulations governing Medicare payment for services furnished to beneficiaries by—

(i) Hospitals;

(ii) Skilled nursing facilities (SNFs);

(iii) Home health agencies (HHAs);

(iv) Comprehensive outpatient rehabilitation facilities (CORFs);

(v) End-stage renal disease (ESRD) facilities; and

(vi) Providers of outpatient physical therapy and speech pathology services (OPTs).

(2) *Applicability.* The principles of payment and the related policies described in this subpart apply to HCFA, to the fiscal intermediaries acting as payors of claims on HCFA's behalf, to the Provider Reimbursement Review Board, and to the hospitals, SNFs, HHAs, CORFs, ESRD facilities, and OPTs receiving payment under this subpart.

(b) *Reasonable cost reimbursement.* Except as provided under paragraphs (c) through (e) of this section, Medicare is generally required, under section 1814(b) of the Act (for services covered under Part A) and under section 1833(a)(2) of the Act (for services covered under Part B) to pay for services furnished by providers on the basis of reasonable costs as defined in section 1861(v) of the Act, or the provider's customary charges for those services, if lower. Regulations implementing section 1861(v) are found generally in this subpart beginning at § 405.402.

(c) *Oupatient maintenance dialysis and related services.* Section 1881 of the Act authorizes special rules for the coverage of and payment for services furnished to ESRD patients. Sections 405.438 through 405.441 implement various provisions of section 1881. In particular, § 405.439 establishes a prospective payment method for outpatient maintenance dialysis services that applies both to hospital-based and independent ESRD facilities, and under which Medicare pays for both home and infacility dialysis services furnished on or after August 1, 1983.

(d) *Payment for inpatient hospital services.*

(1) For cost reporting periods beginning before October 1, 1983, the amount paid for inpatient hospital services is determined on a reasonable cost basis.

(2) Except as provided in paragraph (e) of this section, for cost reporting periods beginning on or after October 1, 1983 the following applies:

(i) Payment to short-term general hospitals (other than children's, psychiatric, and rehabilitation hospitals, and psychiatric and rehabilitation units, as described in § 405.471(c)) located in the 50 States and the District of Columbia for the operating costs of inpatient hospital services is determined prospectively on a per discharge basis under §§ 405.470 through 405.477. Payment to these hospitals for capital-related costs (as described in § 405.414) and direct medical education costs (as described in § 405.421, with the exception of those costs described in § 405.421(d)) is made on a reasonable cost basis.

(ii) Payment to children's, psychiatric, rehabilitation and long-term hospitals (as well as separate psychiatric and rehabilitation units (distinct parts) of short-term hospitals), which are excluded from the prospective payment system under § 405.471(e), and to hospitals outside the 50 States and the District of Columbia is on a reasonable cost basis, subject to the provisions of § 405.463.

(e) *State reimbursement control systems.* Beginning October 1, 1983, Medicare reimbursement for inpatient hospital services may be made in accordance with a State reimbursement control system rather than under the Medicare reimbursement principles set forth in this subpart, if the State system is approved by HCFA. Regulations implementing this alternative reimbursement authority are set forth at 42 CFR Part 403, Subpart C.

§ 405.404 [Removed]

d. Section 405.404 is removed.

e. A new § 405.414 is added to read as follows:

§ 405.414 Capital-related costs.

(a) *General rule.* Capital-related costs and allowance for return on equity are limited to the following:

(1) Net depreciation expense as determined under §§ 405.415, 405.417, and 405.418, adjusted by gains and losses realized from the disposal of depreciable assets under § 405.415(f)(2).

(2) Taxes on land or depreciable assets used for patient care.

(3) Leases and rentals, including license and royalty fees, for the use of depreciable assets, as described in paragraph (b) of this section.

(4) The costs of betterments and improvements as described in paragraph (c) of this section.

(5) The costs of minor equipment that are capitalized, rather than expensed, as described in paragraph (d) of this section.

(6) Insurance expense on depreciable assets, as described in paragraph (e) of this section.

(7) Interest expense as determined under § 405.419, subject to the qualifications of paragraph (f) of this section.

(8) For proprietary providers, return on equity capital, as determined under § 405.429.

(9) The capital-related costs of related organizations (as described in § 405.427), as determined in accordance with paragraph (g) of this section.

(b) *Leases and rentals.* (1) Subject to the qualifications of paragraphs (b)(2) and (4) of this section, leases and rentals, including licenses and royalty fees, are includable in capital-related costs if they relate to the use of assets that would be depreciable if the provider owned them outright. The terms "leases" and "rentals of assets"

signify that a provider has possession, use, and enjoyment of the assets.

(2) A provider must include incurred rental charges in its capital-related costs, as specified in a sale and leaseback agreement with a nonrelated purchaser involving plant facilities or equipment, only if—

(i) The rental charges are reasonable based on consideration of rental charges of comparable facilities and market conditions in the area; the type, expected life, condition and value of the facilities or equipment rented; and other provisions of the rental agreements;

(ii) Adequate alternate facilities or equipment which woud serve the purpose are not or were not available at lower cost; and

(iii) The leasing was based on economic and technical considerations.

(3) If the conditions of paragraph (b)(2) of this section are not met, the amount a provider may include in its capital-related costs as rental or lease expense under a sale and leaseback agreement may not exceed the amount which the provider would have included in capital-related costs had the provider retained legal title to the facilities or equipment, such as interest on mortgage, taxes, depreciation, and insurance costs.

(4) A lease that meets the following conditions is a virtual purchase:

(i) The rental charge exceeds rental charges of comparable facilities or equipment in the area.

(ii) The term of the lease is less than the useful life of the facilities or equipment.

(iii) The provider has the option to renew the lease at a significantly reduced rental, or the provider has the right to purchase the facilities or equipment at a price which appears to be significantly less than what the fair market value of the facilities or equipment would be at the time acquisition by the provider is permitted.

(5)(i) If a lease is a virtual purchase under paragraph (b)(4) of this section, the rental charge is includable in capital-related costs only to the extent that it does not exceed the amount which the provider would have included in capital-related costs if it had legal title to the asset (the cost of ownership), such as straight-line depreciation, insurance, and interest. A provider may not include in its capital-related costs accelerated depreciation in this situation.

(ii) The difference between the amount of rent paid and the amount of rent allowed as capital-related cost is considered a deferred charge and is capitalized as part of the historical cost of the asset when the asset is purchased.

(iii) If an asset is returned to the owner, instead of being purchased, the deferred charge may be included in capital-related costs in the year the asset is returned.

(iv) If the term of the lease is extended for an additional period of time at a reduced lease cost and the option to purchase still exists, the deferred charge may be included in capital-related costs to the extent of increasing the reduced rental to an amount not in excess of the cost of ownership.

(v) If the term of the lease is extended for an additional period of time at a reduced lease cost and the option to purchase no longer exists, the deferred charge may be included in capital-related costs to the extent of increasing the reduced rental to a fair rental value.

(c) *Betterments and improvements.* (1) Betterments and improvement are changes which extend the estimated useful life of an asset at least two years beyond its original estimated useful life, or increase the productivity of an asset significantly over its original productivity.

(2) A provider must capitalize and pro-rate the costs of betterments and improvements over the remaining estimated useful life of the asset, as modified by the betterment or improvement.

(d) *Minor equipment.* A provider must include in its capital-related costs the costs of minor equipment that are capitalized rather than charged off to expense if—

(1) The net book value of minor equipment at the time the provider enters the program is pro-rated over three years (that is, one-third of the net book value is written off each year), and new purchases are also pro-rated over a 3-year period; or

(2) The cost of minor equipment is prorated over their actual useful lives.

(e) *Insurance.* (1) A provider must include in its capital-related costs the costs of insurance on depreciable assets used for patient care or insurance that provides for the payment of capital-related costs during business interruption.

(2) If an insurance policy also provides protection for other than the replacement of depreciable assets or to pay capital-related costs in the case of business interruption insurance, only that portion of the premium related to the replacement of depreciable assets or to pay capital-related costs in the case of business interruption insurance is includable in capital-related costs.

(f) *Interest expense.* (1) A provider must include in its capital-related costs interest expense, as described in § 405.419, if such expense is incurred in—

(i) Acquiring land and/or depreciable assets (either through purchase or lease) used for patient care; or

(ii) Refinancing existing debt, if the original purpose of the refinanced debt was to acquire land an/or depreciable assets used for patient care.

(2) If investment income offset is required under § 405.419(b)(2)(iii), only that portion of investment income that bears the same relationship to total investment income as the portion of capital-related interest expense bears to total interest expense is offset against capital-related costs.

(g) *Costs of supplying organizations.* (1) *Supplying organization related to the provider.*

(i) If the supplying organization is related to the provider within the meaning of § 405.427, except as provided in paragraph (g)(1)(ii) of this section, a provider's capital-related costs include the capital-related costs of the supplying organization.

(ii) If the costs of the services, facilities or supplies being furnished exceed the open market price, or if the provisions of § 405.427(d) apply, no part of the cost to the provider of the services, facilities, or supplies are considered capital-related costs, unless the services, facilities or supplies would otherwise be considered capital-related.

(2) *Supplying organizations not related to the provider.* If the supplying organization is not related to the provider within the meaning of § 405.427, no part of the charge to the provider may be considered a capital-related cost (unless the services, facilities or supplies are capital-related in nature) unless—

(i) The capital-related equipment is leased or rented by the provider;

(ii) The capital-related equipment is located on the provider's premises; and

(iii) The capital-related portion of the charge is separately specified in the charge to the provider.

(h) *Cost excluded from capital-related costs.* The following costs are not capital-related costs. To the extent that they are allowable, they must be included in determining each provider's operating costs:

(1) Costs incurred for the repair or maintenance of equipment or facilities.

(2) Amounts included in rentals or lease payments for repair or maintenance agreements.

(3) Interest expense incurred to borrow working capital (for operating expenses).

(4) General liability insurance or any other form of insurance to provide

protection other than for the replacement of depreciable assets or to pay capital-related costs in the case of business interruption.

(5) Taxes other than those assessed on the basis of some valuation of land or depreciable assets used for patient care. (Taxes not related to patient care, such as income taxes, are not allowable, and are therefore not included among either capital-related or operating costs.)

(6) The costs of minor equipment that are charged off to expense rather than capitalized as described in paragraph (d) of this section.

f. Section 405.421 is amended by revising paragraph (d) to read as follows:

§ 405.421 Cost of educational activities.

* * * * *

(d) *Activities not within the scope of this principle.* The costs of the following activities are not within the scope of this principle but are recognized as normal operating costs and are reimbursed in accordance with applicable principles—

(1) Orientation and on-the-job training;

(2) Part-time education for bona fide employees at properly accredited academic or technical institutions (including other providers) devoted to undergraduate or graduate work;

(3) Costs, including associated travel expense, of sending employees to educational seminars and workshops which increase the quality of medical care or operating efficiency of the provider;

(4) Maintenance of a medical library;

(5) Training of a patient or patient's family in the use of medical appliances; and

(6) Other activities which do not involve the actual operation or support (except through tuition or similar payments) of an approved education program including the costs of interns and residents in anesthesiology who are employed to replace anesthetists.

* * * * *

§ 405.423 [Removed]

g. Section 405.423 is removed.

§ 405.426 [Amended]

h. Section 405.426 is amended by removing paragraph (d).

§ 405.428 [Removed]

i. Section 405.428 is removed.

j. Section 405.429 is amended by revising paragraph (a) to read as follows:

§ 405.429 Return on equity capital of proprietary providers.

(a) *Principle.* (1) *Rate of return.*

(i) A reasonable return on equity capital invested and used in the provision of patient care is paid as an allowance in addition to the reasonable cost of covered services furnished to beneficiaries by proprietary providers.

(ii) Except as provided in paragraph (a)(1)(iii) of this section, the amount allowable on an annual basis is determined by applying to the provider's equity capital a percentage equal to one and one-half times the average of the rates of interest on special issues of public debt obligations issued to the Federal Hospital Insurance Trust Fund for each of the months during the provider's reporting period or portion thereof covered under the program.

(iii) For cost reporting periods beginning on or after April 20, 1983, the amount allowable in determining the return related to inpatient hospital services is determined using a percentage equal to the average of the rates of interest as described in paragraph (a)(1)(ii) of this section.

(2) *Proprietary providers.* For the purposes of this subpart the term "proprietary providers" is intended to distinguish providers, whether sole proprietorships, partnerships, or corporations, that are organized and operated with the expectation of earning profit for the owners, from other providers that are organized and operated on a nonprofit basis.

* * * * *

§ 405.430 [Removed]

k. Section 405.430 is removed.

l. Section 405.432 is amended by reprinting the introductory material of paragraph (f) unchanged and adding a new paragraph (f)(4), to read as follows:

§ 405.432 Reasonable cost of physical and other therapy services furnished under arrangements.

* * * * *

(f) *Exceptions.* The following exceptions may be granted but only upon the provider's demonstration that the conditions indicated are present:

* * * * *

(4) *Exemptions for inpatient hospital services.* Effective with cost reporting periods beginning on or after October 1, 1983, the costs of therapy services furnished under arrangements to a hospital inpatient will be excepted from the guidelines issued under this section if such costs are subject to the provisions of §§ 405.463 or 405.470. The intermediary will grant the exemption without request from the provider.

* * * * *

m. Section 405.434 is amended by reprinting the introductory language of paragraph (c) unchanged, and revising paragraph (c)(3), to read as follows:

§ 405.434 Reasonable cost of extended care services furnished by a swing-bed hospital.

* * * * *

(c) *Principle.* The reasonable cost of extended care services furnished by a swing-bed hospital is determined as follows:

* * * * *

(3) The reasonable cost of ancillary services furnished as extended care services is determined in the same manner as the reasonable cost of other ancillary services furnished by the hospital in accordance with § 405.452(a)(1).

n. Section 405.452 is amended by removing the existing paragraphs (a), (c), (d) and (e), revising paragraph (b) and redesignating it as paragraph (a), and adding new paragraphs (b), (c), (d), and (e). As revised the section reads as follows:

§ 405.452 Determination of cost services to beneficiaries.

(a) *Principle.* Total allowable costs of a provider shall be apportioned between program beneficiaries and other patients so that the share borne by the program is based upon actual services received by program beneficiaries. The methods of apportionment are defined as follows:

(1) *Departmental Method*—(i) *Methodology.* Except as provided in paragraph (a)(1)(ii) of this section with respect to the direct apportionment of malpractice costs, and in paragraph (a)(1)(iii) of this section with respect to the treatment of the private room cost differential for cost reporting periods starting on or after October 1, 1982, the ratio of beneficiary charges to total patient charges for the services of each ancillary department is applied to the cost of the department; to this is added the cost of routine services for program beneficiaries, determined on the basis of a separate average cost per diem for general routine patient care areas as defined in paragraph (b) of this section, taking into account, in hospitals, a separate average cost per diem for each intensive care unit, coronary care unit, and other intensive care type inpatient hospital units.

(ii) *Exception: Malpractice insurance.* For cost reporting periods beginning on or after July 1, 1979, costs of malpractice insurance premiums and self-insurance fund contributions must be separately accumulated and directly apportioned to Medicare. The apportionment must be based on the dollar ratio of the provider's Medicare paid malpractice

losses to its total paid malpractice losses for the current cost reporting period and the preceding 4-year period. If a provider has no malpractice loss experience for the 5-year period, the costs of malpractice insurance premiums of self-insurance fund contributions must be apportioned to Medicare based on the national ratio of malpractice awards paid to Medicare beneficiaries to malpractice awards paid to all patients. The Health Care Financing Administration will calculate this ratio periodically based on the most recent departmental closed claim study. If a provider pays allowable uninsured malpractice losses incurred by Medicare beneficiaries, either through allowable deductible or coinsurance provisions, or as a result of an award in excess of reasonable coverage limits, or as a governmental provider, such losses and related direct costs must be directly assigned to Medicare for reimbursement.

(iii) *Exception: Indirect cost of private rooms.* For cost reporting periods starting on or after October 1, 1982, except with respect to hospital receiving payment under § 405.470, the additional cost of furnishing services in private room accommodations is apportioned to Medicare only when these accommodations are furnished to program beneficiaries, and are medically necessary. To determine routine service cost applicable to beneficiaries.

(A) Multiply the average cost per diem (as defined in paragraph (b) of this section) by the total number of Medicare patient days (including private room days whether or not medically necessary).

(B) Add the product of the average per diem private room cost differential (as defined in paragraph (b) of this section) and the number of medically necessary private room days used by beneficiaries.

(C) The days in paragraphs (b)(iii)

(A) and (B) of this section do not include private rooms furnished for SNF type and ICF services under the swing bed provision.

(2) *Carve out method.* (i) The carve out method is used to allocate hospital inpatient general routine service costs in a participating swing-bed hospital, as defined in § 405.434(b). Under this method, the total costs attributable to the SNF-type and ICF-type services furnished to all classes of patients are subtracted from total general routine inpatient service costs before computing the average cost per diem for general routine hospital care.

(ii) The cost per diem attributable to the routine SNF-type services furnished by a swing-bed hospital is based on the reasonable cost per diem for services determined in accordance with § 405.434.

(iii) The cost per diem attributable to the routine ICF services furnished by the swing-bed hospital is determined as follows:

(A) If the hospital is located in a State that provides for ICF services under Medicaid, the cost per diem for ICF services furnished by a swing-bed hospital in that State is based on the Statewide average rate paid for routine services in ICFs (other than ICFs for the mentally retarded) during the preceding calendar year under the State Medicaid plan. The Statewide average rate will be computed either by the State and furnished to HCFA, or by HCFA directly based on the best available data.

(B) If the hospital is located in a State that does not provide for ICF services under Medicaid or that does not have a Medicaid program, the cost per diem for ICF services will be based on the average ratio of the ICF rate to the SNF rate in those States that provide for both SNF and ICF services under Medicaid. The ratio will be applied to the SNF cost per diem determined under paragraph (a)(2)(ii) of this section.

(iv) The sum of (A) total SNF-type days furnished to all classes of patients multiplied by the SNF cost per diem and (B) total ICF-type days furnished to all classes of patients multiplied by the appropriate ICF cost per diem will be subtracted from inpatient general routine service costs. The cost per diem for inpatient general routine hospital care will be based on the remaining general routine service costs.

(v) Costs other than general inpatient routine service costs will be determined in the same manner as specified in the Departmental Method in paragraph (a) of this section.

(b) *Definitions.* As used in this section—

"Ancillary services" means the services for which charges are customarily made in addition to routine services.

"Apportionment" means an allocation or distribution of allowable cost between the beneficiaries of the health insurance program and other patients.

"Average cost per diem for general routine services" means the following:

(1) For cost reporting periods beginning on or after October 1, 1982, subject to the provisions on swing-bed hospitals, the average cost of general routine services net of the private room cost differential. The average cost per diem is computed by the following methodology:

(i) Determine the total private room cost differential by multiplying the average per diem private room cost differential determined in paragraph (c) of this section by the total number of private room patient days.

(ii) Determine the total inpatient general routine service costs net of the total private room cost differential by subtracting the total private room cost differential from total inpatient general routine service costs.

(iii) Determine the average cost per diem by dividing the total inpatient general routine service cost net of private room cost differential by all inpatient general routine days, including total private room days.

(2) For swing-bed hospitals, the amount computed by (i) subtracting the costs attributable to SNF-type and ICF-type services from the total allowable inpatient cost for routine services (excluding the cost of services provided in intensive care units, coronary care units, and other intensive care type inpatient hospital units, and nursery costs), and (ii) dividing the remainder (excluding the total private room cost differential) by the total number of inpatient hospital days of care (excluding SNF-type and ICF-type days of care, days of care in intensive care units, coronary care units, and other intensive care type inpatient hospital units, and newborn days and including total private room days).

"Average cost per diem for hospital intensive care type units" means the amount computed by dividing the total allowable costs for routine services in each of these units by the total number of inpatient days of care rendered in each of these units.

"Average per diem private room cost differential" means the difference in the average per diem cost of furnishing routine services in a private room and in a semi-private room. (This differential is not applicable to hospital intensive care type units.) (The method for computing this differential is described in paragraph (c) of this section.)

"Charges" means the regular rates for various services which are charged to both beneficiaries and other paying patients who receive the services. Implicit in the use of charges as the basis for apportionment is the objective that charges for services be related to the cost of the services.

"ICF-type services" means routine services furnished by a swing-bed hospital that would constitute intermediate care facility (ICF) services, as defined in § 440.150 of this chapter, if furnished by an ICF. ICF-type services are not covered under the Medicare program.

"Intensive care type inpatient hospital unit" means a hospital unit that furnishes services to critically ill inpatients. Examples of intensive care type units include, but are not limited to, intensive care units, trauma units, coronary care units, pulmonary care units, and burn units. Excluded as intensive care type units are postoperative recovery rooms, postanesthesia recovery rooms, maternity labor rooms, and subintensive or intermediate care units. (The unit must also meet the criteria of paragraph (d) of this section.)

"SNF-type services" means routine services furnished by a swing-bed hospital that would constitute extended care services if furnished by a skilled nursing facility. SNF-type services include routine services furnished in the distinct part SNF of a hospital complex that is combined with the hospital general routine service area cost center under § 405.453(d)(5).

"Ratio of beneficiary charges to total charges on a departmental basis" means the ratio of charges to beneficiaries of the health insurance program for services of a revenue-producing department or center to the charges to all patients for that center during an accounting period. After each revenue-producing center's ratio is determined, the cost of services rendered to beneficiaries of the health insurance program is computed by applying the individual ratio for the center to the cost of the related center for the period.

"Routine services" means the regular room, dietary, and nursing services, minor medical and surgical supplies, and the use of equipment and facilities for which a separate charge is not customarily made.

(c) *Method for computing the average per diem private room cost differential.* Compute the average per diem private room cost differential as follows:

(1) Determine the average per diem private room charge differential by subtracting the average per diem charge for all semi-private room accommodations from the average per diem charge for all private room accommodations. The average per diem charge for private room accommodations is determined by dividing the total charges for private room accommodations by the total number of days of care furnished in private room accommodations. The average per diem charge for semi-private accommodations is determined by dividing the total charges for semi-private room accommodations by the total number of days of care furnished in semi-private accommodations.

(2) Determine the inpatient general routine cost/charge ratio by dividing total inpatient general routine service cost by the total inpatient general routine service charges.

(3) Determine the average per diem private room cost differential by multiplying the average per diem private room charge differential determined in paragraph (c)(1) of this section by the ratio determined in paragraph (c)(2) of this section.

(d) *Criteria for identifying intensive care type units.* For purposes of determining costs under this section, a unit will be identified as an intensive care type inpatient hospital unit only if the unit—(1) Is in a hospital;

(2) Is physically and identifiably separate from general routine patient care areas, including subintensive or intermediate care units, and ancillary service areas. There cannot be a concurrent sharing of nursing staff between an intensive care type unit and units or areas furnishing different levels or types of care. However, two or more intensive care type units that concurrently share nursing staff can be reimbursed as one combined intensive care type unit if all other criteria are met. Float nurses (nurses who work in different units on an as-needed basis) can be utilized in the intensive care type unit. If a float nurse works in two different units during the same eight hour shift, then the costs must be allocated to the appropriate units depending upon the time spent in those units. The hospital must maintain adequate records to support the allocation. If such records are not available, then the costs must be allocated to the general routine services cost areas;

(3) Has specific written policies that include critiera for admission to, and discharge from, the unit;

(4) Has registered nursing care available on a continuous 24-hour basis with at least one registered nurse present in the unit at all times;

(5) Maintains a minimum nurse-patient ratio of one nurse to two patients per patient day. Included in the calculation of this nurse-patient ratio are registered nurses, licensed vocational nurses, licensed practical nurses, and nursing assistants who provide patient care. Not included are general support personnel such as ward clerks, custodians, and housekeeping personnel; and

(6) Is equipped, or has available for immediate use, life-saving equipment necessary to treat the critically ill patients for which it is designed. This equipment may include, but is not limited to, respiratory and cardiac monitoring equipment, respirators, cardiac defibrillators, and wall or canister oxygen and compressed air.

(e) *Application.* (1) *Departmental method; Cost reporting periods beginning on or after October 1, 1982.*

(i) The following example illustrates how costs would be determined, using only inpatient data, for cost reporting periods beginning on or after October 1, 1982, based on apportionment of—

(A) The average cost per diem for general routine services (subject to the private room differential provisions of paragraph (a)(1)(iii) of this section);

(B) The average cost per diem for each intensive care type unit;

(C) The ration of beneficiary charges to total charges applied to cost by department.

HOSPITAL Y

Department	Charges to program beneficiaries	Total charges	Ratio of beneficiary charges to total charges	Total cost	Cost of beneficiary services
			Percent		
Operating rooms	$20,000	$70,000	28½	$77,000	$22,000
Delivery rooms	0	12,000	0	30,000	0
Pharmacy	20,000	60,000	33⅓	45,000	15,000
X-ray	24,000	100,000	24	75,000	18,000
Laboratory	40,000	140,000	28½	96,000	28,000
Others	6,000	30,000	20	25,000	5,000
Total	110,000	412,000		350,000	88,000

	Total inpatient days	Total cost	Average cost per diem	Program in patient days	Cost of beneficiary services
General routine	30,000	$630,000	$21	8,000	$168,000
Coronary care unit	500	20,000	40	200	8,000
Intensive care unit	3,000	108,000	36	1,000	36,000
	33,500	758,000		9,200	212,000
Total					300,000

(ii) The following illustrates how apportionment based on an average cost per diem for general routine services is determined.

HOSPITAL E

Facts	Private accommodations	Semi-private accommodations	Total
Total charges	$820,000	$175,000	$195,000
Total days	100	1,000	1,100
Programs days	70	400	470
Medically necessary for program beneficiaries	20		20
Total general routine service costs			165,000
Average private room per diem charge ($20,000 private room charges ÷ 100 days)			[1] $200
Average semi-private room per diem charge ($175,000 semi-private charge ÷ 1,000 days)			[1] $175

[1] Per diem.

Average per diem private room cost differential.

1. Average per diem private room charge differential ($200 private room per diem—$175, semi-private room per diem), $25.

2. Inpatient general routine cost/charge ratio ($165,000 total costs ÷ $195,000 total charges), .8461538.

3. Average per diem private room cost differential ($25 charge differential × .8461538 cost/charge ratio), $21.15.

Average cost per diem for inpatient general routine services.

4. Total private room cost differential ($21.15 average per diem cost differential × 100 private room days), $2,115.

5. Total inpatient general routine service costs net of private room cost differential ($165,000 total routine cost −$2,115 private room cost differential), $162,885.

6. Average cost per diem for inpatient general routine services ($162,885 routine cost net of private room cost differential ÷ 1,100 patient days), $148.08.

Medicare general routine service cost.

7. Total routine per diem cost applicable to Medicare ($148.08 average cost per diem × 470 Medicare private and semi-private patient days), $69,598.

8. Total private room cost differential applicable to Medicare ($21.15 average per diem private room cost differential × 20 medically necessary private room days), $423.

9. Medicare inpatient general routine service cost ($423 Medicare private room cost differential + $69,598 Medicare cost of general routine inpatient services), $70,021.

(9) *Carve out method.* The following illustrates how apportionment is determined in a hospital reimbursed under the carve out method (subject to the private room differential provisions of paragraph (a)(1)(ii) of this section):

HOSPITAL K

(Determination of cost of routine SNF-type and ICF-type services and general routine hospital services [1])

Facts	Days of care		
	General routine hospital	SNF-type	ICF-type
Total days of care	2,000	400	100
Medicare days of care	600	300	
Average medicaid rate	N/A	$35	$20

Total inpatient general routine service costs: $250,000

Calculation of cost of routine SNF-type services applicable to medicare:
$35 × 300 = $10,500

Calculation of cost of general routine hospital services:

Cost of SNF-type services: $35 × 400	$14,000
Cost of ICF-type services: $20 × 100	2,000
Total	$16,000

Average cost per diem of general routine hospital services:
$250,000 − $16,000 ÷ 2,000 days = $117

Medicare general routine hospital cost:
$117 × 600 = $70,200

Total medicare reasonable cost for general routine inpatient days:
$10,500 + $70,200 = $80,700

o. Section 405.453 is amended by adding a new paragraph (f)(3), and removing and reserving paragraph (g) to read as follows:

§ 405.453 Adequate cost data and cost finding.

* * * * *

(f) *Cost reports.* * * *

(3) *Changes in cost reporting periods.* A provider may change its cost reporting period only if—

(i) The provider requests the change in writing from its intermediary;

(ii) The intermediary receives the request at least 120 days before the close of the new reporting period requested by the provider; and

(iii) The intermediary determines that good cause for the change exists. Good cause would not be found to exist if the effect is to change the initial date by which a hospital would be affected by the rate of increase ceiling (see § 405.463), or be paid under the prospective payment system.

(g) [Reserved]

* * * * *

p. Section 405.454 is amended by revising paragraph (a) and adding a new paragraph (m) to read as follows:

§ 405.454 Payments to providers.

(a) *Principle.*

(1) *Reimbursement on a reasonable cost basis.* Providers of services paid on the basis of the reasonable cost of services furnished to beneficiaries will receive interim payments approximating the actual costs of the provider. These payments will be made on the most expeditious schedule administratively feasible but not less often than monthly. A retroactive adjustment based on actual costs will be made at the end of reporting period.

(2) *Payments under the prospective payment system.* For cost reporting periods beginning on or after October 1, 1983, hospitals and hospital units (see § 405.401(d)) are paid a prospectively determined rate under §§ 405.470 to 405.477 for Medicare Part A inpatient operating costs on a per discharge basis. Part A inpatient hospital operating costs include those costs (including malpractice costs) for general routine service, ancillary service, and intensive care-type unit services with respect to inpatient hospital services but exclude capital-related and direct medical education costs. Payments for capital-related and direct medical education applicable to inpatient costs that are payable under Part A, for certain kidney acquisition costs of renal transplantation centers (see § 405.2102(e)(1)), and for medical and other health services furnished to inpatients under Part B and outpatient services with respect to such hospitals and hospital units continue on a reasonable basis. The method of payment for hospitals under the prospective payment system is described in paragraph (m) of this section.

* * * * *

(m) *Prospective payments.*

(1) For cost reporting periods beginning on or after October 1, 1983, hospitals will receive payments with respect to Part A inpatient operating costs determined on a per discharge basis using prospectively determined rates. The amounts will represent final payment based on the submission of a discharge bill. Medical education costs and capital-related costs are excluded from prospective payments. For these items, reimbursement on the basis of reasonable costs, using Medicare principles of reimbursement, will continue to apply.

(2) (i) No year end retroactive adjustment is made for prospective payments. However, hospitals meeting the criteria in paragraph (j) of this section may elect to receive periodic interim payments. Therefore, at the discretion of the intermediary, the hospital's prospective payments will be estimated and made on a periodic interim basis (26 biweekly payments). These payments are subject to final settlement. Hospitals electing periodic interim payments may convert to

payments on a per discharge basis at any time.

(ii) For the hospitals receiving periodic interim payments for inpatient operating costs, the biweekly interim payment amount is based on the total estimated Medicare discharges for the reporting period multiplied by the hospital's estimated average prospective payment amount. These interim payments are reviewed and adjusted at least twice during the reporting period.

(iii) For purposes of determining periodic interim payments under this paragraph, the intermediary computes a hospital's estimated average prospective payment amount by multiplying its transition payment rates as determined under § 405.474(a)(3), but without adjustment by a DRG weighting factor, by the hospital's case-mix index.

(3) For items applicable to inpatient hospital services not reimbursed on a prospective basis (capital-related costs and direct medical education costs), interim payments are made subject to final cost settlement. Interim payments for the estimated cost of capital-related and approved medical education items (applicable to inpatient costs payable under Part A and for kidney acquisition cost in hospitals approved as renal transplantation centers) are determined by estimating the reimbursable amount for the year based on the previous year's experience and on substantiated information for the current year and divided into 26 equal biweekly payments.

(4) Payments for the indirect costs of medical education (described in § 405.477(d)(2)) are paid based on an estimate of the total for the Federal portion of the DRG revenue to be received in the current period. The total estimated annual amount of the adjustment will be divided into 26 equal biweekly payments and included with other inpatient costs reimbursed on a reasonable cost basis.

(5) Payments for outlier cases (described in § 405.475) are not made on an interim basis. The outlier payments are made based on submitted bills and represent final payment regardless of whether or not the provider is receiving periodic interim payments during the period.

q. Section 405.455 is amended by revising paragraphs (a) and (d)(1) and (2)(ii) to read as follows:

§ 405.455 Amount of payments where customary charges for services furnished are less than reasonable cost.

(a) *Principle.* Providers of services, other than comprehensive outpatient rehabilitation facilities, are paid the lesser of the reasonable cost of services furnished to beneficiaries or the customary charges made by the provider for the same services. (Payment to comprehensive outpatient rehabilitation facilities is based on the reasonable cost of services.) Public providers of service furnishing services free of charge or at a nominal charge are paid fair compensation for services furnished to beneficiaries. This principle is applicable to services furnished by providers in cost reporting periods beginning after December 31, 1973. This principle does not apply to payments for the costs of Part A inpatient hospital services for cost reporting periods subject to the rate of increase ceiling under § 405.463 or the prospective payment system under § 405.471. However, the carryover from previous periods is recognized, subject to the provisions of paragraph (d) of this section. For special rules concerning HMO's and providers of services and other health care facilities that are owned or operated by an HMO, or related to an HMO by common ownership or control, see §§ 405.2042(b)(14) and 405.2050(c).

* * * * *

(d) *Accumulation of unreimbursed costs and carryover to subsequent periods*—(1) *General.* Any provider of services whose charges are lower than costs in any cost reporting period beginning after December 31, 1973, may carry forward costs attributable to program beneficiaries which are unreimbursed under the provisions of this section for the two succeeding reporting periods. Where beneficiary charges exceed reasonable cost in such subsequent periods, such previously unreimbursed amounts carried forward shall be reimbursed to the provider to the extent that such previously unreimbursed amounts carried forward, together with costs applicable to program beneficiaries in such subsequent periods, do not exceed customary charges with respect to services to program beneficiaries in such subsequent periods. If such two succeeding cost reporting periods combined include fewer than 24 full calendar months, the provider may carry forward costs unreimbursed under this section for one additional reporting period. However, no recovery may be made in any period in which costs are unreimbursed under §§ 405.460 or 405.463.

Example. In the reporting period ending December 31, 1974, the provider's reimbursable costs attributable to covered services furnished program beneficiaries were $100,000. The provider's customary charges for these services were $90,000. The provider will, therefore, be reimbursed $90,000 less any deductible and coinsurance amounts but will be permitted to carry the unreimbursed $10,000 forward for the next two succeeding reporting periods. If, in the reporting period ending December 31, 1975, the charges to beneficiaries for covered services exceeded the reimbursable reasonable costs of such services by $10,000 or more, the provider could recover the entire $10,000 previously not reimbursed. If, however, beneficiary charges exceeded costs by $8,000, this amount would be added to the provider's reimbursable costs for this period. The balance of the unreimbursed amount or $2,000 would be carried over to the next reporting period.

(2) *New provider*—(i) *General* * * *

(ii) New provider base period; unreimbursed costs under lower of cost or charges. Where costs of a new provider are unreimbursed under this section, such previously unreimbursed amounts which a provider may recover during any cost reporting period in the new provider base period or carry forward period is limited to the amount by which the aggregate customary charges applicable to health insurance beneficiaries during any such period exceed the aggregate costs applicable to such beneficiaries during that period, except that no recovery may be made in any period in which costs are unreimbursed under §§ 405.460 or 405.463.

* * * * *

r. Section 405.460 is amended by revising paragraph (a)(1), the introductory language of paragraph (e), paragraph (e)(1), the introductory language of paragraph (f), paragraph (f)(9), and paragraph (h), to read as follows:

§ 405.460 Limitations on reimbursable costs.

(a) *Introduction*—(1) *Scope.* This section implements section 1861(v)(1)(A) of the Social Security Act, by setting forth the general rules under which HCFA may establish limits on provider costs recognized as reasonable in determining Medicare program payments, and sections 1861(v)(7)(B) and 1886(a) of the Social Security Act, by setting forth the general rules under which HCFA may establish limits on the operating costs of inpatient hospital services that are recognized as reasonable in determining Medicare program payments. (For cost reporting periods beginning on or after October 1, 1983, the operating cost incurred in furnishing inpatient hospital services is not subject to the provisions of this section.) This section also sets forth rules governing exemptions, exceptions, and adjustments to limits established under this section that HCFA may make

as appropriate in consideration of special needs or situations of particular providers.

* * * * *

(e) *Exemptions.* Exemptions from the limits imposed under this section may be granted in the following circumstances:

(1) *Sole community hospital.*

A sole community hospital is a hospital which, by reason of factors such as isolated location or absence of other hospitals, is the sole source of such care reasonably available to beneficiaries.

* * * * *

(f) *Exceptions.* Limits established under this section may be adjusted upward for a provider under the circumstances specified in paragraphs (f)(1) through (f)(8) of this section, and may be adjusted upward or downward under the circumstances specified in paragraph (f)(9) of this section. An adjustment is made only to the extent the costs are reasonable, attributable to the circumstances specified, separately identified by the provider, and verified by the intermediary.

* * * * *

(9) *Changes in case mix for cost reporting periods beginning before October 1, 1983.* The hospital:

(i) Is subject to limits issued under paragraph (b)(3) of this section for cost reporting periods beginning before October 1, 1983, that are calculated by use of a case-mix index;

(ii) Has added or discontinued services in a year after the year represented in the discharge data used to establish the limits described in paragraph (f)(9)(i) of this section;

(iii) Has experienced a significant and abrupt change in case mix as a result of the addition or deletion of services; and

(iv) Submits discharge data, in the format required by HCFA, for Medicare discharges in the cost reporting period for which the exception is requested.

* * * * *

(h) *Adjustments.* For cost reporting periods beginning on or after October 1, 1982 and before October 1, 1983, HCFA may adjust the amount of a hospital's inpatient operating costs to take into account factors which could result in a significant distortion in the operating costs of inpatient hospital services. Such factors could include a decrease in the inpatient services that a hospital provides that are customarily provided directly by similar hospitals, or the manipulation of discharges to increase reimbursement. A decrease in inpatient services could result from changes that include, but are not limited to, such actions as closing a special care unit or changing the arrangements under which such services may be furnished, such as leasing a department.

8. Section 405.463 is amended by revising paragraphs (a), (b)(2), (c)(1), (2), (3), and (5), (d), and (h), to read as follows:

§ 405.463 Ceiling on rate of hospital cost increases.

(a) *Introduction.*—(1) *Scope.* This section implements section 1886(b) of the Social Security Act establishing a ceiling on the rate of increase of operating costs per case for inpatient hospital services that will be recognized as reasonable for purposes of determining Medicare reimbursement. This ceiling on allowable rate of cost increases applies to hospital cost reporting periods beginning on or after October 1, 1982 and, for cost reporting periods beginning before October 1, 1983, is applied in addition to the limitations on reasonable cost established under § 405.460. This section also sets forth rules governing exemptions from and exceptions and adjustments to the ceiling.

(2) Applicability. (i) This section is not applicable to hospitals reimbursed in accordance with section 1814(b)(3) of the Act, or under State reimbursement control systems that have been approved under section 1886(c) of the Act.

(ii) For cost reporting periods beginning on or after October 1, 1983, this section is applicable to hospitals excluded from the prospective payment system under § 405.471(c), including subprovider psychiatric and rehabilitation units (distinct parts) and those hospitals eligible for special treatment under the prospective payment system as described in § 405.476(f)(2).

(b) *Cost-reporting periods subject to the rate of increase ceiling.* * * *

(2) *Periods subject to the ceiling.* Ceilings established under this section will be applied to all full 12-month cost reporting periods that:

(i) Immediately follow either a base period as described in paragraph (b)(1) of this section, or another 12-month cost reporting period subject to the ceiling; and

(ii) Begin on or after October 1, 1982.

* * * * *

(c) *Procedure for establishing the ceiling (target amount).*

(1)(i) *Costs subject to the ceiling.* The cost per case ceiling established under this section applies to operating costs incurred by a hospital in furnishing inpatient hospital services. (ii) For cost reporting periods beginning on or after October 1, 1982 and before October 1, 1983, these operating costs *include* operating costs of routine services (as described in § 405.158(c)), ancillary service operating costs, and special care unit operating costs. These operating costs *exclude* the costs of malpractice insurance, certain kidney acquisition costs, capital-related costs, and costs a hospital allocates to approved medical education programs (nursing school or approved intern and resident programs) on its Medicare cost report.

(iii) For cost reporting periods beginning on or after October 1, 1983, these operating costs exclude only capital-related costs as described in § 405.414, return on equity capital as described in § 405.429, the costs of approved medical education programs as described in § 405.421. Further, kidney acquisition costs incurred by hospitals approved as renal transplantation centers will be reimbursed on a reasonable cost basis. Appropriate adjustments to a hospital's base year costs will be made under paragraph (h) of this section.

(2) *Cost determined on a per case basis.* Costs subject to the ceiling as described in paragraph (c)(1) of this section will be determined on a per discharge basis.

(3) *Target rate percentage.*

(i) The target rate percentage for each calendar year will equal the prospectively estimated increase in the market basket index for that calendar year, plus one percentage point.

(ii) The market basket index is a hospital wage and price index that incorporates appropriately weighted indicators of changes in wages and prices that are representative of the mix of goods and services included in the most common categories of inpatient hospital operating costs subject to the ceiling as described in paragraph (c)(1) of this section.

* * * * *

(5) *Applicable target rate percentage.*

(i) The intermediary will use the target rate percentage increase applicable to each 12-month cost reporting period to determine the ceiling on the allowable rate of cost increase under this section.

(ii) When a cost reporting period spans portions of two calendar years, the intermediary will calculate an appropriate prorated percentage rate based on the published calendar year percentage rates.

(iii) The applicable target rate percentage will be the prospectively determined percentage published by HCFA. HCFA will publish quarterly **Federal Register** notices, beginning in 1983, including the applicable estimate of the market basket rate of increase

and the resulting target rate percentage for the next two calendar years. The target rate percentage for each hospital will be based on the percentages published in the latest quarterly notice before the beginning of the hospital's cost reporting period, will be applied prospectively, and will be prorated, in accordance with paragraph (c)(5)(ii) of this section, but will not be retroactively adjusted if the actual market basket rate of increase differs from the estimate.

(d) *Application of target amounts in determining reimbursement*—(1) *General process.*

(i) At the end of each 12-month cost reporting period subject to this section, the hospital's intermediary will compare a hospital's allowable cost per case with that hospital's target amount for that period.

(ii) The hospital's actual allowable costs will be determined without regard to the lower of cost or charges provisions of § 405.455, but, for cost reporting periods beginning on or after October 1, 1982 and before October 1, 1983, are subject to other limitations on reimbursable cost established under § 405.460.

(iii) If the hospital's actual allowable costs do not exceed the target amount, reimbursement will be determined under paragraph (d)(2) of this section.

(iv) If the hospital's actual costs exceed the target amount, reimbursement will be determined under paragraph (d)(3) of this section.

(2) *Inpatient operating costs are less than or equal to the target amount.* If a hospital's allowable inpatient operating costs per case do not exceed the hospital's target amount for the applicable cost reporting period, reimbursement to the hospital will be determined on the basis of the lowest of:

(i) The inpatient operating costs per case plus 50 percent of the difference between the inpatient operating cost per case and the target amount;

(ii) The inpatient operating cost per case plus 5 percent of the target amount; or

(iii) The hospital's allowable inpatient operating cost per case under applicable limits established under § 405.460, if applicable.

(3) *Inpatient operating costs are greater than the target amount.* If a hospital's allowable inpatient operating costs per case exceed the hospital's target amount for the applicable cost reporting period, reimbursement to the hospital will be determined as follows:

(i) For cost reporting periods beginning on or after October 1, 1982 and before October 1, 1984, reimbursement will be based on the lower of:

(A) The hospital's target amount plus 25 percent of the allowable operating costs per case in excess of the target amount; or

(B) The hospital's allowable cost per case under applicable limits established under § 405.460, if applicable.

(ii) For cost reporting periods beginning on or after October 1, 1984, reimbursement will be based on the hospital's target amount per case.

* * * * *

(h) *Adjustments*—(1) *Comparability of cost reporting periods.* (i) HCFA may adjust the amount of the operating costs considered in establishing cost per case for one or more cost reporting period(s), including both periods subject to the ceiling and the hospital's case period, to take into account factors which could result in a significant distortion in the operating costs of inpatient hospital services.

(ii) In determining the target amount for cost reporting periods beginning on or after October 1, 1983, the intermediary will adjust the base period costs to explicitly include in the costs subject to the ceiling malpractice insurance costs, FICA taxes (if the hospital did not incur costs for FICA taxes in its base period), and services billed under Part B of the program during the base period, but paid under Part A during the subject cost reporting period.

(iii) HCFA may adjust the amount of operating costs, under paragraph (b)(1)(i) of this section, to take into account factors such as a change in the inpatient hospital services that a hospital provides, that are customarily provided directly by similar hospitals, or the manipulation of discharges to increase reimbursement. A change in the inpatient hospital services provided could result from changes that include, but are not limited to, opening or closing a special care unit or changing the arrangements under which such services may be furnished, such as leasing a department.

(2) *Nursing differential.* Because the Medicare inpatient routine nursing salary cost differential does not apply in the cost reporting periods subject to ceilings established under this section, HCFA will adjust base period costs to remove the effect of this differential.

t. New §§ 405.470 through 405.477, and an undesignated center heading between § 405.466 and § 405.470, are added to read as follows:

Prospective Payment for Inpatient Hospital Services

§ 405.470 Prospective payment: general provisions.

(a) *Scope.*

(1) *Purpose.* Sections 405.470 through 405.477 of this subpart implement section 1886(d) of the Act by establishing a prospective payment system for inpatient hospital services furnished to beneficiaries in cost reporting periods beginning on or after October 1, 1983. Under the prospective payment system, payment for the operating costs of inpatient hospital services furnished by hospitals subject to the system (generally, short-term, acute-care hospitals) is made on the basis of prospectively determined rates and applied on a per discharge basis. Payment for other costs related to inpatient hospital services (capital-related costs, kidney acquisition costs incurred by hospitals with approved renal transplantation centers, and the direct costs of medical education) is made on a reasonable cost basis. Additional payments are made for outlier cases, bad debts, and indirect medical education costs. Under the prospective payment system, a hospital may keep the difference between its prospective payment rate and its operating costs incurred in furnishing inpatient services, and is at risk for operating costs that exceed its payment rate.

(2) *Summary of specific sections.* This section describes the basis of payment for inpatient hospital services under the prospective payment system, and sets forth the general basis of this system. Section 405.471 sets forth the classifications of hospitals that are included in and excluded from the prospective payment system, and sets forth requirements governing the inclusion or exclusion of hospitals in the system as a result of changes in their classification. Section 405.472 sets forth certain conditions that must be met for a hospital to receive payment under the prospective payment system. Section 405.473 sets forth the basic methodology by which prospective payment rates are to be determined. Section 405.474 describes the transition rate-setting methods that are to be used to determine transition payment rates during the first three years of the prospective payment system. Section 405.475 sets forth the methodology for determining additional payments for outlier cases. Section 405.476 sets forth special rules for treatment of sole community hospitals, Christian Science Sanitoria, cancer hospitals, referral

centers, and kidney acquisition costs. Section 405.477 describes the types, amounts, and methods of payment to hospitals under the prospective payment system.

(b) *Basis of payment.*

(1) *Payment on a per discharge basis.* Under the prospective payment system, hospitals are paid a predetermined amount per discharge for inpatient hospital services furnished to Medicare beneficiaries. The prospective payment rate for each discharge (as described in paragraph (c) of this section) is determined according to the methodology described in §§ 405.473, 405.474, or 405.476, as appropriate. An additional payment is made in accordance with § 405.475 for cases that have an atypically long length of stay or are extraordinarily costly to treat.

(2) *Payment in full.*

(i) The prospective payment amounts paid for inpatient hospital services is the total Medicare payment for the inpatient operating costs (as described in paragraph (b)(3) of this section) incurred in furnishing services covered by the Medicare program.

(ii) The full prospective payment amount, as determined under §§ 405.473, 405.474, and 405.476, is made for each stay during which there is at least one Medicare payable day of care.

(iii) Payable days of care, for purposes of paragraph (b)(2)(ii) of this section, include:

(A) Waiver of liability days payable under § 405.330; and

(B) Guarantee of payment days, as authorized under § 409.68, for inpatient hospital services furnished to an individual whom the hospital has reason to believe is entitled to Medicare benefits at the time of admission.

(3) *Inpatient operating costs.* The prospective payment system provides a payment amount for inpatient operating costs, including—

(i) Operating costs for routine services (as described in § 405.452(b)), such as the costs of room, board, and routine nursing services;

(ii) Operating costs for ancillary services, such as radiology and laboratory services furnished to hospital inpatients;

(iii) Special care unit operating costs (intensive care type unit services, as described in § 405.452(b)); and

(iv) Malpractice insurance costs related to services furnished to inpatients.

(4) *Excluded costs.* The following inpatient hospital costs are excluded from the prospective payment amounts and paid for on a reasonable cost basis:

(i) Capital-related costs, as described § 405.414 and an allowance for return on equity, as described in § 405.429.

(ii) Direct medical education costs, for those approved education programs described in § 405.421.

(iii) Costs for direct medical and surgical services of physicians in teaching hospitals exercising the election in § 405.521.

(iv) Kidney acquisition costs incurred by a certified renal transplantation centers.

(5) *Additional payments to hospitals.* In addition to payments based on the prospective payment rates, hospitals will receive payments for:

(i) Outlier cases, as described in § 405.475;

(ii) The indirect costs of graduate medical education (see §§ 405.475(f) and 405.477(d)(2));

(iii) Costs excluded from the prospective payment rate under paragraph (b)(4) of this section (see § 405.477(c)); and

(iv) Bad debts of Medicare beneficiaries (see §§ 405.420 and 405.477(d)(2)).

(c) *Discharges and transfers.*

(1) *Discharges.* A hospital inpatient is discharged when—

(i) The patient is formally released from the hospital (release of the patient to another hospital as described in paragraph (c)(2) of this section will not be recognized as a discharge for the purpose of determining payment under the prospective payment system);

(ii) The patient dies in the hospital; or

(iii) The patient is transferred to a hospital or unit that is excluded from the prospective payment system under § 405.471.

(2) *Transfers.* Except as provided under paragraph (c)(1)(iii) of this section, a discharge of a hospital inpatient is not counted for purposes of the prospective payment system when the patient is transferred—

(i) From one inpatient area or unit of the hospital to another area or unit of the hospital;

(ii) From the care of a hospital paid under this section to the care of another such hospital; or

(iii) From the care of a hospital paid under this section to the care of another hospital—

(A) Excluded from the prospective payment system because of participation in an approved statewide cost control program or demonstration; or

(B) Whose first cost reporting period under the prospective payment system has not yet begun.

(3) *Payment in full to the discharging hospital.* The hospital discharging an inpatient (under paragraph (c)(1) of this section) is paid in full, in accordance with paragraph (b)(2) of this section.

(4) *Payment to a hospital transferring an inpatient to another hospital.* If a hospital paid under the prospective payment system transfers an inpatient to another such hospital, as described in paragraphs (c)(2) (ii) and (iii) of this section, the transferring hospital is paid a per diem rate for each day of the patient's stay in that hospital, not to exceed the amount that would have been paid under §§ 405.473 or 405.474 if the patient had been discharged to another setting. The per diem rate is determined by dividing the appropriate prospective payment rate (as determined under §§ 405.473 or 405.474) by the average length of stay for the specific DRG into which the case falls.

(d) *Cost reporting periods subject to the prospective payment system.*

(1) *Initial cost reporting period.*

(i) Each subject hospital is paid under the prospective payment system for inpatient hospital services effective with the hospital's first cost reporting period beginning on or after October 1, 1983.

(ii) The hospital is paid the applicable prospective payment rate for each discharge occurring on or after the first day of its first cost reporting period subject to the prospective payment system.

(iii) If a discharged beneficiary was admitted to the hospital before the first day of the hospital's first cost reporting period subject to prospective payment, the reasonable costs of services furnished before that day are reimbursable under the cost reimbursement provisions of this subpart. For such discharges, the amount otherwise payable under the applicable prospective payment rate is reduced by the amount paid on a reasonable cost basis for

- Inpatient hospital services furnished to that beneficiary during the hospital stay. Where the amount reimbursed under reasonable cost exceeds the prospective payment amount, the reduction is limited to the prospective payment amount.

(2) *Changes in cost reporting periods.* HCFA will recognize a change in a hospital's cost reporting period made after November 30, 1982 only if the change has been requested in writing by the hospital and approved by the intermediary in accordance with § 405.453(f)(3).

(e) *Publication of schedule for determining prospective payment rates.*

(1) *Initial prospective payment rates.*

(i) HCFA will publish in the **Federal Register** by September 1, 1983, interim

standardized amounts and DRG weighting factors (determined under § 405.473) as needed to compute prospective payment rates effective for discharges occurring in cost reporting periods beginning on or after October 1, 1983.

(ii) HCFA will publish a notice in the **Federal Register** by December 31, 1983 confirming or modifying the interim initial schedule of standardized amounts and weighting factors. If the resulting interim payment rates are modified, the new rates will apply to discharges occurring after 30 days following the date of publication of this notice.

(2) *Annual publication of schedule for determining prospective payment rates.*

(i) Beginning in 1984, HCFA will publish annual notices setting forth the methodology and data used, including the percentage increase factor, to determine prospective payment rates applicable to discharges occurring during the Federal fiscal year beginning on or after October 1 of that year.

(ii) HCFA will propose changes in the methods, amounts, and factors used to determine prospective payment rates in a **Federal Register** notice published for public comment not later than the June 1 before the beginning of the Federal fiscal year in which the proposed changes would apply.

(iii) HCFA will publish a **Federal Register** notice setting forth final methods, amounts, and factors for determining prospective payment rates not later than the September 1 before the Federal fiscal year in which the rates would apply.

(iv) If HCFA does not meet the September 1 publication date requirement of this paragraph, the prospective payment rates in effect on September 1 of the year in question will apply unchanged for the following Federal fiscal year.

§ 405.471 Hospitals and hospital services subject to and excluded from the prospective payment system.

(a) *Hospitals subject to the prospective payment system.*

(1) Except for services described in paragraph (a)(2) of this section, all covered inpatient hospital services furnished to beneficiaries during subject cost reporting periods are paid for under the prospective payment system.

(2) Inpatient hospital services will not be paid for under the prospective payment system if—

(i) The services are furnished by a hospital (or distinct part hospital unit) explicitly excluded from the prospective payment system under paragraphs (b) and (c) of this section;

(ii) The services are emergency services furnished by a nonparticipating hospital in accordance with § 405.152; or

(iii) The services are paid for by a health maintenance organization (HMO) that elects not to have HCFA make payments directly to a hospital for inpatient hospital services furnished to the HMO's Medicare enrollees (see § 405.2040(d)).

(b) *Excluded hospitals: general rules.*

(1) *Criteria.* A hospital will be excluded from the prospective payment system if it meets the criteria for one or more of the excluded classifications described in paragraph (c) of this section.

(2) *Cost reimbursement.* Except for those hospitals specified in paragraph (b)(3) of this section, all excluded hospitals (and distinct part hospital units, as described in paragraph (c)(3)(i) of this section) are reimbursed under the cost reimbursement rules set forth in this subpart, and will be subject to the ceiling on the rate of hospital cost increases described in § 405.463.

(3) *Special reimbursement provisions.* The following classifications of hospitals are reimbursed under special provisions and therefore are not generally subject to the cost reimbursement or prospective payment rules of this subpart:

(i) Veterans Administration hospitals.

(ii) Hospitals reimbursed under State cost control systems approved under Part 403 of this chapter.

(iii) Hospitals reimbursed in accordance with demonstrations projects authorized under section 402(a) of the Social Security Amendments of 1967 or section 222(a) of the Social Security Amendment of 1972.

(iv) Nonparticipating hospitals furnishing emergency services to medicare beneficiaries.

(c) *Excluded hospitals and hospital units: classifications.* Hospitals and distinct part units of hospitals that meet the requirements for the classifications set forth in this paragraph may not be reimbursed under the prospective payment system.

(1) *Psychiatric hospitals.* A psychiatric hospital must—

(i) Be primarily engaged in providing, by or under the supervision of a psychiatrist, psychiatric services for the diagnosis and treatment of mentally ill persons; and

(ii) Meet the conditions of participation for hospitals (§§ 405.1020 through 405.1035) and special conditions of participation for psychiatric hospitals (§§ 405.1036 through 405.1038).

(2) *Rehabilitation hospitals.* A rehabilitation hospital must—

(i) Have a provider agreement under Part 489 of this chapter to participate as a hospital;

(ii) Have treated, during its most recent 12-month cost reporting period, an inpatient population of which at least 75 percent required intensive rehabilitative services for the treatment of one or more of the following conditions:

(A) Stroke.

(B) Spinal cord injury.

(C) Congenital deformity.

(D) Amputation.

(E) Major multiple trauma.

(F) Fracture of femur (hip fracture).

(G) Brain injury.

(H) Polyarthritis, including rheumatoid arthritis.

(iii) Have in effect a preadmission screening procedure under which each prospective patient's condition and medical history are reviewed to determine whether the patient is likely to benefit significantly from an intensive inpatient hospital program or assessment;

(iv) Ensure that the patients receive close medical supervision and furnish, through the use of qualified personnel, rehabilitation nursing, physical therapy, and occupational therapy, plus, as needed, speech therapy, social services or psychological services, and orthotic and prosthetic services;

(v) Have a full-time director of rehabilitation who is a Doctor of Medicine or Osteopathy, is licensed under State law to practice medicine or surgery, and has had, after completing a one-year hospital internship, at least one year of training in the medical management of patients requiring rehabilitation services, or is Board-certified in physiatry, neurology, neurosurgery, orthopedic surgery, or rheumatology;

(vi) Have a plan of treatment for each inpatient that is established, reviewed, and revised as needed by a physician in consultation with other professional personnel who provide services to the patient; and,

(vii) Use a coordinated multidisciplinary team approach in the rehabilitation of each inpatient, as documented by periodic clinical entries made in the patient's medical record to note the patient's status in relationship to goal attainment, and that team conferences are held at least every two weeks to determine the appropriateness of treatment.

(3) *Psychiatric and rehabilitation units (distinct parts).* A psychiatric unit must meet the requirements of paragraphs (c)(3)(i) and (c)(3)(ii) of this section. A rehabilitation unit must meet

the requirements of paragraphs (c)(3)(i) and (c)(3)(iii) of this section.

(i) A distinct part unit must—

(A) Be part of an institution that has in effect an agreement under Part 489 of this chapter to participate as a hospital;

(B) Have written admission criteria that are applied uniformly to both Medicare and non-Medicare patients;

(C) Have admission and discharge records that are separately identified from those of the hospital in which it is located and are readily available;

(D) Have policies specifying that necessary clinical information is transferred to the unit when a patient of the hospital is transferred to the unit;

(E) Meet applicable State licensure laws;

(F) Have utilization review standards applicable for the type of care offered in the unit;

(G) Have beds physically separate from (i.e., not commingled with) the hospital's other beds;

(H) Be serviced by the same fiscal intermediary as the hospital;

(I) Be treated as a separate cost center for cost finding and apportionment purposes;

(J) Use an accounting system that properly allocates costs;

(K) Maintain adequate statistical data to support the basis of allocation; and

(L) Report its costs in the hospital's cost report covering the same fiscal period and using the same method of apportionment as the hospital.

(ii) A psychiatric unit (distinct part) must—

(A) Treat only patients whose primary reason for admission to the unit was for treatment of a diagnosis contained in the Third edition of the American Psychiatric Association's Diagnostic and Statistical Manual;

(B) Be directed by a psychiatrist who is certified by the American Board of Psychiatry and Neurology or is eligible for examination by the Board;

(C) Furnish, through the use of qualified personnel, psychological services, social work services, psychiatric nursing, occupational therapy, and recreational therapy;

(D) Have a supervising nurse who is a registered professional nurse qualified in psychiatric or mental health nursing; and

(E) Have a plan of treatment for each patient which is established, reviewed, and revised as needed by a multidisciplinary team consisting of at least a Doctor of Medicine or Osteopathy, a psychologist, and a psychiatric nurse.

(iii) A rehabilitation unit (distant part) must—

(A) Have treated, during its most recent 12-month cost reporting period, an inpatient population of which at least 75 percent required intensive rehabilitative services for the treatment of one or more of the following conditions:

(1) Stroke.

(2) Spinal cord injury.

(3) Congenital deformity.

(4) Amputation.

(5) Major multiple trauma.

(6) Fracture of femur (hip fracture).

(7) Brain injury.

(8) Polyarthritis, including rheumatoid arthritis.

(B) Have in effect a preadmission screening procedure under which each prospective patient's condition and medical history are reviewed to determine whether the patient is likely to benefit significantly from an intensive inpatient program or assessment;

(C) Ensure that the patients receive close medical supervision and furnish, through the use of qualified personnel, rehabilitation nursing, physical therapy, and occupational therapy, plus, as needed, speech therapy, social services or psychological services, and orthotic and prosthetic services;

(D) Have a plan of treatment for each inpatient that is established, reviewed, and revised as needed by a physician in consultation with other professional personnel who provide services to the patient; and

(E) Use a coordinated multidisciplinary team approach in the rehabilitation of each inpatient, as documented by periodic clinical entries made in the patient's medical record to note the patient's status in relationship to goal attainment, and that team conferences are held at least every two weeks to determine the appropriateness of treatment; and

(F) Have a full-time director of rehabilitation who is a Doctor of Medicine or Osteopathy, is licensed under State law to practice medicine or surgery, and has had, after completing a one-year hospital internship, at least one year of training in the medical management of patients requiring rehabilitation services, or is Board-certified in physiatry, neurology, neurosurgery, orthopedic surgery, or rheumatology.

(4) *Children's hospitals.* A children's hospital must—

(i) Have a provider agreement under Part 489 of this chapter to participate as a hospital; and

(ii) Be engaged in furnishing services to inpatients who are predominantly individuals under the age of 13.

(5) *Long-term hospitals.* A long-term care hospital must—

(i) Have a provider agreement under part 489 of this chapter to participate as a hospital; and

(ii) Have an average length of inpatient stay greater than 25 days—

(A) As computed by dividing the number of total inpatient days (less leave or pass days) by the number of total discharges for the hospital's most recent complete cost reporting period; or

(B) If a change in the hospital's average length of stay is indicated, as computed by the same method for the immediately preceding six-month period.

(6) *Hospitals outside the 50 States or the District of Columbia.* A hospital is excluded from the prospective payment system if it is not located in one of the fifty States or the District of Columbia.

(7) *Hospitals reimbursed under special arrangements.* A hospital must be excluded from prospective payment for inpatient hospital services if it is reimbursed under special arrangement as provided in § 405.471(b)(3).

§ 405.472 Conditions for payment under the prospective payment system.

(a) *General requirements.*

(1) A hospital must meet the conditions of this section to receive payment under the prospective payment system for inpatient hospital services furnished to Medicare beneficiaries.

(2) If a hospital fails to comply with these conditions with respect to a particular inpatient hospital stay for a single individual, HCFA may deny payment for that discharge.

(3) If a hospital fails to comply with these conditions with respect to inpatient hospital services furnished to Medicare beneficiaries generally, HCFA may, as appropriate—

(i) Withhold all Medicare payment to the hospital until the hospital provides adequate assurances of future compliance; or

(ii) Terminate the hospital's provider agreement.

(b) *Charges to beneficiaries.*

(1) *Permitted charges-stay covered.* A hospital furnishing covered inpatient hospital services (in accordance with § 405.310(m)) to a Medicare beneficiary for which it expects to receive payment under the prospective payment system may charge that beneficiary for—

(i) The applicable deductible and coinsurance amounts under §§ 409.82, 409.83, and 409.87 of this chapter;

(ii) Items and services, furnished at any time during the stay, which are excluded from coverage except for items and services excluded from coverage solely on the basis of requirements at § 405.310(g) (custodial care), § 405.310(k)

(medically unnecessary items and services), or § 405.310(m) (nonphysician services furnished to hospital inpatients by other than a hospital or provider or supplier under arrangements made by a hospital);

(iii) Days of care attributable to a length-of-stay outlier (as described in § 405.475(a)(1)) which—

(A) Are not paid for by Medicare because of the patients' benefits under Medicare are exhausted; or

(B) Are not covered under Medicare Part A for other reasons and waiver of liability under § 405.330 does not apply; (when payment is considered for outlier days, the entire stay is reviewed and days up to the number of days by which the total stay exceeds the outlier day threshold may be denied. In applying this rule, the latest days of the stay will be denied first.);

(iv) Items and services attributable to cost outliers which will not be paid for by Medicare because the services are not covered (for reasons other than exhaustion of benefits) and waiver of liability under § 405.330 does not apply. When payment is considered for cost outliers, the coverage of services throughout the stay will be reviewed. If items and services are denied solely on the basis of § 405.310 (g) or (k), the liability of the beneficiary for those items and services is limited to an amount which, when added to the Medicare payment to the hospital (before application of deductibles and coinsurance), does not exceed the total amount which would have been paid (before application of deductible and coninsurance) if all the services had been viewed as covered.); and

(v) The customary charge differential for a private room or other luxury service that is more expensive than is medically required and is furnished for the personal comfort of the beneficiary at his or her request (or that of the person acting on his or her behalf).

(2) *Prohibited charges.* A hospital may not charge a beneficiary for any services for which payment is made by Medicare, even if the hosptial's costs of furnishing services to that beneficiary are greater than the amount the hospital is paid under the prospective payment system.

(c) *Admissions and quality review.* Beginning on October 1, 1984 a hospital must have an agreement with a Utilization and Quality Control Peer Review Organization (PRO) to have its admission patterns, length of stays, transfers, services furnished in outlier cases, the validity of diagnostic information, and the quality of its services reviewed on an on-going bases.

(d) *Medical review activities for hospitals paid under the prospective payment system.*

(1) *Admission pattern monitoring (APM).* HCFA will prepare a report which compares a hospital's discharge rate for a quarter with the same hospital's discharge rate for the previous eight quarters. If the hospital's discharge rate increases significantly, the report will be sent to the medical review agent for analysis.

(i) The medical review agent, during the course of its analysis, may request information or records from the hospital, and may conduct on-site medical record review to determine if the increased discharges reflected medically necessary and appropriate admissions.

(ii) If, as a result of analysis under paragraph (d)(1)(i) of this section, the medical review agent finds a pattern of unnecessary or inappropriate admissions, the medical review agent will intensify medical review activities.

(2) *DRG validation.* (i) The attending physician must, shortly before, at or shortly after discharge (but before a claim is submitted), attest to in writing the principal diagnosis, secondary diagnoses, and names of procedures performed.

(ii) The medical review agent will review, every six months, at the hospital, a random sample of discharges for the previous six-month period, to verify that the diagnostic and procedural coding, used by the hospital for DRG assignment, is substantiated by the corresponding medical records.

(iii) If the diagnostic and procedural information, attested to by the attending physician, is found to be inconsistent with the hospital's coding or DRG assignment, the hospitals' coding will be appropriately changed and payments recalculated, based on the appropriate DRG assignments.

(iv) If the information attested to by the physician as stipulated under paragraph (d)(2)(i) of this section is found not to be correct, the medical review agent will change the coding and assign the appropriate DRG, based upon the changed coding.

(e) *Denial of payment as a result of admissions and quality review.*

(1) If HCFA determines, based upon information supplied by a medical review agent, that a hospital has misrepresented admissions, discharge, or billing information, or has taken an action that results in the unnecessary admission of an individual entitled to benefits under Part A, unnecessary multiple admissions of an individual, or other inappropriate medical or other practices with respect to beneficiaries or billing for services funished to beneficiaries, HCFA may as appropriate—

(i) Deny payment (in whole or in part) under Part A with respect to inpatient hospital services provided with respect to such an unnecessary admission or subsequent readmission of an individual; or

(ii) Require the hospital to take other corrective action necessary to prevent or correct the inappropriate practice.

(2) When payment with respect to admission of an individual patient is denied under paragraph (e)(1)(i) of this section, and liability is not waived in accordance with §§ 405.330 to 405.332—

(i) If the medical review agent is a PRO, notice and appeals will be provided under procedures established by HCFA to implement the provisions of sections 1155 of the Act, Right to Hearing and Judicial Review.

(ii) If the medical review agent is a PSRO, assuming review in accordance with § 463.26(c)(1), notice and appeals will be provided in accordance with regulations in Part 473 of this chapter, Hearings and Appeals on PSRO determinations.

(iii) If, in the absence of a PRO or PSRO, a fiscal intermediary acts as a medical review agent, notice and appeals will be provided in accordance with regulations in Subpart G of this part, Reconsiderations and Appeals under the Hospital Insurance Program.

(3) A determination made by HCFA under paragraph (e)(1) of this section, related to a pattern of inappropriate admissions and billing practices that have the effect of circumventing the prospective payment system, shall be effective at such time and upon such reasonable notice to the public and to the person furnishing the services involved as specified in Part 420 of this chapter. Such determination shall be effective in the manner provided in section 1866(b) (3) and (4) of the Act, and regulations in Part 489 of this chapter, with respect to terminations of agreements, and shall remain in effect until HCFA finds and gives reasonable notice to the public that the basis for such determination has been removed and that there is reasonable assurance that it will not recur.

(3) Any person furnishing services described in paragraph (e)(1) of this section who is dissatisfied with a determination made by HCFA under paragraph (e)(3) shall be entitled to reasonable notice and opportunity for a hearing thereon by HCFA to the same extent as is provided in section 205(b) of the Act and to judicial review of the final decision after such hearing as is provided in section 205(g).

(4) HCFA will promptly notify each State agency which administers or supervises the administration of a State plan approved under title XIX of the Act of any determination made under the provisions of paragraph (e)(3) of this section.

(f) *All inpatient hospital services furnished either directly or under arrangements.* The applicable payments made under the prospective payment system, as described in § 405.477, are payment in full for all inpatient hospital services, as defined in § 409.10, other than physicians' services to individual patients reimbursable on a reasonable charge basis (in accordance with the criteria of § 405.550(b)). Except as provided in § 489.23 of this chapter, HCFA will not pay any provider or supplier other than the hospital for services furnished to a beneficiary who is an inpatient, except for physicians' services reimbursable under § 405.550(b). The hospital must furnish all necessary covered services to the beneficiary either directly or under arrangements (as defined in § 409.3).

(g) *Reporting and recordkeeping requirements.* All hospitals participating in the prospective payment system under this section must meet the recordkeeping and cost reporting requirements of §§ 405.406 and 405.453.

§ 405.473 Basic methodology for determining Federal prospective payment rates.

(a) *DRG classification and weighting factors.*

(1) *Diagnosis-related groups.* HCFA will establish a classification of inpatient hospital discharges by Diagnosis-Related Groups (DRGs).

(2) *DRG weighting factors.* HCFA will assign an appropriate weighting factor for each DRG that reflects the estimated relative cost of hospital resources used with respect to discharges classified within that group compared to discharges classified within other groups.

(3) *Assignment of Discharges to DRGs.* HCFA will establish a methodology for classifying specific hospital discharges within DRGs that ensures that each hospital discharge is appropriately assigned to a single DRG based on essential data abstracted from the inpatient bill for that discharge.

(i) The classification of a particular discharge will, as appropriate, be based on the patient's age, sex, principal diagnosis (that is, the diagnosis established after study to be chiefly responsible for causing the patient's admission to the hospital), secondary diagnoses, procedures performed, and discharge status.

(ii) Each discharge will be assigned to only one DRG (related, except as provided in paragraph (a)(3)(iii) of this section, to the patient's principal diagnosis) regardless of the number of conditions treated or services furnished during the patient's stay.

(iii) When the discharge data submitted by a hospital show a surgical procedure unrelated to a patient's principal diagnosis, the bill will be returned to the hospital for validation and reverification. HCFA's DRG classification system will provide a DRG, and an appropriate weighting factor, for the group of cases for which the unrelated diagnosis and procedure are confirmed.

(4) *Revision of DRG classification and weighting factors.* HCFA will adjust the classifications and weighting factors established under paragraphs (a) (1) and (2) of this section, for discharges as necessary, but at a minimum for fiscal year 1986 and at least every four fiscal years thereafter, to reflect changes in treatment patterns, technology, and other factors which may change the relative use of hospital resources.

(b) *Federal rates for fiscal year 1984.*

(1) *General rule.* HCFA will determine national adjusted DRG prospective payment rates, for each inpatient hospital discharge in fiscal year 1984 involving inpatient hospital services of a hospital in the United States subject to the prospective payment system under § 405.471, and will determine regional adjusted DRG prospective payment rates for such discharges in each region, for which payment may be made under Medicare Part A. Such rates will be determined for hospitals located in urban or rural areas within the United States and within each such region, respectively, as described in paragraphs (b)(2) through (b)(11) of this section.

(2) *Determining allowable individual hospital costs.* HCFA will determine the Medicare allowable operating costs per discharge of inpatient hospital services for each hospital in the data base for the most recent cost reporting period for which data are available.

(3) *Updating for fiscal year 1984.* HCFA will update each amount determined under paragraph (b)(2) of this section for fiscal year 1984 by:

(i) Updating for fiscal year 1983 by the estimated average rate of change of hospital costs industry-wide between the cost reporting period used under paragraph (b)(2) of this section and fiscal year 1983; and

(ii) Projecting for fiscal year 1984 by the applicable percentage increase (as defined in § 405.463(c)(3)) for fiscal year 1984.

(4) *Standardizing amounts.* HCFA will standardize the amount updated under paragraph (b)(3) of this section for each hospital by:

(i) Adjusting for area variations in case mix among hospitals;

(ii) Excluding an estimate of indirect medical education costs;

(iii) Adjusting for area variations in hospital wage levels; and

(iv) Adjusting for the effects of a higher cost of living for hospitals located in Alaska and Hawaii.

(5) *Computing urban and rural averages.* HCFA will compute an average of the standardized amounts determined under paragraph (b)(4) of this section for urban and rural hospitals in the United States and for urban and rural hospitals in each region.

(6) *Geographic classifications.* For purposes of paragraph (b)(5) of this section:

(i) The term "region" means one of the nine census divisions, comprising the fifty States and the District of Columbia, established by the Bureau of the Census for statistical and reporting purposes.

(ii) The term "urban area" means:

(A) A Metropolitan Statistical Area (MSA) or New England County Metropolitan Area (NECMA), as defined by the Executive Office of Management and Budget; or

(B) The following New England counties, which are deemed to be urban areas by section 601(g) of the Social Security Amendments of 1983: Litchfield County, Connecticut; York County, Maine; Sagadahoc County, Maine; Merrimack County, New Hampshire; and Newport County, Rhode Island.

(iii) The term "rural area" means any area outside an urban area.

(7) *Adjusting the average standardized amounts.* HCFA adjusts each of the average standardized amounts determined under paragraphs (b)(3) through (b)(5) of this section by factors representing estimates made by HCFA of:

(i) The estimated amount of Medicare payment for nonphysician services to hospital inpatients that would have been paid under Part B during the first cost reporting period subject to propsective payment were it not for the fact that such services must be furnished either directly by hospitals or under arrangements in order for any payment to be made under Medicare after September 30, 1983 (the effective date of § 405.310(m)).

(ii) The estimated amount of FICA taxes that would be incurred during the first cost reporting period subject to the propsective payment system, by hospitals which had not incurred such

taxes for any or all of their employees during the base period described in paragraph (b)(2) of this section.

(8) *Reducing for value of outlier payments.* HCFA reduces each of the adjusted average standardized amounts determined under paragraph (b)(3) through (b)(7) of this section by a proportion equal to the proportion (estimated by HCFA) of the total amount of payments based on DRG prospective payment rates which are additional payments for outlier cases under § 405.475.

(9) *Maintaining budget neutrality.* HCFA adjusts each of the reduced standardized amounts determined under paragraphs (b)(3) through (b)(8) of this section as required for fiscal year 1984 so that the estimated amount of aggregate payments made, excluding the hospital specific portion (that is, the total of the Federal portion of transition payments, plus any adjustments and special treatment of certain classes of hospitals for Federal fiscal year 1984) is not greater or less than 25 percent of the payment amounts that would have been payable for the inpatient operating costs for those same hospitals for fiscal year 1984 under the Social Security Act as in effect April 19, 1983. The aggregate payments considered under this paragraph exclude payments for per case review by a utilization and quality control peer review organization, as allowed under section 1866(a)(1)(F) of the Act.

(10) *Computing Federal rates for urban and rural hospitals in the United States and in each region.* For each discharge classified within a diagnosis-related group, HCFA will establish a national prospective payment rate and will establish a regional prospective payment rate for each region, each of which is equal:

(i) For hospitals located in an urban area in the United States or in that region respectively, to the product of—

(A) The adjusted average standardized amount (computed under paragraphs (b)(3) through (b)(9) of this section) for hospitals located in an urban area in the United States or that region; and

(B) The weighting factor (determined under paragraph (a)(2) of this section) for that Diagnosis-Related Group; and

(ii) For hospitals located in a rural area in the United States or in that region respectively, to the product of—

(A) The adjusted average standardized amount (computed under paragraphs (b)(3) through (b)(9) of this section) for hospitals located in a rural area in the United States or that region; and

(B) The weighting factor (determined under paragraph (a)(2) of this section) for that Diagnosis-Related Group.

(11) *Adjusting for different wage levels.* HCFA will adjust the proportion (as estimated by HCFA from time to time) of Federal rates computed under paragraph (b)(10) of this section which are attributable to wages and labor-related costs, for area differences in hospital wage levels by a factor (established by HCFA) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level.

(c) *Federal rates for fiscal years after Federal fiscal year 1984.*

(1) *General rule.* HCFA will determine a national adjusted prospective payment rate, for each inpatient hospital discharge in a Federal fiscal year after fiscal year 1984 involving inpatient hospital services of a hospital in the United States subject to the prospective payment system under § 405.471, and will determine a regional adjusted prospective payment rate for such discharges in each region, for which payment may be made under Medicare Part A. Each such rate will be determined for hospitals located in urban or rural areas within the United States and within each such region respectively, as described in paragraphs (c)(2) through (c)(6) of this section.

(2) *Updating previous standardized amounts.*

(i) *For fiscal year 1985.* HCFA will compute an average standardized amount for each group of hospitals described in paragraph (b)(5) of this section (urban areas and rural areas within the United States, and urban areas and rural areas within each region), equal to the respective adjusted average standardized amount computed for fiscal year 1984 under paragraph (b)(7) of this section—

(A) Increased for fiscal year 1985 by the applicable percentage increase under § 405.463(c);

(B) Adjusted by the estimated amount of Medicare payment for nonphysician services furnished to hospital inpatients that would have been paid under Part B were it not for the fact that such services must be furnished either directly by hospitals or under arrangements;

(C) Reduced by a proportion equal to the proportion (estimated by HCFA) of the total amount of prospective payments which are additional payment amounts attributable to outlier cases under § 405.475; and

(D) Adjusted for budget neutrality under paragraph (c)(4) of this section.

(ii) For fiscal year 1986 and thereafter, HCFA will compute an average standardized amount for each group of hospitals described in paragraph (b)(5) of this section, equal to the respective adjusted average standardized amounts computed for the previous fiscal year—

(A) Increased by the applicable percentage increase determined under paragraph (c)(3) of this section; and

(B) Adjusted by the estimated amount of Medicare payment for nonphysician services furnished to hospital inpatients that would have been paid under Part B were it not for the fact that such services must be furnished either directly by hospitals or under arrangements.

(C) Reduced by a proportion equal to the proportion (estimated by HCFA) of the amount of payments based on the total amount of prospective payments which are additional payment amounts attributable to outlier cases under § 405.475.

(3) *Determining applicable percentage changes for fiscal year 1986 and following.* The Secretary will determine for each fiscal year (beginning with fiscal year 1986) the applicable percentage change which will apply for purposes of paragraph (c)(2)(ii) of this section as the applicable percentage increase for discharges in that fiscal year, and which will take into account amounts the Secretary believes necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality. In making this determination, the Secretary will consider the recommendations of the Prospective Payment Assessment Commission.

(4) *Maintaining budget neutrality for fiscal year 1985.* For fiscal year 1985, HCFA will adjust each of the reduced standardized amounts determined under paragraph (c)(2) of this section as required for fiscal year 1985 to ensure that the estimated amount of aggregate payments made, excluding the hospital-specific portion (that is, the total of the Federal portion of transition payments, plus any adjustments and special treatment of certain classes of hospitals for fiscal year 1985) is not greater or less than 50 percent of the payment amounts that would have been payable for the inpatient operating costs for those same hospitals for fiscal year 1985 under the law as in effect on April 19, 1983. The

aggregate payments considered under this paragraph exclude payments for per case review by a utilization and quality control peer review organization, as allowed under section 1866(a)(1)(F) of the Act.

(5) *Computing Federal rates for urban and rural hospitals.* For each discharge classified within a Diagnosis-Related Group, HCFA will establish for the fiscal year a national prospective payment rate and will establish a regional prospective payment rate, for each region, each of which is equal—

(i) For hospitals located in an urban area in the United States or that region respectively, to the product of—

(A) The adjusted average standardized amount (computed under paragraph (c)(2) of this section) for the fiscal year for hospitals located in an urban area in the United States or that region; and

(B) The weighting factor (determined under paragraph (a)(2) of this section) for that diagnosis-related group; and

(ii) For hospitals located in a rural area in the United States or that region (respectively), to the product of—

(A) The adjusted average standardized amount (computed under paragraph (c)(2) of this section) for the fiscal year for hospitals located in a rural area in the United States or that region; and

(B) The weighting factor (determined under paragraph (a)(2) of this section) for that diagnosis-related group.

(6) *Adjusting for different area wage levels.* HCFA will adjust the proportion (as estimated by HCFA from time to time) of Federal rates computed under paragraph (c)(5) of this section which are attributable to wages and labor-related costs, for area differences in hospital wage levels by a factor (established by HCFA) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level.

§ 405.474 Determination of transition period payment rates.

(a) General description. (1) *Transition period.* During the initial three-year transition period, payments to all hospitals paid under the prospective payment system will be based on a combination of the Federal prospective payment rates, as determined under § 405.473, and rates based on each hospital-specific rate as determined under paragraph (b) of this section. For the first two years of the transition period, both portions of the payment rates will also be adjusted to ensure budget neutrality. At the end of the transition period (that is, for cost reporting periods beginning on or after October 1, 1986), payments will be based on the national prospective payment rates determined under § 405.473, except for payments which may be made under the specific treatment provisions of § 405.476.

(2) *Payment amounts based on the hospital-specific portion and the Federal portion.* For discharges occurring in cost reporting periods beginning on or after October 1, 1983 and before October 1, 1986, the Medicare transition payment rate for a particular covered discharge will equal a blend of the applicable portion of the hospital-specific rate, as determined under paragraph (b) of this section, plus the applicable portions of the Federal national and regional prospective payment rates, as described in paragraph (a)(3) of this section, and summarized in the Table. Payments to new hospitals will be based on the Federal national and regional prospective payment rates, as described in paragraph (a)(4) of this section.

(3) *Amount of blended portions.* The blend of hospital-specific and Federal portions will be as follows:

(i) For cost reporting periods beginning on or after October 1, 1983 and before October 1, 1984—

(A) 75 percent of the hospital-specific rate; and

(B) 25 percent of the appropriate Federal prospective payment rate.

(ii) For cost reporting periods beginning on or after October 1, 1984 and before October 1, 1985—

(A) 50 percent of the hospital-specific rate;

(B) 50 percent of the appropriate Federal prospective payment rate.

(iii) For cost reporting periods beginning on or after October 1, 1985, and before October 1, 1986—

(A) 25 percent of the hospital-specific rate;

(B) 75 percent of the appropriate Federal prospective payment rate.

(iv) The appropriate Federal prospective payment rate is a combined regional and national rate and changes with the Federal fiscal year. Beginning October 1, 1984, the combined rate is 75 percent regional and 25 percent national. Beginning October 1, 1985, the combined rate is 50 percent regional and 50 percent national. Effective October 1, 1986, the Federal prospective payment rate is 100 percent national.

TABLE—SUMMARY OF HOSPITAL-SPECIFIC AND FEDERAL PORTION PERCENTAGES FOR DETERMINING TRANSITION PAYMENT RATES

Cost reporting period beginning on or after	Hospital-specific portion percentage	Federal portion*
October 1, 1983	75	25
October 1, 1984	50	50
October 1, 1985	25	75
October 1, 1986	-	100

*Note: The Federal portion percentages are applied to the combined national or regional prospective payment rates, as appropriate, as determined under § 405.473 for the Federal fiscal year in which the discharge occurs.

(4) *Blended portions for new hospitals.* The prospective payment rates for new hospitals will be a blend of the Federal regional and national rates as follows:

(i) For discharges occurring on or after October 1, 1983 and before October 1, 1984, the prospective payment will equal the appropriate Federal regional rate.

(ii) For discharges occurring on or after October 1, 1984 and before October 1, 1985—

(A) 75 percent of the appropriate Federal regional prospective payment rate; and

(B) 25 percent of the appropriate Federal national rate.

(iii) For discharges occurring on or after October 1, 1985 and before October 1, 1986—

(A) 50 percent of the appropriate Federal regional; prospective payment rate; and

(B) 50 percent of the appropriate Federal national prospective payment rate.

(b) Determining the hospital-specific rate. (1) *Base-year costs.*

(i) For each hospital, the intermediary will estimate the hospital's Medicare Part A allowable inpatient operating costs, as described in § 405.470(b)(3), for the 12-month or longer cost reporting period ending on or after September 30, 1982 and before September 30, 1983.

(ii) If the hospital's last cost reporting period ending before September 30, 1983 is for less than 12 months, the base period will be the hospital's most recent 12-month or longer cost reporting period ending before such short-period report, with an appropriate adjustment for inflation. (See paragraph (c) of this section for rules applicable to new hospitals.)

(iii) The intermediary will use the best data available at the time in estimating each hospital's base-year costs.

(A) Higher costs that were incurred for purposes of increasing base year costs, or that have the effect of distorting base year costs as an

appropriate basis for computing the hospital-specific rate, or higher costs that result from changes in hospital accounting principles initiated in the base year will be excluded from base year costs for purposes of this section.

(B) A hospital that becomes subject to the prospective payment system beginning on or after October 1, 1983 and before November 16, 1983, may, up to November 15, 1983, have its base period cost per case recomputed, either at the hospital's request or the intermediary's initiative, to take into account inadvertent omissions in its previous submissions to the intermediary related to changes made by the prospective payment legislation for the purpose of determining base period costs. Such omissions pertain to adjustments to exclude capital-related costs and the direct medical education costs of approved educational activities and to adjustments specified in paragraph (b)(1)(iii)(A) and (b)(2)(ii) of this section.

(iv) The intermediary's estimate of base-year costs is final and may not be changed except as follows:

(A) To correct mathematical errors of calculations. The hospital must report such errors of calculations to the intermediary within 90 days of the intermediary's notification to the hospital of the hospital's payment rates. The intermediary may also identify such errors and initiate their correction during this period. The intermediary will either make an appropriate adjustment or notify the hospital that no adjustment is warranted within 30 days of receipt of the hospital's report of an error. Corrections of errors of calculations will be effective with the first day of the hospital's first cost reporting period subject to the prospective payment system.

(B) To take into account a successful appeal relating to base period costs. If a hospital successfully contests a disallowance of costs incurred in its base year, the intermediary will recalculate the hospital's base year costs, incorporating the additional costs recognized as allowable as a result of the appeal. Adjustments to base period costs to take into account such previously disallowed costs will be effective with the first day of the hospital's first cost reporting period beginning on or after the date of the appeal decision. The hospital's revised base period costs will not be used to recalculate the hospital-specific portion as determined for fiscal years beginning before the date of the appeal decision.

(c) To exclude costs that were unlawfully claimed as determined as a result of criminal conviction, imposition of a civil money penalty or assessment, a civil judgment under the False Claims Act (31 U.S.C. 3729–3731), or a proceeding for exclusion from the Medicare program. In addition to adjusting base year costs, HCFA will recover both the excess costs reimbursed for the base period and the additional amounts paid due to the inappropriate increase of the hospital-specific portion of the hospital's transition payment rates. The amount to be recovered will be computed based on the final resolution of the amount of the inappropriate base-year costs.

(v) Except as provided in paragraphs (b)(1)(iii)(B) and (b)(1)(iv) of this section, the intermediary's estimate of base-year costs for purposes of determining the hospital-specific portion is final, and may not be changed after the first day of the first cost reporting period beginning on or after October 1, 1983.

(2) *Adjustments to base-year cost.*

(i) The intermediary will adjust the hospital's estimated base year inpatient operating costs, as necessary, to eliminate nursing differential costs (as described in § 405.430), direct medical education costs (as described in § 405.421), capital-related costs (as described in § 405.414), and kidney acquisition costs incurred by hospitals approved as renal transplantation centers (as described in § 405.476(h)). Kidney acquisition costs in the base year will be determined by multiplying the hospital's average kidney acquisition cost per kidney times the number of kidney transplants covered by Medicare Part A during the base period. Malpractice insurance costs will be included in the inpatient operating costs, as described in § 405.452.

(ii) A hospital may request the intermediary to further adjust its estimated base period costs to take into account—

(A) Services paid for under Medicare Part B during the hospital's base year that will be paid for under prospective payments. The base year costs may be increased to include estimated payments for certain services previously billed as physicians' services before the effective date of § 405.550(b), and estimated payments for nonphysicians' services that were not furnished either directly or under arrangements before October 1, 1983 (the effective date of § 405.310(m)), but may not include the costs of anesthetists services for which a physician employer continues to bill under § 405.553(b)(4).

(B) The payment of FICA taxes during cost reporting periods subject to the prospective payment system, if the hospital had not paid such taxes for all its employees during its base period and will be required to participate effective January 1, 1984.

(iii) If a hospital requests its base period costs to be adjusted under paragraph (b)(2)(ii) of this section, it must timely provide the intermediary with sufficient documentation to justify the adjustment and adequate data to compute the adjusted costs. The intermediary will determine whether to use part or all of the data based on audit, survey, and other information available.

(3) *Costs on a per discharge basis.* The intermediary will determine the hospital's estimated adjusted base year operating cost per discharge by dividing the total adjusted operating costs by the number of discharges in the base period.

(4) *Case-mix adjustment.* The intermediary will divide the adjusted base year costs by the hospital's 1981 case-mix index. If the hospital's case-mix index is statistically unreliable (as determined by HCFA), the hospital's base year costs will be divided by the lower of:

(i) The hospital's estimated case-mix index; or

(ii) The average case-mix index for the appropriate classifications of all hospitals subject to cost limits, established under § 405.460 for cost reporting periods beginning on or after October 1, 1982 and before October 1, 1983.

(5) *Outlier adjustment.* The intermediary will reduce the case-mix adjusted base year costs by a percentage equal to the proportion (estimated by HCFA) of the amount of payments based on prospective payment rates that will be additional payments for outlier cases under § 405.475.

(6) *Updating base year costs.*

(i) *For Federal fiscal year 1984.* The case-mix adjusted base year cost per discharge will be updated by the applicable updating factor (that is, the target rate percentage determined under § 405.463(c)), as adjusted for budget neutrality.

(ii) *For Federal fiscal year 1985.* The amount determined under paragraph (b)(6)(i) of this section will be updated by the applicable updating factor, as adjusted for budget neutrality.

(iii) *For Federal fiscal year 1986.* The amount determined under paragraph (b)(6)(ii) of this section will be updated by the applicable updating factor, that is, the target rate percentage determined under § 405.463(c).

(7) *Budget neutrality.*

(i) *Federal Fiscal year 1984.* For cost reporting periods beginning on or after October 1, 1983 and before October 1,

1984, HCFA will adjust the target rate percentage used under paragraph (b)(6) of this section by a factor actuarially estimated to ensure that the estimated amount of aggregate Medicare payments made based on the hospital-specific portion of the transition payment rates are neither greater nor less than 75 percent of the payment amounts that would have been payable for the inpatient operating costs for those same hospitals for fiscal year 1984 under the law in effect before April 20, 1983.

(ii) *Federal fiscal year 1985.* For cost reporting periods beginning or or after October 1, 1984 and before October 1, 1985, HCFA will adjust the target rate percentage used under paragraph (b)(6) of this section by a factor actuarially estimated to ensure that the estimated amounts of aggregate Medicare payment made based on the hospital-specific portion of the transition payment rates are neither greater nor less than 50 percent of the payment amounts that would have been payable for the inpatient operating costs for those same hospitals for fiscal year 1985 under the Social Security Act as in effect on April 19, 1983.

(8) *DRG adjustment.* The applicable hospital-specific cost per discharge will be multiplied by the appropriate DRG weighting factor to determine the hospital-specific base payment amount (target amount) for a particular covered discharge.

(c) *Determining transition payment rates for new hospitals.* (1) For purposes of this section, a new hospital is a hospital that:

(i) Is newly participating in the Medicare program (under previous and present ownership); and

(ii) Does not have a 12-month cost reporting period ending before September 30, 1983.

(2) For purposes of computing transition payment rates for a new hospital, HCFA will not use the hospital-specific portion of the prospective payment rate. Payments to new providers will be based solely on the Federal regional and national prospective payment rates, as described in paragraph (a)(4) of this section.

(d) *Recovery of excess transition period payment amounts resulting from unlawful claims.* If a hospital's base year costs, as estimated for purposes of determining the hospital-specific portion, are determined, by criminal conviction or imposition of a civil money penalty or assessment, to include costs that were unlawfully claimed, the hospital's base period costs will be adjusted to remove the effect of the excess costs, and HCFA will recover both the excess costs reimbursed for the base period and the additional amounts paid due to the inappropriate increase of the hospital-specific portion of the hospital's transition payment rates.

§ 405.475 Payment for outlier cases.

(a) *General rule.* HCFA will provide for additional payment, approximating a hospital's marginal cost of care beyond thresholds specified by HCFA, to a hospital for covered inpatient hospital services furnished to a Medicare beneficiary if—

(1) The beneficiary's length of stay (including days at the SNF level of care if a SNF bed is not available in the area) exceeds the mean length of stay for the applicable DRG by the lesser of—

(i) A fixed number of days, as specified by HCFA; or

(ii) A fixed number of standard deviations, as specified by HCFA;

(2) The beneficiary's length of stay does not exceed criteria established under paragraph (a)(1) of this section, but the hospital's charges for covered services furnished to the beneficiary, adjusted to cost by applying a national cost/charge ratio, exceed the greater of—

(i) A fixed dollar amount (adjusted for area wage levels) as specified by HCFA; or

(ii) A fixed multiple of the Federal prospective payment rate. During the transition period, the Federal rate is a combination of the national rate and regional rate as follows:

Federal fiscal year	Regional rate percentage	National rate percentage
October 1, 1983	100	
October 1, 1984	75	25
October 1, 1985	50	50
October 1, 1986		100

(b) *Publication and revision of outlier criteria.* HCFA will issue threshold criteria for determining outlier payment in the annual notice of prospective payment rates published in accordance with § 405.470(f).

(c) *Payment for extended length of stay (day outliers).* (1) If the hospital stay reflected by a discharge includes covered days of care beyond the applicable threshold criterion, the intermediary will make an additional payment, on a per diem basis, to the provider for those days. A special request or submission by the hospital is not necessary to initiate this payment.

(2) The additional payment will be made only after the medical review agent has reviewed and approved:

(i) The admission;

(ii) The number of outlier days; and

(iii) The validity of the diagnostic and procedural coding.

(3) The per diem payment made under paragraph (c)(1) of this section will be based on 60 percent of the average per diem payment for the applicable DRG, as determined by dividing the Federal prospective payment rate as determined under § 405.475(a)(2)(ii) by the mean length of stay for that DRG.

(4) Any days in the stay identified as noncovered will reduce the number of days reimbursed at the day outlier rate but not to exceed the number of days which occur after the day outlier threshold.

(d) *Payment for extraordinarily high-cost cases (cost outliers).*

(1) A hospital may request its intermediary to make an additional payment for inpatient hospital services that meet the criteria established in accordance with paragraph (a)(2) of this section.

(2) The hospital must request additional payment within 60 days of receipt of the intermediary's initial determination of the prospective payment rate for the discharge.

(3) The hospital must request medical review agent review and approval of all services. The review, using the medical records and itemized charges will determine that:

(i) The admission was medically necessary and appropriate,

(ii) All services were medically necessary and delivered in the most appropriate setting,

(iii) All services were actually rendered, ordered by the physician, and not duplicatively billed, and

(iv) The diagnostic and procedural coding are correct.

(4) The intermediary will base the cost of the discharge on 72 percent of the billed charges for covered inpatient services. The cost will be further adjusted to exclude an estimate of indirect medical education costs, and to include the reasonable charges for nonphysician services billed by an outside supplier under § 489.23.

(5) If any of the services are determined to be noncovered, the charges for these services will be deducted from the requested amount of reimbursement but not to exceed the amount claimed above the cost outlier threshold.

(6) The additional payment amount will be 60 percent of the difference between the hospital's adjusted cost for the discharge (as determined under paragraph (d)(3) of this section) and the threshold criteria established under paragraph (a)(2) of this section.

(e) *Relation to indirect medical education costs.* The outlier payment amounts will be included in total DRG

revenue for purposes of determining payments for indirect medical education costs under § 405.477(d)(2).

§ 405.476 Treatment of sole community hospitals, Christian Science sanitoria, cancer hospitals, referral centers, and kidney acquisition costs incurred by hospitals approved as renal transplantation centers.

(a) *General rules.*

(1) *Sole community hospitals.* HCFA may adjust the prospective payment rates determined under §§ 405.473 or 405.474 if a hospital, by reason of factors such as isolated location, weather conditions, travel conditions, or absence of other hospitals, is the sole source of inpatient hospital services reasonably available in a geographic area to Medicare beneficiaries. If a hospital meets the criteria for such an exception under paragraph (b) of this section, its prospective payment rates will be determined under paragraph (c) of this section.

(2) *Christian Science Sanitoria.* HCFA will adjust the prospective payment rates determined under §§ 405.473 or 405.474 if a hospital is a Christian Science sanitorium. Such a sanitorium's prospective payment rates will be determined in accordance with paragraph (e) of this section.

(3) *Hospitals involved extensively in treatment for and research on cancer.* HCFA may adjust the prospective payment rates determined under §§ 405.473 and 405.474 if a hospital is involved extensively in treatment for and research on cancer. Criteria for identifying such hospitals are set forth at paragraph (f) of this section.

(4) *Referral center.* HCFA may make an adjustment to the prospective payment rates determined under §§ 405.473 and 405.474 if a hospital acts as a referral center for patients transferred from other hospitals. Criteria for identifying such referral centers are set forth at paragraph (g) of this section.

(5) *Kidney acquisition costs incurred by hospitals approved as renal transplantation centers.* HCFA will pay for kidney acquisition costs incurred by renal transplantation centers on a reasonable cost basis. The criteria for this special payment provision are set forth at paragraph (h) of this section.

(b) *Requests and criteria for classification as a sole community hospital (SCH).*

(1) *Request for classification.* A hospital may request classification as a sole community hospital according to the following procedures:

(i) The hospital must make its request to its fiscal intermediary.

(ii) The intermediary will review the request and will send the request, with its recommendation, to HCFA.

(iii) HCFA will review the request and the intermediary's recommendation and forward its approval or disapproval to the intermediary.

(iv) An approved classification as a sole community hospital will remain in effect without need for reapproval unless there is a change in the circumstances under which the classification was approved.

(2) For purposes of paragraph (b)(3) of this section:

(i) The term "urban area" means:

(A) A Metropolitan Statistical Area (MSA) or New England County Metropolitan Area (NECMA), as defined by the Executive Office of Management and Budget; or

(B) The following New England counties, which are deemed to be urban areas: Litchfield County, Connecticut; York County, Maine; Sagadahoc County, Maine; Merrimack County, New Hampshire; and Newport County, Rhode Island.

(ii) The term "rural area" means any area outside an urban area.

(3) *Criteria for classification as a sole community hospital.*

(i) A hospital that has been granted an exemption from the hospital cost limits under § 405.460(e)(1) on or before September 30, 1983 will be automatically classified as a sole community hospital under the prospective payment system unless the hospital's classification has been cancelled under paragraph (b)(6) of this section or unless the area in which the hospital is located has been designated as an urban area.

(ii) A hospital will be classified as a sole community hospital if it is located in a rural area; and

(A) The hospital is located more than 50 miles from other like hospitals; or

(B) The hospital is located between 25 and 50 miles from other like hospitals and, either no more than 25 percent of the residents in the hospital's service area are admitted to the other like hospitals for care, or because of local topography or periods of prolonged severe weather conditions, the other like hospitals are inaccessible for at least one month out of each year; or

(C) The hospital is located between 15 and 25 miles from other like hospitals but because of local topography or periods of prolonged severe weather conditions, the other like hospitals are inaccessible for at least one month out of each year.

(4) The term "miles" as used in this section means the distance in miles measured over improved roads. An improved road for this purpose is any road which is maintained by a local, State, or Federal government entity and which is available for use by the general public.

(5) The term "like hospital", as used in this section, means hospitals furnishing short-term, acute care. HCFA will not evaluate comparability of specialty services in making determinations on SCH classification.

(6) *Cancellation of classification.*

(i) A hospital may request to have its classification as a sole community hospital cancelled at any time, and to be paid rates determined under §§ 405.473 or 405.474, as appropriate.

(ii) If a hospital requests to have its sole community hospital classification cancelled, it may not apply later for reclassification as a sole community hospital unless all hospitals within 50 miles of the facility have closed.

(c) *Determining prospective payment rates for sole community hospitals.* For all cost reporting periods beginning on or after October 1, 1983, the prospective payment rates for sole community hospitals will equal 75 percent of the hospital-specific base payment rate (as determined under § 405.474(b)) plus 25 percent of the appropriate regional prospective payment rate (as determined under § 405.473).

(d) *Additional payments to sole community hospitals experiencing a significant volume decrease during the transition period.*

(1) For cost reporting periods beginning on or after October 1, 1983 and before October 1, 1986, HCFA will provide for a payment adjustment for a sole community hospital in any cost reporting period during which the hospital experiences, due to circumstances as described in paragraph (d)(2) of this section, more than a 5 percent decrease in its total discharges of inpatients as compared to its immediately preceding cost reporting period.

(2) To qualify for a payment adjustment due to a decrease in discharges, a sole community hospital must—

(i) Submit documentation to the intermediary demonstrating the size of the decrease in discharges, and the resulting effect on per discharge costs; and

(ii) Show that the decrease is due to extraordinary circumstances beyond the hospital's control. Such circumstance include unusual situations or occurrences externally imposed on the hospital, such as (but not limited to) strikes, fires, earthquakes, floods, inability to recruit essential physician staff, unusual prolonged severe weather

conditions, or similar unusual occurrences with substantial cost effects.

(3) HCFA will determine a per discharge payment adjustment amount, including at least an amount reflecting the reasonable cost of maintaining the hospital's necessary core staff and services, based on—

(i) The individual hospital's needs and circumstances, including minimum staffing requirements imposed by State agencies;

(ii) The hospital's fixed (and semi-fixed) costs, other than those costs reimbursed on a reasonable cost basis under this subpart; and

(iii) The length of time the hospital has experienced a decrease in utilization.

(e) *Determining prospective payment rates for Christian Science sanitoria.*

(1) *General rule.* If a Christian Science Sanitorium is not excluded from the prospective payment system under § 405.471, HCFA will pay for inpatient hospital services furnished to a beneficiary by that sanitorium on a basis of a predetermined fixed amount per discharge based on the sanitorium's historical inpatient operating costs per discharge.

(2) *Prospective payment rates.* For cost reporting periods beginning on or after October 1, 1983, the sanitorium's prospective payment rate will be equal to the amount that would constitute the sanitorium's target amount under § 405.463(c)(4) if the institution were subject to the rate of increase ceiling at 405.463 instead of the prospective payment system. This amount will not be adjusted for the DRG weighting factor.

(3) *Outlier payments.* A Christian Science sanitorium is not eligible for outlier payments under § 405.475.

(f) *Cancer hospitals*

(1) *Criteria for classification.* HCFA will consider a hospital's request for an adjustment to a cancer hospital's prospective payment rates only if the hospital—

(i) Was recognized as a comprehensive cancer center or clinical cancer research center by the National Cancer Institute of the National Institutes of Health as of April 20, 1983;

(ii) Demonstrates that the entire facility is organized primarily for treatment of and research on cancer; and

(iii) Has a patient population such that at least 80 percent of the hospital's total discharges are in Diagnosis-Related Groups incorporating a finding of cancer in the principal diagnosis (that is, the condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital).

(2) *Payment.*

(i) A hospital meeting the criteria in paragraph (f)(1) of this section may elect, during its first cost reporting period subject to the prospective payment system, to be reimbursed on a reasonable cost basis under this subpart, subject to the rate of increase limit under § 405.463.

(ii) If the hospital elects reasonable cost reimbursement under paragraph (f)(2)(i) of this section, it will continue to be reimbursed on that basis until it elects to enter the prospective payment system.

(iii) A hospital that does not elect reasonable cost reimbursement under paragraph (f)(2)(i) of this section before the end of its first cost reporting period subject to prospective payment, or that elects to enter the prospective payment system under paragraph (f)(2)(ii) of this section, may not again apply for an adjustment under this paragraph.

(g) *Referral centers.*

(1) *Criteria.* HCFA will consider a hospital's request for a referral center adjustment to the hospital's prospective payment rates only if the hospital is an acute care hospital that has a provider agreement under Part 489 of this chapter to participate in Medicare as a hospital; and

(i) Is located in a rural area (as defined in § 405.473(b)(6)) and has 500 or more beds available for use; or

(ii) Has an inpatient population such that at least 60 percent of all Medicare patients reside out-of-state or more than 100 miles from the hospital (whichever is further), and at least 60 percent of all the services it furnishes to beneficiaries are furnished to beneficiaries who reside either out of the State or 100 miles or more from the hospital, whichever is further.

(2) *Payments to rural referral centers with 500 or more beds.* A hospital that meets the criteria of paragraph (g)(1)(i) of this section will be paid prospective payments per discharge based on the applicable urban payment rates as determined in accordance with § 405.473 (b)(10) or (c)(7), as adjusted by the hospital's area wage index.

(h) *Adjustments for renal transplantation centers.*

HCFA will adjust the prospective payment rates determined under § § 405.473 and 405.474 for hospitals approved as renal transplantation centers (described at § § 405.2170 and 405.2171) to remove the estimated net expenses associated with kidney acquisition. Kidney acquisition costs will be treated apart from the prospective payment rate and reimbursement to the hospital will be adjusted in each reporting period to reflect an amount necessary to compensate the hospital for reasonable expenses of kidney acquisition. Expenses recognized under this section include costs of acquiring a kidney, from a live donor or a cadaver, irrespective of whether the kidney was obtained by the hospital or through an organ procurement agency. These costs include—

(1) Tissue typing, including tissue typing furnished by independent laboratories;

(2) Donor and recipient evaluation;

(3) Other costs associated with excising kidneys, such as donor general routine and special care services;

(4) Operating room and other inpatient ancillary services applicable to the donor;

(5) Preservation and perfusion costs;

(6) Charges for registration of recipient with a kidney transplant registry;

(7) Surgeons' fees for excising cadaver kidneys;

(8) Transportation;

(9) Costs of kidneys acquired from other providers or kidney procurement organizations;

(10) Hospital costs normally classified as outpatient costs applicable to kidney excisions (services include donor and donee tissue typing, work-up, and related services furnished prior to admission);

(11) Costs of services applicable to kidney excisions which are rendered by residents and interns not in approved teaching programs; and

(12) All pre-admission physicians services, such as laboratory, electroencephalography, and surgeon fees for cadaver excisions, applicable to kidney excisions including the costs of physicians services.

§ 405.477 Payments to hospitals under the prospective payment system.

(a) *Total Medicare payment.* Under the prospective payment system Medicare's total payment for inpatient hospital services furnished to a Medicare beneficiary by a hospital will equal the sum of the payments listed in paragraphs (b), (c), and (d) of this section, reduced by the amounts listed in paragraph (e) of this section.

(b) *Payments determined on a per case basis.* A hospital will be paid on a per case basis the following amounts:

(1) The appropriate prospective payment rate for each discharge as determined in accordance with § § 405.473, 405.474, and 405.476;

(2) The appropriate outlier payment amounts determined under § 405.475.

(c) *Payments determined on a reasonable cost basis*—(1) *Capital-related costs.* Payment for capital-related costs (as described in § 405.414) will be determined on a reasonable cost basis. For cost reporting periods beginning before October 1, 1986, the capital-related costs for each hospital must be determined consistently with the treatment of such costs for purposes of determining the hospital-specific portion of the hospital's prospective payment rate under § 405.474(b).

(2) *Direct medical education costs.* Payment for the cost of approved medical educational activities as defined in § 405.421 will be made on a reasonable cost basis (except with respect to activities defined in § 405.421(d)). For cost reporting periods beginning prior to October 1, 1986, the costs of medical education must be determined consistently with the treatment of such costs for purposes of determining the hospital-specific portion of the transition payment rate in § 405.474.

(d) *Additional payments*—(1) *Bad debts.* An additional payment will be made to each hospital in accordance with § 405.420 for bad debts attributable to deductible and coinsurance amounts related to covered services received by beneficiaries.

(2) *Indirect medical education costs.*

(i) An additional payment may be made to a hospital for indirect medical education costs attributable to an approved graduate medical education.

(ii) To determine the indirect medical education costs, HCFA will determine for each hospital its:

(A) Ratio of full-time equivalent interns and residents to beds, excluding those interns and residents in anesthesiology who are employed to replace anesthetists;

(B) Total revenue based on DRG-adjusted prospective payment rates (for transition period payments, the Federal portion of the hospital's payment rates), including outlier payments determined under § 405.475.

(iii) Based on a comparison of the inpatient operating costs (as defined in § 405.470(b)(3)) of all hospitals, HCFA will determine a factor, expressed as a percentage, representing the effect of teaching activity on operating costs in the same manner as for the limit on hospital inpatient operating costs in effect on January 1, 1983, and will set an education adjustment factor at twice that percentage.

(iv) Each hospital's indirect medical education payment will be determined by multiplying its:

(A) Total DRG revenue, as determined under paragraph (d)(2)(ii)(B) of this section;

(B) A factor representing each 0.1 increase in the hospital's ratio of full-time equivalent interns and residents to beds, as determined under paragraph (d)(2)(ii)(A) of this section; and

(C) The education adjustment factor determined under paragraph (d)(2)(iii) of this section.

(v) The number of full-time equivalent interns and residents under paragraph (d)(2)(ii)(A) will include only interns and residents in teaching programs approved under § 405.421 (excluding those employed by the hospital, but furnishing services at another site), and will equal the sum of:

(A) Interns and residents employed for 35 hours or more per week; and

(B) One half of the total number of interns and residents working less than 35 hours per week (regardless of the number of hours worked).

(e) *Reductions to total payments*—(1) *Deductible and Coinsurance.* Subject to paragraph (e)(2) of this section, the total Medicare payments otherwise payable to a hospital will be reduced by the applicable deductible and coinsurance amounts related to inpatient hospital services as determined in accordance with §§ 409.82, 409.83, and 409.87.

(2) *Payment by Workers' Compensation, Automobile Medical, No-fault or Liability Insurance or an employer Group Health Plan Primary to Medicare.* If workers' compensation, automobile medical, no-fault, or liability insurance or an employer group health plan which is primary to Medicare pays in full or in part, the Medicare payment will be determined in accordance with the following guidelines:

(i) If workers compensation pays, in accordance with the applicable provisions of §§ 405.316 through 405.321.

(ii) If automobile medical, no-fault, or liability insurance pays, in accordance with the applicable provisions of §§ 405.322 through 405.325.

(iii) If an employer group health plan which is primary to Medicare pays for services to ESRD beneficiaries, in accordance with the applicable provisions of §§ 405.326 through 405.329.

(iv) If an employer group health plan which is primary to Medicare pays for services to employees age 65–69 and their spouses age 65–69, in accordance with the applicable provisions of §§ 405.340 through 405.344.

(3) HCFA will reduce payments for inpatient hospital services to take into account 100 percent of the reasonable charges (before application of Medicare Part B deductible and coinsurance amounts) for nonphysician services furnished, to beneficiaries entitled to benefits under Medicare Part A, by an outside supplier under § 489.23.

(f) *Effect of change of ownership on payments under the prospective payment system.*

(1) When a hospital's ownership changes, as described in § 489.18 of this chapter, payment for the operating costs of inpatient hospital services for each patient, including outlier payments, as described in paragraph (b) of this section, and payments for indirect medical education costs as described in paragraph (d)(2) of this section, will be made to the legal owner of the hospital at the time of discharge. Payments will not be prorated between the buyer and seller.

(i) The owner on the date of discharge is entitled to submit a bill for all inpatient hospital services furnished to a beneficiary regardless of when the beneficiary's coverage began or ended during a stay, or of how long the stay lasted.

(ii) Each bill submitted must include all information necessary for the intermediary to compute the payment amount, whether or not some of that information is attributable to a period during which a different party legally owned the hospital.

(2) Payment for costs described in paragraphs (c) and (d)(1) of this section, will be made to each owner or operator of the hospital (buyer and seller) in accordance with the principles of reasonable cost reimbursement.

4. Section 405.482 is amended by revising paragraph (a) to read as follows:

§ 405.482 Limits on compensation for services of physicians in providers.

(a) *Principle and scope.* (1) Except as provided in paragraphs (a) (2) and (3) of this section, HCFA will establish reasonable compensation equivalent (RCE) limits on the amount of compensation paid to physicians by providers. These limits will be applied to a provider's costs incurred in compensating physicians for services to the provider, as described in § 405.480(a).

(2) Limits established under this section will not apply to costs of physician compensation attributable to furnishing inpatient hospital services that are paid for under the prospective payment system implemented under §§ 405.470 to 405.477.

(3) Compensation that a physician receives for activites that may not be paid for under either Part A or Part B of

Medicare will not be considered in applying these limits.

* * * * *

4. Subpart E is amended as follows:

Subpart E—Criteria for Determination of Reasonable Charges; Reimbursement for Services of Hospital Interns, Residents, and Supervising Physicians

a. The authority citation for Subpart E is revised to read as follows:

Authority: Secs. 1102, 1814(b), 1832, 1833(a), 1842 (b) and (h), 1861 (b) and (v), 1862(a)(14), 1866(a), 1871, 1881, 1886 and 1887 of the Social Security Act as amended (42 U.S.C. 1302, 1395f(b), 1395k, 1395(a), 1395u (b) and (h), 1395x (b) and (v), 1395y (a)(14), 1395cc(a), 1395hh, 1395rr, 1395ww and 1395xx).

b. In the table of contents of subpart E, the title of § 405.552 is amended as set forth below:

Subpart E—Criteria for Determination of Reasonable Charges; Reimbursement of Services of Hospital Interns, Residents, and Supervisory Physicians

Sec.

* * * * *

405.552 Conditions for payment of charges: Anesthesiology services.

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c. Section 405.550 is amended by revising paragraphs (d) (1) and (2) and (e) as follows:

§ 405.550 Conditions for payment of charges for physician services to patients in providers: General provisions.

* * * * *

(d) *Effect of billing charges for physician services to a provider.* (1) If services performed by a physician may be paid for under the reasonable cost rules in §§ 405.480 and 405–481, neither the provider nor physician may seek charge payment for the carrier, beneficiary, or another insurer.

(2) The carrier will not pay on a reasonable charge basis for services furnished by a physician to an individual patient that do not meet the applicable conditions in §§ 405.552, 405.554, and 405.556.

* * * * *

(e) *Effect of physician's assumption of operating costs.* If a physician or other entity enters into an agreement (such as a lease or concession) with a provider, under which the physician (or entity) assumes some or all of the operating costs of the provider department in which the physician furnishes physician services in the provider, the following rules apply:

(1) The carrier will make reasonable charge payments only for a physician's services to an individual patient.

(2) To the extent the provider incurs a cost reimbursable on a reasonable cost basis under Subpart D of this part, the intermediary will pay the provider on a reasonable cost basis for the costs associated with producing these services, including overhead, supply, and equipment costs, and services furnished by nonphysician personnel.

(3) The physician (or other entity) will be treated as related to the provider within the meaning of § 405.427.

(4) The physician (or other entity) must make its books and records available to the provider and the intermediary as necessary to verify the nature and extent of the costs of the services furnished by the physician (or other entity).

d. In § 405.552, the title and paragraph (a) are revised to read as follows:

§ 405.552 Conditions for payment of charges: Anesthesiology services.

(a) *Services furnished directly or concurrently.* The carrier will reimburse a physician for anesthesiology services furnished to patients in a provider on a reasonable charge basis only if the services meet the conditions for reasonable charge payment in § 405.550(b) and the following additional conditions are met:

(1) For each patient, the physician—

(i) Performs a pre-anesthetic examination and evaluation;

(ii) Prescribes the anesthesia plan;

(iii) Personally participates in the most demanding procedures in the anesthesia plan, including induction and emergence;

(iv) Ensures that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified individual;

(v) Monitors the course of anesthesia administration at frequent intervals;

(vi) Remains physically present and available for immediate diagnosis and treatment of emergencies; and

(vii) Provides indicated postanesthesia care.

(2) The physician either performs the procedure directly, without the assistance of an anesthetist, or directs no more than four anesthesia procedures concurrently, and does not perform any other services while he or she is directing the concurrent procedures.

* * * * *

e. Section 405.553 is amended by revising paragraph (b) to read as follows:

§ 405.553 Reasonable charges for anesthesiology services.

* * * * *

(b) *Services furnished by the anesthesiologist or by an anesthetist employed by the anesthesiologist.*

(1)(i) The provisions of this paragraph apply to anesthesia services furnished by an anesthesiologist without the assistance of an anesthetist or to anesthesia services furnished to hospital outpatients or SNF or CORF patients by an anesthetist who is employed by an anesthesiologist.

(ii) Except as provided in paragraph (b)(4) of this section, anesthesia services furnished to a hospital inpatient by an anesthetist under the medical direction of an anesthesiologist will be paid for in accordance with paragraph (c) of this section.

(iii) If the anesthetist who administers anesthesia under the direction of the anesthesiologist is employed by the anesthesiologist, the carrier will determine the amount of payment for the services under the reasonable charge rules for physician services in providers in § 405.551 and the general reasonable charge rules in §§ 405.501 through 405.508.

(2) In determining reasonable charges for these anesthesia services, the carrier will allow for no more than one time unit for each 15 minute interval, or fraction thereof, beginning from the time the physician or anesthetist begins to prepare the patient for induction of anesthesia, and ending when the patient may be safely placed under post-operative supervision and the physician or anesthetist is no longer in personal attendance.

(3) If a physician constructs his or her charges using time units of other than 15 minutes, the carrier will adjust the customary and prevailing charge screens to ensure that in a one-hour period the value of four 15-minute intervals will not be less than would have been allowed if the entire hour had consisted of intervals of another length, such as five 12-minute intervals or six 10 minute intervals.

(4) If the following conditions are met, the provisions of paragraph (b)(1)(ii) of this section do not apply to inpatient hospital services furnished by an anesthetist employed by a physician:

(i) The services are furnished to inpatients of a hospital during a cost reporting period beginning before October 1, 1986.

(ii) It was the physician's practice to employ anesthetists as of the last day of the hospital's most recent 12-month or longer cost reporting period ending before September 30, 1983.

(iii) The cost of the anesthetist services are not added to the hospital's base year costs, as otherwise allowed

under § 405.474(b)(2)(ii)(A), for purposes of determining transition period payment rates under the prospective payment system.

* * * * *

f. Section 405.554 is amended by revising paragraph (b) to read as follows:

§ 405.554 Conditions for payment of charges: Radiology services.

* * * * *

(b) *Services to providers.*—The carrier will not pay on a reasonable charge basis for physician services to the provider (for example, administrative or supervisory services) or for provider services needed to produce the X-ray films or other items that are interpreted by the radiologist. However, allowable costs for such services will be paid to the provider by the intermediary. (See § 405.480 for provider costs, and § 405.550(e) for costs borne by a physician, such as under a lease or concession agreement.)

g. Section 405.555 is amended by revising paragraph (c)(2) to read as follows:

§ 405.555 Reasonable charges for radiology services.

* * * * *

(c) *Services furnished in providers.*

* * *

* * * * *

(2) The reasonable charge for a physician's radiology service furnished to a hospital inpatient or furnished in a provider to a provider patient may not exceed 40 percent of the prevailing charge for a similar service furnished in a nonprovider setting.

h. Section 405.556 is amended by revising paragraph (a) and adding a new paragraph (c) to read as follows:

§ 405.556 Conditions for payment of charges: Physician laboratory services.

(a) *Physician laboratory services.*—The carrier will reimburse laboratory services furnished by a physician to an individual patient on a reasonable charge basis only if the services meet the conditions for reasonable charge payment in § 405.550(b) and are—

(1) Anatomical pathology services;

(2) Consultative pathology services that meet the requirements in paragraph (b) of this section; or

(3) Services performed by a physician in personal administration of test devices, isotopes, or other materials to an individual patient.

* * * * *

(c) *Independent laboratory services furnished to hospital inpatients.* Laboratory services furnished to a hospital inpatient by an independent laboratory (as defined in § 405.1310(a)) will be reimbursed on a reasonable charge basis under this Subpart only if they are physician laboratory services as described in paragraph (a) of this section. Payment for nonphysician services furnished to a hospital inpatient by an independent laboratory will be made by the intermediary to the hospital in accordance with Subpart D.

5. Subpart G is amended as follows:

Subpart G—Reconsiderations and Appeals Under the Hospital Insurance Program

a. The authority citation for Subpart G is revised to read as follows:

Authority: Secs. 1102, 1154, 1155, 1869(b), 1871, 1872 and 1879 of the Social Security Act (42 U.S.C. 1302, 1320c, 1395ff(b), 1395hh, 1395ii and 1395pp).

b. Section 405.704 is amended by reprinting the introductory language of paragraph (b) unchanged and revising paragraph (b)(12) to read as follows:

§ 405.704 Actions which are initial determinations.

* * * * *

(b) *Requests for payment by or on behalf of individuals.* An initial determination with respect to an individual includes any determination made on the basis of a request for payment by or on behalf of the individual under Part A of Medicare, including a determination with respect to:

* * * * *

(12) When items or services are excluded from coverage pursuant to § 405.310(g) or § 405.310(k) or a determination by a Peer Review Organization under section 1154(a)(1) of the Act, whether such individual or the provider of services who furnished such items or services, or both, knew or could reasonably have been expected to know that such items or services were excluded from coverage (see § 405.332); and

* * * * *

c. Section 405.706 is revised by designating the single undesignated paragraph as paragraph (a), and adding a new paragraph (b). As revised the section reads as follows:

§ 405.706 Decisions of utilization review committees.

(a) *General rule.* A decision of a utilization review committee is a medical determination by a staff committee of the provider or a group similarly composed and does not constitute a determination by the Secretary within the meaning of section 1869 of the Act. The decision of a utilization review committee may be considered by HCFA along with other pertinent medical evidence in determining whether or not an individual has the right to have payment made under Part A of title XVIII.

(b) *Applicability under the prospective payment system.* HCFA may consider utilization review committee decisions related to inpatient hospital services paid for under the prospective payment system (see §§ 405.470 through 405.477) only as those decisions concern:

(1) The appropriateness of admissions resulting in payments under §§ 405.473, 405.474, and 405.476;

(2) The covered days of care involved in determinations of outlier payments under § 405.475(a)(1); and

(3) The necessity of professional services furnished in high cost outliers under § 405.475(a)(2).

6. Subpart J is amended as set forth below:

Subpart J—Conditions of Participation; Hospitals

a. The Table of Contents for Subpart J is amended by adding the heading for new § 405.1042 and revising the authority citation to read as follows:

Subpart J—Conditions of Participation; Hospitals

Sec.

* * * * *

§ 405.1042 Condition of participation—Special utilization review requirements for hospitals paid under the prospective payment system.

Authority: Sections 1102, 1154(a)(10), 1861 (e), (f), (g), and (k), 1871, and 1886 of the Social Security Act, as amended (42 U.S.C. 1302, 1395x (e), (f), (g), and (k), 1395hh, and 1395ww).

b. New § 405.1042 is added to read as follows:

§ 405.1042 Condition of participation: Special utilization review requirements for hospitals paid under the prospective payment system.

The hospital must have in effect a utilization review plan that provides for review of services furnished by the institution and by members of the medical staff to patients entitled to benefits under the Medicare and Medicaid programs. The provisions of this section do not apply to a hospital for which a Professional Standards Review Organization or a Utilization and Quality Control Peer Review Organization has assumed binding review.

(a) *Applicability of Utilization Review (UR) plan requirements under titles XVIII and XIX.*

(1) Except as specified in paragraph (a)(2) of this section, for title XVIII purposes the facility must meet the UR requirements specified in this section.

(2) If HCFA determines that the UR procedures established by the State under title XIX of the Act are superior to the procedures required in this section, HCFA may require hospitals in that State to meet the UR plan requirements under §§ 456.50 through 456.245 of this chapter.

(b) *Standard: Composition of utilization review committee.* A UR committee, of which at least two members must be doctors of medicine or Osteopathy, with or without participation of other professional personnel, must carry out the UR functions.

(1) Except as specified in paragraphs (b) (2) and (3) of this section, the UR committee must be one of the following:

(i) A staff committee of the institution;

(ii) A group outside the institution—

(A) Established by the local medical society and some or all of the hospitals in the locality; or

(B) Established in a manner approved by HCFA.

(2) If, because of the small size of the institution, it is impracticable to have a properly functioning staff committee the UR committee must be established as specified in paragraph (b)(1)(ii) of this section.

(3) The committee's or group's reviews may not be conducted by any physician who—

(i) Has a direct financial interest (for example in ownership interest) in the hospital; or

(ii) Was professionally involved in the care of the patient whose case is being reviewed.

(c) *Standard: Scope and frequency of reviews.*

(1) Except as provided in paragraph (c)(2) of this section, the UR plan must provide for review with respect to the medical necessity of—

(i) Admissions to the institution;

(ii) The duration of stays; and

(iii) Professional services furnished, including drugs and biologicals.

(2) In hospitals paid for inpatient hospital services under the prospective payment system (see § 405.470–405.477), the UR plan must provide for:

(i) Review of the duration of stays as required under paragraph (c)(1)(ii) of this section only in cases reasonably assumed by the hospital to be outlier cases based on extended length of stay, as described in § 405.575(a)(1); and

(ii) Review of services furnished as required under paragraph (c)(1)(iii) of this section only in cases reasonably assumed by the hospital to be outlier cases based on extraordinarily high costs, as described in §405.475(a)(2).

(3) Except as specified in paragraph (e) of this section, reviews may be conducted on a sample basis.

(4) The UR plan may provide for review of admissions before, at, or after hospital admission.

(d) *Standard: Final determination regarding admissions or continued stays.*

(1) The final determination that an admission or continued stay is not medically necessary—

(i) May be made by one physician on the UR committee in cases where the attending physician concurs with the determination or fails to present his or her views when afforded the opportunity; and

(ii) Must be made by a least two physicians on the UR committee in all other cases.

(2) Before making a final determination that an admission or continued stay is not medically necessary the UR committee must consult the attending physician and afford him or her the opportunity to present his or her views.

(3) If the committee decides that admission to or further stay in the hospital is not medically necessary, written notification must be given—

(i) To the hospital, the attending physicain and the individual;

(ii) No later than two days after the determination;

(iii) No later than two days after the end of the certified period.

(e) *Standard: Extended stay review.*

(1) Except as provided in paragraph (e)(2) of this section, the UR committee must make a periodic review, as specified in the UR plan, of each current inpatient receiving hospital services during a continuous period of extended duration. The scheduling of the periodic reviews may—

(i) Be the same for all cases; or

(ii) Differ for different classes of cases.

(2) In hospitals paid under the prospective payment system (see §§ 405.470 to 405.477), the UR committee must review all cases reasonably assumed by the hospital to be outlier cases based on extended length of stay (as described in § 405.475(a)(1)).

(3) The UR committee must make the periodic review no later than 7 days after the day required in the UR plan.

(f) *Standard: Review of professional services:* The committee must review professinal services provided, to determine medical necessity and to promote the most efficient use of available health facilities and services.

7. Subpart P is amended as set forth below:

Subpart P—Certification and Recertification; Claims and Benefit Payment Requirements; Check Replacement Procedures

a. The authority citation for Subpart P reads as follows:

Authority: Sections 1102, 1814, 1835, 1871, and 1883, 49 Stat. 647 as amended; 79 Stat. 294; 79 Stat. 303; 79 Stat. 331; 42 U.S.C. 1302, 1395f, 1395n, 1395hh, 1395it, unless otherwise noted.

b. Section 405.1627 is amended by revising paragraphs (a)(1) and (4) and (b) to read as follows:

§ 405.1627 Inpatient hospital services other than inpatient psychiatric or tuberculosis hospital services; certification and recertification for services furnished on or after January 3, 1968.

(a) *General.*

(1) The certification and recertification statement should contain the following information:

(i) An adequate written record of the reasons for:

(A) Continued hospitalization of the patient for medical treatment or for medically required inpatient diagnostic study; or

(B) In the case of certifications or recertifications required under paragraph (b)(2)(i)(B) of this section, special or unusual services;

(ii) The estimated period of time the patient will need to remain in the hospital, or, in the case of certifications or recertifications required under paragraph (b)(2)(i)(B) of this section, the estimated period of time that special or unusual services will be required; and

(iii) Any plans, where appropriate, for posthospital care.

* * * * *

(4) A separate recertification statement is not necessary where the requirements for a second or subsequent recertification are satisfied through utilization review consistent with paragraph (b)(3) of this section. It is sufficient if records of the utilization review committee show that consideration was given to the reasons for continued hospitalization, estimated time the patient will need to remain in the hospital, and plans for posthospital care.

(b) *Timing of certifications and recertifications.*

(1) *For inpatient hospital services that are not paid for under the prospective payment system.* When inpatient

hospital services are not paid for under the prospective payment system (see §§ 405.470 through 405.477), certification is required no later than as of the 12th day of hospitalization. A hospital may, at its option, provide for the certification to be made earlier, or it may vary the timing of the certification within the 12-day period by diagnostic or clinical categories. The first recertification is required no later than as of the 18th day of hospitalization. Thereafter, subsequent recertifications are to be made at intervals established by the utilization review committee (on a case by case basis if it so chooses), but in no event may the prescribed interval between recertifications exceed 30 days.

(2) *For inpatient hospital services that are paid for under the prospective payment system.*

(i) When inpatient hospital services are paid for under the prospective payment system (see §§ 405.470 through 405.477), certification is required as follows:

(A) In cases reasonably assumed by the hospital to be day outlier cases, certification is required no later than one day after the case reasonably appears to meet the day outlier criteria, established under § 405.475(a)(1), or no later than 20 days into the hospital stay, whichever is earlier. The first recertification is required at an interval to be established by the UR Committee (which can be pursuant to a general rule or on a case by case basis) and subsequent recertifications are to be made consistent with paragraph (b)(1) of this section as it relates to subsequent recertifications.

(B) In cases for which payment may be made or has been requested for a cost outlier, as described in § 405.475(a)(2), certification is required no later than the date on which the hospital requests cost outlier payment, or no later than 20 days into the hospital stay, whichever is earlier, except that, where possible, certification is to occur prior to the hospital incurring costs for which it will seek cost outlier payment. In cost outlier cases, the first recertification and subsequent recertifications are to be made at intervals established by the utilization review committee (on a case by case basis if it so chooses).

(ii) Delayed certifications and recertifications, consistent with § 405.1625(e), are acceptable.

(3) *Option to conduct review of stay of extended duration.* At the option of the hospital, review of a stay of extended duration, pursuant to the hospital's utilization review plan, may take the place of the second and any subsequent physician recertifications required under paragraphs (b)(1) and (b)(2)(i)(A) of this section. Such review may be performed before the date on which such physician recertification would otherwise be required, but would be considered timely if performed as late as the seventh day following such date. The next physician recertification would need to be made no later than the 30th day following such review; if review by the utilization review committee took the place of this physician recertification, the review could be performed as late as the seventh day following such 30th day.

(4) *Description of procedure.* The hospital should have available in the files a written description of the procedure it adopts on timing of certifications and recertifications—that is, the intervals at which the necessary statements are required and whether review of long-stay cases by the utilization review committee serves as an alternative to recertification by a physician in the case of the second or subsequent recertifications required under paragraphs (b)(1) and (b)(2)(i)(A) of this section.

c. Section 405.1629 is amended by revising the introductory paragraph to read as follows:

§ 405.1629 Inpatient tuberculosis hospital services and inpatient psychiatric hospital services; certification and recertification.

The requirements for physician certification and recertification for inpatient psychiatric and tuberculosis hospital services are generally similar to the requirements for certification and recertification for inpatient hospital services under § 405.1627. However, for inpatient tuberculosis and psychiatric hospital services, certification is required at the time of admission or as soon thereafter as is reasonable and practicable, and the content of the certification and recertification statements is to conform with the requirements of this section and, in the case of patients admitted to the hospital on or after January 1, 1970, recertification statements are to be obtained in accordance with the intervals set forth in § 405.1627(b)(1). The content requirements differ because of recognition that there frequently is a difference between treatment provided in mental and tuberculosis hospitals and the treatment provided in other hospitals. Often the care provided in such hospitals is purely custodial, while the Medicare program's intent is to cover only active care and not to cover custodial care.

* * * * *

d. Section 405.1630 is revised to read as follows:

§ 405.1630 Certification and recertification for beneficiary admitted to a hospital before entitlement to benefits.

(a) *General rule.* If an individual is admitted to a hosptial (including a psychiatric or tuberculosis hospital) before he is entitled to hospital insurance benefits (for example, before he reaches age 65), the following rules are applicable when he does become entitled.

(b) *For hospitals that are not included in the prospective payment system.* If the hospital is not included in the prospective payment system under § 405.471, certifications and recertifications are required as of the time they would be required under § 405.1627(b)(1) has the patient been admitted to the hospital on the day he became entitled. Such certifications and recertifications must satisfy the content requirements in § 405.1627(a)(1) in the case of inpatient hospital services; § 405.1629(b) in the case of inpatient psychiatric hospital services; and §405.1629(d) in the case of inpatient tuberculosis hospital services. For example, if a patient becomes entitled on September 1, 1968, but was admitted to a general hospital 1 week prior to that date, the certification is required no later than September 14; the first recertification no later than September 21; subsequent recertifications are required at intervals not to exceed 30 days.

(c) *For hospitals included in the prospective payment system.* If the hospital is included in the prospective payment system under § 405.471, certifications and recertifications are required as of the time they would be required under § 405.1627(b)(2) if the patient had been entitled to benefits on the day he or she was admitted. However, delayed certifications and recertifications, consistent with § 405.1625(e), are acceptable in these cases.

8. Subpart R is amended as set forth below:

Subpart R—Provider Reimbursement Determinations and Appeals

a. The authority citation for Subpart R is revised to read as follows:

Authority: Secs. 205, 1102, 1814(b), 1815(a), 1833, 1861(v), 1871, 1872, 1878 and 1886 of the Social Security Act (42 U.S.C. 405, 1302, 1395f(b), 1395g(a), 1395, 1395x(v), 1395hh, 1395ii, 1395oo and 1395ww).

b. The table of contents for Subpart R is amended by adding a new § 405.1804 and revising the title of § 405.1835 as follows:

Subpart R—Provider Reimbursement Determinations and Appeals

Sec.

* * * * *

405.1804 Matters not subject to administrative or judicial review under prospective payment.

* * * * *

405.1835 Right to Board hearing.

* * * * *

c. Section 405.1801 is amended by revising the definition of "intermediary determination" in paragraph (a)(1) and revising paragraphs (b) and (c) to read as follows:

§ 405.1801 Introduction.

(a) *Definitions.* As used in this subpart:

(1) "Intermediary determination" means the following:

(i) With respect to a provider of services that has filed a cost report under §§ 405.406 and 405.453(f), the term means a determination of the amount of total reimbursement due the provider for items and services furnished to beneficiaries for which reimbursement may be made on a reasonable cost basis under Medicare for the period covered by the cost report.

(ii) With respect to a hospital that has filed a cost report and receives payments for inpatient hospital services based on reasonable cost subject to the target rate system (§ 405.463), the term includes a determination of the total amount of payment due the hospital under that system for the period covered by the cost report.

(iii) With respect to a hospital that receives payments for inpatient hospital services under the prospective payment system (§§ 405.470–405.477), the term includes a determination of the total amount of payment due the hospital under that system for the hospital's cost reporting period covered by the determination.

(iv) For purposes of appeal to the Provider Reimbursement Review Board, the term is synonymous with the phrases "intermediary's final determination" and "final determination of the Secretary", as those phrases are used in section 1878(a) of the Act.

(v) For purposes of § 405.374 concerning claims collection activities, the term does not include an action by HCFA with respect to a compromise of a Medicare overpayment claim, or termination or suspension of collection action on an overpayment claim, against a provider or physician or other supplier.

* * * * *

(b) *General rule.*

(1) *Providers.* The principles of reimbursement for determining reasonable costs, reasonable cost subject to the target rate, and prospective payment are contained in Subpart D of this part. In order to be reimbursed for covered services furnished to Medicare beneficiaries, providers of services are obliged to file cost reports with their intermediaries as specified in § 405.453(f). Where the term "provider" appears in this subpart, it includes hospitals paid under the target rate or the prospective payment systems for purposes of applying the appeal procedures described in this subpart to those hospitals.

(2) *Other entities participating in Medicare Part A.* In addition to providers of services whose status as such is indicated in the Act, there are entities (such as health maintenance organizations) that do not meet the statutory test for providers of services, which may also participate in Medicare. These entities are required to file periodic cost reports and are reimbursed on the basis of information furnished in the reports. Although the entities do not qualify for Board review, the rules as set forth in this subpart with respect to intermediary hearings are applicable to the entities to the maximum extent possible, for cost-reporting periods ending on or after December 31, 1971, where the amount of program reimbursement in controversy is at least $1,000.

(c) *Effective dates.*

(1) Except as provided in paragraphs (c)(2), (c)(3), and (c)(4) of this section or in § 405.1885(e), this subpart applies to all cost reporting periods ending on or after December 31, 1971, for which reimbursement may be made on a reasonable cost basis.

(2) Sections 405.1835–405.1877 apply only to cost reporting periods ending on or after June 30, 1973, for which reimbursement may be made on a reasonable cost basis.

(3) With respect to hospitals under the reasonable cost subject to target rate system (see § 405.463), the appeals procedures in §§ 405.1811–405.1877 that apply become applicable with a hospital's first cost reporting period beginning on or after October 1, 1982.

(4) With respect to hospitals under the prospective payment system (see §§ 405.470–405.477), the appeals procedures in §§ 405.1811–405.1877 that apply become applicable with the hospital's first cost reporting period beginning on or after October 1, 1983.

d. Section § 405.1803 is revised to read as follows:

§ 405.1803 Intermediary determination and notice of amount of program reimbursement.

(a) *General requirement.* Upon receipt of a provider's cost report, or amended cost report where permitted or required, the intermediary must within a reasonable period of time (see § 405.1835(b)), furnish the provider and other parties as appropriate (see § 405.1805) a written notice reflecting the intermediary's determination of the total amount of reimbursement due the provider. The intermediary must include the following information in the notice, as appropriate:

(1) *Reasonable cost.* The notice must—

(i) Explain the intermediary's determination of total program reimbursement due the provider on the basis of reasonable cost for the reporting period covered by the cost report or amended cost report; and (ii) Relate this determination to the provider's claimed total program reimbursement due the provider for this period.

(2) *Target rate.* With respect to a hospital that receives payments for inpatient hospital services under the reasonable cost subject to the target rate system (see § 405.463), the intermediary must include in the notice its determination of the total amount of payment due the hospital under that system for the cost reporting period covered by the notice. The notice must explain (with appropriate use of the applicable money amounts) the procedure the intermediary followed under § 405.463 in making its determination.

(3) *Prospective payment.* With respect to a hospital that receives payments for inpatient hospital services under the prospective payment system (see § 405.470–405.477), the intermediary must include in the notice its determination of the total amount of the payments due the hospital under that system for the cost reporting period covered by the notice. The notice must explain (with appropriate use of the applicable money amounts) any difference in the amount determined to be due, and the amounts received by, the hospital during the cost reporting period covered by the notice.

(b) *Requirements for intermediary notices.* The intermediary must include in each notice appropriate references to law, regulations, HCFA Rulings, or program instructions to explain why the intermediary's determination of the amount of program reimbursement for the period differs from the amount the provider claimed. The notice must also

inform the provider of its right to an intermediary or Board hearing (see §§ 405.1809, 405.1811, 405.1815, 405.1835, and 405.1843) and that the provider must request the hearing within 180 days after the date of the notice.

(c) *Use of notice as basis for recovery of overpayments.* The intermediary's determination as contained in its notice constitutes the basis for making the retroactive adjustment (required by § 405.454(f)) to any program payments made to the provider during the period to which the determination applies, including the suspending of further payments to the provider in order to recover, or to aid in the recovery of, any overpayment identified in the determination to have been made to the provider, notwithstanding any request for hearing on the determination the provider may make under § 405.1811 or § 405.1835. Any suspension will remain in effect as specified in § 405.373(a).

e. A new § 405.1804 is added to read as follows:

§ 405.1804 Matters not subject to administrative and judicial review under prospective payment.

(a) *Limitation.* In accordance with section 1886(d)(7) of the Act, administrative or judicial review under this subpart is precluded for certain aspects of the prospective payment system, as provided in paragraph (b) of this section.

(b) *Subject matter.* Administrative or judicial review is not permitted for controversies about the following matters:

(1) The determination of the requirement, or the proportional amount, of any budget neutrality adjustment in the prospective payment rates.

(2) The establishment of—

(i) Diagnosis related groups (DRGs);

(ii) The methodology for the classification of inpatient discharges within the DRGs; or

(iii) Appropriate weighting factors that reflect the relative hospital resources used with respect to discharge within each DRG.

f. Section 405.1805 is revised to read as follows:

§ 405.1805 Parties to intermediary determination.

The parties to the intermediary's determination are the provider and any other entity found by the intermediary to be a related organization of the provider under § 405.427.

g. Section 405.1809 is revised to read as follows:

§ 405.1809 Intermediary hearing procedures.

(a) *Hearings.* Each intermediary must establish and maintain written procedures for intermediary hearings, in accordance with the regulations in this subpart, for resolving issues that may arise between the intermediary and a provider concerning the amount of reasonable cost reimbursement, reasonable cost subject to the target rate, or prospective payment due the provider (except as provided in § 405.1804) under the Medicare program. The procedures must provide for a hearing on the intermediary determination contained in the notice of program reimbursement (§ 405.1803), if the provider files a timely request for a hearing.

(b) *Amount in controversy.* In order for an intermediary to grant a hearing, the following dates and amounts in controversy apply:

(1) For cost reporting periods ending prior to June 30, 1973, the amount of program reimbursement in controversy must be at least $1000.

(2) For cost reporting periods ending on or after June 30, 1973, the amount of program reimbursement in controversy must be at least $1000 but less than $10,000.

h. Section 405.1811 is amended by revising paragraphs (a) and (b) to read as follows:

§ 405.1811 Right to intermediary hearing; time, place, form, and content of request for intermediary hearing.

(a) A provider that has been furnished a notice of amount of program reimbursement may request an intermediary hearing if it is dissatisfied with the intermediary's determination contained in the notice and the amount in controversy requirement described in § 405.1809 is met. The request must be in writing and be filed with the intermediary within 180 calendar days after the date of the notice. (See § 405.1835(c)). No other individual, entity, or party has the right to an intermediary hearing.

(b) The request must (1) identify the aspect(s) of the determination with which the provider is dissatisfied, and (2) explain why the provider believes the determination on these matters is incorrect, and (3) be submitted with any documentary evidence the provider considers necessary to support its position.

* * * * *

i. Section 405.1813 is revised to read as follows:

§ 405.1813 Failure to timely request an intermediary hearing.

If a provider requests an intermediary hearing on an intermediary's determination after the time limit prescribed in § 405.1811, the designated intermediary hearing officer or panel of hearing officers will dismiss the request and furnish the provider a written notice that explains the time limitation, except that for good cause shown, the time limit prescribed in § 405.1811 may be extended. However, an extension may not be granted if the extension request is filed more than 3 years after the date of the original notice of the intermediary determination.

j. Section 405.1835 is revised to read as follows:

§ 405.1835 Right to Board hearing.

(a) *Criteria.* The provider (but no other individual, entity, or party) has a right to a hearing before the Board about any matter designated in § 405.1801(a)(1), if:

(1) An intermediary determination has been made with respect to the provider; and

(2) The provider has filed a written request for a hearing before the Board under the provisions described in § 405.1841(a)(1); and

(3) The amount in controversy (as determined in § 405.1839(a)) is $10,000 or more.

(b) *Prospective payment exceptions.* Except with respect to matters for which administrative or judicial review is not permitted as specified in § 405.1804, hospitals that are paid under the prospective payment system are entitled to hearings before the Board under this section if they otherwise meet the criteria described in paragraph (a) of this section.

(c) *Right to hearing based on late intermediary determination about reasonable cost.* Notwithstanding the provisions of paragraph (a)(1) of this section, the provider also has a right to a hearing before the Board if an intermediary determination concerning the amount of reasonable cost reimbursement due a provider is not rendered within 12 months after receipt by the intermediary of a provider's perfected cost report or amended cost report (as permitted or as required to furnish sufficient data for purposes of making such determination—see § 405.1803(a)) provided such delay was not occasioned by the fault of the provider.

k. Section 405.1837 is revised to read as follows:

§ 405.1837 Group appeal.

(a) *Criteria for group appeals.* Subject to paragraph (b) of this section, a group of providers may bring an appeal before the Board but only if—

(1) Each provider in the group is identified as one which would, upon the filing of a request for a hearing before the Board, but without regard to the $10,000 amount in controversy requirement, be entitled to a hearing under § 405.1835;

(2) The matters at issue involve a common question of fact or of interpretation of law, regulations or HCFA Rulings; and

(3) The amount in controversy is, in the aggregate, $50,000 or more.

(b) *Providers under common ownership or control.* Effective April 20, 1983, any appeal filed by providers that are under common ownership or control must be brought by the providers as a group appeal in accordance with the provisions of paragraph (a) of this section with respect to any matters involving an issue common to the providers and for which the amount in controversy is, in the aggregate, $50,000 or more (see § 405.1841(a)(2)). A single provider involved in a group appeal that also wishes to appeal issues that are not common to the other providers in the group must file a separate hearing request (see § 405.1841(a)(1)) and must separately meet the requirements in § 405.1811 or § 405.1835, as applicable.

l. Section 405.1839 is revised to read as follows:

§ 405.1839 Amount in controversy.

(a) *Single appeals.* The $1000 amount in controversy required under § 405.1809 for an intermediary hearing and the $10,000 amount in controversy required under § 405.1835 for a Board hearing is the combined total of the amounts computed as follows:

(1) By deducting the adjusted total reimbursable program costs due the provider on the basis of reasonable cost from the total reimbursable program costs (less any amounts excluded by section 1862 of the Act) claimed by the provider.

(2) By deducting, as applicable, the total amount of payment due the hospital for inpatient hospital services under the reasonable cost subject to the target rate system or the prospective payment system from the total amount under that system that would be payable after a recomputation that takes into account any exemption, exception, exclusion, adjustment, or additional payment denied the hospital under § 405.463 or §§ 405.470–405.477, as applicable, and for which it has requested a hearing.

(b) *Group appeals.* The $50,000 amount in controversy required under § 405.1837 for group appeals to the Board is the combined total of the amounts computed as follows:

(1) By deducting the adjusted total reimbursable program costs due the provider on the basis of reasonable cost (in the aggregate) from the total reimbursable program costs (less any amounts excluded by section 1862 of the Act) which are claimed in the aggregate by the providers and are related to a common issue or interpretation of law or regulations.

(2) By deducting, as applicable, the total amount of payment due the hospitals (in the aggregate) for inpatient hospital services under the reasonable cost subject to the target rate system or the prospective payment system from the total amount (in the aggregate) under that system that would be payable after a recomputation that takes into account any exemption, exception, exclusion, adjustment, or additional payment denied the hospitals under § 405.463 or §§ 405.470–405.477, as applicable, and for which they have requested a hearing with respect to any matter involving an issue common to the hospitals.

m. Section 405.1841 is revised to read as follows:

§ 405.1841 Time, place, form, and content of request for Board hearing.

(a) *General requirements.* (1) The request for a Board hearing must be filed in writing with the Board within 180 days of the date the notice of the intermediary's determination was mailed to the provider or, where notice of the determination was not timely rendered, within 180 days after the expiration of the period specified in § 405.1835(c). Such request for Board hearing must identify the aspects of the determination with which the provider is dissatisfied, explain why the provider believes the determination is incorrect in such particulars, and be accompanied by any documenting evidence the provider considers necessary to support its position. Prior to the commencement of the hearing proceedings, the provider may identify in writing additional aspects of the intermediary's determination with which it is dissatisfied and furnish any documentary evidence in support thereof.

(2) Effective April 20, 1983, any request for a Board hearing by providers that are under common ownership or control (see § 405.427) must be brought by the providers as a group appeal (see § 405.1837(b)) with respect to any matters at issue involving a question of fact or of interpretation of law, regulations, or HCFA Rulings common to the providers and for which the amount in controversy is $50,000 or more in the aggregate. If a group appeal is filed, the provider seeking the appeal must be separately identified in the request for hearing, which must be prepared and filed consistently with the requirements of paragraph (a)(1) of this section.

(b) *Extension of time limit for good cause.* A request for a Board hearing filed after the time limit prescribed in paragraph (a) of this section shall be dismissed by the Board, except that for good cause shown, the time limit may be extended. However, no such extension shall be granted by the Board if such request is filed more than 3 years after the date the notice of the intermediary's determination is mailed to the provider.

n. Section 405.1873 is revised to read as follows:

§ 405.1873 Board's jurisdiction.

(a) *Board decides jurisdiction.* The Board decides questions relating to its jurisdiction to grant a hearing, including (1) the timeliness of an intermediary determination (see § 405.1835(c)), and (2) the right of a provider to a hearing before the Board when the amount in controversy is in issue (see §§ 405.1835(a)(3) and 405.1837).

(b) *Matters not subject to board review.* The determination of a fiscal intermediary that no payment may be made under title XVIII of the Act for any expenses incurred for items and services furnished to an individual because such items and services are excluded from coverage pursuant to section 1862 of the Act, 42 U.S.C. 1395y (see Subpart C of this part), may not be reviewed by the Board. (Such determination shall be reviewed only in accordance with the applicable provisions of Subpart G or H of this part.)

(2) The Board may not review certain matters affecting payments to hospitals under the prospective payment system as provided in § 405.1804.

o. Section 405.1877 is revised to read as follows:

§ 405.1877 Judicial review.

(a) *General rule.* Section 1878(f) of the Act, 42 U.S.C. 1395oo(f), permits providers to obtain judicial review of any final decision of the Board, or of any reversal, affirmance, or modification of a Board decision by the Secretary, by a civil action commenced against the Secretary within 60 days of the date on which notice of any final decision by the Board or of any reversal, affirmance, or modification by the Secretary is received.

(b) *Matters not subject to judicial review.* Certain matters affecting payments to hospital under the prospective payment system are not subject to judicial review, as provided in section 1886(d)(7) of the Act and § 405.1804.

(c) *Group appeals.* Any action under this section by providers that are under common ownership or control (see § 405.427) must be brought by the providers as a group with respect to any matter involving an issue common to the providers.

(d) *Venue for appeals.* An action for judicial review must be brought in the District Court of the United States for the judicial district in which the provider if located (or, effective April 20, 1983, in an action brought jointly by several providers, the judicial district in which the greatest number of such providers are located) or in the District Court for the District of Columbia. Effective April 20, 1983, any action for judicial review by providers under common ownership or control (§ 405.427), must be brought by such providers as a group with respect to any matter involving an issue common to the providers.

(e) *Service of process.* Process must be served as described under 45 CFR Part 4.

9. Subpart T is amended as follows:

Subpart T—Health Maintenance Organizations

a. The authority citation for Subpart T reads as follows:

Authority: Secs. 1102, 1871, and 1876, 49 Stat. 647, as amended, 79 Stat. 331, 86 Stat. 1396 (42 U.S.C. 1302, 1395hh, and 1395mm).

b. Section 405.2041 is amended by revising paragraph (d) to read as follows:

§ 405.2041 Cost reimbursement—general.

* * * * *

(d) An HMO may elect to have providers of services that furnish covered services to enrollees who are title XVIII beneficiaries, obtain reimbursement directly from the health insurance program. The election, which is binding for the entire contract period, must be made in writing to HCFA prior to the beginning of the contract period. When the HMO makes the election, the providers are each paid for covered services they furnish enrollees of the organization in accordance with Subpart D of this part. The amount of such reimbursement will not be included in payments made to the HMO.

B. Part 409, Subpart A, is amended as set forth below:

PART 409—MEDICARE BENEFITS, LIMITATIONS, AND EXCLUSIONS

Subpart A—Hospital Insurance

1. The authority citation for Subpart A is revised to read as follows:

Authority: Secs. 1102, 1812, 1813, 1814, 1866, 1871, 1881, and 1883 of the Social Security Act (42 U.S.C. 1302, 1395d, 1395e, 1395f, 1395x, 1395cc, 1395hh, 1395rr, and 1395tt). Sec. 602(k) of Pub. L. 98-21 (42 U.S.C. 1395y note).

2. Section 409.65 is amended by revising paragraph (e) to read as follows:

§ 409.65 Lifetime reserve days.

* * * * *

(e) *Period covered by election.*

(1) *General rule.* Except as provided in paragraph (e)(2) of this section, an election not to use lifetime reserve days may apply to an entire hospital stay or to a single period of consecutive days in a stay, but cannot apply to selected days in a stay. For example, a beneficiary may restrict the election to the period covered by private insurance but cannot use individual lifetime reserve days within that period. If an election not to use reserve days is effective after the first day on which reserve days are available, it must remain in effect until the end of the stay, unless it is revoked in accordance with § 409.66.

(2) *Exception.* A beneficiary election not to use lifetime reserve days for an inpatient hospital stay for which payment may be made under the prospective payment system (see §§ 405.470-405.477) is subject to the following rules:

(i) If the beneficiary has one or more regular benefit days (see § 409.61(a)(1) of this chapter) remaining in the benefit period upon entering the hospital, an election not to use lifetime reserve days will apply automatically to all days that are not outlier days. The beneficiary may also elect not to use lifetime reserve days for outlier days but this election must apply either to all outlier days or to all outlier days after a specified date.

(ii) If the beneficiary has no regular benefit days remaining in the benefit period upon entering the hospital, an election not to use lifetime reserve days must apply either to the entire hospital stay, to all outlier days, or to all outlier days after a specified date.

3. Section 409.69 is revised to read as follows:

§ 409.69 Amounts payable.

The amounts payable for Medicare Part A services are subject to the deductible and coinsurance requirements set forth in this subpart, and are generally determined in accordance with Part 405, Subpart D of this chapter. (See §§ 405.153(c)(2) and 405.158(a) for payment on a charge basis for certain services furnished by hospitals outside the United States or by hospitals not participating in Medicare.)

C. Part 489 is amended as set forth below:

PART 489—PROVIDER AGREEMENTS UNDER MEDICARE

1. The table of contents for Part 489 is amended by adding a new § 489.23 under Subpart B, to read as follows:

Sec.

* * * * *

Subpart B—Essentials of Provider Agreements

489.23 Special provisions for waiver of certain inpatient hospital services requirements.

* * * * *

2. The authority citation for Part 489 is revised to read as follows:

Authority: Secs. 1102, 1861, 1864, 1866, and 1871 of the Social Security Act (42 U.S.C. 1302, 1395x, 1395aa, 1395cc, and 1395hh).

3. Section 489.3 is revised to read as follows:

§ 489.3 Definition.

"Provider agreement" means an agreement between HCFA and one of the providers specified in § 489.2(b) to provide services to Medicare beneficiaries and to comply with the requirements of section 1866 of the Act.

4. Section 489.20 is amended by reprinting the undesignated introductory language unchanged and adding paragraphs (d) and (e) to read as follows:

§ 489.20 Basic commitments.

The provider agrees—

* * * * *

(d) In the case of a hospital that furnishes inpatient hospital services to a beneficiary to either furnish directly or make arrangements for all items and services (other than physicians' services as described in § 405.550(b) of this chapter) for which the beneficiary is entitled to have payment made under Medicare.

(e) In the case of a hospital that furnishes inpatient hospital services for which payment may be made under Subpart D of Part 405 of this chapter, to maintain an agreement with a utilization and quality control peer review organization (if there is such an organization for the area in which the hospital is located, which has a contract with HCFA under Part B of title XI of the

Act) for that organization to review the admissions, quality, appropriateness, and diagnostic information related to such inpatient hospital services.

5. Section 489.21 is amended by reprinting the undesignated introductory language unchanged and adding new paragraphs (e) and (f) to read as follows:

§ 489.21 Specific limitations on charges.

Except as specified in Subpart C of this part, the provider agrees not to charge a beneficiary—

* * * * *

(e) For inpatient hospital services for which a beneficiary would be entitled to have payment made under Part A of Medicare but for a denial or reduction in payments under regulations at § 405.472(e) of this chapter or under section 1886(f) of the Act.

(f) For items and services furnished to a hospital inpatient (other than physicians' services as described in § 405.550(b)) for which Medicare payment would be made if furnished by the hospital or by other providers or suppliers under arrangements made with them by the hospital. For this purpose, a charge by another provider or supplier for such an item or service is treated as a charge by the hospital for the item or service, and is also prohibited.

6. A new § 489.23 is added to read as follows:

§ 489.23 Special provisions for waiver of certain inpatient hospital services requirements.

(a) *General rule.* For any cost reporting period beginning before October 1, 1986, HCFA may waive the requirements of §§ 489.20(d) and 489.21(f), regarding items and services furnished to hospital inpatients, for a hospital that—

(1) Since before October 1, 1982, has extensively followed the practice of allowing suppliers of items and services furnished to the hospital's inpatients to bill directly under Medicare Part B for those items and services.

(2) Could not comply with the requirements of §§ 489.20(d) and 489.21(f) by October 1, 1983 without threatening the stability of patient care furnished to its inpatients.

(b) *Procedure.*

(1) The hospital must submit a written request to its intermediary for a waiver under this section not later than September 10, 1983.

(2) The intermediary will forward the request and their opinion as to whether the hospital meets the criteria for a waiver to the appropriate HCFA Regional Office within 10 days of receipt of the request.

(3) The Regional Office will determine if the hospital's waiver request meets the criteria of paragraph (c) of this section.

(4) The Regional Office will notify the hospital whether its waiver request has been approved not later than October 1, 1983.

(5) The Regional Office's determination to approve or deny a waiver request is final.

(6) The hospital must request revocation of a waiver under this section in writing at least 60 days before the date on which the revocation is to take effect.

(7) Upon 60 days written notice, the Regional Office may revoke a waiver under this section if the outside supplier does not comply with the terms of the billing agreement under paragraph (c)(2) of this section.

(8) Unless a waiver is revoked, it will apply to all cost reporting periods beginning before October 1, 1986.

(c) *Waiver criteria.*

(1) The hospital must show that, before October 1, 1982, a significant proportion of all ancillary services furnished to the hospital's inpatients have been furnished by outside suppliers and directly billed by those suppliers under Medicare Part B.

(2) The criteria in paragraph (c)(1) of this section are met if—

(i) The outside suppliers' reasonable charges for nonphysician services in the hospital's base period (as described in § 405.474(b)(1)) are at least 125 percent of the reasonable cost of the nonphysician ancillary services furnished to Medicare inpatients by the hospital exclusive of the costs of operating room, recovery room, labor and delivery room, pharmacy, and medical supplies; and

(ii) The hospital's inpatients receive at least three distinct types of ancillary services (such as pathology, radiology, and physical therapy services) primarily from outside suppliers.

(3) The hospital must show that outside suppliers furnishing items and services to its Medicare inpatients under the waiver have agreed that:

(i) The supplier will bill only for services for which payment may be made under Part B (or would be made if the beneficiary were entitled to Part B benefits);

(ii) The supplier will bill the program directly for services furnished to an inpatient of the hospital (even if assignment is not accepted) within 30 days of his or her discharge from the hospital;

(iii) The supplier's billing will specify that the services were furnished to an inpatient of a particular hospital, identify the nonphysician services that were furnished, and identify the charge for each service.

(Catalog of Federal Domestic Assistance Program No. 13.733, Medicare—Hospital Insurance, No. 13774, Medicare—Supplementary Medical Insurance)

Dated: August 26, 1983.

Carolyne K. Davis,

Administrator, Health Care Financing Administration.

Approved: August 26, 1983.

Margaret M. Heckler,

Secretary.

[**Editorial Note.**—The following addendum will not appear in the Code of Federal Regulations.]

Addendum.—Schedule of Standardized Amounts and Relative Weights Effective With Cost Reporting Periods Beginning on or After October 1, 1983

I. Summary and Background

This addendum sets forth the schedule of standardized amounts and relative weights that will be used to calculate prospective payment amounts under the Medicare program for inpatient, nonphysician services associated with a discharge occurring during cost reporting periods, beginning on or after October 1, 1983, and before October 1, 1984. This schedule is combined, for publication purposes, with the interim final rule implementing the prospective payment system because of the close relationship between this schedule, applicable for fiscal year (FY) 1984, and the rules governing prospective payment as a whole. In the future, notices, similar to this schedule, will be published on or before September 1, of each year, setting forth the schedule of standardized amounts and, if appropriate, relative weights applicable for future periods. The attached preamble to the interim final rule contains a detailed explanation of prospective payment, how the rates have been determined, and its overall relationship to the Medicare program.

II. Calculation of Adjusted Standardized Payment Amounts

This section contains a brief explanation of how the adjusted standardized payment amounts, applicable for FY 84, have been derived. The methodology for arriving at the appropriate rate structure is essentially prescribed in section 1886(d)(2) of the Act.

A. *Base Year Data*

Section 1886(d)(2)(A) of the Act requires the establishment of base year cost data containing allowable operating

costs per discharge of inpatient hospital services for each hospital. See section III C.1.a. of the preamble which contains a detailed explanation of how base year cost data are established.

B. *Updating for Inflation*

Section 1886(d)(2)(B) of the Act requires that the base year cost data be updated for FY 84. A two-step process is necessary.

1. The base year cost data, representing allowable costs per Medicare discharge (per hospital), are inflated through FY 83 using actuarial estimates of the rate of increase in hospital costs nationwide.

2. The resulting amounts are further inflated through FY 84 by using the estimated annual rate of increase in the hospital market basket, plus 1 percentage point, in accordance with the section 1886(b)(3)(B) of the Act.

Since July 1, 1979, the hospital cost limit schedules have incorporated a "market basket index" to reflect changes in the prices of goods and services that hospitals use in producing general inpatient services. We developed the current market basket by identifying the most commonly used categories of hospital inpatient operating expenses and by weighting each category to reflect the estimated proportion of total hospital operating expenses attributable to that category. We then obtained historical and projected rates of increase in the resource prices for each category. Based on the rate of increase and the weight of each category, we developed an overall annual rate of increase in the hospital market basket. The categories of expenses used to develop the revised market basket are based primarily on those used by the American Hospital Association in its analysis of costs, and by the U.S. Department of Commerce in publishing price indexes by industry.

For the purpose of updating base year cost data for FY 84, we revised the market basket previously used under the hospital cost limits, which was published in the **Federal Register** (47 FR 43313) on September 30, 1982. First, we have added malpractice insurance as a new category of expense in the market basket. This change was necessary because malpractice insurance premiums, which were excluded from the hospital cost limits, are to be included under the prospective payment rates. Second, because of the addition of this new category, it was also necessary to revise the relative proportions assigned to each expense category.

Table 2, section VII contains the price variables used to predict price changes for each category of expense. For further background on the development of the market basket index, see Freeland, Anderson and Schendler, "National Hospital Input Price Index", *Health Care Financing Review*, Summer 1979, pp. 37–61.

C. *Standardization*

Section 1886(d)(2)(C) of the Act requires that the updated base year per discharge costs be standardized. Standardization means the removal of the effects of certain causes of variation in cost among hospitals from the cost data.

1. *Variations in Case Mix Among Hospitals*

Section 1886(d)(2)(c)(iii) of the Act requires that the updated amounts be standardized to adjust for variations in case mix among hospitals. The methodology used for determining the appropriate adjustment factor (i.e., the case-mix index) is comparable to that used for the hospital cost limits published in the **Federal Register** on September 30, 1982 (47 FR 43303). A case-mix index has been calculated for each hospital based on 1981 cost and billing data.

Standardization, necessary to neutralize the effects of variations in case mix, is accomplished by dividing the hospital's average cost per Medicare discharge by that hospital's case-mix index. Table 3, section VII contains the case-mix index values used for this purpose.

2. *Indirect Medical Education Costs*

Section 1886(d)(2)(C)(i) of the Act requires that the updated amounts be standardized for indirect medical education costs. Therefore, after adjusting each hospital's inpatient operating cost per discharge for inflation and case-mix, we divided each cost by 1.0 plus the product of double the education adjustment factor (11.59 percent) and the individual hospital's adjusted intern-and-resident to bed ratio. We determined that adjusted ratio by dividing the hospital's number of FTE interns and residents for the cost reporting period by the hospital's bed size determined at the beginning of the cost reporting period represented in the data base period to obtain the hospital's intern-and-resident to bed ratio, and dividing that ratio by .1. See section III.C.1.c.ii. of the attached preamble which contains an example of the above calculation.

3. *Adjustments for Variation in Hospital Wage Levels*

Section 1886(d)(2)(C)(ii) of the Act requires that the updated amounts be standardized by adjusting for variations among hospitals in the average area hospital wage level. Therefore, the updated average cost per discharge is divided into labor-related and non labor-related portions. We determined the labor-related portion by multiplying each hospital's cost per discharge by 79.15 percent which is the labor-related portion of costs from the market basket. The labor-related portion is then divided by the appropriate wage index for the geographic area in which the hospital is located to remove the effects of local wage differences from hospital costs. See section III.C.1.c.iii. of the preamble, which contains a detailed explanation of the hospital wage indexes. An example of standardization for area wage differences follows.

Assume a hospital has an average cost per Medicare discharge of $3,000 and the wage index for the area is 1.0293.

$3000 \times 79.15\% = 2374.50$ (labor share)

$\frac{2374.50}{1.0293} = 2306.91$ (wage adjusted labor share)

Table 4, section VII, contains the wage indexes. Basically, the wage index relates wage and employment data, gathered by the Bureau of Labor Statistics, to a single national average. Since the wage index is used for measuring the differences between wages in any area and the national average, the index does not vary with changes in State or census division designations. The variation in adjusted standardized amounts between regions (as shown in Table 1) is significantly less than it would have been if regional wage indexes had been used. We considered but rejected using regional wage indexes for the following reasons:

- Since DRG weighting factors are determined using national cost data, regional wage indexes would have to be converted to a national base to derive the appropriate weighting factor for each DRG.
- The use of regional wage indexes would not result in prospective payment rates that are different from those based on a national wage index.
- Regional wage indexes would confuse hospitals because the numerous base levels would result in index values that could not be directly compared across areas.

4. *Cost-of-Living Factor for Alaska and Hawaii*

Section 1886(d)(5)(C)(iv) of the Act authorizes the Secretary to provide for such adjustments to the payment amounts as the Secretary deems appropriate to take into account the unique circumstances of hospitals located in Alaska and Hawaii.

Generally, these two States have higher levels of cost in comparison to other States in the nation. The high cost of labor is accounted for in the wage index adjustments discussed above. However, the high cost-of-living in these States also affects the cost of nonlabor items (e.g., supplies and equipment). Therefore, in order to remove the effects of the higher nonlabor costs from the overall cost data (i.e., for standardization purposes), the nonlabor portion of the average cost per Medicare discharge in hospitals located in Alaska and Hawaii is divided by an appropriate cost-of-living adjustment factor. Below are the factors used for this adjustment.

TABLE.—COST-OF-LIVING ADJUSTMENT FACTORS, ALASKA AND HAWAII HOSPITALS

Alaska—All areas	1.25
Hawaii—	
Oahu	1.20
Kauai	1.175
Maui	1.20
Molokai	1.20
Lanai	1.20
Hawaii	1.10

(The above factors are based on data obtained from the U.S. Office of Personnel Management, published in their FPM-591 letter series.)

The formula used to make the standardization adjustments for the nonlabor related costs in Alaska and Hawaii is as follows:

(Average Cost Per Medicare Discharge) × (20.85%) (Cost-of-Living Adjustment Factor)

D. *Urban-Rural Averages Within Geographic Areas*

Section 1886(d)(2)(D) of the Act requires that average standardized amounts per discharge be determined for hospitals located in urban and rural areas of the nine census divisions and the nation. Table 1, section VII contains the 18 regional standardized amounts (further divided into labor/nonlabor portions). The national standardized amounts are not included in the table because, for FY 84, Federal rates are based on regional averages only. The statute further specifies that the term "urban area" means an area within a Standard Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget (EOMB), or within such similar area as the Secretary has recognized by regulation. As explained in detail in section III.C.1.d. of the preamble, EOMB began using Metropolitan Statistical Areas (MSAs), in lieu of SMSAs, on June 30, 1983. The term "rural area" means any area outside of urban areas.

As a result, the average standardized amounts per Medicare discharge for each hospital have been grouped according to urban or rural designation into the nine census divisions (i.e. 18 separate means).

E. *Adjustments to Average Standardized Amounts*

The average standardized amounts, calculated as described above, were further adjusted as explained below.

1. *Part B Costs*

Section 602(e) of Pub. L. 98–21 amends section 1862(a) of the Act to prohibit payments for nonphysicians services furnished to hospital inpatients unless the services are furnished either directly by the hospital or by an entity under arrangements made by the hospital. Section III.C.1.e.i. of the preamble contains a detailed explanation of this provision. While this provision applies both to inpatient hospital services paid for on the basis of prospective payment rates and to such services paid for on a reasonable cost basis (i.e., furnished by hospitals excluded from prospective payment), it is discussed here only as it applies to adjustments to the standardized amounts for prospective payment.

Essentially, the prospective payment rates are intended to cover all inpatient services except "physicians' services". Since, in the past, many services for inpatients were billed under Part B, the standardized amounts calculated here were derived from data which did not reflect all services provided to inpatients. Therefore, in order to adjust the standardized amounts per discharge so that they represent costs previously billed under Part B, the amounts were increased by .13 percent. This is an estimate of the costs of inpatient hospital services previously billed to HCFA under Part B (updated to reflect 1984 costs) made by HCFA's Office of Financial and Actuarial Analysis.

2. *FICA Taxes*

Section 102 of Pub. L. 98–21 requires that certain hospitals (i.e., non-profit organizations), enter the Social Security system and begin paying FICA taxes for employees beginning January 1, 1984. Section 1886(b)(6) of the Social Security Act is also amended requiring that adjustments be made in the base period costs used to determine the hospital-specific portion of the prospective payment rate (see section III.C.1.e.ii. of the preamble) in recognition of these higher payroll costs. The conference committee report accompanying Pub. L. 98–21 expressed the intent that the Federal rate also be adjusted to reflect this change. HCFA's actuaries have estimated the amount of the adjustment to the standardized amounts necessary to account for additional costs of payroll taxes for hospitals entering the Social Security system to be .18 percent. Therefore, we have increased the standardized amounts by this percentage.

3. *Outliers*

Section 1886(d)(5)(A) of the Act requires that payments, in addition to the basic prospective payment rates, be made for discharges involving day or cost outliers as explained in section III.C.1.e.iii. of the preamble. Section 1886(d)(2)(E) of the Act correspondingly requires that the standardized amounts be reduced by a proportion which is estimated to reflect additional payments for outlier cases. The statute further directs that outlier payments may not be less than 5 percent or more than 6 percent of total payments projected to be made based on the prospective payment rates in any year. In accordance with these requirements, we have calculated a factor necessary to adjust standardized amounts for FY 84 to take into account outlier payments of 6.0 percent of total payments. This factor is .943.

4. *Budget Neutrality*

Section 1886(e)(1) of the Act requires that the prospective payment system result in aggregate program reimbursement equal to "what would have been payable" under the reasonable cost provisions of prior law; that is, for fiscal years 1984 and 1985, the prospective payment system should be "budget neutral."

Under the Amendments, the prospective payment rates are a blend of a hospital-specific portion and a Federal portion. Section 1886(e)(1)(A) of the Act requires that aggregate payments for the hospital specific portion should equal the comparable share of estimated reimbursement under prior law. Similarly, section 1886(e)(1)(B) of the Act requires that aggregate reimbursement for the Federal portion of the prospective payment rates plus any adjustments and special treatment of certain classes of hospitals should equal the corresponding share of estimated outlays prior to the passage of Pub. L. 98–21. Thus, for fiscal year 1984, 75 percent of total projected reimbursement based on the hospital-specific portion should equal 75 percent of total estimated outlays under law as in effect prior to April 20, 1983. Likewise, total estimated prospective payment system outlays deriving from the 25 percent Federal portion, including adjustments and special payment provisions, should equal 25 percent of projected reimbursement under prior laws.

The adjustment of the Federal portion was determined as follows:

- *Step 1*—Estimate total incurred payments for inpatient hospital operating costs for fiscal year 1984 that would have been made on a reasonable cost basis under Medicare prior to Pub. L. 98–21.
- *Step 2*—Multiply total incurred payments by 25 percent, i.e., the Federal portion of total payment amounts for fiscal year 1984.
- *Step 3*—Estimate the Federal portion of total payments that would have been made without adjusting for budget neutrality, but with the adjustment for outlier payments.
- *Step 4*—Add an estimate of total adjustments and payments under special payment provisions to the Federal portion (e.g., outliers, indirect medical education).
- Step 5—The difference between the step 2 and step 4 amounts is divided proportionally among the standardized amounts, resulting in the budget neutrality adjusted (standardized) amounts.

The resulting adjustment factor for the fiscal year 1984 Federal portion is .969. Payment amounts of hospitals excluded from the prospective payment system (e.g., psychiatric and children's hospitals) and of hospitals not participating in prospective payment because of their participation in demonstrations and studies were not included in the calculations above. For a more detailed explanation of budget neutrality, see section VIII of this addendum.

F. *Summary of Calculations Resulting in Adjusted Standardized Amounts*

In summary, we began our calculations by developing base year cost data for individual hospitals; we updated these amounts to account for inflation through fiscal year 1984; we standardized the data for variations in case mix, indirect medical education, area wage levels, and cost-of-living in Alaska and Hawaii; we grouped the data from individual hospitals and calculated average standardized amounts for urban and rural hospitals located in the nine census divisions and the nation; and we adjusted the resulting 18 average amounts in accordance with requirements of the Act. Throughout the remainder of this addendum, when we refer to "adjusted standardized amounts", we are referring to the 18 separate average amounts calculated as described above.

III. Adjustments for Area Wage Levels and Cost-of-Living in Alaska and Hawaii

This section contains an explanation of the application of two types of adjustments to the adjusted standardized amounts that will be made by the fiscal intermediaries in determining the prospective payment rates as described in section IV below. For discussion purposes, it is necessary to present the adjusted standardized amounts divided into labor and non-labor portions. Table 1, section VII contains the actual labor-related and nonlabor-related shares which will be used to calculate the prospective payment rates.

A. *Adjustment for Area Wage Levels*

Section 1886(d)(2)(H) of the Act requires that an adjustment be made to the labor-related portion of the national and regional prospective payment rates to account for area differences in hospital wage levels. This adjustment will be made by the fiscal intermediaries by multiplying the labor-related portion of the adjusted standardized amount by the appropriate wage index for the area in which the hospital is located. The wage indexes applicable for fiscal year 1984 are presented in Table 4, section VII of this addendum.

B. *Adjustment for Cost-of-Living in Alaska and Hawaii*

As explained in section III.C.1.c.iv. of the attached preamble the statute provides for an adjustment to take into account the unique circumstances of hospitals in Alaska and Hawaii. Higher labor-related costs for these two States were included in the adjustment for area wages above. The adjustment necessary for nonlabor-related costs for hospitals in Alaska and Hawaii will be made by the fiscal intermediaries by multiplying the nonlabor portion of the standardized amounts by the appropriate adjustment factor contained in the table in section II.C.4. of this addendum.

IV. Federal Prospective Payment Rates

This section contains a brief explanation of how the adjusted standardized amounts are converted to prospective payment rates per dishcharge.

A. *Discharge*

The prospective payment system provides for payment of an amount per discharge. See section III.B.2. of the attached preamble which provides a detailed explanation of discharges and transfers. A "discharge" is defined in the attached regulations at 42 CFR 405.470(c). Generally, a patient will be considered discharged when:

- Formally released from the hospital (but not transferred as explained in section III.B.2 of the preamble);
- The patient dies in the hospital; or
- When the patient is transferred to another institution or unit that is excluded from the prospective payment system.

B. *DRG Classification System*

All inpatient hospital discharges will be categorized according to one of 470 DRGs. (Note that no payment is made for DRG numbers 469 and 470). Every hospital discharge case will fit into a DRG category and no case will apply to more than one category. The assignment is based on the principal diagnosis, secondary diagnoses (if any), procedures performed, and age, sex, and discharge status of the patient. Table 5, section VII, contains the list of DRGs. See section III.B.3 of the preamble, which provides background information regarding the development of the DRG classification system.

C. *DRG Weighting Factors*

We have developed weighting factors for each DRG that are intended to reflect the relative resource consumption associated with each DRG. Each factor reflects the average cost, across all hospitals, of treating cases classified in that DRG relative to all other DRGs. In establishing the weighting factors, we used data from the MEDPAR file, from Medicare cost reports, and from non-Medicare discharge records for Maryland and Michigan hospitals. Table 5, section VII, contains the weighting factors corresponding to each DRG applicable for fiscal year 1984. See Section III.C.3.b of the preamble, which contains a detailed explanation of the calculation of DRG weighting factors.

V. Calculation of Prospective Payment Rates for fiscal year 1984

To ease the sudden impact of a completely new method of payment for hospital services, Pub. L. 98–21 provides for a 3-year transition period. This addendum contains the method that will be used for calculating prospective payment rates for cost reporting periods beginning on or after October 1, 1983.

Section 1886(d)(1)(C)(i) of the Act requires that the prospective payment rate for cost reporting periods beginning on or after October 1, 1983 be a blend of 25 percent of a Federal portion and 75 percent of a hospital-specific portion. See section III.C.4. of the attached preamble, which explains in detail how

the portions will be determined throughout the transition period.

General Formula for Calculation of Prospective Payment Rates for Cost Reporting Periods Beginning on or after October 1, 1983 and Before October 1, 1984.

Prospective Payment rate = Hospital – Specific Portion plus Federal Portion

A. *Hospital-Specific Portion*

The hospital-specific portion (HSP) of the prospective payment rate is based on a hospital's historical cost experience. The conference committee report expresses the committee's expectation that the hospital-specific portion be based on the best data available at the time the rate is established for purposes of the transition period. Therefore, fiscal intermediaries will be estimating the hospital-specific portion amounts using the best data for the base period cost reporting period available prior to the hospital's entry into the prospective payment system. Once the amounts have been calculated, they will be applied without further adjustment throughout the entire 3-year transition period, unless the calculations contain a mathematical error, the hospital successfully appeals their base period allowable costs within the specified time or the facility establishes a distinct part.

The hospital-specific portion is an amount derived from the following formula:

$$\frac{\text{(Base year costs)}}{\text{(Case-mix index)}} \times \text{Outlier adjustment} \times \text{Updating factor} \times \text{75 percent} \times \text{DRG weight}$$

1. Base-year Costs

Base year costs, necessary for calculating the hospital-specific portion of the prospective payment rates, are developed from cost data for the 12-month (or longer) reporting period ending on or after September 30, 1982 and before September 30, 1983. If the applicable period is less than 12 months, then the preceding 12-month (or longer) period is used. Costs in excess of the routine cost limits (i.e., the section 223 limits) will be excluded from base year costs in calculating the hospital-specific portion in the same manner as they are excluded when determining base period costs for the rate-of-increase ceiling under 42 CFR 405.463.

Each hospital's total allowable Part A costs will be adjusted:

- To remove any capital-related costs;
- To remove any medical education costs;
- To remove the nursing differential previously permitted;
- To remove net kidney acquisition costs incurred in hospitals approved as renal transplantation centers;
- To include allowable malpractice insurance costs;
- To include estimated FICA taxes for those hospitals that did not incur such costs in the base period;
- To include the costs of services that were billed under Part B of the program during the base period but will be billed under Part A as inpatient hospital services effective October 1, 1983.

In order to make some of these adjustments, the intermediary must receive documentation from the hospitals as outlined in PRM Chapter 2800 (Transmittal 291).

Total allowable Medicare inpatient operating costs for each hospital, resulting from the above adjustments, are divided by the number of Medicare discharges during the applicable base year. The amount resulting from this calculation will be used as the base year cost per case for purposes of calculating the hospital-specific portion (HSP) of the transition period prospective payment rates.

2. Case-Mix Adjusted Base Year Cost

In order to take into consideration the hospital's individual case mix, the base year cost amount is divided by the case-mix index. (See Table 3, section VII, which contains applicable case-mix indexes.) Adjusted base period costs are divided by the hospital's case-mix index to neutralize them for the effects of the mix of patients treated.

The effects of individual case complexity will be taken into account at the time the rate is applied by multiplying the hospital-specific rate by the weighting factor for the corresponding DRG in which the case is classified to determine the hospital-specific portion of payment for each case.

See section III.C.4.a.ii. of the preamble which contains a detailed explanation of the need for this case-mix adjustment and an explanation of statistically unreliable case-mix indexes.

3. Outlier Adjustment

The case-mix adjusted base year costs are multiplied by a factor calculated to take into account outlier payments of 6.0 percent of total payments. This factor is .943.

4. Budget Neutrality

The hospital-specific portion of the payment rates will be adjusted for cost reporting periods that begin between October 1, 1983 and October 1, 1985, to maintain budget neutrality in accordance with section 1886(e)(1)(A) of the Act. The hospital-specific portion of the rate is set at 75 percent in the first year.

An adjustment will be made to the otherwise applicable target rate percentage to maintain budget neutrality of the hospital-specific portion of the payment. To determine the necessary adjustment we estimated total expenditures under the reasonable cost methodology under TEFRA. The appropriate share of this estimate is compared to a projection of aggregate payments from the hospital-specific portion of the prospective payment amount. For example, if estimated outlays for inpatient operating payments under the law as in effect before April 20, 1983 would have been $10 billion, the total payments under the hospital-specific portion must equal $7.5 billion (75 percent of $10 billion) for fiscal year 1984. In making the above estimates, the statute specifies that payments made or estimated to be made for utilization review activities be excluded. The applicable adjustment factor for maintaining budget neutrality in the hospital-specific portion is .984. This factor has been included in the updating factor discussed in section 5 below. For a more detailed explanation of budget neutrality, see section VIII of this addendum.

5. Updating Factor

The hospital-specific rate is calculated by increasing the case-mix adjusted base year costs (further adjusted for outlier payments as described in paragraph 3. above) by an applicable updating factor in accordance with sections 1886(d)(2)(B) and 1886(e)(1)(A). For cost reporting periods beginning on or after October 1, 1983 and before October 1, 1984, the updating factor is equal to the compounded applicable target rate percentage (as used for the rate-of-increase ceiling under revised 42 CFR 405.463), multiplied by the adjustment factor for budget neutrality (.984) and added to 1. The table below sets forth the updating factors applicable in fiscal year 1984.

If base year cost reporting period ends	And first cost reporting period under PPS ends	Updating factor
Sept. 30, 1982	Sept. 30, 1984	1.13570
Oct. 31, 1982	Oct. 31, 1984	1.13265
Nov. 30, 1982	Nov. 30, 1984	1.12961
Dec. 31, 1982	Dec. 31, 1984	1.12658
Jan. 31, 1983	Jan. 31, 1985	1.12658
Feb. 28, 1983	Feb. 28, 1985	1.12658
Mar. 31, 1983	Mar. 31, 1985	1.12658
Apr. 30, 1983	Apr. 30, 1985	1.12658
May 31, 1983	May 31, 1985	1.12658
June 30, 1983	June 30, 1985	1.12658
July 31, 1983	July 31, 1985	1.12658
Aug. 31, 1983	Aug. 31, 1985	1.12658

If a hospital's base year cost reporting period ends on a day other than those listed above, the update factor for the month nearest to (i.e., either before or after) the actual ending date will be used. For example, if a hospital's cost reporting period ends between October 16 and November 15, the October 31 update factor will be used.

6. Example of Calculation of Hospital Specific Rate

Assume that a hospital's base year costs equal $3,000, its case-mix index is 1.0235, the outlier adjustment is .943, and the update factor for its cost reporting period is 1.14258 percent. The hospital specific rate would be computed as follows:

Base Year Costs / Case-Mix Index	×	Outlier adjustment	×	Updating factor	=	Hospital-specific rate
$3,000 / 1.0235		.943		1.14258		$3,171

7. Calculation of Hospital-Specific Portion

The hospital-specific portion of a hospital's payment rate for a given discharge is calculated by:

Step 1—Multiplying the hospital-specific rate (as determined in subsection 1 through 6 above) by 75 percent, and

Step 2—Multiplying the amount resulting from Step 1 by the specific DRG weighting factor applicable to the discharge (see Table 5, section VII). The result is the hospital-specific portion.

8. New Providers

Hospitals that have not completed a 12 month cost reporting period under Medicare (either under current or previous ownership) prior to September 30, 1983 will be considered new providers for purposes of the prospective payment system. These hospitals do not have any historical cost experience from which we could calculate a hospital-specific rate. Therefore, prospective payment rates for new providers will be computed without regard to the hospital-specific portion. Thus, new providers will be paid 100 percent of the Federal regional rate for discharges occurring on or after October 1, 1983 and before October 1, 1984.

B. *Federal Portion.* For discharges occurring before October 1, 1984, the Federal portion of the prospective payment rate is 25 percent of the Federal regional prospective rate. The Federal rates are determined by:

Step 1—Selecting the appropriate regional adjusted standardized amount considering the location and urban/rural designation of the hospital (See Table 1, section VII);

Step 2—Multiplying the labor-related portion of the standardized amount by the appropriate wage index;

Step 3—For hospitals in Alaska and Hawaii, multiplying the nonlabor-related portion of the standardized amount by the appropriate cost-of-living adjustment factor;

Step 4—Summing the amounts from step 2 and the nonlabor portion of the standardized amount (adjusted if appropriate under step 3); and

Step 5—Multiplying the final amount from step 4 by the weighting factor corresponding to the appropriate DRG Classification.

VI. Additional Payment Amounts

In addition to prospective payment rates per discharge, payments will be made for items or services as specified below.

A. *Outliers.* In accordance with the statute, and as explained in the attached preamble (section III.D.1.), additional amounts are to be paid on a per case basis for atypical cases known as "outliers." These cases are those that have either an extremely long length of stay or extraordinarily high costs when compared to most discharges classified in the same DRG. See § 405.475 of the attached regulations regarding payment for outliers cases.

The statute specifies that outlier payments are to be between 5 and 6 percent of total projected prospective payment amounts. Within this overall requirement, we established as our objectives in FY 84 to define the outlier criteria so that total outlier payments for both types of outlier cases would amount to approximately 6.0 percent of total basic prospective payments (exclusive of outlier payments) that would be payable based on 100 percent of Federal (regional) rates and that approximately 85 percent of the outlier payments would be paid for day outliers and the remaining 15 percent would be paid for high cost outliers.

We analyzed the 1981 MEDPAR file to identify the criteria that would meet our objectives. In doing so, we set the per diem payment for day outliers at 60 percent of the hospital's Federal rate divided by the national geometric mean length of stay for the DRG. For high cost outliers, we set the payment at 60 percent of the difference between adjusted covered charges and the applicable cost criterion for the DRG. We calculated the adjusted covered charges by inflating the covered charges for the case to FY 84, multiplying them by .72 (the national ratio of operating cost to total inpatient charges, and dividing the result by the hospital's educational adjustment factor).

We tested alternative sets of criteria to identify the combination that would result in the desired levels of outlier payments. Based on this analysis, we are providing that a discharge in FY 84 will be considered an outlier if the number of days in the stay exceeds the mean length of stay for discharges within that DRG by the lesser of 20 days or 1.94 standard deviations. The first criterion will primarily identify cases in the long-stay resource intensive DRGs whereas the second criterion should identify slightly less than 2 percent of the cases within primarily short-stay DRGs as outliers. In total, we estimate 5.1 percent of all cases will qualify as day outliers.

For fiscal year 1984, we are also providing that a discharge that does not qualify as a day outlier will be considered a high cost outlier if the cost of covered services exceeds the greater of 1.5 times the Federal rate (regional) for the DRG or $12,000. Both criteria will be adjusted for area wage differences. The first criterion will operate only for the relatively few DRGs with a Federal rate of $6,000 or more. In most cases, the $12,000 criterion will operate. In total, we estimate .9 percent of all cases will qualify as high cost outliers.

For an explanation of payment for alternate placement days, see section III.D.2 of the preamble. In summary, alternate placement days are paid only when a case is in outlier status and are paid the same as outliers.

B. *Additional Payments on Reasonable Cost Basis.*

1. *Capital-Related Costs.* In accordance with the statute, payment for capital-related costs (as described in § 405.414) will be determined on a reasonable cost basis. The capital-related costs must be determined consistently with the treatment of such costs for purposes of determining the hospital-specific portion of the hospital's

prospective payment rate under § 405.474(b).

2. *Direct Medical Education.* In accordance with the statute, the direct costs of medical education programs will be paid on the basis of reasonable cost subject to applicable regulations at § 405.421.

3. *Direct Medical and Surgical Services of Teaching Physicians.* In accordance with the statute, payment for direct medical and surgical services of physicians in teaching hospitals will be made on a reasonable cost basis under § 405.465 where the hospital exercises the election as provided for in § 405.521(d).

C. *Bad Debts.* An additional payment will be made to each hospital in accordance with § 405.420 for bad debts attributable to deductibles and coinsurance amounts related to covered services received by beneficiaries.

D. *Indirect Medical Education.* Section 1886(d)(5)(8) of the Act provides for additional payments to be made to hospitals under the prospective payment system for the indirect costs of medical education. This payment is computed in the same manner as the indirect teaching adjustment under the notice of hospital cost limits published September 30, 1982 (47 FR 43310), except that the educational adjustment factor is to equal twice the factor computed under that method. See section III.D.S. of the preamble for a detailed explanation of additional payments for indirect medical education, and § 405.477(d)(2) of the regulations.

If a hospital has a graduate medical education program approved under 42 CFR 405.421, an additional payment will be made equal to 11.59 percent of the aggregate payments made to the hospital, based on the Federal portion of prospective payments and outlier payments related to those portions, for each .1 increase (above zero) in the hospital's ratio of full-time equivalent (FTE) interns and residents (in approved programs) to its bed size. The number of FTE interns and residents is the sum of:

1. Interns and residents employed for 35 hours or more per week, and

2. One-half of the total number of interns and residents working less than 35 hours per week (regardless of the number of hours worked).

For purposes of this payment, a hospital will be allowed to count only interns and residents in teaching programs approved under 42 CFR 405.421 who are employed at the hospital. Interns and residents in unapproved programs, interns and residents employed to replace anesthetists, and those who are employed by the hospital but furnish services at another site or in a psychiatric or rehabilitation distinct part unit will not be counted in determining this payment amount. An example of the application of the indirect medical education payment follows:

A 686-bed hospital in Queens County, New York has a total revenue from the Federal portion of the prospective payments of $1.32 million. The hospital employed 77 FTE interns and residents in approved teaching programs on September 30, 1983 (their cost reporting period ending date).

77 divided by 686 = .11224 (ratio of interns and residents to beds) divided by .1 = 1.1224 (adjusted ratio)

Federal portion × teaching adjustment factor × adjusted ratio = additional payment amount.

$1,320,000 × .1159 × 1.1224 = $171,714

VII. Tables

This section contains all tables referred to throughout the preamble to the interim final and this addendum.

TABLE 1.—ADJUSTED STANDARDIZED AMOUNTS, LABOR/NONLABOR

Region	Urban		Rural	
	Labor related	Nonlabor related	Labor related	Nonlabor related
1. New England (CN, ME, MA, NH, RI, VT)	2,342.75	638.28	2,003.02	484.24
2. Middle Atlantic (PA, NJ, NY)	2,106.03	630.78	1,993.64	491.11
3. South Atlantic (DL, D.C., FL, GA, MD, NC, SC, VA, WV)	2,192.95	584.52	1,803.89	408.07
4. East North Central (IL, IN, MI, OH, WS)	2,340.95	660.40	1,959.42	457.10
5. East South Central (AL, KT, MS, TN)	1,990.97	520.25	1,619.64	381.83
6. West North Central (IA, KS, MN, MO, NB, ND, SD)	2,263.48	605.26	1,826.58	392.30
7. West South Central (AR, LA, OK, TX)	2,146.37	572.51	1,762.03	380.42
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	2,106.90	607.69	1,826.56	426.96
9. Pacific (AK, CA, HA, OR, WA)	2,219.82	711.58	1,908.93	497.87

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Table 2. - HOSPITAL PROSPECTIVE REIMBURSEMENT INPUT PRICE INDEX (the "Market Basket")

Category of costs[1]	Relative Importance[2] 1981	Forecaster,[3] percent changes, 1982-1985	Price variable used
1. Wages and salaries	56.53	DRI-CPS.....	Percentage change in average hourly earnings of hospital industry workers (SIC 806). Source: U.S. Department of Labor, Bureau of Labor Statistics, Employment and Earnings (monthly).
2. Employee benefits	8.16	DRI-MM.....	Percentage change in supplements to wages and salaries per worker in nonagricultural establishments. Sources: For supplements to wages and salaries - U.S. Department of Commerce, Bureau of Economic Analysis, Survey of Current Business (monthly). July issue has detailed components. For total employment - U.S. Dept. of Labor, Bureau of Labor Statistics, Employment and Earnings (monthly).
3. Professional fees, other (legal, auditing, consulting, etc.)	0.56	DRI-MM.....	Percentage change in hourly earnings index for production or nonsupervisory workers on private nonagricultural payrolls, total private. Source: U.S. Dept. of Labor, Bureau of Labor Statistics, Monthly Labor Review.
4. Malpractice insurance	2.12	DHHS, HCFA.....	Percentage change in hospital malpractice insurance premiums. Source: Unpublished data compiled by the Health Care Financing Administration. Historical percent changes beginning with 1982 are from the Insurance Services Organization (ISO).
5. Food	3.32	DRI-MM.....	A. Percentage change in food and beverages component of Consumer Price Index, All Urban (relative importance, 1.71). Source: U.S. Dept. of Labor, Bureau of Labor Statistics, Monthly Labor Review.
		DRI-MM.....	B. Percentage change in processed foods and feeds component of Producer Price Index (relative importance, 1.61). Source: U.S. Dept. of Labor, Bureau of Labor Statistics, Monthly Labor Review.
6. Fuel and other utilities	3.52	DRI-MM.....	A. Percentage change in implicit price deflator - consumption of fuel oil and coal (derived from fuel oil component of Consumer Price Index) (relative importance, 1.73) Source: U.S. Dept. of Commerce, Bureau of Economic Analysis, Survey of Current Business.
		DRI-MM.....	B. Percentage change in implicit price deflator - consumption of electricity (derived from electricity component of Consumer Price Index) (relative importance, 0.80) Source: U.S. Dept. of Commerce, Bureau of Economic Analysis. Unpublished data provided to Data Resources, Inc. by the Bureau of Economic Analysis. Historical time series data are available from the Health Care Financing Administration or the Bureau of Economic Analysis.
		DRI-MM.....	C. Percentage change in implicit price deflator for natural gas, derived from utility (piped) gas component of Consumer Price Index (relative importance, 0.67). Source: Same as B., electricity, above.

Table 2. - HOSPITAL PROSPECTIVE REIMBURSEMENT INPUT PRICE INDEX (the "Market Basket")

Category of costs[1]	Relative Importance[2] 1981	Forecaster,[3] percent changes, 1982-1985	Price variable used
		DRI-CPS.....	D. Percentage change in water and sewerage maintenance component of Consumer Price Index (relative importance, 0.32). Source: U.S. Dept. of Labor, Bureau of Labor Statistics, Monthly Labor Review.
7. Drugs	2.61	DRI-CPS.....	Percentage change in pharmaceutical preparations, ethical component of Producer Price Index. Source: U.S. Dept. of Labor, Bureau of Labor Statistics, Producer Prices and Price Indexes (monthly), Table 6.
8. Chemicals and cleaning products	2.17	DRI-MM.....	Percentage change in chemicals and allied products components of Producer Price Index. Source: U.S. Dept. of Labor, Bureau of Labor Statistics, Monthly Labor Review.
9. Surgical and medical instruments and supplies	2.09	DRI-CPS.....	Percentage change in special industry machinery and equipment component of Producer Price Index. Source: U.S. Dept. of Labor, Bureau of Labor Statistics, Monthly Labor Review.
10. Rubber and miscellaneous plastics	1.73	DRI-MM.....	Percentage change in rubber and plastic products component of Producer Price Index. Source: U.S. Dept. of Labor, Bureau of Labor Statistics, Monthly Labor Review.
11. Business travel and motor freight	1.84	DRI-CPS.....	Percentage change in transportation component of Consumer Price Index. All Urban. Source: U.S. Dept. of Labor, Bureau of Labor Statistics, Monthly Labor Review.
12. Apparel and textiles	1.45	DRI-MM.....	Percentage change in textile products and apparel component of Producer Price Index. Source: U.S. Dept. of Labor, Bureau of Labor Statistics, Monthly Labor Review.
13. Business services	5.00	DRI-MM.....	Percentage change in services component of Consumer Price Index. All Urban. Source: U.S. Dept. of Labor, Bureau of Labor Statistics, Monthly Labor Review.
14. All other miscellaneous expenses[4]	8.90	DRI-MM.....	Percentage change of Consumer Price Index for all items. All Urban. Source: U.S. Dept. of Labor, Bureau of Labor Statistics, Monthly Labor REview.
Total	100.00		

[1]Costs not within the scope of the limits (i.e. capital, medical education, and medical professional fees) were excluded in deriving the input price index.

[2]A Laspeyres price index was constructed using 1977 base value weights and the price variables indicated in the table. Base value weights (cost shares) were derived from special studies by the Health Care Financing Administration using primarily data from the American Hospital Association and the Interindustry Economics Division of the Bureau of Economic Analysis, U.S. Department of Commerce. In 1977 each price variable has an index value of 100.00. The "relative importance" changes over time in accordance with price changes for each variable. Cost categories with relatively higher price increases get higher relative importance values and vice versa. For an explanation of the basic methodology used, see Freeland, Mark S., Anderson, Gerard, and Schendler, Carol Ellen, "National Hospital Input Price Index," Health Care Financing Review, Summer 1979, pp. 37-61.

[3]DRI-CPS = Data Resources, Inc., Cost Forecasting Service, 1750 K Street, NW., Washington, D.C. 20006 (Forecast 833). DRI-MM = Data Resources, Inc., Macro Model, 29 Hartwell Avenue, Lexington, Massachusetts 02173 (Trendlong 0783)

[4]This is a residual category of costs not included in the 13 specific categories above. It consists primarily of miscellaneous and unallocated items.

TABLE NO. 5a HOSPITAL CASE MIX INDEXES Page 1

PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX
01-0001	.9852	* 01-0057	.9686	01-0117	.8900	03-0001	1.1067	03-0064	1.2277
01-0004	.9292	01-0058	1.0098	01-0118	.9385	03-0002	1.2290	03-0065	1.1227
01-0005	1.0134	01-0059	.8585	01-0119	1.0191	03-0003	1.0627	03-0067	.9569
01-0006	1.1006	01-0060	.9637	01-0120	.9346	* 03-0004	.9546	03-0068	1.0042
01-0007	.8912	01-0061	.9109	01-0121	.9376	03-0005	.9971	03-0069	.9869
01-0008	.9718	01-0062	.8962	01-0122	.8813	03-0006	1.1888	03-0070	1.0158
01-0009	.8826	01-0064	1.1158	01-0123	.9277	03-0007	1.0447	* 03-0081	.9167
01-0010	.8842	01-0065	.9792	01-0124	.9376	03-0008	1.0430	04-0001	.9389
01-0011	1.0440	01-0066	.8290	01-0125	.8582	03-0009	1.2163	04-0002	.9696
01-0012	.9722	01-0067	.9057	01-0126	.9575	03-0010	1.1295	04-0003	.9221
01-0014	.8941	01-0068	1.0269	01-0127	.9812	03-0011	1.0386	04-0004	1.1041
01-0015*	.9070	01-0069	.9465	01-0128	.9409	03-0012	.9647	04-0005	.9428
01-0016	1.0052	01-0070	.9310	01-0129	.9362	03-0013	1.1089	04-0006	.9051
01-0017	.9734	01-0072	1.0348	01-0130	.9118	03-0014	1.0825	04-0007	1.0971
01-0018	.8066	01-0073	.9218	01-0131	.8060	03-0016	.9908	04-0008	1.0078
01-0019	.9667	01-0074	.8335	01-0132	.8846	03-0017	1.0508	04-0009	.9171
01-0020	.8956	* 01-0075	.8507	01-0134	.8892	03-0018	1.1135	04-0010	.9737
01-0021	.8749	01-0078	1.0557	* 01-0136	.8258	03-0019	.9815	04-0011	.8466
01-0022	.9486	01-0079	.9873	01-0137	1.1134	03-0020	1.0141	04-0013	.9411
01-0023	1.0350	01-0080	.8676	01-0138	1.0109	03-0022	1.1599	04-0014	.9634
01-0024	.9904	01-0081	1.1292	01-0139	1.1461	03-0023	1.0633	04-0015	.9548
01-0025	.9636	01-0082	.9586	01-0142	.7670	03-0024	1.2056	04-0016	1.1255
01-0026	.5789	01-0083	.9181	01-0143	.9605	03-0025	.9732	04-0017	1.0617
01-0027	.8641	01-0084	.9815	01-0144	.9422	* 03-0026	.8584	04-0018	.9772
01-0028	.9321	01-0085	.9504	01-0145	.9505	03-0027	.9358	04-0019	.8971
01-0029	1.0417	01-0086	.9490	01-0146	.9112	03-0030	1.1025	04-0020	1.0279
01-0030	.9686	01-0087	1.1789	* 01-0147	1.0651	03-0033	1.0059	04-0021	.9896
01-0031	.9615	01-0089	.9310	01-0148	.9206	03-0034	1.0011	04-0022	.9887
01-0032	.8727	01-0090	1.0335	01-0149	1.0685	03-0035	1.0006	04-0024	.9274
01-0033	1.3224	01-0091	1.0037	01-0150	.9657	03-0036	1.0490	04-0025	.9033
01-0034	.8579	01-0092	1.0878	* 01-0151	1.3335	03-0037	1.2471	04-0026	1.0343
01-0035	.9150	01-0094	.8665	* 01-0152	1.1303	03-0038	1.1375	04-0027	1.0504
01-0036	.8431	01-0095	.8548	02-0001	1.1090	* 03-0039	.9586	04-0028	.9798
01-0038	.8893	* 01-0096	.8250	* 02-0002	.9209	03-0040	.9408	04-0029	.9853
01-0039	1.1250	01-0097	.9487	* 02-0004	1.0177	03-0041	.9891	04-0030	.8746
01-0040	1.0180	01-0098	.9372	* 02-0005	.8172	03-0043	1.0309	04-0031	.9531
* 01-0041	.9162	01-0099	.9679	* 02-0006	.5725	03-0044	1.0026	04-0032	.9178
01-0042	.8921	01-0100	1.0522	* 02-0007	.9763	* 03-0046	.9470	04-0033	.8764
01-0044	.8588	01-0101	.8824	02-0008	1.0302	* 03-0047	.9182	04-0035	.9711
01-0045	.8635	01-0102	.9121	* 02-0009	.8583	* 03-0048	1.0781	04-0036	1.0482
01-0046	1.0349	01-0103	1.1826	* 02-0010	1.0603	03-0049	.9377	04-0037	.9515
01-0047	.8284	01-0104	1.1231	* 02-0011	.8499	03-0051	1.0685	04-0039	.9464
01-0048	.9141	01-0108	.9146	02-0012	1.0808	03-0054	1.0038	04-0040	.9523
01-0050	.8993	01-0109	.8935	* 02-0013	.8552	03-0055	1.0446	04-0041	.9741
01-0051	.9815	01-0110	.9393	* 02-0014	.9464	03-0057	1.0562	04-0042	1.0488
01-0052	.8788	* 01-0111	.7712	* 02-0016	1.0212	03-0059	.8912	04-0043	.9039
01-0053	.9076	01-0112	1.0060	02-0017	1.0744	03-0060	.9687	04-0044	.8782
01-0054	1.0025	01-0113	1.0462	* 02-0024	.9003	03-0061	1.1040	04-0045	.8946
01-0055	.9292	01-0114	.9671	* 02-0025	1.1863	03-0062	.9891	04-0047	.9744
01-0056	1.0784	01-0115	.9794	* 02-0026	1.1107	03-0063	1.1397	04-0048	.9765

INDEXES DERIVED FROM FEWER THAN 50 DISCHARGES DO NOT MEET THE SELECTED STATISTICAL PRECISION CRITERION FOR RELIABILITY. THESE CASE MIX INDEXES ARE ASTERISKED.

TABLE NO. 3a HOSPITAL CASE MIX INDEXES Page 2

PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX
04-0050	.9526	04-0124	.9450	05-0058	1.0126	05-0115	1.1034	05-0174	1.1936
04-0051	.9651	04-0125	.8485	05-0060	1.0282	05-0116	1.1430	05-0175	1.0239
04-0052	.9207	* 04-0126	.9780	05-0061	1.0225	05-0117	1.1211	05-0177	1.1591
04-0054	.9055	05-0002	1.1385	05-0063	1.0752	05-0118	1.0667	05-0179	1.0400
04-0055	1.0786	05-0004	1.0327	05-0065	1.0174	* 05-0119	.8404	05-0180	1.1148
04-0057	.9252	05-0005	1.0288	05-0066	1.0339	05-0121	.9999	05-0181	.9668
04-0058	.9073	05-0006	1.1518	05-0067	1.0413	05-0122	1.1187	05-0182	.9947
04-0060	.9856	05-0007	1.1022	05-0068	.9389	05-0124	1.0588	05-0183	1.0824
04-0062	1.0553	05-0008	1.0878	05-0069	1.2049	05-0125	1.1113	* 05-0185	.8810
04-0063	1.0360	05-0009	1.1206	05-0070	1.1731	05-0126	1.0191	05-0186	1.0043
04-0064	.9226	* 05-0010	1.0116	05-0071	1.0732	05-0127	1.1234	05-0187	1.0359
04-0066	.9167	05-0011	.9354	05-0072	1.0956	05-0128	1.0531	05-0188	1.0902
04-0067	.9235	05-0013	1.2513	05-0073	1.0940	05-0129	1.1500	05-0189	.9212
04-0068	.9588	05-0014	1.0081	05-0074	.9628	05-0131	1.1071	* 05-0190	.9895
04-0069	.9488	05-0015	1.0016	05-0075	1.1624	05-0132	1.0643	05-0191	1.0849
04-0070	.9115	05-0016	1.0410	05-0076	1.1348	05-0133	1.0023	05-0192	1.0037
04-0071	1.0258	05-0017	1.1733	05-0077	1.1256	05-0134	1.0381	05-0193	1.0351
04-0072	.9259	05-0018	1.0222	05-0078	1.0842	05-0135	1.0607	05-0194	1.0166
04-0074	.9664	05-0019	.8854	05-0079	1.1006	05-0136	1.0472	05-0195	1.0233
04-0075	.9705	* 05-0020	1.0482	05-0080	1.0622	05-0137	1.0703	05-0196	1.0938
04-0076	.9283	05-0021	1.0188	05-0081	1.1310	05-0138	1.1345	05-0197	1.1920
04-0077	.9189	05-0022	1.0812	05-0082	1.0461	05-0139	1.1072	05-0199	.9775
04-0078	.9827	05-0024	1.0932	05-0084	1.2228	05-0140	1.0790	05-0200	1.0114
04-0080	.9183	05-0025	1.1997	05-0085	1.1193	05-0141	1.0617	05-0201	1.0076
04-0081	.8732	05-0026	1.0994	* 05-0086	1.1714	05-0143	.9257	05-0202	1.0306
04-0082	.9355	05-0028	1.1142	05-0087	1.1316	05-0144	1.1692	05-0204	1.1812
04-0084	.9617	05-0029	1.1326	* 05-0088	1.0211	05-0145	1.1063	05-0205	1.1367
04-0085	.9383	05-0030	1.0527	05-0089	1.0871	05-0146	1.1302	05-0207	1.1068
04-0087	.9332	* 05-0031	1.0965	05-0090	1.0779	* 05-0147	.9817	05-0208	1.0878
04-0088	1.0211	05-0032	.9707	05-0091	.9535	05-0148	1.0125	05-0210	1.0813
04-0090	.9449	05-0033	1.0855	05-0092	1.0324	05-0149	1.0185	05-0211	1.0585
04-0091	.9376	05-0034	1.0090	05-0093	1.1938	05-0150	1.1131	05-0212	.9981
04-0092	.8671	05-0036	1.0962	05-0095	.9543	05-0151	1.0858	05-0213	1.0898
04-0095	.8956	05-0038	1.1626	05-0096	1.0251	05-0152	1.0843	05-0214	1.0915
04-0096	1.0614	05-0039	1.2292	05-0097	1.0619	05-0153	1.1884	05-0215	1.1320
04-0100	.9924	05-0040	1.0349	05-0098	.9974	05-0154	1.0767	05-0217	1.0607
04-0105	1.0183	05-0041	.9848	05-0099	1.0963	05-0155	1.0277	05-0219	1.1221
04-0106	.9498	05-0042	1.0266	05-0100	1.2490	05-0156	1.1163	05-0220	.9967
04-0107	.9721	05-0043	1.2187	05-0101	1.1182	05-0158	1.0694	05-0221	1.1069
04-0108	.8972	05-0045	1.0441	05-0102	1.0768	05-0159	1.0142	05-0222	1.0517
04-0109	.9786	05-0046	1.1551	05-0103	1.1692	05-0161	1.0142	05-0224	1.0852
* 04-0113	.8520	05-0047	1.2084	05-0104	1.0904	05-0162	.8979	05-0225	1.0448
04-0114	1.1386	05-0049	1.1119	05-0107	1.0585	05-0164	1.1066	05-0226	1.0850
04-0115	.9741	05-0051	1.0122	05-0108	1.0811	* 05-0166	1.0496	05-0228	1.0938
04-0116	1.0959	* 05-0052	.9275	05-0109	1.3608	05-0167	1.1218	05-0229	1.0446
04-0118	.9936	05-0053	1.0955	05-0110	.9176	05-0168	1.1716	05-0230	1.0127
04-0119	.9330	05-0054	1.0502	05-0111	1.1660	05-0169	1.1219	05-0231	1.0750
* 04-0121	.8541	05-0055	1.0378	05-0112	1.1477	05-0170	1.0584	05-0232	1.0588
04-0122	1.0113	05-0056	1.0363	05-0113	.9883	05-0172	1.2717	05-0233	1.0372
04-0123	.8984	05-0057	1.0244	05-0114	1.0449	05-0173	.9447	05-0234	.9944

INDEXES DERIVED FROM FEWER THAN 50 DISCHARGES DO NOT MEET THE SELECTED STATISTICAL PRECISION CRITERION FOR RELIABILITY. THESE CASE MIX INDEXES ARE ASTERISKED.

TABLE NO. 3.a HOSPITAL CASE MIX INDEXES Page 3

PROVIDER NUMBER	CASE MIX INDEX
05-0235	1.1215
05-0236	1.0357
05-0238	1.0586
05-0239	1.1063
05-0240	1.0716
05-0241	1.0493
05-0242	1.1156
05-0243	1.0036
05-0245	1.0870
05-0248	1.1474
05-0251	.8793
05-0253	.9465
05-0254	1.0036
05-0255	.9844
05-0256	1.2091
05-0257	.9582
05-0258	.9892
* 05-0260	.9916
05-0261	1.0582
05-0262	1.1009
05-0263	1.0583
05-0264	1.1435
05-0266	1.0458
05-0267	1.1399
05-0268	1.1927
05-0269	1.0928
05-0270	1.0821
05-0272	1.0783
* 05-0273	.8927
* 05-0274	.9532
* 05-0275	.8918
05-0276	.9729
05-0277	1.0113
05-0278	1.0725
05-0279	.9703
05-0280	1.1014
05-0281	1.1742
05-0282	1.0434
05-0283	1.0971
* 05-0284	1.0275
* 05-0285	.9818
05-0286	1.0108
05-0289	1.1077
05-0290	.9776
05-0291	1.1263
05-0292	1.1311
* 05-0293	.9192
05-0295	1.0285
05-0296	1.1007
05-0298	.9560

PROVIDER NUMBER	CASE MIX INDEX
05-0299	1.0735
05-0300	1.1298
05-0301	1.0586
05-0302	1.1442
05-0303	1.0700
05-0305	1.0989
05-0307	1.0852
05-0308	1.1922
05-0309	1.0678
05-0310	1.0596
05-0312	1.1227
05-0313	.9923
* 05-0314	.9753
05-0315	1.0882
05-0317	1.0984
05-0318	.8862
05-0319	.9726
05-0320	1.0348
* 05-0322	1.1381
05-0323	1.0705
05-0324	1.1126
05-0325	1.0766
05-0326	1.0763
05-0327	1.1379
05-0328	1.0433
05-0329	.9231
05-0331	1.1220
* 05-0333	.9669
05-0334	1.1080
05-0335	.9975
05-0336	1.1107
05-0337	1.1016
05-0342	1.0352
05-0343	1.0500
05-0345	.9503
05-0348	1.0730
* 05-0349	.9562
05-0350	1.1807
05-0351	1.0815
05-0352	1.0546
05-0353	1.1031
* 05-0355	.9078
05-0357	1.1089
05-0359	1.0792
05-0360	1.0767
* 05-0361	.9867
05-0362	1.1200
05-0363	1.0186
05-0366	1.0584
05-0367	1.1085

PROVIDER NUMBER	CASE MIX INDEX
05-0368	1.0107
05-0369	1.0912
05-0371	1.0653
05-0372	1.0541
05-0373	1.0012
05-0375	1.0311
05-0376	1.0137
05-0377	.9907
05-0378	.9926
05-0379	.9518
05-0380	1.2889
05-0381	.9380
05-0382	1.0376
* 05-0383	1.1250
05-0385	1.0993
05-0387	.8981
05-0388	.9952
05-0390	1.0616
05-0391	1.0709
* 05-0392	.8399
05-0393	1.0531
05-0394	1.0846
05-0395	.9552
05-0396	1.2081
* 05-0397	.9978
05-0400	1.1283
05-0401	1.1014
05-0403	.9771
05-0404	1.0778
05-0405	1.0504
* 05-0406	.8711
05-0407	1.1328
05-0410	.9344
05-0411	1.0912
05-0413	1.1422
05-0414	.9633
* 05-0415	.9389
* 05-0416	1.0857
05-0417	1.0566
05-0418	1.0979
05-0419	1.0122
05-0420	1.0520
05-0421	1.1279
05-0423	.9584
05-0424	1.0862
05-0425	1.1030
05-0426	1.0332
* 05-0427	.9510
* 05-0428	.9424
* 05-0429	.9406

PROVIDER NUMBER	CASE MIX INDEX
05-0430	.9004
* 05-0431	1.0235
05-0432	1.1696
* 05-0433	.8973
05-0434	1.0507
05-0435	1.0889
05-0436	.9550
05-0438	1.1464
05-0440	1.0273
05-0441	1.3670
05-0442	1.0084
* 05-0443	.8811
05-0444	1.0651
05-0446	.9367
05-0447	1.0182
05-0448	.9638
05-0449	.9852
* 05-0450	.9135
* 05-0451	.9219
05-0454	1.3758
05-0455	1.1145
05-0456	1.1351
05-0457	1.1980
05-0458	1.0651
05-0459	1.0883
05-0464	1.2063
05-0467	1.1166
05-0468	.9893
05-0469	.9773
05-0470	1.0117
05-0471	1.1025
05-0473	1.0825
05-0476	.9565
05-0477	.9771
05-0478	1.0818
05-0481	1.0233
* 05-0482	.9323
05-0483	1.0209
05-0485	1.0870
05-0486	1.1087
* 05-0487	1.0801
05-0488	1.1072
05-0489	.9734
05-0491	1.0349
05-0492	1.1737
05-0494	.9604
05-0496	1.1867
* 05-0497	.8447
05-0498	1.0463
* 05-0500	.8565

PROVIDER NUMBER	CASE MIX INDEX
05-0502	1.3153
05-0503	1.0598
05-0506	1.1033
05-0510	1.0360
05-0512	1.0835
* 05-0513	.6051
05-0515	1.1152
05-0516	1.1152
05-0517	1.0380
* 05-0521	.7630
05-0522	1.0828
05-0523	1.0154
* 05-0525	.8705
05-0526	1.0795
05-0527	.9795
05-0528	1.0444
* 05-0530	.9808
05-0531	.9648
05-0534	.9087
05-0535	1.0652
05-0537	1.2116
05-0539	1.0444
05-0540	.9018
05-0541	1.2708
05-0542	1.0126
05-0543	1.1597
05-0544	1.0349
05-0549	1.1777
05-0550	.9311
05-0551	1.1195
05-0552	.9229
05-0557	1.1092
05-0559	1.0808
05-0560	1.0865
05-0561	1.0326
05-0562	.8976
05-0564	1.0579
05-0565	1.0056
* 05-0566	.9527
05-0567	1.0019
05-0568	1.0034
05-0569	1.0953
05-0570	1.1743
05-0571	1.0619
05-0573	1.1165
05-0575	1.0466
05-0576	1.1037
05-0577	1.0757
05-0578	.9951
05-0579	.9730

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TABLE NO. 3a HOSPITAL CASE MIX INDEXES Page 4

PROVIDER NUMBER	CASE MIX INDEX
05-0580	1.0407
05-0581	1.0587
05-0582	1.2832
05-0584	1.0659
05-0585	1.0746
05-0586	1.0962
05-0587	1.0209
05-0588	1.0730
05-0589	1.0100
05-0590	1.0888
05-0591	1.0349
05-0592	1.0240
05-0593	1.0135
05-0594	1.0578
* 05-0595	1.0550
05-0597	.9991
05-0598	.9759
05-0599	1.1840
05-0601	1.0236
05-0602	1.1318
05-0603	1.0694
05-0604	1.0808
* 05-0605	.9702
* 05-0606	1.1507
05-0607	.9494
05-0608	1.1844
05-0609	1.1681
* 05-0610	.9382
05-0615	1.1514
05-0616	.9886
05-0617	.9037
* 05-0618	.9848
05-0619	1.0745
05-0622	1.0244
05-0623	.8703
05-0624	1.0340
05-0625	1.1915
05-0626	.8177
05-0627	.8239
05-0628	.8183
* 05-0629	.8568
05-0630	1.1223
* 05-0631	.8194
* 05-0632	1.1394
05-0633	1.1203
05-0635	1.0908
05-0636	1.0441
05-0637	1.0448
* 05-0638	1.0921
* 05-0640	.5021
05-0641	1.0741
* 05-0642	.8194
05-0644	1.1762
* 05-0645	1.2401
* 05-0646	.8148
* 05-0648	.9371
* 05-0650	.7355
06-0001	.9766
06-0003	1.0307
06-0004	.9264
06-0005	1.0385
06-0006	1.0115
* 06-0007	1.0706
06-0008	.9748
06-0009	1.0370
06-0010	1.0874
06-0011	1.0180
06-0012	1.0365
06-0013	.9855
06-0014	1.1360
06-0015	1.0779
06-0016	.9070
06-0017	1.0158
06-0018	.9065
06-0019	1.0646
06-0020	1.1525
06-0022	.9652
06-0023	.9920
06-0024	1.2706
06-0025	.9073
06-0026	1.0283
06-0027	1.0882
06-0028	1.0918
* 06-0029	.9002
06-0030	1.0277
06-0031	1.1204
06-0032	1.0281
06-0033	1.0823
06-0034	1.0785
06-0035	1.0038
06-0036	1.1184
06-0037	.9545
* 06-0038	.9473
06-0039	.9093
* 06-0041	.8816
* 06-0042	.9578
* 06-0043	.8800
06-0044	.9595
06-0045	.9538
* 06-0046	1.0590
* 06-0047	.9735
* 06-0049	1.0569
06-0050	.9110
06-0051	1.0440
* 06-0052	.8830
* 06-0053	.9271
06-0054	.9205
* 06-0055	.9238
* 06-0056	1.0222
* 06-0057	1.2874
* 06-0058	.9523
* 06-0059	1.0491
* 06-0060	.9717
06-0061	.9398
* 06-0062	1.0009
* 06-0063	.9830
06-0064	.9851
06-0065	.9874
* 06-0066	.9155
* 06-0067	.9246
* 06-0068	1.0324
* 06-0069	.9111
* 06-0070	.9513
06-0071	1.0276
* 06-0072	.9264
* 06-0073	.6120
* 06-0074	.9640
06-0075	1.0738
06-0076	1.0534
* 06-0077	.8436
* 06-0083	.8367
* 06-0085	.8034
06-0087	1.0867
* 06-0088	.9126
* 06-0090	1.0171
* 06-0092	.8104
* 06-0093	1.0408
* 06-0096	1.2619
07-0001	1.2649
07-0002	1.1663
07-0003	1.0895
07-0004	1.0698
07-0005	1.0958
07-0006	1.1094
07-0007	1.1398
07-0008	.9974
07-0009	1.0739
07-0010	1.1312
07-0011	1.1014
07-0012	1.1253
07-0013	1.0861
07-0014	1.0478
07-0015	1.0927
07-0016	1.1340
07-0017	1.0725
07-0018	1.0242
07-0019	1.0727
07-0020	1.1070
07-0021	1.0243
07-0022	1.1782
07-0023	1.0325
07-0024	1.0418
07-0025	1.2112
07-0026	1.0548
07-0027	1.1202
07-0028	1.1668
07-0029	.9829
07-0030	1.0638
07-0031	1.0532
07-0033	1.1269
07-0034	1.0543
07-0035	1.1471
07-0036	1.1461
* 07-0038	1.1131
08-0001	1.1347
08-0002	.9799
08-0003	1.0952
08-0004	1.1281
08-0005	.9634
08-0006	1.0334
08-0007	.9906
09-0001	1.1448
09-0002	1.1164
09-0003	1.0848
09-0004	1.1598
09-0005	1.0715
09-0006	1.0445
09-0007	.9484
09-0008	1.1052
09-0009	1.0053
* 09-0010	1.0990
09-0011	1.2288
10-0001	1.0682
10-0002	1.0739
10-0004	.8855
10-0005	.9529
10-0006	1.0106
10-0007	1.1365
10-0008	1.0724
10-0009	1.0806
10-0010	1.0935
10-0011	.8948
10-0012	1.0005
10-0013	.9917
10-0014	.9613
10-0015	1.0740
10-0016	1.0385
10-0017	1.0732
10-0018	1.1244
10-0019	1.0590
10-0020	.9692
10-0021	1.0124
10-0022	1.2099
10-0023	.9897
10-0024	1.0638
10-0025	1.1482
10-0026	1.0235
10-0027	.8842
10-0028	.9967
10-0029	1.0272
10-0030	.9146
10-0031	.8162
10-0032	1.1125
10-0033	1.0085
10-0034	1.1234
10-0035	1.0316
10-0036	.9988
10-0038	1.0969
10-0039	1.0944
10-0040	1.1597
10-0042	.9668
10-0043	1.0705
10-0044	1.0579
10-0045	1.0774
10-0046	.9336
10-0047	1.0081
10-0048	.8103
10-0049	1.1048
10-0050	.9604
10-0051	.9206
10-0052	.9763
10-0053	1.0482
10-0054	.9049
10-0055	.9604
10-0056	.9161
10-0057	.9799
10-0059	1.0683
10-0060	1.2135
10-0061	1.1032
10-0062	1.1738

INDEXES DERIVED FROM FEWER THAN 50 DISCHARGES DO NOT MEET THE SELECTED STATISTICAL PRECISION CRITERION FOR RELIABILITY. THESE CASE MIX INDEXES ARE ASTERISKED.

TABLE NO. 3a HOSPITAL CASE MIX INDEXES Page 5

PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX
10-0063	1.1144	10-0126	1.0640	10-0185	.9440	* 10-0245	1.1042	11-0044	.9777
10-0065	1.0366	10-0127	1.1200	10-0186	1.1082	10-0246	1.0694	11-0045	.8755
10-0067	1.0551	10-0128	1.6495	10-0187	1.0223	* 10-0247	.8934	11-0046	1.0003
10-0068	1.0204	10-0129	1.0563	10-0189	1.0065	10-0248	1.0608	11-0047	.9205
10-0069	.9949	10-0130	1.0389	10-0191	1.0607	10-0249	1.0087	11-0048	.9806
10-0070	1.1454	10-0131	1.0484	10-0193	.8154	10-0251	.9416	11-0049	.8592
10-0071	.9462	10-0132	1.0491	10-0194	.9307	10-0252	.9774	* 11-0050	.9055
10-0072	.9720	* 10-0133	.7304	10-0195	1.0393	10-0253	1.1254	11-0051	.8806
10-0073	1.1166	10-0134	.8981	10-0196	1.0745	10-0254	1.0055	11-0052	.8946
10-0074	.9340	10-0135	1.0937	10-0199	1.0670	10-0255	.9890	11-0054	1.0631
10-0075	1.0288	10-0137	.9508	10-0200	1.1049	10-0256	1.0832	11-0055	.9383
10-0076	.9971	10-0138	.8588	* 10-0201	1.0267	11-0001	1.0519	11-0056	.9213
10-0077	.9529	10-0139	.9637	10-0203	1.0578	11-0002	.9640	11-0059	.9808
10-0078	.8304	10-0140	.9484	10-0204	1.1522	11-0003	.9917	11-0061	.9265
10-0079	.9714	10-0142	.9485	10-0206	1.0562	11-0004	1.0138	11-0062	.9056
10-0080	1.1434	10-0143	1.0168	10-0207	1.0625	11-0005	.9454	11-0063	.9116
10-0081	.9140	10-0144	1.0074	10-0208	1.0151	11-0006	1.0901	11-0064	1.0884
10-0082	1.0811	10-0145	.9808	10-0209	1.0666	11-0007	1.1442	11-0065	.8885
10-0083	1.0445	10-0146	.9618	10-0210	1.0601	11-0008	.9432	11-0066	1.1061
10-0084	.9633	10-0147	.8898	10-0211	.9674	11-0009	.9493	11-0067	.9104
10-0085	1.0009	10-0149	1.1224	10-0212	1.0909	11-0010	1.3363	11-0069	1.0165
10-0086	1.0531	10-0150	.8953	10-0213	1.0958	11-0011	.9824	11-0070	.8622
10-0087	1.1042	10-0151	1.0853	10-0214	.9939	11-0013	.9816	11-0071	.9172
10-0088	1.1095	10-0152	.9622	10-0217	1.0519	11-0014	.8929	11-0072	.9016
10-0089	1.0600	10-0153	.8243	10-0218	.9841	11-0015	1.0211	11-0073	.9176
10-0090	.9528	10-0154	1.0969	10-0219	1.0176	11-0016	1.0565	11-0074	1.0833
10-0092	1.0443	10-0156	.8921	10-0220	1.1208	11-0017	.9680	11-0075	.9963
10-0093	.9963	10-0157	1.0616	10-0221	1.2535	11-0018	.9423	11-0076	1.1442
10-0096	1.0257	10-0159	.8523	10-0222	.9690	11-0020	.9665	11-0077	.8655
10-0099	.9673	10-0160	.9428	10-0223	1.0461	11-0023	.8969	11-0078	1.1304
10-0100	1.0049	10-0161	1.0513	10-0224	1.0023	11-0024	1.0558	11-0079	1.0339
10-0102	.8946	10-0162	1.0735	10-0225	1.0309	11-0025	1.0642	11-0080	.9843
10-0103	.9386	10-0164	.9035	10-0226	1.0312	11-0026	.9091	11-0081	.9231
10-0105	1.0643	10-0165	.9334	* 10-0227	.8552	11-0027	.9145	11-0082	1.2646
10-0106	.9344	10-0166	.9976	10-0228	.9461	11-0028	1.1037	11-0083	1.0904
10-0107	.9687	10-0167	.9926	10-0229	1.0374	11-0029	.9616	11-0084	.9123
10-0108	.9320	10-0168	1.1004	10-0230	.9871	11-0030	.9779	11-0085	1.0407
10-0109	.9931	10-0169	1.1685	10-0231	1.2066	11-0031	1.0098	11-0086	.9502
10-0110	1.0207	10-0170	1.0858	10-0232	.9872	11-0032	.9862	11-0087	.9528
10-0112	.9481	10-0172	1.0283	10-0234	1.0546	11-0033	1.0009	* 11-0088	.8658
10-0113	1.2969	10-0173	1.0432	10-0235	1.0059	11-0034	1.0439	11-0089	.9022
10-0114	1.0162	10-0174	1.0298	10-0236	1.0693	11-0035	1.0316	11-0091	1.0836
10-0115	1.0214	10-0175	.8913	10-0237	1.2402	11-0036	1.2982	11-0092	.9700
10-0117	1.0215	10-0176	1.1192	10-0238	1.0036	11-0037	.9232	11-0093	.9375
10-0118	.8933	10-0177	1.0443	10-0239	1.0142	11-0038	1.0123	11-0094	.8218
10-0120	.9384	10-0179	1.1436	10-0240	.5811	11-0039	1.0365	11-0095	1.0566
10-0121	.8768	10-0180	1.1645	10-0241	.8441	11-0040	.9155	11-0096	.9680
10-0122	.8883	10-0181	.8386	10-0242	.9964	11-0041	.9430	11-0097	.8496
10-0124	.9826	* 10-0182	.7765	10-0243	1.0448	11-0042	.9496	11-0098	.8959
10-0125	.9702	10-0183	.9580	10-0244	1.0602	11-0043	1.0475	11-0099	.9589

INDEXES DERIVED FROM FEWER THAN 50 DISCHARGES DO NOT MEET THE SELECTED STATISTICAL PRECISION CRITERION FOR RELIABILITY. THESE CASE MIX INDEXES ARE ASTERISKED.

TABLE NO. 3B HOSPITAL CASE MIX INDEXES Page 6

PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX
11-0100	1.0060	11-0165	1.1029	13-0002	1.0657	14-0008	1.0198	14-0066	.9968
11-0101	.9142	11-0166	1.0236	13-0003	1.0849	14-0009	.9615	14-0067	1.0883
11-0102	1.0011	11-0168	.9848	13-0005	.9590	14-0010	1.0866	14-0068	1.0140
11-0104	1.0013	11-0169	.9502	13-0006	1.2374	14-0011	.9835	14-0069	.9858
11-0105	1.0075	11-0170	.8359	13-0007	1.1374	14-0012	.9508	14-0070	1.0107
11-0107	1.2246	11-0171	1.0729	* 13-0008	1.1162	14-0013	1.0468	14-0072	.9986
11-0108	.9378	11-0172	1.0751	13-0009	.9710	14-0014	.9741	14-0074	1.0464
11-0109	.9521	11-0174	.8839	13-0010	1.0040	14-0015	1.0298	14-0075	1.1733
11-0111	.9188	11-0175	1.0178	13-0011	1.0358	14-0016	1.0195	* 14-0076	1.0612
11-0112	.5127	11-0176	.8922	* 13-0012	.9443	14-0017	1.0693	14-0077	.9727
11-0113	1.0123	11-0177	1.0456	13-0013	1.0266	14-0018	1.1214	14-0079	1.0622
11-0114	.9408	11-0178	.6516	13-0014	1.0386	14-0019	.8946	14-0080	1.1877
11-0115	1.0540	11-0179	1.0162	13-0015	.9223	14-0023	.9319	14-0081	1.0367
11-0117	.5752	11-0181	1.0134	13-0016	1.0009	14-0024	.8915	14-0082	1.0584
11-0118	.9134	11-0182	.9651	* 13-0017	.9126	14-0025	1.0586	14-0083	1.0592
11-0120	.5052	11-0183	1.0087	13-0018	1.0991	14-0026	1.0121	14-0084	1.0529
11-0121	.9130	11-0184	1.0163	13-0019	1.0681	14-0027	1.0208	14-0085	1.0529
11-0122	1.0306	11-0185	.9735	* 13-0021	.9488	14-0029	1.0745	14-0086	1.0597
11-0123	.9745	11-0186	.9589	13-0022	.9851	14-0030	1.0324	14-0087	1.0682
11-0124	.9226	11-0187	.9004	13-0024	1.0057	14-0031	1.0378	14-0088	1.1969
11-0125	.5551	11-0188	1.0465	13-0025	.9795	14-0032	.9316	14-0089	.9670
11-0127	.8652	11-0189	.9092	13-0026	1.1308	14-0033	1.0267	14-0090	1.0303
11-0128	.9626	11-0190	.8736	13-0027	.9108	14-0034	.9350	14-0091	1.1295
11-0129	1.1402	11-0191	1.0976	13-0028	1.0524	14-0035	1.0017	14-0093	.9552
11-0130	.5027	11-0192	1.0347	13-0029	.9766	14-0036	.9385	14-0094	1.0678
* 11-0131	.8366	11-0193	.9768	* 13-0030	.8698	14-0037	.9191	14-0095	1.0778
11-0132	.9492	11-0194	.9190	* 13-0031	.8937	14-0038	1.0347	14-0097	.9668
11-0133	1.0048	11-0195	1.0051	* 13-0032	.5382	14-0039	.9487	14-0098	1.0323
11-0134	.8720	* 11-0196	1.3425	13-0034	.9412	14-0040	1.0124	14-0099	.9979
11-0135	.9242	12-0001	1.1640	13-0035	.9567	14-0041	1.0290	14-0100	1.0324
* 11-0136	1.1293	12-0002	1.1302	13-0036	1.0433	14-0042	.9170	14-0101	.9887
11-0140	.8943	12-0003	1.0201	13-0037	.8699	14-0043	.9866	14-0102	.9306
11-0141	.5208	12-0004	.9541	* 13-0038	.9225	* 14-0044	.9107	14-0103	1.0306
11-0142	.8852	12-0005	1.0775	* 13-0039	1.2372	14-0045	.9940	14-0104	.9278
11-0143	1.0519	12-0006	1.0852	* 13-0040	.5952	14-0046	1.0195	14-0105	1.0717
11-0144	.9968	12-0007	1.0316	* 13-0041	.8561	14-0047	1.0167	14-0107	.9960
11-0146	.8830	* 12-0008	.8456	13-0042	.9667	14-0048	1.0089	14-0108	1.0141
11-0149	.9328	* 12-0009	.9751	* 13-0044	.9363	14-0049	1.0803	14-0109	.9597
11-0150	1.0311	12-0010	1.2607	13-0045	.9561	14-0051	1.0160	14-0110	.9663
11-0151	1.0358	12-0011	1.0968	* 13-0048	.5749	14-0052	.8966	14-0111	1.0219
11-0152	.9408	* 12-0012	1.0962	13-0049	1.0238	14-0053	1.1470	14-0112	.9595
11-0153	.8838	12-0014	1.0788	* 13-0050	.8341	14-0054	1.0592	14-0113	1.0894
11-0154	.5238	* 12-0015	.7600	13-0051	.8803	14-0055	.9848	14-0114	1.0628
11-0155	.9615	* 12-0016	.5687	* 13-0053	.8164	14-0058	1.0065	14-0115	.9881
* 11-0156	.9015	* 12-0018	1.0077	* 13-0054	.8738	14-0059	.9643	14-0116	1.0492
11-0157	.5318	12-0019	.9944	14-0001	1.0277	14-0061	.9687	14-0117	1.0594
11-0158	.9313	12-0020	1.0181	14-0002	1.0154	14-0062	1.0376	14-0118	1.1804
11-0161	1.1617	* 12-0021	1.0288	14-0004	.9768	14-0063	1.0669	14-0119	1.2373
11-0162	1.0685	12-0022	1.2126	14-0005	.5269	14-0064	1.1127	14-0120	1.0277
11-0164	.9875	13-0001	1.0328	14-0007	1.0623	14-0065	1.0496	14-0121	1.0368

INDEXES DERIVED FROM FEWER THAN 50 DISCHARGES DO NOT MEET THE SELECTED STATISTICAL PRECISION CRITERION FOR RELIABILITY. THESE CASE MIX INDEXES ARE ASTERISKED.

TABLE NO. 3a HOSPITAL CASE MIX INDEXES Page 7

PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX
14-0122	1.0336	14-0174	1.0244	14-0235	.9163	15-0018	1.0779	15-0073	.9974
14-0123	1.0282	14-0176	.9796	* 14-0236	1.0097	15-0019	.9761	15-0074	1.1167
14-0124	.9125	14-0177	1.0729	14-0239	1.0830	15-0020	.9428	15-0075	1.0620
14-0125	1.0030	14-0178	.9726	14-0240	.9743	15-0021	1.1973	15-0076	1.0254
14-0126	1.1078	14-0179	1.0392	* 14-0241	.8370	15-0022	.9621	15-0077	1.0728
14-0127	1.0273	14-0180	1.0997	14-0242	1.0811	15-0023	1.0327	15-0078	.9737
14-0128	.9813	14-0181	1.0294	14-0243	1.0343	15-0024	1.0790	15-0079	.9515
14-0129	.9581	14-0182	1.0989	14-0245	.9070	15-0025	1.0217	15-0081	.9309
14-0130	1.0423	14-0184	1.0193	14-0246	.9258	15-0026	.9829	15-0082	1.1202
14-0131	1.0872	14-0185	1.0796	14-0247	.9483	15-0027	.9562	15-0083	1.0475
14-0132	1.1623	14-0186	1.0022	14-0248	1.0350	15-0029	1.0923	15-0084	1.2278
14-0133	1.0902	14-0187	1.0205	14-0250	1.1370	15-0030	.9730	15-0085	.9222
14-0134	.9524	14-0188	.8778	14-0251	.9657	15-0031	.9514	15-0086	.9950
14-0135	1.0306	14-0189	1.0883	14-0252	1.0885	15-0032	1.2476	15-0088	.9758
14-0136	.9395	14-0190	.9395	14-0253	1.0041	15-0033	1.0836	15-0089	1.1158
14-0137	.9600	14-0191	1.0881	* 14-0255	.7836	15-0034	.9923	15-0090	.9765
14-0138	.8954	14-0192	1.0466	14-0257	.9008	15-0035	1.0681	15-0091	.9802
14-0139	.9609	14-0193	.9301	14-0258	1.0638	15-0036	.8788	15-0092	.9807
14-0140	1.0022	14-0197	1.0797	14-0261	1.1199	15-0037	1.0385	15-0094	.9333
14-0141	.9896	14-0199	.9740	14-0271	.9059	15-0038	1.0181	15-0095	.9943
14-0142	.9786	14-0200	1.0789	14-0273	.8767	15-0039	1.0479	15-0096	.8796
14-0143	.9780	* 14-0201	.9595	14-0275	1.0002	15-0042	1.0232	15-0097	.9699
14-0144	.9931	14-0202	1.0490	14-0276	1.3641	15-0043	1.0047	15-0098	.9801
14-0145	1.0337	14-0203	1.0754	14-0280	1.0668	15-0044	1.0204	15-0099	1.0215
14-0146	.9216	14-0204	1.0753	14-0281	1.1752	15-0045	1.0154	15-0100	1.0903
14-0147	.9855	14-0205	1.0238	14-0285	1.0664	15-0046	1.0829	15-0101	.9390
14-0148	1.0767	14-0206	.9232	14-0286	1.0756	15-0047	1.0160	15-0102	.9763
14-0150	1.1012	14-0207	1.0589	14-0288	1.0559	15-0048	1.0461	15-0103	.9166
14-0151	.9463	14-0208	1.1441	14-0289	1.0571	15-0049	.9429	15-0104	1.0193
14-0152	1.1137	14-0209	1.0960	14-0290	1.0453	15-0050	.9927	15-0105	1.0120
14-0153	1.0424	14-0210	.9720	14-0291	.9999	15-0051	1.0169	15-0106	.9096
14-0154	1.0703	14-0211	1.0875	14-0292	1.1100	15-0052	.8753	15-0109	1.0529
14-0155	.9720	14-0212	.9684	14-0293	.8747	15-0053	.9116	15-0110	.9597
14-0156	1.0435	14-0213	1.0751	* 14-0294	1.0786	15-0054	.9866	15-0111	.9880
14-0157	.9074	14-0215	1.0135	15-0001	.9564	15-0056	1.1972	15-0112	1.0499
14-0158	1.1130	* 14-0216	.7820	15-0002	1.0920	15-0057	.8407	15-0113	.9976
14-0159	.9561	14-0217	1.0471	15-0003	1.0777	15-0058	1.1102	15-0114	.9526
14-0160	1.0525	14-0218	.9678	15-0004	1.0839	15-0059	.9781	15-0115	.9627
14-0161	1.0470	14-0219	.9898	15-0005	1.0581	15-0060	.9536	15-0122	.9145
14-0162	1.0437	14-0220	.9876	15-0006	1.0462	15-0061	1.0629	15-0123	.9314
14-0163	.9480	14-0223	1.0668	15-0007	.9287	15-0062	.9157	15-0124	.9832
14-0164	1.0330	14-0224	1.0981	15-0008	1.1659	15-0063	1.0806	15-0125	1.0338
14-0165	.8155	14-0226	1.0135	15-0009	.9703	15-0064	.9821	15-0126	1.1981
14-0166	1.0201	14-0228	1.1015	15-0010	1.0147	15-0065	.9536	15-0127	.9988
14-0167	.9930	* 14-0229	.9464	15-0011	1.0328	15-0066	1.0205	15-0128	1.0406
14-0168	.9918	* 14-0230	1.0367	15-0012	1.1669	15-0067	1.0234	15-0129	1.0023
14-0170	.9867	14-0231	1.0343	15-0013	.9508	15-0069	.9804	15-0130	1.0826
14-0171	.9638	14-0232	.9209	15-0014	1.0265	15-0070	.9564	15-0132	1.1104
14-0172	1.0901	14-0233	1.1146	15-0015	.9955	15-0071	.9961	15-0133	1.0384
14-0173	1.0407	14-0234	.9709	15-0017	1.1603	15-0072	1.0550	15-0134	.9459

INDEXES DERIVED FROM FEWER THAN 50 DISCHARGES DO NOT MEET THE SELECTED STATISTICAL PRECISION CRITERION FOR RELIABILITY. THESE CASE MIX INDEXES ARE ASTERISKED.

TABLE NO. 3B HOSPITAL CASE MIX INDEXES Page 8

PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX
* 15-0135	.9007	16-0058	1.1575	16-0114	.9217	17-0019	1.0838	17-0077	.8956
16-0001	.8709	16-0059	1.0513	16-0115	.9608	17-0020	.9913	* 17-0079	.8607
16-0002	.9441	16-0060	.9737	16-0116	.9758	17-0021	.9021	17-0080	.8378
16-0003	.9332	16-0061	.8915	16-0117	1.1057	17-0022	.9968	17-0081	.9772
16-0004	1.0530	16-0062	.9512	16-0118	.9012	17-0023	.9711	* 17-0082	.9883
16-0005	.9311	* 16-0063	1.0559	16-0119	1.0276	17-0024	.9493	17-0084	.9362
16-0007	.8993	16-0064	1.0414	16-0120	.9099	17-0025	.9338	* 17-0085	.9806
16-0008	.9701	16-0065	.8879	16-0121	1.0462	17-0026	1.0273	17-0086	1.1570
16-0009	.9438	16-0066	.9823	16-0122	.9339	17-0027	.8861	17-0087	1.0730
16-0012	.9383	16-0067	1.0505	16-0123	1.0544	17-0030	.8896	17-0088	.8904
16-0013	1.1140	16-0068	.9216	16-0124	.9847	17-0031	.9888	* 17-0089	.9639
16-0014	.9151	16-0069	1.1521	16-0126	.9564	17-0032	.9338	* 17-0090	.9407
16-0016	1.0586	16-0070	.8766	16-0129	1.0416	17-0033	.9641	17-0091	.9707
16-0018	.9486	16-0071	.9612	16-0130	.9575	* 17-0034	.8950	17-0092	.9160
16-0020	.9144	16-0072	1.0014	16-0131	.9614	17-0035	.9429	17-0093	1.0174
16-0021	.9182	16-0073	.9424	* 16-0132	.8988	* 17-0036	.9685	17-0094	.9874
16-0023	1.0287	16-0074	.9539	16-0133	.9465	17-0037	1.1138	17-0095	.9817
16-0024	.9645	16-0075	.9192	16-0134	.9036	17-0038	.8767	* 17-0096	.8736
16-0025	1.1566	16-0076	.9317	16-0135	.9458	17-0039	.9387	17-0097	.9641
16-0026	.9562	16-0077	.8631	* 16-0136	.9803	17-0040	1.1560	17-0098	.9076
16-0027	1.0405	16-0079	1.0715	16-0138	1.0581	17-0041	.9614	* 17-0099	1.0587
16-0028	1.0014	16-0080	.9411	* 16-0139	.8507	17-0043	.9060	* 17-0100	.8790
16-0029	1.0760	16-0081	.9912	16-0140	.9611	17-0044	.8957	17-0101	.8871
16-0030	1.0370	16-0082	1.1875	* 16-0141	.9379	17-0045	.7839	17-0102	.9581
16-0031	.9211	16-0083	1.1702	* 16-0142	.9689	17-0046	.9319	17-0103	1.1044
16-0032	1.0155	16-0085	1.0772	16-0143	.9327	17-0049	.9345	17-0104	.9702
16-0033	1.0315	16-0086	.8919	16-0145	1.0121	* 17-0050	1.0050	17-0105	.9291
16-0034	.9966	16-0088	.9259	16-0146	1.0205	17-0051	1.0296	17-0106	.9148
16-0035	.9234	16-0089	.9876	16-0147	1.0292	17-0052	.9623	* 17-0108	.8051
16-0036	.9854	16-0090	.9605	16-0151	1.0654	17-0053	.9401	17-0109	.9384
16-0037	.9965	16-0091	1.0612	16-0152	.9475	17-0054	.9468	17-0110	.8804
16-0038	1.0089	16-0092	.9327	16-0153	1.0515	17-0055	.8655	17-0112	.8976
16-0039	.9037	16-0093	.8604	17-0001	.9209	* 17-0056	.9463	17-0113	.9585
16-0040	1.0277	16-0094	.9919	17-0002	.9120	17-0057	.9217	17-0114	.9562
16-0041	.9537	* 16-0095	1.0695	17-0003	1.0064	17-0058	.9632	17-0115	.9775
16-0042	.9584	16-0097	.9817	17-0004	.9135	17-0060	.9343	17-0116	.9307
16-0044	.9758	16-0098	.9321	17-0005	.8775	17-0061	.9587	* 17-0117	.8014
16-0045	1.1178	16-0099	.9470	17-0006	1.0041	* 17-0062	.8347	* 17-0119	.8537
16-0046	1.0272	16-0101	1.0357	17-0007	1.0314	* 17-0063	.8519	17-0120	.9813
16-0047	1.0414	16-0102	1.0704	17-0008	.9434	* 17-0064	.9365	* 17-0121	.9287
16-0048	.8794	16-0103	.8999	17-0009	1.0711	17-0066	.8725	17-0122	1.1276
16-0049	.8741	16-0104	1.0503	17-0010	.9820	17-0067	.9339	17-0123	1.0627
16-0050	.9462	16-0106	.9766	17-0011	1.0016	17-0068	.9690	17-0124	.8710
16-0051	.8637	16-0107	.9454	17-0012	1.1158	* 17-0069	.8835	17-0125	.9324
16-0052	1.0065	16-0108	1.0012	17-0013	.9495	17-0070	.9707	17-0126	.8839
16-0053	1.0201	* 16-0109	.9942	17-0014	.9052	17-0072	.9159	17-0128	.9710
16-0054	.9344	16-0110	1.1255	17-0015	.9207	17-0073	1.0027	* 17-0130	.8772
16-0055	.9558	* 16-0111	.9188	17-0016	1.2296	17-0074	1.0609	17-0131	.9727
16-0056	.9519	16-0112	.9775	17-0017	1.0086	* 17-0075	.9490	17-0133	1.0174
16-0057	1.0402	16-0113	1.0005	17-0018	.9673	17-0076	.9065	17-0134	.9429

INDEXES DERIVED FROM FEWER THAN 50 DISCHARGES DO NOT MEET THE SELECTED STATISTICAL PRECISION CRITERION FOR RELIABILITY. THESE CASE MIX INDEXES ARE ASTERISKED.

PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX
17-0137	1.0300	18-0026	.9524	18-0053	1.0960	19-0019	1.0792	19-0106	.9494
17-0138	.9568	18-0027	1.0494	18-0054	.9676	19-0020	1.0083	19-0109	.9969
* 17-0139	.9025	18-0028	.9286	18-0055	1.0038	19-0023	.9024	19-0110	.9550
17-0140	.9322	18-0029	.9826	18-0059	.9301	19-0025	1.0134	19-0111	1.0267
17-0142	.9367	18-0030	.9566	18-0100	1.0877	19-0026	1.0334	19-0112	1.0251
17-0143	1.0395	18-0031	.9172	18-0101	.9670	19-0027	1.0244	19-0113	1.0366
17-0144	1.0269	18-0032	.9468	18-0102	1.0800	19-0029	.9529	19-0114	.9081
17-0145	1.0038	18-0033	.9249	18-0103	1.1573	19-0033	.8821	19-0115	1.0686
17-0146	1.0101	18-0034	1.0210	18-0104	1.0384	19-0034	.8966	19-0116	.9871
17-0147	.9919	18-0035	1.0821	18-0105	.9566	19-0035	1.0852	19-0117	.9891
17-0148	1.0253	18-0036	.9155	18-0106	.9495	19-0036	1.2043	19-0118	.9556
17-0150	.8949	18-0037	1.0433	18-0108	.8972	* 19-0037	.8452	19-0119	.9256
17-0151	.9642	18-0038	1.0249	18-0112	.9275	19-0039	1.0430	19-0120	.9692
17-0152	.9458	18-0040	1.2040	18-0114	.8872	19-0040	.9363	19-0122	.9477
* 17-0155	.9979	18-0041	1.0190	18-0115	.9391	19-0041	1.1263	19-0124	1.0370
17-0160	.8553	18-0042	.9739	18-0116	1.0192	19-0043	.9607	19-0125	1.0734
17-0164	.9367	18-0043	.9556	18-0117	.9116	19-0044	.9607	19-0127	1.0161
* 17-0166	1.1136	18-0044	.9701	18-0118	.9479	19-0045	1.0243	* 19-0128	1.1076
* 17-0168	.9231	18-0045	.9771	18-0120	.8757	19-0046	1.1456	19-0130	.8181
* 17-0170	.9325	18-0046	.9832	* 18-0121	.8679	19-0047	.9124	19-0131	.8982
17-0171	.9876	18-0047	.9707	18-0122	.8533	19-0048	1.0231	19-0132	.9495
17-0172	1.0079	18-0048	1.0651	18-0123	1.0630	19-0049	.9818	19-0133	.8491
* 17-0173	.8992	18-0049	1.0335	18-0124	.9706	19-0050	.8941	19-0134	.8713
* 17-0174	.8474	18-0050	.9865	18-0125	.9849	19-0053	.9793	19-0135	1.1397
17-0175	1.0205	18-0051	1.0648	18-0126	.9759	19-0054	1.0709	19-0136	.9008
17-0176	1.0583	18-0053	.9462	18-0127	1.0378	19-0058	.9625	19-0137	.8813
* 17-0177	.9725	18-0054	.9867	18-0128	1.0156	19-0059	.9436	19-0138	.6082
18-0001	1.0709	18-0055	.9061	18-0129	.9727	19-0060	.9820	19-0139	.9407
18-0002	.9511	18-0056	1.0333	18-0130	1.0472	19-0064	1.0936	19-0140	.9449
18-0004	1.0031	18-0058	.9297	18-0132	1.0321	19-0065	1.1627	19-0141	.8396
18-0005	1.0411	18-0059	.9138	18-0133	1.0776	19-0067	.9807	19-0142	.8827
18-0006	.8580	18-0060	.9834	* 18-0134	.9591	19-0071	.9339	19-0144	1.0087
18-0007	1.0447	18-0062	.9355	19-0001	.8346	19-0073	.8813	19-0145	.9399
18-0008	1.0612	18-0063	.9572	19-0002	1.2784	19-0075	1.0185	19-0146	1.1908
18-0009	.9809	18-0064	1.0531	19-0003	.9550	19-0077	.8931	19-0147	.9493
18-0010	1.0681	18-0065	.8582	19-0004	1.0482	19-0078	.9861	19-0148	.8992
18-0011	.9270	18-0066	.9475	19-0005	1.0586	19-0079	.9848	19-0149	.9251
18-0012	1.0211	18-0067	1.2336	19-0006	1.0253	19-0081	.9389	19-0151	.9897
18-0013	1.0650	18-0069	1.0367	19-0007	.8952	19-0083	.8574	* 19-0152	.9584
18-0014	1.0480	18-0070	.9486	19-0008	1.0114	19-0086	1.0223	19-0155	.8901
18-0015	1.0048	18-0072	1.0455	19-0009	1.1204	19-0088	.9180	19-0156	.8743
18-0016	1.0495	18-0075	.8683	19-0010	.9805	19-0089	.9412	19-0157	.9419
18-0017	1.0015	18-0078	.9242	19-0011	.9175	19-0090	.8945	19-0158	.9832
18-0018	1.0143	18-0079	.9287	19-0012	.9089	19-0092	.9731	19-0160	.9594
18-0019	.9566	18-0080	1.0033	19-0013	1.0048	19-0095	.8903	19-0161	.9101
18-0020	.9264	18-0081	1.0882	19-0014	.9054	19-0098	1.1622	19-0162	1.0585
18-0021	.9814	18-0085	1.0867	19-0015	.9235	19-0099	.9808	* 19-0163	.8486
18-0022	.8962	18-0087	1.0065	19-0016	.9625	19-0101	.9144	19-0164	.8771
18-0024	.9564	18-0088	1.1082	19-0017	.9791	19-0102	1.1039	19-0165	.8665
18-0025	1.0485	18-0092	.9451	19-0018	1.0120	19-0103	.8790	19-0166	.8529

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PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX
19-0167	.9391	20-0040	.9538	21-0037	1.0339	22-0040	1.0443	22-0099	.9926
19-0168	1.1499	20-0041	.9559	21-0038	1.0228	22-0041	1.0764	22-0100	1.1699
19-0169	.9533	20-0043	1.0265	21-0039	1.0652	22-0042	1.0339	22-0101	1.1010
19-0170	.8832	20-0044	1.0559	21-0040	1.1181	22-0045	1.0373	* 22-0102	.9951
* 19-0172	.9060	20-0046	1.0178	21-0041	1.1473	22-0046	1.1115	22-0104	1.0761
19-0173	1.0689	20-0047	1.0097	21-0042	1.1731	22-0048	1.0542	22-0105	1.0542
19-0175	1.0057	* 20-0049	.9825	21-0043	1.1080	22-0049	1.0116	22-0106	1.0614
19-0176	1.1424	20-0050	1.0132	21-0044	.9528	22-0050	.9545	22-0107	1.0067
19-0177	.9806	20-0051	.9798	21-0045	1.1417	22-0051	1.0834	22-0108	1.0809
19-0178	.8678	20-0052	1.0005	21-0046	.9388	22-0052	1.0779	22-0110	1.4383
19-0179	.9197	20-0055	.9629	21-0047	.8841	22-0053	1.0180	22-0111	1.0552
19-0180	.9477	* 20-0056	.6173	21-0048	1.0411	22-0054	1.0932	22-0114	1.0488
19-0182	.9571	20-0062	.9783	21-0049	1.0495	22-0055	1.0671	22-0115	1.0770
19-0183	.8654	20-0063	1.0755	21-0051	1.1342	22-0057	1.0101	22-0116	1.2472
19-0184	.8515	* 20-0065	.8455	21-0054	1.0338	22-0058	.9629	22-0117	1.0851
19-0185	1.0029	20-0066	1.0966	21-0055	1.0622	22-0060	1.1056	22-0118	1.3412
19-0186	.9097	21-0001	1.1188	21-0056	1.1138	22-0061	1.0457	22-0119	1.1389
19-0187	.8960	21-0002	1.3013	21-0057	1.0593	22-0062	.9252	22-0120	1.0075
19-0190	.8587	21-0003	1.1090	22-0001	1.0446	22-0063	1.0140	22-0121	.9789
20-0001	1.1242	21-0004	1.1257	22-0002	1.1860	22-0064	1.0855	22-0123	1.0710
20-0002	1.0394	21-0005	1.1249	22-0003	1.0149	22-0065	1.0460	22-0126	1.0763
20-0003	1.0132	21-0006	1.0503	22-0004	1.0500	22-0066	1.0916	22-0128	1.0649
20-0005	.9714	21-0007	1.1316	22-0005	1.0124	22-0067	1.1152	22-0129	1.0683
20-0006	1.0168	21-0008	1.0889	22-0006	1.0948	22-0068	.9373	* 22-0130	.8748
20-0007	.9863	21-0009	1.1551	22-0008	1.1228	22-0069	1.0008	22-0131	.9983
20-0008	1.0973	21-0010	.9992	22-0009	.9923	22-0070	1.0336	* 22-0133	.9459
20-0009	1.2182	21-0011	1.0896	22-0010	1.0801	22-0071	1.3760	22-0135	1.0700
20-0012	1.0153	21-0012	1.0857	22-0011	1.1204	22-0072	.9717	* 22-0153	.8645
20-0013	1.0606	21-0013	1.0941	22-0012	1.1164	22-0073	1.0552	22-0154	.9329
20-0015	1.0176	21-0015	1.1154	* 22-0014	.9750	22-0074	1.0290	22-0156	1.0487
20-0016	.9980	21-0016	1.1283	22-0015	1.1118	22-0075	.6230	22-0162	.9720
20-0017	1.0576	21-0017	1.0638	22-0016	1.0657	22-0076	1.0961	22-0163	1.2228
20-0018	1.0278	21-0018	1.1381	22-0017	1.1005	22-0077	1.1132	22-0171	1.2348
20-0019	1.1084	21-0019	1.1574	22-0019	1.0433	22-0079	1.1111	23-0001	.9684
20-0020	1.0029	21-0021	.9903	22-0020	1.0950	22-0080	1.0542	23-0002	1.0687
20-0021	1.0446	21-0022	1.1216	22-0021	1.0692	* 22-0081	.8834	23-0003	1.0892
* 20-0023	.8911	21-0023	1.1240	22-0022	.9330	22-0082	1.0513	23-0004	1.0978
20-0024	1.0771	21-0024	1.1571	22-0023	1.0161	22-0083	1.0553	23-0005	.9592
20-0025	1.0167	21-0025	1.0231	22-0024	1.0928	22-0084	.9993	23-0006	.9310
20-0026	.9758	21-0026	1.1061	22-0025	1.0893	22-0086	1.2005	23-0007	.8410
20-0027	1.0305	21-0027	1.0826	22-0026	1.0469	22-0087	.8742	* 23-0008	.9513
20-0028	.8993	21-0028	.9538	22-0028	1.0623	22-0088	1.1413	23-0011	1.0340
* 20-0029	.8341	21-0029	1.1682	22-0029	1.0088	22-0089	1.0278	23-0012	.9573
20-0031	1.0622	21-0030	.9736	22-0030	.9845	22-0090	.9752	23-0013	1.1130
20-0032	1.2217	21-0031	1.3379	22-0031	1.1018	* 22-0091	1.1029	23-0014	.9290
20-0033	1.2252	21-0032	1.0141	22-0033	1.0340	22-0092	1.0759	23-0015	.9740
20-0034	1.0034	21-0033	1.0383	22-0034	.9989	22-0094	1.0097	23-0017	1.1286
20-0037	1.0063	21-0034	1.0842	22-0035	1.1012	22-0095	1.0326	23-0019	1.1608
20-0038	.9629	21-0035	1.0260	22-0036	1.1360	22-0097	.9499	23-0020	1.0908
20-0039	1.1013	21-0036	1.0354	22-0038	1.0724	22-0098	.9898	23-0021	1.0901

INDEXES DERIVED FROM FEWER THAN 50 DISCHARGES DO NOT MEET THE SELECTED STATISTICAL PRECISION CRITERION FOR RELIABILITY THESE CASE MIX INDEXES ARE ASTERISKED.

PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX
23-0022	1.0352	23-0087	1.0522	23-0146	1.1130	23-0208	.9804	24-0011	.9650
23-0024	1.1680	23-0089	1.0754	23-0147	1.0221	23-0211	.9526	24-0013	1.0063
23-0027	.9279	23-0090	1.0731	23-0149	.9541	23-0212	1.0166	24-0014	.8950
23-0029	1.0605	23-0092	1.0385	23-0150	1.0510	23-0213	.9733	24-0016	1.1454
23-0030	1.1263	23-0093	.9824	23-0151	1.1209	23-0216	1.0185	24-0017	.9702
23-0031	1.0636	23-0095	1.0167	23-0152	1.0040	23-0217	.9583	24-0018	1.0439
23-0032	1.2695	23-0096	.9551	23-0153	1.0729	23-0219	.9277	24-0019	.8819
23-0034	1.0322	23-0097	1.1004	23-0154	.9359	23-0221	1.0057	24-0020	.9670
23-0035	.9756	23-0098	1.1159	23-0155	.9281	23-0222	1.0540	24-0021	.9412
23-0036	1.0768	23-0099	.9793	23-0156	1.2181	23-0223	1.0657	24-0022	1.0012
23-0037	1.0628	23-0100	.9677	23-0157	1.0853	23-0224	.9286	24-0023	.9747
23-0038	1.3303	23-0101	.9823	23-0158	.9418	23-0225	.9959	24-0024	.9931
23-0039	1.1440	23-0102	1.0724	23-0159	1.0099	23-0227	.9992	24-0025	.9953
23-0040	1.0684	23-0103	.9594	* 23-0161	.8507	23-0228	1.1018	24-0026	1.1332
23-0041	1.0495	23-0104	1.1643	* 23-0162	.9122	23-0230	1.1027	24-0027	.9556
23-0042	1.0437	23-0105	1.1648	23-0163	.8140	23-0231	.9444	24-0028	.9996
23-0043	.8528	23-0106	1.0109	23-0165	1.1788	* 23-0232	.9400	24-0029	1.0552
23-0046	1.1290	23-0107	.9550	23-0167	1.0682	23-0235	.9706	24-0030	.9814
23-0047	1.0119	23-0108	1.0005	23-0168	.9775	23-0236	1.0135	24-0031	.9032
23-0051	.9524	23-0110	1.0366	23-0169	1.0731	23-0237	1.0454	* 24-0033	.8338
23-0052	1.0233	23-0111	.9198	* 23-0170	1.0616	23-0238	.9359	24-0036	1.0376
23-0053	1.2677	23-0113	.8222	23-0171	.9091	23-0239	.9743	24-0037	.9374
23-0054	1.1038	23-0114	.7375	23-0172	1.0217	23-0241	.9633	24-0038	1.1108
23-0055	.9545	23-0115	.9726	23-0173	1.0398	23-0244	1.0353	24-0040	1.0081
23-0056	.9174	23-0116	.9404	23-0174	1.0264	23-0253	.9854	24-0041	1.0902
23-0057	.9261	23-0117	1.2480	23-0175	1.0687	23-0254	1.0412	24-0043	1.0826
23-0058	.9616	23-0118	.9968	23-0176	.9781	23-0255	.9263	24-0044	1.0217
23-0059	1.1477	23-0119	.9517	23-0177	.9469	23-0256	.9779	24-0045	1.0477
23-0061	.9874	23-0120	.9371	23-0178	.9548	23-0257	.8808	24-0046	1.1560
23-0062	.9766	23-0121	.9387	* 23-0179	.9752	* 23-0258	1.0079	24-0047	1.0904
23-0063	1.1055	23-0122	1.1144	23-0180	.9314	23-0259	.9562	24-0048	.8959
23-0065	1.0275	* 23-0123	.9917	23-0181	1.0110	23-0261	.9214	24-0049	1.2813
23-0066	1.0457	23-0124	.9620	23-0183	1.0031	23-0264	.8772	24-0050	1.0450
* 23-0067	1.0845	23-0125	1.1132	23-0184	.9285	23-0265	1.0251	24-0051	1.0010
23-0068	1.1545	23-0128	1.0558	23-0186	.9236	23-0266	1.0126	24-0052	1.0800
23-0069	1.0468	23-0129	1.2222	23-0188	.9488	23-0269	1.0547	24-0053	1.1423
23-0070	1.0550	23-0130	1.1437	23-0189	1.0176	23-0270	1.0600	24-0054	.9837
* 23-0071	.8333	23-0132	1.1141	* 23-0190	.8368	23-0271	.9425	24-0055	1.0975
23-0072	.9993	23-0133	1.0595	23-0191	.8730	* 23-0272	.9660	24-0056	1.0470
23-0075	1.0727	23-0134	1.0621	23-0193	1.0149	23-0273	1.1709	24-0057	1.1405
23-0076	1.0635	23-0135	1.0575	23-0194	1.0518	24-0001	1.1200	* 24-0058	.8842
23-0077	1.1086	23-0137	1.0053	23-0195	1.0813	24-0002	1.1281	24-0059	.9382
23-0078	.9278	* 23-0138	.8944	* 23-0196	.9290	24-0003	1.0405	24-0061	1.1568
23-0079	1.0153	23-0139	.9367	23-0197	1.0365	24-0004	1.2734	24-0062	1.0451
23-0080	.9590	23-0140	.9524	23-0199	.9684	* 24-0005	.9712	24-0063	1.0950
23-0081	1.0119	23-0141	1.1356	23-0201	.9362	24-0006	.9450	24-0064	.9896
23-0082	1.0066	23-0142	1.1282	* 23-0203	.8411	24-0007	.9134	24-0065	.9073
23-0084	.9423	23-0143	1.0450	23-0204	1.1133	24-0008	1.0126	24-0066	.9587
23-0085	.9174	23-0144	.9640	23-0205	1.0821	24-0009	.8950	24-0069	.9657
23-0086	.9450	23-0145	1.0005	23-0207	1.0026	24-0010	1.3895	24-0071	.9605

INDEXES DERIVED FROM FEWER THAN 50 DISCHARGES DO NOT MEET THE SELECTED STATISTICAL PRECISION CRITERION FOR RELIABILITY. THESE CASE MIX INDEXES ARE ASTERISKED.

TABLE NO. 5a HOSPITAL CASE MIX INDEXES Page 12

PROVIDER NUMBER	CASE MIX INDEX
24-0072	.8222
24-0073	.9130
24-0074	.8752
24-0075	.9339
24-0076	.9721
24-0077	.9534
24-0078	1.0248
24-0079	.9036
24-0080	1.1540
24-0081	1.1226
24-0082	1.1233
24-0083	1.0034
24-0084	1.0369
24-0085	.9380
24-0086	.9187
24-0087	1.0874
24-0088	1.0921
24-0089	.9716
24-0090	.9960
* 24-0091	.8966
24-0093	1.1343
24-0094	.9883
24-0096	.9614
24-0097	1.0680
24-0098	.8585
24-0099	.9422
24-0100	.9688
24-0101	1.0012
24-0102	.9193
24-0103	.9451
24-0104	.9808
24-0105	.8945
24-0106	1.1511
24-0107	.8999
24-0108	.9163
24-0109	.9367
24-0110	1.0056
24-0111	.8554
24-0112	.9230
24-0114	.9981
24-0115	1.1096
24-0116	.9385
24-0117	.9734
* 24-0118	.8565
* 24-0119	.9079
24-0120	1.0441
24-0121	.8929
24-0122	.9424
24-0123	1.0043
24-0124	.9603
* 24-0125	.9851
* 24-0127	.9177
24-0128	1.0353
24-0129	.9310
24-0130	.9318
24-0131	1.0914
24-0132	1.0222
24-0133	.9449
24-0134	.9991
* 24-0135	.7673
24-0136	.9484
24-0137	.9445
24-0138	.9277
24-0139	1.0546
* 24-0140	.9546
24-0141	.9094
24-0142	.9791
* 24-0143	.9427
24-0144	.9451
* 24-0145	.8650
24-0146	.8759
* 24-0148	.9009
24-0150	.8836
24-0152	.9588
24-0153	.9358
24-0154	.8975
24-0155	.9028
* 24-0156	.9408
24-0157	.9809
24-0158	.9804
24-0160	.9598
24-0161	.8726
24-0162	1.0457
* 24-0163	.8375
* 24-0165	.9575
24-0166	.9476
* 24-0167	.9711
24-0169	.9358
24-0170	.9890
24-0171	.8899
24-0172	1.0088
24-0173	.9526
24-0175	1.0362
* 24-0176	1.0251
* 24-0177	.9334
24-0179	.9393
24-0180	.9083
24-0183	.8928
* 24-0184	.9664
24-0187	.9601
* 24-0189	.8866
* 24-0192	.8474
* 24-0193	1.0278
* 24-0194	.8868
* 24-0195	1.0512
24-0196	1.0864
* 24-0200	1.0219
* 24-0201	.9029
* 24-0204	1.0355
25-0001	1.2191
25-0002	.8921
25-0003	.8625
25-0004	1.0664
25-0005	.8959
25-0006	.9593
25-0007	.9961
25-0008	.8665
25-0009	1.0087
25-0010	.8812
25-0012	.9510
25-0014	.8995
25-0015	.8968
25-0016	.8497
25-0017	.9303
25-0018	.9288
25-0019	1.0827
25-0020	.9160
25-0021	.9002
25-0023	.8388
25-0024	.9121
25-0025	.9465
25-0026	.8344
25-0027	.9356
25-0029	.9334
25-0030	.9132
25-0031	1.0279
25-0032	1.0534
25-0033	.8983
25-0034	.8715
25-0035	.9447
25-0036	.8618
25-0037	.9271
25-0038	.9142
25-0039	.8664
25-0040	1.0201
25-0041	.8957
25-0042	.9965
25-0043	.8357
25-0044	.8783
25-0045	.9749
25-0046	.9159
25-0047	.8940
25-0048	1.1494
25-0049	.9255
25-0050	.9851
25-0051	.9377
* 25-0054	.9136
25-0057	.9451
25-0058	.9919
25-0059	.8961
25-0060	.9139
25-0061	.9153
25-0062	.9288
25-0063	.8733
25-0065	.9245
25-0066	.8765
25-0067	.9375
25-0068	.8567
25-0069	1.0010
25-0071	.9685
25-0072	1.0273
25-0073	.9419
25-0075	.9071
25-0076	.8516
25-0077	.9046
25-0078	1.0535
* 25-0079	.9380
25-0080	.9363
25-0081	1.0674
25-0082	1.0475
25-0083	.9142
25-0084	.9577
25-0085	.8883
25-0086	.9019
* 25-0087	.9578
25-0088	.9532
25-0089	.9936
25-0091	.9802
25-0093	.9470
25-0094	1.0130
25-0095	.8524
25-0096	.9758
25-0097	.9781
25-0098	.8437
25-0099	.9716
25-0100	1.0533
* 25-0101	.8603
25-0102	1.0449
25-0103	.8964
25-0104	1.0482
25-0105	.8514
* 25-0106	.9617
25-0107	.8977
25-0109	.9361
25-0110	.9658
25-0111	.8626
25-0112	.8660
25-0113	.9875
* 25-0114	.9063
* 25-0116	.8799
25-0117	.9704
25-0118	1.1073
25-0119	.9110
25-0120	1.0279
* 25-0121	.8468
25-0122	.8881
25-0123	.9257
25-0124	.8461
25-0125	1.0594
25-0126	.9385
* 25-0127	1.0294
25-0128	.9731
25-0129	.9344
* 25-0130	.9012
* 25-0131	.8633
25-0132	.9443
* 25-0133	.8452
* 25-0134	.9787
26-0001	.9644
26-0002	.9760
26-0003	.8945
26-0004	.9927
26-0005	.9590
26-0006	.9707
26-0007	.8953
26-0008	1.0054
26-0009	.9322
26-0010	.9614
26-0011	.9505
26-0012	.8546
26-0013	.9324
26-0014	.9735
26-0015	.9031
26-0016	.9535
26-0017	.9627
26-0018	.9506
26-0019	.9283
26-0020	.9704
26-0021	.9500
26-0022	.9547

INDEXES DERIVED FROM FEWER THAN 50 DISCHARGES DO NOT MEET THE SELECTED STATISTICAL PRECISION CRITERION FOR RELIABILITY. THESE CASE MIX INDEXES ARE ASTERISKED.

TABLE NO. 5a HOSPITAL CASE MIX INDEXES Page 13

PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX
26-0023	.9153	26-0082	.9438	* 26-0146	1.0181	* 27-0027	.9490	28-0014	.8279
26-0024	.9829	26-0083	.9712	26-0147	.9331	27-0028	.9417	28-0015	.8809
26-0025	.9210	26-0084	.9589	26-0148	.8746	27-0029	.9094	28-0017	.9270
* 26-0026	1.0170	26-0085	.9953	26-0150	1.0352	* 27-0030	.9040	28-0018	.8896
26-0027	1.0792	* 26-0086	1.1100	26-0158	.9628	* 27-0031	.8988	28-0020	1.1066
26-0029	.9282	26-0088	.8732	26-0159	.8431	27-0032	.9623	28-0021	.9512
26-0030	.9339	26-0089	.9329	26-0160	1.0073	* 27-0033	.8449	* 28-0022	1.0049
26-0031	.9682	26-0090	1.0125	26-0162	.9831	27-0035	.9876	28-0023	1.0940
26-0032	1.0257	26-0091	1.0110	26-0163	.8918	* 27-0036	1.0833	28-0024	.8972
26-0033	.9945	26-0092	.8941	* 26-0164	.8924	27-0039	.9156	28-0025	.8989
26-0034	.9170	* 26-0093	.9800	26-0165	.9064	27-0040	1.0056	* 28-0026	.8580
26-0035	.8850	26-0094	.9346	26-0166	.9959	27-0041	1.0437	28-0028	.9489
26-0036	.9142	26-0095	.9412	26-0172	.9036	* 27-0042	.8319	* 28-0029	.9457
26-0037	.9322	26-0096	1.0226	* 26-0173	.9660	27-0043	.8881	28-0030	1.1435
26-0039	.9779	26-0097	.9186	26-0175	.9815	27-0044	1.0093	28-0031	.9067
26-0040	1.0646	26-0100	.9276	26-0176	.9454	27-0046	.9132	28-0032	.9558
* 26-0041	.9710	* 26-0102	.9959	26-0177	1.0081	* 27-0047	1.0169	28-0033	.8678
26-0042	.7859	26-0103	.9968	26-0178	.9355	27-0048	.9130	28-0034	1.0480
26-0044	.9556	26-0104	1.0058	26-0179	.9867	27-0049	1.1399	28-0035	.9352
26-0045	.9641	26-0105	1.2045	26-0180	.9842	27-0050	.9492	28-0037	1.0073
26-0047	.9308	* 26-0106	.8694	* 26-0182	.9038	27-0051	.9831	28-0038	.9523
26-0048	1.0269	26-0107	.9496	26-0183	.9198	* 27-0052	.9202	28-0039	.8805
* 26-0049	.9620	26-0108	.9835	26-0186	.9706	* 27-0053	.9622	28-0040	1.1572
26-0050	.9045	* 26-0109	.9157	* 26-0187	1.0212	27-0054	1.0716	28-0041	.8828
26-0051	.9812	26-0110	.9594	26-0188	.9590	27-0057	1.0499	28-0042	.8660
26-0052	.9894	26-0111	.9231	* 26-0189	.9921	27-0058	1.0114	28-0043	.9727
26-0053	.9643	26-0112	.9957	26-0190	1.1026	* 27-0059	.8726	28-0045	.9956
26-0054	.9649	26-0113	.9468	26-0191	.9102	* 27-0060	.9411	28-0046	.9703
26-0055	.9035	26-0115	.9790	26-0192	.6325	* 27-0061	.9799	28-0047	1.0296
26-0056	.9158	26-0116	.9124	* 26-0193	.8196	* 27-0063	.9714	28-0048	.9766
26-0057	.9627	* 26-0117	.9501	* 27-0001	.9560	27-0065	1.0095	28-0049	.9450
26-0058	1.0491	26-0118	1.0480	27-0002	.9860	* 27-0067	.9620	* 28-0050	.8994
26-0059	.9515	26-0119	.9357	27-0003	1.0115	* 27-0068	.7694	28-0051	.9311
26-0061	.9217	26-0120	.9517	27-0004	1.3210	* 27-0070	.9134	28-0052	.9781
26-0062	.9694	26-0121	.9700	* 27-0006	.8997	* 27-0071	.8458	28-0054	1.0389
26-0063	1.0457	26-0122	.9597	27-0007	.9377	* 27-0072	.9772	28-0055	1.0058
26-0064	.9622	* 26-0123	1.0046	27-0008	.8427	* 27-0073	.8259	* 28-0056	.8730
26-0065	1.0444	26-0127	.9554	27-0009	.9368	* 27-0079	1.0242	28-0057	.9139
26-0066	.9198	26-0128	.9418	27-0011	.9962	27-0080	.9823	28-0058	1.0419
26-0067	.9021	26-0129	.8653	27-0012	1.0398	* 27-0081	.8917	28-0060	1.0656
26-0068	1.0179	26-0131	.9346	27-0013	1.0006	28-0001	.9406	28-0061	1.0217
26-0070	.9391	* 26-0133	.9302	27-0014	1.0960	28-0003	1.0863	28-0062	.9484
* 26-0072	.8490	26-0134	.9431	* 27-0016	.8855	28-0004	1.0572	* 28-0063	.7933
26-0073	.8225	26-0136	.9398	27-0017	1.0804	28-0005	1.1059	28-0064	.9530
26-0074	.9675	26-0137	.9291	27-0018	.9102	28-0006	1.0326	28-0065	.9742
26-0077	.9567	26-0138	1.1557	* 27-0019	.8785	28-0009	1.0231	28-0066	.9890
26-0078	.9558	* 26-0140	1.2003	27-0021	.9631	28-0010	1.0548	28-0068	.9595
26-0079	.9272	26-0141	1.0604	27-0023	1.1087	28-0011	.9380	* 28-0070	.8623
* 26-0080	1.0343	26-0142	.9863	27-0024	1.0212	28-0012	.9814	* 28-0071	.9270
26-0081	.9821	* 26-0143	.9603	* 27-0026	.9051	28-0013	1.1002	28-0073	.8898

INDEXES DERIVED FROM FEWER THAN 50 DISCHARGES DO NOT MEET THE SELECTED STATISTICAL PRECISION CRITERION FOR RELIABILITY. THESE CASE MIX INDEXES ARE ASTERISKED.

TABLE NO. 3a HOSPITAL CASE MIX INDEXES Page 14

PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX
28-0074	1.0289	* 29-0013	.6597	31-0015	1.0960	31-0070	1.0536	32-0018	1.0059
28-0075	.9726	* 29-0014	1.0151	31-0016	1.1085	31-0071	1.0804	32-0019	1.0040
28-0076	.9315	* 29-0015	.9930	31-0017	1.1523	31-0072	1.0768	32-0021	1.1639
28-0077	.9993	* 29-0016	1.0624	31-0018	.9787	31-0073	1.0272	32-0022	1.0315
* 28-0078	.8858	* 29-0018	.6031	31-0019	1.0951	31-0074	1.0366	32-0023	.8735
28-0079	.9294	29-0019	1.0605	31-0020	1.0467	31-0075	1.1427	32-0027	.9523
28-0080	.8883	* 29-0020	.5352	31-0021	1.0751	31-0076	1.1005	32-0030	.9663
28-0081	1.0496	29-0021	1.0904	31-0022	1.0882	31-0077	1.1304	* 32-0031	.9315
28-0082	.9424	29-0022	1.1776	31-0024	1.1180	31-0078	1.1169	32-0032	.9578
28-0083	.9457	29-0024	.8157	31-0025	1.0936	31-0081	1.1154	32-0033	1.0266
28-0084	.9439	* 29-0027	.9567	31-0026	1.1187	31-0083	1.0242	32-0035	.9305
28-0085	1.0672	30-0001	1.0626	31-0027	1.0293	31-0084	1.0749	32-0036	1.1487
28-0087	1.0595	30-0002	.9741	31-0028	1.0569	31-0085	1.0174	32-0037	.9401
28-0088	1.0779	30-0003	1.1819	31-0029	1.2483	31-0086	1.0579	32-0038	.9487
28-0089	.9877	30-0005	.9971	31-0031	1.3207	31-0087	1.0287	32-0046	1.0988
28-0090	.9650	30-0006	.9597	31-0032	.9895	31-0088	1.0745	32-0048	1.0943
28-0091	1.0010	30-0007	.9384	31-0033	1.0555	31-0090	1.0206	32-0049	.9361
28-0092	.9385	30-0008	1.0189	31-0034	1.0798	31-0091	1.0166	* 32-0051	.9649
28-0093	.8676	30-0009	.8804	31-0036	1.0578	31-0092	1.0290	32-0053	.8844
28-0094	.9857	30-0010	.9994	31-0037	1.0913	31-0093	.9869	* 32-0058	.9535
28-0097	.8671	30-0011	.9992	31-0038	1.0798	31-0094	.9889	32-0063	1.0416
* 28-0098	.9802	30-0012	1.0274	31-0039	1.0524	31-0096	1.2247	32-0065	1.0216
* 28-0100	.8165	30-0013	1.0017	31-0040	1.0365	31-0104	.9909	* 32-0066	.9907
* 28-0101	.9180	30-0014	1.0027	31-0041	1.0710	31-0105	1.0052	* 32-0067	.8004
* 28-0102	1.0040	30-0015	.9829	31-0042	1.0500	31-0106	1.2050	* 32-0068	.8874
28-0103	.9752	30-0016	1.0131	31-0043	.9773	31-0108	1.0989	* 32-0069	.8979
28-0104	.9310	30-0017	.9052	31-0044	1.0680	31-0110	1.0527	* 32-0070	.9775
28-0105	1.1237	30-0018	.9756	31-0045	1.0901	31-0111	1.1177	* 32-0071	.8792
28-0106	.8789	30-0019	1.0318	31-0046	1.0617	31-0112	1.0997	33-0001	1.0707
28-0107	.8592	30-0020	.9870	31-0047	1.1547	31-0113	1.0318	33-0002	1.0852
28-0108	.9354	30-0021	.9215	31-0048	1.1085	31-0115	1.0557	33-0003	1.0985
28-0109	.9743	30-0022	.9373	31-0049	1.0498	31-0116	1.1307	33-0004	1.0721
28-0110	.9892	30-0023	1.0989	31-0050	1.0937	31-0117	1.1102	33-0005	1.1711
28-0111	.9747	30-0024	.9893	31-0051	1.1191	31-0118	1.0360	33-0006	1.0927
* 28-0114	.9218	30-0028	.9610	31-0052	1.0896	31-0119	1.0545	33-0007	1.0835
28-0115	.9347	30-0029	.9965	31-0053	1.0204	31-0120	.9947	33-0008	1.0168
* 28-0116	.9174	30-0033	1.0008	31-0054	1.1130	32-0001	1.1152	33-0009	.9728
28-0117	.9483	30-0034	1.0394	31-0056	1.0607	32-0002	1.0754	33-0010	1.0223
28-0118	.9424	31-0001	1.1071	31-0057	1.1844	32-0003	.9701	33-0011	1.0800
29-0001	1.1310	31-0002	1.2552	31-0058	1.0344	32-0004	.8990	33-0012	1.1143
* 29-0002	.9180	31-0003	1.0655	31-0059	1.0421	32-0005	1.0387	33-0013	1.1827
29-0003	1.0872	31-0005	1.0424	31-0060	1.0512	32-0006	.9850	33-0014	1.1195
29-0004	.9375	31-0006	1.0930	31-0061	1.0492	32-0009	1.0646	33-0015	1.0311
29-0006	.9524	31-0008	1.0950	31-0062	.9188	32-0010	1.0269	33-0016	.9488
29-0007	1.1624	31-0009	.9945	31-0063	1.1017	32-0011	1.0163	33-0019	1.0086
29-0008	.9312	31-0010	1.1064	31-0064	1.0868	32-0012	.9105	33-0020	.9321
29-0009	1.0545	31-0011	1.0063	31-0065	1.0511	32-0013	.9888	33-0022	1.0063
29-0010	.9113	31-0012	1.1359	31-0067	1.0537	32-0014	.8386	33-0023	1.0816
* 29-0011	.8946	31-0013	1.0653	31-0068	1.0371	32-0016	1.0045	33-0024	1.2231
29-0012	1.1681	31-0014	1.1715	31-0069	1.0405	32-0017	1.0669	33-0025	.9994

INDEXES DERIVED FROM FEWER THAN 50 DISCHARGES DO NOT MEET THE SELECTED STATISTICAL PRECISION CRITERION FOR RELIABILITY. THESE CASE MIX INDEXES ARE ASTERISKED.

TABLE NO. 3 A HOSPITAL CASE MIX INDEXES Page 15

PROVIDER NUMBER	CASE MIX INDEX
33-0027	1.1568
33-0028	1.1000
33-0029	1.0881
33-0030	.9901
33-0032	1.0244
33-0033	1.0796
33-0034	1.0166
33-0036	.9811
33-0037	1.0347
33-0038	.9770
33-0039	1.0497
33-0041	1.0334
33-0042	1.0369
33-0044	1.1218
33-0045	1.1361
33-0046	1.1211
33-0047	1.0517
33-0048	1.0661
33-0049	1.0643
33-0050	.9954
33-0052	.9577
33-0053	.9650
33-0055	1.1121
33-0056	1.0973
33-0057	1.1700
33-0058	1.0612
33-0059	1.1475
33-0061	1.1003
33-0062	.9374
33-0063	1.0309
33-0064	1.1060
33-0065	1.0396
33-0066	1.0373
33-0067	1.0176
33-0069	1.1045
33-0072	1.1107
33-0073	1.0287
33-0074	1.0515
33-0075	.9582
33-0076	1.0459
33-0077	.9745
33-0078	1.1013
33-0079	1.0304
33-0080	1.0165
33-0082	1.0240
33-0084	1.0201
33-0085	1.1516
33-0086	1.0412
33-0087	1.0157
33-0088	1.0735
33-0090	1.2251
33-0091	1.1041
33-0092	1.0457
33-0094	1.0626
33-0095	1.0544
33-0096	.9804
33-0097	.9803
33-0098	1.0529
33-0100	.6004
33-0101	1.2181
33-0102	1.0728
33-0103	1.1154
33-0104	1.1164
33-0106	1.1934
33-0107	.9918
33-0108	1.0468
33-0109	.9744
33-0110	.8375
33-0111	1.0875
33-0114	.9619
33-0115	1.0590
33-0116	.9167
33-0117	1.0633
33-0118	1.1670
33-0119	1.0664
33-0120	1.2460
33-0121	.9859
33-0122	1.0275
33-0124	1.0004
33-0125	1.2926
33-0126	1.0589
33-0127	1.0748
33-0128	1.1179
33-0132	1.0034
33-0133	1.0475
33-0134	1.0091
33-0135	1.0392
33-0136	1.1556
33-0139	1.0244
33-0140	1.1922
33-0141	1.0800
33-0142	1.0605
33-0143	1.0425
33-0144	1.0347
33-0146	.9432
33-0148	.9610
33-0150	.8648
33-0151	1.0140
33-0152	1.0912
33-0153	1.0988
33-0154	1.2640
33-0155	1.0282
33-0157	1.0659
33-0158	1.0628
33-0159	1.1886
33-0160	1.0955
33-0161	.9691
33-0162	1.1546
33-0163	.9961
33-0164	1.2089
33-0165	.9417
33-0166	1.0457
33-0167	1.1779
33-0168	1.0165
33-0169	1.0373
33-0171	1.1459
33-0172	.9834
33-0174	.9227
33-0175	1.0321
33-0176	.9614
33-0177	.8571
33-0179	.8857
33-0180	1.0152
33-0181	1.1301
33-0182	1.4320
33-0183	1.1687
33-0184	1.1186
33-0185	1.1468
33-0186	1.0037
33-0188	1.0661
33-0189	.7159
33-0191	1.1037
33-0193	1.1702
33-0194	1.1064
33-0195	1.2097
33-0196	1.1279
33-0197	.9373
33-0198	1.0912
33-0199	1.0833
33-0201	1.0811
33-0202	1.0452
33-0203	1.1069
33-0204	1.0981
33-0205	1.0164
33-0208	1.0613
33-0209	1.0500
33-0210	.9254
33-0211	1.0233
33-0212	.9992
33-0213	.9730
33-0214	1.2031
33-0215	.9964
33-0217	1.0142
33-0218	.9970
33-0219	1.1063
33-0221	1.0512
33-0222	1.0143
33-0223	.9113
33-0224	1.0632
33-0225	1.0908
33-0226	1.0164
33-0229	1.0657
33-0230	1.0298
33-0231	1.0120
33-0232	1.0488
33-0233	1.0865
33-0234	1.1982
33-0235	1.0735
33-0236	1.1379
33-0238	1.0087
33-0239	1.0850
33-0240	1.0837
33-0241	1.2926
33-0242	1.1195
33-0244	1.0890
33-0245	1.0816
33-0246	1.0420
33-0247	.6252
33-0249	1.0115
33-0250	1.0200
33-0252	.8745
33-0254	1.0387
33-0256	.9811
33-0257	1.0552
33-0258	1.0920
33-0259	1.0583
33-0260	1.0813
33-0261	1.1243
33-0263	1.0096
33-0264	1.0187
33-0265	1.0718
33-0266	.8913
33-0267	1.0505
33-0268	1.0409
33-0270	1.5653
33-0272	1.0135
33-0273	1.0301
33-0275	1.1081
33-0276	.9637
33-0277	.9725
33-0279	1.0998
33-0281	.9534
33-0283	.9941
33-0285	1.2526
33-0286	1.1182
33-0288	1.1165
33-0290	1.2041
33-0291	.9870
33-0293	1.0680
33-0297	1.0436
33-0298	.9786
33-0299	1.0555
33-0300	.8906
33-0304	1.1065
33-0305	1.0328
33-0306	1.1225
33-0307	.9876
33-0308	1.1567
33-0309	1.0575
33-0314	1.0316
33-0315	1.1244
33-0316	1.0730
33-0318	1.0805
33-0320	1.0562
33-0323	.9037
33-0324	1.0485
33-0327	.9465
33-0331	1.0617
33-0332	.9698
33-0333	.8983
33-0335	1.0876
33-0336	1.0547
33-0338	1.0322
33-0339	.9743
33-0340	.9705
33-0342	1.0631
33-0345	.7929
33-0350	1.3625
33-0351	.9095
33-0353	1.0596
33-0354	1.0517
33-0355	.9424
33-0357	1.0703
33-0359	1.0117
33-0372	1.0078
33-0377	.8905
33-0382	1.0292
33-0383	1.0506
33-0385	1.0565
33-0386	1.0233

INDEXES DERIVED FROM FEWER THAN 50 DISCHARGES DO NOT MEET THE SELECTED STATISTICAL PRECISION CRITERION FOR RELIABILITY. THESE CASE MIX INDEXES ARE ASTERISKED.

TABLE NO. 3a HOSPITAL CASE MIX INDEXES Page 16

PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX
* 33-0387	.9398	* 34-0048	.8616	34-0109	1.0377	35-0011	1.2418	36-0011	1.0796
33-0389	1.2152	34-0045	.8589	34-0111	1.0052	35-0012	.9328	36-0012	1.4608
33-0390	.9752	34-0050	1.0301	34-0112	.9553	35-0013	1.0078	36-0013	1.0238
33-0391	1.2093	34-0051	1.0809	34-0113	1.2067	35-0014	.8766	36-0014	.9537
* 33-0392	.6925	34-0052	.8838	34-0114	1.0484	35-0015	1.1057	36-0015	1.1237
33-0393	1.1718	34-0053	1.0003	34-0115	1.0584	35-0016	1.0155	36-0016	1.1150
33-0394	1.0248	34-0054	.9077	34-0116	1.0335	35-0017	1.0131	36-0017	.9883
34-0001	.9741	34-0055	.9726	34-0117	.9773	35-0018	.9567	36-0018	1.0505
34-0002	1.1400	* 34-0056	.9608	34-0119	1.0044	35-0019	1.0875	36-0019	1.0409
34-0003	1.0405	* 34-0057	1.0531	34-0120	.9806	35-0020	1.0380	36-0020	1.1056
34-0004	1.0236	* 34-0058	1.0752	34-0121	.9397	* 35-0021	.9119	36-0021	.9931
34-0005	.9905	34-0060	.9955	* 34-0122	.5160	35-0023	1.0153	36-0022	1.0285
34-0006	.5681	34-0061	1.1783	34-0123	1.0102	35-0024	.9512	36-0023	1.0295
34-0007	1.0058	34-0063	1.0023	34-0124	.9331	* 35-0025	.8645	36-0024	1.0183
34-0008	.9985	34-0064	1.0206	34-0125	1.0693	* 35-0027	.8704	36-0025	.9981
34-0009	.5144	34-0065	1.0398	34-0126	1.0907	35-0029	.8971	36-0026	1.0028
34-0010	.9796	34-0067	.9137	34-0127	1.0247	35-0030	.9782	36-0027	1.1155
34-0011	.9845	34-0068	.9898	34-0128	.9549	* 35-0031	.9170	36-0028	.9949
34-0012	.9789	34-0069	1.1732	34-0129	.9703	35-0032	.9798	36-0029	1.0437
34-0013	1.0099	34-0070	1.0106	34-0130	1.0217	35-0033	.9452	36-0030	1.0109
34-0014	1.1303	34-0071	.9409	34-0131	1.0431	35-0034	1.0534	36-0031	1.0144
34-0015	.9909	34-0072	.9590	34-0132	1.0114	* 35-0035	.9173	36-0032	1.0423
34-0016	.5427	34-0073	.9790	34-0133	1.0075	* 35-0036	1.2218	36-0033	.9773
34-0017	1.0251	34-0075	.9454	34-0141	1.0749	* 35-0037	.9749	36-0034	.9620
34-0018	1.0222	34-0076	.9780	34-0142	1.0741	35-0038	.9155	36-0035	1.1233
34-0015	.9777	* 34-0077	.9453	34-0143	.9256	35-0039	.9529	36-0036	.9439
34-0020	1.0158	* 34-0078	.9382	34-0144	.9936	35-0041	.9835	36-0037	1.1652
34-0021	1.0000	* 34-0079	.5001	34-0145	.5350	* 35-0042	.9055	36-0038	.9396
34-0022	.9519	34-0080	.9130	* 34-0146	.5714	35-0043	1.0368	36-0039	.9894
34-0023	.9727	34-0084	1.0024	34-0147	1.0595	35-0044	.9927	36-0040	1.0036
34-0024	1.0054	34-0085	1.0074	34-0148	.5563	* 35-0045	.8731	36-0041	1.1285
34-0025	.5611	34-0086	.8971	* 34-0150	1.0683	35-0047	.9444	36-0042	.9897
34-0026	.9728	34-0087	.9174	34-0151	.9405	* 35-0048	.8176	36-0044	.9619
34-0027	.9826	34-0088	.9856	34-0153	1.4737	* 35-0049	1.1046	36-0045	1.0771
34-0028	1.0533	34-0089	.9673	34-0155	1.1230	35-0050	.9277	36-0046	.9283
34-0030	1.1685	34-0090	1.0533	34-0157	.7927	35-0051	.9237	36-0047	.9730
34-0031	.9671	34-0091	1.1142	34-0158	.9663	* 35-0053	.9083	36-0048	1.2269
34-0032	1.0805	34-0092	.9497	34-0159	1.1848	* 35-0055	.8444	36-0049	1.0857
34-0034	1.0289	34-0093	1.0536	34-0160	.9757	35-0056	1.0108	36-0050	.9790
34-0035	.8948	34-0094	.9662	34-0162	.8613	* 35-0058	.9643	36-0051	1.1254
34-0036	.9876	34-0096	.9677	35-0001	.9186	* 35-0060	.9139	36-0052	1.1578
34-0037	.9526	34-0097	1.0448	35-0002	1.0391	35-0061	.9721	36-0053	1.0776
34-0038	.9646	34-0098	1.0293	35-0003	1.0331	36-0001	1.0895	36-0054	1.1116
34-0039	.9841	34-0099	.9603	35-0004	1.1571	36-0002	.9625	36-0055	1.0974
34-0040	1.1093	34-0100	1.0567	* 35-0005	1.1135	36-0003	1.0940	36-0056	1.0224
34-0041	1.0171	34-0101	.9882	35-0006	1.0913	36-0006	1.1718	36-0057	1.0020
34-0042	1.0318	34-0104	.9199	35-0007	.9269	36-0007	.9259	36-0058	.9586
34-0044	.9854	34-0105	1.1105	35-0008	.9307	36-0008	.9790	36-0059	1.1235
34-0045	.9658	* 34-0106	.8760	35-0009	.9720	36-0009	1.0952	36-0060	.9223
34-0047	1.2335	34-0107	.9824	35-0010	.9393	36-0010	1.0342	* 36-0061	.9028

INDEXES DERIVED FROM FEWER THAN 50 DISCHARGES DO NOT MEET THE SELECTED STATISTICAL PRECISION CRITERION FOR RELIABILITY. THESE CASE MIX INDEXES ARE ASTERISKED.

TABLE NO. 3a HOSPITAL CASE MIX INDEXES Page 17

PROVIDER NUMBER	CASE MIX INDEX
36-0062	1.1544
36-0063	.8658
36-0064	1.1829
36-0065	1.1058
36-0066	1.0667
36-0067	1.0041
36-0068	1.1507
36-0069	.9993
36-0070	1.0933
36-0071	.9924
36-0072	1.0804
36-0074	1.0359
36-0075	1.1012
36-0076	.9501
36-0077	1.0830
36-0078	.9825
36-0079	1.2200
36-0080	.9633
36-0081	1.0383
36-0082	1.1571
36-0083	1.0172
36-0084	1.0879
36-0085	1.1935
36-0086	1.0338
36-0087	1.1116
36-0088	.9955
36-0089	1.0159
36-0090	1.0401
36-0091	1.0473
36-0092	.9971
36-0093	.9100
36-0094	1.0636
36-0095	1.0227
36-0096	.9950
36-0097	1.0243
36-0098	1.1312
36-0099	.9826
36-0100	1.0466
36-0101	1.1817
36-0102	1.1652
36-0103	1.0859
36-0104	1.0052
36-0106	1.0791
36-0107	.9999
36-0108	1.0231
36-0109	1.0235
* 36-0110	.8935
36-0112	1.1642
36-0113	1.1358
36-0114	.9545

PROVIDER NUMBER	CASE MIX INDEX
36-0115	1.0000
36-0116	.9414
36-0118	1.1334
36-0119	.9808
36-0120	.9272
36-0121	1.1484
36-0122	1.0133
36-0123	1.0655
36-0124	1.0460
36-0125	1.0383
36-0126	1.0077
36-0127	.9767
36-0128	.9670
36-0129	.9113
36-0130	.9889
36-0131	1.0519
36-0132	1.0124
36-0133	1.0582
36-0134	1.1740
36-0135	.9492
36-0136	.9489
36-0137	1.2097
36-0139	.9762
36-0140	.8724
36-0141	1.1088
36-0142	.9103
36-0143	1.0616
36-0144	1.0320
36-0145	1.1032
36-0147	.9634
36-0148	1.0261
36-0149	.9417
36-0150	1.0525
36-0151	1.0654
36-0152	1.0898
36-0153	1.0404
36-0154	1.0588
36-0155	1.0752
36-0156	.9481
36-0159	1.0809
36-0161	.9793
36-0162	1.0396
36-0163	1.1769
36-0164	.9659
36-0165	1.0014
36-0166	.9560
36-0167	.9606
36-0168	.9213
36-0169	.9278
36-0170	1.0265

PROVIDER NUMBER	CASE MIX INDEX
36-0171	1.0938
36-0172	1.0445
36-0174	.5680
36-0175	.5584
36-0176	1.0147
36-0177	1.0918
36-0178	.9198
36-0179	1.0498
36-0180	1.2534
36-0184	.9930
36-0185	1.0499
36-0186	.9275
36-0187	1.0512
36-0188	.9658
36-0189	.9954
36-0190	1.0679
36-0192	1.0675
36-0193	1.0552
36-0194	.9926
36-0195	1.0265
36-0197	.9712
36-0200	.9887
36-0203	.9831
36-0204	1.0782
36-0210	.9511
36-0211	.9764
36-0212	1.1325
36-0213	.9947
36-0218	1.0783
36-0220	1.1072
36-0231	.9767
36-0232	1.0383
36-0234	1.0488
36-0236	1.1009
* 36-0237	.7847
* 36-0238	.9432
36-0239	1.0575
36-0345	.9899
37-0001	1.1255
37-0002	.9834
* 37-0003	.8822
37-0004	.9952
37-0005	.9382
37-0006	1.0279
37-0007	1.0877
37-0008	1.0420
37-0011	.9587
37-0012	.9018
37-0013	1.0845
37-0014	.9531

PROVIDER NUMBER	CASE MIX INDEX
37-0015	.9608
37-0016	.9962
37-0017	.9076
37-0018	1.0054
37-0019	.8402
37-0020	.9963
37-0021	.9500
37-0022	1.0255
37-0023	1.0188
37-0025	1.0122
37-0026	1.0173
37-0028	1.2163
37-0029	.9646
37-0030	1.0015
37-0032	.9443
37-0033	.9760
37-0034	.9932
37-0035	1.2044
37-0036	.8567
37-0037	1.1276
37-0038	.8961
37-0039	.9826
37-0040	.9518
37-0041	.9457
37-0042	.8995
37-0043	.8652
37-0045	.9202
37-0046	.9134
37-0047	.9496
37-0048	.8820
37-0049	1.0442
37-0050	.8428
37-0051	.9990
37-0054	1.0056
37-0056	1.0518
37-0057	1.0434
37-0059	.9242
37-0060	.9893
37-0061	.9341
37-0063	.9210
37-0064	.9293
37-0065	.9527
37-0069	.9568
37-0071	.8754
37-0072	.8873
37-0076	1.0016
37-0077	.9764
37-0078	1.0240
37-0079	.9619
37-0080	.9963

PROVIDER NUMBER	CASE MIX INDEX
37-0082	.9106
37-0083	.8954
37-0084	.8921
37-0085	.9673
37-0086	1.0435
37-0089	.9394
37-0090	.9999
37-0091	1.1486
37-0092	.9452
37-0093	1.0779
37-0094	1.0269
37-0095	.8612
* 37-0096	.8888
37-0097	.9353
37-0098	.8436
37-0099	.8841
37-0100	.8725
37-0103	.8297
37-0105	1.4783
37-0106	.9301
37-0107	.9141
37-0108	.9427
* 37-0109	.9113
37-0110	.9251
37-0112	.9040
37-0113	.9019
37-0114	1.1370
37-0116	.8567
37-0117	.9884
37-0121	1.0397
37-0122	.9038
37-0123	.9674
37-0125	.8649
37-0126	1.0155
37-0130	.9780
* 37-0131	.8865
37-0133	.9134
37-0136	.9288
37-0138	.8483
37-0139	.9997
37-0140	.8988
37-0141	1.0358
37-0144	1.0192
* 37-0146	.8437
37-0148	1.0321
37-0149	1.0381
37-0153	.9367
37-0154	.9479
37-0156	.9291
37-0157	.9119

INDEXES DERIVED FROM FEWER THAN 50 DISCHARGES DO NOT MEET THE SELECTED STATISTICAL PRECISION CRITERION FOR RELIABILITY. THESE CASE MIX INDEXES ARE ASTERISKED.

TABLE NO. 3a HOSPITAL CASE MIX INDEXES Page 18

PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX
37-0158	.9127	38-0039	1.0715	39-0006	1.1436	39-0058	1.0721	39-0112	1.0510
37-0159	1.0243	38-0040	.9400	39-0007	1.0298	39-0059	1.1402	39-0113	1.0157
37-0161	1.0204	38-0041	.8696	39-0008	1.0156	39-0060	1.0690	39-0114	1.0837
37-0162	.8728	38-0042	.9850	39-0009	1.1233	39-0061	1.0849	39-0115	1.1414
37-0165	.8425	38-0043	.9894	39-0010	1.0774	39-0062	.9557	39-0116	.9872
37-0166	.8721	* 38-0044	.8237	39-0011	1.1019	39-0063	1.1498	39-0117	1.0054
* 37-0168	.9874	38-0045	1.0737	39-0012	1.0437	39-0064	1.1415	39-0118	.9534
37-0169	.9466	38-0047	1.1668	39-0013	.9767	39-0065	1.0619	39-0119	1.0595
37-0176	.9470	38-0048	.9716	39-0014	.9684	39-0066	1.0203	39-0120	1.0328
* 37-0177	1.0181	38-0050	1.1133	39-0015	1.0674	39-0067	1.1552	39-0121	1.0640
37-0178	.9450	38-0051	1.1105	39-0016	1.0367	39-0068	1.0696	39-0122	.9651
* 37-0179	.8989	38-0052	1.0269	39-0017	1.0228	39-0069	1.0162	39-0123	1.0854
* 37-0180	1.0253	* 38-0054	.8491	39-0018	1.0770	39-0070	1.0286	39-0125	1.0178
* 37-0181	.8430	38-0055	1.1223	39-0019	1.0016	39-0071	1.0387	39-0126	1.1532
* 37-0182	.8461	38-0056	1.0097	39-0020	1.0052	39-0072	.9451	39-0127	1.0920
37-0183	.9819	* 38-0059	.9955	39-0021	1.1208	39-0073	1.0897	39-0128	1.0515
* 37-0184	.8629	38-0060	1.1123	39-0022	1.1046	39-0074	1.1130	39-0130	.9994
38-0001	1.0744	38-0061	1.1552	39-0023	1.0745	39-0075	1.0788	39-0131	1.0946
38-0002	1.0186	* 38-0062	.9218	39-0024	.8069	39-0076	1.0302	39-0132	.9771
38-0003	1.1055	38-0063	1.0768	* 39-0025	.9388	39-0077	1.1055	39-0133	1.1867
38-0004	1.2504	38-0064	1.0051	39-0026	1.1525	39-0078	.9577	39-0135	1.1171
38-0005	.9453	38-0065	.8970	39-0027	1.1783	39-0079	1.2673	39-0136	1.0486
38-0006	.9698	38-0066	1.0498	39-0028	1.2008	39-0080	1.1272	39-0137	1.0927
38-0007	1.1346	* 38-0067	.8543	39-0029	1.1751	39-0081	1.0898	39-0138	1.0961
38-0008	1.0419	38-0068	1.0221	39-0030	1.0073	39-0082	.9883	39-0139	1.1548
38-0009	1.1940	38-0069	.8637	39-0031	1.0187	39-0083	1.1348	39-0142	1.1643
38-0010	1.1183	38-0070	1.0181	39-0032	1.0900	39-0084	.9850	39-0143	.7425
38-0011	1.0279	38-0071	1.0905	39-0034	1.0420	39-0086	1.0332	39-0145	1.0743
38-0013	.9988	38-0072	.9935	39-0035	1.1584	39-0087	.9579	39-0146	.9705
38-0014	1.0885	38-0074	.9591	39-0036	1.0277	39-0088	1.0060	39-0147	1.0260
* 38-0016	.8116	38-0075	1.0598	39-0037	1.0681	39-0090	1.1688	39-0148	1.0638
38-0017	1.1698	38-0077	.9402	39-0038	1.0694	39-0091	1.0183	39-0149	1.0167
38-0018	1.1393	38-0078	1.0513	39-0039	1.0191	39-0092	1.0336	39-0150	1.0053
38-0019	1.1874	38-0079	1.1512	39-0040	.9606	39-0093	1.0495	39-0151	1.0847
38-0020	1.0357	38-0081	.9335	39-0041	1.0789	39-0095	.9274	39-0152	.9963
38-0021	1.0401	38-0082	1.0666	39-0042	1.0320	39-0096	1.1145	39-0153	1.0971
38-0022	1.1219	38-0083	1.0300	39-0043	1.0302	39-0097	1.1207	39-0154	1.0410
38-0023	.9264	38-0084	1.0011	39-0044	1.1304	39-0098	1.1712	39-0155	1.0401
38-0024	1.0594	38-0087	.9149	39-0045	1.1232	39-0099	.9809	39-0156	1.0997
38-0025	1.0199	38-0088	.8695	39-0046	1.1702	39-0100	1.1075	39-0157	1.0135
38-0026	1.0577	38-0089	1.0801	39-0047	1.1586	39-0101	1.0554	39-0158	1.0732
38-0027	1.0579	38-0090	1.1300	39-0048	1.0956	39-0102	1.1027	39-0159	1.0777
38-0029	.9990	38-0091	1.0424	39-0049	1.1245	39-0103	.9400	39-0160	1.0009
38-0030	.8691	* 38-0093	.8194	39-0050	1.2457	39-0104	.9452	39-0161	.9495
38-0031	.9401	* 38-0094	.8473	39-0051	1.2259	39-0106	.9886	39-0162	1.0707
38-0033	1.1882	39-0001	1.1594	39-0052	1.0127	39-0107	1.0792	39-0163	1.1397
38-0035	1.0398	39-0002	1.0724	39-0054	1.0564	39-0108	1.0969	39-0164	1.2645
38-0036	1.0213	39-0003	1.0407	39-0055	1.2206	39-0109	.9741	39-0165	.9831
38-0037	1.0622	39-0004	1.0333	39-0056	1.0502	39-0110	1.0483	39-0166	1.0449
38-0038	1.1055	39-0005	.9678	39-0057	1.1322	39-0111	1.3768	39-0167	1.0790

INDEXES DERIVED FROM FEWER THAN 50 DISCHARGES DO NOT MEET THE SELECTED STATISTICAL PRECISION CRITERION FOR RELIABILITY. THESE CASE MIX INDEXES ARE ASTERISKED.

PROVIDER NUMBER	CASE MIX INDEX
39-0168	1.0296
39-0169	1.0846
39-0170	1.3111
39-0171	1.0564
39-0172	1.1009
39-0173	1.0125
39-0174	1.3002
39-0176	1.0156
39-0177	.9120
39-0178	1.1707
39-0179	1.0880
39-0180	1.0695
39-0181	.9947
39-0183	.9169
39-0184	.9331
39-0185	1.0842
39-0186	1.0343
39-0187	1.0254
39-0188	1.0219
39-0189	1.0100
39-0190	.9659
39-0191	.9519
39-0192	.9161
39-0193	1.0347
39-0194	.9857
39-0195	1.2539
39-0196	1.2122
39-0197	1.0204
39-0198	1.0026
39-0199	1.0026
39-0200	1.0758
39-0201	1.0867
39-0202	1.0921
39-0204	1.1139
39-0205	1.0547
39-0206	1.1282
39-0209	1.0082
39-0211	.9874
39-0213	.8861
39-0215	1.0197
39-0217	1.0402
39-0219	1.0379
39-0220	1.0677
39-0222	1.0329
39-0223	1.1655
39-0224	.9623
39-0225	1.0557
39-0226	1.2274
39-0228	1.1033
39-0229	1.1642
39-0231	1.1058
39-0232	1.0140
39-0233	1.1090
39-0234	1.0842
39-0235	1.1258
39-0236	1.0019
39-0237	1.0924
* 39-0238	.8421
39-0240	.9750
39-0242	1.0722
39-0244	.8741
39-0245	1.0583
39-0246	.9446
39-0247	1.0126
* 39-0248	1.3254
39-0249	.9531
* 39-0252	.8421
39-0256	1.2816
39-0258	1.1590
39-0260	1.1116
39-0261	1.4337
39-0262	.9566
39-0263	1.1069
39-0265	1.0866
39-0266	1.0072
39-0267	1.1041
39-0268	1.0543
39-0269	1.0581
39-0270	1.0079
41-0001	1.1671
41-0002	1.1419
41-0004	1.1600
41-0005	1.1154
41-0006	1.0272
41-0007	1.2133
41-0008	.9721
41-0009	1.1547
* 41-0010	.9250
41-0011	1.0369
41-0012	1.1392
41-0013	1.0159
41-0014	1.0062
41-0016	.8815
42-0002	.9587
42-0003	.9693
42-0004	.9422
42-0005	.9254
42-0006	.9979
42-0007	1.0074
42-0009	.9277
42-0010	.9179
42-0011	.8723
42-0014	.8506
42-0015	.9568
42-0016	.9478
42-0017	.8453
42-0018	1.0100
42-0019	.9654
42-0020	.9616
42-0022	.9688
42-0023	.9465
* 42-0024	.8990
42-0026	.9142
42-0027	.9578
42-0028	.9035
42-0029	1.0440
42-0030	.9026
42-0031	.9165
42-0032	1.0077
42-0033	.9922
42-0036	1.0166
42-0037	1.0705
42-0038	.9249
42-0039	.9353
42-0040	.9547
42-0042	.8870
42-0043	.9269
42-0044	.9234
42-0048	.9042
42-0049	.9206
42-0050	.9789
42-0051	.9752
42-0053	.9432
42-0054	1.0222
42-0055	.9029
42-0056	.9294
42-0057	.9190
42-0059	.9513
42-0061	.9388
42-0062	.9278
42-0064	.9128
42-0065	.9679
42-0066	.9034
42-0067	.9398
42-0068	.9629
42-0069	.9156
42-0070	.9763
42-0071	.9797
42-0072	.9237
42-0073	.9680
42-0074	.8984
42-0075	.8916
42-0076	.8662
* 42-0077	.8790
42-0078	.9164
42-0079	1.1670
42-0080	.9757
* 42-0081	.9106
42-0082	.9570
42-0083	.9175
* 42-0084	.7081
42-0085	.9578
42-0086	1.0027
42-0087	1.0379
* 42-0088	.8182
43-0001	1.0078
43-0004	.9762
43-0005	.9782
43-0007	.9632
43-0008	.9092
43-0009	1.0603
43-0010	.9381
43-0011	1.0255
43-0012	1.0129
43-0013	.9245
43-0014	1.0866
43-0015	.9406
43-0016	1.0928
43-0017	.8968
43-0018	.8715
43-0020	1.0227
43-0022	.9047
43-0023	.9364
43-0024	.9729
* 43-0025	.8603
* 43-0026	.9256
43-0027	1.1824
43-0028	.9313
43-0029	.8949
* 43-0030	.9588
43-0031	.8533
43-0033	.9459
43-0034	.8856
43-0036	1.0099
43-0037	.8821
43-0038	.9551
* 43-0039	.9286
43-0040	.9506
* 43-0041	.9002
43-0042	.9088
43-0043	.9891
43-0044	.9706
43-0047	.8958
43-0048	.9184
* 43-0049	.9482
* 43-0051	.8875
43-0054	.9157
* 43-0056	.8944
43-0057	.8753
* 43-0060	.8120
43-0062	.7729
43-0064	.8416
* 43-0065	.9263
43-0066	.8469
43-0072	.9549
43-0073	.9603
43-0076	.9809
43-0077	1.0850
* 43-0079	.9269
* 43-0080	.8998
43-0087	.8439
44-0001	.9338
44-0002	1.0785
44-0003	.9778
44-0005	.9321
44-0006	1.0028
44-0007	.9111
44-0008	.8963
44-0009	.9006
44-0010	.9068
44-0011	1.0544
44-0012	1.0241
44-0014	.9124
44-0015	1.0940
44-0016	.9447
44-0017	1.0036
44-0018	.9984
44-0019	1.0185
44-0020	.9153
44-0022	.9264
44-0023	.8699
44-0024	.9589
44-0025	.9489
44-0026	1.0677
* 44-0028	.9120
44-0029	.9276
44-0030	.9898
44-0031	.9189
44-0032	.8641
44-0033	.9484

INDEXES DERIVED FROM FEWER THAN 50 DISCHARGES DO NOT MEET THE SELECTED STATISTICAL PRECISION CRITERION FOR RELIABILITY. THESE CASE MIX INDEXES ARE ASTERISKED.

TABLE NO. 3a HOSPITAL CASE MIX INDEXES Page 20

PROVIDER NUMBER	CASE MIX INDEX
44-0034	1.0083
44-0035	1.0420
44-0036	.9381
44-0039	1.2889
44-0040	.9168
44-0041	.8904
* 44-0044	.7143
44-0046	.9524
44-0047	.9129
44-0048	1.1881
44-0049	1.1111
44-0050	.9869
44-0051	.9302
44-0052	.9224
44-0053	.9336
44-0054	.9400
* 44-0055	.8293
44-0056	.8747
44-0057	.9158
44-0058	.9166
44-0059	.9098
44-0060	.9034
44-0061	.9790
44-0063	1.0710
44-0064	.8574
44-0065	.9039
44-0067	.9196
44-0068	.9508
44-0069	.9624
44-0070	.9291
44-0071	1.0051
44-0072	1.0049
44-0073	1.0112
44-0074	.8190
44-0078	.9555
44-0079	.9063
44-0081	1.0117
44-0082	1.2130
44-0083	.8667
44-0084	.9443
* 44-0086	.9272
44-0087	.8825
* 44-0090	.8440
44-0091	1.0386
44-0095	.8652
44-0100	.8912
* 44-0101	.9051
44-0102	.9471
44-0103	.9369
44-0104	1.0256

PROVIDER NUMBER	CASE MIX INDEX
44-0105	.5525
44-0109	.9419
44-0110	.9136
44-0111	1.1246
44-0113	.8869
44-0114	.9130
44-0115	.9444
44-0117	.8080
44-0120	1.0542
44-0121	.9318
44-0123	.9541
44-0125	1.0525
44-0130	1.0013
44-0131	.9542
44-0132	.8581
44-0133	1.1839
44-0134	.9001
44-0135	.9437
44-0136	.9505
44-0137	.8763
44-0141	.9453
44-0142	.7948
44-0143	.9371
44-0144	.9113
44-0145	.9121
* 44-0146	.9710
* 44-0147	.6601
44-0148	.9199
44-0149	.8956
44-0150	1.0217
44-0151	.9021
44-0152	1.0729
44-0153	.8931
44-0156	1.0108
44-0157	.8904
44-0159	1.0280
44-0160	.9229
44-0161	1.0599
44-0162	.8901
44-0166	1.1648
44-0167	1.0541
44-0168	1.1194
44-0169	.6271
44-0170	.6472
44-0171	.9201
44-0173	.9747
44-0174	.9008
44-0175	.9236
44-0176	1.0016
44-0177	.9015

PROVIDER NUMBER	CASE MIX INDEX
44-0178	.9014
44-0180	.9308
44-0181	.8956
44-0182	.8691
44-0183	1.1206
44-0184	1.0724
44-0185	1.0134
44-0186	.9228
44-0187	.8603
44-0189	.9844
44-0191	.9104
44-0192	.9981
44-0193	.9846
44-0194	1.0105
44-0196	.8673
44-0197	1.1010
44-0200	.8473
45-0001	.9886
45-0002	.9836
45-0004	.9023
45-0005	.9433
45-0007	.9322
45-0008	.9350
45-0010	.9784
45-0011	.9348
45-0013	.9910
45-0014	.8851
45-0015	1.0901
45-0016	.9933
45-0018	1.0552
45-0019	.9892
45-0020	.9025
45-0021	1.0548
45-0022	.9225
45-0023	1.0007
45-0024	.9746
45-0025	1.0152
45-0027	.8588
45-0028	1.0261
45-0029	.9684
45-0031	.9588
45-0032	.9204
45-0033	.9946
45-0034	1.0143
45-0035	.9587
45-0037	.9882
45-0039	1.1286
45-0040	.9487
45-0041	.9283
45-0042	1.0002

PROVIDER NUMBER	CASE MIX INDEX
45-0043	.9430
45-0044	1.0250
* 45-0045	1.0360
45-0046	.9588
45-0047	.9667
45-0048	.9189
45-0050	.9893
45-0051	1.0168
45-0052	.9533
45-0053	1.0153
45-0054	1.0182
45-0055	.9084
45-0056	.9819
45-0057	.9374
45-0058	.9922
45-0059	.9682
45-0060	.9781
* 45-0063	.8766
45-0064	.9571
45-0065	.9168
45-0066	.9124
45-0068	.9903
* 45-0069	.9632
45-0070	.8780
45-0072	.8999
45-0073	.9112
45-0074	.9282
45-0076	1.0584
45-0077	.9001
45-0078	.8339
45-0079	.9547
45-0080	.9660
45-0081	.9490
45-0082	.8706
45-0083	.9567
45-0084	.9044
45-0085	.9289
* 45-0086	.5919
45-0087	.9468
45-0090	.8948
45-0092	.8929
* 45-0093	.9869
45-0094	.9329
45-0095	.8701
45-0096	.9579
45-0097	.9980
45-0098	.9517
45-0099	.9400
45-0101	.9269
45-0102	.8449

PROVIDER NUMBER	CASE MIX INDEX
45-0104	.9724
45-0107	1.0183
* 45-0108	1.0055
45-0109	.9143
45-0110	1.0171
45-0111	.9374
45-0112	.9262
45-0113	.9069
45-0115	.9277
45-0116	1.0063
45-0118	1.0444
45-0119	.9336
45-0121	.9568
* 45-0122	.7965
45-0123	.9580
45-0124	1.0599
45-0126	.9094
45-0127	.9597
45-0128	.8748
* 45-0129	.8428
45-0130	.9315
45-0131	.8831
45-0132	.9218
45-0133	1.0165
45-0134	.9608
45-0135	1.0444
* 45-0136	1.0614
45-0137	.9482
* 45-0140	.8575
45-0141	.8468
45-0142	.9215
* 45-0143	1.0436
45-0144	1.0023
* 45-0145	.8649
* 45-0146	.8732
45-0147	.9646
45-0148	.9449
45-0149	.9490
45-0150	.9456
45-0151	.9488
45-0152	1.0192
45-0153	.9831
45-0154	.8997
45-0155	.9335
45-0157	.9330
* 45-0160	.9190
45-0162	1.0377
45-0163	.9036
45-0164	.8554
45-0165	.8910

INDEXES DERIVED FROM FEWER THAN 50 DISCHARGES DO NOT MEET THE SELECTED STATISTICAL PRECISION CRITERION FOR RELIABILITY. THESE CASE MIX INDEXES ARE ASTERISKED.

PROVIDER NUMBER	CASE MIX INDEX
* 45-0166	.8610
45-0169	.9488
* 45-0170	.9027
45-0173	.8625
45-0174	.9591
45-0175	.9767
45-0176	.9595
45-0177	.8860
* 45-0178	.9079
45-0179	.9444
* 45-0181	.8546
45-0182	.8747
45-0183	.9428
45-0184	.9622
45-0185	.8596
* 45-0186	.9867
45-0187	.9757
45-0188	.9266
45-0190	.9882
45-0191	.9552
45-0192	.9244
45-0193	1.1852
45-0194	.9710
45-0195	.9426
45-0196	.9176
45-0197	.9133
45-0198	.8855
45-0200	.9546
45-0201	.8532
45-0203	.9050
45-0206	.9111
45-0207	.8655
45-0208	.9176
45-0209	1.0026
45-0210	.9050
45-0211	.9881
45-0213	1.0813
45-0214	.8559
* 45-0215	.7973
45-0216	.9911
45-0217	.9118
45-0218	.9174
45-0219	.9110
45-0221	.8664
45-0222	.9822
45-0224	.9957
45-0225	.9066
* 45-0230	.8956
45-0231	1.0165
45-0233	.8697
45-0234	.8626
45-0235	.9954
45-0236	.8780
45-0237	1.0121
45-0239	.9862
45-0241	.8569
* 45-0242	.8844
* 45-0243	.9124
45-0244	.9044
45-0246	.8544
45-0247	.9096
45-0248	.8918
45-0249	.9036
45-0250	.8302
45-0253	.9670
45-0256	.9010
45-0258	.8754
45-0259	1.0154
* 45-0260	.8722
45-0261	.9219
* 45-0263	.9431
* 45-0264	.8843
* 45-0265	.8376
* 45-0267	.9090
45-0268	.9341
* 45-0269	.9033
45-0270	.9423
45-0271	.9603
45-0272	.9284
* 45-0274	.8225
45-0275	.9235
45-0276	.9339
45-0278	.8801
45-0280	.9815
45-0281	.9256
45-0282	.9064
45-0283	.9005
45-0284	.8616
45-0286	.9715
45-0288	.9322
45-0289	.9654
45-0292	.9963
45-0293	.8672
45-0296	.8752
45-0297	.8745
45-0299	.9002
45-0300	.9416
45-0303	.9279
45-0304	.8813
* 45-0305	.9573
45-0306	.8623
* 45-0307	.7899
45-0309	.9592
45-0311	.8742
45-0312	.9273
45-0315	.9242
45-0317	.8655
45-0319	.9196
45-0320	1.0014
45-0321	.9260
* 45-0322	.8024
45-0324	.9870
45-0325	.9443
45-0327	.7962
45-0328	.8566
45-0330	.9534
45-0331	.8782
45-0332	.8772
45-0333	.9810
45-0334	.9561
* 45-0335	.8913
45-0337	.9765
* 45-0338	1.0130
45-0340	.8826
45-0341	.8951
* 45-0342	.9252
45-0343	.8803
45-0346	.9468
45-0347	.8934
45-0348	.8931
45-0349	.9303
45-0351	.9326
45-0352	.9789
45-0353	.9506
* 45-0355	.9424
45-0357	.9648
45-0358	1.0750
* 45-0359	1.0499
45-0362	.9072
45-0365	.9365
45-0366	.9657
45-0369	.9061
45-0370	.7397
45-0371	.9058
45-0372	1.0286
45-0373	.9349
* 45-0374	.8965
45-0376	.9339
45-0378	1.0025
45-0379	1.0080
45-0381	.9547
45-0382	.8449
45-0388	.9795
45-0389	.9687
45-0391	.9760
45-0393	.9125
45-0394	.9271
45-0395	.8604
45-0398	.8822
45-0399	.9591
45-0400	.8527
45-0402	.9508
45-0403	.9080
* 45-0405	1.1684
45-0410	.8714
45-0411	.8850
45-0415	.9568
45-0416	.9814
45-0417	.8972
45-0418	.9708
45-0419	.8904
* 45-0421	.9775
45-0422	.5411
45-0423	.7937
45-0424	.9350
45-0425	.8940
45-0429	.9147
45-0431	.9141
45-0438	.9207
* 45-0440	.8591
* 45-0446	.9539
45-0447	1.0694
45-0450	.8269
* 45-0451	.7982
45-0454	.9156
45-0455	.8796
45-0457	1.0650
* 45-0458	.8336
45-0459	.8454
45-0460	.8679
45-0462	1.0075
45-0464	.8847
45-0465	.8954
45-0467	.9180
45-0469	.9377
45-0472	.9677
45-0473	.9114
45-0475	.9199
45-0476	.8953
45-0481	.8954
* 45-0482	.9105
45-0484	.9409
45-0486	.9008
45-0488	.9183
45-0489	.8876
* 45-0490	.9014
45-0492	.8934
45-0493	.8719
45-0497	.9414
45-0498	.9162
45-0508	1.0109
45-0513	.8632
45-0514	.9877
45-0517	.8323
45-0518	1.0252
45-0523	1.0247
45-0527	.8860
45-0530	.9441
45-0534	.8623
45-0535	.9344
45-0537	.9718
45-0538	.9328
45-0539	.9256
45-0544	.9362
45-0545	.8856
45-0546	.9374
45-0547	.8818
45-0550	1.0186
45-0551	.9159
45-0552	.9082
* 45-0557	.9265
45-0558	.9385
* 45-0559	.8889
45-0561	.8983
45-0563	.8778
45-0565	.9651
45-0568	1.0093
45-0569	.9974
45-0570	.8961
45-0571	.9884
45-0573	.8736
45-0574	.9195
45-0575	1.0019
45-0577	.8737
* 45-0578	.9076
* 45-0579	.8813
45-0580	.9763
45-0581	.9319
* 45-0582	.8724
* 45-0583	.8221

INDEXES DERIVED FROM FEWER THAN 50 DISCHARGES DO NOT MEET THE SELECTED STATISTICAL PRECISION CRITERION FOR RELIABILITY. THESE CASE MIX INDEXES ARE ASTERISKED.

TABLE NO. 3a HOSPITAL CASE MIX INDEXES Page 22

PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX
45-0584	.8535	45-0651	1.0862	* 45-0706	.9857	47-0016	.9271	49-0048	1.0334
45-0586	.9287	45-0652	.8562	46-0001	1.0254	47-0018	.9547	49-0050	1.0803
45-0587	.9282	45-0653	.9701	46-0003	1.0681	* 47-0020	.9265	* 49-0051	1.0335
45-0588	.9664	45-0654	.9205	46-0004	1.0855	47-0023	.9435	49-0052	1.0734
45-0590	.9341	* 45-0655	.9524	46-0005	.9546	47-0024	.9576	49-0053	1.0719
45-0591	.8962	45-0656	.9345	46-0006	1.0434	48-0001	.9970	49-0054	.9467
45-0592	.9975	* 45-0657	.8949	46-0007	1.0015	48-0002	.9477	49-0055	.9010
45-0595	.9453	45-0658	.8899	46-0008	1.0302	49-0001	.9536	49-0056	.8233
45-0596	.9723	45-0659	1.0655	46-0009	1.1584	49-0002	.8822	49-0057	1.0614
45-0597	.8769	45-0660	1.0184	46-0010	1.1425	49-0003	.5799	49-0059	1.1129
45-0600	.9658	* 45-0661	.9153	46-0011	1.0131	49-0004	1.0534	49-0060	.9194
* 45-0601	.8602	45-0662	1.0413	46-0012	1.1321	49-0005	1.0918	49-0063	1.1684
* 45-0603	.8630	45-0665	.8625	46-0013	.9540	49-0006	.9935	49-0066	1.0461
45-0604	.9410	45-0666	.9563	* 46-0014	1.0508	49-0007	1.1950	49-0067	1.0266
45-0605	.9330	45-0667	.8950	46-0015	.9932	49-0008	.9928	49-0069	1.0772
* 45-0607	.8471	45-0668	.9495	46-0016	.9402	49-0009	1.2700	49-0071	1.0622
45-0609	.8612	45-0669	1.0072	46-0017	1.0854	49-0010	.9715	49-0073	.9937
45-0610	.9511	45-0670	.9424	* 46-0018	.9740	49-0011	1.1117	49-0074	.9731
45-0611	.9192	45-0671	.9491	* 46-0019	.8904	49-0012	.9269	49-0075	1.0398
45-0613	.9247	45-0672	.9867	* 46-0020	.9694	49-0013	1.0269	49-0077	1.0363
45-0614	.8830	* 45-0673	.9642	46-0021	1.0212	49-0014	1.0581	49-0078	.8829
45-0615	.8837	* 45-0674	.8254	* 46-0022	.9723	49-0015	1.0896	49-0079	1.0296
* 45-0616	.9179	45-0675	1.0250	46-0023	.9891	49-0017	1.0981	49-0083	.9535
45-0617	1.0593	* 45-0676	.8609	* 46-0024	.8690	49-0018	1.0109	49-0084	.9272
* 45-0618	.8862	45-0677	.9829	* 46-0025	.8435	49-0019	1.0046	49-0085	.8819
45-0620	.8918	45-0678	.9230	46-0026	.8752	49-0020	.9501	49-0088	.9534
45-0621	.9177	45-0679	.9369	* 46-0027	.8264	49-0021	1.0299	49-0089	.9320
45-0623	.9335	45-0681	.9545	* 46-0029	.8898	49-0022	.9719	49-0090	1.0218
45-0624	.9016	45-0682	.9028	46-0030	1.0205	49-0023	1.0727	49-0091	1.1151
45-0626	.8826	45-0683	.9402	* 46-0032	.9128	49-0024	1.1107	49-0092	.9970
45-0627	.8646	45-0684	1.0288	* 46-0033	.9657	49-0027	1.0082	49-0093	1.0323
45-0628	.8864	45-0685	.8987	* 46-0035	.9272	49-0028	1.0557	49-0094	1.0094
45-0629	.9216	45-0686	1.0537	* 46-0036	.8464	49-0029	.9999	49-0095	1.0228
45-0630	1.1784	45-0687	.9722	46-0037	.9908	49-0030	.9494	49-0097	1.0161
45-0631	1.1791	45-0688	1.0055	* 46-0038	1.0251	49-0031	1.0272	49-0098	1.0205
45-0632	.8935	45-0690	1.0460	* 46-0039	.9337	49-0032	1.3347	49-0099	.9566
45-0633	.9823	* 45-0691	.9974	* 46-0040	.8194	49-0033	1.0259	49-0100	1.0523
45-0634	1.0538	* 45-0693	.8490	46-0041	1.0147	49-0034	.8661	49-0101	1.0457
45-0635	1.1044	45-0694	.5890	46-0042	1.0947	49-0035	.9023	* 49-0104	1.0536
45-0637	.9485	45-0695	.8154	47-0001	1.0074	49-0037	.9962	49-0107	.9579
45-0638	.9566	45-0696	.8508	47-0003	1.1952	49-0038	1.0013	49-0110	.9437
45-0639	.9549	45-0697	1.0079	47-0004	1.0491	* 49-0039	.8315	49-0111	.9582
45-0641	.9071	45-0698	.8650	47-0005	1.0046	49-0040	1.0954	49-0112	1.1454
45-0642	.9150	45-0699	.9352	47-0006	.8514	49-0041	.9070	49-0113	1.0125
45-0644	1.0156	45-0700	.8766	47-0008	.9455	49-0042	.9930	49-0114	.9866
45-0645	1.0152	* 45-0701	.8792	47-0010	1.0212	49-0043	.9952	49-0115	.9709
45-0647	1.1791	45-0702	.9384	47-0011	.9357	49-0044	.9964	49-0116	.9767
45-0648	.9447	45-0703	.9303	47-0012	1.0441	49-0045	1.1164	49-0117	.9781
45-0649	.9208	45-0704	.8647	47-0013	1.0117	49-0046	1.0549	49-0118	1.0856
* 45-0650	.8206	* 45-0705	.7538	47-0015	1.0710	49-0047	1.0935	49-0119	1.0813

INDEXES DERIVED FROM FEWER THAN 50 DISCHARGES DO NOT MEET THE SELECTED STATISTICAL PRECISION CRITERIA FOR RELIABILITY. THESE CASE MIX INDEXES ARE ASTERISKED.

PROVIDER NUMBER	CASE MIX INDEX
49-0120	1.1419
49-0122	1.1050
49-0123	1.1050
49-0124	1.0271
* 49-0125	.7661
49-0126	.9935
49-0127	.9642
50-0001	1.1115
50-0002	1.0546
50-0003	1.0520
50-0005	1.2008
50-0006	1.0971
50-0007	1.1018
50-0008	1.3425
50-0009	1.0167
50-0010	1.1090
50-0011	1.0376
50-0012	1.1831
50-0014	1.1016
50-0015	1.1142
50-0016	1.1583
50-0017	1.1128
50-0019	1.0327
50-0020	1.0858
50-0021	1.1576
50-0022	.9862
50-0024	1.1953
50-0025	1.4125
50-0026	1.0829
50-0027	1.1987
50-0028	.9625
50-0029	.8550
50-0030	1.1864
50-0031	1.0363
50-0032	.9881
50-0034	.9713
50-0035	1.0452
50-0036	1.0438
50-0037	1.0253
50-0038	1.1232
50-0040	.9227
50-0041	1.1154
50-0042	.9347
* 50-0043	.5182
50-0044	1.2015
50-0045	1.0452
50-0046	1.1289
50-0048	1.0151
50-0049	1.1098
50-0050	.9555
50-0051	1.1453
50-0052	.9577
50-0053	1.0902
50-0054	1.1854
50-0055	1.0015
50-0057	1.0206
50-0058	1.0740
50-0059	.9561
50-0060	.9915
50-0061	.9833
* 50-0062	1.0287
50-0064	1.1139
50-0065	1.0221
* 50-0066	.7883
50-0068	.9228
50-0069	.9256
50-0070	.9969
50-0071	1.0021
50-0072	1.0612
* 50-0073	.9906
50-0074	.8896
50-0075	1.0264
50-0076	.9518
50-0077	1.0854
50-0078	1.0603
50-0079	1.0671
* 50-0080	.7897
50-0081	.5735
50-0084	1.0786
50-0085	.8664
50-0086	.9865
50-0087	1.0951
50-0088	1.0554
50-0089	1.0643
* 50-0090	.7980
* 50-0092	.9846
50-0093	1.0425
50-0094	.8150
50-0096	.9863
50-0097	1.0252
* 50-0098	.8788
* 50-0100	.9668
50-0101	.9279
* 50-0102	.5032
50-0104	1.0521
* 50-0106	.8332
50-0107	.5928
50-0108	1.2193
50-0109	.9536
50-0110	1.0895
50-0111	1.1112
50-0118	1.0620
50-0119	1.0226
* 50-0121	.5237
50-0122	1.1391
* 50-0123	1.0264
50-0124	1.1361
* 50-0125	1.0155
* 50-0127	.8194
50-0129	1.1829
50-0130	.8120
* 50-0132	.5323
51-0001	1.1357
51-0002	1.0171
51-0003	1.0150
* 51-0004	.9083
51-0005	.9445
51-0006	1.0332
51-0007	1.0738
51-0008	1.0243
51-0009	.9795
* 51-0011	1.0343
51-0012	.9319
51-0013	.9730
51-0014	.9672
51-0015	.9693
51-0016	.9304
51-0018	1.0011
* 51-0019	.5526
51-0020	1.0253
51-0022	1.1713
51-0023	1.0197
51-0024	1.0476
51-0025	.9083
51-0026	.9258
51-0027	.9713
51-0028	.9186
51-0029	1.0160
51-0030	.9575
51-0031	.9533
51-0033	1.1249
51-0035	.9665
51-0036	.8573
51-0038	.9658
51-0039	1.0826
* 51-0040	.8995
* 51-0041	.8643
* 51-0043	.5502
51-0045	.9049
51-0046	1.0098
51-0047	1.0409
51-0048	.9360
51-0050	.9995
51-0052	.9733
51-0053	.9819
51-0054	.8739
51-0055	1.0007
51-0058	1.1020
51-0059	.6972
51-0060	.9343
51-0061	1.0094
51-0062	.9854
51-0063	.9118
51-0064	.9435
51-0065	.8868
51-0066	1.0072
51-0067	.7935
51-0068	.9455
51-0070	1.0025
51-0071	.9983
51-0072	.9415
51-0074	.9200
* 51-0076	.8332
51-0077	.9993
51-0080	.9391
51-0081	.9190
51-0082	.9558
* 51-0083	1.0264
51-0084	.9114
52-0001	1.0504
52-0002	1.0937
52-0003	.9690
52-0004	.9844
52-0006	1.0247
52-0007	.9630
52-0008	.9837
52-0009	1.0875
52-0010	1.0290
52-0011	.9900
52-0012	.9688
52-0013	1.0001
52-0014	1.0323
52-0015	1.1151
52-0016	.9945
52-0017	1.0065
52-0018	.9419
52-0019	1.0788
52-0020	1.0474
52-0021	1.0104
52-0022	.9474
52-0024	.8822
52-0025	.9436
52-0026	1.0809
52-0027	.9274
52-0028	1.0831
52-0029	.9215
52-0030	1.0835
52-0031	1.0037
52-0032	1.0706
52-0033	1.0264
52-0034	.9994
52-0035	1.0455
52-0037	1.2080
52-0038	1.0239
52-0039	.9805
52-0040	1.0656
52-0041	.9240
52-0042	.9689
52-0043	1.1278
52-0044	1.0060
52-0045	1.1357
52-0047	.9357
52-0048	1.0390
52-0049	1.2907
52-0051	1.1577
52-0053	.9608
52-0054	.9893
52-0056	1.0067
52-0057	.8910
52-0058	.9612
52-0059	.9832
52-0060	.9931
52-0062	1.0305
52-0063	1.0530
52-0064	1.1446
52-0066	1.0332
52-0067	1.1307
52-0068	.9087
52-0069	.9828
52-0070	1.0799
52-0071	1.0065
52-0074	.9549
52-0075	1.0264
52-0076	.9799
52-0077	.8965
52-0078	1.1014
52-0081	1.1486
52-0082	.9717
52-0083	1.1348
52-0084	.9425

INDEXES DERIVED FROM FEWER THAN 50 DISCHARGES DO NOT MEET THE SELECTED STATISTICAL PRECISION CRITERION FOR RELIABILITY. THESE CASE MIX INDEXES ARE ASTERISKED.

TABLE NO. 3a HOSPITAL CASE MIX INDEXES Page 24

PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX
52-0087	1.1425	52-0112	.9396	52-0135	1.0400	52-0161	.9014	53-0008	.9574
52-0088	1.0933	52-0113	.9780	52-0136	1.0884	* 52-0164	.8194	53-0009	.9445
52-0089	1.0739	52-0114	.9198	52-0138	1.2047	* 52-0165	.8757	53-0010	1.0170
52-0090	.9255	52-0115	1.0573	52-0139	1.0442	52-0167	.9620	53-0011	1.0919
52-0091	1.0339	52-0116	1.0002	52-0140	1.0873	52-0170	1.0195	53-0012	1.0588
52-0092	.9520	52-0117	.9757	52-0141	1.0612	52-0171	.8855	53-0015	.9940
52-0094	1.0451	52-0118	.9264	* 52-0142	.9243	52-0173	.9723	53-0016	.9997
52-0095	.9578	52-0119	.9428	* 52-0143	.9135	52-0174	1.1057	* 53-0017	.9316
52-0096	1.1377	* 52-0120	1.1297	52-0144	1.0248	* 52-0175	.8194	53-0018	.8243
52-0097	1.0299	52-0121	1.1022	52-0145	.9961	* 52-0176	.7895	53-0019	.8440
52-0098	1.2397	52-0122	.9882	52-0146	.9278	52-0177	1.1405	* 53-0021	.9321
52-0100	1.0606	52-0123	1.0863	52-0148	.9311	52-0178	.9735	53-0022	.9425
52-0101	.9410	52-0124	.9328	52-0149	.9637	* 52-0179	.8194	* 53-0023	.7906
52-0102	1.0271	52-0125	.8269	52-0151	.9411	* 52-0180	.8194	* 53-0024	.9282
52-0103	1.1217	52-0126	.9649	52-0152	.9841	53-0001	1.0338	53-0025	.9396
52-0104	.9020	52-0127	.9720	52-0153	1.0404	53-0002	1.0746	53-0026	.8943
* 52-0105	.9169	* 52-0129	.8519	52-0154	.9765	* 53-0003	.9331	* 53-0027	.9491
52-0107	.9893	52-0130	.9099	52-0156	.9639	53-0004	1.0450	* 53-0029	.9590
52-0109	.9444	52-0131	.9638	52-0157	.9830	* 53-0005	1.0770	* 53-0031	.8191
52-0110	.9190	52-0132	.9973	52-0159	.9524	53-0006	.9996		
52-0111	1.0312	52-0134	.9678	52-0160	1.1446	53-0007	.9001		

INDEXES DERIVED FROM FEWER THAN 50 DISCHARGES DO NOT MEET THE SELECTED STATISTICAL PRECISION CRITERION FOR RELIABILITY. THESE CASE MIX INDEXES ARE ASTERISKED.

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TABLE 3b.—AVERAGE CASE-MIX INDEXES BY HOSPITAL CLASSIFICATION GROUP

Bed size	Mean case-mix index
Urban Hospitals:	
Less than 100	0.9692
100 to 404	1.0485
405 to 684	1.1077
685 and above	1.1408
Rural Hospitals:	
Less than 100	.9449
100 to 169	.9881
170 and above	1.0262

TABLE 4a.—WAGE INDEX FOR URBAN AREAS

MSA area	Wage index
Abilene, TX	.9414
Taylor, TX	
Akron, OH	1.0734
Portage, OH	
Summit, OH	
Albany, GA	[1].8907
Dougherty, GA	
Lee, GA	
Albany-Schenectady-Troy, NY	.8925
Albany, NY	
Greene, NY	
Montgomery, NY	
Rensselaer, NY	
Saratoga, NY	
Schnectady, NY	
Albuquerque, NM	1.0579
Bernalillo, NM	
Alexandria, LA	.9735
Rapides, LA	
Allentown-Bethlehem, PA-NJ	1.0518
Warren, NJ	
Carbon, PA	
Lehigh, PA	
Northampton, PA	
Alton-Granite City, IL	.9587
Jersey, IL	
Madison, IL	
Altoona, PA	1.0249
Blair, PA	
Amarillo, TX	.9696
Potter, TX	
Randall, TX	
Anaheim-Santa Ana, CA	1.2445
Orange, CA	
Anchorage, AK	1.4657
Anchorage, AK	
Anderson, IN	.9690
Madison, IN	
Anderson, SC	.8748
Anderson, SC	
Ann Arbor, MI	1.2090
Washtenaw, MI	
Anniston, AL	.8625
Calhoun, AL	
Appleton-Oshkosh-Neenah, WI	.9704
Calument, WI	
Outagamie, WI	
Winnebago, WI	
Asheville, NC	.9508
Buncombe, NC	
Athens, GA	.8817
Clarke, GA	
Jackson, GA	
Madison, GA	
Oconee, GA	
Atlanta, GA	.9417
Barrow, GA	
Butts, GA	
Cherokee, GA	
Clayton, GA	
Cobb, GA	
Coweta, GA	
De Kalb, GA	
Douglas, GA	
Fayette, GA	
Forsyth, GA	
Fulton, GA	
Gwinnett, GA	
Henry, GA	
Newton, GA	
Paulding, GA	
Rockdale, GA	
Spalding, GA	
Walton, GA	
Atlantic City, NJ	1.0649
Atlantic, NJ	
Cape May, NJ	
Augusta, GA-SC	.9514
Columbia, GA	
McDuffie, GA	
Richmond, GA	
Aiken, SC	
Aurora-Elgin, IL	.9958
Kane, IL	
Kendall, IL	
Austin, TX	1.0590
Hays, TX	
Travis, TX	
Williamson, TX	
Bakersfield, CA	1.2271
Kern, CA	
Baltimore, MD	1.0960
Anne Arundel, MD	
Baltimore, MD	
Baltimore City, MD	
Carroll, MD	
Harford, MD	
Howard, MD	
Queen Annes, MD	
Bangor, ME	.9271
Penobscot, ME	
Baton Rouge, LA	1.0174
Ascension, LA	
East Baton Rouge, LA	
Livingston, LA	
West Baton Rouge, LA	
Battle Creek, MI	1.0600
Calhoun, MI	
Beaumont-Port Arthur, TX	.9874
Hardin, TX	
Jefferson, TX	
Orange, TX	
Beaver County, PA	1.0663
Beaver, PA	
Bellingham, WA	[1] 1.0544
Whatcom, WA	
Benton Harbor, MI	.8734
Berrien, MI	
Bergen-Passaic, NJ	1.0290
Bergen, NJ	
Passaic, NJ	
Billings, MT	[1].9648
Yellowstone, MT	
Biloxi-Gulfport, MS	.8710
Hancock, MS	
Harrison, MS	
Binghamton, NY	.9528
Broome, NY	
Tioga, NY	
Birmingham, AL	1.0047
Blount, AL	
Jefferson, AL	
Saint Clair, AL	
Shelby, AL	
Walker, AL	
Bismarck, ND	1.0100
Burleigh, ND	
Morton, ND	
Bloomington, IN	[1].9143
Monroe, IN	
Bloomington-Normal, IL	[1] 1.0139
McLean, IL	
Boise City, ID	1.0755
Ada, ID	
Boston-Lawrence-Salem-Lowell-Brockton, MA	1.0949
Essex, MA	
Middlesex, MA	
Norfolk, MA	
Plymouth, MA	
Suffolk, MA	
Boulder-Longmont, CO	.9982
Boulder, CO	
Bradenton, FL	[1].9199
Manatee, FL	
Brazoria, TX	.8409
Brazoria, TX	
Bremerton, WA	[1].8989
Kitsap, WA	
Bridgeport-Stamford-Norwalk-Danbury, CT	1.1572
Fairfield, CT	
Brownsville-Harlingen, TX	.9217
Cameron,TX	
Bryan-College Station, TX	.9077
Brazos, TX	
Buffalo, NY	.9787
Erie, NY	
Burlington, NC	.8480
Alamance, NC	
Burlington, VT	[1].9654
Chittenden, VT	
Grand Isle, VT	
Canton, OH	.9797
Carroll, OH	
Stark, OH	
Casper, WY	1.0255
Natrona, WY	
Cedar Rapids, IA	.9379
Linn, IA	
Champaign-Urbana-Rantoul, IL	1.0245
Champaign, IL	
Charleston, SC	1.0262
Berkeley, SC	
Charleston, SC	
Dorchester, SC	
Charleston, WV	1.1033
Kanawha, WV	
Putnam, WV	
Charlotte-Gastonia-Rock Hill, NC-SC	.9776
Cabarrus, NC	
Gaston, NC	
Lincoln, NC	
Mecklenburg, NC	
Rowan, NC	
Union, NC	
York, SC	
Charlottesville, VA	1.2925
Albermarle, VA	
Charlottesville City, VA	
Fluvanna, VA	
Greene, VA	
Chattanooga, TN-GA	.9671
Catoosa, GA	
Dade, GA	
Walker, GA	
Hamilton, TN	
Marion, TN	
Sequatchie, TN	
Chicago, IL	1.2196
Cook, IL	
DuPage, IL	
McHenry,IL	
Chico, CA	1.0558
Butte, CA	
Cincinnati, OH-KY-IN	1.0558
Dearborn, IN	
Boone, KY	
Campbell, KY	
Kenton, KY	
Clermont, OH	
Hamilton, OH	
Warren, OH	
Clarksville-Hopkinsville, TN-KY	.8342
Christian, KY	
Montgomery,TN	
Cleveland, OH	1.2026
Cuyahoga, OH	
Geauga, OH	
Lake, OH	
Medina, OH	
Colorado Springs, CO	1.1069
El Paso, CO	
Columbia, MO	1.1357
Boone, MO	
Columbia, SC	.9803

TABLE 4a.—WAGE INDEX FOR URBAN AREAS—Continued

MSA area	Wage index
Lexington, SC	
Richland, SC	
Columbus, GA-AL	.9199
Russell, AL	
Chattahoochee, GA	
Muscogee, GA	
Columbus, OH	1.0423
Delaware, OH	
Fairfield, OH	
Franklin, OH	
Licking, OH	
Madison, OH	
Pickaway, OH	
Union, OH	
Corpus Christi, TX	.9648
Nueces, TX	
San Patricio, TX	
Cumberland, MD-WV	.9460
Allegany, MD	
Mineral, WV	
Dallas, TX	1.0774
Collin, TX	
Dallas, TX	
Denton, TX	
Ellis, TX	
Kaufman, TX	
Rockwall, TX	
Danville, VA	[1].8701
Danville City, VA	
Pittsylvania, VA	
Davenport-Rock Island-Moline, IA-ILL	.9621
Scott, IA	
Henry, IL	
Rock Island, IL	
Dayton-Springfield, OH	1.1117
Clark, OH	
Greene, OH	
Miami, OH	
Montgomery, OH	
Daytona Beach, FL	.9693
Volusia, FL	
Decatur, IL	[1].9831
Macon, IL	
Denver, CO	1.2141
Adams, CO	
Arapahoe, CO	
Denver, CO	
Douglas, CO	
Jefferson, CO	
Des Moines, IA	1.0709
Dallas, IA	
Polk, IA	
Warren, IA	
Detroit, MI	1.1992
Lapeer, MI	
Livingston, MI	
Macomb, MI	
Monroe, MI	
Oakland, MI	
Saint Clair, MI	
Wayne, MI	
Dothan, AL	.8846
Dale, AL	
Houston, AL	
Dubuque, IA	1.0281
Dubuque, IA	
Duluth, MN-WI	.9154
St. Louis, MN	
Douglas, WI	
East St Louis-Belleville, IL	.9717
Clinton, IL	
St. Clair, IL	
Eau Claire, WI	.9703
Chippewa, WI	
Eau Claire, WI	
El Paso, TX	.8991
El Paso, TX	
Elkhart-Goshen, IN	[1].8907
Elkhart, IN	
Elmira, NY	1.0257
Chemung, NY	
Enid, OK	.9018
Garfield, OK	
Erie, PA	.9927
Erie, PA	
Eugene-Springfield, OR	.9862
Lane, OR	
Evansville, IN-KY	1.0093
Posey, IN	
Vanderburgh, IN	
Warrick, IN	
Henderson, KY	
Fargo-Moorhead, ND-MN	1.0051
Clay, MN	
Cass, ND	
Fayetteville, NC	[1].9325
Cumberland, NC	
Fayetteville-Springdale, AR	.8307
Washington, AR	
Flint, MI	1.1523
Genesee, MI	
Florence, AL	.8088
Colbert, AL	
Lauderdale, AL	
Florence, SC	.8072
Florence, SC	
Fort Collins-Loveland, CO	.9278
Larimer, CO	
Fort Lauderdale-Hollywood-Pompano Beach, FL	1.1105
Broward, FL	
Fort Myers, FL	.9242
Lee, FL	
Fort Pierce, FL	.9843
Martin, FL	
St. Lucie, FL	
Fort Smith, AR-OK	.9705
Crawford, AR	
Sebastian, AR	
Sequoyah, OK	
Fort Walton Beach, FL	[1].7673
Okaloosa, FL	
Fort Wayne, IN	.9446
Allen, IN	
De Kalb, IN	
Whitley, IN	
Fort Worth-Arlington, TX	.9261
Johnson, TX	
Parker, TX	
Tarrant, TX	
Fresno, CA	1.1951
Fresno, CA	
Gadsden, AL	.9234
Etowah, AL	
Gainesville, FL	.9709
Alachua, FL	
Bradford, FL	
Galveston-Texas City, TX	1.1822
Galveston, TX	
Gary-Hammond, IN	1.1222
Lake, IN	
Porter, IN	
Glens Falls, NY	.8813
Warren, NY	
Washington, NY	
Grand Forks, ND	[1].9762
Grand Forks, ND	
Grand Rapids, MI	.9998
Kent, MI	
Ottawa, MI	
Great Falls, MT	[1] 1.0307
Cascade, MT	
Greeley, CO	[1] 1.0629
Weld, CO	
Green Bay, WI	.9974
Brown, WI	
Greensboro-Winston-Salem-High Point, NC	.9578
Davidson, NC	
Davie, NC	
Forsyth, NC	
Guilford, NC	
Randolph, NC	
Stokes, NC	
Yadkin, NC	
Greenville-Spartanburg, SC	.9474
Greenville, SC	
Pickens, SC	
Spartanburg, SC	
Hagerstown, MD	1.0091
Washington, MD	
Hamilton-Middletown, OH	1.0435
Butler, OH	
Harrisburg-Lebanon-Carlisle, PA	1.0356
Cumberland, PA	
Dauphin, PA	
Lebanon, PA	
Perry, PA	
Hartford-New Middletown-Britain-Bristol, CT	1.0692
Hartford, CT	
Litchfield, CT	
Middlesex, CT	
Tolland, CT	
Hickory, NC	.9503
Alexander, NC	
Burke, NC	
Catawba, NC	
Honolulu, HI	1.1471
Honolulu, HI	
Houma-Thibodaux, LA	.9786
Lafourche, LA	
Terrebonne, LA	
Houston, TX	1.1119
Fort Bend, TX	
Harris, TX	
Liberty, TX	
Montgomery, TX	
Waller, TX	
Huntington-Ashland, WV-KY-OH	.9609
Boyd, KY	
Carter, KY	
Greenup, KY	
Lawrence, OH	
Cabell, WV	
Wayne, WV	
Huntsville, AL	.8996
Madison, AL	
Indianapolis, IN	1.0555
Boone, IN	
Hamilton, IN	
Hancock, IN	
Hendricks, IN	
Johnson, IN	
Marion, IN	
Morgan, IN	
Shelby, IN	
Iowa City, IA	1.1423
Johnson, IA	
Jackson, MI	[1] 1.0281
Jackson, MI	
Jackson, MS	.9110
Hinds, MS	
Madison, MS	
Rankin, MS	
Jacksonville, FL	.9914
Clay, FL	
Duval, FL	
Nassau, FL	
St. Johns, FL	
Jacksonville, NC	[1].8848
Onslow, NC	
Janesville-Beloit, WI	.8907
Rock, WI	
Jersey City, NJ	1.0913
Hudson, NJ	
Johnston City-Kingsport-Bristol, TN-VA	.9240
Carter, TN	
Hawkins, TN	
Sullivan, TN	
Unicoi, TN	
Washington, TN	
Bristol City, VA	
Scott, VA	
Washington, VA	
Johnstown, PA	1.0264
Cambria, PA	
Somerset, PA	
Joliet, IL	1.0893
Grundy, IL	
Will, IL	
Joplin, MO	.9579
Jasper, MO	
Newton, MO	
Kalamazoo, MI	1.2269
Kalamazoo, MI	
Kankakee, IL	.9143
Kankakee, IL	
Kansas City, KS	.9764
Johnson, KS	
Leavenworth, KS	
Miami, KS	
Wyandotte, KS	
Kansas City, MO	.9910

TABLE 4a.—WAGE INDEX FOR URBAN AREAS—Continued

MSA area	Wage index
Cass, MO	
Clay, MO	
Jackson, MO	
Lafayette, MO	
Platte, MO	
Ray, MO	
Kenosha, WI	[1]1.0913
Kenosha, WI	
Killeen-Temple, TX	.9402
Bell, TX	
Coryell, TX	
Knoxville, TN	.9186
Anderson, TN	
Blount, TN	
Grainger, TN	
Jefferson, TN	
Knox, TN	
Sevier, TN	
Union, TN	
Kokomo, IN	.9610
Howard, IN	
Tipton, IN	
LaCrosse, WI	[1].9402
LaCrosse, WI	
Lafayette, LA	1.0162
Lafayette, LA	
St. Martin, LA	
Lafayette, IN	.9112
Tippecanoe, IN	
Lake Charles, LA	.9942
Calcasieu, LA	
Lake County, IL	1.1086
Lake, IL	
Lakeland-Winter Haven, FL	.9276
Polk, FL	
Lancaster, PA	1.0372
Lancaster, PA	
Lansing-East Lansing, MI	1.0514
Clinton, MI	
Eaton, MI	
Ingham, MI	
Laredo, TX	[1].8561
Webb, TX	
Las Cruces, NM	[1].8455
Dona Ana, NM	
Las Vegas, NV	1.2190
Clark, NV	
Lawrence, KS	[1].9797
Douglas, KS	
Lawton, OK	[1].9278
Comanche, OH	
Lewiston-Auburn, ME	[1].9177
Androscoggin, ME	
Lexington-Fayette, KY	.9574
Bourbon, KY	
Clark, KY	
Fayette, KY	
Jessamine, KY	
Scott, KY	
Woodford, KY	
Lima, OH	.9967
Allen, OH	
Auglaize, OH	
Lincoln, NE	.8670
Lancaster, NE	
Little Rock-North Little Rock, AR	1.0183
Faulkner, AR	
Lonoke, AR	
Pulaski, AR	
Saline, AR	
Longview-Marshall, TX	.8561
Gregg, TX	
Harrison, TX	
Lorain-Elyria, OH	1.0549
Lorain, OH	
Los Angeles-Long Beach, CA	1.3037
Los Angeles, CA	
Louisville, KY-IN	1.0654
Clark, IN	
Floyd, IN	
Harrison, IN	
Bullitt, KY	
Jefferson, KY	
Oldham, KY	
Shelby, KY	
Lubbock, TX	1.0087
Lubbock, TX	
Lynchburg, VA	.9240

TABLE 4a.—WAGE INDEX FOR URBAN AREAS—Continued

MSA area	Wage index
Amherst, VA	
Campbell, VA	
Lynchburg City, VA	
Macon-Warner Robins, GA	.9650
Bibb, GA	
Houston, GA	
Jones, GA	
Peach, GA	
Madison, WI	1.0259
Dane, WI	
Manchester-Nashua, NH	.9348
Hillsboro, NH	
Merrimack, NH	
Mansfield, OH	.9177
Richland, OH	
McAllen-Edinburg-Mission, TX	.8378
Hidalgo, TX	
Medford, OR	.9853
Jackson, OR	
Melbourne-Titusville-Palm Bay, FL	.9333
Brevard, FL	
Memphis, TN-AR/MS	1.0765
Crittenden, AR	
De Soto, MS	
Shelby, TN	
Tipton, TN	
Miami-Hialeah, FL	1.1492
Dade, FL	
Middlesex-Somerset-Hunterdon, NJ	1.0633
Hunterdon, NJ	
Middlesex, NJ	
Somerset, NJ	
Midland, TX	1.0783
Midland, TX	
Milwaukee, WI	1.0522
Milwaukee, WI	
Ozaukee, WI	
Washington, WI	
Waukesha, WI	
Minneapolis-St. Paul, MN-WI	1.0271
Anoka, MN	
Carver, MN	
Chisago, MN	
Dakota, MN	
Hennepin, MN	
Isanti, MN	
Ramsey, MN	
Scott, MN	
Washington, MN	
Wright, MN	
St. Croix, WI	
Mobile, AL	.9330
Baldwin, AL	
Mobile, AL	
Modesto, CA	1.0795
Stanislaus, CA	
Monmouth-Ocean, NJ	.9863
Monmouth, NJ	
Ocean, NJ	
Monroe, LA	.9550
Ouachita, LA	
Montgomery, AL	.9726
Autauga, AL	
Elmore, AL	
Montgomery, AL	
Muncie, IN	[1].9763
Delaware, IN	
Muskegon, MI	.9325
Muskegon, MI	
Nashville, TN	1.2287
Cheatham, TN	
Davidson, TN	
Dickson, TN	
Robertson, TN	
Rutherford, TN	
Sumner, TN	
Williamson, TN	
Wilson, TN	
Nassau-Suffolk, NY	1.2093
Nassau, NY	
Suffolk, NY	
New Bedford-Fall River-Attleboro, MA	.9662
Bristol, MA	
New Haven-Waterbury-Meriden, CT	1.0667
New Haven, CT	
New London-Norwich, CT	[1].0667
New London, CT	
New Orleans, LA	1.0164

TABLE 4a.—WAGE INDEX FOR URBAN AREAS—Continued

MSA area	Wage index
Jefferson, LA	
Orleans, LA	
St. Bernard, LA	
St. Charles, LA	
St. John The Baptist, LA	
St. Tammany, LA	
New York, NY	1.3657
Bronx, NY	
Kings, NY	
New York City, NY	
Putnam, NY	
Queens, NY	
Richmond, NY	
Rockland, NY	
Westchester, NY	
Newark, NJ	1.1288
Essex, NJ	
Morris, NJ	
Sussex, NJ	
Union, NJ	
Niagara Falls, NY	.8741
Niagara, NY	
Norfolk-Virginia Beach-Newport News, VA	.9783
Chesapeake City, VA	
Gloucester, VA	
Hampton City, VA	
James City Co., VA	
Newport News City, VA	
Norfolk City, VA	
Poquoson, VA	
Portsmouth City, VA	
Suffolk City, VA	
Virginia Beach City, VA	
Williamsburg City, VA	
York, VA	
Oakland, CA	1.2815
Alameda, CA	
Contra Costa, CA	
Ocala, FL	[1]1.0100
Marion, FL	
Odessa, TX	[1].9776
Ector, TX	
Oklahoma City, OK	1.0573
Canadian, OK	
Cleveland, OK	
Logan, OK	
McClain, OK	
Oklahoma, OK	
Pottawatomie, OK	
Olympia, WA	[1]1.0573
Thurston, WA	
Omaha, NE-IA	.8944
Pottawattamie, IA	
Douglas, NE	
Sarpy, NE	
Washington, NE	
Orange County, NY	1.0061
Orange, NY	
Orlando, FL	1.0146
Orange, FL	
Osceola, FL	
Seminole, FL	
Owensboro, KY	[1].8848
Daviess, KY	
Oxnard-Ventura, CA	1.1987
Ventura, CA	
Panama City, FL	[1].9077
Bay, FL	
Parkersburg-Marietta, WV-OH	.9953
Washington, OH	
Wood, WV	
Pascagoula, MS	[1]1.0139
Jackson, MS	
Pensacola, FL	.9110
Escambia, FL	
Santa Rosa, FL	
Peoria, IL	1.1158
Peoria, IL	
Tazewell, IL	
Woodford, IL	
Philadelphia, PA-NJ	1.1760
Burlington, NJ	
Camden, NJ	
Gloucester, NJ	
Bucks, PA	
Chester, PA	
Delaware, PA	
Montgomery, PA	
Philadelphia, PA	
Phoenix, AZ	1.1122

TABLE 4a.—WAGE INDEX FOR URBAN AREAS—Continued

MSA area	Wage index
Maricopa, AZ	
Pine Bluff, AR	[1].8774
Jefferson, AR	
Pittsburgh, PA	1.1387
Allegheny, PA	
Fayette, PA	
Washington, PA	
Westmoreland, PA	
Pittsfield, MA	.9815
Berkshire, MA	
Portland, ME	.9654
Cumberland, ME	
Sagadahoc, ME	
York, ME	
Portland, OR	1.1194
Clackamas, OR	
Multnomah, OR	
Washington, OR	
Yamhill, OR	
Portsmouth-Dover-Rochester, NH	.8455
Rockingham, NH	
Strafford, NH	
Poughkeepsie, NY	1.0919
Dutchess, NY	
Providence-Pawtucket-Woonsocket, RI	.9773
Bristol, RI	
Kent, RI	
Newport, RI	
Providence, RI	
Washington, RI	
Provo-Orem, UT	.9471
Utah, UT	
Pueblo, CO	1.1600
Pueblo, CO	
Racine, WI	1.0014
Racine, WI	
Raleigh-Durham, NC	1.0139
Durham, NC	
Franklin, NC	
Orange, NC	
Wake, NC	
Reading, PA	1.0285
Berks, PA	
Redding, CA	1.0544
Shasta, CA	
Reno, NV	1.2988
Washoe, NV	
Richland-Kennewick-Pasco, WA	.9547
Benton, WA	
Franklin, WA	
Richmond-Petersburg, VA	.8866
Charles City Co., VA	
Chesterfield, VA	
Colonial Hieghts City, VA	
Dinwiddie, VA	
Goochland, VA	
Hanover, VA	
Henrico, VA	
Hopewell City, VA	
New Kent, VA	
Petersburg City, VA	
Powhatan, VA	
Prince George, VA	
Richmond City, VA	
Riverside-San Bernardino, CA	1.1753
Riverside, CA	
San Bernardino, CA	
Roanoke, VA	1.0019
Botetourt, VA	
Roanoke, VA	
Roanoke City, VA	
Salem City, VA	
Rochester, MN	1.0255
Olmsted, MN	
Rochester, NY	1.0379
Livingston, NY	
Monroe, NY	
Ontario, NY	
Orleans, NY	
Wayne, NY	
Rockford, IL	1.0432
Boone, IL	
Winnebago, IL	
Sacramento, CA	1.1422
Eldorado, CA	
Placer, CA	
Sacramento, CA	
Yolo, CA	
Saginaw-Bay City-Midland, MI	1.0850

TABLE 4a.—WAGE INDEX FOR URBAN AREAS—Continued

MSA area	Wage index
Bay, MI	
Midland, MI	
Saginaw, MI	
St. Cloud, MN	.8606
Benton, MN	
Sherburne, MN	
Stearns, MN	
St. Joseph, MO	.9876
Buchanan, MO	
St. Louis, MO-IL	1.0716
Monroe, IL	
Franklin, MO	
Jefferson, MO	
St. Charles, MO	
St. Louis, MO	
St. Louis City, MO	
Salem, OR	1.0580
Marion, OR	
Polk, OR	
Salinas-Seaside-Monterey, CA	1.2763
Monterey, CA	
Salt Lake City-Ogden, UT	.9659
Davis, UT	
Salt Lake, UT	
Weber, UT	
San Angelo, TX	.9288
Tom Green, TX	
San Antonio, TX	1.0517
Bexar, TX	
Comal, TX	
Guadalupe, TX	
San Diego, CA	1.1897
San Diego, CA	
San Francisco, CA	1.3974
Marin, CA	
San Francisco, CA	
San Mateo, CA	
San Jose, CA	1.2954
Santa Clara, CA	
Santa Barbara-Santa Maria-Lompoc, CA	1.1117
Santa Barbara, CA	
Santa Cruz, CA	1.1367
Santa Cruz, CA	
Santa Rosa-Petaluma, CA	1.1832
Sonoma, CA	
Sarasota, FL	.9880
Sarasota, FL	
Savannah, GA	.9521
Chatham, GA	
Effingham, GA	
Scranton-Wilkes Barre, PA	.9762
Columbia, PA	
Lackawanna, PA	
Luzerne, PA	
Monroe, PA	
Wyoming, PA	
Seattle, WA	1.0881
King, WA	
Snohomish, WA	
Sharon, PA	.9660
Mercer, PA	
Sheboygan, WI	.8857
Sheboygan, WI	
Sherman-Denison, TX	.9015
Grayson, TX	
Shreveport, LA	1.0656
Bossier, LA	
Caddo, LA	
Sioux City, IA-NE	1.0322
Woodbury, IA	
Dakota, NE	
Sioux Falls, SD	.9448
Minnehaha, SD	
South Bend-Mishawaka, IN	.8989
St. Joseph, IN	
Spokane, WA	1.1193
Spokane, WA	
Springfield, IL	1.1417
Menard, IL	
Sangamon, IL	
Springfield, MO	.9537
Christian, MO	
Greene, MO	
Springfield, MA	.9875
Hampden, MA	
Hampshire, MA	
State College, PA	[1] 1.0573
Centre, PA	
Steubenville-Weirton, OH-WV	.9763

TABLE 4a.—WAGE INDEX FOR URBAN AREAS—Continued

MSA area	Wage index
Jefferson, OH	
Brooke, WV	
Hancock, WV	
Stockton, CA	1.1647
San Joaquin, CA	
Syracuse, NY	1.4557
Madison, NY	
Onondaga, NY	
Oswego, NY	
Tacoma, WA	1.0445
Pierce, WA	
Tallahassee, FL	.9270
Gadsden, FL	
Leon, FL	
Tampa-St. Petersburg-Clearwater, FL	.9983
Hernando, FL	
Hillsborough, FL	
Pasco, FL	
Pinellas, FL	
Terre Haute, IN	.8874
Clay, IN	
Vigo, IN	
Texarkana-TX-Texarkana, AR	1.1104
Miller, AR	
Bowie, TX	
Toledo, OH	1.1330
Fulton, OH	
Lucas, OH	
Wood, OH	
Topeka, KS	1.1131
Shawnee, KS	
Trenton, NJ	1.0366
Mercer, NJ	
Tucson, AZ	1.0161
Pima, AZ	
Tulsa, OK	1.0392
Creeks, OK	
Osage, OK	
Rogers, OK	
Tulsa, OK	
Wagoner, OK	
Tuscaloosa, AL	1.0186
Tuscaloosa, AL	
Tyler, TX	1.0029
Smith, TX	
Utica-Rome, NY	.9351
Herkimer, NY	
Oneida, NY	
Vallejo-Fairfield-Napa, CA	1.3293
Napa, CA	
Solano, CA	
Vancouver, WA	[1] 1.0829
Clark, WA	
Victoria, TX	.8634
Victoria, TX	
Vineland-Millville-Bridgeton, NJ	.9498
Cumberland, NJ	
Visalia-Tulare-Portervile, CA	1.1354
Tulare, CA	
Waco, TX	.8330
McLennan, TX	
Washington, D.C.-MD-VA	1.1637
District of Columbia, DC	
Calvert, MD	
Charles, MD	
Frederick, MD	
Montgomery, MD	
Prince Georges, MD	
Alexandria City, VA	
Arlington, VA	
Fairfax, VA	
Fairfax City, VA	
Falls Church City, VA	
Loudoun, VA	
Manassas City, VA	
Manassas Park City, VA	
Prince William, VA	
Stafford, VA	
Waterloo-Cedar Falls, IA	.9100
Black Hawk, IA	
Bremer, IA	
Wausau, WI	[1] .9315
Marathon, WI	
West Palm Beach-Boca Raton-Delray Beach, FL	.9806
Palm Beach, FL	
Wheeling, WV-OH	.9831

TABLE 4a.—WAGE INDEX FOR URBAN AREAS—Continued

MSA area	Wage index
Belmont, OH	
Marshall, WV	
Ohio, WV	
Wichita, KS	1.1213
Butler, KS	
Sedgwick, KS	
Wichita Falls, TX	.8718
Wichita, TX	
Williamsport, PA	1.0262
Lycoming, PA	
Wilmington, DE-NJ-MD	1.0893
New Castle, DE	
Cecil, MD	
Salem, NJ	
Wilmington, NC	.9015
New Hanover, NC	
Worcester-Fitchburg, Leominstar, MA	.9769
Worcester, MA	
Yakima, WA	1.0039
Yakima, WA	
York, PA	1.0307
Adams, PA	
York, PA	
Youngstown-Warren, OH	1.1040
Mahoning, OH	
Trumbull, OH	
Yuba City, CA	1.0829
Sutter, CA	
Yuba, CA	

[1] Approximate value for area.

TABLE 4b.—WAGE INDEX FOR RURAL AREAS

Non-MSA area	Wage Index
Alabama	.7791
Alaska	1.3768
Arizona	.8949
Arkansas	.7810
California	1.0108
Colorado	.8322
Connecticut	.9973
Delaware	.9015
Florida	.8721
Georgia	.8502
Hawaii	1.1771
Idaho	.9002
Illinois	.8683
Indiana	.8617
Iowa	.8174
Kansas	.8135
Kentucky	.8154
Louisiana	.8356
Maine	.8672
Maryland	.9315
Massachusetts	.9710
Michigan	.9475
Minnesota	.8589
Mississippi	.8020
Missouri	.8297
Montana	.8701
Nebraska	.7426
Nevada	1.0178

TABLE 4b.—WAGE INDEX FOR RURAL AREAS—Continued

Non-MSA area	Wage Index
New Hampshire	1.0318
New Jersey [1]	
New Mexico	.9293
New York	.8716
North Carolina	.8503
North Dakota	.8326
Ohio	.9145
Oklahoma	.8592
Oregon	.9562
Pennsylvania	1.0329
Rhode Island [1]	
South Carolina	.8087
South Dakota	.7873
Tennessee	.7876
Texas	.8123
Utah	.8261
Vermont	.8774
Virginia	.8519
Washington	.9498
West Virginia	.9182
Wisconsin	.8302
Wyoming	.9565

[1] All counties within the State are classified urban.

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LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC MEAN LENGTH OF STAY, AND LENGTH OF STAY OUTLIER CUTOFF POINTS USED IN THE PROSPECTIVE PAYMENT SYSTEM

DRG	MDC		TITLE	RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER CUTOFFS
1	1	SURG	CRANIOTOMY AGE >17 EXCEPT FOR TRAUMA	3.3548	19.4	39
2	1	SURG	CRANIOTOMY FOR TRAUMA AGE >17	3.2829	15.8	36
3	1	SURG	* CRANIOTOMY AGE <18	2.9489	12.7	33
4	1	SURG	SPINAL PROCEDURES	2.2452	16.0	36
5	1	SURG	EXTRACRANIAL VASCULAR PROCEDURES	1.6780	9.8	30
6	1	SURG	CARPAL TUNNEL RELEASE	.3993	2.6	8
7	1	SURG	PERIPH + CRANIAL NERVE + OTHER NERV SYST PROC AGE >69 +/OR C.C.	1.0279	5.3	25
8	1	SURG	PERIPH + CRANIAL NERVE + OTHER NERV SYST PROC AGE <70 W/O C.C.	.7239	4.1	23
9	1	MED	SPINAL DISORDERS + INJURIES	1.3958	9.1	29
10	1	MED	NERVOUS SYSTEM NEOPLASMS AGE >69 AND/OR C.C.	1.3087	9.6	30
11	1	MED	NERVOUS SYSTEM NEOPLASMS AGE <70 W/O C.C.	1.2545	8.5	29
12	1	MED	DEGENERATIVE NERVOUS SYSTEM DISORDERS	1.1136	9.4	29
13	1	MED	MULTIPLE SCLEROSIS + CEREBELLAR ATAXIA	1.0150	8.9	29
14	1	MED	SPECIFIC CEREBROVASCULAR DISORDERS EXCEPT TIA	1.3527	9.9	30
15	1	MED	TRANSIENT ISCHEMIC ATTACKS	.6673	5.6	24
16	1	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS WITH C.C.	.8592	7.4	27
17	1	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W/O C.C.	.8392	7.2	27
18	1	MED	CRANIAL + PERIPHERAL NERVE DISORDERS AGE >69 AND/OR C.C.	.7915	6.6	27
19	1	MED	CRANIAL + PERIPHERAL NERVE DISORDERS AGE <70 W/O C.C.	.6975	5.7	26
20	1	MED	NERVOUS SYSTEM INFECTION EXCEPT VIRAL MENINGITIS	1.3141	7.6	28
21	1	MED	* VIRAL MENINGITIS	.6301	4.5	15
22	1	MED	HYPERTENSIVE ENCEPHALOPATHY	.7869	6.4	26
23	1	MED	NONTRAUMATIC STUPOR + COMA	1.1568	5.9	26
24	1	MED	SEIZURE + HEADACHE AGE >69 AND/OR C.C.	.7279	5.6	26
25	1	MED	SEIZURE + HEADACHE AGE 18-69 W/O C.C.	.6392	4.9	25
26	1	MED	* SEIZURE + HEADACHE AGE 0-17	.4349	3.3	13
27	1	MED	* TRAUMATIC STUPOR + COMA, COMA >1 HR	1.1368	4.1	24
28	1	MED	TRAUMATIC STUPOR + COMA, COMA <1 HR AGE >69 AND/OR C.C.	1.0701	5.9	26
29	1	MED	* TRAUMATIC STUPOR + COMA <1 HR AGE 18-69 W/O C.C.	.7175	3.8	24
30	1	MED	* TRAUMATIC STUPOR + COMA <1 HR AGE 0-17	.3576	2.0	8
31	1	MED	CONCUSSION AGE >69 AND/OR C.C.	.6051	4.6	25
32	1	MED	CONCUSSION AGE 18-69 W/O C.C.	.4519	3.3	19
33	1	MED	* CONCUSSION AGE 0-17	.2483	1.6	5
34	1	MED	OTHER DISORDERS OF NERVOUS SYSTEM AGE >69 AND/OR C.C.	.9927	7.1	27
35	1	MED	OTHER DISORDERS OF NERVOUS SYSTEM AGE <70 W/O C.C.	.8460	6.2	26
36	2	SURG	RETINAL PROCEDURES	.7093	5.0	15
37	2	SURG	ORBITAL PROCEDURES	.5630	3.4	11
38	2	SURG	PRIMARY IRIS PROCEDURES	.4325	3.0	9
39	2	SURG	LENS PROCEDURES	.5010	2.8	6
40	2	SURG	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE >17	.3977	2.4	7
41	2	SURG	* EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE 0-17	.3695	1.6	4
42	2	SURG	INTRAOCULAR PROCEDURES EXCEPT RETINA, IRIS + LENS	.5906	3.8	12
43	2	MED	* HYPHEMA	.3828	4.2	12
44	2	MED	ACUTE MAJOR EYE INFECTIONS	.6258	6.5	22
45	2	MED	NEUROLOGICAL EYE DISORDERS	.5641	4.3	18

* MEDPAR DATA HAVE BEEN SUPPLEMENTED BY DATA FROM MARYLAND AND MICHIGAN FOR LOW VOLUME DRGS.
** DRG CATEGORIES COMBINED (IN PAIRS) IN THE CALCULATION OF THE CASE MIX INDEX.
*** DRGS 469 AND 470 CONTAIN CASES WHICH COULD NOT BE ASSIGNED TO VALID DRGS.

LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC MEAN LENGTH OF STAY, AND LENGTH OF STAY (UTLIER CUTOFF POINTS USED IN THE PROSPECTIVE PAYMENT SYSTEM

DRG	MDC		TITLE	RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER CUTOFFS
46	2	MED	OTHER DISORDERS OF THE EYE AGE >17 WITH C.C.	.5964	4.1	23
47	2	MED	OTHER DISORDERS OF THE EYE AGE >17 W/O C.C.	.5064	3.0	12
48	2	MED	* OTHER DISORDERS OF THE EYE AGE 0-17	.4060	2.9	13
49	3	SURG	MAJOR HEAD + NECK PROCEDURES	2.5270	13.6	34
50	3	SURG	SIALOADENECTOMY	.7160	4.6	14
51	3	SURG	SALIVARY GLAND PROCEDURES EXCEPT SIALOADENECTOMY	.6702	4.2	15
52	3	SURG	* CLEFT LIP + PALATE REPAIR	.6488	3.8	11
53	3	SURG	SINUS + MASTOID PROCEDURES AGE >17	.5895	3.5	11
54	3	SURG	* SINUS + MASTOID PROCEDURES AGE 0-17	.6961	3.2	11
55	3	SURG	MISCELLANEOUS EAR, NOSE + THROAT PROCEDURES	.4153	2.5	7
56	3	SURG	RHINOPLASTY	.4144	2.8	8
57	3	SURG	* T+A PROC EXCEPT TONSILLECTOMY +/OR ADENOIDECTOMY AGE >17	.5251	2.7	8
58	3	SURG	* T+A PROC EXCEPT TONSILLECTOMY +/OR ADENOIDECTOMY AGE 0-17	.3130	1.5	3
59	3	SURG	* TONSILLECTOMY AND/OR ADENOIDECTOMY ONLY AGE >17	.3147	2.0	4
60	3	SURG	* TONSILLECTOMY AND/OR ADENOIDECTOMY ONLY AGE 0-17	.2643	1.5	3
61	3	SURG	* MYRINGOTOMY AGE >17	.4273	2.1	5
62	3	SURG	* MYRINGOTOMY AGE 0-17	.3121	1.3	3
63	3	SURG	OTHER EAR, NOSE + THROAT O.R. PROCEDURES	1.1090	5.8	26
64	3	MED	EAR, NOSE + THROAT MALIGNANCY	1.0812	5.7	26
65	3	MED	DYSEQUILIBRIUM	.4857	4.6	17
66	3	MED	EPISTAXIS	.4116	3.7	15
67	3	MED	* EPIGLOTTITIS	.6762	4.3	17
68	3	MED	OTITIS MEDIA + URI AGE >69 AND/OR C.C.	.6289	6.0	22
69	3	MED	OTITIS MEDIA + URI AGE 18-69 W/O C.C.	.5417	4.8	19
70	3	MED	* OTITIS MEDIA + URI AGE 0-17	.3697	3.1	10
71	3	MED	* LARYNGOTRACHEITIS	.3589	2.9	9
72	3	MED	NASAL TRAUMA + DEFORMITY	.4857	3.8	18
73	3	MED	OTHER EAR, NOSE + THROAT DIAGNOSES AGE >17	.5217	3.5	17
74	3	MED	* OTHER EAR, NOSE + THROAT DIAGNOSES AGE 0-17	.3463	2.1	8
75	4	SURG	MAJOR CHEST PROCEDURES	2.6044	14.4	34
76	4	SURG	O.R. PROC ON THE RESP SYSTEM EXCEPT MAJOR CHEST WITH C.C.	1.8734	10.6	31
77	4	SURG	O.R. PROC ON THE RESP SYSTEM EXCEPT MAJOR CHEST W/O C.C.	1.8178	9.5	30
78	4	MED	PULMONARY EMBOLISM	1.4095	10.4	30
79	4	MED	RESPIRATORY INFECTIONS + INFLAMMATIONS AGE >69 AND/OR C.C.	1.7982	11.2	31
80	4	MED	RESPIRATORY INFECTIONS + INFLAMMATIONS AGE 18-69 W/O C.C.	1.7445	10.9	31
81	4	MED	* RESPIRATORY INFECTIONS + INFLAMMATIONS AGE 0-17	.8743	6.1	26
82	4	MED	RESPIRATORY NEOPLASMS	1.1400	7.4	27
83	4	MED	MAJOR CHEST TRAUMA AGE >69 AND/OR C.C.	.9809	8.1	28
84	4	MED	* MAJOR CHEST TRAUMA AGE <70 W/O C.C.	.7738	5.3	22
85	4	MED	PLEURAL EFFUSION AGE >69 AND/OR C.C.	1.1461	8.4	28
86	4	MED	PLEURAL EFFUSION AGE <70 W/O C.C.	1.1217	7.6	28
87	4	MED	PULMONARY EDEMA + RESPIRATORY FAILURE	1.5529	7.7	28
88	4	MED	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	1.0412	7.5	28
89	4	MED	SIMPLE PNEUMONIA + PLEURISY AGE >69 AND/OR C.C.	1.1029	8.5	29
90	4	MED	SIMPLE PNEUMONIA + PLEURISY AGE 18-69 W/O C.C.	.9849	7.6	28

* MEDPAR DATA HAVE BEEN SUPPLEMENTED BY DATA FROM MARYLAND AND MICHIGAN FOR LOW VOLUME DRGS.
** DRG CATEGORIES COMBINED (IN PAIRS) IN THE CALCULATION OF THE CASE MIX INDEX.
*** DRGS 469 AND 470 CONTAIN CASES WHICH COULD NOT BE ASSIGNED TO VALID DRGS.

TABLE 5 Page 3 of 11

LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC MEAN LENGTH OF STAY, AND LENGTH OF STAY OUTLIER CUTOFF POINTS USED IN THE PROSPECTIVE PAYMENT SYSTEM

DRG	MDC		TITLE	RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER CUTOFFS
91	4	MED	* SIMPLE PNEUMONIA + PLEURISY AGE 0-17	.5131	4.6	14
92	4	MED	INTERSTITIAL LUNG DISEASE AGE >69 AND/OR C.C.	1.0370	7.8	28
93	4	MED	INTERSTITIAL LUNG DISEASE AGE <70 W/O C.C.	.9724	6.9	27
94	4	MED	PNEUMOTHORAX AGE >69 AND/OR C.C.	1.4374	9.2	29
95	4	MED	PNEUMOTHORAX AGE <70 W/O C.C.	1.1252	7.7	28
96	4	MED	BRONCHITIS + ASTHMA AGE >69 AND/OR C.C.	.7996	6.9	24
97	4	MED	BRONCHITIS + ASTHMA AGE 18-69 W/O C.C.	.7256	6.2	21
98	4	MED	* BRONCHITIS + ASTHMA AGE 0-17	.4275	3.7	11
99	4	MED	RESPIRATORY SIGNS + SYMPTOMS AGE >69 AND/OR C.C.	.8035	5.5	26
100	4	MED	RESPIRATORY SIGNS + SYMPTOMS AGE <70 W/O C.C.	.7730	5.1	24
101	4	MED	OTHER RESPIRATORY DIAGNOSES AGE >69 AND/OR C.C.	.9035	6.8	27
102	4	MED	OTHER RESPIRATORY DIAGNOSES AGE <70	.9024	6.1	26
103	5	SURG	* HEART TRANSPLANT	.0000	.0	0
104	5	SURG	** CARDIAC VALVE PROCEDURE WITH PUMP + WITH CARDIAC CATH	6.8527	20.9	41
105	5	SURG	** CARDIAC VALVE PROCEDURE WITH PUMP + W/O CARDIAC CATH	5.2308	16.2	36
106	5	SURG	** CORONARY BYPASS WITH CARDIAC CATH	5.2624	20.4	40
107	5	SURG	** CORONARY BYPASS W/O CARDIAC CATH	3.9891	13.5	34
108	5	SURG	CARDIOTHOR PROC,EXCEPT VALVE + CORONARY BYPASS,WITH PUMP	4.3756	13.3	33
109	5	SURG	CARDIOTHORACIC PROCEDURES W/O PUMP	3.6963	12.1	32
110	5	SURG	MAJOR RECONSTRUCTIVE VASCULAR PROCEDURES AGE >69 AND/OR C.C.	2.9328	14.3	34
111	5	SURG	MAJOR RECONSTRUCTIVE VASCULAR PROCEDURES AGE <70 W/O C.C.	2.5851	13.2	33
112	5	SURG	VASCULAR PROCEDURES EXCEPT MAJOR RECONSTRUCTION	2.3500	11.2	31
113	5	SURG	AMPUTATION FOR CIRC SYSTEM DISORDERS EXCEPT UPPER LIMB + TOE	2.6800	21.6	42
114	5	SURG	UPPER LIMB + TOE AMPUTATION FOR CIRC SYSTEM DISORDERS	2.1067	16.6	37
115	5	SURG	PERMANENT CARDIAC PACEMAKER IMPLANT WITH AMI OR CHF	3.9150	15.8	36
116	5	SURG	PERMANENT CARDIAC PACEMAKER IMPLANT W/O AMI OR CHF	2.8665	9.3	29
117	5	SURG	CARDIAC PACEMAKER REPLACE + REVIS EXC PULSE GEN REPL ONLY	1.8210	6.4	26
118	5	SURG	CARDIAC PACEMAKER PULSE GENERATOR REPLACEMENT ONLY	1.7809	4.2	18
119	5	SURG	VEIN LIGATION + STRIPPING	1.0610	7.2	27
120	5	SURG	OTHER O.R. PROCEDURES ON THE CIRCULATORY SYSTEM	2.5204	15.0	35
121	5	MED	** CIRCULATORY DISORDERS WITH AMI + C.V. COMP. DISCH. ALIVE	1.8648	11.9	32
122	5	MED	** CIRCULATORY DISORDERS WITH AMI W/O C.V. COMP. DISCH. ALIVE	1.3651	9.8	30
123	5	MED	CIRCULATORY DISORDERS WITH AMI, EXPIRED	1.1360	3.1	23
124	5	MED	CIRCULATORY DISORDERS EXC AMI,WITH CARD CATH + COMPLEX DIAG	2.2200	8.4	28
125	5	MED	CIRCULATORY DISORDERS EXC AMI,WITH CARD CATH W/O COMPLEX DIAG	1.6455	5.0	25
126	5	MED	ACUTE + SUBACUTE ENDOCARDITIS	2.6645	18.4	38
127	5	MED	HEART FAILURE + SHOCK	1.0408	7.8	28
128	5	MED	DEEP VEIN THROMBOPHLEBITIS	.8639	9.6	28
129	5	MED	CARDIAC ARREST	1.5506	4.6	25
130	5	MED	PERIPHERAL VASCULAR DISORDERS AGE >69 AND/OR C.C.	.9645	7.1	27
131	5	MED	PERIPHERAL VASCULAR DISORDERS AGE <70 W/O C.C.	.9451	6.4	26
132	5	MED	ATHEROSCLEROSIS AGE >69 AND/OR C.C.	.9182	6.7	27
133	5	MED	ATHEROSCLEROSIS AGE <70 W/O C.C.	.8599	5.2	25
134	5	MED	HYPERTENSION	.7049	6.1	26
135	5	MED	CARDIAC CONGENITAL + VALVULAR DISORDERS AGE >69 AND/OR C.C.	.9922	6.1	26

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LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC MEAN LENGTH OF STAY, AND LENGTH OF STAY OUTLIER CUTOFF POINTS USED IN THE PROSPECTIVE PAYMENT SYSTEM

DRG	MDC		TITLE	RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER CUTOFFS
136	5	MED	CARDIAC CONGENITAL + VALVULAR DISORDERS AGE 18-69 W/O C.C.	.9674	4.9	25
137	5	MED	* CARDIAC CONGENITAL + VALVULAR DISORDERS AGE 0-17	.6381	3.3	20
138	5	MED	CARDIAC ARRHYTHMIA + CONDUCTION DISORDERS AGE >69 AND/OR C.C.	.9297	5.7	26
139	5	MED	CARDIAC ARRHYTHMIA + CONDUCTION DISORDERS AGE <70 W/O C.C.	.8303	4.8	23
140	5	MED	ANGINA PECTORIS	.7548	5.5	21
141	5	MED	SYNCOPE + COLLAPSE AGE >69 AND/OR C.C.	.6475	5.0	21
142	5	MED	SYNCOPE + COLLAPSE AGE <70 W/O C.C.	.5680	4.3	18
143	5	MED	CHEST PAIN	.6814	4.4	19
144	5	MED	OTHER CIRCULATORY DIAGNOSES WITH C.C.	1.1267	7.0	27
145	5	MED	OTHER CIRCULATORY DIAGNOSES W/O C.C.	1.0020	6.4	26
146	6	SURG	RECTAL RESECTION AGE >69 AND/OR C.C.	2.7082	19.1	39
147	6	SURG	RECTAL RESECTION AGE <70 W/O C.C.	2.5087	17.9	38
148	6	SURG	MAJOR SMALL + LARGE BOWEL PROCEDURES AGE >69 AND/OR C.C.	2.5493	17.0	37
149	6	SURG	MAJOR SMALL + LARGE BOWEL PROCEDURES AGE <70 W/O C.C.	2.2154	15.2	35
150	6	SURG	PERITONEAL ADHESIOLYSIS AGE >69 AND/OR C.C.	2.3746	15.3	35
151	6	SURG	PERITONEAL ADHESIOLYSIS AGE <70 W/O C.C.	2.0274	13.4	33
152	6	SURG	MINOR SMALL + LARGE BOWEL PROCEDURES AGE >69 AND/OR C.C.	1.4851	10.6	31
153	6	SURG	MINOR SMALL + LARGE BOWEL PROCEDURES AGE <70 W/O C.C.	1.2599	9.3	29
154	6	SURG	STOMACH, ESOPHAGEAL + DUODENAL PROCEDURES AGE >69 AND/OR C.C.	2.6901	14.8	35
155	6	SURG	STOMACH, ESOPHAGEAL + DUODENAL PROCEDURES AGE 18-69 W/O C.C.	2.3336	13.0	33
156	6	SURG	* STOMACH, ESOPHAGEAL + DUODENAL PROCEDURES AGE 0-17	.8470	6.0	20
157	6	SURG	ANAL PROCEDURES AGE >69 AND/OR C.C.	.7985	6.0	25
158	6	SURG	ANAL PROCEDURES AGE <70 W/O C.C.	.6408	5.2	19
159	6	SURG	HERNIA PROCEDURES EXCEPT INGUINAL + FEMORAL AGE >69 AND/OR C.C.	.9297	7.1	23
160	6	SURG	HERNIA PROCEDURES EXCEPT INGUINAL + FEMORAL AGE 18-69 W/O C.C.	.7676	6.0	18
161	6	SURG	INGUINAL + FEMORAL HERNIA PROCEDURES AGE >69 AND/OR C.C.	.7068	5.7	16
162	6	SURG	INGUINAL + FEMORAL HERNIA PROCEDURES AGE 18-69 W/O C.C.	.5854	4.8	12
163	6	SURG	* HERNIA PROCEDURES AGE 0-17	.4358	2.1	6
164	6	SURG	APPENDECTOMY WITH COMPLICATED PRINC. DIAG AGE>69 AND/OR C.C.	1.8320	11.9	32
165	6	SURG	APPENDECTOMY WITH COMPLICATED PRINC. DIAG AGE <70 W/O C.C.	1.6154	11.3	29
166	6	SURG	APPENDECTOMY W/O COMPLICATED PRINC. DIAG AGE >69 AND/OR C.C.	1.4328	9.4	29
167	6	SURG	APPENDECTOMY W/O COMPLICATED PRINC. DIAG AGE <70 W/O C.C.	1.0818	7.4	22
168	6	SURG	PROCEDURES ON THE MOUTH AGE >69 AND/OR C.C.	.8631	4.3	24
169	6	SURG	PROCEDURES ON THE MOUTH AGE <70 W/O C.C.	.8992	4.2	24
170	6	SURG	OTHER DIGESTIVE SYSTEM PROCEDURES AGE >69 AND/OR C.C.	2.6602	14.6	35
171	6	SURG	OTHER DIGESTIVE SYSTEM PROCEDURES AGE <70 W/O C.C.	2.3976	13.3	33
172	6	MED	DIGESTIVE MALIGNANCY AGE >69 AND/OR C.C.	1.2268	8.2	28
173	6	MED	DIGESTIVE MALIGNANCY AGE <70 W/O C.C.	1.0517	6.7	27
174	6	MED	G.I. HEMORRHAGE AGE >69 AND/OR C.C.	.9281	6.7	27
175	6	MED	G.I. HEMORRHAGE AGE <70 W/O C.C.	.8236	5.8	24
176	6	MED	COMPLICATED PEPTIC ULCER	1.2438	8.1	28
177	6	MED	UNCOMPLICATED PEPTIC ULCER >69 AND/OR C.C.	.7422	6.6	24
178	6	MED	UNCOMPLICATED PEPTIC ULCER <70 W/O C.C.	.6141	5.5	20
179	6	MED	INFLAMMATORY BOWEL DISEASE	1.0153	8.0	28
180	6	MED	G.I. OBSTRUCTION AGE >69 AND/OR C.C.	.8197	6.2	26

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DRG	MDC		TITLE	RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER CUTOFFS
181	6	MED	G.I. OBSTRUCTION AGE <70 W/O C.C.	.7845	5.9	26
182	6	MED	ESOPHAGITIS,GASTRCENT.+ MISC. DIGEST. DIS AGE >69 +/OR C.C.	.6185	5.4	22
183	6	MED	ESOPHAGITIS,GASTRCENT.+ MISC. DIGEST. DIS AGE 18-69 W/O C.C.	.5652	4.8	19
184	6	MED	* ESOPHAGITIS, GASTROENTERITIS + MISC. DIGEST. DISORDERS AGE 0-17	.3822	3.3	11
185	6	MED	DENTAL + CRAL DIS. EXC EXTRACTIONS + RESTORATIONS,AGE >17	.6681	4.2	24
186	6	MED	* DENTAL + CRAL DIS. EXC EXTRACTIONS + RESTORATIONS,AGE 0-17	.4155	2.9	11
187	6	MED	DENTAL EXTRACTIONS + RESTORATIONS	.3990	2.7	8
188	6	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >69 AND/OR C.C.	.7444	5.1	25
189	6	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE 18-69 W/O C.C.	.6576	4.5	23
190	6	MED	* OTHER DIGESTIVE SYSTEM DIAGNOSES AGE 0-17	.3379	2.1	8
191	7	SURG	MAJOR PANCREAS, LIVER + SHUNT PROCEDURES	4.1791	20.8	41
192	7	SURG	* MINOR PANCREAS, LIVER + SHUNT PROCEDURES	3.9197	20.1	40
193	7	SURG	BILIARY TRACT PROC EXC TOT CHOLECYSTECTOMY AGE >69 +/OR C.C.	2.4513	17.3	37
194	7	SURG	BILIARY TRACT PROC EXC TOT CHOLECYSTECTOMY AGE <70 W/O C.C.	1.9881	13.9	34
195	7	SURG	** TOTAL CHOLECYSTECTOMY WITH C.D.E. AGE >69 AND/OR C.C.	2.1690	16.8	36
196	7	SURG	** TOTAL CHOLECYSTECTOMY WITH C.D.E. AGE <70 W/O C.C.	2.0594	15.8	36
197	7	SURG	** TOTAL CHOLECYSTECTOMY W/O C.D.E. AGE >69 AND/OR C.C.	1.4868	11.5	29
198	7	SURG	** TOTAL CHOLECYSTECTOMY W/O C.D.E. AGE <70 W/O C.C.	1.2752	10.1	24
199	7	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR MALIGNANCY	2.4574	17.9	38
200	7	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR NON-MALIGNANCY	2.5818	15.1	35
201	7	SURG	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES	2.7291	16.9	37
202	7	MED	CIRRHOSIS + ALCOHOLIC HEPATITIS	1.1965	9.3	29
203	7	MED	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS	1.0937	8.0	28
204	7	MED	DISORDERS OF PANCREAS EXCEPT MALIGNANCY	.9682	7.5	28
205	7	MED	DISORDERS OF LIVER EXC MALIG,CIRR,ALC HEPA AGE >69 AND/OR C.C.	1.0822	7.9	28
206	7	MED	DISORDERS OF LIVER EXC MALIG,CIRR,ALC HEPA AGE <70 W/O C.C.	.9247	6.8	27
207	7	MED	DISORDERS OF THE BILIARY TRACT AGE >69 AND/OR C.C.	.8492	6.6	27
208	7	MED	DISORDERS OF THE BILIARY TRACT AGE <70 W/O C.C.	.7315	5.5	24
209	8	SURG	MAJOR JOINT PROCEDURES	2.2912	17.1	37
210	8	SURG	HIP + FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >69 AND/OR C.C.	2.0833	17.8	38
211	8	SURG	HIP + FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 18-69 W/O C.C.	1.9530	15.9	36
212	8	SURG	* HIP + FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 0-17	1.7132	11.1	31
213	8	SURG	AMPUTATIONS FOR MUSCULOSKELETAL SYSTEM + CONN. TISSUE DISORDERS	2.1315	14.3	34
214	8	SURG	BACK + NECK PROCEDURES AGE >69 AND/OR C.C.	1.8427	15.6	36
215	8	SURG	BACK + NECK PROCEDURES AGE <70 W/O C.C.	1.4920	13.8	33
216	8	SURG	BIOPSIES OF MUSCULOSKELETAL SYSTEM + CONNECTIVE TISSUE	1.5596	11.3	31
217	8	SURG	WND DEBRIC + SKN GRFT EXC HAND,FOR MUSCSKELETAL + CONN.TISS.DIS	2.2824	13.1	33
218	8	SURG	LOWER EXTREM + HUMER PROC EXC HIP,FOOT,FEMUR AGE >69 +/OR C.C.	1.4250	10.9	31
219	8	SURG	LOWER EXTREM + HUMER PROC EXC HIP,FOOT,FEMUR AGE 18-69 W/O C.C.	1.0790	8.3	27
220	8	SURG	* LOWER EXTREM + HUMER PROC EXC HIP,FOOT,FEMUR AGE 0-17	.9339	5.3	25
221	8	SURG	KNEE PROCEDURES AGE >69 AND/OR C.C.	1.2727	8.3	28
222	8	SURG	KNEE PROCEDURES AGE <70 W/O C.C.	.9897	6.4	26
223	8	SURG	UPPER EXTREMITY PROC EXC HUMERUS + HAND AGE >69 AND/OR C.C.	1.0723	6.9	27
224	8	SURG	UPPER EXTREMITY PROC EXC HUMERUS + HAND AGE <70 W/O C.C.	.8952	5.6	24
225	8	SURG	FOOT PROCEDURES	.6476	4.8	15

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DRG	MDC	TITLE	RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER CUTOFFS
226	8 SURG	SOFT TISSUE PROCEDURES AGE >69 AND/OR C.C.	.7984	5.1	25
227	8 SURG	SOFT TISSUE PROCEDURES AGE <70 W/O C.C.	.6337	4.2	18
228	8 SURG	GANGLION (HAND) PROCEDURES	.3626	2.2	7
229	8 SURG	HAND PROCEDURES EXCEPT GANGLION	.5998	3.4	14
230	8 SURG	LOCAL EXCISION + REMOVAL OF INT FIX DEVICES OF HIP + FEMUR	1.3594	8.9	29
231	8 SURG	LOCAL EXCISION + REMOVAL OF INT FIX DEVICES EXCEPT HIP + FEMUR	.9519	5.3	25
232	8 SURG	ARTHROSCOPY	.6063	3.6	15
233	8 SURG	OTHER MUSCULOSKELET SYS + CONN TISS O.R. PROC AGE >69 +/OR C.C.	1.7737	13.1	33
234	8 SURG	OTHER MUSCULOSKELET SYS + CONN TISS O.R. PROC AGE <70 W/O C.C.	1.2454	8.2	28
235	8 MED	FRACTURES OF FEMUR	1.7586	13.6	34
236	8 MED	FRACTURES OF HIP + PELVIS	1.3855	11.9	32
237	8 MED	SPRAINS, STRAINS, + DISLOCATIONS OF HIP, PELVIS + THIGH	.7929	6.4	26
238	8 MED	OSTEOMYELITIS	1.5511	12.3	32
239	8 MED	PATHOLOGICAL FRACTURES + MUSCULOSKELETAL + CONN.TISS.MALIGNANCY	1.0979	9.2	29
240	8 MED	CONNECTIVE TISSUE DISORDERS AGE >69 AND/OR C.C.	.9709	8.6	29
241	8 MED	CONNECTIVE TISSUE DISORDERS AGE <70 W/O C.C.	.9048	8.0	28
242	8 MED	SEPTIC ARTHRITIS	1.5880	11.2	31
243	8 MED	MEDICAL BACK PROBLEMS	.7551	7.5	28
244	8 MED	BONE DISEASES + SEPTIC ARTHROPATHY AGE >69 AND/OR C.C.	.7792	7.5	28
245	8 MED	BONE DISEASES + SEPTIC ARTHROPATHY AGE <70 W/O C.C.	.7177	6.3	26
246	8 MED	NON-SPECIFIC ARTHROPATHIES	.7147	6.8	27
247	8 MED	SIGNS + SYMPTOMS OF MUSCULOSKELETAL SYSTEM + CONN TISSUE	.6559	5.8	26
248	8 MED	TENDONITIS, MYOSITIS + BURSITIS	.6136	5.4	24
249	8 MED	AFTERCARE, MUSCULOSKELETAL SYSTEM + CONNECTIVE TISSUE	1.0203	7.6	28
250	8 MED	FX,SPRNS,STRNS + DISL OF FOREARM,HAND,FOOT AGE >69 +/OR C.C.	.7428	6.0	26
251	8 MED	FX,SPRNS,STRNS + DISL OF FOREARM,HAND,FOOT AGE 18-69 W/O C.C.	.5964	4.2	24
252	8 MED	* FX,SPRNS,STRNS + DISL OF FOREARM,HAND,FOOT AGE 0-17	.3533	1.8	7
253	8 MED	FX,SPRNS,STRNS + DISL OF UPARM,LOWLEG EX FOOT AGE >69 +/OR C.C.	.7466	6.6	27
254	8 MED	FX,SPRNS,STRNS + DISL OF UPARM,LOWLEG EX FOOT AGE 18-69 W/O C.C.	.6258	5.3	25
255	8 MED	* FX,SPRNS,STRNS + DISL OF UPARM,LOWLEG EX FOOT AGE 0-17	.4687	2.9	15
256	8 MED	OTHER DIAGNOSES OF MUSCULOSKELETAL SYSTEM + CONNECTIVE TISSUE	.8706	6.5	27
257	9 SURG	TOTAL MASTECTOMY FOR MALIGNANCY AGE >69 AND/OR C.C.	1.1085	9.3	23
258	9 SURG	TOTAL MASTECTOMY FOR MALIGNANCY AGE <70 W/O C.C.	1.0729	8.9	21
259	9 SURG	SUBTOTAL MASTECTOMY FOR MALIGNANCY AGE >69 AND/OR C.C.	1.0141	7.4	27
260	9 SURG	SUBTOTAL MASTECTOMY FOR MALIGNANCY AGE <70	.9325	6.4	26
261	9 SURG	BREAST PROC FOR NON-MALIG EXCEPT BIOPSY + LOC EXC	.7329	4.8	19
262	9 SURG	BREAST BIOPSY + LOCAL EXCISION FOR NON-MALIGNANCY	.4617	3.0	10
263	9 SURG	SKIN GRAFTS FOR SKIN ULCER OR CELLULITIS AGE >69 AND/OR C.C.	2.4737	21.3	41
264	9 SURG	SKIN GRAFTS FOR SKIN ULCER OR CELLULITIS AGE <70 W/O C.C.	2.2031	18.2	38
265	9 SURG	* SKIN GRAFTS EXCEPT FOR SKIN ULCER OR CELLULITIS WITH C.C.	1.4959	8.6	29
266	9 SURG	SKIN GRAFTS EXCEPT FOR SKIN ULCER OR CELLULITIS W/O C.C.	.9485	5.9	26
267	9 SURG	PERIANAL + PILONIDAL PROCEDURES	.6113	5.0	18
268	9 SURG	SKIN,SUBCUTANEOUS TISSUE + BREAST PLASTIC PROCEDURES	.5388	3.0	15
269	9 SURG	OTHER SKIN, SUBCUT TISS + BREAST O.R. PROC AGE >69 +/OR C.C.	.9947	5.7	26
270	9 SURG	OTHER SKIN, SUBCUT TISS + BREAST O.R. PROC AGE <70 W/O C.C.	.8123	4.5	25

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DRG	MDC		TITLE	RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER CUTOFFS
271	9	MED	SKIN ULCERS	1.3802	12.1	32
272	9	MED	MAJOR SKIN DISORDERS AGE >69 AND/OR C.C.	.8620	7.8	28
273	9	MED	MAJOR SKIN DISORDERS AGE <70 W/O C.C.	.8286	7.3	27
274	9	MED	MALIGNANT BREAST DISORDERS AGE >69 AND/OR C.C.	1.0108	7.5	28
275	9	MED	MALIGNANT BREAST DISORDERS AGE <70 W/O C.C.	.9014	6.4	26
276	9	MED	NON-MALIGANT BREAST DISORDERS	.6066	4.2	22
277	9	MED	CELLULITIS AGE >69 AND/OR C.C.	.8863	8.3	28
278	9	MED	CELLLLITIS AGE 18-69 W/O C.C.	.8096	7.2	27
279	9	MED	* CELLULITIS AGE 0-17	.4789	4.2	13
280	9	MED	TRAUMA TO THE SKIN, SUBCUT TISS + BREAST AGE >69 +/OR C.C.	.6201	5.4	25
281	9	MED	TRAUMA TO THE SKIN, SUBCUT TISS + BREAST AGE 18-69 W/O C.C.	.5377	4.2	23
282	9	MED	* TRAUMA TO THE SKIN, SUBCUT TISS + BREAST AGE 0-17	.3460	2.2	9
283	9	MED	MINOR SKIN DISORDERS AGE >69 AND/OR C.C.	.6394	5.3	25
284	9	MED	MINOR SKIN DISORDERS AGE <70 W/O C.C.	.5971	4.4	24
285	10	SURG	AMPUTATIONS FOR ENDOCRINE,NUTRITIONAL + METABOLIC DISORDERS	2.8658	24.0	44
286	10	SURG	* ADRENAL + PITUITARY PROCEDURES	2.8952	16.1	36
287	10	SURG	SKIN GRAFTS + WOUND DEBRIDE FOR ENDOC,NUTRIT + METAB DISORDERS	2.8143	22.8	43
288	10	SURG	* C.R. PROCEDURES FOR OBESITY	1.5695	10.0	24
289	10	SURG	PARATHYROID PROCEDURES	1.3736	8.3	28
290	10	SURG	THYROID PROCEDURES	.8549	6.0	17
291	10	SURG	* THYROGLOSSAL PROCEDURES	.4909	2.9	8
292	10	SURG	OTHER ENDOCRINE, NUTRIT + METAB O.R. PROC AGE >69 +/OR C.C.	2.0307	10.8	31
293	10	SURG	* OTHER ENDOCRINE, NUTRIT + METAB O.R. PROC AGE <70 W/O C.C.	1.4951	8.0	28
294	10	MED	DIABETES AGE =>36	.8087	7.7	28
295	10	MED	DIABETES AGE 0-35	.7457	5.6	26
296	10	MED	NUTRITIONAL + MISC. METABOLIC DISORDERS AGE >69 AND/OR C.C.	.8979	7.3	27
297	10	MED	NUTRITIONAL + MISC. METABOLIC DISORDERS AGE 18-69 W/O C.C.	.7923	6.0	26
298	10	MED	* NUTRITIONAL + MISC. METABOLIC DISORDERS AGE 0-17	.7538	5.4	25
299	10	MED	INBORN ERRORS OF METABOLISM	.9407	6.8	27
300	10	MED	ENDOCRINE DISORDERS AGE >69 AND/OR C.C.	.9731	7.8	28
301	10	MED	ENDOCRINE DISORDERS AGE <70 W/O C.C.	.8143	6.4	26
302	11	SURG	KIDNEY TRANSPLANT	6.6322	24.1	44
303	11	SURG	KIDNEY,URETER + MAJOR BLADDER PROCEDURE FOR NEOPLASM	2.5397	16.2	36
304	11	SURG	KIDNEY,URETER + MAJ BLDR PROC FOR NON-MALIG AGE >69 +/OR C.C.	1.7952	12.8	33
305	11	SURG	KIDNEY,URETER + MAJ BLDR PROC FOR NON-MALIG AGE <70 W/O C.C.	1.7043	11.9	32
306	11	SURG	PROSTATECTOMY AGE >69 AND/OR C.C.	1.1399	8.6	29
307	11	SURG	PROSTATECTOMY AGE <70 W/O C.C.	.9513	7.2	26
308	11	SURG	MINOR BLADDER PROCEDURES AGE >69 AND/OR C.C.	1.0441	7.1	27
309	11	SURG	MINOR BLADDER PROCEDURES AGE <70 W/O C.C.	.9290	5.7	26
310	11	SURG	TRANSURETHRAL PROCEDURES AGE >69 AND/OR C.C.	.7071	4.9	20
311	11	SURG	TRANSURETHRAL PROCEDURES AGE <70 W/O C.C.	.5871	4.1	15
312	11	SURG	URETHRAL PROCEDURES, AGE >69 AND/OR C.C.	.7424	5.2	22
313	11	SURG	URETHRAL PROCEDURES, AGE 18-69 W/O C.C.	.6857	5.1	21
314	11	SURG	* URETHRAL PROCEDURES, AGE 0-17	.4368	2.3	11
315	11	SURG	OTHER KIDNEY + URINARY TRACT O.R. PROCEDURES	2.4884	9.8	30

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*** DRGS 469 AND 470 CONTAIN CASES WHICH COULD NOT BE ASSIGNED TO VALID DRGS.

LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC MEAN LENGTH OF STAY, AND LENGTH OF STAY OUTLIER CUTOFF POINTS USED IN THE PROSPECTIVE PAYMENT SYSTEM

DRG	MDC		TITLE	RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER CUTOFFS
316	11	MED	RENAL FAILURE W/O DIALYSIS	1.3314	6.7	27
317	11	MED	* RENAL FAILURE WITH DIALYSIS	.2385	1.2	3
318	11	MED	KIDNEY + URINARY TRACT NEOPLASMS AGE >69 AND/OR C.C.	.9142	5.5	26
319	11	MED	KIDNEY + URINARY TRACT NEOPLASMS AGE <70 W/O C.C.	.7942	4.2	24
320	11	MED	KIDNEY + URINARY TRACT INFECTIONS AGE >69 AND/OR C.C.	.8123	7.0	27
321	11	MED	KIDNEY + URINARY TRACT INFECTIONS AGE 18-69 W/C C.C.	.6803	5.6	23
322	11	MED	* KIDNEY + URINARY TRACT INFECTIONS AGE 0-17	.4553	3.7	13
323	11	MED	URINARY STONES AGE >69 AND/OR C.C.	.7131	4.9	25
324	11	MED	URINARY STONES AGE <70 W/O C.C.	.5472	3.9	19
325	11	MED	KIDNEY + URINARY TRACT SIGNS + SYMPTOMS AGE >69 AND/OR C.C.	.7247	5.4	25
326	11	MED	KIDNEY + URINARY TRACT SIGNS + SYMPTOMS AGE 18-69 W/O C.C.	.5875	4.3	21
327	11	MED	* KIDNEY + URINARY TRACT SIGNS + SYMPTOMS AGE 0-17	.5027	3.1	14
328	11	MED	URETHRAL STRICTURE AGE >69 AND/OR C.C.	.6508	4.8	22
329	11	MED	URETHRAL STRICTURE AGE 18-69 W/O C.C.	.5326	3.9	17
330	11	MED	* URETHRAL STRICTURE AGE 0-17	.2817	1.6	5
331	11	MED	OTHER KIDNEY + URINARY TRACT DIAGNOSES AGE >69 AND/OR C.C.	.8919	6.3	26
332	11	MED	OTHER KIDNEY + URINARY TRACT DIAGNOSES AGE 18-69 W/O C.C.	.7763	5.8	25
333	11	MED	* OTHER KIDNEY + URINARY TRACT DIAGNOSES AGE 0-17	.5146	3.2	18
334	12	SURG	MAJOR MALE PELVIC PROCEDURES WITH C.C.	1.5612	12.7	38
335	12	SURG	MAJOR MALE PELVIC PROCEDURES W/O C.C.	1.3590	11.8	29
336	12	SURG	TRANSURETHRAL PROSTATECTOMY AGE >69 AND/OR C.C.	1.0079	8.4	22
337	12	SURG	TRANSURETHRAL PROSTATECTOMY AGE <70 W/O C.C.	.8491	7.2	17
338	12	SURG	TESTES PROCEDURES, FOR MALIGNANCY	.9069	6.3	26
339	12	SURG	TESTES PROCEDURES, NON-MALIGNANT AGE >17	.6093	4.5	15
340	12	SURG	* TESTES PROCEDURES, NON-MALIGNANT AGE 0-17	.4381	2.4	7
341	12	SURG	PENIS PROCEDURES	.9983	6.0	23
342	12	SURG	CIRCUMCISION AGE >17	.4228	2.8	10
343	12	SURG	* CIRCUMCISION AGE 0-17	.3828	1.7	4
344	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROCEDURES FOR MALIGNANCY	1.1204	7.4	27
345	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXCEPT FOR MALIG	.8334	5.6	26
346	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, AGE >69 AND/OR C.C.	.9395	6.9	27
347	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, AGE <70 W/C C.C.	.8304	5.7	26
348	12	MED	BENIGN PROSTATIC HYPERTROPHY AGE >69 AND/OR C.C.	.8864	6.2	26
349	12	MED	BENIGN PROSTATIC HYPERTROPHY AGE <70 W/O C.C.	.6998	4.9	22
350	12	MED	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM	.6096	5.2	20
351	12	MED	* STERILIZATION, MALE	.2655	1.3	3
352	12	MED	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES	.6385	4.4	20
353	13	SURG	PELVIC EVISCERATION, RADICAL HYSTERECTOMY + VULVECTOMY	1.9376	12.4	32
354	13	SURG	NON-RADICAL HYSTERECTOMY AGE >69 AND/OR C.C.	1.1108	9.6	20
355	13	SURG	NON-RADICAL HYSTERECTOMY AGE <70 W/C C.C.	1.0156	8.8	17
356	13	SURG	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES	.8460	8.1	18
357	13	SURG	UTERUS + ADNEXA PROCEDURES, FOR MALIGNANCY	1.9188	13.9	34
358	13	SURG	UTERUS + ADNEXA PROC FOR NON-MALIGNANCY EXCEPT TUBAL INTERRUPT	1.0890	8.0	28
359	13	SURG	* TUBAL INTERRUPTION FOR NON-MALIGNANCY	.4279	2.3	7
360	13	SURG	VAGINA, CERVIX + VULVA PROCEDURES	.5985	4.2	19

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DRG	MDC		TITLE	RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER CUTOFFS
361	13	SURG	* LAPAROSCOPY & ENDOSCOPY (FEMALE) EXCEPT TUBAL INTERRUPTION	.4864	2.6	10
362	13	SURG	* LAPAROSCOPIC TUBAL INTERRUPTION	.3126	1.4	5
363	13	SURG	D&C,CONIZATION & RADIO-IMPLANT, FOR MALIGNANCY	.6516	4.3	18
364	13	SURG	D&C,CONIZATION EXCEPT FOR MALIGNANCY	.4028	2.6	9
365	13	SURG	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES	1.7965	12.7	33
366	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM AGE >69 AND/OR C.C.	.8444	5.2	25
367	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM AGE <70 W/O C.C.	.5786	3.5	24
368	13	MED	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM	.7944	6.7	27
369	13	MED	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS	.6959	5.1	25
370	14	SURG	* CESAREAN SECTION WITH C.C.	.9912	7.6	15
371	14	SURG	* CESAREAN SECTION W/O C.C.	.7535	6.1	10
372	14	MED	* VAGINAL DELIVERY WITH COMPLICATING DIAGNOSES	.5534	3.8	9
373	14	MED	VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	.4063	3.2	9
374	14	SURG	* VAGINAL DELIVERY WITH STERILIZATION AND/OR D&C	.5492	3.6	7
375	14	SURG	* VAGINAL DELIVERY WITH O.R. PROC EXCEPT STERIL AND/OR D&C	.6889	4.4	15
376	14	MED	* POSTPARTUM DIAGNOSES W/O O.R. PROCEDURE	.4158	2.9	10
377	14	SURG	* POSTPARTUM DIAGNOSES WITH O.R. PROCEDURE	.4761	2.2	8
378	14	MED	* ECTOPIC PREGNANCY	.8094	5.5	11
379	14	MED	* THREATENED ABORTION	.3169	2.2	8
380	14	MED	* ABORTION W/O D&C	.2705	1.5	4
381	14	MED	* ABORTION WITH D&C	.3602	1.4	4
382	14	MED	* FALSE LABOR	.1842	1.2	2
383	14	MED	* OTHER ANTEPARTUM DIAGNOSES WITH MEDICAL COMPLICATIONS	.4317	3.4	14
384	14	MED	* OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS	.3245	2.2	9
385	15		* NEONATES, DIED OR TRANSFERRED	.6883	1.8	14
386	15		* EXTREME IMMATURITY, NEONATE	3.6863	17.9	38
387	15		** PREMATURITY WITH MAJOR PROBLEMS	1.8459	13.3	33
388	15		** PREMATURITY W/O MAJOR PROBLEMS	1.1693	8.6	29
389	15		* FULL TERM NEONATE WITH MAJOR PROBLEMS	.5482	4.7	16
390	15		* NEONATES WITH OTHER SIGNIFICANT PROBLEMS	.3523	3.4	9
391	15		* NORMAL NEWBORNS	.2241	3.1	7
392	16	SURG	SPLENECTOMY AGE >17	2.7746	16.4	36
393	16	SURG	* SPLENECTOMY AGE 0-17	1.5366	9.1	29
394	16	SURG	OTHER O.R. PROCEDURES OF THE BLOOD & BLOOD FORMING ORGANS	1.1146	6.1	26
395	16	MED	RED BLOOD CELL DISORDERS AGE >17	.7839	6.1	26
396	16	MED	* RED BLOOD CELL DISORDERS AGE 0-17	.6295	4.1	18
397	16	MED	COAGULATION DISORDERS	.9863	6.7	27
398	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS AGE >69 AND/OR C.C.	.8900	6.1	26
399	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS AGE <70 W/O C.C.	.8459	5.6	26
400	17	SURG	LYMPHOMA OR LEUKEMIA WITH MAJOR O.R. PROCEDURE	2.8272	16.9	37
401	17	SURG	LYMPHOMA OR LEUKEMIA WITH MINOR O.R. PROC AGE >69 AND/OR C.C.	1.2409	8.9	29
402	17	SURG	* LYMPHOMA OR LEUKEMIA WITH MINOR O.R. PROCEDURE AGE <70 W/O C.C.	1.1316	7.1	27
403	17	MED	LYMPHOMA OR LEUKEMIA AGE >69 AND/OR C.C.	1.1715	7.1	27
404	17	MED	LYMPHOMA OR LEUKEMIA AGE 18-69 W/O C.C.	1.1787	6.4	26
405	17	MED	* LYMPHOMA OR LEUKEMIA AGE 0-17	1.0517	4.9	25

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DRG	MDC		TITLE	RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER CUTOFFS
406	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPLASM W MAJ O.R.PROC + C.C.	2.2671	15.0	35
407	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W/O C.C.	2.1366	13.3	33
408	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL WITH MINOR O.R.PROC	1.1389	7.1	27
409	17	MED	* RADIOTHERAPY	.8134	5.7	26
410	17	MED	CHEMOTHERAPY	.3527	2.6	12
411	17	MED	HISTORY OF MALIGNANCY W/O ENDOSCOPY	.7221	4.7	25
412	17	MED	HISTORY OF MALIGNANCY WITH ENDOSCOPY	.3480	2.0	8
413	17	MED	OTHR MYELOPROLIF DISORD OR POORLY DIFF NEOPL DX AGE>69 +/OR C.C	1.0975	7.3	27
414	17	MED	OTHR MYELOPROLIF DISORD OR POORLY DIFF NEOPL DX AGE<70 W/O C.C.	1.0359	6.4	26
415	18	SURG	O.R. PROCEDURE FOR INFECTIOUS + PARASITIC DISEASES	3.0027	15.1	35
416	18	MED	SEPTICEMIA AGE >17	1.5504	9.2	29
417	18	MED	* SEPTICEMIA AGE 0-17	.7152	5.2	20
418	18	MED	POSTOPERATIVE + POST-TRAUMATIC INFECTIONS	.9968	8.4	28
419	18	MED	FEVER OF UNKNOWN ORIGIN AGE >69 AND/OR C.C.	.8628	6.9	27
420	18	MED	FEVER OF UNKNOWN ORIGIN AGE 18-69 W/O C.C.	.8022	6.2	26
421	18	MED	VIRAL ILLNESS AGE >17	.6045	5.4	21
422	18	MED	* VIRAL ILLNESS + FEVER OF UNKNOWN ORIGIN AGE 0-17	.4360	3.2	10
423	18	MED	OTHER INFECTIOUS + PARASITIC DISEASES DIAGNOSES	1.2107	8.8	29
424	19	SURG	O.R. PROCEDURES WITH PRINCIPAL DIAGNOSIS OF MENTAL ILLNESS	2.1938	14.2	34
425	19	MED	ACUTE ADJUST REACT + DISTURBANCES OF PSYCHOSOCIAL DYSFUNCTION	.6812	5.8	26
426	19	MED	DEPRESSIVE NEUROSES	.9495	9.4	29
427	19	MED	NEUROSES EXCEPT DEPRESSIVE	.7678	6.9	27
428	19	MED	DISORDERS OF PERSONALITY + IMPULSE CONTROL	.9741	8.3	28
429	19	MED	ORGANIC DISTURBANCES + MENTAL RETARDATION	.9523	8.8	29
430	19	MED	PSYCHOSES	1.0934	10.8	31
431	19	MED	* CHILDHOOD MENTAL DISORDERS	2.2519	15.4	35
432	19	MED	* OTHER DIAGNOSES OF MENTAL DISORDERS	1.0525	7.2	27
433	20		** SUBSTANCE USE + SUBST INDUCED ORGANIC MENTAL DISORDERS, LEFT AMA	.4457	2.5	17
434	20		** DRUG DEPENDENCE	1.0404	9.1	29
435	20		** DRUG USE EXCEPT DEPENDENCE	1.0738	8.0	28
436	20		** ALCOHOL DEPENDENCE	.8853	8.1	28
437	20		** ALCOHOL USE EXCEPT DEPENDENCE	.6183	3.5	24
438	20		** ALCOHOL + SUBSTANCE INDUCED ORGANIC MENTAL SYNDROME	.8420	6.9	27
439	21	SURG	* SKIN GRAFTS FOR INJURIES	1.8219	8.9	29
440	21	SURG	* WOUND DEBRIDEMENTS FOR INJURIES	1.4807	7.2	27
441	21	SURG	* HAND PROCEDURES FOR INJURIES	.7180	3.0	16
442	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES AGE >69 AND/OR C.C.	1.9026	9.1	29
443	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES AGE <70 W/O C.C.	1.5211	6.6	27
444	21	MED	MULTIPLE TRAUMA AGE >69 AND/OR C.C.	.8830	6.7	27
445	21	MED	MULTIPLE TRAUMA AGE 18-69 W/O C.C.	.7530	5.2	25
446	21	MED	* MULTIPLE TRAUMA AGE 0-17	.4846	2.4	10
447	21	MED	ALLERGIC REACTIONS AGE >17	.4785	3.7	15
448	21	MED	* ALLERGIC REACTIONS AGE 0-17	.3505	2.9	8
449	21	MED	TOXIC EFFECTS OF DRUGS AGE >69 AND/OR C.C.	.7331	5.6	26
450	21	MED	TOXIC EFFECTS OF DRUGS AGE 18-69 W/O C.C.	.5957	3.9	23

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LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC MEAN LENGTH OF STAY, AND LENGTH OF STAY OUTLIER CUTOFF POINTS USED IN THE PROSPECTIVE PAYMENT SYSTEM

DRG	MDC		TITLE	RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER CUTOFFS
451	21	MED	* TOXIC EFFECTS OF DRUGS AGE 0-17	.2912	2.1	8
452	21	MED	COMPLICATIONS OF TREATMENT AGE >69 AND/OR C.C.	.8492	5.5	26
453	21	MED	COMPLICATIONS OF TREATMENT AGE <70 W/O C.C.	.9020	5.1	25
454	21	MED	OTHER INJURIES, POISONINGS & TOXIC EFF DIAG AGE >69 AND/OR C.C.	.8224	5.3	25
455	21	MED	* OTHER INJURIES, POISONINGS & TOXIC EFF DIAG AGE <70 W/O C.C.	.6185	3.5	22
456	22		** BURNS, TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	2.0902	11.6	32
457	22		** EXTENSIVE BURNS	6.8631	12.6	33
458	22	SURG	** NON-EXTENSIVE BURNS WITH SKIN GRAFTS	2.8572	18.3	38
459	22	SURG	** NON-EXTENSIVE BURNS WITH WOUND DEBRIDEMENT & OTHER O.R. PROC	2.7568	12.7	33
460	22	MED	** NON-EXTENSIVE BURNS W/O O.R. PROCEDURE	1.4225	9.0	29
461	23	SURG	O.R. PROC WITH DIAGNOSES OF OTHER CONTACT WITH HEALTH SERVICES	1.6507	8.0	28
462	23	MED	* REHABILITATION	1.8268	13.5	34
463	23	MED	SIGNS & SYMPTOMS WITH C.C.	.7702	6.3	26
464	23	MED	SIGNS & SYMPTOMS W/O C.C.	.7322	6.0	26
465	23	MED	** AFTERCARE WITH HISTORY OF MALIGNANCY AS SECONDARY DX	.2071	1.5	4
466	23	MED	** AFTERCARE W/O HISTORY OF MALIGNANCY AS SECONDARY DX	.6377	3.7	24
467	23	MED	OTHER FACTORS INFLUENCING HEALTH STATUS	.9799	6.1	26
468			UNRELATED OR PROCEDURE	2.1037	11.2	31
469			***PDX INVALID AS DISCHARGE DIAGNOSIS	.0000	.0	0
470			***UNGROUPABLE	.0000	.0	0

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VIII. Technical Explanation of the Budget Neutrality Adjustment Methodology

A. *Overview*

Section 1886(e)(1) of the Act requires that, for Federal fiscal years 1984 and 1985, prospective payments be adjusted so that aggregate payments for the operating costs of inpatient hospital services are neither more nor less than we estimate would have been paid under prior legislation for the costs of the same services. To implement this provision, we are making actuarially determined adjustments to the average standardized amounts used to determine Federal national and regional payment rates and to the updating factors used to determine the hospital-specific per case amounts incorporated in the blended transition payment rates for fiscal years 1984 and 1985. Section 1886(d)(6) of the Act requires that the annual published notice of the methodology, data and rates include an explanation of any budget neutrality adjustments. This section is intended to fulfill that requirement.

In determining the amount of the budget neutrality adjustment factors, we have considered all hospital costs, including pass-through costs such as capital-related and direct medical education costs. However, it should be noted that the *aggregate payments* that will be adjusted to be budget neutral do not include payment for capital-related costs or direct medical education costs, payments for hospital and distinct part unit services excluded from the prospective payment system, payment of a return on equity capital, or payments on a reasonable cost basis to hospitals under the prospective payment system for outpatient services.

The budget neutrality adjustments required by the statute are determined by comparing an estimate of fiscal year 1984 reimbursement per discharge, under the law in effect prior to enactment of Pub. L. 98–21, with an estimate of DRG-related payments per discharge (Federal rates, outlier payments, and payments for the indirect costs of medical education, before budget neutral adjustment) and with an estimate of the hospital-specific payments per discharge (before budget neutral adjustment). Therefore, payment under each of the three systems (reasonable cost reimbursement, Federal rates, and hospital-specific rates) must be estimated separately.

Although, for methodological reasons, the budget neutrality adjustment is calculated on a per discharge basis, it should be emphasized that the ultimate comparison is between the aggregate payments to be made under the prospective payment system and the aggregate payments that would have been incurred under the prior legislation. Therefore, changes in hospital behavior from that which would have occurred in the absence of the prospective payment system are required to be taken into account in determining the budget neutrality adjustment if they affect aggregate payment. For example, any expectation of increased admissions beyond the level that would have occurred under prior law would have to be considered in the adjustment. To assist in making the budget neutrality adjustment for, and take account of, fiscal year 1985, HCFA will monitor for changes in hospital behavior attributable to the new system.

Based on the estimates of projected payments under all three systems, we must derive two budget neutrality adjustment factors for Federal fiscal year 1984. The first such factor will be applied in computing Federal regional rates for cost reporting periods beginning during Federal fiscal year 1984. The second budget neutrality adjustment factor will be applied in computing the updating factors used to determine the hospital-specific portion of transition payment rates for cost reporting periods beginning during that fiscal year.

B. *Assumptions and Data*

The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) established a DRG-adjusted limit on the allowable amount of inpatient operating costs per case and a per case limit on the rate of increase of operating costs of inpatient hospital services. Due to these per case limits, the incentives that influence hospital admission patterns are similar under TEFRA and prospective payment. Accordingly, we have assumed that the number of admissions under both prior law and the prospective payment system will be the same. As a result, the budget neutrality factors can be calculated by comparing reimbursement per discharge for each of the systems, and there is no need to estimate an actual number of hospital admissions.

A hospital will begin receiving payment under the prospective payment system at the beginning of its first cost reporting period starting on or after October 1, 1983. Therefore, most hospitals will not be under the prospective payment system for the entire Federal fiscal year 1984. Hence, the payment per discharge under each of the systems should be estimated only for those portions of hospital cost reporting periods beginning October 1, 1983 or later that overlap Federal fiscal year 1984. To properly compute payment per discharge, total payment is divided by the number of discharges across all hospitals. We developed a distribution of discharges that occur between the start of a hospital's cost reporting period (that starts in Federal fiscal year 1984) and September 30, 1984. This distribution, which was developed from the March 1983 update of the 1982 discharge notice file, was applied to the number of discharges in the hospital's 1981 data. This procedure properly weights the relative sizes of hospitals and cost reporting period distributions for computing payments per discharge.

Since the prospective payment system is to be budget neutral for included hospitals, and since the prospective payment system will not change payments to hospitals that are excluded from that system, excluded hospitals were removed from the determinations (for example, long term care, psychiatric, and children's hospitals). Further, four States (Maryland, Massachusetts, New Jersey, and New York) currently operate alternative reimbursment systems under Medicare waivers. Since payment amounts in these States will not change because of the prospective payment system, hospitals in these States were removed from the determination of payment per discharge under each of the three systems for purposes of determining budget neutrality.

We also assumed that the means of affording exceptions or special treatment for sole community hospitals under different systems would provide comparable relief to those relatively few hospitals that qualify for such exceptions and treatment. Since the amounts of special payments to these hospitals are assumed to be the same under the different systems, the budget neutrality determination is not affected by these payments. Therefore, we did not make explicit allowance for additional payments to these hospitals in our estimates and comparisons.

Section 1881(e)(1) of the Act requires that total payments under the DRG system and under the HSP system be the same as total payments that would have been payable under provisions of the prior law (that is, for fiscal year 1984, the limits that would have been implemented under provisions of TEFRA). To achieve this we have equalized the amounts payable under the Federal rate and HSP systems with those that would have been payable on a periodic basis under TEFRA, not with

the total end-of-year cash amounts. As a result, changes of cash flow, timing of payments, and retroactive payments will not affect the budget neutrality determination.

Operating costs are defined differently under the different systems. We excluded malpractice costs and kidney acquisition costs from operating costs under the TEFRA limits. However, the Federal rate and HSP systems exclude the same kidney acquisition costs but include malpractice costs under operating costs. We must use a method of comparing costs that takes into account "the payment amounts which would have been payable for such services for those same hospitals", as required by law. If we were to compare only the operating costs of the different payment systems we would not fulfill the statutory requirement, since the actual amounts paid are comparable only if we include both operating and nonoperating costs. Hence, nonoperating costs (excluding payments to proprietary hospitals for a return on equity capital) must also be included in the calculation of the budget neutrality adjustment factors. By using total costs, including nonoperating costs, in the comparisons necessary to determine budget neutrality adjustments, we will ensure that the amounts considered under the Federal and hospital-specific rate systems are comparable to amounts payable under prior law.

These comparisons will yield adjustments reflecting differences between the systems in a way that prevents distortions by differing definitions of operating costs. The equations below illustrate that comparing total costs in determining budget neutrality adjustments produces results identical to those that would have been produced using only operating costs under the Federal rate system and comparable costs under the TEFRA system.

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Cost Components under Federal rate and TEFRA systems

Federal rate x budget neutral factor	=	TEFRA operating costs + Malpractice costs
Federal rate x budget neutral factor + (kidney acquisition costs + capital costs + direct medical education costs)	=	TEFRA operating costs + (Malpractice costs + capital costs + kidney acquisition costs + direct medical education costs)
Federal rate x budget neutral factor + Federal system nonoperating costs	=	TEFRA operating costs + TEFRA nonoperating costs

The analysis is identical for the hospital-specific rate system. Note that payments for a return on equity (which are not classified as operating costs) are excluded from the equations. Since the amounts for return on equity differ among the systems, adding in return on equity would unbalance the equations. (Under prior law, which must be reflected in the TEFRA estimates, the rate of return was set at 1.5 times the Hospital Insurance Trust Fund interest rates, whereas under Pub. L. 98–21 the rate of return applicable to the costs related to inpatient hospital services was reduced to 1.0 times that rate.)

C. *Estimated Payment Per Discharge Under Prior Law (TEFRA Limits)*

To estimate payment per discharge under prior law, the TEFRA limits that would have been published must first be determined. These limits are calculated in the same manner as the fiscal year 1983 limits, except that the most recent data available (that is, 1981 cost report and billing data) are used, and the fiscal year 1984 limit is set at 115 percent of the mean, instead of 120 percent of the mean, in accordance with section 1886(a)(1)(A)(ii) of the Act.

To estimate payment per discharge under the TEFRA limits, cost per discharge must be estimated for each hospital and compared to the costs allowable under the TEFRA limits, that is, DRG-adjusted cost per case limits on inpatient operating costs and the separate limit on the rate of increase of those costs. Since the rate of increase target rate percentage is less than the average rate of increase in hospital costs, comparison of the rate of increase target rate percentage to the average rate of increase in hospital costs would lead to the conclusion that all hospitals would be penalized by the rate of increase limit and that no hospital would receive a bonus. (Under section 1886(b)(1) of the Act, a hospital that has per case costs less than its target amount would be paid a bonus of 50 percent of the amount by which the target amount exceeds its cost, or five percent of its target amount, whichever is less. Alternatively, a hospital that has costs in excess of its target amount would, for cost reporting periods beginning in Federal fiscal years 1983 or 1984, be paid only 25 percent of its costs in excess of the target amount.) To overcome this erroneous conclusion, the rate of increase target must be compared to cost increases that vary by hospital.

Hospital cost per discharge data for cost report years 1978, 1979, 1980, and 1981 were analyzed for patterns in rates of increase in costs per discharge. Study found that the statistical distributions of rates of increase in cost per discharge closely fit the normal distribution. Since the second year of TEFRA uses a two-year rate of increase target over the hospital's base year, we analyzed two-year rates of increase and found that a normal distribution with a standard deviation of 12 percent closely approximated the distributions. To compute a hospital's cost per discharge for comparison to the hospital's TEFRA rate-of-increase target amount, the hospital's base year costs were increased by a randomly determined factor. This factor was computed by adding the estimated two-year average rate of increase in cost per case to a random number. This random number is generated from a statistical distribution that is normal with a mean of zero, and has a standard deviation of 12 percent. Further, the random numbers were restricted so that none were further than three standard deviations from the mean. This randomly determined cost per admission for a hospital was compared to the rate of increase limit target amount for determining the reimbursement per discharge under TEFRA. Because of the randomizing process, not all hospitals are shown to be penalized by the targets; hospitals with cost per case over the target amount are shown as receiving one quarter of their excess costs over that limit (in accordance with section 1886(b) of the Act), and some hospitals are shown to receive bonus payments. To measure the overall stability, the model was tested with ten different sets of random numbers and found to be stable.

The cost per discharge that is compared to the TEFRA limits was adjusted by 0.1326 percent before

comparison to the TEFRA limits to account for the shift of certain types of costs to Part A of Medicare because of the regulations on payment for physicians' services to patients and providers, published March 2, 1983. (These rules implement section 1887 of the Act, established by section 108 of TEFRA. (48 FR 8902; 42 CFR 405.480 through 405.482, and 405.550 through 405.556.)) Since this adjustment increases the costs of hospitals below the limits, it will have the effect of raising slightly the estimate on TEFRA payment per discharge.

D. *Estimated Payment on a Federal Rate (DRG) Basis*

The estimated payment per discharge based on DRG-related payments (that is, Federal rates plus outlier payments) was estimated by directly using the adjusted average standardized amounts, adjusted by the applicable wage index, cost of living adjustment (for hospitals in Alaska and Hawaii), and case mix for each hospital. Additional outlier payments were computed using each hospital's historical experience in the MEDPAR file. The payment amounts were further adjusted to include the indirect costs of medical education.

Before the ratio of estimated DRG-related payments to the estimated payments under prior law is computed, the estimated DRG-related payment was increased by 3.38 percent to reflect improvements and greater completeness in the coding of diagnoses and procedures on the bills. This adjustment is necessary because payment will depend on the diagnoses and procedures coded on the bill, and hospitals will have the incentive to be more complete than in the past in reporting diagnoses and procedures.

Hospitals reported diagnoses on the bills that are included in the 1981 MEDPAR data. For a variety of reasons, these diagnoses were not always completely or accurately coded, especially when payment did not depend on the diagnoses coded. Since payments under the prospective system depend on the diagnoses and procedures coded, hospitals will submit complete and accurate data. We studied the differences between bills coded for the MEDPAR and bills coded after medical review. The carefully and completely coded bills were provided from the PSRO Uniform Hospital Discharge Data Set (UHDDS) data base. The data base included about 9 million bills from all States except Nebraska and Texas. The study found that reimbursement under the prospective system using the PSRO data would be 3.38 percent higher than reimbursement using the MEDPAR Data. Since the prospective rates are set using the MEDPAR data, actual reimbursement under the prospective system will be higher than predicted from the MEDPAR data; hence, the factor (3.38 percent) for improvements in diagnostic coding must be used for the budget neutral calculation.

E. *Estimated Hospital-Specific (HSP) Payment Per Discharge*

To properly estimate the payments per discharge based on the hospital-specific rates to be used during the transition period, the hospital's base year cost per case must first be estimated, since actual base year data are not available. To estimate the base year, the 1981 cost report data were adjusted by the change in the nursing differential from 1981 to the base year. These data were updated to the base year and the resulting routine operating costs were compared with the appropriate routine cost limit applicable to base year cost reporting periods, as calculated from the September 30, 1981 **Federal Register** notice, to compute the savings resulting from application of the routine cost limits. Total costs were also reduced by the remainder of the amounts based on the Medicare nursing differential, since section 103 of TEFRA, by amending section 1861(v)(1)(J) of the Act, eliminated this differential effective with services furnished on or after October 1, 1982.

Operating costs were computed by carving out of total costs direct medical education, capital-related, and certain kidney acquisition costs. Operating costs were increased by 0.18 percent and 0.13 percent to adjust, respectively, for the extra estimated costs hospitals will report for their base year because of required coverage of their employees under FICA (as required by section 1886(b)(6) of the Act) and for the requirement that certain services are now required to be paid under Part A of Medicare which were formerly paid under Part B (as required by section 1886(b)(5)(D) of the Act). Operating costs were further increased by 0.1326 percent to account for the shift of certain types of costs to Part A of Medicare because of regulations on payment for physicians' services to patients and providers, published March 2, 1983. (Those rules implement section 1887 of the Act, established by section 108 of TEFRA (48 FR 8902; 42 CFR 405.480 through 405.482, and 405.550 through 405.556.)) The base year operating costs were increased by two years of the market basket index increased by one percentage point for each year. This result was further increased by 3.38 percent to allow for improvements and greater completeness in the coding of diagnoses and procedures. This adjustment, discussed above under the Federal rate system, is necessary because the hospital-specific portion will be adjusted by the DRG weighting factors.

F. Adjustment for Outlier Payments

Sections 1886(d)(2)(E) and (d)(3)(B) of the Act require that the average standardized amounts for the Federal rates be reduced so that, when combined with the outlier payments, the resulting payments will be the same as payments under a DRG-related system with no outlier payments but full standard DRG-adjusted rates.

For cost-reporting periods beginning during Federal fiscal year 1984, transition payment rates will be a blend of 25 percent of the applicable Federal rate and 75 percent of the applicable hospital-specific rate. However, as explained in section III.D. of the preamble to these interim rules, we have decided to pay the full outlier payment for outlier cases, rather than to pay only a percentage equal to the Federal portion percentage of the blended rate. As a result, both the Federal rates and the hospital-specific rates must also be adjusted so that when payments based on them are combined with the outlier payments, the resulting aggregate payments equal the payments from full Federal or hospital-specific rates with no outliers.

The determinations of the outlier payment criteria budget neutrality adjustments was done only with respect to hospitals that will be reimbursed under the prospective payment system, since outlier payments and standard payments under the prospective payment system will not be on behalf of exempt hospitals and hospitals in waiver States. Reimbursement to exempt hospitals and hospitals in waiver States is not changed by the provisions of the prospective payment system.

The outlier criteria were calibrated using experience in the 1981 MEDPAR file so that outlier payments would be 6 percent of standard payments. Since budget neutrality is determined based on total payments, the outlier payments should be compared to total payments (the sum of standard payments and outlier payments). Example: Suppose standard payments are $100 so that the desired outlier payments would be $6. Outlier payments as a percent of total payments would be $6 divided by ($100 + $6) = 5.7 percent.

The outlier adjustment ratio for Federal rates is calculated by dividing

the total estimated payments on the basis of Federal rates by the sum of the Federal rate payments and the outlier payments. The outlier adjustment ratio for hospital-specific rates is calculated by subtracting the outlier payments (as calculated from the DRG-adjusted Federal rates, as adjusted for outlier payments and budget neutrality) from the hospital-specific payments and dividing the result by the hospital-specific payments. The budget neutrality adjustments are applied to the outlier-adjusted Federal rates and the outlier-adjusted hospital-specific rates.

Example: Computation of outlier adjustment ratios of Federal rates and hospital-specific payments

Estimated Values

Federal rate payment per discharge (before outlier adjustment), $3,403.33
Federal rate outlier payment per discharge (before outlier adjustment)*, $207.44
Hospital-specific payment per discharge (before outlier adjustment), $3,348.96

Computation of Federal Rate Outlier Adjustment ($3,403.33 + $207.44) × Federal rate outlier adjustment = $3,403.33
Federal rate outlier adjustment = $3,403.33 ÷ $3,403.33 + $207.44
Federal rate outlier adjustment = .943
Outlier adjusted Federal rate payment per discharge = $3,403.33 × .943 = $3,209.34.

Computation of Adjusted Outlier Payment per Discharge

To compute the HSP outlier adjustment, we must first determine the outlier payment per discharge as adjusted to take into account outlier and budget neutrality adjustments to the Federal rates. The estimated outlier payment used above was derived from unadjusted Federal rates. Since the actual outlier payments are derived from Federal rates that have already been adjusted for outlier payments and to achieve budget neutrality, the outlier payments will also indirectly reflect those adjustments. To take this into account in computing estimated outlier payments, the outlier payment per discharge must be adjusted by the Federal rate outlier adjustment of .943 and the Federal rate budget neutrality adjustment factor of .969. Therefore, the adjusted outlier payment per discharge (as calculated from the adjusted Federal rate) = $207.44 × .943 × .969 = $189.56

Computation of HSP Outlier Adjustment

($3,348.96 × HSP outlier adjustment) + $189.56 = $3,348.96
HSP outlier adjustment = $3,348.96 − $189.56 ÷ $3,348.96
HSP outlier adjustment = .943
Outlier adjusted HSP standard payment per discharge = $3,348.96 × .943 = $3,158.07

G. *Calculation of Budget Neutrality Adjustment Factors*

As noted above, we must compute two budget neutrality adjustment factors—one for adjusting Federal rates and the other for adjusting the updating factors used to determine the hospital-specific rates.

For the Federal rate system, the following equation must be solved:

(Federal standard (outlier adjusted) payment per discharge + Outlier payment per discharge (computed from outlier adjusted Federal rates)) × Federal rate budget neutral factor (FRBN) + Federal rate system nonoperating cost per discharge = TEFRA operating reimbursement per discharge + TEFRA nonoperating cost per discharge.

Example: Computation of Federal Rate Budget Neutrality Adjustment Factor

Estimated Values

TEFRA operating reimbursement per discharge, $3,266.10
TEFRA nonoperating cost per discharge, $350.06
Federal rate standard payment (outlier adjusted) per discharge, $3,209.34
Federal rate outlier payment (based on above number) per discharge, $195.62
Federal nonoperating cost per discharge, $318.28

Solve:
($3,209.34 + $195.62) × FRBN + $318.28 = $3,266.10 + $350.06
$3,404.96 × FRBN + $318.28 = $3,616.16
FRBN = $3,616.16 − $318.28 ÷ $3,404.96
FRBN = .969

For the HSP system, the following must be solved:

(HSP payment per discharge × hospital-specific budget neutral factor (HSBN) + Outlier payment per discharge adjusted for Federal rate budget neutrality + HSP system nonoperating cost per discharge = TEFRA operating reimbursement per discharge + TEFRA nonoperating cost per discharge.

Example: Computation of Hospital-Specific Rate Budget Neutrality Adjustment Factor

Estimated Values

TEFRA operating reimbursement per discharge, $3,266.10
TEFRA nonoperating cost per discharge, $350.06
HSP payment per discharge (outlier adjusted), $3,158.07
HSP outlier payment per discharge (based on outlier adjusted Federal rates), $195.62
HSP nonoperating cost per discharge, $318.28
Federal rate budget neutral factor (FRBN), .969

Solve:
($3,158.07 × HSBN) + ($195.62 × .969) + $318.28 = $3,266.10 + $350.06
($3,158.07 × HSBN) + $507.84 = $3,616.16
HSBN = $3,616.16 − $507.84 ÷ $3,158.07
HSBN = .984

Note that the HSP budget neutral factor is not applied to the outlier payments. Outlier payments are paid in full based on applicable Federal rates, which already incorporate an adjustment for budget neutrality.

Note that payments per discharge were computed at 100 percent for purposes of the budget neutrality calculations. The calculated budget neutrality adjustment factors would be unchanged if computed from Federal rates at 25 percent compared with payments under prior law at 25 percent, and HSP rates at 75 percent compared with prior law payments at 75 percent.

H. SUMMARY—TABLE OF OUTLIER AND BUDGET NEUTRALITY ADJUSTMENT FACTORS—FEDERAL FISCAL YEAR 1984

Adjustment factors	Federal rates	Hospital-specific rates
Outlier	0.943	0.943
Budget neutrality	0.969	0.984

* This payment per discharge was calculated by applying the cost and length-of-stay outlier criteria to the MEDPAR experience and using all discharges, including discharges for which no outlier payments would be made.

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Part V

Department of the Interior

Office of Surface Mining Reclamation and Enforcement

Surface Coal Mining and Reclamation Operations, Permanent Regulatory Program: Postmining Land Uses and Variances From Approximate Original Contour

DEPARTMENT OF THE INTERIOR

Office of Surface Mining Reclamation and Enforcement

30 CFR Parts 701, 785, 816, 817, and 824

Surface Coal Mining and Reclamation Operations, Permanent Regulatory Program: Postmining Land Uses and Variances From Approximate Original Contour

AGENCY: Office of Surface Mining Reclamation and Enforcement, Interior.

ACTION: Final rule.

SUMMARY: The Office of Surface Mining Reclamation and Enforcement (OSM) is adopting revised final rules on postmining land uses and on variances from the requirement to restore disturbed areas to their approximate original contour (AOC). These final rules simplify procedures for approval of alternative postmining land uses and broaden the situations under which variances may be obtained from the requirement to restore affected lands to their AOC. These changes will facilitate reclamation and allow operators to take advantage of unique land use development opportunities provided by surface coal mining and reclamation operations.

EFFECTIVE DATE: October 3, 1983.

FOR FURTHER INFORMATION CONTACT: Charles R. Meyers, Office of Surface Mining, U.S. Department of the Interior, 1951 Constitution Avenue, NW., Washington, DC 20240; 202–343–5587.

SUPPLEMENTARY INFORMATION:

I. Background.
II. Discussion of Rules Adopted and Responses to Comments.
III. Procedural Matters.

I. Background

On April 14, 1982 (47 FR 16152), OSM proposed to amend its permanent program rules regarding allowable postmining land uses and regarding the situations under which variances may be granted from the requirement to restore areas disturbed by surface mining and reclamation operations to AOC. After several extensions the comment period closed on September 10, 1982. These final rules finalize the April 14 proposal.

General Performance Standards

Section 515(b) of the Surface Mining Control and Reclamation Act of 1977, 30 U.S.C. 1201 *et seq.* (the Act), contains a number of minimum general performance standards applicable to all surface coal mining and reclamation operations. Section 515(b)(2) of the Act, pertaining to postmining land conditions and uses, requires an operator to—"restore the land affected to a condition capable of supporting the uses which it was capable of supporting prior to any mining, or higher or better uses of which there is reasonable likelihood, so long as such use or uses do not present any actual or probable hazard to public health or safety or pose any actual or probable threat of water diminution or pollution, and the permit applicants' declared proposed land use following reclamation is not deemed to be impractical or unreasonable, inconsistent with applicable land use policies and plans, involves unreasonable delay in implementation, or is violative of Federal, State, or local law."

Section 515(b)(3) of the Act establishes the general AOC restoration standard and requires the operator to—"backfill, compact (where advisable to insure stability or to prevent leaching of toxic materials), and grade in order to restore the approximate original contour of the land with all highwalls, spoil piles, and depressions eliminated (unless small depressions are needed in order to retain moisture to assist revegetation or as otherwise authorized pursuant to this Act) * * *." [Provisos follow for thin and thick overburden situations.]

Section 516(b)(10) of the Act generally imposes the standards of Section 515 of the Act with regard to the surface effects of underground mining.

The postmining land use rules implementing the performance standards of Section 515(b)(2) of the Act were published originally on March 13, 1979 (44 FR 15312) as 30 CFR 816.133 and 817.133.

The AOC restoration (backfilling and grading) rules implementing Section 515(b)(3) of the Act were published originally on March 13, 1979 (44 FR 15312) as 30 CFR 816.101–816.105 and 817.101–817.103, and revised final rules were published on May 24, 1983 (48 FR 23356) as 30 CFR 816.102, 816.104, 816.105, 816.107, 817.102, and 817.107.

Mountaintop removal

Section 515(c) of the Act permits an exception to the AOC restoration requirement for mountaintop removal operations which, after reclamation, would be capable of supporting specified postmining uses. In such operations, "where an entire coal seam or seams running through the upper fraction of a mountain, ridge, or hill" is removed, the operator is permitted to remove all the overburden and to create "a level plateau or a gently rolling contour with no highwalls remaining" instead of restoring AOC. Such land has to be capable of supporting certain specified postmining uses which include "an industrial, commercial, agricultural, residential, or public facility (including recreational facilities) use." The regulatory authority may grant a permit of this nature if a number of additional specific conditions are also satisfied.

Variances from AOC restoration

Section 515(e) of the Act allows "a variance from the requirement to restore [lands] to approximate original contour * * * for surface mining of coal where the owner of the surface knowingly requests, in writing, as a part of the permit application that such a variance be granted so as to render the land, after reclamation, suitable for an industrial, commercial, residential, or public use (including recreational facilities)." Such variances are allowed "provided that the watershed control of the area is improved; and further provided that backfilling with spoil material * * * cover[s] completely the highwall which material will maintain stability following mining and reclamation."

Specific requirements for a variance under Section 515(e) of the Act are that—

(1) "After consultation with the appropriate land use planning agencies, if any, the potential use of the affected land is deemed to constitute an equal or better economic or public use;"

(2) The potential postmining use "is designed and certified by a qualified registered professional engineer in conformance with professional standards established to assure the stability, drainage, and configuration necessary for the intended use of the site;"

(3) "[A]fter approval of the appropriate state environmental agencies, the watershed of the affected land is deemed to be improved;" and

(4) "[O]nly such amount of spoil will be placed off the mine bench as is necessary to achieve the planned postmining land use, insure stability of the spoil retained on the bench," and all other requirements of the Act.

In *In re: Permanent Surface Mining Regulation Litigation*, Civil Action No. 79–1144 (D.D.C., February 26, 1980), pp. 69–70, U.S. District Court Judge Flannery ruled that the provisions of Section 515(e) of the Act apply only to steep slope mining. That is the position OSM took before the district court in that case. However, upon carefully examining the legislative history of Section 515(e), OSM has reconsidered its previous interpretation of that section and has concluded for the

reasons described in detail under "Discussion of Rules Adopted and Responses to Comments" in this preamble that the variance from AOC allowed under Section 515(e) of the Act is not limited to mining on steep slopes.

The two provisions of the Act allowing for exception to the AOC restoration requirement, Sections 515 (c) and (e), were implemented in the March 13, 1979, rules by 30 CFR 785.14 and Part 824 for mountaintop removal mining operations and by 30 CFR 785.16 and 826.15 for steep slope mining operations.

II. Discussion of Rules Adopted and Responses to Comments

After evaluating the comments received, OSM has adopted the rules substantially as proposed for the reasons discussed in the Federal Register preamble to the proposal. Section 701.5 contains a definition of the new term "higher or better uses" and revisions to the definition of the term "land use." Section 785.16 contains revisions to the permit requirements for variances from AOC restoration requirements. Sections 816.133 and 817.133 contain revisions to the postmining land use performance standards for surface and underground mining activities. Because these two sections are substantially the same, they are discussed together in the preamble. Final §§816.133(d) and 817.133(d) adopt proposed Alternative A for AOC variances. The following is a discussion of the final rules and the comments received in response to proposed revisions to Parts 701, 785, 816, 817, and 826 of 30 CFR Chapter VII.

Section 701.5 "Land use" definition

The definition of the term "land use" in the previous rule emphasized the use or management aspects of a land parcel, rather than the vegetation or cover of the land surface. In addition, 10 categories of use were defined. The discussion of the land use definition in the preamble to the previous rule (44 FR 14933) stated that "[i]n practice, land use categories will only be used to determine if the postmining use has changed from the premining use. A different or alternative use occurs when any change of use occurs." In the April 14, 1982, proposal, OSM proposed only a minor change in the definition that consisted of removing from the land use categories the repetitive language concerning support facilities that are integral with each use and including similar language in the first paragraph of the definition. The definition has been adopted as proposed.

In addition, the proposal contained a request for comments addressing whether the 10 categories are needed and if consolidation would further the purposes of the Act. Sixteen comments were received pertaining to the subject of land use categories and the specific postmining land uses required to qualify for a variance in Sections 515(c)(3) and 515(e)(2) of the Act. Several commenters recommended specific changes within land use categories or conveyed their support for consolidation of the existing categories.

Two commenters recommended that the categories be retained in detail to provide consistent explanation of each category of land use. This was thought to be necessary to avoid confusion and misunderstanding between the operator, landowner, and the regulatory authority. Another commenter recommended that the categories be consolidated into a general land use definition, thereby giving the regulatory authority proper discretion to make land use decisions.

Another commenter recommended that the categories be modified to clarify which land uses are suitable for a variance. Another commenter recommended deleting all of the land use categories and using only the proposed definition of the phrase "higher or better uses."

After consideration of these comments, OSM has decided to retain the 10 separate land use categories of the previous and proposed rules. These basic land use categories are needed to help identify proposed land use changes that will trigger the requirements of § 816.133(c), which sets criteria under which regulatory authorities may approve alternative postmining land uses that are higher or better uses. Consolidation of these categories into a general land use definition would fail to provide a means to ensure that § 816.133(c) will be applied uniformly and evenhandedly. It could also result in potential problems when applying the minimum revegetation success standards in § 1816.116 which are keyed to specific postmining land uses.

The land use categories identified in the land use definition are more detailed than those identified in Sections 515(c)(3) and 515(e)(2) of the Act because the land use definition is relevant generally and is not limited to variance situations. In Section 515(c)(3) a variance may be granted for mountaintop removal where the planned postmining land use is industrial, commercial, agricultural, residential, or public facility (including recreational facilities). In Section 515(e)(2), an AOC variance is permissible where the planned postmining land use is industrial, commercial, residential, or public (including recreational facilities). The final land use categories adopted in § 701.5 include cropland, pastureland or land occasionally cut for hay, grazingland, forestry, residential, industrial/commercial, recreation, fish and wildlife habitat, developed water resources, and undeveloped land or no current use or land management. Agricultural use is interpreted as including cropland, pastureland or land occasionally cut for hay, grazingland, and forestry.

"Public use" is another term used in the Act and in the rules for which there is no specific land use category. In this regard, two commenters recommended adding a definition of the term "public use." A specific public use definition is unnecessary in the rules and could be confusing because public use overlaps more than one of the existing land use categories. A use is a public use if it involves benefit, utility, or advantage to the public generally or any part of the public, as distinguished from benefitting an individual or a few specific individuals. This interpretation is consistent with the definition provided in "The Language of Cities: A Glossary of Terms," (Charles Abrams, 1971, Viking Press, New York, p. 251). States may add such a definition or other land use definitions if deemed necessary to a State's regulatory program.

Several comments pertaining to specific changes within categories and to editorial changes were also received. One commenter recommended that the definition specify only the use and not the management aspects of the land. Other commenters recommended emphasizing management and omitting the term "specific uses" in the introductory text of the definition. Still other commenters suggested that the definition of fish and wildlife habitat be revised to emphasize management.

OSM agrees that the management activities practiced on the land normally are an accurate reflection of the land's use. In general, as the intensity of the management increases, the land use becomes more well defined. However, in some instances, a specific use can be identified without active management. For this reason, OSM has not altered the definition of the term "fish and wildlife habitat" as suggested by the commenters.

Two commenters voiced agreement with OSM's view stated in the preamble language in the proposal that the categories are not hierarchical.

Another commenter identified a typographical error that has been corrected.

Section 701.5 "Higher or better uses" definition

As described in the preamble to the proposed rule (47 FR 16154), the proposed definition of the term "higher or better uses" was intended to clarify the requirement in §§ 816.133(a) and 817.133(a) relating to restoration of disturbed areas to conditions capable of supporting (1) the premining uses or (2) higher or better uses. OSM received 12 comments on the proposed definition of "higher or better uses." The definition is adopted as proposed, with one change. Under the final rule, "higher or better uses" means those postmining land uses that have a higher economic value or nonmonetary benefit to the landowner or community than the premining land use.

Three commenters supported the definition as proposed and specifically the improvement made by the clarification in the preamble to the proposal of the inclusion of nonmonetary benefits. One of those commenters recommended that further clarification could be made by inserting the word "nonmonetary" in the definition. OSM has accepted this suggested change because it reduces the chance of confusion or misinterpretation of the word "other" in the proposed definition.

Another commenter supported the proposed definition, if used as a guide in evaluating postmining land use. Such usage is OSM's intention. Two commenters criticized the proposed definition and raised questions about specific terms used. One raised the question of who will determine economic value or benefit. It is the regulatory authorities who will determine increased value or benefit of local land use changes. Land use decisions are traditionally made by State and local authorities. OSM anticipates that the regulatory authorities, working with other State agencies and local governments, will develop specific postmining land use criteria that meet their specific geographic conditions.

The other commenter questioned the meaning of the proposed word "community." The word is used in a general manner to indicate postmining land use benefits accruing to a group rather than to an individual such as the landowner. OSM, in its definition of higher or better uses, has provided only the basic limits—both monetary and nonmonetary benefits must be considered, and these benefits can accrue to either the landowner or the community. Further refinement of this definition, if needed, is left to the regulatory authorities.

Three commenters misinterpreted the use of the proposed definition of higher or better uses to be applicable also to proposed §§ 816.133(d)(4) and 817.133(d)(4), which contain the phrase "equal or better economic or public use".

The definition of higher or better uses applies only to that specific term as it is used in §§ 816.133 (a) and (c) and §§ 817.133 (a) and (c) of the final rules. These sections of the rules set criteria under Section 515(b)(2) of the Act for the return to conditions capable of supporting premining uses or higher or better postmining land uses. Sections 515 (c) and (e) of the Act, which are implemented by §§ 816.133(d) and 817.133(d) and Part 824 and which require the potential use to constitute an "equal or better economic or public use," apply only to a variance from AOC or to mountaintop removal.

Two commenters suggested that the proposed definition of higher or better uses be changed to allow economic and other benefits to be measured against the community and not to allow landowner benefits to be considered. The commenters based this recommendation on emphasis of the term "economic or public use" in Sections 515(c)(3)(A) and 515(e)(3)(A) of the Act. OSM has rejected the commenters' recommendation for two reasons. First, the criteria in Section 515 (c) and (e) of the Act are not applicable to situations where reclamation to an alternative postmining land use does not require a variance. Second, benefits to the landowner are clearly relevant in determining whether the proposed use of an area after mining is higher or better than before mining. In some situations, a regulatory authority may have to weigh the benefits to the landowner against benefits to the community in making that determination.

Although the phrase "equal or better economic or public use" is applicable only to an AOC variance or to mountaintop removal, in such situations the criteria of §§ 816.133 (a) and (c) or 817.133 (a) and (c) are also applicable. Thus, the applicability of the phrase "equal or better economic or public use" will often be tied to the phrase "higher or better uses."

Section 785.14 Mountaintop removal mining

Section 785.14 contains the permit requirements for mountaintop removal mining. OSM proposed (47 FR 16152) to revise the mountaintop removal permit requirements of § 785.14(c)(1)(ii) in order to clarify that the performance standards applicable to mountaintop removal would include the general alternative postmining land use criteria of proposed § 816.133(c), but not those of proposed § 816.133(d).

One comment was received on this proposed change. The commenter recommended that the former language be restored because the reference to § 816.133(c) is insufficient, since the method for determining premining use in § 816.133(b) is equally applicable to mountaintop removal operations. OSM agrees with the commenter. A mountaintop removal operation must include reclamation to a condition capable of supporting a higher or better postmining land use in accordance with the requirements of Paragraphs (a), (b), and (c) of § 816.133. However, because § 816.133(d) pertains only to AOC variances, a requirement for mountaintop removal operations to meet all of the § 816.133 performance standards is inappropriate. Thus, the final rule references §§ 816.133(a)—(c).

In addition, the references to the backfilling and grading requirements of §§ 816.101–816.105 in previous §§ 785.14(c) and (c)(2) have been changed to agree with the final backfilling and grading rules (48 FR 23356, May 24, 1983).

Section 785.16 Permits incorporating variances from AOC

General.—Section 785.16 contains the requirements for permits that incorporate AOC variances for nonmountaintop removed mining and, together with §§ 816.133(d) and 817.133(d), is intended to implement Section 515(e) of the Act.

Under Section 515(e) of the Act, State regulatory authorities may, but are not required to, allow for AOC variances. However, if AOC variances are allowed by a State, they must conform to the requirements of Section 515(e) of the Act. Those State that wish to allow for these variances must include provisions which, at a minimum, meet the requirements of § 785.16. The requirements of § 785.16 are derived from the specific conditions in Section 515(e) of the Act.

Previous § 785.16 set out the permit requirements for obtaining an AOC variance for steep slope mining. Final § 785.16 is expanded to include mining on both steep slope and nonsteep slope terrain. This will be explained in more detail in the discussion of final §§ 816.133(d) and 817.133(d).

Several commenters expressed their support of the expansion of § 785.16 to include nonsteep slope terrain. One

commenter raised objection to this expansion. Although these comments were directed to § 785.16, they were more applicable to §§ 816.133(d) and 817.133(d). Therefore, responses to them are included in the discussion of those two sections.

To eliminate redundancy, OSM has removed previous §§ 785.16(a) and (b), which specified the applicability and purpose of § 785.16. The substance of these paragraphs continues to be contained in the remainder of the section, particularly final § 785.16(a).

Section 785.16(a)

Final § 785.16(a), which was proposed as § 785.16(c), provides that the regulatory authority may issue a permit for nonmountaintop removal surface coal mining and reclamation operations which includes a variance from the requirements for restoration of the disturbed areas to their AOC under §§ 816.102, 816.104, 816.105, and 816.107 or 817.102 and 817.107. These references have been updated from proposed § 785.16(a) to conform to the final backfilling and grading rules. The permit may contain an AOC variance only if the regulatory authority finds, in writing, that the applicant has demonstrated on the basis of a complete application that all of the requirements of the § 785.16(a) are met. These requirements are discussed below.

In response to a commenter's suggested change to proposed § 785.16(c), the phrase "that the applicant has demonstrated" has been inserted before the phrase "on the basis of a complete application." As a result, the phrase "the applicant has demonstrated that" in proposed §§ 785.16(c)(1)—(c)(4) has been removed in final §§ 785.16(a)(1)—(a)(4). This change simplifies the wording of the rules without changing the substance.

Section 785.16(a)(1)

Final § 785.16(a)(1), which was proposed as § 785.16(c)(1), requires that, after reclamation, the lands to be affected by the variance must be suitable for an industrial, commercial, residential or public land use (including recreational facilities). Final § 785.16(a)(1) is derived from Section 515(e)(2) of the Act.

OSM received seven comments concerning the land use restrictions of proposed §§ 785.16(b)(2) and (c)(1) that are contained in final § 785.16(a)(1). Seven commenters recommended the addition of agricultural land use to the list of acceptable uses under this variance. These commenters described the need for flat agricultural land in areas where surface mining reclamation could provide a bench suitable for agricultural uses. In addition, the commenters pointed out that the mountaintop removal variance does contain the provision to allow agricultural uses and this provision should also be extended to the AOC variance.

OSM has rejected these comments and has adopted in final § 785.16(a)(1) the acceptable postmining land uses that were enumerated in the proposal, because Section 515(e)(2) of the Act is specific as to postmining uses allowed. The variance must facilitate the development of these specific land uses. It was not the intent of Congress to extend an AOC variance for reclamation to conditions suitable for agricultural uses. Other comments expressed a similar recommendation that OSM consider other land uses in place of, or in addition to, the ones listed in proposed § 785.16(b)(2). One suggestion was to allow any land use defined under § 701.5; another suggested omitting the specific uses and allowing "higher or better uses." OSM has also rejected these comments for the same reason stated above. The Act does not provide OSM authority to add or delete categories of uses.

Section 785.16(a)(2)

Final § 785.16(a)(2), which combines proposed § 785.16(c)(2) and (c)(5), requires a demonstration that the requirements of §§ 816.133 or 817.133 will be met. By cross-referencing §§ 816.133 and 817.133 in § 785.16, two duplicative requirements of previous § 785.16 have been eliminated: There is no need to repeat the general alternative postmining land use requirements of §§ 816.133(a)-(c) and 817.133(a)-(c) or the specific criteria for an AOC variance of § 816.133(d) and 817.133(d).

One commenter suggested that previous § 785.16(c)(2) be retained because it is mandated by Section 515(e)(3)(A) of the Act. This commenter also suggested retaining previous § 785.16(c)(7) because this section "reflects the limited nature of the AOC configuration variance." OSM has rejected these suggestions because the specific requirements of those sections are included in final §§ 816.133(d)(4) and (d)(3), respectively. Under final § 785.16(b)(1), all requirements of § 816.133(d) or § 817.133(d) will be a specific condition of a permit containing an AOC variance.

Section 785.16(a)(3)

Final § 785.16(a)(3), which was proposed as § 785.16(c)(3), requires a demonstration that the watershed of lands within the proposed permit and adjacent areas will be improved by the operations. It is derived from Section 515(e)(1) of the Act. In clarification of the proposed rule, the final rule specifies that the improvement may be determined either on the basis of the condition of the watershed before mining or its condition if AOC were to be restored. Final §§ 785.16(a)(3)(i)-(a)(3)(iii) contain the criteria for measuring such improvement. They were proposed in § 785.16(c)(3) and were previously set forth in § 785.16(c)(4).

Two commenters suggested that in proposed § 785.16(c)(3) the term "permit area and adjacent areas" be changed to "affected area." These commenters asserted that Section 515(e)(3)(C) of the Act specifically requires the watershed of the "affected land" to be improved. OSM has rejected these comments and has adopted the phrase "permit and adjacent areas" in final § 785.16(a)(3) because the terms "permit area" and "adjacent area" have been redefined (48 FR 14814, April 5, 1983) in a manner that is consistent with Section 515(e) of the Act. The adjacent area encompasses resources, such as a watershed, that are or may reasonably expected to be impacted by the proposed mining operations. (48 FR 14821, April 5, 1983)

Several commenters provided suggestions on proposed § 785.16(c)(3) dealing with watershed improvement. One commenter recommended that the watershed improvement should be compared with conditions equal to those which would exist if AOC were to be restored. The basis for this suggested change is that the regulatory authority's decision in granting a variance pertains to whether the final configuration of the land is to be returned to AOC upon the issuance of a permit, and not to whether mining will be allowed at all. Another commenter suggested that the provisions of this section be streamlined by omitting the specific means by which an applicant must demonstrate watershed improvement. Another commenter suggested that the operator be required to demonstrate that the permit and adjacent areas will be "equivalent to the natural premining conditions" and that proposed § 785.16(c)(3)(i) be deleted. This commenter asserted that there should be no concern with granting a variance as long as the watershed control is not degraded but is maintained in its premining condition. Another commenter suggested that OSM provide examples of improved watershed control in the preamble to the final rule. Another commenter suggested substituting the words "the affected areas" for the words "lands within the

proposed permit area and adjacent areas" in proposed § 785.16(c)(3); substituting "no increase" for "a reduction" and "affected" for "permit" in proposed § 785.16(c)(3)(i); and substituting "estimated postmining runoff" for "the total volume of flows" and "affected" for "permit," and omitting "during every season of the year" in proposed § 785.16(c)(3)(ii).

OSM has considered these comments pertaining to the watershed improvement and has made only one change to the language of the proposed requirements in final § 785.16(a)(3). This change allows comparison either to premining watershed conditions or to conditions if AOC were to be restored. The other suggestions are rejected. OSM, in establishing a basis for the comparison, considered three alternatives. First, allow watershed improvement to be based upon comparison with the premining conditions (as in the previous and proposed rules). Second, allow the improvement to be based upon comparison with conditions if AOC were to be restored (as suggested by a commenter). Third, allow a comparision with premining conditions that requires only equivalent watershed control (as suggested by a commenter).

The first two alternatives meet the requirements of the Act. The third alternative is contrary to the requirements of Section 515(e)(3)(C) of the Act, which allows a variance only where "the watershed of the affected land is deemed to be improved."

OSM is adopting a combination of the first and second alternatives. Given that the land will likely be mined whether or not the variance is allowed, it is logical to compare the probable postmining conditions to determine if there will be an improvement of watershed conditions. Comparing two hypothetical postmining conditions, which differ only in slope, is more logical than comparing the postmining condition to the premining condition which could differ in erodibility, permeability, vegetative cover, etc. Final § 785.16(c)(3) will allow comparison with either premining conditions or the condition of the watershed if it were returned to AOC. In the Kentucky State program, OSM determined that language similar to this final rule was no less effective than the previous rule.

OSM has rejected the comments that suggested omission of the specific means of measuring improvement. The Act is clear that improvement must occur, and the two specific situations in which watersheds would be deemed improved are also founded in the requirements of the Act (43 FR 41714). The suggestion to alter the areal extent of the watershed considered is also rejected because it was not the congressional intent to examine improvement of the permit area alone. Where the term "watershed improvement" is used in the legislative history, the discussion is in the context of an areal unit larger than the permit area.

Three commenters suggested changes to proposed § 785.16(c)(3)(iii). Two questioned the meaning of an "appropriate State environmental agency." The other suggested adding the words "if required."

OSM has rejected the comment suggesting the addition of "if required" because Section 515(e)(3)(C) of the Act requires "approval of the appropriate State environmental agencies." It is not possible on a national basis to specify precisely which environmental agencies must approve the planned improvement of the watershed. Within particular States, the regulatory authorities should have little difficulty in discerning the particular agencies with expertise and/or responsibility for the watershed.

Section 785.16(a)(4)

Final § 785.16(a)(4), which was proposed as § 785.16(c)(4) and was contained in previous § 785.16(c)(5), sets the requirement that the surface owner of the lands within the permit area must knowingly request that a variance be granted. This paragraph is derived from Section 515(e)(2) of the Act. The surface owner's request must be separate from the general consent given under 30 CFR 778.16 or 782.15 for the operations to be conducted.

One commenter asserted that in proposed §785.16(c)(4), the requirement "that the owner of the surface of the lands within the permit area has knowingly requested, in writing . . . that a variance be granted" should also provide for written request from a surface managing agency for public lands.

OSM has considered this suggestion and has not made any change to the proposed requirement. The word "owner" in final § 785.16(a)(4) means any owner, whether public or private. Thus, the requirement applies to a managing agency of public lands as well as to a private landowner.

Section 785.16(b)

Final § 785.16(b), which was proposed as § 785.16(d), requires that a permit containing an AOC variance must include the variance criteria of § 816.133(d) or 817.133(d) as a specific permit condition and must be specifically marked as containing an AOC variance.

Section 785.16 (c) and (d)

Final § 785.16(c), which was proposed as § 785.16(e), provides that a permit incorporating an AOC variance must be reviewed by the regulatory authority at least every 30 months following the issuance of the permit to evaluate the progress and development of the surface coal mining and reclamation operations to establish that the operator is proceeding in accordance with the terms of the variance.

Proposed § 785.16(e)(1)–(e)(3), which would have required that the permit review occur within the 6-month period preceding the third year from the date of issuance, before each permit renewal, and not later than the middle of each permit term, have been simplified by the single requirement in final § 785.16(c) that review must occur at least every 30 months. This change is consistent with the suggestion of a commenter and will require a review by the midpoint of the permit term.

Final § 785.16(d), which was proposed as § 785.16(f), is a companion to final § 785.16(c). It provides that the review required by § 785.16(c) need not be held upon a demonstration that the operations have been, and continue to be, conducted in compliance with the terms and conditions of the permit, the requirements of the Act, and applicable regulations.

The requirement for regulatory authority review is found in Section 515(e)(6) of the Act. This requirement states that "[a]ll exceptions granted under the provisions of this subsection shall be reviewed not more than three years from the date of issuance of the permit, unless the permittee affirmatively demonstrates that the proposed development is proceeding in accordance with the terms of the reclamation plan." Final §§ 785.16 (c) and (d) implement these requirements.

Section 785.16(e)

Final § 785.16(e), which was proposed as § 785.16(g), was previously contained in § 785.16(g). It provides that the terms and conditions of a permit incorporating an AOC variance may be modified at any time if more stringent measures are necessary to ensure compliance with the Act and applicable rules.

Section 785.16(f)

Final § 785.16(f), which was proposed as § 785.16(h) and is unchanged from previous § 785.16(h), implements the requirement under Section 515(e)(1) of the Act that AOC variances may be

issued only if specific procedures are included in the applicable regulatory program. It provides that such variance may be granted by a regulatory authority if specific rules are promulgated to govern such actions. Any such rules must be consistent with §785.16 and any necessary additional, more stringent requirements.

Sections 816.133 and 817.133 Postmining land use

Sections 816.133 and 817.133 set forth criteria and procedures for determining premining use of the disturbed area and approving postmining land uses which are different from premining uses. In most respects, final §§ 816.133 and 817.133 have been adopted as proposed. The preamble to the proposed rules explains the reasons for a number of changes from the previous rules.

Each section is divided into four lettered paragraphs. Paragraph (a) sets forth the general requirement that the disturbed areas must be restored to conditions capable of supporting premining uses or higher or better uses. Paragraph (b) sets forth criteria for determining premining uses. Paragraph (c) sets forth the criteria for approval of alternative postmining uses, and Paragraph (d) sets forth criteria for AOC variances.

Sections 816.133(a) and 817.133(a) General performance standards

Proposed §§ 816.133(a) and 817.133(a) set forth the general requirement that the disturbed area must be restored to conditions capable of supporting the premining use or an alternative higher or better use. The principal change in the proposed rules was that the previous rules required that all "affected" areas be restored and the proposed rules required that all "disturbed" areas be restored. In addition, the preamble to the proposed section (47 FR 16153) clarified that operators are not required to develop or construct a higher or better use; rather, in accordance with Section 515(b)(2) of the Act, operators are required to return the disturbed area to a condition that is capable of supporting the uses that it was capable of supporting prior to mining or to a condition capable of supporting a higher or better use. Final §§ 816.133(a) and 817.133(a) are the same as proposed, except for removal of the proposed phrase "achievable under criteria and procedures of this section" in Paragraph (a)(2). That a higher or better use must be achievable under this section is understood from §§ 816.133(c) and 817.133(c).

OSM received 11 comments on the proposed change to §§ 816.133(a) and 817.133(a). Two commenters supported the proposed change because the language provides a clarification and better alinement of the rules with the Act. Another commenter supported the proposed substitution of the term "disturbed area" for "affected area" but raised a question about the language in the preamble stating that the operator is no longer responsible for developing or constructing a higher or better use. This commenter suggested that specific language be inserted in the rule to clarify this point.

The proposed wording is clear, and OSM has not made a change in the final rule. The language in the preamble to the proposal (47 FR 16153) was included for two reasons. First, previous §§ 816.133(c) and 817.133(c) included all the mountaintop removal requirements and additional detail beyond that called for in Section 515(b)(2) of the Act as general criteria for alternative postmining land use reclamation. Therefore, in the past, considerable confusion existed over who was responsible for developing the postmining land use. Second, the district court in *In re: Permanent Surface Mining Regulation Litigation*, Civ. No. 79–1144, (D.D.C., May 16, 1980) at pp. 55–56, overturned a portion of the previous rule that did not allow previously mined land to be restored to its capability before any mining. Thus the final rule emphasizes the lands' capability, both with regard to premining uses and higher or better uses, in this implementation of Section 515(b)(2) of the Act. This requirement is distinct from the revegetation or prime farmland rules, which under some circumstances may require actual production on the reclaimed land as a measure of successful reclamation.

Another commenter said that reference to "disturbed areas" rather than "affected areas" impermissibly restricts the scope of the provision beyond that intended in Section 515(b)(2) of the Act, so the previous language containing the word "affected" should be retained. OSM has rejected this commenter's suggestion because the term "disturbed" is consistent with the Act. Section 515(b)(2) of the Act applies to the land disturbed during the surface coal mining operations that must be restored. Under OSM's recently revised definition (48 FR 14821, April 5, 1983), the term "affected area" includes areas, such as those overlying underground workings, which may have no surface disturbance and thus would not have to be reclaimed. Thus, final §§ 816.133(a) and 817.133(a) focus on the areas actually subject to surface disturbance, the "disturbed areas."

Several commenters raised the question of using "equal or better" in place of "higher or better" to be consistent with Section 515(e)(3)(A) of the Act. OSM rejects this suggestion. Final §§ 816.133(a) and 817.133(a) directly implement Section 515(b)(2) of the Act, which uses the term "higher or better" in reference to postmining land use. Sections 515(c)(3)(A) and 515(e)(3)(A) of the Act, which include specific criteria for variances, use the term "equal or better." These terms are not generally interchangeable. Therefore, OSM has retained the "higher or better uses" requirement in final §§ 816.133(a) and 817.133(a).

Another commenter expressed concern with OSM's intent stated in the preamble to the proposed rules that operators would not be responsible for developing postmining land uses. This commenter agreed with OSM that the operator is not responsible for developing the higher or better uses, but expressed concern that the OSM rules will not contain the specific criteria prescribing the operator's responsibilities. This comment has been rejected. The final language is consistent with the Act.

Final §§ 816.133(a) and 817.133(a) do not remove the responsibility of the operator who seeks approval of an alternative postmining land use to show, prior to the issuance of a permit, how the criteria for higher or better uses, under §§ 816.133(c) and 817.133(c), are to be met. The operator's reclamation plan must describe in detail how the operator intends to reclaim the land to a capability of attaining the proposed postmining land use; moreover, the operator's performance bond cannot be totally released until reclamation is achieved.

Sections 816.133(b) and 817.133(b) Determining premining uses of land

Final §§ 816.133(b) and 817.133(b) contain the standards for determining the premining uses of the land to which postmining land use is to be compared. OSM proposed (47 FR 16153) that §§ 816.133(b) and 817.133(b) would continue the previous requirement that the premining uses of land to which the postmining land use is compared must be those uses which the land previously supported, if the land has not been previously mined and has been properly managed. If the land has been previously mined and cannot be reclaimed to the land use that existed prior to any mining, the postmining land use must be judged on the basis of the highest and best use that can be achieved which is compatible with

surrounding areas and does not require the disturbance of areas previously unaffected by mining. OSM received eight comments on proposed §§ 816.133(b) and 817.133(b). After evaluating these comments, OSM has decided to adopt the language of proposed §§ 816.133(b) and 817.133(b) in the final rule.

Four commenters supported the change as proposed. One commenter suggested that the first sentence be deleted because it creates confusion. Another commenter pointed out that for previously mined areas the premining use is that use which has existed since the previous mining operation, *not* that which existed before *any* mining. OSM disagrees with these latter two comments. The first sentence of final §§ 816.133(b) and 817.133(b) is the basis of the premining determination. In addition, Section 515(b)(2) of the Act is clear in this requirement to "restore the land affected to a condition capable of supporting the uses which it was capable of supporting prior to *any* mining" [emphasis added].

One commenter stated that the proposed revision of § 816.133(b) unduly limits the restoration requirements for previously mined lands, in light of recent litigation. This commenter makes the point that the proper standards, where the land is previously mined and not reclaimed, should not be the use that existed prior to mining, but instead the restoration to a condition capable of supporting the use the land was capable of supporting prior to mining. OSM does not disagree with this comment that restoration is to be to a condition capable of supporting premining uses and not the actual redevelopment or construction of the premining use. However, if the land following reclamation is not capable of supporting the premining use, § 816.133(b) establishes the standard to be attained.

One commenter suggested an editorial change. In the proposed rule, the word "used" should have been "use." This typographical error is corrected in the final rule.

Sections 816.133(c) and 817.133(c) Criteria for alternative postmining uses

Sections 816.133(c) and 817.133(c) contain the criteria for approval by the regulatory authority of higher or better postmining land uses. The previous rules included the detailed requirements of Sections 515 (c) and (e) of the Act that are specific requirements for mountaintop removal and an AOC variance. OSM originally included these requirements in the general alternative postmining land use requirements stating "that a composite of these concepts is a reasonable approach to setting forth the regulatory requirements for approval of proposed postmining land uses" (44 FR 15243). As stated in the preamble to the proposed rules (47 FR 16154), OSM now disagrees with its earlier conclusion.

Final §§ 16.133(c) and 817.133(c) impose the standards of Section 515(b)(2) of the Act as the general criteria for allowing higher or better uses as alternative postmining land uses. The rule provides that higher or better uses may be approved by the regulatory authority as alternative postmining land uses after consultation with the landowner or the land managment agency having jurisdiction over the lands, if the proposed uses meet the following criteria:

1. There is a reasonable likehood for achievement of the use.

2. The use does not present any actual or probable hazard to public health or safety or threat of water diminution or pollution.

3. The use will not (i) be impractical or unreasonable; (ii) be inconsistent with applicable land use policies or plans; (iii) involve unreasonable delay in implementation; or (iv) cause or contribute to violation of Federal, State, or local law.

OSM received and considered 17 comments pertaining to proposed §§ 816.133(c) and 817.133(c). With a few changes, OSM has adopted the proposed language.

Two commenters suggested that in the introductory paragraph of §§ 816.133(c) and 817.133(c) the requirement for "consultation" with the landowner be changed to "written consent" of the landowner. In analyzing these comments, OSM recognizes the potential problem of approving a postmining land use which is in conflict with the landowner's goals; however, Section 515(b)(2) of the Act does not specify that the owner must give written consent for a higher or better postmining land use. Section 508(a)(3) of the Act does require that the reclamation plan (for both reclamation to premining condition or an alternative higher or better use) contain a statement of the proposed use and comments of any surface owner. Section 508(a)(8) of the Act requires a statement of the consideration that has been given to making the surface mining and reclamation operation consistent with surface owner plans. The regulatory authority has the responsibility for making the determination whether an alternative postmining land use should be allowed and must use all the available information and comments.

Five commenters supported the proposed change because it provides more flexibility and replaces the unworkable and complex previous procedure with a practical one which gives the regulatory authority the necessary guidelines to approve an alternative postmining land use. One commenter also added that it was hoped the regulatory authority would be responsible in its data collection requirements.

Three commenters recommended that OSM retain the language of previous §§ 816.133(c) and 817.133(c). One suggested retaining the language of the previous rule because, without specific criteria, operators will dramatically increase the creation of postmining land use configurations that lack the useful purpose Congress intended. Another stated that previous §§ 816.133(c) and 817.133(c) properly implemented the congressional intent and that all the requirements are mandated by general provisions of the Act. This commenter also recommended information and plan requirements that should be included in the permit application. OSM has analyzed these suggestions and has rejected the recommendation to retain previous §§ 816.133(c) and 817.133(c). OSM does not disagree with the commenters' point that Section 508 of the Act does contain specific postmining land use requirements that must be included in the reclamation plan. However, these specific reclamation plan requirements do not justify inclusion of the detailed requirements set forth in previous §§ 816.133(c) and 817.133(c). Final §§ 816.133(c) and 817.133(c) are intended to include as performance standards the postmining land use requirements authorized in Section 515 of the Act. The provisions of Section 508 of the Act are implemented in the permitting sections of the rules. They need not be repeated in §§ 816.133 and 817.133 and do not serve as a justification for performance standards that the Act does not require. Furthermore, OSM does not agree that a "composite," using standards established under Sections 515(c) and 515(e) for special circumstances, is justified in establishing general alternative postmining land use standards. This is supported by the legislative history of the Act. In describing a predecessor to the Act, one Senate report stated that "there are three provisions in the bill which permit variance to the mining reclamation standards of the bill. The first permits mountaintop mining by granting a variance to the requirement for restorat on to approximate original contour and

the prohibition of placing spoil on the downslope. *Rigid criteria are specified for the granting of such a variance."* [Emphasis added.] Senate Report No. 94-28; 94th Congress, 1st sess., 178 (1975). Thus, Congress intended additional, more specific requirements to be used only when variances were permitted. This is reflected in the distinctly different criteria found in Sections 515 (b)(2) and 515(c) or (e) of the Act. OSM has followed this congressional intent in these rules by separately incorporating the postmining land use criteria of Section 515(b)(2) of the Act and those of Sections 515 (b), (c), and (e) of the Act in corresponding sections of the rules. This provides a framework for States to add more specific requirements that are compatible with their geographic conditions and land use plans.

A number of commenters suggested that the word "equal" be substituted for the word "higher" in the phrase "higher or better uses" in §§ 816.133(c) and 817.133(c). These commenters thought this change should be made to be consistent with the term "equal" used in Section 515(e)(3)(A) of the Act. OSM has rejected these comments for the reasons described earlier regarding similar changes to other provisions.

One commenter suggested adding the following fourth requirement to the proposed §§ 816.133(c) and 817.133(c) criteria:

"The proposed postmining action should include a reasonable attempt to restore any threatened or endangered species habitat destroyed during mining operations and minimize impact on endangered species or critical habitat that may be near or adjacent to the mined site."

OSM has rejected this suggestion because the requirements concerning endangered species and their critical habitats are addressed in §§816.97 and 817.97 and need not be repeated. Those sections will not allow surface or underground mining activities which will jeopardize the continued existence of endangered or threatened species or will result in the destruction or adverse modification of designated critical habitats. Furthermore, it should be noted that the criteria in §§ 816.133(c)(3) and 817.133(c)(3) include the requirement that the proposed postmining land use will not cause or contribute to violation of Federal, State, or local laws. The protection of endangered species and critical habitats provided under the Endangered and Threatened Species Act, 16 U.S.C. 1531 *et seq.*, is included under this provision.

Commenters requested that previous §816.133(c)(8), requiring approval of appropriate State and Federal fish and wildlife agencies, be retained to protect fish and wildlife. OSM disagrees. Adequate protection of fish and wildlife will be provided through the consultation process provided in §§816.97 and 817.97 and the coordination procedures with interested government agencies under the permitting rules of Subchapter G of 30 CFR Chapter VII. Consent of fish and wildlife management agencies is thus unnecessary.

Sections 816.133(d) and 817.133(d) Approximate original contour: Criteria for variance

Because of commenters' assertions that OSM's interpretation of Section 515(e) of the Act is not correct, particularly in light of Judge Flannery's earlier referenced ruling, it is appropriate to explain OSM's rationale in detail in this preamble. Much of this discussion was contained in the preamble to the proposed rule.

Legislative History of Section 515(e) of the Act

On May 20, 1977, Senator Wendell Ford introduced the original AOC variance provision as an amendment to Senate Bill S. 7, the Senate predecessor to the Act [123 Cong. Rec. S8097, daily ed., May 20, 1977), to allow variances from the AOC restoration requirement for certain postmining land uses. It was aimed chiefly at Appalachia, but did not apply only to steep slope mining. The provision, Section 415(d) of S. 7, would have allowed variances from the general AOC restoration requirement of Section 415(b)(3) of Bill S. 7 and the additional steep slope AOC restoration requirement, Section 415(c)(2) of Bill S. 7. These sections were the Senate predecessors to Sections 515(b)(3) and 515(d)(2) of the Act, respectively.

Senator Ford's original amendment would have allowed retention of highwalls when variances were granted. The highwall retention aspect generated considerable controversy and a modification to the amendment was introduced on the same day which would have allowed retention of highwalls in variance situations only when sound engineering technology indicated that the highwalls could not be completely eliminated. The modified Ford amendment, referring both to Sections 415(b)(3) and 415(c)(2), ultimately became part of the Senate bill that went to the House-Senate conference.

Also on May 20, 1977, Senator Jennings Randolph stated that because the managers of Bill S. 7 accepted the modified Ford amendment, he would not offer his own AOC variance provision. Senator Randolph asked that his amendment be printed in the Congressional Record, together with accompanying remarks. These appear at 123 Congressional Record at S8102–8103 (daily ed., May 20, 1977]. The scope of the Randolph amendment, that is a variance from the requirement to restore the approximate original contour set forth in subsection 415(b)(3) or 415(c)(2), would have been the same as the Ford amendment, except that the Randolph amendment would have required complete elimination of the highwalls. In his printed remarks, Senator Randolph stated that his proposal was generally designed for use in non-steep slope regions.

The bill passed by the House of Representatives, H.R. 2, which the House-Senate conference was considering, had no AOC variance provision (other than for mountaintop removal). Conference Staff Recommendation No. 3 (at p. 48), in presenting the issue before the conference, described S. 7 as containing "a *general* variance provision, not requiring complete backfilling of highwalls." [Emphasis added.]

In the conference there was strong objection to any provision that would allow retention of highwalls. To resolve the issue, the conferees were presented with a new subsection as an amendment to Section 515 (the renumbered Section 415). The new subsection was the Randolph amendment, which required complete elimination of highwalls, that had been printed in the Congressional Record. The only difference between the conference version of the Randolph amendment and the version printed in the May 20, 1977, Congressional Record was the deletion of the reference to Section 515(b)(3), the general AOC restoration requirement.

The deletion in Section 515(e)(2) of the reference to Section 515(b)(3) left the plain meaning of the language unclear. For example, a variance from the provisions of Section 515(b)(3) of the Act is necessary to apply the variance even on steep slopes because the provisions of Section 515(d) of the Act complement the provisions of Section 515(b) but do not replace them. Therefore, a variance from Section 515(b)(3) must be read into Section 515(e) to give it *any* meaning.

In the preamble to the proposed rule, OSM asserted that apparently the deletion of the reference was not intentional. OSM reasoned that because both of the previous amendments on the subject, Senators Randolph's and Ford's in S. 7, contained a reference to the general AOC restoration requirement,

deletion of the reference would have been noted if it was intentional, particularly in light of Senator Randolph's earlier remarks that the variance was intended for non-steep slope regions. Although OSM now acknowledges that the deletion may have been made intentionally by the Conference Committee staff, it was neither noted nor discussed in the conference itself. In conference, the discussion of the Randolph amendment focused on the highwall provision and Senator Ford's insistence that in some situations the retention of highwalls be allowed. While there was an implicit assumption that the variance provision was needed mainly in Appalachia, there was no explicit statement that it was limited to steep slopes. On the contrary, at one point when the chairman of the conference was discussing the width of benches that would remain after covering the highwalls, he acknowledged that it would depend upon the terrain. (OSM agrees with this latter assertion. In steep slope areas, after the highwall is backfilled in a stable manner, the benches are not likely to be wide enough for many uses. For Section 515(e) of the Act to have practical utility, it should apply to non-steep slope areas.)

The conference adopted the Randolph amendment with one further change relating to the disposal of spoil. The conference report, House Report 95-493 (95th Cong., 1st sess. 108 (1977)), focused exclusively on the highwall retention issue and the opportunity for a broad range of postmining land uses on very wide benches. Specifically, it states that the variance "gives an opportunity for a broad range of postmining land uses on those operations which would result in a very wide bench accommodating both the stable and complete backfilling of the highwall as well as additional areas for planned land uses."

On July 21, 1977, the chairman of the Conference Committee, Congressman Udall, described to the House of Representatives a summary of the major changes made during the conference, along with related legislative history. This description included the following discussion related to the variance from approximate original contour:

"Both the House and Senate bills provided for [returning] to approximate original contour including the complete backfilling of the highwall.

"The Senate bill however provided a variance to the approximate original contour and backfilling highwalls completely for a wide range of post mining land uses. In addition, if sound engineering technology indicated that the highwall cannot be completely backfilled, then the operator would have been required to reduce the highwall to the maximum extent consistent with sound engineering technology and develop a revegetation plan that is reasonably calculated to screen the remaining highwall within 5 years.

"The conference report includes a modified variance to the approximate original contour standard which, requires however that in every instance all highwalls are to be completely backfilled. This amounts to a variance from the configuration aspects of the approximate original contour regarding standard. This gives an opportunity for a potential range of postmining land uses from those operations which would result in a very wide bench accommodating both the stable and complete backfilling of the highwall as well as additional areas for the planned land uses. This variance however is only for developed land uses such as industrial, residential or commercial sites. Agricultural, open space and similar types of land uses do not qualify. This variance procedure in section 515(e) contemplates only one variance procedure for the entire subsection *which is conditioned by the constraints discussed above* including the complete backfilling of all highwalls." [Emphasis added.] 123 Cong. Rec. H7584, daily ed., July 21, 1977.

In his discussion of the variance and its associated constraints, Chairman Udall made no reference to limiting its applicability to steep slope mining operations.

OSM's interpretation is further buttressed by remarks of Representative Seiberling, a member of the House-Senate Conference on the Act. The following colloquy occurred during an OSM oversight hearing in March 1979. Although not official legislative history, the remarks shed some light on one Conference member's view of the applicability of Section 515(e) of the Act.

"Mr. SEIBERLING. Thank you. One other question. Governor Carroll said that your regulations say that section 515 (e) of the act are applicable only to steep slopes. Section 515 (e) (1) is the provision that says that you may have variances from the original contour requirements provided that the watershed control of the area is improved, and you cover the highwall. *I do not interpret that section as applying only to steep slopes.* Is that the interpretation that your regulation proposes? [Emphasis added.]

"Mr. HEINE. As you know, Mr. Seiberling, that particular provision was drafted on the floor of the Senate, I believe, and—

"Mr. SEIBERLING. And, subsequently, fought over very hard in the conference.

"Mr. HEINE. That is correct, and it probably lacks perfection in writing, and it is one of those where, if you got a room full of lawyers, you would get a room full of different answers. We are reexamining that issue to see if it really makes more sense to change our policy on it.

"Mr. SEIBERLING. I strongly disagree with Governor Carroll's feeling that this is an impractical provision, that they should leave the highwalls, and that would improve the drainage. I suggest that the word improve, does not mean that you have to improve only the drainage. But if you are not going to restore the original contour, it ought to be a little bit better result overall. The idea behind this section was that you could have a kind of terracing effect provided that the highwall was covered up. That was a very hard-fought provision, and the Senator from Kentucky himself was one of the leading proponents of relaxation, and we worked out this compromise. *My personal view is that it does not just apply to steep slopes, and I would hope you would take another look at it.*" [Emphasis added.] Implementation of the Surface Mining Control and Reclamation Act of 1977, Oversight Hearings Before the Subcommittee on Energy and the Environment of the Committee on Interior and Insular Affairs, H. Rep. Serial No. 96-4, 96th Cong., 1st sess., 47, March 5, 1979.

Judge Flannery held that Section 515 (e) provides for only one variance and that the variance applies to steep slopes. However, Judge Flannery was not informed in the briefs filed prior to his February 26, 1980, decision that both earlier versions of Section 515 (e) would have allowed variances from the general AOC restoration requirement. No attempt was made in the briefs to explain the removal of the reference to Section 515 (b)(3) of the Act by the Conference Committee.

OSM agrees that Section 515 (e) of the Act provides for only one variance, but for the reasons described above concludes that the section allowing for AOC variances is not limited to steep slope operations.

Description of final §§ 816.133 (d) and 817.133 (d)

Final §§ 816.133 (d) and 817.133 (d) establish the minimum standards for a surface coal mining operation under an AOC variance. The standards set out in §§ 816.133 (d) and 817.133 (d) are required in Section 515 (e) of the Act. OSM proposed two alternative

standards for an AOC variance (47 FR 16156). Alternative A has been adopted since it directly implements OSM's interpretation of Section 515 (e) of the Act. This interpretation allows for a variance from the requirement to restore disturbed areas to AOC, regardless of the terrain, if the following conditions are satisfied:

(1) The regulatory authority grants the variance under a permit issued in accordance with § 785.16.

(2) The alternative postmining land use requirements of § 816.133 (c) and 817.133 (c) are met.

(3) All applicable requirements of the Act and the regulatory program, other than the requirement to restore affected areas to their approximate original contour, are met.

(4) After consultation with the appropriate land use planning agencies, if any, the potential use is shown to constitute an equal or better economic or public use.

(5) The proposed use is designed and certified by a qualified registered professional engineer in conformance with professional standards established to assure the stability, drainage, and configuration necessary for the intended use of the site.

(6) After approval, where required, of the appropriate State environmental agencies, the watershed of the permit and adjacent areas is shown to be improved. The phrase "permit and adjacent areas" has been substituted for the proposed term "affected land" for the reasons described in the discussion of final § 785.16(a)(3).

(7) The highwall is completely backfilled with spoil material, in a manner which results in a static factor of safety of at least 1.3, using standard geotechnical analysis.

(8) Only the amount of spoil as is necessary to achieve the postmining land use, ensure the stability of spoil retained on the bench, and meet all other requirements of the Act and this chapter can be placed off the mine bench. All spoil not retained on the bench must be placed in accordance with §§ 816.71–816.74 or 817.71–817.74.

(9) The surface landowner of the permit area has knowingly requested, in writing, that a variance be granted, so as to render the land, after reclamation, suitable for an industrial, commercial, residential, or public use (including recreational facilities). The word "knowingly" has been inserted to parallel § 785.16(a)(4) and the Act.

(10) Federal, State, and local government agencies with an interest in the proposed land use have an adequate period in which to review and comment on the proposed use. Although OSM proposed a maximum 60-day period, in the final rule the regulatory authority may use its discretion to determine how much time is adequate. Depending on the situation, 60 days may be too little or too much time.

Discussion of comments on §§ 816.133(d) and 817.133(d)

OSM received 48 comments pertaining to the alternatives of §§ 816.133(d) and 817.133(d). Twenty-five comments supported Alternative A; 2 comments supported Alternative B; 5 comments supported the previous rules with no change; and 14 comments recommended specific change without support to either alternative. OSM has reviewed and evaluated these comments and adopted the language of Alternative A for §§ 816.133(d) and 817.133(d).

OSM received 25 comments that supported Alternative A. The commenters recommended adoption of this alternative because it would provide practical benefits to both the operators and communities, regardless of landform. In addition, several of these commenters voiced support for OSM's interpretation of the legislative history and provided documents supporting this interpretation.

Two commenters supported Alternative B. These commenters suggested that there is no need for an AOC variance in rolling terrain because flat land is abundant and enough flexibility exists in the definition of AOC to allow the needed minor alteration to the terrain to accommodate alternative postmining land uses. Another of these commenters said Alternative B would allow for operations in areas steeper than 20 degrees and would allow the regulatory authority latitude in determining the regions where AOC variance could be applied. OSM has rejected these comments for the following reasons. Landowners and communities located in some steep slope terrain can clearly benefit from a mining operation that reclaims to conditions capable of supporting an alternative postmining land use. However, substantial benefits can also accrue to landowners or communities in non-steep slope terrain due to the site-improvement opportunities reclamation offers in preparing the land for an alternative postmining land use. The intent of Congress was not to regulate land use or guide development patterns, but to encourage the best postmining land use for the reclaimed land.

There may have been confusion regarding Alternative B providing a variance for areas steeper than 20 degrees. Either of the two alternatives would be equally applicable to terrain with slopes of more than 20 degrees.

Five commenters suggested that OSM retain the previous § 826.12 instead of either proposed alternative. Two of these commenters said OSM should retain the previous language and thought the proposed rule was illegal. Two of these commenters suggested that the AOC variance is limited to steep slope surface mining conditions as defined in Section 515(d) of the Act and provided elaboration on legislative history and subsequent actions to support what Congress said in the text of Section 515(e) as the best evidence of its intent. Another commenter thought the proposed rules granting a variance in nonsteep slope areas were a direct violation of both the statute and a Federal district court opinion. As described above, the final rule does not violate the Act. Although the final rule is not in accord with Judge Flannery's 1980 interpretation of the Act, he did not rule on the validity of the present rule and thus OSM is not in violation of the district court order.

Commenters recommended specific changes to the proposed §§ 816.133(d) and 817.133(d) performance standards. One commenter suggested deletion of the reference to the backfilling and grading rules because all spoil not retained on the bench must be placed in accordance with the excess spoil disposal rules (according to Section 515(e)(4) of the Act.) OSM has accepted this comment and has deleted the reference to "§§ 816.101 through 816.106" and "817.101 through 817.106" in §§ 816.133(d)(8) and 817.133(d)(8). Final §§ 816.102(k) and 817.102(k) exempt from the AOC restoration requirements operations that have a variance under § 785.16. (See 48 FR 23369 and 23370, May 24, 1983.)

OSM received one comment suggesting that proposed §§ 816.133(d)(10) and 817.133(d)(10) be deleted because any agency with an interest in the proposed postmining land use has already had an opportunity to comment under the public participation provisions of the permit process. Another commenter questioned whether OSM intended to have a "minimum or maximum" 60-day review period in proposed §§ 816.133(d)(10) and 817.133(d)(10). OSM has considered these two comments pertaining to the government agency review and has modified the provision as described above.

Another commenter suggested that proposed §§ 816.133 (d)(7) and (d)(8) and 817.133 (d)(7) and (d)(8) include a better definition of "static factor of safety" and

"mine bench." OSM has considered the suggestion of adding these definitions, but has rejected the suggestion. Both of these terms are commonly used in the surface coal mining industry, and OSM finds no confusion or ambiguity in their meaning.

One commenter suggested that agricultural land use be added to the list of acceptable postmining land uses in §§ 816.133(d)(9) and 817.133(d)(9). OSM has rejected this comment because the Act authorizes specific postmining land uses that are allowable as a variance and does not include agriculture as a qualifying use.

One commenter suggested changing §§ 816.133(d)(6) and 817.133(d)(6) by deleting the word "improved" and substituting the words "equivalent to the natural, premining condition." Another commenter suggested that the words "equal or" be added in §§ 816.133(d)(6) and 817.133(d)(6) so that the watershed of the affected lands could be shown to be equal or improved. This change would make the watershed improvement requirement consistent with the equal or better land use requirement. These suggested changes are rejected for the reasons discussed under § 785.16(a)(3). Both the Act and legislative history are specific in the requirement of watershed improvement.

One commenter suggested that in proposed §§ 816.133(d)(9) and 817.133(d)(9) OSM "provide for a written request from a surface managing agency for public lands." This identical comment was also made for proposed § 785.16(c)(4). OSM has rejected this comment for the reason described earlier in the discussion of final § 785.16(a)(4). This requirement is not limited to a private owner but also applies to a land management agency with jurisdiction over the surface.

Two commenters suggested that in prime farmland areas, no AOC variance should be granted that allows postmining slopes of higher grade than the original average contour. In addition, it was recommended that land be reclaimed to its former or higher land use in order to maintain its agricultural viability. OSM has made no special provision in §§ 816.133(d) and 817.133(d) for prime farmland. However, for lands whose premining use is prime farmland, it is not anticipated that an alternative postmining land use will be approved, except as specifically identified in 30 CFR Part 823.

One commenter suggested the OSM not add Paragraph (d) to §§ 816.133 and 817.133. This commenter thought that proposed Paragraphs (d)(5)–(d)(10) belong in the Part 785 permit requirements, that proposed Paragraph (d)(1) is unnecessary, and that proposed Paragraph (d)(2) is misleading because a change in use is not necessary to obtain approval for an alternative postmining land use. The commenter uses the example that an existing recreation use may be enhanced to a higher or better recreation use. OSM has reviewed the suggestions contained in this comment and has rejected the suggested changes. The criteria required in Paragraphs (d)(1)–(d)(10) are specific performance standards required in Section 515(e) of the Act. These performance standards are the basic measures that the operation will be judged against for allowing a variance and, thus, serve a different purpose from the information that the operator provides in a permit application.

OSM received several comments pertaining to the §§ 816.133(d)(7) and 817.133(d)(7) requirement to completely cover the highwalls. Two commenters suggested that highwalls could be beneficial and that provision should be made to allow the regulatory authority to approve the retention of highwalls on a case-by-case basis. On commenter suggested that §§ 816.133(d)(7) and 817.133(d)(7) contradict one of the original reasons for introducing the AOC variance. This commenter also suggested that highwalls be allowed on a case-by-case basis. OSM has rejected the recommendation that some highwalls be allowed because Section 515(e)(1) specifically requires that "complete backfilling with spoil material shall be required to cover completely the highwall." Other comments pertained to highwalls that were integral with a postmining land use. These commenters specifically questioned the applicability of this requirement to completely cover the highwall under the waterline of a final-cut lake. OSM considered these suggested changes and has not made any change in this rule. Requirements for final-cut lakes are included in a separate rulemaking on impoundments.

Another commenter said that proposed §§ 816.133(d)(4) and (d)(6) present a "pass the buck attitude that results in duplication of review." OSM disagrees with the commenter because the Act requires this review by other appropriate agencies.

Section 824.11(a)(4) Special permanent program performance standards—mountaintop removal

Part 824 contains the conditions under which an operator engaged in mountaintop removal surface mining activities could be exempted from the requirement to restore affected areas to AOC. Previous § 824.11(a)(4) specified that all the requirements of § 816.133 were to be met.

In the proposed rule (47 FR 16160), OSM changed § 824.11(a)(4) to clarify that the performance standards applicable to mountaintop removal mining would include the general alternative postmining land use criteria of § 816.133(c) but not the criteria for variance from AOC of § 816.133(d).

OSM received no comment on this proposed revision and has thus adopted this proposed language in the final rule, except that the final reference is to Paragraphs (a)–(c) of § 816.133, not just Paragraph (c).

Removal of Section 826.15 Special permanent program performance standards—operations on steep slopes (steep slopes: limited variances)

Previous § 826.15 contained the performance standards for the AOC variance applicable only to steep slope mining. This section was duplicative of either alternative proposed for § 816.133(d). Because OSM has adopted the necessary provisions of previous § 826.15 in §§ 816.133(d) and 817.133(d), § 826.15 is no longer needed. It has already been removed as part of the backfilling and grading rules (48 FR 23356, May 24, 1983). No comments were received on this proposed revision.

III. Procedural Matters

Federal Paperwork Reduction Act

The information collection requirements for Parts 785, 816, and 817 were approved by the Office of Management and Budget (OMB) under 44 U.S.C. 3507 and assigned approval numbers 785–1029–0040, 816–1029–0047, and 817–1029–0048, respectively. These approvals have been codified under final §§ 785.10, 816.10, and 817.10. The information required by Parts 785, 816, and 817 will be used by the regulatory authority in granting permits and in monitoring and inspecting surface and underground mining activities to ensure that they are conducted in a manner which preserves and enhances environmental and other values of the Act. This information required by Parts 785, 816, and 817 is mandatory.

Executive Order 12291 and the Regulatory Flexibility Act

The Department of the Interior (DOI) has determined that these rules are not major rules requiring a regulatory impact analysis under Executive Order 12291. Also, DOI certifies that these rules will not have a significant economic effect on a substantial number of small entities and therefore do not require a regulatory flexibility analysis

under Public Law 96-354. The rules will allow small coal operators increased flexibility in meeting performance standards and should especially ease the regulatory burden on small coal operators in Appalachia.

Agency Approval

Section 516(a) of the Act requires the written concurrence of the head of the department that administers the Federal Mine Safety and Health Act of 1977, the successor to the Federal Coal Mine Health and Safety Act of 1969, in rules concerning the surface effects of underground mining. OSM has obtained the written concurrence of the Assistant Secretary for Mine Safety and Health, U.S. Department of Labor.

National Environmental Policy Act

OSM has analyzed the impacts of these final rules in the "Final Environmental Impact Statement OSM-EIS-1: Supplement" (FEIS) according to Section 102(2)(C) of the National Environmental Policy Act of 1969 (NEPA) (42 U.S.C. 4332 (2)(C)). The FEIS is available in OSM's Administrative Record in Room 5315, 1100 L Street, NW., Washington, D.C., or by mail request to Mark Boster, Chief, branch of Environmental Analysis, Room 134, Interior South Building, U.S. Department of the Interior, Washington, D.C. 20240. This preamble serves as a record of decision under NEPA. The final rules differ from the preferred alternative in Volume III of the EIS in that: (1) The definition of "fish and wildlife habitat" is unchanged from the existing rules and thus has no environmental effect. (2) The permitting rules for mountaintop removal operations do not revise variance review procedures in § 785.14(d) and thus are encompassed by Alternative B in the FEIS. (3) Proposed § 785.16(a) and (b) have been removed to eliminate redundancy, but with no environmental or other substantive effect. (4) The maximum 60-day review period for other agency review of AOC variances has been changed to assure adequate time for review. This will have no environmental effect. (5) The review of permits incorporating an AOC variance must occur at least every 30 months following the issuance of the permit and is not specifically tied to the middle of the permit term. The environmental effect of this change is negligible and is no different from the FEIS preferred alternative. (6) Sections 816.133(c)(3)(iv) and 817.133(c)(3)(iv) use the words "cause or contribute." This is more environmentally protective than the preferred alternative. (7) The use of the word "disturbed" in §§ 816.133(d) and 817.133(d) will have no effect. (8) The FEIS preferred alternative included a definition for the phrase "equal or better economic or public use" that had not been proposed. Not adopting that definition has no environmental effect. (9) A number of other editorial changes have no effect.

List of Subjects

30 CFR Part 701

Coal mining, Law enforcement, Surface mining, Underground mining.

30 CFR Part 785

Coal mining, Reporting requirements, Surface mining, Underground mining.

30 CFR Part 816

Coal mining, Environmental protection, Reporting and recordkeeping requirements, Surface mining.

30 CFR Part 817

Coal mining, Environmental protection, Reporting and recordkeeping requirements, Underground mining.

30 CFR Part 824

Coal mining, Environmental protection, Surface mining.

Accordingly, 30 CFR Parts 701, 785, 816, 817, and 824 are amended as set forth herein.

Dated: August 25, 1983.

William P. Pendley,

Deputy Assistant Secretary, Energy and Minerals.

PART 701—PERMANENT REGULATORY PROGRAM

1. Section 701.5 is amended by adding the definition of "higher or better uses" in alphabetical order and by revising the definition of "land use" to read as follows:

§ 701.5 Definitions.

* * * * *

Higher or better uses means postmining land uses that have a higher economic value or nonmonetary benefit to the landowner or the community than the permining land uses.

* * * * *

Land use means specific uses or management-related activities, rather than the vegetation or cover of the land. Land uses may be identified in combination when joint or seasonal uses occur and may include land used for support facilities that are an integral part of the use. Changes of land use from one of the following categories to another shall be considered as a change to an alternative land use which is subject to approval by the regulatory authority.

(a) *Cropland.* Land used for the production of adapted crops for harvest, alone or in rotation with grasses and legumes, that include raw crops, small grain crops, hay crops, nursery crops, orchard crops, and other similar crops.

(b) *Pastureland or land occasionally cut for hay.* Land used primarily for the long-term production of adapted, domesticated forage plants to be grazed by livestock or occasionally cut and cured for livestock feed.

(c) *Grazingland.* Land used for grasslands and forest lands where the indigenous vegetation is actively managed for grazing, browsing, or occasional hay production.

(d) *Forestry.* Land used or managed for the long-term production of wood, wood fiber, or wood-derived products.

(e) *Residential.* Land used for single- and multiple-family housing, mobile home parks, or other residential lodgings.

(f) *Industrial/Commercial.* Land used for—

(1) Extraction or transformation of materials for fabrication of products, wholesaling of products, or long-term storage of products. This includes all heavy and light manufacturing facilities.

(2) Retail or trade of goods or services, including hotels, motels, stores, restaurants, and other commercial establishments.

(g) *Recreation.* Land used for public or private leisure-time activities, including developed recreation facilities such as parks, camps, and amusement areas, as well as areas for less intensive uses such as hiking, canoeing, and other undeveloped recreational uses.

(h) *Fish and wildlife habitat.* Land dedicated wholly or partially to the production, protection, or management of species of fish or wildlife.

(i) *Developed water resources.* Land used for storing water for beneficial uses, such as stockponds, irrigation, fire protection, flood control, and water supply.

(j) *Undeveloped land or no current use or land management.* Land that is undeveloped or, if previously developed, land that has been allowed to return naturally to an undeveloped state or has been allowed to return to forest through natural succession.

* * * * *

PART 785—REQUIREMENTS FOR PERMITS FOR SPECIAL CATEGORIES OF MINING

2. In § 785.14, the introductory language in paragraph (c) is revised and

paragraphs (c)(1)(ii) and (c)(2) are revised to read as follows:

§ 785.14 Mountaintop removal mining.

* * * * *

(c) The regulatory authority may issue a permit for mountaintop removal mining, without regard to the requirements of §§ 816.102, 816.104, 816.105, and 816.107 of this chapter to restore the lands disturbed by such mining to their approximate original contour, if it first finds, in writing, on the basis of a complete application, that the following requirements are met:

(1) * * *

(ii) The applicant demonstrates compliance with the requirements for acceptable alternative postmining land uses of paragraphs (a)–(c) of § 816.133 of this chapter;

* * * * *

(2) The applicant demonstrates that in place of restoration of the land to be affected to the approximate original contour under §§ 816.102, 816.104, 816.105, and 816.107 of this chapter, the operation will be conducted in compliance with the requirements of Part 824 of this chapter.

* * * * *

3. Section 785.16 is revised to read as follows:

§ 785.16 Permits incorporating variances from approximate original contour restoration requirements.

(a) The regulatory authority may issue a permit for nonmountaintop removal mining which includes a variance from the requirements of §§ 816.102, 816.104, 816.104, 816.105, and 816.107 or 817.102 and 817.107 of this chapter to restore the disturbed areas to their approximate original contour. The permit may contain such a variance only if the regulatory authority finds, in writing, that the applicant has demonstrated, on the basis of a complete application, that the following requirments are met:

(1) After reclamation, the lands to be affected by the variance within the permit area will be suitable for an industrial, commercial, residential, or public postmining land use (including recreational facilities).

(2) The requirements of § 816.133 or 817.133 of this chapter will be met.

(3) The watershed of lands within the proposed permit and adjacent areas will be improved by the operations when compared with the condition of the watershed before mining or with its condition if the approximate original contour were to be restored. The watershed will be deemed improved only if—

(i) The amount of total suspended solids or other pollutants discharged to ground or surface water from the permit area will be reduced, so as to improve the public or private uses or the ecology of such water, or flood hazards within the watershed containing the permit area will be reduced by reduction of the peak flow discharge from precipitation events or thaws;

(ii) The total volume of flow from the proposed permit area, during every season of the year, will not vary in a way that adversely affects the ecology of any surface water or any existing or planned use of surface or ground water; and

(iii) The appropriate State environmental agency approves the plan.

(4) The owner of the surface of the lands within the permit area has knowingly requested, in writing, as part of the application, that a variance be granted. The request shall be made separately from any surface owner consent given for the operations under § 778.15 or 782.15 of this chapter and shall show an understanding that the variance could not be granted without the surface owner's request.

(b) If a variance is granted under this section——

(1) The requirements of § 816.133(d) or 817.133(d) of this chapter shall be included as a specific condition of the permit; and

(2) The permit shall be specifically marked as containing a variance from approximate original contour.

(c) A permit incorporating a variance under this section shall be reviewed by the regulatory authority at least every 30 months following the issuance of the permit to evaluate the progress and development of the surface coal mining and reclamation operations to establish that the operator is proceeding in accordance with the terms of the variance.

(d) If the permittee demonstrates to the regulatory authority that the operations have been, and continue to be, conducted in compliance with the terms and conditions of the permit, the requirements of the Act, this chapter, and the regulatory program, the review specified in Paragraph (c) of this section need not be held.

(e) The terms and conditions of a permit incorporating a variance under this section may be modified at any time by the regulatory authority, if it determines that more stringent measures are necessary to ensure that the operations involved are conducted in compliance with the requirements of the Act, this chapter, and the regulatory program.

(f) The regulatory authority may grant variances in accordance with this section only if it has promulgated specific rules to govern the granting of variances in accordance with the provisions of this section and any necessary, more stringent requirements.

PART 816—PERMANENT PROGRAM PERFORMANCE STANDARDS—SURFACE MINING ACTIVITIES

4. Section 816.133 is revised to read as follows:

§ 816.133 Postmining land use.

(a) *General.* All disturbed areas shall be restored in a timely manner to conditions that are capable of supporting—

(1) The uses they were capable of supporting before any mining; or

(2) Higher or better uses.

(b) *Determining premining uses of land.* The premining uses of land to which the postmining land use is compared shall be those uses which the land previously supported, if the land has not been previously mined and has been properly managed. The postmining land use for land that has been previously mined and not reclaimed shall be judged on the basis of the land use that existed prior to any mining: *Provided that,* if the land cannot be reclaimed to the land use that existed prior to any mining because of the previously mined condition, the postmining land use shall be judged on the basis of the highest and best use that can be achieved which is compatible with surrounding areas and does not require the disturbance of areas previously unaffected by mining.

(c) *Criteria for alternative postmining land uses.* Higher or better uses may be approved by the regulatory authority as alternative postmining land uses after consultation with the landowner or the land management agency having jurisdiction over the lands, if the proposed uses meet the following criteria:

(1) There is a reasonable likelihood for achievement of the use.

(2) The use does not present any actual or probable hazard to public health or safety, or threat of water diminution or pollution.

(3) The use will not—

(i) Be impractical or unreasonable;

(ii) Be inconsistent with applicable land use policies or plans;

(iii) Involve unreasonable delay in implementation; or

(iv) Cause or contribute to violation of Federal, State, or local law.

(d) *Approximate original contour: Criteria for variance.* Surface coal mining operations that meet the requirements of this paragraph may be

conducted under a variance from the requirement to restore disturbed areas to their approximate original contour, if the following requirements are satisfied:

(1) The regulatory authority grants the variance under a permit issued in accordance with § 785.16 of this chapter.

(2) The alternative postmining land use requirements of paragraph (c) of this section are met.

(3) All applicable requirements of the Act and the regulatory program, other than the requirement to restore disturbed areas to their approximate original contour, are met.

(4) After consultation with the appropriate land use planning agencies, if any, the potential use is shown to constitute an equal or better economic or public use.

(5) The proposed use is designed and certified by a qualified registered professional engineer in conformance with professional standards established to assure the stability, drainage, and configuration necessary for the intended use of the site.

(6) After approval, where required, of the appropriate State environmental agencies, the watershed of the permit and adjacent areas is shown to be improved.

(7) The highwall is completely backfilled with spoil material, in a manner which results in a static factor of safety of at least 1.3, using standard geotechnical analysis.

(8) Only the amount of spoil as is necessary to achieve the postmining land use, ensure the stability of spoil retained on the bench, and meet all other requirements of the Act and this chapter is placed off the mine bench. All spoil not retained on the bench shall be placed in accordance with §§ 816.71–816.74 of this chapter.

(9) The surface landowner of the permit area has knowingly requested, in writing, that a variance be granted, so as to render the land, after reclamation, suitable for an industrial, commercial, residential, or public use (including recreational facilities).

(10) Federal, State, and local government agencies with an interest in the proposed land use have an adequate period in which to review and comment on the proposed use.

PART 817—PERMANENT PROGRAM PERFORMANCE STANDARDS—UNDERGROUND MINING ACTIVITIES

5. Section 817.133 is revised to read as follows:

§ 817.133 Postmining land use.

(a) *General.* All disturbed areas shall be restored in a timely manner to conditions that are capable of supporting—

(1) The uses they were capable of supporting before any mining; or

(2) Higher or better uses.

(b) *Determining premining uses of land.* The premining uses of land to which the postmining land use is compared shall be those uses which the land previously supported, if the land has not been previously mined and has been properly managed. The postmining land use for land that has been previously mined and not reclaimed shall be judged on the basis of the land use that existed prior to any mining: *Provided that,* if the land cannot be reclaimed to the land use that existed prior to any mining because of the previously mined condition, the postmining land use shall be judged on the basis of the highest and best use that can be achieved which is compatible with surrounding areas and does not require the disturbance of areas previously unaffected by mining.

(c) *Criteria for alternative postmining land uses.* Higher or better uses may be approved by the regulatory authority as alternative postmining land uses after consultation with the landowner or the land management agency having jurisdiction over the lands, if the proposed uses meet the following criteria:

(1) There is a reasonable likelihood for achievement of the use.

(2) The use does not present any actual or probable hazard to public health and safety, or threat of water diminution or pollution.

(3) The use will not—

(i) Be impractical or unreasonable;

(ii) Be inconsistent with applicable land use policies or plans;

(iii) Involve unreasonable delay in implementation; or

(iv) Cause or contribute to violation of Federal, State, or local law.

(d) *Approximate original contour: Criteria for variance.* Surface coal mining operations that meet the requirements of this paragraph may be conducted under a variance from the requirement to restore disturbed areas to their approximate original contour, if the following requirements are satisfied:

(1) The regulatory authority grants the variance under a permit issued in accordance with § 785.16 of this chapter.

(2) The alternative postmining land use requirements of paragraph (c) of this section are met.

(3) All applicable requirements of the Act and the regulatory program, other than the requirement to restore disturbed areas to their approximate original contour, are met.

(4) After consultation with the appropriate land use planning agencies, if any, the potential use is shown to constitute an equal or better economic or public use.

(5) The proposed use is designed and certified by a qualified registered professional engineer in conformance with professional standards established to assure the stability, drainage, and configuration necessary for the intended use of the site.

(6) After approval, where required, of the appropriate State environmental agencies, the watershed of the permit and adjacent areas is shown to be improved.

(7) The highwall is completely backfilled with spoil material, in a manner which results in a static factor of safety of at least 1.3, using standard geotechnical analysis.

(8) Only the amount of spoil as is necessary to achieve the postmining land use, ensure the stability of spoil retained on the bench, and meet all other requirements of the Act and this chapter is placed off the mine bench. All spoil not retained on the bench shall be placed in accordance with §§ 817.71–817.74 of this chapter.

(9) The surface landowner of the permit area has knowingly requested, in writing, that a variance be granted, so as to render the land, after reclamation, suitable for an industrial, commercial, residential, or public use (including recreational facilities).

(10) Federal, State, and local government agencies with an interest in the proposed land use have an adequate period in which to review and comment on the proposed use.

PART 824—SPECIAL PERMANENT PROGRAM PERFORMANCE STANDARDS—MOUNTAINTOP REMOVAL

6. Section 824.11(a)(4) is revised to read as follows:

§ 824.11 Mountaintop removal: Performance standards.

(a) * * *

(4) The alternative land use requirements of § 816.133(a)–(c) of this chapter are met;

* * * * *

(Pub. L. 95–87, 30 U.S.C. 1201 *et seq.*)

[FR Doc. 83-23976 Filed 8-31-83; 8:45 am]

BILLING CODE 4310-05-M

federal register

Thursday
September 1, 1983

Part VI

Department of Transportation

National Highway Traffic Safety Administration

Federal Motor Vehicle Safety Standards; Occupant Crash Protection; Automatic Occupant Restraint Requirement; Suspension of Rule and Request for Comments

DEPARTMENT OF TRANSPORTATION

National Highway Traffic Safety Administration

49 CFR Part 571

[Docket No. 74-14; Notice 31]

Federal Motor Vehicle Safety Standards Occupant Crash Protection; Automatic Occupant Restraint Requirement

AGENCY: Department of Transportation.

ACTION: Suspension of rule and request for comments.

SUMMARY: This notice suspends the automatic occupant restraint requirements of Safety Standard No. 208, Occupant Crash Protection. This action permits the agency time for the further review contemplated by the recent Supreme Court decision that found NHTSA's rescission of the requirement to be arbitrary and capricious. This suspension is issued without a prior opportunity for notice and comment; the rule might otherwise be deemed effective on September 1, 1983. However, public comment on the suspension is requested and the suspension will be revised or revoked, if appropriate, in response to the comments received.

DATES: *Suspension*—The mandatory automatic restraint requirement of Standard No. 208 is suspended until September 1, 1984. This suspension is effective on September 1, 1983.

Public Comments—Comments on this notice must be received on or before October 3, 1983.

ADDRESSES: Comments should refer to the docket and notice numbers set forth above and be submitted to: Docket Section, Room 5109, 400 Seventh Street, S.W., Washington, D.C. 20590. Docket hours are 8:00 am to 4:00 p.m. (e.d.t.), Monday through Friday.

FOR FURTHER INFORMATION CONTACT: Mr. Kennerly Digges, Acting Associate Administator for Rulemaking, National Highway Traffic Safety Administration, 400 Seventh Street, S.W., Washington, D.C. 20590 (202-426-1810).

SUPPLEMENTARY INFORMATION: On October 29, 1981 (49 FR 53419), the Department of Transportation's National Highway Traffic Safety Administration (NHTSA) published a notice rescinding the automatic restraint requirements of Safety Standard No. 208, Occupant Crash Protection. (The language of Standard 208 as it was codified prior to the rescission is contained in Appendix A to this notice.) On June 1, 1982, the U.S. Court of Appeals for the D.C. Circuit found the agency's action to be arbitrary and capricious and overturned the agency's action. (*State Farm Mutual Automobile Insurance Co.* v. *Department of Transportation*, 680 F. 2d 206.) On August 4, 1982, the Court of Appeals issued an order staying the effective date of the requirement until September 1, 1983.

In June 1983, the United States Supreme Court rejected the scope of review used by the lower court, but also found the rescission to be arbitrary and capricious. The Supreme Court vacated the judgment of the Court of Appeals and remanded the case to that Court with directions to remand it to NHTSA for further consideration consistent with the Supreme Court's opinion. (*Motor Vehicle Manufacturers Association* v. *State Farm Mutual Automobile Insurance Co.* (No. 82-354; June 24, 1983)).

Because the Supreme Court vacated the judgment of the Court of Appeals, it could be argued that the rescission of the automatic restraint requirement technically continues in effect pending the further agency review contemplated by the Supreme Court. However, if that were not the case, compliance with the rule could be considered to be required by September 1, 1983. In order to clarify this situation, the Department has determined that it is appropriate to issue this notice suspending the effect date of the requirement.

The Suprement Court stated that the agency has sufficient justification to suspend Standard 208 pending any further consideration in accordance with the Court's decision. The Department believes that further consideration is necessary and, as part of our review efforts, it is our intention to issue a notice of proposed rulemaking (NPRM) by October 15, 1983. We intended to expedite this rulemaking and reach a final decision as quickly as possible and well before the end of the one-year suspension. At that time, we will establish an appropriate effective date either for the rule that was rescinded, if we decide to retain it, or for any other action that we take, including re-rescission of the rule.

We believe that it would be inappropriate to require compliance with the rule during this short review period. Neither consumers nor manufacturers should be required to incur additional expenses to comply with a requirement that is being actively reviewed.

Moreover, there is substantial evidence showing that a September 1, 1983, effective date is not practicable. After the D.C. Circuit entered its of August 4, 1982, resinstating the automatic restrain requirement on September 1, 1983, NHTSA obtained current information from vehicle and automatic restraint equipment manufacturers concerning their ability to comply with a September 1, 1983, effective date. After reviewing and analyzing the letters and affidavits submitted by the manufacturers, NHTSA concluded, in an October 1, 1982, submission to the D.C. Circuit Court, that a September 1, 1983, effective date was not achievable at that time and that a significantly longer time period would be needed before practicable compliance with the automatic restraint requirements could be achieved. Based on that data, the Department has concluded that it would not be practicable for vehicle manufacturers to comply with the September 1, 1983, requirement because there is not sufficient leadtime for them to make all the necessary design, development, testing, and production preparations by that date.

Because it is not practicable for the manufacturers to comply by September 1, 1983, the Department also has determined that notice and public procedure on this notice of suspension are impracticable, unnecessary, and contrary to the public interest. The recency of the Supreme Court decision and the imminence of the deadline for compliance with the rule justify this determination. We wish to stress, however, that we are providing an opportunity for public comment on this suspension immediately subsequent to its issuance. After reviewing the public comment that is received, the Department will determine whether this suspension should be revised or revoked and we will issue a document stating our final decision.

This suspension may be made effective immediately upon publication in the **Federal Register** because it relieves a restriction.

This suspension is a major action within the meaning of Executive Order 12291 and a significant action under the Department's Regulatory Policies and Procedures. The benefits and costs of the automatic restraint requirements have been carefully reviewed in the prior final regulatory impact analysis dated October 1981, which has been placed in the docket for the automatic restraint rulemaking. That analysis also provides an assessment of the impact of this suspension. The prior regulatory impact analysis also discusses the impact of the rescission of the automatic restraint requirements on small businesses and governmental entities. Based on that

prior analysis, I hereby certify that this suspension will not have a significant economic impact on a substantial number of small entities. The Department has also evaluated this suspension in accordance with the National Environmental Policy Act and has determined that this action is not a major Federal action significantly affecting the quality of the human environment.

Interested persons are invited to submit comments on the notice of suspension. It is requested but not required that 10 copies be submitted.

All comments must be limited not to exceed 15 pages in length. (49 CFR 553.21). Necessary attachments may be appended to these submissions with regard to the 15 page limit. This limitation is intended to encourage commenters to detail their primary arguments in a concise fashion.

If a commenter wishes to submit certain information under a claim of confidentiality, three copies of the complete submission, including purportedly confidential information, should be submitted to the Chief Counsel, NHTSA, at the street address given above, and seven copies from which the purportedly condifential information has been deleted should be submitted to the Docket Section. A request for confidentiality should be accompanied by a cover letter setting forth the information specified in the agency's confidential business information regulations.

All comments received before the close of business on the comment closing date indicated above will be considered, and will be available for examination in the docket at the above address both before and after that date. To the extent possible, comments filed after the closing date will also be considered. However, we may proceed with further action at any time after that date, and comments after the closing date and too late for consideration in regard to the action will be treated as suggestions for future action. The NHTSA will continue to file relevant material as it becomes available in the docket after the closing date, tha it is recommended that interested persons continue to examine the docket for new material.

Those persons desiring to be notified upon receipt of their comments in the rules docket should enclose, in the envelope with their comments, a self addressed stamped postcard. Upon receiving the comments, the docket supervisor will return the postcard by mail.

List of Subjects in 49 CFR Part 571

Imports, Motor vehicle safety, Motor vehicles, Rubber and rubber products, Tires.

(Secs. 103, 119, Pub. L. 89-563, 80 Stat. 718 (15 U.S.C. 1392, 1407)

Issued in Washington D.C. on August 30, 1983.

James H. Burnley, IV,

Acting Secretary of Transportation.

Appendix A

The text of S4.1.3 of Standard No. 208, *Occupant Crash Protection*, (49 CFR Part 571.208) that was rescinded on October 29, 1981 (46 FR 53419) reads as follows:

S4.1.3 *Passenger cars manufactured on or after September 1, 1983.* Each passenger car manufactured on or after September 1, 1983 shall—

(a) At each front designated seating position meet the frontal crash protection requirements of S5.1 by means that require no action by vehicle occupants;

(b) At each rear designated seating position have a Type 1 or Type 2 seat belt assembly that conforms to Standard No. 209 and S7.1 and S7.2; and

(c) Either—

(1) Meet the lateral crash protection requirement of S5.2 and the roll-over crash protection requirements of S5.3 by means that require no action by vehicle occupants; or

(2) At each front designated seating postion have a Type 1 or Type 2 seat belt assembly that conforms to Standard No. 209 and S7 through 7.3, and meet the requirements of S5.1 with front test dummies as required by S5.1, restrained by the Type 1 or Type 2 seat belt assembly (or the pelvic portion of any Type 2 seat belt assembly which has a detachable upper torso belt) in addition to the means that require no action by the vehicle occupant.

[FR Doc. 83-24219 Filed 8-31-83; 10:09 am]

BILLING CODE 4910-59-M

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Federal Register

Vol. 48, No. 171

Thursday, September 1, 1983

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FEDERAL REGISTER PAGES AND DATES, SEPTEMBER

39595-39910.....1

List of Public Laws

Note: No public bills which have become law were received by the Office of the Federal Register for inclusion in today's **List of Public Laws.**

Last Listing August 31, 1983

TABLE OF EFFECTIVE DATES AND TIME PERIODS—SEPTEMBER 1983

This table is for determining dates in documents which give advance notice of compliance, impose time limits on public response, or announce meetings.

Agencies using this table in planning publication of their documents must allow sufficient time for printing production.

In computing these dates, the day after publication is counted as the first day.

When a date falls on a weekend or a holiday, the next Federal business day is used. (See 1 CFR 18.17)

A new table will be published in the first issue of each month.

Dates of FR publication	15 days after publication	30 days after publication	45 days after publication	60 days after publication	90 days after publication
September 1	September 16	October 3	October 17	October 31	November 30
September 2	September 19	October 3	October 17	November 1	December 1
September 6	September 21	October 6	October 21	November 7	December 5
September 7	September 22	October 7	October 24	November 7	December 6
September 8	September 23	October 11	October 24	November 7	December 7
September 9	September 26	October 11	October 24	November 8	December 8
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September 14	September 29	October 14	October 31	November 14	December 13
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September 20	October 5	October 20	November 4	November 21	December 19
September 21	October 6	October 21	November 7	November 21	December 20
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September 23	October 11	October 24	November 7	November 22	December 22
September 26	October 11	October 26	November 10	November 25	December 27
September 27	October 12	October 27	November 14	November 28	December 27
September 28	October 13	October 28	November 14	November 28	December 27
September 29	October 14	October 31	November 14	November 28	December 28
September 30	October 17	October 31	November 14	November 29	December 29

CFR CHECKLIST; 1982/83 ISSUANCES

This checklist, prepared by the Office of the Federal Register, is published in the first issue of each month. It is arranged in the order of CFR titles, and shows the revision date and price of the volumes of the Code of Federal Regulations issued to date for 1982/83. New units issued during the month are announced on the back cover of the daily **Federal Register** as they become available.

For a checklist of current CFR volumes comprising a complete CFR set, see the latest issue of the LSA (List of CFR Sections Affected), which is revised monthly.

The annual rate for subscription to all revised volumes is $615 domestic, $153.75 additional for foreign mailing.

Order from Superintendent of Documents, Government Printing Office, Washington, D.C. 20402.

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3	6.00
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5 Parts:	
1-1199	8.50
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1060-1119	6.50
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1945-end	7.00
8	6.50
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200-399	7.50
400-499	6.50
500-end	7.00
12 Parts:	
1-199	7.00
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200-1199	7.00
1200-end	6.50
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240-end	7.00
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150-399	8.00
400-end	6.50
20 Parts:	
1-399	5.50
400-499	7.00
500-end	7.50
21 Parts:	
1-99	6.00
100-169	6.50
170-199	6.50
200-299	4.75
300-499	8.00
500-599	6.50
600-799	5.00
800-1299	6.00
1300-end	5.00
22	8.50
23	7.00
24 Parts:	
0-199	6.00
500-799	5.00
1700-end	6.00
25	8.00
26 Parts:	
1 (§§ 1.0-1.169)	8.00
1 (§§ 1.301-1.400)	6.00
1 (§§ 1.401-1.500)	7.00
1 (§§ 1.501-1.640)	6.50
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1 (§§ 1.1201-end)	8.50
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300-499	6.00
600-end	5.00
27 Parts:	
1-199	6.50
200-end	6.50

CFR Unit (Rev. as of July 1, 1983):

Title	Price
29 Parts:	
100-499	5.50
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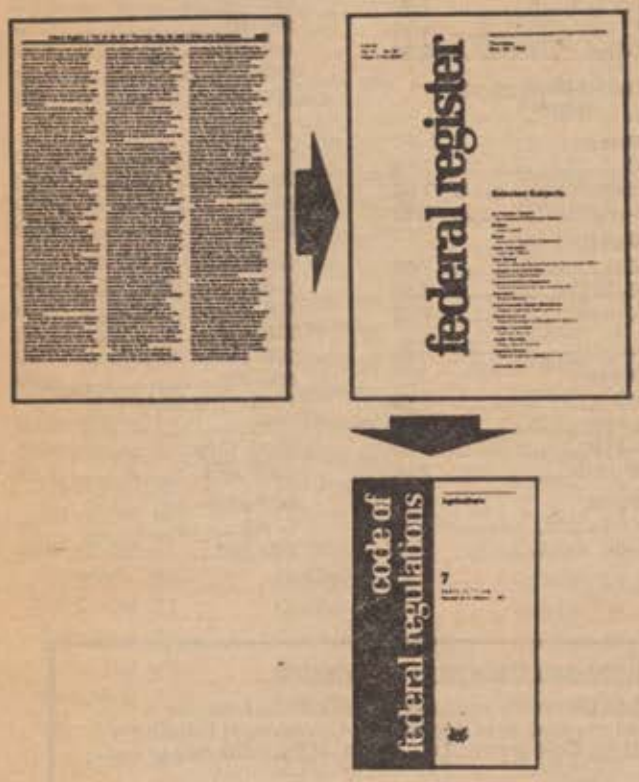
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